A Reflection on the Subjective Transgender Experience in Healthcare Context: Emotion and Identity as Figures of Life Course

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Abstract

Our experience with transgender individuals in healthcare is based on a psychological path, where the needs expressed by individuals are considered in the perspective of the life-course. Comprehension and attention on psychological figures are considered as the expression of identity, desires, and life projects. The current evolutions of the phenomenon open doors to the possibility to reduce the distance between sexual and gender identity, also considering the social role and all the interactions that people experiencing gender dysphoria have in their social interactions. This work has considered important guidelines suggested by the American Psychological Association, to share our experience on the themes of identity, affectivity, and psychological phenomena involved in the clinical relationship.

1. Background and context

Our experience in the field of the lesbian, gay, bisexual, and transgender (LGBT) population is referred to individuals experiencing gender dysphoria (GD), requesting our intervention as a service of Clinical Psychology in the healthcare context of the University Hospital G. Martino of Messina, Italy. Our collaboration with Endocrinology is the first necessary step for people requesting to begin the path of hormonal and surgical gender reassignment surgery (GRS).

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Some of the contributions of the Italian network on transgender health, in which our practice is based, have served as a robust methodological basis and model for a proper practice with people asking for our assistance. In particular, we are referring to "Guidelines for Psychological Practice with Transgender and Gender Nonconforming People" from the American Psychological Association (APA, 2015), in their Italian adaptation provided by Valerio *et al*. (2018) and affirmative practice (Scandurra *et al*., 2019).

This contribution would express what can be considered in line with the abovementioned research and what may be the core of the clinical practice, regardless of orientations or theoretical perspectives. Actual nosographic considerations open doors to the theme of the subject's experience of discomfort (DSM-5), instead of considering the phenomenon as a disorder (DSM-IV). Our choice to take into account the APA Guidelines (2015) is based on our psychological and phenomenological perspective, close to the consideration of subjects' realities as representative of their experience and their necessity to assimilate with society.

The reality we are talking about puts us in contact with some different perspectives, such as the social consideration of the delicate phenomenon of transgender individuals, the background of healthcare workers, the scientific state of the art, law, and others. Our point of view is above all clinical so that the central theme we would like to introduce is the 'clinical contact'.

Our need to address this theme needs a clarification about involved figures, such as sexual identity based on the biological sex (Signorelli, 2014), gender identity referred to as a persistent perception in line with male and female sex (Simonelli, 2002), and social role as a central theme in expectations, emotional reactions, and approaches experienced through society (Beemer, 1996).

This reflection is aimed at highlighting the adaptation process of transgender clients in our institutional healthcare context, as conditioned by the main phenomena that emerged in our clinical experience.

2. Basic phenomena involving emotions and identity

What should emerge refers to the basic phenomena, as suggested by Gallagher and Zahavi (2008), citing Thompson (2007). According to these authors, we suggest a study that consists of a description, an analysis, and an interpretation of experience, in the specific case linked to corporeality (Varela, Thompson, and Rosch, 2017). In this specific case, our attention is directed to a peculiar form of dualism and to what emerges from its impact in relation with others.

We assist in the need of contact among parts, as listed earlier, a central theme for the word 'clinic'. Whether it is referred to just the subjective experience or to social phenomena, contact is one of the main categories to be mentioned. Our clinical practice provides a form of contact that is articulated according to a continuum that goes from direct communication to psychometric measures and projective practices. More specifically, the distance between a clinical interview and the test administration is relevant. In accordance with our orientation, we always prefer direct contact, which is the main scope of clinical practice. We understand that some practices may be required by institutions (as in the case of psychometrics).

Our orientation foresees that the difficulties that subjects may have in providing information about their psychological states can be avoided through the effective use of certain phenomena, common to states of health and pathology. This is the case of paraeidolia and apperception, which are the basis of two of the most renowned projective tests, which are discussed below. The specific phenomena on the social and subjective experience of transgender people will be further discussed later on in this paper; for now, the necessity to express our perspective is linked to the difference between two faces of contact: the perception of phenomena and their representation.

From a phenomenological point of view, through the way of "going back to the things themselves", Husserl (1900-1901: 267) meant a necessary study in which the central phenomenon of experience figures as a comprehensive foundation. The *epochè* throws the foundations through which starting from the experience itself will be possible to provide an accurate description, both referable to perceptive phenomena, as well as to imaginative fragments and in several cases fragmented imaginations.

In our opinion, it is possible to postulate a transposition between distances. The evident distances between sexual and gender identity can be considered in our experience as a form of dualism typical of gender dysphoria. Our transposition refers to the distance between representations derived from the perception of a body image and those related to the desire of the experimented gender.

The themes of corporeality (i.e., 'body memory', according to Fuchs (2011) and Koch (2012)) and embodied cognition (Shapiro, 2010) highlight the role of the body as involved in every single activity and proposition. In this sense, the relevance of the first transposition for sexual and gender issues can be explained better. All individuals in their own experience filter the incoming reality depending on its fundamental phenomenological basis. In our experience, we assist to this fact, depending on the phenomenon we choose to consider. In the case of the paraeidolia, we can reach the intimate emotive resonance of representations (Erlebnistypus-Rorschach); we analyse the more reflexive figures of the embodied mind and body memory, through apperception.

In terms of the social impact of these issues, a previous example of this difference can be testified by the 'distance' between the stigma and internalisation phenomena. In particular, beginning from the first topic, we assist to a psycho-social process coming from the majority of the population towards minorities (Link and Phelan, 2001), highly experienced by transgender people with adverse health outcomes (Scandurra *et al.*, 2017a).

The second perspective is linked to the representational dimension, where the individual has the necessity to build images of absent objects. In line with the dynamics of desire, the void represented by the absence of biological connotations (referred to the perceived gender) generates representations and fantasies. The role and the particular articulations of such fantasies represent another face of the above-mentioned dualism: a psycho-traumatic connotation of perceptive sexual identity (Settineri, Frisone and Merlo, 2018) and the opening resulting from the possibility of creating fantasies close to gender identity.

2.1. Dualism and emotions

The natural development of emotions starts from proto-emotions to arrive to emotions and, then, feelings. Every time we assist to a strong and rigid response, even in social terms, the path is inverted: the response is stronger, and the emotion involved is more ancient.

Considering emotions as a central factor in relationships is not a new point. Here, we are introducing this perspective in order to build a transversal vision based on common phenomena, both social and subjective. We know from a classical phenomenological perspective, that when there are not enough elements as a foundation to build an acceptable statement, we find prejudice (Jaspers, 1913). Moreover, when a strong emotional core serves as a strong basis for prejudicial elements, we are facing a complex, with a specific emotional connotation. In this regard, we consider a real social evolution of representations when images and elements related to a phenomenon are closer to a mature emotional organisation than to typically ancient reactions to unknown phenomena. This 'concordance' towards non-conforming realities is not present in previously mentioned reactions, such as stigma, sexism, and the internalisation of transphobia or homophobia (Scandurra *et al*., 2017b).

We believe that health professionals must be aware of the basic phenomena linked in our case to gender dysphoria. This constitutes a basis through which prejudice can be avoided. What has been argued is useful for proposing some knowledge and a study of the relationships among the body, mind, and environment, defined as 'embodied' (Shapiro, 2010). This approach is necessary in order to clarify what happens in the case of embodied cognitive experience and significant discrepancies, involving the whole experience and adaptation process. We are faced with a possible adaptation passing through body transformation, and we assist to the attempt to solve a discrepancy between sexual identity and gender identity, dimensions that involve the classic body-mind problem, not in metaphorical terms.

Healthcare workers and academic scholars are not excluded from prejudice and not separated from society. As previously reported, the appreciated guidelines report different statements close to the necessity to foresee proper and non-discriminatory assistance, as a real commitment against discrimination based on knowledge. An example regards the 4th Guideline (e.g., "Psychologists are aware of how their attitudes about and knowledge of gender identity and gender expression may affect the quality of care they provide to TGNC people and their families"): as the lack of competence could affect the quality of care for the single individual and for the population in general, it could affect the quality of research and deny the publication of scientific articles.

We are now reporting this experience in general terms because our intent is only to testify the weight of such guidelines. In specific, a study about proto-emotions in gender conforming and non-conforming people has been judged as discriminatory because of the term 'disgust', content and well-known as a proto-emotion. In the academic world, as for society, the mechanism does not change, as an example of an institutional barrier to knowledge.

2.2. Identity and transformation

It should not be forgotten that the study of the human being always provides relevant information even in the case of non-recurring profiles. This applies both for general classification and for single case studies. The possibility that state law offers to individuals the

opportunity to change their civil status can be considered as a progress in the field of rights. From our perspective, it also becomes a change to implement knowledge about themes such as identity, gender identity, sexual orientation, social role, etc.

Moreover, individuals experiencing GD who come to our attention no longer consider themselves as affected by some illness, except for independent phenomena that can happen to anyone. The obligation of psychological observation to exclude the secondary status (for example, the psychotic one) offers reasoning opportunities to the processes of the transformation of choices. The psycho-diagnostic procedure reveals something that goes beyond the usefulness of mental health for the guarantee of the integrity of consciousness.

We know the impact of dualism. Despite the legitimate scientific efforts aimed at highlighting the unsustainability of a similar cognitive modality, the persistent permeating capacity of dualism is evident. This can be referred both to the general distinction between mind and body and to this specific case. The disharmony or dissonance, in terms of dimensions, can emerge from the totality between the active parts, or from the partiality of precise objects. Our case involves a desire for bodily transformation.

Identity leads to the process of the formation of one's own image; from the clinical point of view, the process can be observed from three distinct perspectives. The first refers to the formation, the second to functions and contents, and the third a synthesis between the previous processes (Weinryb, 1991).

The role of what Merleau-Ponty (1962) called *schéma corporel* is relevant for identity, as we found in reference to psychosomatic conditions. Thus, we distinguish the *schéma corporel* closer to representations, from the body image closer to perception. The weight of this clarification is expressed in the phenomenological perspectives by Husserl (1962) and Merleau-Ponty (1962), later taken up by Clark (1997), Varela (1991), Thompson (2007), Thompson and Varela (2001), and Sheets-Johnstone (1990, 1999). The phenomenology of the body includes among its contributions those of Sartre and Merleau-Ponty.

In the psychosomatic study previously mentioned, we treated the experience of two very different clinical realities, such as post-myocardial infarction patients and patients with psoriasis. With Rorschach's paraeidolia and the study of phenomenological evidence, we reached these two different ways to experience the body and its subsequent effect on identity. In the first case, the infarcted patients experienced stronger difficulties due to inner body representations (heart-tissue damages). This result was closer to their representational world and their way to approach representations. In the second case, the patients with psoriasis have shown more difficulties linked to the significance of their skin damage. We have distinguished these different realities as two expressions of representation and perceptive difficulties related to identity, respectively emerged through the Rorschach (paraeidolia) and linked to the Body (infarcted) and Self (psoriasis).

The research on the body image and the *schéma corporel* has clarified some fundamental points, such as intentional elements involving identity: (1) the perceptive body experience; (2) the conceptual understanding of the corporeal subject (scientific or common sense); and (3) the emotional attitude.

Merleau-Ponty's contribution on the *schéma* includes a pre-reflexive dynamic, at the centre of the phenomenological treatment in continuity with the body representations emerging from projective methods. With reference to methodological analysis, it appears to be linked to basic natural phenomena and transversal to human experience, as in the case of paraeidolia with

Rorschach (Jaspers, 1913; Rorschach, 1921) and in the case of apperception (Herbart 1776-1841; Lange, 1893, in Stout, 1896).

The history of transgender individuals we assist shows that the perception of their gender identity condition is quite early and perhaps accessible to the autobiographical memory much earlier than it usually happens. The emphasis here is on the objective body image deriving from the external genitalia, an operation that is biologically and genetically determined and linked to the maturation processes.

The fragmentary nature of the image will find unity only in that possibility of synthesis in what Lacan calls 'mirror stage'. We have a notion of this fragmentary nature through experimental projective methods where the answer in front of the paraeidolia is far from a unity and different from phenomenological psychotic facts as for *spaltung* (Settineri, Frisone and Merlo, 2018). More specifically, we support a dimensional phenomenology of fragmentation phenomena, which is therefore far from the consideration of presence-absence of the phenomenon, as for the first studies on *spaltung*. As for the *spaltung*, we are witnessing manifestations of phenomena that were considered under the exclusive domain of operations without contact with reality. A striking example concerns the phenomenon of the illness denial, where the manifestation of the denial does not exclude the rest of psychic functioning but takes on its meaning and function, relative to the experience of illness. We have knowledge of this phenomenon, in the chronic forms of more or less disabling diseases, as a psychological manifestation of overcoming simple denial, very widespread and clinically relevant (Livneh, 2009; Nowak, Wańkowicz and Laudanski, 2015).

It is in the world of anatomical responses, for instance, that the representations of GD can be connected to an attribution of the meaning of reality. In other words, through paraeidolia, the individual manages with difficulty in the attribution meaning, reaching categories close to common sense and sublimated creativity. The recognition of eternal sexual characteristics is an aesthetic fact that generates anguish in the individual in the meaning of '*unheimlich*' (i.e., 'disturbing', 'ambiguous'): the first anxiety is then generated by the somatic encounter found in the aforementioned German word different translations that mask a difficulty that science has in front of something not clearly describable.

Probably, in the GD, anxiety arises in the moment of recognition, a time that has different dynamics between biological phenomena and consciousness. In this case, we reach an example of non-conforming images, in line with sexual and gender identities. As the basis for the subsequent emotional experience, the above-mentioned components can reflect the traumatic role of images in the constitution of dualistic bodily experiences. The word '*unheimlich*' is still convincing, considered from different angles and from different languages, but in the particular case, it refers to feelings that are common for individuals experiencing GD.

The origin of uncertainty and its disturbance arises in the conflict between biological aesthetics and their desire. It is not an intellectual uncertainty, much less a Cartesian doubt as of a symbolic substitution, which also occurs at a level of awareness. Of course, the individual knows what their biological sex is; we are not in front of a cognitive deficit, but we are facing a feeling of strangeness and, at the same time, typical condition of double.

3. Psychological-phenomena as a base for research

From a phenomenological point of view, we consider this phenomenon as one of the many ways of being in the world, as Binswanger (1973) described the concept of *Dasein* coming from Heidegger. On this point, Vitelli (2015) suggested the phenomenological study of the discrepancy among the abovementioned dynamics, considering the psychic functioning and the experience of the subject. In these terms, GD cannot be considered as a mode of failed existence. As suggested by Vitelli (2015), thanks to the encounter supported by clinical experience, the closure that makes a failed existence is in these terms far away. Moreover, we consider as relevant the possibility to reach those representations linked to desire. Even if only representational, for us, this form of contact can be considered as a form of encounter, dependent on the resolution of dualism. Furthermore, this result may consist of the passage from the representational desire to the perception of a new existential possibility due to the transition. The study of every individual we meet allows us to comprehend this point. A comprehensive approach, in fact, must take into account the difference between understanding and comprehension, explanation and comprehension. In some previous research, we clarified our way to approach this phenomenon, as closer to comprehension than to explanation (Settineri *et al.*, 2016).

Starting from the phenomena involved, we are referring mainly to paraeidolia and apperception. Referring to Binswanger (1946), phenomenology arises its commitment beginning from the subsequent statement: the consideration of the human being in the world through empathy, eidetic, and comprehensive dialectic. This perspective must take into account the state of *homo existentialis* more than *homo natura*. In 1946, Binswanger cited the Rorschach method, referring to the possibility that a method can reveal the subject's world and Self, as a form of existence (*Dasainform*). Being in front of our clients, for us, it is a clinical moment in which it could be expressed, as for the *Erlebnis*. To this end, in a previous article (Settineri, Merlo and Mento, 2017), we highlighted how answers to inkblots can be considered as representative of forms of consciousness and of Ego manifestation. In our experience, desires go beyond what have been defined as symptoms. The ending of the work suggested the need to get closer to the study of more complex representations such as those of the Self and the Body. For this reason, last year, we conducted research directly referring to Self and Body, with particular attention on the role of such images on identity (Settineri, Frisone and Merlo, 2018). We used the word 'psychotraumatic' to point attention to the relevant role of images referred to the transformation of identity.

The abovementioned mirror stage can serve as a comprehensive example of the discrepancy experienced, then testified by sexual and gender diversity. We found that body images were the basis of discomfort then transmitted to a more global representation of the Self. To comprehend this state and this impediment, it is in our experience through which we establish a clinical relation with transgender individuals, involving the possible links with psychodynamic psychology, that need a constant historical reconstruction of theoretical approaches (Vitelli, 2018) to be adapted to clinical practice.

4. Conclusions

As suggested by the Institute of Medicine (IOM, 2011), the psychological work with LGBT people must take into account at least one of the following perspectives: minority stress, intersectionality, life course, and social ecology. Our experience is close to the analysis of life course and the related subjective experience, as transgender individuals subjective experience is a way to express a project useful to reach integrity far from the discussed dualism.

In conclusion, we would like to consider our reflection as a suggestion about the certain advantages coming from the perspective of clinical contact. The possibility given to transgender individuals, in our experience, was not just a psychological or clinical occasion. We are referring to Self-narratives coming from our clients and to the comprehension of the richness of human contents around us expressed as Narrative Identity (Bourlot, 2018).

The intent to discuss the relevance of the dualism often encountered in transgender individuals was aimed at highlighting the openness deriving from the expression close to gender identity. Our aim was to report our experience and to suggest how important it could be to point out this phenomenon. In our opinion, the professional figures involved in the healthcare contexts should consider the relevance of such phenomena.

Keywords:

transgender; gender dysphoria; emotion; identity; LGBT; life course

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