

Affective symbolizations of the meeting between a psychologist and a transsexual: textual analysis of reports between clinical practice and context of intervention.

by Valentina Boursier*

«A physical trace that is more than a record for the memory. It is rather a sort of “photographic evidence” of psychic panoramas, but also holograms of experience, emotions, and persistence of the thoughts aroused: little networks designed to maintain the power of the evocative memory, including all the elaborative and theoretical references branching out from the words heard. Not exactly recordings and not yet narrations, and yet able to reproduce at each re-reading that “meaningful uniqueness” of form and meaning that was impressed on the mind, when listening».

(*La trascrizione clinica: sul prendere appunti*. Vigneri, 2002).

1. Introduction

In clinical psychology the activity of reporting is often a fundamental, indivisible part of clinical work, closely connected to it as a reflection on the practice (Lancia, 1990), orienting the intervention and explaining change. Insofar as suspending action and pausing in a space of potential signification makes it possible to reflect on events, the activity of reporting becomes a tool for exploration, a vehicle of knowledge and understanding of the self, the other and the relationship (and of the context establishing the relationship) between oneself and the other person. But ‘reporting’/‘giving an account’ (in Italian ‘reso-contare’) seems to embrace different shades of meaning, depending on whether the scales are tipped more towards the first or the second factor, towards the ‘giving’ or the ‘account’. The Italian ‘resoconto’ comes from the Latin ‘rendere’, once ‘reddere’, transformed under the influence of ‘vendere’ (sell) and ‘prendere’ (take) (cfr. Cortelazzo & Zolli, 1999), and it means “giving”, but also “representing, expressing, describing, translating”. So, while on the one hand there is the implicit reference to the dimension of the relationship entailing an exchange of giving and taking, and at the same time there is an aspect of evaluation or result, both in terms of debits and credits¹, on the other hand, there is the implicit idea of an expressiveness underway, a progressive unfolding. Yet again, thinking about the value of an ‘account’, what happens enriches the idea of a communication which, being transmitted, becomes a story. As a “detailed narration”, with the intent of accounting for (giving back, translating, telling) something to someone, the report therefore contains in itself sender and addressee, subject and purpose, text and context.

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¹ The Italian ‘resoconto’, synonym of ‘rendiconto’, in the old meaning concerned the act of ‘rendering accounts’ (Cortelazzo & Zolli, 1999), which indicates the *returning* of ‘accounts’, results, evaluations, where *account* represents “entries of debits and credits, evaluation, estimate, profit”, although, since it derives from *count* “tell, recount”, also implies the idea of a communication and not just of an evaluation. On the whole – and in its usual meaning – the *report/account* expresses the idea of “giving reasons, explaining”.

It remains to be seen, therefore, what is written in a clinical report? Who writes it, who is it written for, and above all, why? The answers to these questions seem to combine in the description of a context, which is the scenario and device for structuring and making sense of the report, as well as of the psychological encounter.

Depending on whether the domain is personal, of training, comparative or divulgative and whether the report is therefore addressed to a public, be it of superiors (supervision), of peers (interview) or the scientific community, the writer narrates the story of another person and of their meeting, and more or less explicitly, of himself; he writes for himself or to share with others or understand, through others, something about himself, the other person and the relationship, so as to satisfy his desire for knowledge, enrich his own training process and orient the clinical intervention. The “working” psychologist and the “writing” psychologist therefore merge, embodying a role towards the task and the context which, in the words of Freda (2004), is connoted symbolically and affectively; so the drafting of the clinical report, as a subjective construction of meanings, conveys an intentionality that “brings the clinical psychologist up against dimensions of belonging and of projectuality” (Lancia, 1990), which cannot be ignored. Transcribing the clinical material and communicating one’s own experience to others in fact expresses not only a historical-literary reproduction of what has happened, but also a meaningful reconstruction of contents and events according to one’s own personal style; in itself it is therefore an initial form of subjective psychic elaboration of one’s experiences, which presents and translates the external reality in terms of the inner reality².

Using the multiple meanings mentioned above, the clinical report therefore gives a result that is usually presented by the clinical psychologist to a public that is different from the person who constitutes the other side of the exchange in the clinical relationship (the patient or, if you like, the client) and is only indirectly returned to him, as restitution, often with this first step. This is a representation by means of signs, translation into words of a lived experience, of confused, impalpable sensorial and mnemonic traces which, in taking shape, help what has happened and been acted out by oneself and by the other person to unfold, within the clinical space. It is narration that, according to the purposes and the context, is addressed to whoever is there to accept it.

2. The research context: problematic transsexual and request for intervention

Transsexualism poses a stiff challenge for clinical psychologists, due both to the perturbing effect (Freud, 1919) that it evokes on a personal level - psychic and corporeal – and also to complex questions that affect the professional level. In the first place, we should mention the nosographic classification of the transsexual psychopathology (gender identity disorder G.I.D.)³, which does not seem to take sufficiently into account the complex transsexual

² This is what has made and still makes it valuable, in the psychoanalytical tradition, to *transcribe* clinical sessions as a means of spreading the theory of the technique and as an object/means of analysis in situations of supervision. It is above all in training, in fact, that the report (of sessions like the observations of the mother-child relationship) acquires considerable significance: as the subjective elaboration of facts, fantasies and feelings, it enables phenomena of transference and countertransference to be analysed, thus representing a fundamental tool for reflection about oneself and one’s own work. And yet this also represents what, in the current debate about the possibilities of research in the clinical and psychotherapeutic field, is presented as the limit of this discipline; consequently “transcription from memory” more and more takes second place to the “purer” “*verbatim* transcription”, done by an *objective* mechanical recording (cfr. Dazzi, Lingiardi & Colli, 2006).

³ Given the complexity of the phenomenon, a clear definition of transsexualism as a syndrome and its precise positioning in the psychiatric nosography is taking considerable time. It was only at the beginning of the 1970s, in fact, that the growing number of people asking for sex reassignment surgery (SRS) seems to have brought the international psychiatric community and the jurisprudence of various countries face to face with the need to deal with the problem more specifically (cfr. Valerio &

combination of sexualization, sexuality and gender in the development of identity, as well as the breadth (or the ambiguity) of gender as a dimension of meaning (complex and multi-sided) and which therefore makes one reflect about the use of this category in a clinical domain⁴. Secondly, it is important to consider the request which, as we will see more specifically, influences the psychodiagnostic assessment in the legal and surgical process of sex reassignment.

We must first briefly describe the scenario we are dealing with.

Transsexualism configures a profound identity crisis (Nunziante Cesàro & Chiodi, 2006), in which one's body is rejected due to a declared inner membership of the opposite sex. Therefore, "imprisoned" in the wrong body, extraneous to his/her way of thinking, the transsexual asks for a rectification of the external appearance, so as to attain the "recognition" – essentially social and legal – of what is, however, related to being and feeling; in other words to an "impalpable" though "real" experience/inner world. The energetic claim for "femininity" or "masculinity" which, inevitably detached from bodily feeling and from the fantastic vicissitudes connected to sexualization, becomes instead "what seems describable, therefore visible, culturally recognisable as such" (Galiani, 2005), increases the transsexual's strong need for external recognizability. Alongside this, the sliding of the psychic into the sexual and of the sexual into the cultural – sustained by the now well-known distinction between "sex and gender" (Stoller, 1968)⁵ – supposedly legitimates both the exteriorization of the inner sensibility (Galiani, 2005), reflected in the transsexual's desire to function as a member of the opposite sex (Benjamin, 1966), the signification of an otherwise nameless existential drama, and lastly, also physical removal⁶ by means of a surgical transformation-solution.

The failure of sex to correspond to gender, which in the aetiology of transsexualism is attributed to the failure of the primary relationship⁷, thus comes to be inevitably perpetuated

Zito, 2006). Since 1994, the *DSM IV (Diagnostic and Statistical Manual of mental disorders)* has contained a section for "Sexual and Gender Identity Disorders", in which a chapter is devoted to "Gender identity disorders" with the relevant diagnostic criteria. We will give the main ones, as an example: A. *A strong persistent identification with the opposite sex (not only a desire for some presumed cultural advantage deriving from belonging to the opposite sex)*; B. *Persistent malessere about one's sex or sense of extraneity about the sexual role of one's sex*; C. *The anomaly is not concomitant with an intersexual physical condition*; D. *The anomaly causes clinically significant distress or compromise of the social and working area and other important areas of functioning*.

⁴ This is a reflection that, though important in the approach to transsexualism, plays a tangential role in terms of the discourse we want to deal with here; we will therefore just mention it, giving references to other authors (Chiland, 1997; Reiche, 2004; Boursier & De Rosa, 2006).

⁵ R. Stoller (1968) links the terms male and female to the notion of sex in reference to the body's biological aspect; however he/she uses the term gender in a more intrapsychic version, close to the cultural dimension, which shows the "amount" of *masculinity* or *femininity* present, in combination and in different proportions, in each individual. The definition of the core gender identity, which is structured for both sexes in the pre-Oedipal relationship with the maternal-object, corresponds to the conscious and unconscious awareness of belonging to one sex rather than the other. This gender membership, around which the attributes of masculinity or femininity coalesce, is the product of the mixing of many factors deriving from biological-hormonal components, from bodily information – in other words the anatomical characteristics of the external genitals which determine the sex assigned at birth – and from the relational components more or less consciously acted out by the adult in relating to the newborn infant of a different sex. Quoting Money (1955), Stoller also stresses the complementary and, as it were, "public" experience of *gender identity* while more personal and "private" experience is represented by the *gender role* which, tied to aspects defined by the social role, is expressed in male and female attitudes acted out in interpersonal relationships.

⁶ Perhaps to reinforce the *rejection* of a perceived reality. This aspect has been studied in depth in another article (Boursier, 2007).

⁷ In the bond with the vicissitudes of the *sexualization* process on which the process of acquiring one's own *sexualized*, *sexual* and *gendered* identity draws. Exponents of European and American psychoanalysis (Oppenheimer, 1992/2001; Chiland, 1997; Lothstein, 1983, just to mention a few)

and legally ratified. In fact, it is only the achievement of a sort of visible conformity of the sexual characteristics to the felt and claimed sexual identity that allows a legal rectification of sex and registry office data; so the “surgical remedy” not only allows an adjustment that would otherwise be impossible, but in practice legitimates the sex-change demand and provides a social and legal imprimatur, as well as a solution to the intense inner dissonance. This is the complex situation in which the request for psychological intervention is put forward.

More specifically, in the complicated process of surgical reassignment of the anatomical sex (S.R.S.) and of registry office correction, the psychiatrist or clinical psychologist is “assigned” a role that could be defined “inconvenient” and in a sense restricted and binding. The demand for intervention which, though this rarely happens, is made initially by an individual intending to reflect on his own existential state, generally comes from the legal domain with the purpose of producing a certification to, as the law says⁸, “attest to the psychosexual condition of the subject” and declare the existence of a malaise (that is, a G.I.D.) therefore with no psychiatric pathologies (which would compromise the capacity to understand and decide), which might lead to the whole process being suspended⁹.

And yet, the discretionary nature of the judge’s request for a consultation aimed at verification (an option increasingly used) and the lack of transparency concerning the professional figure whose specific competence should be used, make us think about the position psychiatrists and psychologists are forced to assume in this context. In fact, while the presentation of two different domains (the “psychic”, generally merging with the “mental”, and the “sexual”, generally merging with the “bodily”) on the one hand increases the contrast between the psychic and the biological, on the other it means that it is possible to entrust the verification to a technical figure who is a specialist in only one of the two different sectors (Galiani, 2005) and that it is therefore sometimes the doctor (surgeon, endocrinologist) who asks, on behalf of his patient, for a consultation in the psychological and/or psychiatric domain¹⁰.

In short, while at one extreme there is the request, optional and ambiguous, for a psychodiagnostic investigation which, by its nature, constrains and orients the intervention, designing it for the difficult demonstration of something that, in a certain respect, sounds like a sort of paradox¹¹; at the other extreme there is the complexity of this profound identity crisis

concentrate their thinking on a profound narcissistic fragility and on a faulty mirroring of sexualized identity which, characterizing the transsexual psychopathology, would also explain the strong urge to seek a new identity, first of all bodily, through which to find in the Other the recognition and evidence of the self, lacking in the past; this therefore underlines the weight that the recognition by the social other assumes in the so-called “transsexual choice”.

⁸ Law n. 164 of 14 April 1982 (art. 2).

⁹ It is complicated to explain in detail what is involved in the whole question which, affecting different disciplines (medical, legal, psychological-psychiatric), refers to the profound malaise experienced by the transsexual individual, to the diagnosis of the disorder (there is no unanimous vision; the debate continues about the origin more or less frankly psychotic of the disorder in question) and to the surgical response, which in Italy is not only legally ratified but a necessary prerequisite to proceed with the change of registry office data. Consequently, while in some cases the paradoxical nature of the solution of bodily adjustment is examined (Chiland 1997), in others the focus is on the wisdom, especially in some situations (primary transsexualism), of intervening surgically. Stoller, for example, thought it useful to go ahead with a “sex change” in cases where men were extremely “feminine”, and he stated the pointlessness of psychoanalytical treatments or moral exhortation (cfr. Vitelli, 2001).

For more detail, however, see (just to mention a few) the books by Valerio, Bottone, Galiani & Vitelli (eds.) 2001; Galiani, 2005; Nunziante Cesàro & Valerio (eds.), 2006.

¹⁰ Along with the legal cases taken out against surgeons who failed to ascertain the psychological conditions of the transsexual subject before operating, this is probably what led to the growing collaboration between surgeons, endocrinologists and psychology/psychiatry consultants (Hausman, 1995, in Galiani, 2005).

¹¹ In fact, while in some cases there is discussion on the non psychotic nature of the disorder: for Stoller (1975) the *transsexual illusion* is supposedly produced by “an error in interpretation” of the reality of the person’s anatomical sex, that is, an erroneous recognition and not its reconstruction;

which, translating itself into the body and acting on the body, forces the “psych” domain (which has trouble finding an exact positioning) to deal with it and to deal with the request for surgery¹², urgent and unquestionable, which annuls the possibility of thought and of representability.

In this sense the operator encounters “a profound feeling of frustration accentuated by the experiences of castration he feels he must submit to before the task assigned. His identity, too, is in fact challenged. What is the role he is playing: the impotent sorter of clients for a surgeon, or psychotherapist who does nothing to help the person in front of him, but simply has to accept the solution chosen by him?” (Valerio *et al.*, 2000).

3. Models of affective symbolization: the textual analysis of clinical reports

In the perspective of a psychodynamic matrix and orientation, the initial assumption is that, though the nosographic classification is difficult, the sex change request might be a sort of *bodily acting out* which, in the *mistaken recognition* or in the *rejection-denial* of one’s own reality (anatomical, but it should not be forgotten that there is also the rejection of a part of one’s identity and one’s past), responds to the need to annul the intolerable past, creating a different reality (though not completely new)¹³. This is firstly a bodily reality which, constructed artificially, and being inevitably incomplete, will however allow the person to *feel* and to *appear complete*. Moreover, while the request coming from the broader medical or legal domain affects the psychological intervention, conveying elements of strong ambiguity, accompanied by the urgency of a *bodily acting out* (which the transsexual individual brings directly into the clinical consultation) - in a system that seems to respond to psychic suffering with a *bodily counter-acting out* – this demand (both by the nature of the pathology, and by the complexity of the request) seems in a sense to constrain and bind the “psych” dimension of the intervention (more so perhaps if the interpretation of the malaise is anchored in a psychodynamic perspective). It is also within the psychodynamic perspective that the possibility is considered that the surgical remedy will actually be a solution, though questionable, not to be excluded a priori¹⁴.

In the light of this, benefiting from the long and varied experience of the working group on gender identity disorders of the Clinical Psychology and Applied Psychoanalysis Unit (“Federico II” University of Naples)¹⁵, it was decided to think about the psychological

other cases suggest its probable affinity: Oppenheimer (1992) considers, for example, that “permanent acting out” (the sex change) shows the need to construct a *neo-reality* or *neo-identity*, so although the psychosis is not exactly proven, in the transsexual pathology it is possible to see the two stages characteristic of psychotic processes, namely the withdrawal from reality and the creation of a neo-reality, which in this case focuses above all on the body and anatomical sex.

¹² The expression, according to Chiland (1997), of a *mad* desire-expectation which medicine seems to answer with “a mad offer”.

¹³ It is no coincidence that the term *bodily acting out* has been chosen, since – as has been explained elsewhere (Boursier, 2007) – in transsexualism the inner conflict does not seem to find expression so much *in* the body, but rather in a drastic action involving it and which, *by means of* the body, takes *concrete* form in an *act of non-thought* (Etchegoyen, 1986), an *acting out* that, as the result of a coercion of thought, fills the space.

¹⁴ Follow-up studies conducted on transsexual individuals who have been operated on, reveal along with a few cases of suicide, a good level of satisfaction concerning external appearance, above all in cases of transsexualism in adolescence; however the methodological criteria adopted would seem to limit the success of the intervention to the assessment of degree of satisfaction concerning the aesthetic factor. The need to offer social and psychological post-operative support was confirmed. For further detail, see Landi, Napolitano & Zurolo (in Galiani, 2005).

¹⁵ I am very grateful to Prof. Paolo Valerio (Head of the Unit and Director of the School of Specialization in Clinical Psychology based at the University Polyclinic) and his team of assistants, who have been working for years in this complex sector, both at the research level and at the clinical one. The group of research and clinical intervention in gender disorders uses the collaboration of

intervention that is part of the process of medico-legal sex conversion, identifying the emotional dimensions underlying the *meeting* between the psychologist and the transsexual individual, in the institutional framework where it takes place.

In other words, it was decided to analyse the *collusive dynamic* (Carli & Paniccchia, 2002) typical of the context and what is acted out in it; therefore, adopting the perspective of reflecting on the operators' "emotional position", it was asked how they *affectively symbolize* (Fornari, 1979) their intervention (the demand, the task and the relationship), in the individual-group-context dynamic of which, as we shall see, they are part. To this end, use was made of textual analysis of clinical reports, drawn up following interviews with transsexual subjects, in a theoretical and interpretative perspective which, keeping in mind the *double reference* – lexical and symbolic –¹⁶ implicitly connected to the language act (Fornari, 1979), is oriented to understanding the emotional dimensions *running through* the text, apart from its intentional structuring (Carli & Paniccchia, 2002).

In the specific context of work we referred to, mainly oriented towards a psychodynamic approach, the clinical report represents an indispensable object and tool of reflection, sharing and education (personal and professional), being both the *restitution* to the peer group and supervisors of the work done (and indirectly, to the institutional client who commissioned it), and being the translation, development and narration of what happened inside and outside the clinical space. It is a sort of well organized "canvas" which reflection of the group and *in* the group helps to enrich with further possible meanings. As the personal construction of a subject participating in emotively connoted experiences (the clinical interview, then the drafting of the report and the belonging to *that* working context), the report expresses a construction of the meaning of what happened, which – as we have specified – has a strongly *referential* character, both because it is addressed to *someone*, and because it refers simultaneously to the "inner world" and the "outer world" (Fornari, 1979). Moreover, there converge on it both intentional meanings, related to the divisive logic of conscious thought, and emotional meanings, the manifestation of the unconscious system (Matte Blanco, 1975), which are tied to the object of experience, to the individuals involved and to the writer who, in the first person, lives and narrates contents and impressions. As a result, the clinical report's possibility or meaning lies in the "semantic field", in the relational and contextual interlacing, dense with emotionality and mediated by semiotic processes (Freda, 2004), in which everything originates.

On the other hand, in a perspective linking a psychodynamic approach to a constructivist, interactionist one, while the clinical process is the expression of a *negotiation and co-construction of meanings* (Gill, 1994), the contextual dimension in which it takes place weaves together (*contextëre*) and informs the relationship between the subjects, *instituting it* and *signifying it* on the intentional plane, as well as on the plane of unconscious emotional symbolization. In this sense, the *context*, far from being merely a background or frame, appears as a symbolic-affective construction of the relationship (Carli & Paniccchia, 2002, 2005), a "product of the unconscious semiosis" (Salvatore, 2004) decisive in the negotiation of meanings, insofar as the actors of a relationship produce and share (unconscious) affective symbolizations of the situations they participate in (Carli & Paniccchia, 2002; Salvatore et al., 2003).

psychotherapists and psychiatrists of trained in psychodynamics, as well as specialist psychologists. Part of the clinical and research work in this context involves group reporting and discussion of the clinical material, for the purpose both of intervision and of supervision.

¹⁶ With his '*double reference*' Fornari (1979) wants to differentiate between a *lexical reference* which, corresponding to the literal meaning of the single words, has to do with the sharing of meanings conveyed by the source culture and a *coinemic reference* which, with the figurative meaning, would perhaps have a more subjective inner force; in this case, in fact, the perception of the reality would come about through projection into the external object, of the internal object which would thus be signified by the signifier (external object).

The process of interpreting reality can therefore be traced back to the affective categories constructed and shared by the individuals who are part of the same context and, in the perspective we are taking, should be linked both to the reciprocal interaction between the psychologist and the transsexual person in the clinical space, and to the fact of colleagues sharing the same context of work, tasks and goals, *specific* and yet *shared*. The clinical report therefore represents a possible link between two levels/moments of intervention, interacting and mutually influencing each other, or between the work done “with two pairs of hands” in the interview room and the work done “with many pairs of hands” in the intervention/supervision room; between the affective symbolizations generated in the context of the clinical consultation and the affective symbolizations which, at some level, are “expressions of the semiotic work of the group” (Salvatore, 2004, p. 134). Therefore, being the element *resulting* from the meeting of the first and second aspect/moment of clinical work, the report *stemming* from the psychological interview, *predisposes* one for group sharing.

In this sense, one must consider the implicit psychic (and emotional) functioning (complementary to the intentional register) in the construction of the clinical text, from a perspective that takes into account the relational processes involved in it and which, in the specific context we are dealing with, links the unconscious functioning of the individual also to relational and institutional processes (Carli & Panizza, 2002, 2003; Salvatore *et al.*, 2003). For this reason it was decided to think about the emotional dimensions of the *meeting* between the psychologist and the transsexual person, seeking a fuller understanding of the dynamics occurring inside and outside the interview room, in the institutional context. From this angle, in fact, the textual analysis of reports allows their *re-construction* as unconscious emotional affective symbolizations, both *produced by* the meeting and *producing it*; where it is precisely through the connection of these with the aspects of the context that generated them (Freda, 2004) that makes it possible to think about psychological work, between *clinical practice and intervention context*.

For the purposes of the study, the reports drawn up by the Service operators after the first 4 interviews¹⁷ with 25 transsexual individuals awaiting S.R.S were examined. The material, consisting of 93 texts (99175 occurrences, of which 9891 distinct forms and 5197 hapax), was codified using some illustrative variables (Tab. 1); among these we will look at the aspect of *gender in the relationship*, the *operator's training* (in-service or finished) and the variables that define the *modality of psychological intervention*, both in how it was agreed on initially (a “contract” envisaging the issuing of the diagnostic certification after a little psychological counselling or following a longer period of reflection); and in how the relationship then ended (with the issuing of the diagnostic certification, or with the premature interruption by the transsexual subject)¹⁸.

¹⁷ The choice of the first 4 interviews is due to the fact that the main working modality at the Facility is psychodynamically oriented psychological counselling which is known to be a precise mode of intervention in the clinical domain. Designed for assessment with the purpose of the diagnosis and monitoring of the defences of the person involved in the interview (cfr. Valerio, 2001), it in fact constitutes an established way of working which may or may not lead to further possibilities of detailed examination, by continuing the psychological work of reflection about the self. In the first 4 interviews therefore, the intervention is “at risk” or it is made possible, a diagnosis is elaborated and any “contractual” coordinates are established for the work of in-depth examination or for psychotherapy.

¹⁸ In particular, as will become clearer, if the first two variables help to enrich the interpretation of the different isotopies in question (since they are significantly associated with the headwords making up the clusters under analysis), the last, which defines the coordinates of the clinical interviews and *organizes* the modes of psychological intervention in the institutional pathway, has been the object and tool for detailed consideration. The choice of this variable, in its many different forms (see tab. 1), reflects the way in which in various periods the working group has approached the urgency of the demand made by the transsexual person and by the institutional context. It is an urgency that is after all innate to the pathology itself, and that for various contingent institutional reasons, at first was

Tab.1 – VARIABLES	
GENDER RELATIONSHIPS *	
Rel. M-M	Indicates a relationship between a male operator and a transsexual individual (MtoF) whose original sex is male, but who feels female.
Rel. M-F	Indicates a relationship between a male operator and a transsexual individual (FtoM) whose original sex is female, but who feels male.
Rel. F-F	Indicates a relationship between a female operator and a transsexual individual (FtoM) whose original sex is female, but who feels male.
Rel. F-M	Indicates a relationship between a female operator and a transsexual individual (MtoF) whose original sex is male, but who feels female.
TRAINING OF THE OPERATOR	
Op. SPEC	Psychologist doing specialization, or in-service training
Op. STRUT	Permanent Psychotherapist, or who has finished his/her specialization.
MODALITY OF INTERVENTION	
Mod. BC	Brief contract (B), for psychodynamic counselling, ending with the issue of diagnostic certification (C)
Mod. BI	Brief contract (B), for psychodynamic counselling, ending with the patient prematurely breaking off the process (I)
Mod. LC	Long contract (L), ending with the issue of diagnostic certification (C)
Mod. LI	Long contract (L), ending with the patient prematurely breaking off the process (I)
Mod. LTC	Long contract (L), with administration of tests by another operator (T), ending with the issue of diagnostic certification (C)
Mod. LTI	Long contract (L), with administration of tests by another operator (T), ending with the patient prematurely breaking off the process (I)
Mod. CLI	Long contract (L), preceded by the issue of diagnostic certification (C) and then ending with the patient prematurely breaking off the process (I)
* The first letter indicates the operator's sex; the second indicates the biological sex of the transsexual person: therefore M (male), F (female). The transsexual's desire to belong to the opposite sex is usually indicated with the term MtoF, when a biologically male individual wants to belong to and live as a member of the other sex, i.e. female. Vice versa, FtoM, when a biologically female individual wants to be a male.	

The corpus was taken from a specific software for textual analysis *T-Lab PRO 4.1* (Lancia, 2004) which includes the function of fragmenting the text, eliminating the logical linkers joining the words in the intentional discourse, and identifying isotopic relations between headwords, or a recurrence of words with shared semantic traits within a syntagmatic unit¹⁹.

presented as being *un-postponable*, thus inducing an urgent response (the CLI modality goes in this direction, i.e. it opts for a quicker response by issuing the certificate, but offers a longer "accompaniment" process in which to reflect); but it was then faced up to and managed by attempting a mediation between the different, complex demands (the proposal of a longer contract, LC, LI, for example, with or without the help of tests, LTC, LTI, presents itself as an opportunity for reflection in a process of in-depth examination which can somehow remain bound to the issuing of the certification laid down for the end of the psychological work). The modality of brief intervention (BC, BI) is representative of the counselling work we have already mentioned. A summary, though an oversimplification, makes it easier to read the results, in fact these different aspects of the *intervention modality* variable can essentially be grouped into two broad categories: brief (B) and long modalities (L) of psychological work; relationships that led to the issuing of the diagnostic certificate (C) and relationships broken off prematurely (I).

¹⁹ The concept of semantic isotopy (*same place*) "refers to a conception of meaning as "effect of the context" ", that is, as something that does not belong to the words taken singly, but which results from their relations within the text. The function of the isotopies is to facilitate the interpretation of discourses (or of texts); actually each of them identifies a context of reference "shared" by several words, which however does not derive from their specific meanings" (Lancia, 2004, p.73). The

Subjecting the textual corpus to *cluster analysis*, five *semantic isotopies* were revealed (sets of words grouped together based on the principle of maximum semantic homogeneity which, by characterizing the single cluster, differentiates it from the others), or five different ways of symbolizing the relationship of the transsexual person with the context of the intervention. The next step, the projection of the clusters into the factorial space organized by the variables related to the meeting modality (fig. 1), made it possible to connect the semantic isotopies to each other (interpreting the relations and contrasts) and to contextualize them, or to capture the relations between the different models of symbolization of the relationship in this specific context, thus identifying which emotional dimensions of the meeting underlie, orient and signify the psychological relationship in the context of intervention.

For the *emotional re-construction* of the text (destructured by the analysis procedure), we applied some interpretative principles introduced by Carli and Paniccia (2002) in the perspective of *Emotional Analysis of the Text*, which is known to base its theoretical assumptions on the emotional categorization of reality (Matte Blanco, 1975) and on the double reference of language (Fornari, 1979), presenting itself on the methodological plane as a tool for the study and discovery of *collusive processes* (or of the symbolic-affective dynamic organizing relationships) in the specific shared contexts. We then went on to interpret the associative links (obviously no longer intentional) which, *due to the context*, hold together the headwords in each cluster, offering the construction of a semantic pathway for which the etymological derivation was also used, enabling us to understand the original, unconscious emotional structure which forms the basis of the meaning of the word (Carli & Paniccia, 2002).

The pathway taken within each cluster shows the more frequent headwords and the *modality of intervention*, *gender relationship* and *operator training* variables most significantly associated with them.

Cluster I, including words like *girl*, *male*, *strike*, *invitation*, *comment*, *believe*, *prefer*, *room*, *wait*, *finish*, *start*, can be defined as **the space of ambivalence**, insofar as it seems to symbolize a relationship and a meeting which, right from the initial impact, seem to be characterized by feelings, perceptions and desires of an ambivalent kind. The Italian word '*ragazza*' (*girl*), which immediately suggests a contrast with *male*, deriving from the Latin *radica* (root), refers to what has to do with the beginning, with nature (what provides a plant with force and nourishment and provides a stable base) and at the same time, with what is hidden from the gaze, deep down. This evokes a subterranean dimension, perhaps natural and "original", which seems to contrast with what is manifested, placed in front (*prefer*, from *prae-ferre*). With the Italian word '*colpire*' (*strike*) (from the Greek *kólaphos*, slap) it evokes an idea of a collision which in this semantic context seems to remind us of the idea of the initial impact (perhaps an ambiguous, concealing external appearance) which strikes and shakes. The Italian '*attendere*' (*wait*) (from the Latin *ad-tendere*, in the sense of "tend towards") evokes the aspect of waiting, which is also a movement towards something with the aim of reaching a goal. The Italian '*stanza*' (*room*) on the other hand, indicates the act of "staying still in one place" and being linked to the image of waiting, which expresses immobility in a place, contrasts with the previous tension, evoking an idea of the uncertainty and ambivalence of desire; as do, on the other hand, the words *start* and *finish*. '*Comment*', deriving from the Latin *cum-mentem* (with the mind) seems to suggest what is said or done with intention or reason; while this on the one hand has to do with the clinical interview, on the other it evokes the idea of a judgement (the diagnostic certification) or of an opinion expressed "behind one's back", thus introducing the aspect of suspicion, well represented by *believe*. The latter term, in fact, (the Italian term '*credere*' derives from the Latin *credĕre*, hold to be true) in ancient times meant "tasting the food prepared for people of high rank to prove

occurrence and the recurrence of these headwords (rather than of others), within the groupings of words, therefore allows a semantic link to be highlighted (effect of a shared context of words), which it is necessary to *re-construct* by means of an interpretative process.

that it was not poisoned” (Cortelazzo & Zolli, 1999, p. 411) and therefore seems to be linked to the possibility of trusting somebody. Lastly, ‘*invitation*’ suggests a double, ambivalent position: while on the one hand it is linked to the idea of “giving hospitality”, on the other hand the Latin derivation *invitus* (“who acts unwillingly, against his will, forced”) seems to be linked to the idea of a forced, non-voluntary action, due to an unwelcome constriction.

The variables that we find associated to the cluster in question (tab. 2) indicate a relation between *operators* (of both sexes) *doing specialist training* and transsexual individuals MtoF and FtoM, in a gender relationship that “conforms” but is “inverted” on the basis of sex²⁰ and rather long *intervention modalities*, ending with the issuing of the diagnostic certification. This implies that an emotional dimension strongly characterised by ambivalence is supposedly present in the reports of psychologists undergoing their specialist traineeships; an ambivalence that, in the light of the semantic pathway proposed, first seems to be due to the relationship in terms of its strong initial impact (a dimension of manifest externality which, betraying an inner sphere that is hidden, but deeply-rooted, strikes and confounds), and also in this direction goes the presumably arduous²¹ elaboration of “gender conformity” in the clinical interview. Secondly, the ambivalence could be attributed both to the space of the clinical interview, and to the complex institutional process of medical-legal sex reassignment, in which the psychological intervention will be included, insofar as there are contradictory elements that seem to emerge. These can perhaps be linked to the uncertainty and the “forced” nature of a process of “moving towards” and at the same time of stopping (probably connected to the transsexual individual as well as to the psychologist; in this sense this could also be linked to a prolonged intervention modality which, being at times constrained by the diagnostic certification, can be configured as ambivalent: no longer just diagnosis, but also psychotherapy). Lastly, the ambivalence is supposedly also expressed in suspicion and judgement, in the reciprocal intention of having confidence in the other person and in working with the other person, of believing him and being believed (the judgement in this case concerns not only the transsexual individual awaiting a diagnostic assessment, but also the trainee psychologist whose work will be reported on and supervised).

It would therefore seem that the semantic isotopy presented so far is significantly associated with reports drawn up by psychologists training for their specialization, and presents a symbolization of the relationship and of the context in terms of marked ambivalence.

Cluster II (*mother, father, feminine, house, tie, call, die, become*) seems able to define the semantic dimension of the **origin, between severance and transformation**. Terms like *mother, father, feminine* (from *fecundus*, evocative of producing children), *house* (representation of an element that contains and encloses, but also of what “gives a name”, the dynastic house, which designates, identifies and also establishes membership), evoke the dimension of birth, of origins. Similarly *call* which, besides the idea of a relationship, also

²⁰ It may seem difficult – and at times paradoxical – to think in these terms, since the anatomical sex and the gender attributes of masculinity and femininity, as a part of the feeling of belonging to one sex or the other, usually coincide. In transsexualism however this is not so. Consequently a suggestion might be to remember that in this case there is a split and an opposition between anatomical (bodily) sex and psychic and/or cultural gender (in the sense both of externals: appearing as male or female, and of the inner sphere: feeling that one is male or female). The situation therefore becomes more complicated when it is approached in a relationship perspective (which psychological work obviously cannot disregard), when, that is, it is necessary to keep in mind what, at a deeper level, is triggered by the confrontation between the two sexes and the two genders. So the terms “conformity” and “inversion” in this case do not indicate the individual dimension but that of “relating”.

²¹ On this, see the reflection made by Valerio & al. (2000) on countertransference with transsexual subjects, where it is underlined how much the relationship tends to focus on the “gaze”: on the one hand, the “compulsive need for the transsexual individual to capture the gaze of the other person” (of the operator), since the gaze enables one to *substantiate* one’s existence; on the other hand, the operator’s annoying perception of a gaze that *steals* (appropriating his/her “gender” qualities) or that *decorates* (invading the other with what represents, for the transsexual subject, the gender image that conforms with his/her own *being*).

suggests the operation of “naming somebody”. The Latin etymology of the Italian ‘*legare*’ (*tie*), which at first sight suggests the idea of solid relationships, and also of an enveloping aspect (reassuring or perhaps constrictive), also refers to what “is established by law”. A meaning that seems to be strongly evocative in this context of intervention and that seems even more indicative if it is tied semantically to the idea of origins represented so far, and to that of *die* and *become* (the Italian ‘diventare’ from the Latin ‘divenire’, meaning to acquire new shape and conditions different from the previous ones).

In this case, too, the *specializing* variable seems to be associated to the cluster in question (tab. 2), though with little significance, along with an “inverted” gender relationship, which is homosexualized on the basis of the anatomical facts and of an *intervention modality* essentially characterized by a premature interruption of the psychological work, which however appear quite significant. This semantic isotopy, represented by themes involved in a dimension that is generative, transformational and at the same time deathlike, of recognition and “naming”, would seem more closely associated with the reports drawn up by male operators undergoing specialist training (they too engaged in their own dynamics of identity recognition, above all on the professional plane). In this case however what may appear significant, is the association of these issues - evocative of a “severance”, of an “interruption”- with the premature breaking off of the psychological work, reposed and acted out, therefore, also in the clinical space and with the gender relation which presumably triggers in the operator (of the same biological sex as the transsexual person) dynamics tied to the transformation of the body, to loss, to giving up parts of oneself, of one’s past and what might be one’s future.

In this case, the isotopy described above would seem to refer to the contents of the psychological interview, to the reports which (due perhaps both to the specific configuration of gender in the relationship, and to the operators’ training) capture and narrate in a historical (and developmental) perspective the beginning of the relationship and the aspects of the transsexual person’s life, presenting a symbolization of the relationship and of the context in terms of what defines the self and the other, starting and finishing the relationship.

The semantic isotopy that can be identified in **cluster III** (*change, now, psychologist, operate, trans, doctor, name, hormone, afterwards, reality, be born, deny, make mistake, error, exist, document*), recalls the contents of the demand made by the transsexual person, the institutional figures and the mode of change proposed in the medico-legal process, expressing the idea of an ***intervention as correction***. The current nature (*now*) of a *change* that is needed – of name, of reality (one might ask what this reality is, whether it be internal or external) – in which to deny and correct a previous error (the name given to “the mistake” once made by nature which shaped an “inexact” body) predisposes for *afterwards*, for the possibility of “having a life”. *Being born* and *existing*, seen as “getting out, appearing” (from the Latin *ex-sistere*) and as “being and feeling” in time and in reality, which seem possible only if they are in relation to a *trans-formation* and only if demonstrated by new, “corrected” evidence (*document*) of the self, correcting a previous error and being the goal of the unsustainable, anguished wandering without sense or destination (*error* from ‘errare’, “to wander without a destination”).

The variables associated with the cluster in question (tab. 2) indicate its strong relationship with brief, circumscribed, specifically designed *intervention modalities*, (*counselling*) and with reports drawn up by *specialist operators*. There is a lower degree of association with the *gender relationship* which is “conforming” but “inverted” on the basis of sex, and even less with a relationship between operators and FtM transsexuals, of the same original sex. Therefore the most significant data seems actually to concern the presence of an association between the reports of specialist operators, brief, thematic, “designer” intervention modalities related to the aspects of the intervention seen as correction, or to the contents of the demand made to the operator, how it was presented by the transsexual subject and how it was inserted in the institutional process (which envisages the assignment of a place for the psychological intervention in which this is positioned). In this case, therefore, the affective

symbolization of the relationship and the context, associated to the reports of the specialist operators, is represented in the image of change as correction.

Cluster IV (*tell, meeting, explain, friend, difficulty, journey, silence, communicate, help, fear, word, comprehend*) identifies the semantic dimension of the **relationship as a journey**. Right from the first term, *tell* (in Italian 'raccontare', from the Latin *contare*), the idea of narration is evoked in the space of the psychological interview, as well as the narration about the self and the non-self, in the clinical report. The affective symbolization of the *meeting*, with its *difficulties, fears* and *silences*, is positioned between "coming to meet one", joining up, and "going against" (the Italian 'incontro', from the Latin *in-contra*), clashing, connoting a certainly ambivalent dimension, perhaps too onerous, in which however there emerges the idea of sharing. So *communicate*, in the sense of "making common" (from the Latin *communem*, literally "that carries out a task with others") and *ex-plain*, in the sense of doing, unravelling, seem to refer to what is unravelled and revealed, put into *words*, in a difficult process of sharing (of a common task) and *comprehending* (from the Latin *comprehendere*, "to take with"); this is a journey that while on the one hand evokes a dynamic that is egalitarian, *comprehensive* and *friendly*, of doing and sharing together, on the other hand seems to open to the possible functions of psychological work such as "case acceptance".

The variables most associated with this cluster present a link between reports drawn up by female *specialist operators* and long *intervention modalities* which however end with the premature interruption of the relationship. The semantic isotopy described seems to show an emotionally dense relational dimension, full of contents that seem to refer to it, as well as its possible functions; this dimension seems after all to bring together aspects related to the dynamics of the clinical interview and the drawing up of the report, to "interview" in the *communicative* exchange (of a shared task).

The affective symbolization of the relationship and of the context therefore in this case seem to be defined in terms of narrating/narrating oneself, which is based on the sharing of the journey.

Lastly, semantic isotopy **V** (*relating, homosexuality, sing, gesture, photo, image, project, closure, protocol, glasses, violence, prostitution*) identifies a dimension of an **embodied language**. The first term, *relating*, evokes the idea of a "written report that contains facts to be made known" (Cortelazzo & Zolli 1999, p.1321) and with *protocol*, clearly recalls one of the tasks the operator has to carry out²², but also a relationship that is established in order to "make a report", linked to the idea of a judgement, of a third dimension that acts as referent/institutional commissioner for both the actors in the relationship. *Photo, image, glasses*, alludes to the idea of a lens through which the external aspect of the body is captured and presented, but also to what can mystify and flatten it by fixing it in a two-dimensional form, of a surface lacking depth, where the body in its external appearance, becomes not a part but the whole, not an aspect of the self but what is *entirely* the self. Like *project* which, beyond its common use, implies the idea of what is "put, thrown forward" (from the Latin *projcĕre*) and shown, exhibited, used; like *prostitution* (from *prostituĕre* "place in front, display"), which recalls a dimension of sexuality as *violence* on the body, as the body, being *sign* and *gesture*, is displayed, presenting itself concretely also in the situation of a meeting, with no possibility of finding representation and meaning.

The variables associated with this last semantic isotopy link the theme of embodied language to the presence of reports drawn up by male *operators* doing *specialist training*, to the *gender relationship* that is "inverted" but "conforming" to sex, and lastly to a specific *meeting modality* which, although it – seemingly – frees a longer psychological relationship,

²² This is the name usually given to the report of the interview, the object of group discussions. It is interesting that it is used above all in this sense that, as we know, refers to a set of rules to follow and initial formulae "including invocation, inscription and salutation" (Cortelazzo & Zolli 1990, p.1276) to be respected in some formal contexts. It appears significant that in any case, the idea of report (also in the sense of protocol) involves a marked referentiality, referring to someone or, more broadly, to a third contextual dimension, to which it is necessary to refer and report.

“of accompaniment”, from the duty of issuing diagnostic certification (actually produced after just a few interviews), seems to remain indissolubly tied to it. This bond seems to be shown in the premature interruption of the psychological work provided after the issuing of the certification, both in reference to the drawing up of the protocol, which, prepared for the supervision (and in this case the link with the reports of the trainee operators appears clearly) and the discussion of the intervention, constitutes the basis of what will be returned to the patient and to the institutional commissioner by means of the diagnostic certification. Finally, the *acted out, objectified* bodily aspect which, conveying a “concrete” affectivity, is urgently and vehemently proffered, seems to pervade the interview space and also the clinical report at the level of contents and emotions, annulling (even more perhaps in this kind of “gender relationship”) the functions of thought and representability²³. There is therefore a depiction of the symbolization of the relationship and of the content of embodied language, which incorporates the idea of an acted out, experienced concreteness in “having rapport” with the other person.

Tab. 2 – INDEXES OF ASSOCIATION (CHI ²) CLUSTERS AND VARIABLES			
SEMANTIC ISOTOPIES	OPERATOR	GENDER RELATIONSHIP	MEETING MODALITY
Cl. 1 The space of ambivalence	in training (152,53)	op. sex F – trans. sex. M (92,78) op. sex M – trans. sex F (57,53)	LTC (513,33) LC (102,17)
Cl. 2 The origin between breakdown and transformation	in training (4,21)	op. sex M – trans. sex M (180,19)	CLI (226,90) BI (62,57)
Cl. 3 Intervention as correction	specialist (138,66)	op. sex M – trans. sex F (48,01) op. sex F – trans. sex F (10,21)	BC (409,02)
Cl. 4 The relationship as a process	specialist (230,05)	op. sex F –trans. sex F (12,38) op. sex F –trans. sex M (150,65)	LI (311,32) LTI (162,85) LC (10,86)
Cl. 5 Embodied language	in training (70,73)	op. sex M –trans. sex M (195,14)	CLI (562,41)

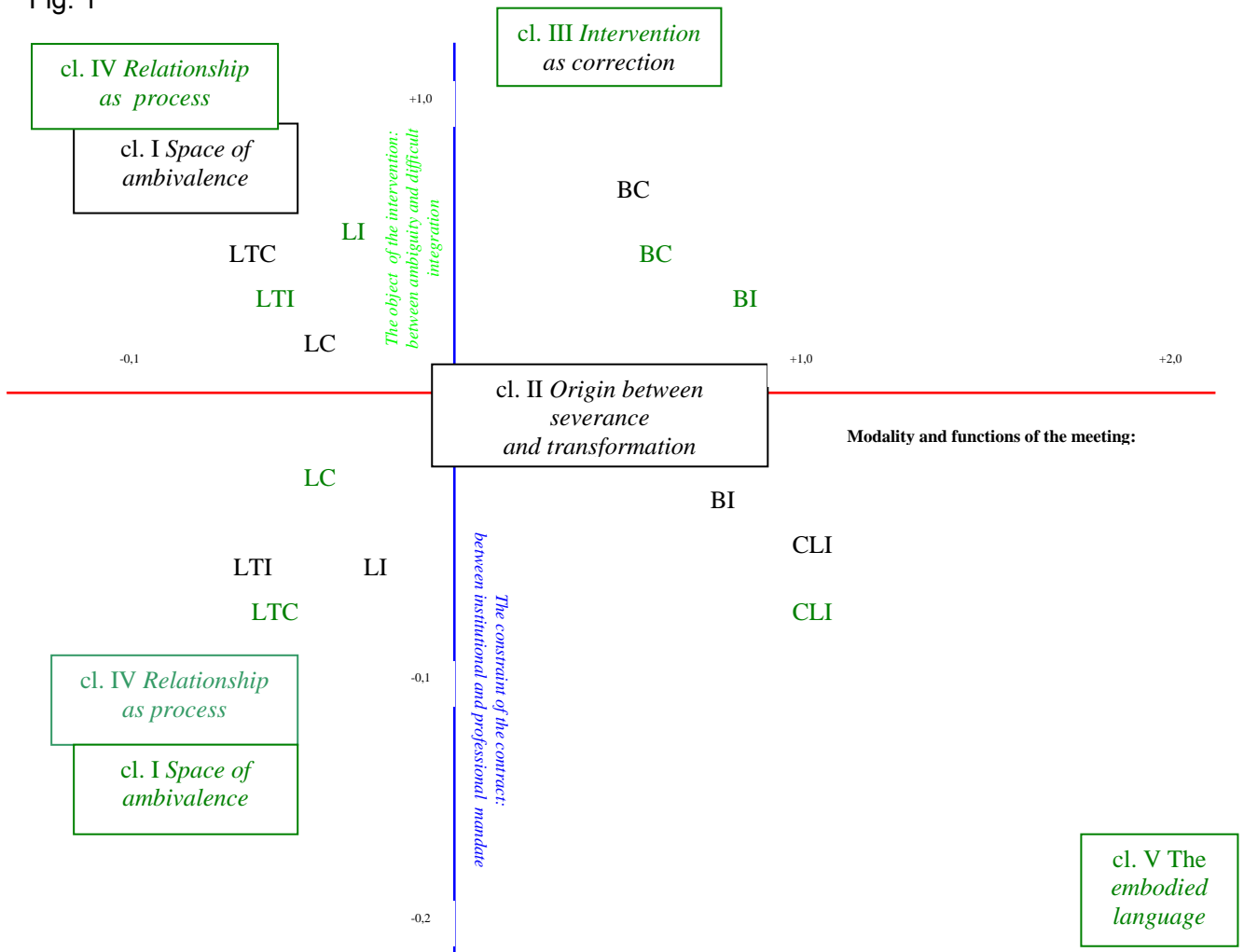
At this point, having posed the corpus some questions based on the variables defining the modalities in which the psychological interview is carried out, we have to move on to the interpretation of the layout (showing association or opposition) of the semantic isotopies (depicting the different models of symbolization of the “relationship in the context” and of the “context in the relationship”) in the three-dimensional space²⁴ that represents the contextual aspects of the intervention.

²³ Remember what Valerio *et al.* (2000) underline on this point: “the wealth of detail, the “lively”, provocative style of [the transsexual subject’s] narration creates a certain disquiet in the operator, who feels enveloped in an “eroticized atmosphere” that seems to possess an unusual, indefinable quality that cannot easily be linked to other sensations”; this eroticism expresses an “attack on the bond”, since the concrete, provocative modality of narrating seems to produce in the operator a vacuum and block of the capacity for thought and symbolization. This reminds us of the reflection made by Quinodoz (2002) about the “language that touches” – a language that does not confine itself to verbally communicating thoughts, but that reactivates forgotten bodily sensations and sensorial experiences – which the author finds necessary in order to enter into contact with those subjects that have difficulty with the symbolic elaboration of the affects and with translating this into words.

²⁴ Projected onto the factorial space defined by the *meeting modality* variables under study (fig. 1), the clusters were analysed on the basis of the first three factors, which enables 60,03% of the total inertia

to be interpreted. The percentages of the self-values of each single factor are distributed thus: factor I 23.67%, factor II 18.55%, factor III 18,08 %.

Fig. 1



Factor I (X axis) Projecting the cluster on the X axis shows the opposition between cl. V (in black) and the cl. I-IV pair (in black), briefer intervention modalities BC-BI-CLI (in black) and longer modalities LC-LTC-LI-LTI (in black). **Factor II (Y axis)** Projecting the cluster on the Y axis shows the opposition between the cl. I-III pair (in black) and the cl. IV-V pair (in black), intervention modalities ending in the issue of diagnostic certification BC-LC-LTC (in black) and relationships that are prematurely broken off BI-LI-LTI-CLI (in nero). **Factor III (Y axis in the relation factor 1 X axis – factor 3 Y axis)** The position of the clusters and of the variables on factor III (in green), shows an inversion concerning cl. I and IV and the intervention modalities associated with them. In this case, in fact, there is the opposition between the cl. I-V pair and the cl. III-IV pair (in green), as well as between the meeting modalities that led to the issue of diagnostic certification (LC-LTC-CLI) and relationships prematurely interrupted (BI-LI-LTI), except for the modality BC (in green).

As becomes clear (fig. 1), the symbolic emotional dimension depicting the relationship and the context as *origin between severance and transformation* (cl. II) is placed in a position that expresses a not highly significant contribution in the arrangement of the factorial space; this is explained by considering that as it is a highly significant dimension in the whole transsexual problem, both as far as the contents narrated and reported are concerned (the life stories of transsexual individuals seem to focus greatly on aspects related to the family, to the break with the past and to the need for naming and recognition of the self), and as regards the relational dynamic that unfolds inside and outside the interview room (see the previous interpretation of this semantic isotopy), this dimension probably almost completely saturates the isotopy of the discourse.

It seems that *modalities and functions of the meeting: between transformativity and coercion* is positioned along factorial axis I (X axis). A brief intervention modality, characterizing a dimension in which *body language* – conveying acting-out – seems to coerce thought, in the space of a relationship strictly tied to a referential dynamic (in the domain of a judgement/assessment of the self and of the other), is opposed to a longer meeting modality, where the *space of ambivalence*, on an individual, relational plane, in a dimension of *relationship seen as a process*, seems to find a possibility of elaboration and comprehension, serving for the triggering of a process of transformational thought.

This means that while on the one hand, the pole of the “relationship” seems to be highlighted (the ambivalence connoting the individual, relational, perceptive and desiderative dimension along with the functions of a relationship that becomes a narration, a shared journey), on the other hand there seems to emerge the pole of “content”, ostentatiously displayed in its concreteness, with no chance of being translated into thought or representation.

Factor II (Y axis), however, seems to define the dichotomy of the *constraint of the contract: between institutional and professional mandates*. On this axis, in fact, intervention modalities ending with the issuing of the diagnostic certification, characterizing the emotional dimensions of *ambivalence* and of the *intervention seen as correction* and new evidence of the self, are opposed to relationships prematurely interrupted, characterizing the meeting between the dimensions of *embodied language* and of the *relationship as process*. This latter emotional dimension seems to illustrate the attempt to promote, in the context of the psychological intervention, a thought *about* the body, a process of elaboration of acted-out corporeality and therefore of deferment of urgency, of suspension of action so as to have the possibility of signification which though it may respond to a “professional mandate”, does not always coincide with an “institutional mandate”.

On the one hand, therefore, there seems to be a clear attempt to connect “content” and “relationship”, mind and body, thought and action, as the representation of one of the functions of the psychological intervention (above all in a psychodynamic perspective, which invites reflective thought instead of an acted-out mode) but that in this case leads to the premature interruption of the process. On the other hand, instead, there seems to emerge a dimension of the relationship that unfolds in the *here and now* of the intervention, in the institutional context of which it is part and which therefore responds to the question posed at the beginning, with the tools available to clinical psychology. In this dynamic, however, the “promise of certification” may represent what constrains the relationship (on the other hand it seems that suspicion and ambivalence may be tied to the strong referentiality involved in the situation).

Finally, factor III seems to highlight the *object of the intervention: between ambiguity and difficult integration*. In this case, in fact, a prematurely interrupted relationship modality (modality BC is an exception), characterising the aspect of the *relationship as a journey and of the intervention as correction*, is opposed to intervention modalities involving the issuing of certification, characterising the *space of ambivalence* and *embodied language*. This is an emotional dimension that while on the one hand seems to offer the body as the object of intervention, in a space of thought strongly connoted by ambivalence and referentiality, on the other, it offers the intervention itself, and the change it infers in “corrective” terms (perhaps responding to an interventionist request) as well as in “elaborative” terms (perhaps

promoted by a curative request), as the object of reflection in a process of shared work. In this latter case, however, the relationship seems to collapse, breaking off prematurely. Here, on the other hand, a briefer and more specifically designed intervention modality (BC) responding to the request for a preconstituted process, and keeping more closely to it, is successful.

This means that the object of intervention is represented on the one hand in the work on the possible integration between the process of psychological reflection and the institutional process (or between the “professional mandate” and the “institutional mandate”, which were earlier defined as being in opposition), while on the other hand, the object of intervention would be found in the work on the evacuative aspect of the body which (being material and external) presents itself at the level of contents and relationships as binding and potentially constrictive (body and certificate as the *concrete* objects of the intervention).

4. Concluding remarks.

The potentialities of carrying out clinical work, which are revealed in the interaction between the actors of the relationship, while originating in the combining of the different subjectivities, cannot ignore the “instituting” and “signifying” function performed by the psychological context, with its explicit rules and with the combination of reality with affective levels and dimensions. The clinical report, which arises as the product of the interlacing of relationship and context, seems to become the ‘spokesperson’ of this complex mixture, since, given the purposes for which it was created, it includes, like an amalgam, the levels (intentional and emotional), the reality (internal and external), and dimensions (individual, relational and institutional). The object of reflection therefore becomes the possible signification of the clinical work through the report, and, by analysing the product of this activity and function, also the interpretation of the collusive processes (Carli & Panicia, 2002) that represent the symbolic source (emotional, affective) of the relationship acted out in the context.

The scenario described so far therefore makes it possible to interweave various interpretative levels.

In the first, the different models of symbolization of the relationship and of the context can be read in connection with the experience and the professional training of the writers. Reports written by psychologists who are doing their specialist training seem to be tied, with a certain degree of association, to content and relational dimensions which seem inherent to the space of the clinical interview and its subsequent reporting, in its multiple forms (supervision, reflection orienting the intervention, restitution). So the ways of symbolizing the relationship in the context and the context in the relationship (depicting the idea of a strong ambivalence, of concreteness acted-out and experienced in “having rapport” with the other, and of definition as beginning, severance and transformation, of the self and the other) seem to present a rather self-centred view or, in a mirror image, centred on oneself and/or on the client. While this may be related to a situation of operative difficulty of a “developmental” kind which, certainly legitimated by a professional identity still being defined, makes the assumption of the role uncertain and impregnates the task completion with marked referentiality, it should probably be seen in relation to the complex “contextual” interlacing (psychopathological suffering, the operative ideal and the ambiguous demand for intervention), whose attention to contents and relational dynamics may be a defensive aspect. In the reports written by specialist operators, instead, the gaze seems to turn more critically to the clinical relationship in its connection with the demand and with the context of intervention. Therefore when the role and acquired experience make one’s operativity less uncertain, the symbolization models would tend to concentrate on the conditions for carrying out one’s intervention in the context, perhaps by presenting and questioning the different possible functions of psychological work (a process of reflection or “correction”) and how it can be carried out in the complex institutional process.

The second interpretative proposal, on the other hand, considers the configuration of different ways of relating to the intervention in the context, allowing for reflection on the possible source of affective meaning which, shared by the individuals that are part of that context, guides the intervention. In this case, keeping in mind that the models of symbolization, which indicate the way one operates, reflect the meeting between a reference model that is theoretical and operative (in this case psychodynamic), an object (the task, the intervention) and a context (the demand, the group and institutional dimensions), we have seen the interweaving of three possible perspectives which may outline a continuity of development. From one standpoint, underlining the focus on the psychodynamic reading both of the transsexual pathology, and of the functions of clinical work, the possible intervention is defined as such in its functions insofar as the coercion of thought in the desiderative and operative urgency is juxtaposed to its capacity to be represented and translated into communication. From the other standpoint, bringing into play the transformative functions of psychodynamic/psychological work on acted-out corporeality, in the clash with the pre-existing insistence on correction in the process of change, the operative modality foreshadowed seems to lie in the contrast between a curative ideal and the reality of the intervention; in other words, in the oscillation between two possible forms of response to the request for intervention: the operator as saviour or as impotent sorter?

Lastly, from a third standpoint, it seems possible to represent the psychological intervention in the opposition between a potentially flexible opening to the conditions for carrying out the "change" (curative-corrective), in the context (in what, after all, has been shown to be the perspective of the specialist) and a more hesitant attitude of closure towards the concrete side (in the relational perspective of the trainee operator). Therefore the association between the dimension of a curative intervention and a corrective intentionality, in the fusion of the demands, foreshadows the possible risk of symbolizing one's intervention in terms of a "saving omnipotence"; on the other hand, the possible integration of these aspects is evidence of openness towards critical reflection on the meaning, functions and feasibility of one's intervention and towards dialogue between different demands, operative modalities and purposes (medico-legal and psychological, whose opposition risks fruitlessly perpetuating the irreconcilability of body and mind, sex and gender). Analogously, while work on the concrete objects of the intervention (the mutilated body and the request for the certificate) in the symbolization of a relationship and of a context connoted by ambivalence (individual, relational and operative) and by binding referentialities seems to indicate the possible risk of collusion, elaborating it represents its potential development.

The ambiguity of the demand, in an obscure, deceptive process of delegating to the representatives of the "psych factor", is a constraint on clinical action (which responds implicitly, having seen the arrogance of the assumption or the irreconcilability of the viewpoints). It channels into impotent concession or saving opposition, the potential transformational power whose awareness of this guides, protects and, by shattering the collusive fantasy (Carli & Paniccia, 2002), opens the way to new possibilities of maturation.

Therefore, while the difficult meeting between the psychologist and the transsexual person seems perhaps to evoke a more complex possibility of integration, that of mind and body, gender and sex, psychological intervention and medical-legal process, the object of clinical work in the context is prefigured in the potential elaboration of its functions, as well as its constraints.

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