Our Body Project: From Mourning to Creating the Transgender Body

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ABSTRACT. As much as one may attempt to determine the gender of one’s psyche, something will always be lacking, something will be left to reckon with, specifically, the body’s deception of the psychic body image. The mourning of one’s body for a trans* person may follow a unique path but it shares the universal human experience of self-acceptance. A person must come to feel the body in order to accept that aspects of the physical body do not match the person’s gender; there is a loss for what was never present and what will never be of the person’s body. The phenomena of phantom limb experience will be explored as a means for understanding trans* embodiment and how the bodily phantom must be mourned to be reclaimed. In addition, this paper will explore the concept and relationship of phantom sensations and prosthetics in transgender individuals and how to make clinical use of them. The process of selecting physical interventions to reconstruct oneself will be explored through a schema illustrating the public and private aspects of each bodily intervention available for medical transition. This schema can be used in clinical settings and the public/private realms of the body will be discussed using psychotherapy case material.

KEYWORDS. Transgender, body image, gender dysphoria, psychotherapy, phantom sensation

Our Body Project reflects the collective experience of transition. Anyone having trans* related medical care is able to have successes based on the people who came before them. Someone has to be in a surgeon’s first hundred or two hundred patients and those coming afterward owe the successes of their bodies to those first bodies. In addition, the transmission and absorption of information particularly on the web in the form of websites with advice, testimonials, blogs, YouTube videos, and pictures is equivalent to trans* folks building their bodies out of pieces of everyone else’s and then offering it back to the group. We are a collective construction.

The aim here is to elucidate the universals of body image for transgender, transsexual, and genderqueer people, but within those universals there are a myriad of expressions for each individual, in particular, regarding how the private and public aspects of the body are considered for each person.

To be clear, it is important to understand that this project is speaking of the trans* phenomena, to return to Harry Benjamin’s terminology (Benjamin, 1966). When we look specifically at the definition, a phenomenon is an object or aspect known through the senses rather than by thought or intuition.
This paper’s focus is on the senses. Two examples illustrate the long history of humans’ complicated relationship with their bodies: First, from On the Life of Plotinus and the Arrangement of His Work, a book on the philosopher who died in 270 AD, “Plotinus, the philosopher . . . seemed ashamed of being in the body” and, second, of the present day, from Saturday Night Live’s Weekend Update segment, the story of a robot that was programmed to recognize itself in a mirror but couldn’t be fully human until it learned to hate what it saw there (Porphyry, 1992, p. 1; Myers, 2011).

As close as one may attempt to arrive at the gender of one’s psyche, there will always be something lacking, to reckon with, specifically, the body’s deception of the imagined (felt) physicality. The mourning of one’s body for a trans* person may follow a unique path but it shares the universal human experience of self-acceptance.

**BODY IMAGE**

This process of understanding the body leads to Schilder (1950), who developed the concept of body image. His work incorporated neuroscience, psychoanalysis, and sociology to understand how the postural model of the body is formed in our minds. Our body image is developed through our body’s interaction with the world, the tactile and interpersonal experiences and their impression on our brains. Body image also includes proprioception, the felt sense on the internal body as a whole and a sense of locomotion that is positioned in space, such as balance.

In addition, our body image is developed through our visual experience of our bodies, through the bodies’ topography. “The topography of the postural model of the body will be the basis of emotional attitudes towards the body” (Schilder, 1950, p. 15). Thus for the gender non-conforming (GNC) child, when the topography is sensed as distorted and incongruent, poor body image begins to develop and only worsens at pubertal development.

Our body image is projected out and the world is introjected (Schilder, 1950). The GNC child presents gender-crossing behavior and the world says no. From infancy, mirroring takes a gendered undertone. From facial expressions to verbalizations to even how we physically handle infants has referenced gender (Brooks-Gunn & Matthews, 1979; Kleeman, 1971). The child’s own internal sense of self is consistently undermined—implicitly to directly (and violently). One of the consequences of this is shame. “Shame is connected to impressions of being degraded, humiliated, and rejected as a person, at which point it resembles catastrophe” (Frølund, 1997, p. 37).

Undoing this negative mirroring is a primary process of our work in therapy, with all our patients but in particular with our trans* patients. Winnicott elucidates the role of the therapist as displacing the negative mirroring of the caregiver and offering the patient a transformed and positive mirroring throughout treatment (Winnicott, 1971). Many times, psychotherapists are the first accepting person of their patient’s gender identity, especially when there is no visual representation yet. Therapists reflect back the felt gender, even before there are outward manifestations of it. As therapists, we believe and affirm our clients.

The majority of a person’s body image is constructed and located in the unconscious. This material, which is resistant and repressed, needs to be called up in treatment. The depersonalization from the individual’s body image has been a source of survival, and only in creating a holding environment in conjunction with extra-therapy supports can an individual safely settle into one’s self. In treatment, the trans* person must connect with the painful aspects of the body in order to fully realize what changes are necessary to create a more livable existence.

**BRAIN OUT—PHANTOMS AND MOURNING**

Furthermore, body image is experienced from the brain out as can be understood by the phenomenon of phantom limbs. When a part of the body is lost due to surgery, accident, and even birth defect, the majority of the time, the sensation of a phantom remains. This feeling is a sensation activated in the part of the brain, which
understands real feeling, not “as if feeling” (Willoch et al., 2000).

The strength of connection to the external world of the body part determines the length of time the phantom continues to exist. For instance, if it is an arm, in the beginning the whole arm will be the phantom. As time goes on, the phantom arm may disappear but not the hand. The individual will feel a hand protruding from the shoulder. Schilder (1950) explains that because the hand has more contact with the external world and has more concentrated nerves, the brain holds onto it longer (1950). In addition, he concludes that body image is not only constructed on sensations but also on emotional processes. Our minds need to have the force of the energy, which is directed by nerves, the brain holds onto it longer (1950).

In addition, he concludes that body image is constructed on sensations but also on emotional processes. Our minds need to have complete bodies (a shift from wrong to right body). Schilder says, “[T]he phantom . . . is . . . the reactivation of a given perceptive pattern by emotional forces” (p. 67). The varieties of phantoms are understood through humans’ emotional reactions to their bodies.

William James’ (1887) research on phantom limbs after the Civil War concludes that the only common experience of phantoms is that they exist, but the form they take is based on the individual; it is a personal phenomenon.

Prosser (1998) compares phantom limbs and the transsexual experience in Second Skins. He equated the memory of the missing part (i.e., breasts for transwomen, the penis for transmen, etc.) with “nostalgia” that the transsexual feels, as if it were a desire of a “fantasized ideal of home” (Prosser, 1998, p. 84). The arguments here disagree with that in the sense that in this author’s clinical experience, the trans* person’s feeling is a more rational and practical need coming from bodily sensations. Prosser’s use of phantom in this manner seems to perpetuate the myth about trans* people as unrealistic and immature with regard to their psychic development in relation to their body image.

If we move from the pathologizing discussion of a trans* person’s belief or desire to using the words sensation and self-knowledge to describe the trans* phenomena, it shifts the lens of the discussion. The phantom is the sensation, which haunts the trans* person. The project here is to carry further the phantoms and the experience of gender dysphoria—that dysphoria is in essence

protracted mourning. Just as in mourning the loss of a loved one, the mourner “forgets” that the loss has happened and experiences the lost person as alive.

In the trans* phenomenon, it is the loss of what one never had but should have had, that is mourned. There is such a phenomenon in neuroscience, called the expectation of sensation effect. This effect creates sensation where external stimuli have not occurred, it comes from within the brain, not the brain responding to an external stimuli. A trans* person’s sense of their body is analogous to this phenomenon.

It is misleading to describe trans* experience as a desire for the opposite sex genitals and secondary sex characteristics. In the author’s clinical experience, this relates more to the sensation of the phantom and the expectation of sensation effect. The person feels what is missing or what feels like a superfluous and distressing addition. There is an experience of something that was lost, be it genitals or chest or hips or a clumsy addition that does not belong. The physical presence is missing and the necessity of that part of the body is mourned, which has also been characterized as dysphoria.

Devor (2004) describes the experience of transmen as imagining a phantom penis but the following research takes the “imagine” out if it. Research in neuroscience on phantom experience and transsexuals is being conducted at the Center for Brain and Cognition at University of California San Diego. Researchers find that 60% of transmen report feeling a phantom penis over the course of their lifetime (Ramachandran & McGeoch, 2008). Just as some people born without arms have phantom sensation of arms, so too do trans* people have phantoms of their missing body parts. Ramachandran and McGeoch (2008) explain how remarkable it is that these phantoms have survived despite years of doubt, visual feedback, and the world telling the individuals the opposite.

In addition, 10% of transmen experience breast phantom following mastectomy surgery while only one third of cisgendered women experience this. Among transwomen, 30% report phantom penis after vaginoplasty, while 58% of cisgendered men that have had penectomy surgery due to illness experience phantom
penis (Ramachandran & McGeoch, 2008). The researchers assert that this disparity was significant enough to begin to conclude that the sensation of cross-gender identification may be hard-wired in the brain. This is not to say that only genetic factors legitimize trans* experience; trans* experience is already a legitimate part of human experience. This research brings to light one of many factors, all of which are related to the human experience of gender.

Hansbury (2005) discusses people in transition mourning their pretransition selves and the idealized image of Man or Woman. This paper, in contrast, is speaking about the mourning of the future self in relation to the limits of the body and the interventions. What is and is not possible to achieve in physical transition? This aspect of the psychic work needs to be done before the physical interventions begin.

**FEELING THE BODY**

Feeling is the perception of the body (James, 1884). Without the sensations of our bodies, our emotions are dampened.

Once the process begins of the individual recognizing the individual’s own gender identity by connecting to this internal sense of self and awareness of how that clashes with public perception is when the individual considers modifications. It is knowing that dressing is not enough and something of the material body has to change. It is about feeling and not thinking, because one needs to stop listening to the world and communicate with one’s body. The individual’s grief at aspects of the body, which cannot be fully created, even if completely socially performed, needs to be worked through in treatment. Through the process of mourning, the subject finds the livable compromises and the good-enough body. But in order to know what needs to be changed, one needs to fully feel the body. This can be a painful process of being fully aware of all the aspects of our body. But awareness is necessary in order to determine what feels uncomfortable and what is unbearable.

In treatment, we work on helping patients to recognize their own sensations of their bodies while supporting them emotionally through that oftentimes traumatic process. Overcoming the depersonalization, separation from one’s body image, is worked through in psychotherapy in conjunction with experiential elements. We need to help patients to find ways in which they can connect to their bodies in an activity they can enjoy through their body. For some people these are sports, yoga, meditation, or sex; for others it could be a minimum of ceasing to do harm to oneself. Finding these “good enough” compromise activities is a kind of truce with the body before there can be acceptance and enjoyment. The work is to unknot the image that one’s body is something through which one only experiences pain. How much enjoyment is experienced can also depend on how gendered these activities are, such as certain sports or sex, whereas yoga and meditation are completely ungendered activities, thus offering some gender-neutral relief.

**PROSTHESES AND STRAP-ONS**

Fantasy is not something that the subject does, but rather something that enables the subject. (Salamon, 2010, p. 36)

When the body is amended to achieve congruence, there is a rapport between the psychic self and the bodily self, be it surgical or prosthetic. This rapport is emotional unity. The prosthetic is for some people a good-enough replacement, whereas for others it is a rehearsal for what will need to be created otherwise.

The phenomenon of the phantom limb is helpful and in many ways necessary when the individual is beginning to use prostheses. It aids in embodying and animating this piece of metal or plastic attached to the person’s body. This can be extended to clothing as well.

Similarly, when a transman wears a strap-on it aids in him finding gender congruence during sex, and when a transwoman wears women’s underwear, it helps the transwoman to maintain her body image. One patient was struggling in treatment to feel sure if he needed to transition, if he really was a transman. The session after he used a strap-on, he started the session by saying, of course he needed to transition, it all made...
sense to him. It felt as if his penis was always there. It was all so clear to him now.

Our bodies’ manifestation of sexuality is essential to our being (Salamon, 2010). Other parts of the body, other than the genitals, can be more cathected than others. How deeply cathected is dependent on how one thinks about these parts. The libidinous energy is directed to more gender congruent parts of the body—that is, muscular arms for a transman, soft legs for a transwoman. The ability to ask one’s partner to relate to you in those specific ways facilitates a more fulfilled and congruent sexual life. Many a patient has reported that even before they were aware of their need to transition, their sexual partners recognized their true gender through how they engaged in sex.

Through the use of prosthetics, some may find acceptance of their good-enough body and completion in this compromise. Whereas for others, it is a more difficult compromise position in which the gap will need to be filled through mental and emotional work by the individual if medical intervention has not or cannot help them. This is an example from the aptly named Original Plumbing magazine:

The long list of things I find frustrating starts with the fact that when I want to have the kind of sex that includes any sort of hip thrusting, it often requires a harness. Now I don’t have too many complaints about this kind of sex, nor do I judge people who choose to avoid the strap-on completely, however what I will say is that my little man is tired of ramming up against his stunt double during these types of engagements. Nothing says “you can’t drive the car” more than being forced into the back seat every time you turn on the engine. (Joynt, 2010, p. 7)

For this person, the prosthetic has become a blockage instead of a facilitator. At some point it surely provided a useful bridge instead of representing an endpoint. This is a moment that someone who felt similarly may need to work through in treatment to decide whether to accept this compromise or that bottom surgery is necessary.

**CREATING A NEW BODY THROUGH LANGUAGE**

Fantasy and cathexis are not only mental projective processes, they rely on language as well. When a transman can be with a partner who will refer to his genitals as his dick, he can connect and feel the sensations better. Similarly, language can help a transwoman who has her first “lesbian experience” before vaginoplasty if her partner can relate physically and verbally to her genitals as a clitoris and not a penis. These linguistic accommodations can be a beginning of enjoyment of sex through the connection of language. There can be enough of a match up for language to bridge what is missing or in the way.

**BODY MODIFICATION—BEYOND THE LIMITS OF LANGUAGE**

The trans* individuals may have access to gender-affirming medical interventions or other means of bodily modification, however the limits of their acceptability and effectiveness need to be considered as well as the fear of rejection, internal and external transphobia, and finances. Many of these will need to be worked through in psychotherapy. The body must ultimately be accepted as an imperfect project. “Ambiguity is of the essence of human existence” (Merleau-Ponty, 1996, p. 169). And the ability to tolerate it is one of the hallmarks of mental health.

Thus in working through emotionally and physically, one’s body can move from something to be endured to something to be invented—not just a body one is born with but, rather, a self-created work of art. The search for a surgeon, in particular, is analogous to finding a tattoo artist. You want someone who can carry out your vision. Consults happen, past work of the artist or surgeon is reviewed; online searches and chats are conducted. (It is remarkable how similar the websites are for these two professions.) Then you put your body into another’s hands and hope you do not need revisions. The ultimate question in gender-affirming surgeries is, will my body be more gender congruent? Even though it is cosmetic surgeons performing the work, the core goal is congruence, not aesthetics.
The interventions in the therapy room, in the “here and now,” are aiding patients in regulating their affect in order to tolerate their gender-incongruent bodies, working with patients on being able to identify where in their body they feel anything (for some individuals that is developing the ability to recognize when they need to use the bathroom or when they are hungry), especially those who have experienced other traumas to their bodies. Depersonalization and pain tolerance has developed over many years of separating from the body; these become useful skills when it comes to surgery and electrolysis.

INTERVENTIONS WHO NEED AN(OTHER): FROM LANGUAGE TO ACTION

Part of this paper’s project is the new conceptualization of bodily interventions into a schema: the private body and public body and the intersection between them. This is decidedly an American perspective, given our system of a la carte bodily interventions. In clinics in some other countries such as the Netherlands, once one is accepted for treatment, the basic medical interventions (hormones, GRS, Mastectomy, etc.) are provided in full. There are no in-betweens. In the tradition of the American idealism of the individual and the refusal of most insurance policies to cover trans* health care, trans* persons create their own path with their own money.

PRIVATE AND PUBLIC BODY

The schemas shown in Figures 1 through 10 are of the public and private aspects of the majority of bodily interventions available at this time for physical medical transition. There is no objective value to the public and private aspects of the schema, the value depends on the individual’s subjective psychological, interpersonal, and socioeconomic experience. Figures 1 through 10 are ordered beginning with, primarily, private interventions to progressively more public interventions. The private aspects are listed in the left-side circle and the public on the right. The public and private intersections in the middle of the Venn diagram hold the place for the intimate space of sexual partners, but can also include interactions with medical providers and law enforcement—for example, physical exams and strip searches. These three realms hold varying importance for the individual.

As seen in Figure 1, the schemas start with the generally private considerations of a hysterectomy, which does not have any public considerations except regarding interacting with medical providers. People decide to have a hysterectomy for a variety of reasons such as ceasing menstruation. When ovaries are removed testosterone treatment can be reduced; if everything including the cervix is removed pelvic exams become unnecessary. The hysterectomy prepares the body if the person needs bottom surgery in the future. Obviously, the surgery also renders the individual sterile and provokes immediate menopause. These are major, mostly private, changes that certainly would be explored in the treatment of anyone having this surgery.
Similarly, one could have an orchiectomy (Figure 2) without social transition. This could bring much body-image relief to the individual, with the reduction of testosterone in the patient’s system and an adjustment to the hormone regimen. The “bottom surgeries”—vaginoplasty, metoidioplasty and phalloplasty (Figures 2 and 3)—happen very late in a transition for most people, since living fully as their affirmed gender is not dependent on these surgeries. In addition, the prohibitive cost and 1-year real-life experience (RLE) are contributing factors to these interventions, coming much later than others. When one wants to live a completely stealth public life, even with intimate partners, bottom surgery becomes a public and private endeavor.

For some people, social transition aided by hormone therapy (Figures 4 and 5) is the most powerful because it leads to more consistent public recognition and gender congruence of the bodily topography with their gender identity. As can be seen in the schema, the list of public-body changes is significant with feminizing and masculinizing hormone treatment. It is also the intervention that provides the most benefits for the lowest cost. The effects on the body primarily involve hair, skin, and muscles for feminizing and masculinizing hormones. Testosterone offers a voice change, which is an important aspect of public recognition for a transman; whereas, transwomen do not benefit this way from hormone therapy—voice consultation with a trained speech-language pathologist is necessary. As the saying goes, hormones can give but not take away, such is the case that they can bring breast development but not rid the body of them.

Hip/buttock augmentation (Figure 6) was of high priority for one patient who “always felt that they were there,” as the phantom experience implies. She was a transwoman who had a very lean frame. She would walk past mirrors and be “surprised that they (her hips) weren’t already there.” This intervention topped her list of importance since the feeling was so strong and since she was not living full-time (as a woman) yet, it could be easily concealed.

Double mastectomy (Figure 7), if one does not take one’s shirt off in public, is a primarily private intervention for the genderqueer person.
FIGURE 7. Double incision/Keyhole (mastectomy): Schema of public and private body

or transman. Public recognition only happens to a shirtless person, but top surgery does offer significant personal body-image relief. It also has the flexibility that one can have the surgery with or without social transition. The public and private aspects which are more important depend on the individual’s needs. One patient who was not ready to socially transition at work was able to get “top surgery” before beginning testosterone, which he could time with his work transition. For another person, who was competing in athletics as a woman, top surgery could relieve some gender dysphoria without the person having to report a gender change to the athletic league, as testosterone would force the person to do. The distinction between the two in terms of public recognition as a trans* person lies in the scars: double incision has them, “keyhole” does not. Some people do not have a choice as to which surgery they can have due to various issues primarily linked to breast-tissue size and nipple size and skin type. For those who can choose, scars versus the type of result of each surgery is a complicated issue and may need to be talked through in therapy since the choice may not be clear-cut and a surgeon’s consult is brief. To illustrate the complication of scars, one patient who had “double incision” was caught off guard when a new, casual friend asked about his scars when his shirt accidently revealed them. He did not want to out himself yet as trans*, so he said, “[C]hainsaw.”

Breast augmentation (Figure 8) will almost always be preceded by a social transition. A therapist, who was out as a transwoman for many years, still had to prepare her patients for the change in her body. The difference would be very obvious and dramatic (not a slow progression over time, like weight gain). It would have been poor practice not to inform people, even though it was the type of personal revelation therapists try to avoid making to their patients.

The schema ends with the mostly public interventions of facial feminization surgery (FFS) and hair removal/replacement (Figures 9 and 10). One patient discussed how emotionally painful it was for her that when she looked in the mirror she still saw a male face looking back. It held more importance for her than bottom

FIGURE 8. Breast augmentation: Schema of public and private body


FIGURE 10. Hair removal and replacement: Schema of public and private body
surgery since it felt like she had more interaction with her face than with her genitals. The pain of inconsistent public recognition was worth the delay of vaginoplasty.

Hair replacement can be essential for a transwoman to feel she will have public recognition of her gender as well to experience a less-male face in the mirror. It is also an intervention any gendered person can engage in without having to come out to anyone. Hair removal is a painful, unpleasant process.

It can seem and feel as if one is at war with one’s body, reviewing this list of interventions. To make the experience more tolerable, it is imperative to help reframe this process, not with a warfare mentality and vernacular but as a more positive process.

This schema can be used as a tool in clinical settings to help patients think through their process when physical intervention is found to be necessary. One can weigh what will be gained and what will be lost; the intimate and interpersonal public and the deeply personal-private needs can be explored thoroughly. Of course, the individual can use these schemas of their own accord as well. The schema offers a non-pathologizing method of thinking about necessary gendered body modification. It can be an overwhelming process to work through what is necessary, and this model can at least bring some order and structure to the process.

The schema also distinguishes these surgical interventions from general aesthetic plastic surgery. This is about gender identity and expression and not “good-looks.” For most trans people, they would prefer to be an average man or woman than an exceptionally attractive person in their assigned gender from birth. The irritation one feels from poor aesthetics is like a pebble in your shoe; whereas gender incongruence is more like a boulder on your chest—there is no ignoring it or getting used to it. It is more informed for the clinician to think of these as reconstructive gendered interventions than as cosmetic, aesthetic ones.

CONCLUSION

The process of knowing the body is a nuanced and rambling path. Clinicians need to be aware of the constellation of considerations regarding transition and aid patients in finding ways to know themselves and connect to their bodies. This is the new standard—to respect and listen to patients’ needs (Bockting et al., 2006; Coleman et al., 2011; Fraser, 2009; Rachlin, 2002).

Individuals’ needs and fears are so unique that the public and private domains should be fully explored in treatment. The compromises cisgendered and gender nonconforming individuals alike need to make around the imperfections of being in human bodies should be discerned from the need for gender congruence—from the recognition that transition is not only about aesthetics but about identity. What we are all searching for is realistic expectations and the ability to live with ourselves. It is necessary for one to be in connection with one’s own body in order to fully know what is right for oneself. Our patients must be intimately in touch with their sensations and we need to process in treatment how to understand them. We work with words in session to understand the actions and feelings outside of session. A clinician’s goal is to help our patients understand the dissonance between their internal signals and the mirroring they receive in the world and to accompany patients through what is possible to change and to traverse from dysphoria to a celebration of their bodies.

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