The Dawn of A New Identity: Aspects of A Relational Approach to Psychotherapy with A Transsexual Client

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The importance of developing a certain consciousness in which one is present and autonomous while being intimately interconnected with larger meaning is an important dimension of a relational approach to psychotherapy. Based on the premise that both client and therapist bring something of themselves and of their respective past emotional experience to the therapeutic relationship, a relational approach to therapy is very attentive to the dynamics in the therapy room. It stresses the co-creation of the therapeutic relationship at conscious, explicit verbal levels and unconscious, implicit levels of functioning, and establishes the therapist's emotional behaviour as a significant factor in fostering change (Aron, 1996).

Therapist responsiveness to client's affective impact is discussed with emphasis on its centrality to clinical practice and its relationship to countertransference. A case study of the psychotherapeutic journey with 'Dawn' (previously 'David'), a 53 year-old client who was awaiting sex-reassignment surgery, is presented which illustrates how the therapist's struggle in the countertransference represents part of a complex relational body/mind system of parallel processes, re-enactment and potential for therapeutic change.

What we call the beginning is often the end. And to make an end is to make a beginning. The end is where we start from.

(T. S. Eliot, 1944, p. 42)

Introduction

The complex inner world of each person is the unknown territory through which we accompany our clients on their psychotherapeutic journeys. Transitioning, however, is much more than a physical/superficial journey. Indeed the transsexual's relentless pursuit of personal transformation which includes an insistence on mutilatory surgery in order to address what is perceived as a discrepancy between their psychological sex and their biological and social sex could be considered in terms of an archetypal journey of life, death and rebirth.

Lothstein (1977) contends that to establish a therapeutic alliance when working with a transsexual client includes having an open mind about the possibility of surgery, a willingness to partially gratify some of the client's narcissistic needs, and recognition of the need to immediately handle the countertransference by interpreting the therapist's emotional reactions to the client.

Indeed, a therapist's responsiveness to client's affective impact is a topic that has engendered much debate for many years. That therapists do have affective

responses is by no means a new concept (Aron, 1996; Freud, 1912; Heimann, 1950; Klein, 1946; Mitchell, 2000; Mitchell & Aron, 1999; Ogden, 1979; Racker, 1968; Searles, 1979; Stolorow, 1996). Explicated under the headings countertransference, projective identification, mutuality or intersubjectivity, the literature offers widely divergent views about the meaning and handling of such material.

A relational approach holds that the transference and countertransference relationship is always co-constructed. The relationship between the intrapsychic and interpersonal is dialectic and evolving; there are two people, two scripts and two sides to the story in a psychotherapy process and, out of their meeting, many meanings are discovered or created:

The individual discovers himself within an interpersonal field of interactions in which he has participated long before the dawn of his own self-reflective consciousness. The mind of which he
becomes self-aware is constituted by a stream of impulses, fantasies, body sensations, which have been patterned through interaction and mutual regulation with caregivers. (Mitchell, 1993, p. 132)

So, based on the premise that both client and therapist bring something of themselves and of their respective past emotional experience to the therapeutic relationship, a relational approach to psychotherapy is very attentive to the dynamics in the therapy room. It attends to how the client and the therapist interact with each other; a 'shared dimension of experience' belonging to both client and therapist that has been given meaning and significance by the therapeutic relationship (Samuels, 1989, p. 173).

From this relational perspective the emphasis is not so much on interpretation and insight as on creating new relational patterns. In other words the client is seen as bringing to the psychotherapeutic relationship internalized relational patterns. Although old patterns are inevitably repeated, what is important is that the client has a new experience of relating based on a new relationship. From this perspective, interpretation and verbally achieved insights are relational experiences, and interaction is itself interpretive and conveys meaning. Maroda (1991) cites Watchel who contends that in the very act of participating the therapist learns what is most important to know about the client. Thus relational theory does not dictate a particular form of therapeutic activity so much as it insists on the recognition of inevitable and continuous participation. As Ferenczi in Aron (1996, p. 140) suggests: ‘The analyst, like an elastic band, must yield to the client's pull, but without ceasing to pull in his/her own direction’.

As the case illustration herein shows, it was through the intersubjective nature of our work together that understanding occurred. It demonstrates that my own thoughts, feelings, personal history and past experiences are critical to the way I understand and work with clients.

So underlying this relational approach are the questions: What did the client do and in what way did the client act that would evoke those responses in the therapist? What is there in the therapist that would respond in that way to what the client did? Indeed, several theorists emphasize the importance of the process by which the therapist is able to reflect on and verbalize the experience evoked by the patient (Aron, 1996; Ehrenberg, 1992; Ogden, 1994a). Aron (1996, p. 116) suggests:

A picture is worth a thousand words, and a patient's or analyst's actions can have a greater impact than some verbal communications. We have come to value a patient's acting out as an important communication, similarly an analyst's actions may at times be more valuable than their interpretations.

**Clinical Illustration**

For Dawn psychotherapy was not so much about exploring her gender identity per se, rather it was about reflecting on the consciously lived dynamic interplay between embodied and socially/personally constructed aspects of gender expression. When I met Dawn she had already chosen a gender role to live in and was on the waiting list for sexual reassignment surgery. However, feeling frustrated, stressed and depressed at how long the whole process was taking on the NHS route Dawn was going private. The surgery would be performed in just three months' time in Thailand and in the meantime, as Ettner (1999) would suggest, Dawn had presented herself for ‘gender loving care’.

Working relationally (Renik, 1993), I always have my feelers out for the implicit relational flow of the therapeutic interaction. I want to take in through my body sense the rich complexity of my experience of our interaction and also my sense of the client's experience of me and of our togetherness. Every relationship is unique and has its own path of development - its own style, rhythms, rituals and flow. Being present requires me to be open to each person's way of connecting; ready as a good dance partner to come in quite close or allow space, to flow from feisty engagement to tender, quiet listening - from welcoming the stories that want to be told to me, to encouraging the slower pace of focusing reflection. I want to welcome and receive as many strands of the implicit relational intricacy of our interaction as I can, so in effect I open a space and wait to see what will fill it. We think of deepening therapeutic process by responding to affect, but these feelings embedded in the content are not only distinct, clear emotions; they are a complex union of affects, thoughts, body sense, memories, expectations, etc.

Lothstein (1977) suggests that when working with this client group the initial contact is quite revealing as the verbal and nonverbal reactions of the therapist to the outward appearance of the client alternatively reveal and conceal the specific affects which will either impede or facilitate therapeutic work, and Dawn really tested my ability to be fully present. From our very first meeting I struggled to feel fully comfortable. I was aware of a little niggly feeling deep in
the pit of my stomach. I initially put this discomfort down to anxiety about my limited experience of working with a transsexual client. However, bearing in mind Cohen's (1952) assertion that the therapist's anxiety might be expressed in a variety of ways including unreasonable dislike for the client, my discomfiture was closely scrutinized in both supervision and personal therapy. Yet, at the same time, Dawn was easy to be with. She was also desperate to be accepted by me. I quickly realized that having avoided this gender identity issue for decades she came with a mix of feelings: joyful relief at breaking her silence and being heard, a sense of long-awaited, unapologetic entitlement, guilt about the burden and shock this had created in her 19 year-old son, shame about the lies David had lived, regrets about what she saw as her now limited opportunities to experience an authentic life, and overwhelming self-doubts regarding her own capacity to transition acceptably.

Background

David's family of origin is probably most accurately described as being highly dysfunctional. He described his mother as a depressed, lonely woman who had strongly wished for the birth of a daughter. However, although David felt she encouraged him to be 'soft and cuddly like a girl', she did not wish him to be a girl. She did not dress him in girl's clothes (although she did leave his hair to grow long, much to David's delight). He became a feminized boy though not one with a clear feminine gender identity, an adolescent closet cross-dresser, a young adult with transsexual fantasies, pushed into marriage and parenthood to 'prove' his manhood.

The only adult figure with whom David felt any closeness in childhood was a grandfather who died when he was 8 years old which probably added to David's internal ambivalence about his gender conflict. I was aware that Dawn did not maintain eye contact as she told me that granddad had been a ‘real man's man’. I felt her choice of vocabulary revealed the stereotypical nature of his internal objects.

Dad was described as distant, womanizing and financially reckless, himself fatherless after his father died when he was 11 years old. Although neither parent was seriously neglectful or abusive, David often felt like a low priority in his parents' conflictual lives. As Dawn regaled me with her family history I felt quite breathless and could feel a huge lump in my throat. I could hear the barely contained contempt as she told me: 'I was never a "real boy" and my father wanted to make me one. He hated me for my lack of masculinity and showed his dislike, ridiculing my curly hair and the way I walked. I hated my father and I still hate him.' An additional complicating factor was David's conservative Catholic upbringing which also condemned his transgender self. When Dawn told me that her Catholic roots were characterized more by 'hellfire and damnation' than 'Jesus loves you', it gave me an opportunity to explore her associations to my suggestion that there seemed to be a lot of hurt and anger that had to be swallowed. It felt like the flood-gates had opened as Dawn spilled out her frustrations and agony in response to a childhood fraught with difficulties. Overwhelmed by mum's smothering delight in his delicate features and so determined to escape a masculine burden that seemed fraught with violence, competitiveness and disapproval, David imagined himself female - not female like his mother, but an idealized, more powerful, ultra-feminine version.

Ogden (2001, p. 106) describes how the unspoken and the unspeakable are present (sometimes in their absence) in the language that is spoken, in the manner in which it is spoken, in the sounds of the words and sentences, in the feelings elicited in the listener, and (in the analytic setting) in the behaviour and bodily sensations that accompany what is being said. I thought about the shorter life expectancy of the male lineage from which Dawn had come and the resultant internal object relations fight for dominance which was being played out. Internally, I was screaming silently with both horror and sympathy as I met what felt like the full force of Dawn's loathing toward the genitalia with which she had been born, and her envy of the woman/mother/therapist.

The Transsexual Picture
Gender identity is one of the most important things in everyone's life. The individual's sex is determined by genotype, phenotype (including gonadal sex determined by the internal and external sex organs), endocrine and metabolic status, psyche and birth certificate sex designation. Western culture is deeply committed to the idea that there are only two sexes; as feminist philosopher Jaggar (1975, p. 464) argues: ‘To be a woman is no more and no less than to be a female human being. All and only female human beings are women’. Transsexuals therefore breach one of the key taken for granted assumptions of gender - ‘that people are born into and remain in a single gender category’ (Garfinkel, 1967, p. 122). Transsexualism has historically prompted a diverse range of cultural responses including fear, shame and acceptance. Bornstein (1995, p. 101) points out: ‘The choice between two of something is not a choice at all, but rather a chance to subscribe to the value system which holds the two presented choices as mutually exclusive alternatives’. So, to seek to appreciate transsexualism is to witness the experience of difference.

According to Denny and Green (1996) clients usually seek out therapists just before transition when they are having trouble functioning in school, work or social situations; are confused about their sexual orientation; are depressed or experiencing substance abuse problems; or are engaging in fetishist behaviours.

West and Zimmerman (1987) assert that doing gender in a way that validates identity relies on both internal and external factors, and that being able to look like one feels inside is key to the contentment of many transsexuals. Transsexuals embark on a journey to alter their bodies so as to be seen by themselves and others as belonging to an identity to which they are deeply attached. Moreover, it is an opportunity to reclaim the real self where nature itself imposed a false self upon the person.

Winnicott (1965) described the development of a ‘false self’ in childhood which may be analogous to a repressed gender-variant identity. More recently, Scharff (1998, p. 90) asserts that: ‘Patients who seek sex-reassignment surgery generally have a deficient ego organization on the borderline, narcissistic, or even psychotic level’.

It might be suggested that there is little difference between a narcissist who seeks to avoid his ‘true’ self (and thus positively to become his ‘false’ self) and a transsexual who seeks to discard his true (birth) gender. The transsexual's self-preoccupation and self-objectification certainly could be seen as a grandiose sense of omnipotent entitlement. It is perhaps interesting to note that both narcissism and gender dysphoria are early childhood phenomena. This could be explained by problematic primary objects, dysfunctional families or a genetic or biochemical problem. Beitel (1985), however, proposes a view that the gender identity part of the self is split off during psychosexual development which results in the conviction, ‘I, a male, am she’. He contends that the desire for sexual transformation has unconscious roots manifested in conscious phantasies, behaviour, defences and ego adaptation in which the body is objectified in order to create a sense of identity. Furthermore, the splitting between the rejected body-self and other parts of the self is more about the splitting between good and bad objects than between male and female per se.

According to DSM-IV-TR (2000) Gender Identity Disorder (GID) is a psychosexual disorder whose essential feature is discrepancy between anatomic sex and psychological sex, with evidence of clinically significant distress or impairment in social, occupational or other areas of functioning. However, throughout the past 30 years or so, there has been much controversy surrounding the inclusion of GID into the DSM. Some claim that GID was added in to replace homosexuality which was deleted from the DSM-II in 1973 (Zucker & Spitzer, 2005).

Feminist and queer theories of gender developed in opposition to traditional biologically essentialist ideas about gender that served to maintain the dominant position of men over women in society. These theories emphasized that gender roles and sexual orientation were social constructs to which individuals could choose to adhere or not. The experiences of transgenders, however, suggest that gender identity is both embodied and personally/socially constructed, with life experiences providing the dynamic continuity and integration between
these two aspects of identity. This is consistent with an emerging transgender theory of the nature of gender that reconciles and transcends essentialist traditional, as well as social constructivist feminist and queer theories. Salamon (2010) makes original use of the notion of the bodily schema (from phenomenology) and the bodily ego (from psychoanalysis) to argue in the most persuasive and deft terms that the body's materiality assumes a form through a schema that provides for its articulation.

Reid et al. (1996) presenting the current medical viewpoint about diversity in sexual formation suggest that research will confirm preliminary neurological observations and the hypothesis that it is the human brain which differentiates as to sex. With this increased understanding of how gender identity is formed, some clinicians advocate the complete removal of any reference to gender issues in the next edition of DSM whilst others advocate a non-pathologizing inclusion that recognizes gender variance as a naturally occurring phenomenon requiring a combination of psychological and medical attention. This perspective sees gender as dealing with a core existential element in the human psyche and the therapist is advised to avoid the gate-keeper role as it is ultimately the client's choice as to which gender role they will choose (Vitale, 2010).

Indeed, France removed transsexualism from an official list of mental illnesses becoming one of the first countries in the world to do so. As a clinician, I am taking a stance in supporting the view that transsexualism is not, in and by itself, a mental illness. If choosing to support the client's choice - to have elective surgery in order to correct what they consider to be their incorrect gender - is seen as collusive with the client's fantasy, then choosing neutrality is collusive both with the stereotypical, transphobic society and disrespectful of Dawn. Indeed, Renik (1996) has written about ‘the perils of neutrality’, which serves to highlight how the issue of neutrality is not conceptualized, within relational psychoanalysis, in the same way that it may be in other schools.

David or Dawn?

As previously stated, Western culture is deeply committed to the idea that there are only two sexes; a person is either male or female. Efforts to force the assigned gender to ‘take hold’ are often what cause these ‘gender conflicted’ individuals to marry and produce children, all in the hope of burying or even ‘curing’ the transgender issue. And so it had been for David. Hoping to cure his gender issues, he married at the age of 23 a 19 year-old girl whose femininity he envied with irrational possessiveness. He succeeded in fathering a son and, although a good provider with his own business, the marriage disintegrated into a co-dependent existence where his wife wore the trousers and he became the victim of his wife's violent alcoholic outbursts.

However, following the death of his wife 12 months prior to commencing therapy and thus released from the need to ‘keep up the appearance of normality’, the gender conflict issue had become intolerable. This is in keeping with Lothstein's (1979) observation that some type of loss often precipitates the decision to seek sexual reassignment surgery along with the desire to be loved and admired as an attractive female and to receive social acceptance. It seemed that the sense of time slipping away had made reassignment surgery a ‘now or never’ decision. Add to this the decision to sell his business, David was in a position to pay for the operation instead of having to wait for NHS treatment, and the scene was set for the Dawn of a new identity.

In supervision I was glad of the chance to reflect on these issues. With my supervisor we thought about the importance of castration anxiety and vagina envy. In so far as both are about identifications with the mother, we also considered the possible impact of my being a female therapist. Dawn wants to remove his old man (penis) surgically and fulfil his wish to become a woman. He portrays his mother as encouraging him to become a woman and portrays his father as violent. He wishes to dis-identify with his father and identify with mother by literally getting inside her.

Would I become, in the transference, the mother who wished to feminize him and collude with his transitional journey? Would I be cast into the role model of the ideal woman of whom Dawn is envious and jealous? In vagina envy the determining factor is the envy of the woman's/mother's capacity for procreation and creating life. This envy is characterized by feelings of inferiority and may lead to destructive phantasy attacks on the mother's body and her reproductive capabilities. So were my feelings of discomfort picking up some of Dawn's projections as well as being about my own unconscious impulses? We extended our thinking to the more recent death of David's abusive wife from cancer of the womb and how this had given him the impetus to seek reassignment surgery. So, we wondered together, who is castrating/killing whom? We agreed that there is no wonder I have the sense of
something unpalatable when I sit with Dawn. As Dwivedi (1997, p. 44) points out: ‘We live immersed in narrative, recounting and reassessing the meaning of past actions, anticipating the outcome of future projects, situating ourselves at the intersection of several stories not yet completed.’

**The Transitional Space**

Dawn's first session had been a true test of courage. To be able to have the reassignment surgery David had to prove himself able to live in the real world full-time as a woman. Stepping out in daylight dressed as a woman was a whole new way of existence for him as he had never ventured outside in female attire before although he told me he had often worn feminine undergarments (bra, panties) in public. Dawn's nervousness had been tangible as she sat opposite me. Her greatest physical handicap at that time was the dark stubble that she battled to cover up with seemingly layers upon layer of makeup, giving the impression of a clownish exterior. I did however feel she had gone to a lot of trouble with her appearance from the stylish wig, designer clothes to the co-ordinating nail varnish and sparkling jewellery. It seemed Dawn was determined to make the most of every feminine adornment possible. So in our early work together, mindful of the fact that she seemed eager for me to admire her careful presentation, I met Dawn on the surface. Indeed, Lothstein (1977) has commented how in the early stages of transformation many male-female patients convey a freakish appearance while experiencing intense narcissistic needs to be admired by the therapist. Voice training had helped moderate Dawn's voice into a pleasant sounding contralto, so why did I struggle with feelings of revulsion? Where was this feeling coming from? Was it all mine? No. But it took time to understand these feelings. What Dawn is most craving to possess, a natural vagina, also highlights David's active wish to have something introduced into his body; but at whose cost? It seemed both abused and abuser were tangible presences.

We must tune into the nonverbal expressions of 'unverbalized' experience. What cannot be said will tend to be evoked in others, enacted with others, or embodied. We must therefore attend to our own subjective experience, the transference/countertransference enactments we co-create with our clients, and the language of emotion and the body - for all these are routes to accessing and eventually integrating disowned and dissociated experience; Indeed, for Winnicott (1969) the therapist's task becomes to provide a holding environment for the client so they have the opportunity to meet neglected ego needs and allow their true self to emerge. One of the most important attributes of the therapist is simple patience.

If only we can wait, the patient arrives at understanding creatively and with immense joy …

The principle is that it is the patient and only the patient who has the answers. (Winnicott, 1969, p. 711)

Ogden (1997) describes how the apparently random images that come to mind during sessions can be surprisingly illuminating. As Dawn regaled me with stories of learning how to apply makeup, of shopping for clothes and trying on new shoes, I could not help but think of an advert with the theme 'here come the girls' and, due to its playful quality, I decided to share it. Certainly Dawn was tickled pink by my disclosure seeing it as validation. It also led her to talk more openly about where she currently was, where she wanted to go and what she needed to do. In an emotional outpouring she owned her revulsion with her 'male' parts and her inability to conceal the hated bulge. ‘I loathe all this,’ she told me, pointing downward. ‘It does not belong to me; it must go and the sooner the better; I can't wait.’

So our journey together continued sitting with these uncomfortable 'objects' in the room with us. This was a period of work together filled with confusion, conflict, guilt, panic and a sense of Dawn purging herself from David.

My own feelings of repulsion were never far below the surface. Even when she became tearful telling me how difficult it was for her seeing other women and knowing she could never be quite like them, I found it hard to feel compassionate as I could not help but also be aware of Dawn's frequent covert glances at my breasts when she spoke. Part of me felt repelled and angry but I was also aware of a sense of superiority quickly followed by shame as I was transported back in time; Bollas (1987, p. 202) suggests that: ‘In order to find the patient, we must look for him within ourselves’. I remembered my own envy of my peers when at the age of 15 years I was still flat-chested and they all seemed to have beautiful, large breasts. Well, I am not flat-chested now and, although Dawn is not an adolescent girl, she is however receiving oestrogen medication, which should help the development of breasts. This reminded me that therapy also needed to speak to Dawn's real-life everyday needs, supporting her to meet
change and transformation with consciousness and grace. So we talked about how bodies change, thoughts change, emotions flow - there is no final form of any aspect of life. Naturally there was an eagerness to get on with her 'new self,' right now. Her impatience was tangible and it felt like she had become obsessed by her body form, down-playing or even missing other mental, behavioural, social and emotional aspects.

Sessions generally began with Dawn eager to talk about her week. On one occasion she talked about her surprise and annoyance in finding how emotional she felt winding down her business. She was now finding the manual aspect of this exhausting.

As she talked I was distracted by the sound of an aeroplane overhead. The question begging an answer is why did I need to distract myself at that particular moment? What didn't she want me to know or what did she want me to avoid? What could I not bear to witness? What must always be left unacknowledged, unformed, unsaid or isolated as dissociated material? What was too painful to feel? What really longed to be understood? Most usually those very thoughts and images have something to do with what is going on within the client's mind-body, not just by the client, but also by the therapist and therapeutic dyad.

So now I sense that Dawn's thoughts or feelings are defensively taking flight, or cannot yet be verbalized. This prompted me to ask what thought or feeling just took off. After a moment during which she stared really hard at me; it seemed almost psyching me out or testing how much she dare say, Dawn told me: 'I can't stand being so emotional and weak'.

'And feminine?' I reflected.

'That was below the belt.' (I sensed from the tone of voice and injured sense of injustice that it was David who jumped in with the spontaneous retort. Although not intended to hurt, my comment had indeed hit a sensitive spot.)

I could see how tense she was yet I was ashamed to notice that I was finding it hard not to laugh. I took the risk of speaking to this contradiction of attitudes between us and, to my relief, she laughed too. Having been able to see the funny side of it we become a bit more serious again as we thought about how there is both male and female in everyone - as well as a victim and abuser.

Dawn could now see how bringing the previously vilified male aspects of her character to the fore could be helpful in this stage of letting go of her business, being able to 'stand firm' in the face of harassment by a potential buyer trying to take advantage of what he sees as a vulnerable 'queer', a push-over.

The winding up of the business proves far more painful than she had expected and we spend several sessions picking our way through the emotional up-heavals. On one of these occasions Dawn arrived particularly exhausted and proceeded to sit yawning telling me she felt like she could sleep for a week. Looking at her drooping eyelids as she struggled to stay awake, I found myself thinking maybe she would like a bedtime story.

I shared my thoughts with Dawn and without a moment's hesitation, almost as if the clock had been turned back and I was sitting with the young boy, David, she told me that his favourite story when he was younger was 'The Ugly Duckling (Hans Christian Anderson, 1843, in Tatar, 2008). According to Carl Jung (1964),

we have a favourite story that goes with us throughout life. By connecting clients to their cherished early stories, the therapist can highlight the means for coping and problem-solving and suggest to one still struggling that they too can discover solutions to problems. Fairy-tales define elements of experience related to personal concerns, such as emotional development, side-by-side with problems of self-identity, giving voice to common experiences shared by one and all. It is part of their universal appeal. Yet they can also be said to be uniquely tuned to the perspectives of difference. Although fairy-tales take us into an imaginary realm, the world of reality is interconnected. The story of the ugly duckling is beloved around the world as a tale about personal transformation for the better. It tells of a homely little bird born in a barnyard who suffers abuse from his neighbours until, much to his delight (and to the surprise of others), he matures into a graceful swan, the most beautiful bird of all. Transformed into the swan, as the lucky duckling is, communicates different levels of meaning. Because such original experiences take place on a level of being not yet available for conscious interpretation, or even preconscious integration, it can be likened to trauma itself, also the fact that the symbol of the swan has come to be seen as an image of Hermaphrodite, the androgynous Greek deity in which masculine and feminine no longer stand apart. Meeting with the reflection in the fairy-tale pond is, so to speak, the recognition of one's own true Self; it also mourns the most problematic aspect of Dawn - her acute awareness of her gendered self being discordant with her biological sex. I point out that the story of 'The Ugly Duckling', as such, is perhaps a fitting therapeutic metaphor charting a course through the difficulties faced by Dawn as she transitions; it thus gives voice to a powerful vision, symbolically representing the full range of
problems and possibilities inherent in the understanding of transition. However, as Lothstein (1979) asserts: ‘There is little chance that the aging patient will be gratified by admiring looks and glances when cross-dressing or masquerading as a woman [and] greater likelihood of public ridicule and harassment’ (p. 434).

No wonder then that Dawn has put all her faith and future into the hands of a surgeon so that her body would at least resemble those of the sex to which she feels she belongs and to which she ardently wants to belong. For most men or women, it is almost inconceivable that anyone should want to change the sex or gender into which he or she was born, especially by such radical means as major surgery. Therefore, it is extremely difficult for a transsexual to find understanding, sympathy and, most of all, empathy. I must admit I was again struggling with this issue. My revulsion was hard to contain at times, especially when given graphic details of the surgical process that was drawing ever closer. I felt there was something almost sadistically abusive in the way it was told. Did Dawn intend to repulse me, or was there some other process at work here?

The body-mind speaks many languages from the behavioural to imagery to words. Within the intersubjective sphere of the transference-countertransference milieu, we work to access and decode the many communications that we receive in the service of our clients. Ogden (1994b) defined this working, overlapping ‘we’ space as the ‘analytic third’. He described how he tracks the moment-by-moment interplay of the oscillating therapist-patient engagement in this intersubjective matrix. Its prototype is the mother-baby unit of infancy described by Winnicott (1960) and the emergence of transitional space, yet it is more nuanced and complex because, while we are interacting with what we call the ‘analytic baby’, the more archaic components of self, we are also with the more intellectually developed adult. We have to track on all levels. We sit with a client, listening and observing with all our sensory organs until we begin to grasp something. What we experience is not yet fully formed; in fact, it may be as unformed as our client's subjective experience. We scroll through the session without knowing what we will find, without preconceived expectations, ‘without memory or desire’ (Bion, 1970) until we begin to form our own associations. We have an impulse, a strong feeling, an aversion, a sensation. And this is how we begin to work in the place where you and I overlap and become ‘we’. This is the transference-countertransference influence.

As Dawn continued to regale me with information about how her ‘new vagina’ would be fashioned by inverting the skin from David's penis I became aware of a piercingly sharp pain in my own vagina. Momentarily I was transported back to a painful surgical procedure I underwent years before. This body memory was very much alive and resonating with Dawn's expected experience; the difference, however, was I would have preferred not to have the operation whereas Dawn is choosing it. So both scenarios represent a conflictual process. Now I could begin to make sense of my revulsion and discomfort. Aron (1996), Davies (1998), Jacobs (1986), Levenson (1983), Mitchell (1988), Ogden (1997) and Renik (1996) suggest that unless the client and therapist enter one another's emotional world, as active participants in creating and interpreting another's lived experience, the relational matrix that comprise the psychotherapeutic factor fails to emerge. Without an emotionally engaged therapist, treatment is never fully realized. Moreover, the emotional experience of the client cannot be understood apart from the emotional experience of the therapist and vice versa.

It follows that the therapist is not simply responding to the client's emotional behaviour. In adapting to the therapeutic situation, the therapist is also initiating emotional behaviour in moving toward actualizing his or her own intentions, goals and prejudices. At the same time, the client is similarly trying to get the therapist to acknowledge the client's own emotional states and intentions and to respond in a particular way. These affect-laden negotiations between the client and the therapist not only define the therapeutic interaction, they also determine the therapist's emotional behaviour as a significant factor in fostering change. The experience of the therapist is not an exact replica of the patient's projected internal self or object-representation; the analyst's subjectivity lends a new element to the recreation of the past and the present, what Ogden (1994b) would call the ‘analytic third’.

Whilst I did not think it was appropriate to share my newfound understanding in its entirety with Dawn I was, nevertheless, now able to support her therapeutic journey more ably in a way that attempted to integrate the rejected and un-owned aspects. The core of the analytic process, in Ogden’s view, is the dialectical movement of subjectivity and intersubjectivity. Just as Winnicott (1960) noted that an infant cannot be conceptualized apart from a maternal environment, Ogden (1994a, p. 63) has made a similar point regarding analysis:
There is no such thing as an analysand apart from the relationship with the analyst, and no such thing as an analyst apart from the relationship with the analysand.

**Conclusion**

How is it that change happens in psychotherapy? One response to this simple, yet truly essential question is that movement towards healing and wholeness is born out of being with what is in the present. In the clinical situation, relational therapists continuously track both the client's subjectivity and their own. The relational matrix is understood to involve mutuality, conflict and co-creation. Overall, the aim of relational psychoanalysis is to enrich the patient's experience, to expand the client's degrees of personal freedom and to examine the enormous complexities of the mind. Working with Dawn has certainly been a journey of discovery for both client and therapist. Dawn did present with many of the characteristic historical factors common to transsexual clients. As ‘David’, the death of his grandfather in latency, his distant father who failed to protect him from the feminizing urges of his dominant mother, his idealization of female roles and functions as well as the death of his wife a year before commencing therapy were all important considerations during our work together. Although this account of our journey together reveals, by the unavoidable limitations of the often protective ways we organize and make sense of our experiences with others, only some aspects, I believe it does adequately illustrate how the countertransference is amplified when working relationally with a transsexual client.

As a growing body of clinical writing and research shows, the complex relational tones within each therapeutic relationship are expressions of the ever-present processes of mutual intersubjective influence that occur with or without our awareness. Indeed, the realization that out of awareness we always respond to the other's communication, thus inevitably and nonconsciously becoming engaged in various levels of enactments, is no longer in doubt (Aron, 1996; Ginot, 2007; Schore, 2005; Stern, 2004; Watt, 2003).

Beisser (1970) suggests that it is not possible to change something about ourselves by trying to be different. We change when we become aware of what we are as opposed to trying to become what we are not. We are required to be present with all our thoughts, sensations and feelings - and also to extend this to those aspects of our clients. It is from within this connection that our shared humanity emerges and blossoms, resulting in a moment with the potential for change. I strongly believe that the challenge comes when some of our clients give us the opportunity to do the real in-depth work they require of us. To do it we must have first done that work for ourselves. Then, in order to understand the depths of the co-created space in the now and to bring about real change, we must inevitably rely on the relationship we build between us. We gradually form an in-depth understanding of how that mind, that self, that person has been created on their journey through life before coming to therapy.

**References**


