Ricerca Psicoanalitica | pISSN 1827-4625 | Year XXXV, n. 2, 2024
doi:10.4081/rp.2024.791

The double 'double bind' of transgender persons and ways to overcome it

*Fulvio Frati**

ABSTRACT. – In the transition to affirm their gender identity transgender persons sometimes get 'entangled' in a sort of 'double double bind': one based on the contraposition of anatomical sex and gender identity, and the other on the divergence between individual gender expectations and those manifested in the family and social environment. In order to help subjects deal with a situation which is often the source of significant personal distress, the author proposes psychological treatment or psychotherapy based on the so-called 'affirmative gender model of informed consent' from the Italian model of Psychoanalysis of Relationships, supplemented by contributions from the 'Theory of non-linear dynamic complex systems', Infant Research, from other authors in the psychoanalytic field, Neurophenomenology, and lastly, from *the psychoanalytic field* concept introduced in the last century by the Barangers and later developed by others, including Italian authors.

Key words: double bind, gender dysphoria, gender expression, gender identity, gender orientation, transgender.

Gender identity, gender expression and sexual orientation

The term 'gender identity' is particularly widespread in the scientific debate on sexual attitudes and consequent behaviours, and refers specifically to the subjective psychological sense of gender that a person presents, and which, failing to conform to family and social expectations generally attributed to that gender (otherwise known as 'gender-nonconforming') can generate significantly high levels of personal distress.

First, let us clarify that the term 'gender identity' is different from the term 'gender expression'. A person's gender expression cannot always be superimposed on the gender identity they present; considering a purely external level, it concerns the way one presents oneself to the world in relation to one's gender.

*Psychologist, Psychoterapist, Clinical Criminologist and Psychoanalist of SIPRe. Past-Director of the SIPRe Center of Parma, Italy. E-mail: fulviofrati@libero.it

For example, in much of the 'Western' world (including Italy), wearing a tight-fitting mini dress is considered an 'expression of the female gender' while a tuxedo with a black jacket and tie is generally considered an 'expression of the male gender'. These social interpretations of the way we dress are culturally defined and therefore vary over time and according to the environment (it is not particularly unusual to see in 'high-end' fashion shows female models dressed in menswear and male models in miniskirts and stilettos, but these extremes occur in specific situations and represent more the 'exception that confirms the rule' rather than the actual rule). Furthermore, terms such as gender identity and gender expression, in addition to designating different aspects of a single individual personality, should be distinguished from sexual orientation: the latter refers specifically to the types of people one is sexually attracted to.

Those whose gender assigned at birth matches both their gender identity and gender expression are sometimes referred to as 'cisgender' (a neologism from the Latin preposition *cis,* 'on this side of' and the English noun 'gender', which in this case means 'assigned gender' and therefore is based on substantially anatomical and/or genetic criteria): the term is used in relation to 'a person who feels at ease with the sex assigned at birth'. However, the term cisgender is little used in the scientific field and is only useful in a general, descriptive sense as it fails to take into account the important criterion of sexual orientation.

In fact, a person who feels at ease with the sex assigned to him at birth is exclusively attracted to, or almost exclusively attracted to persons of the opposite sex (and is defined as heterosexual), but a person can also be attracted exclusively or almost exclusively to persons of the same sex, and therefore be homosexual (hence the terms 'gay males' or 'lesbian women') without ever manifesting the desire for those bodily characteristics typical of the opposite sex. A cisgender person can also feel attraction towards persons of both genders and in this case, they are known as 'bisexual'.

The persons whose gender identity does not align with their sex at birth but rather aligns with the gender identity of the opposite sex are generally termed transgender, while the previous term transsexual*,* being generic and imprecise, appears to be dying out (many transgender persons*,* for example, do not identify completely either with the gender assigned to them at birth or with the new gender they adopt, and often – despite carrying out complete gender transition legally and officially – do not completely change their primary sexual characteristics). Transgender persons, substantially, like cisgender persons, also present a very wide range of sexual orientation: for example, a transgender woman (*i.e.*, male-to-female transsexual, or MTF) can be both heterosexual, bisexual and lesbian, in the same way that a transsexual man (*i.e.*, female-to-male, or FTM) can be heterosexual, gay or even bisexual.

In their everyday lives transgender persons will experience a far superior range of difficulties than *cisgender* persons and this tends to place them in a sort of 'double bind' (we use this term in the sense assigned to it by Gregory Bateson and his colleagues of the so-called 'School of Palo Alto ' in the second half of the 1950s but which today covers a much broader perspective than the one originally conceived by the scholars of the last century, also because instruments of communication have changed enormously in the meantime) with regard to two main problems: the divergence between one's anatomical sex and one's gender identity on the one hand, and, on the other, one's individual gender expectations and those expressed towards them by the family and social environment.

The double 'double bind' of transgender persons

The term 'double bind' refers to a situation in which two or more persons are involved in a sort of 'communicative ambivalence' in which a message of a certain nature is sent by a sender to a specific recipient, but the recipient also receives messages of a contrasting nature from the same (or similar) sender. Usually, the first type of message is of a verbal nature, while the contrasting messages are non-verbal. However, this is not a fixed rule and sometimes the situation can arise through verbal messages only or non-verbal messages only (as are implicit messages that transgender persons receive from their body, or even simply from their anatomical sex, whenever they do not identify with it).

However that may be, the presence of contradictory messages usually gives rise, in the recipient of this confusing communication, to a sort of self-perpetuating conflict which, albeit to a different extent in each case, tends to produce significant subjective discomfort that is often long-lasting and potentially capable of giving rise to conditions of subjective psychological suffering of significant clinical relevance which include, not infrequently, the very real risk of self-harm or even self-suppression.

Unlike what happens in explicitly conflicting circumstances, where at least in theory those involved are able to choose and decide which actions to take to overcome them, in situations of double bind the way out is often much more difficult to find. This is because the situation is determined by a paradox with a contradictory message: the same thing is affirmed and denied at the same time, and one finds oneself 'trapped' in a situation that one cannot bring into clear focus, and in which one is unable either to identify how it relates to his own consequent discomfort, or develop a functional strategy to resolve and overcome it.

In particular with transgender persons, not infrequently, the condition of an 'intrinsically conflictual paradox' typical of double bind occurs simulta-

neously on two levels. On one level – when a person gradually and autonomously reaches greater levels of self-explication and, therefore, of self-consciousness and self-awareness – concerns the contradiction between the messages of one's physical body as perceived by other people, and one's gender identity as perceived by oneself and others. On another level – often much more 'implicit' even in relationships between the person and other significant figures on a family and social level – involves one's own individual gender expectations more directly and those that are manifested towards them by their external proximal environment.

In actual reality, for example, a parent who has proven to be an effective caregiver for their son or daughter may not present too much difficulty demonstrating it in the case of a transgender son or daughter, and therefore may not generate excessively high inner conflict regarding both aspects indicated above. However, especially in situations in which the hostility towards the gender identity expressed by the transgender person is more or less explicit or, on the contrary, veiled, it is clear that the latter is exposed to high levels of uncertainty, doubt, or even clear disconfirmation regarding the radically important sense of gender identity common to all human beings.

Furthermore, regardless of the presence or absence of adequate support for transgender persons on the part of their caregiver, implicit disapproval or even explicit hostility can also be manifested towards them on the part of other socially significant actors. Considering this, it is evident that the potential double conflict of transgender persons (between gender identity and body, on the one hand, and gender identity and the significant relational and interpersonal sphere on the other) exposes them to the 'double double bind' condition that we want to focus on here, and the often not negligible, and in some cases, particularly significant psychic suffering that it can give rise to.

The familial and social rejection of gender identity is today almost universally considered to be one of the strongest predictors of subjective difficulty for transgender persons. Family therapy, or couple therapy for parents, can therefore be extremely useful in creating a supportive environment that can promote the psychic and psychophysical well-being of persons in this situation.

The experiences conducted so far also demonstrate that, as a rule, parents of transgender children and adolescents can also derive significant benefits from regular attendance at support groups, whether based on the model of self-help between peers or conducted by one or more (usually at most two) experienced professionals. Peer support groups for transgender persons have also often been very useful for sharing – and possibly invalidating or validating – different aspects of their transition experiences. Finally, individual psychological support or psychotherapy programmes aimed at the transgender person or at their most significant family member, for example, a partner, play a particularly important role.

The condition of subjective distress that the term 'gender dysphoria' used to bring to mind, today appears – also in the light of the considerations expressed here – to be linked more particularly to aspects of a social and relational nature than to the problems of psychological functioning considered in their own right. Moreover, it is for these reasons, in my opinion, that the diagnostic category 'gender dysphoria' has been rightly eliminated from the latest version of the Diagnostic Manual adopted by the World Health Organization (World Health Organization, 2018).

The diagnostic category of 'gender dysphoria' has not only been replaced by that of 'gender incongruence' (thus removing any depiction of psychopathology), but above all, and as a consequence, the term has been removed from the chapter on 'Mental and Behavioral Disorders' (which specifically concerns so-called 'mental health') and instead, the new denomination has been included in a new, purposely-written chapter concerning 'sexual health'.

The diagnosis of 'gender dysphoria'

Therefore, in my opinion, some further considerations concerning so-called 'gender dysphoria' are appropriate at this point. In fact, there are no doubts that in this regard, at the present time, the question of its scientific usefulness or not is by no means resolved. Moreover, as a rule, in the field of clinical psychology and psychopathology, no question of this type is ever resolved once and for all, and it is precisely for this reason that the diagnostic categories pertaining to these areas are continually updated.

Having said that, to date, a clear 'array of signs and symptoms' that define with sufficient precision an individual situation that can be clinically delineated as gender dysphoria which is shared by international psychopathology, is lacking, also because – as has already been underlined – the International Classification of Diseases (ICD) has already completely eliminated the term, at least under this denomination, from its overall psychodiagnostic classification (World Health Organization, 2018).

However, this important revision process has not yet been carried out with regard to the international Diagnostic and Statistical Manual of Mental Disorders DSM-5-TR, recently revised by the Association of Psychiatrists of the United States (American Psychiatric Association, 2022). It still retains the use of the term 'gender dysphoria' understood as clinically significant psychological discomfort associated with a subjective inconsistency between the sex expressed at the level of individual identity, and the sex assigned at birth. This permanence of meaning, with the evident risk of a psychopathological connotation, is still present in the DSM-5-TR, and is in no way, in my opinion, a negligible or minimiseable fact, especially if one

considers that the Manual continues to be adopted in its entirety and is used by a large part of the international scientific community.

In this regard, exactly as was the case with the DSM-5, and without any change with respect to it, this cataloging system provides two different specific identification systems of the clinical picture based on the age of the person considered, and just as many series of criteria which are specific, distinct and separate from each other: one for adolescents and adults, and one for children up to 12 years of age.

Let us now look in detail at the two different identification systems or *diagnostic criteria*.

1) The DSM-5-TR first defines gender dysphoria in adolescents and adults as 'a marked incongruence between experienced/expressed gender and assigned gender, lasting at least 6 months, as manifested by at least two of the following symptoms:
   a. A marked incongruence between experienced/expressed gender and primary and/or secondary sexual characteristics (or in young adolescents, predicted secondary sexual characteristics).
   b. A strong desire to shed one's primary and/or secondary sexual characteristics due to a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of anticipated secondary sexual characteristics).
   c. A strong desire for the primary and/or secondary sexual characteristics of the other gender
   d. A strong desire to be the other gender (or some alternative gender other than the gender assigned at birth).
   e. A strong desire to be treated as the other gender (or an alternative gender other than the gender assigned at birth).
   f. A strong belief that one has the feelings and reactions typical of the other gender (or some alternative gender other than the assigned gender).'

Moreover, in order to meet the criteria for the diagnosis, the individual condition must also be associated with clinically significant personal distress or apparent impairment in social, occupational, or other important areas of individual functioning.

2) The DSM-5-TR also defines gender dysphoria in children as 'a marked incongruence between experienced/expressed gender and assigned gender, lasting at least 6 months, as manifested by at least six of the following (one of which must be the first criterion among the following) symptoms:
   a. A strong desire to belong or urgency to be of the other gender (or some other gender other than the assigned gender).
   b. In boys (assigned gender), a strong preference for cross-dressing or simulating women's clothing; in girls (assigned gender), a strong

preference for wearing only typical male clothing and a strong resistance to wearing typical female clothing.

c. A strong preference for cross-gender roles in pretend or fantasy games.
d. A strong preference for activities, games, or toys stereotypically used by the other gender.
e. A strong preference for persons of the other gender as regular playmates.
f. In boys (assigned gender): a strong rejection of typically male activities, games, and toys, and a strong avoidance of rough play; in girls (assigned gender): a strong rejection of typically feminine activities, games and toys.
g. A strong aversion to one's sexual anatomy.
h. A strong desire for physical sexual characteristics that match one's experienced gender.

Moreover, as already underlined also for the diagnostic criteria for adolescents and adults, the individual condition of the child considered must be associated with a clinically significant subjective discomfort, or with evident impairment in social, occupational or other important areas of overall personal functioning.

Regarding the presence of this specific psychological condition within the general population of Western countries, the portal of the 'Italian National Institute of Health*:* Inquire, know, choose' (*Istituto Superiore di Sanità ISSalute: Informarsi, conoscere, scegliere)* specifies, under the heading 'gender dysphoria', that it can concern both female and male subjects. Specifically, 'the prevalence of gender dysphoria in adults (>18 years) is 0.005-0.014% for biologically male sex persons and 0.002-0.003% for biologically female sex persons' (Zucker, 2017).

Gender dysphoria, therefore, in adults is more frequent in those assigned male gender at birth, with a male/female ratio of approximately 3:1.

In children under 12, 'the male/female ratio ranges from 3:1 to 2:1; while in adolescents (>12 years old) the male/female ratio is approximately 1:1.7' (Zucker, 2017).

From a rough analysis of the data, it would seem that, for females, adolescence may constitute a more critical moment with respect to their gender identity than other periods of their lives. Obviously, this hypothesis requires further investigation by other studies before any type of significant conclusion can be drawn from it.

Moreover, according to various studies attributable to various Italian and international authors (*e.g.*, Crapanzano *et al.*, 2021; Drescher, 2010; 2016), the permanence of the diagnosis of 'gender dysphoria' within DSM-5 and DSM-5-TR still seems to constitute, for many transgender persons, a concrete obstacle to gaining access to an adequate system to tackle their overall

problems. This is because for many years insurance companies have, legally, had a policy of not covering the health expenses entailed in accompanying the process of transition without this specific psychopathological diagnosis, a diagnosis which not all transgender persons – for understandable and in my opinion unquestionable personal reasons of social stigma resulting from any diagnosis of psychopathology – are willing to accept.

Psychological support and psychotherapy treatment for transgender persons according to the gender-affirmative model of 'informed consent'

Psychological support and psychotherapy treatment for transgender persons according to the so-called 'gender-affirmative model of informed consent', irrespective of individual differences in technique, style or the overall theoretical reference adopted by individual professionals, is mainly based on a 'holistic' and 'humanistic' approach to the person, which, in its turn, includes the contributions of authors who are integrated and aligned to respond in the most effective way possible to the concrete psychological, emotional and relational needs of individuals and specific patients. The approach is generally based on the open exploration of feelings and experiences of gender identity as well as gender expression, with no expression or inclination shown by the therapist towards any one gender identity or expression in preference to another – quite the contrary; the therapist is committed to having total respect for the relational, emotional and sexual choices made by the patient in his/her concrete daily reality.

Psychological attempts to direct a transgender person towards a cisgender identity (sometimes referred to in the literature as reparative therapies, or even as gender identity conversion therapies) are today regarded as highly unethical, and potentially very harmful, by almost all of the world's scientific community, and this approach is expressly forbidden to medical professionals and psychologists in almost all countries of the so-called 'Western industrialized area'. The nature of psychological support and psychotherapy for transgender persons, according to these premises, is today basically understood as providing support and accompaniment towards the gender affirmation of the patient him/herself, as he or she expressly desires and wishes it, in the areas of daily activity where one's gender identity is expressed.

Social gender affirmation, for example, may include the individual choosing to adopt pronouns, nouns, and various other aspects of gender expression that most closely match their gender identity. Legal gender assertion may also involve changing the name(s) and gender markers assigned at birth on various identification documents or data processing documents at both governmental and local levels.

Medical affirmation may, in turn, include pharmacological or surgical treatments up to and including, for example, suppression of pubertal activity for adolescents with gender incongruence or gender dysphoria and administration of gender-affirming hormones (such as estrogen and testosterone) for older adolescents and adults: at the present time (March 2023), however, this is not recommended for prepubertal children, at least in our country. Adults (but less often teenagers, especially minors) can already undergo various aspects of medical affirmation in Italy, including – if already adult, and following authorization issued in this regard by a local or regional Civil Court – surgical affirmation of the sex they identify with.

Psychological support and psychotherapy treatment for transgender persons according to the gender-affirming model of informed consent, with these premises, is therefore configured in many cases as a complex approach which requires that the professional responsible should take charge of the person and all the personal, and family and social problems that this person might present. For this reason, treatment should normally be carried out in collaboration with an integrated multi-professional team made up of professionals from various medical, health, and possibly social disciplines, and requires that the professional responsible for psychological treatment should have extensive skills based on a thorough knowledge of various aspects of clinical psychology, so as to be able to respond as appropriately and as thoroughly as possible to the problems presented.

Among the various psychological and psychotherapeutic theories and techniques that can be concretely used in the context of psychological support and psychotherapy for transgender persons, I can illustrate here only a few of the better ones known by the undersigned. These are essentially based on the model of Psychoanalysis of the Relationship appropriately integrated with acquisitions from the 'Theory of complex dynamic non-linear systems', from so-called 'Infant Research' (*i.e.*, the line of research on the psychic development of the child which, although originating in Psychoanalysis and its advances in early mental activity, later partially detaches from it to adhere instead to methodological and research methods which are more referable to Cognitivist Psychology), from the contributions of various other authors in the psychoanalytic field such as, Donald W. Winnicott (1949; 1958) and Wilfred R. Bion (1961; 1962; 1963; 1965; 1967; 1970; 1996), from Neurophenomenology (a momentary synthesis between contemporary Neurosciences based on intersubjectivity and Phenomenological philosophy of Edmund Husserl, Edith Stein and Maurice Merleau-Ponty) and, finally, from the concept of 'psychoanalytic field' as introduced in the last century by the Baranger spouses (1961-2) and later developed by others, including Italian authors, *e.g.*, Francesco Corrao (1986), Antonino Ferro (2009; 2011) and Gabriele Lenti (2021).

Let us now examine in more detail the role of these contributions, if

mutually and adequately integrated, in the practical application of Clinical Psychology and Psychotherapy. First, we will consider them on a more comprehensive, general level and, subsequently, more specifically on their application to transgender persons.

Gabriele Lenti, psychoanalyst, an expert in complex systems and the concept of *analytic field,* states:

> *'It was Bion who first proposed that the transformation of emotional experience, and one's psychic structure may be activated through analytic change. Interpretation is the main vehicle for transforming emotional experience in contact with the patient. The specific task of the analyst lies precisely in a commitment to transform latent emotional content into communicable meaning. In field theory, transformations become the central aspect of the new psychoanalysis, because the emphasis on intersubjectivity also underlines the transformability of experiences, and, as a consequence, psychic structure. In this research tradition, the most innovative tool undoubtedly lies in weak interpretation, a non-censoring and non-peremptorily decoding intervention, which opens to new developments of sense validated intersubjectively'* (Lenti, 2005, pg. 188).

Furthermore, with regard to the concept of 'weak interpretation', quoting the Italian psychoanalysts Bezoari and Ferro, Lenti himself specifies that the concept '*does not convey in explanatory terms an already clearly configured meaning, but rather it contains a highly unsaturated semantic design, which can actualise and better define itself only with the active contribution of the patient [...] interpretations acquire shape and meaning thanks to hermeneutic cooperation which sees the patient engaged with equal – even if not symmetrical – dignity of function, the best colleague of the analyst in the fullest sense of the term (Bezoari , Ferro, 1989, pg. 1048)'* (Lenti, 2005, pg. 188).

Moreover, Wilfred Bion's theoretical contribution is considered particularly important not only for so-called 'field theory' as applied to general psychotherapy, but also – for using appropriate psychological instruments, and along with the theories of DW Winnicott, current Neuroscience, and *Neurophenomenology* – for addressing one of the absolutely crucial aspects of the transgender person's therapeutic treatment, namely the relationship between the latter and their body. This aspect, as we have pointed out, is one of the most critical aspects of the general equilibrium of transgender persons, and if it fails to be adequately managed can create that 'double bond' referred to earlier, between the message they receive in perceiving their physical body and the messages they receive through the channels of emotionality and sexual identity they identify with, and to which they would like to physically belong.

The question of the mind-body relationship in human beings has played a very significant role within many cultures all over world since ancient times. Various often conflicting theories have been put forward (consider our

so-called 'Western' culture, and the Greek and Latin philosophers who based some of their theories on indivisibility, others on a clear separation or on the famous 'dualism' reiterated in more recent times by Descartes). The well-structured approach to the problem as it was applied by Psychoanalysis and then by Phenomenological and Cognitive sciences certainly makes the concept of 'psychophysical unit' much more credible and shareable in this regard today (within the psychophysical unit, if we wish to analyse more circumscribed, specific aspects, we can still use the terms 'mind' and 'body', but should consider them essentially as 'two sides of the same coin', to be interpreted, respectively, as the 'experiences' and 'corporeity' of one and the same person and always constituted indivisibly by both aspects).

Freud, moreover, had assigned an absolutely central role to the body in his general theoretical analysis, as well as in the constitution of the individual psychic apparatus, especially in his famous statement in the 1922 volume 'The Ego and the Id' according to which 'The Ego is above all a bodily entity' (Freud, 1922, pg 488). With this therefore, despite some 'body-mind dualism' present in the first Freudian writings, for the founder of Psychoanalysis and for his overall construction, the body and its effects become absolutely and definitively priorities in the construction of the Ego; it constitutes one of the three basic components of the human psychic apparatus according to the so-called 'Second Topical' of Freudian theory in its definitive formulation.

No less important than Freud's, was the contribution of the French philosopher Maurice Merleau-Ponty (1908-1961), a leading exponent of Phenomenology of the last century, who aimed to re-establish the primacy of a 'unitary' and 'holistic' vision of the human being in contrast to Plato and Descartes' 'dualistic' vision. For this author (1945) the body is not only the instrument through which we perceive and understand the world, but the very instrument through which we 'are' in the world and of the world.

In other words, Merleau-Ponty states that 'primacy of perception' in the acquisition of each person's sufficiently appropriate and harmonious 'psycho-physical unity' also establishes for humankind the 'primacy of experience' through which perception plays an active and constitutive role in human personality, in its completeness and uniqueness.

Following Merleau-Ponty, and going back to the psychoanalytic tradition, Donald W. Winnicott and Wilfred R. Bion developed a conception of the body's psychoanalytic meaning which is even more profound and significant than that of Freud's, and is based, on both cases – even though they tapped into theories and concepts that were original and different from each other – on the recognition of an almost absolute continuity between the organic and the psychic and on the importance of the mother's role in the proper integration between these two aspects in the child's psychological evolution.

In particular, it was Winnicott (1949) who suggested that corporeity was the starting point for the development of the ego. This author claims not only that there is only one 'psyche-soma unit' but that only when the mind is intimately connected to the body (which occurs above all through the function of so-called 'psychic containment' or holding, exercised by a 'sufficiently good mother') do we gradually come to experience ourselves as inhabitants of our bodies and therefore adequately develop our 'true self'. Conversely, when the mother fails to adequately exercise this fundamental 'holding' function, a child's mind remains 'isolated' in whole or in part from the body, and as a result moves away from the perspective of any real possibility of affirming one's authentic self and instead develops, to a lesser or greater degree, a so-called 'false self'

Since the early 1960s, Wilfred R. Bion expanded on Freud's hypothesis that thought and emotion are inseparable, explicitly arguing that in humans the body is the starting point of the phenomena of thought. In this regard, the author developed a complex but highly accredited theory, claiming that the ability to contain and process emotions lies at the basis of one's ability to learn from one's own experience and that the child acquires the ability practically from birth through the function of so-called maternal *reverie.*

Bion uses the term *reverie* (difficult to translate into Italian, although some use the expressions *sogno ad occhi aperti*, or *fantasticheria*) to indicate, in particular the mother's ability to absorb the sensory and emotional impressions of the newborn and process them to create a new mental formation that the child's psyche can re-introject and assimilate in a less anxiety-provoking and more useful form for the construction of the child's mental apparatus.

A particularly interesting comparison of Winnicott's model of mind-body integration based on the *holding* maternal function, and Bion's model based on *reverie,* was made by Vittorio Gallese, Paolo Migone, and Morris Eagle in their article 'Embodied simulation, mirror neurons, the neurophysiological basis of intersubjectivity and some implications for psychoanalysis' (2006). To be precise, in this study, the authors considered and compared not only the two basically psychoanalytic concepts of holding and *reverie*, but also the concept of *attunement* advanced in 1985 by Daniel N. Stern (1934-2012). Stern was one of the main promoters and developers of so-called *Infant research* (according to his theory the pursuit of relationships constitutes a primary need, like water and food, which orients the child from the very first moments of life, and clearly shows that the construction of the psychic apparatus of every human being is founded on a basically interpersonal matrix).

Summarising the work very briefly, these three authors conclude that both Winnicott's *holding,* Bion's *reverie,* and Stern's 'affective *attunement*' describe, from different perspectives, processes that are at least partially

similar, since they are all based mentally and relationally on the common factor of *empathy* which, in turn, constitutes the psychic expression of the physiological mechanism of the functioning, at a cerebral level, of the so-called 'mirror neuron system'.

Furthermore, the authors admit that the contributions of Winnicott, Bion, and Stern are only some of the contributions to be found in the scientific literature relative to the interpersonal processes at the basis of individual psychic development: the theoretical contribution of Sterba (1934) with his concept of 'self-reflection' as a particular mental activity of the human being would also be easily assimilable; Lacan (1936), with his theorisation of the 'mirror phase' during which the 8-10 month-old child acquires the total image of Self; Kohut (1984), with his concepts of 'mirror transference' and 'transmuting internalisation'; Freud himself (1919) with his description of that 'self-observing' psychic structure which is the result of a previous internalisation (that of the *caregiver)* which gradually takes on an autonomous 'guiding function' in the mind and will subsequently give rise to the *Superego.* In other words, these conceptualisations highlight the fundamental role that the quality of one's early relationship with one's *caregiver* plays in the progressive organisation of an individual's 'mind-body' system.

Bion, in particular, claims that the mind develops through a continuous process of learning from emotional experience and is in continual transformation, through a dynamic process of elaboration of 'raw' sensory data from the body (*i.e.*, psychologically unprocessed data), stimuli which in Bion's conceptualisation are called 'beta elements'.

Bion points out that 'beta elements' cannot be used directly as material for reflection and cognitive processing (in other words, they cannot be 'thought') without first being transformed into something else, something which constitutes 'thinkable' material and therefore constitutes the basis for building our reflections, our conscious mental activity, our 'thoughts'.

Those elements that may be used to 'think thoughts' Bion named 'alpha elements' and the process through which beta elements are transformed into alpha elements was defined by him as the 'alpha function'.

According to Bion, the alpha function is the ability to create meaning from raw, unprocessed sensory data represented by 'beta elements'. The alpha function acts on the unprocessed beta elements and transforms them into alpha elements in a way that is in some respects comparable to what happens in our digestive system when we ingest food: through digestion, nutritional elements contained in food – which cannot be assimilated by our body without a transformative process – undergo a series of chemical reactions which make them assimilable as 'fuel' for life, for the very survival of our bodies.

Similarly, on a mental level, through the 'alpha function' the 'beta elements' are 'digested', *i.e.*, modified, so as to become usable for real thought processes; they literally become, to use Bion's words, 'food for thought'.

In adult human beings this 'alpha function' is performed by the overall psychic apparatus formed over the years, but the young child – whose apparatus is not sufficiently formed – is not able to perform the function autonomously. Bion explains that the maternal figure comes to the rescue and acts for the child through the mechanism of 'reverie', thereby carrying out an essential function for the child's psychic health.

Furthermore, the alpha function exercised by the mother protects the child from emotions and anxieties caused by stimuli from outside and inside the child's body which the child is unable to cope with independently. The exercise of 'reverie' properly carried out by the mother constitutes for Bion a concrete and obvious example of alpha function activity: the mother and the small child, form, in the conceptualisation of the author, a real 'thinking couple' and represent the 'prototype of the thought process' which will continue to develop throughout the individual's life, as well as being the obvious natural expression of the above-mentioned 'analytic field' a term used in psychotherapy.

Conversely, the failure of the mother to contain her child's emotions and anxieties (especially the fear of dying) can lead, as a result, to the onset of a psychotic experience. In this situation, that is, when the mother is unable to stem and contain the child's fears, the child's fears and anxieties that had been projected onto the mother are returned to her, often intensified. As a result of this failure of maternal *reverie*, the establishment of alpha function in the child is severely impeded and the development of his thinking ability can consequently be severely impaired.

The alpha function implemented through the *reverie* mechanism takes place, according to Bion, through a series of rapid and reciprocal exchange of mental impulses – which flow from the child to the mother and *vice versa*, especially through the eye channel, but which also make use of all the other main sensory pathways (particularly hearing, touch, proprioception, taste, and smell) – through a complex and basically unconscious 'cross-play' of archaic mental functioning mechanisms, which Sigmund Freud had already identified in projection, splitting and introjection. Let us now take a brief look at what these three fundamental mechanisms of psychic functioning consist of and how they act according to psychoanalytic theory.

1. Projection: attributing to another person characteristics – generally unconsciously experienced as negative – which are instead present in the structure of the individual's own ego.
2. Splitting: tendency of the subject, by inclination or necessity, to effect a clear division of external objects into 'all good' or 'all bad'.
3. Introjection: extremely early mental functioning mechanism present in very young children. It is also called 'incorporation' because in psychoanalysis it indicates the unconscious incorporation of the values, attitudes and qualities of another person into the structure of the individual's

own ego. In other words, it is that mechanism that tends to make one's own and carry within oneself both the desirable parts of the external world and the undesirable parts; in the former case making them one's own in order to take possession of them, and in the latter case, neutralising them by making them disappear in the self. According to the theory of Melanie Klein (the famous English psychoanalyst whose theoretical contribution can be placed chronologically – or at least schematically – after that of Freud and before that of Bion who was certainly influenced by her) the very young child is used to using these archaic modes of functioning, combining them, thus giving rise to two other distinct primitive mental mechanisms that Klein names, respectively, projective identification and introjective identification.

4. Projective identification: consists of the combined action of the psychic mechanisms of projection and introjection. Through it, parts of the subject are projected into the object, and the subject identifies with them by re-introjecting them.
5. Introjective identification: this also consists of the combined and often complementary action of the two mechanisms of projection and introjection, but in the opposite form of projective identification. Parts of the object are introjected by the subject, who can thus project outside him/herself the parts of him/herself which are referable to them.

The alpha function exercised towards the child by the mother during the process of *reverie* would therefore be based, according to Bion, on the combined action of these archaic mechanisms: the child 'projects' onto the mother the beta elements that make up 'unthinkable' negative experiences (*i.e.*, whatever through the body gives rise to tensions and anxieties, as well as the aggression and anger deriving from them); the mother 'introjects' this psychic material charged with aggression into herself and, through her own alpha function 'deaggressivises' it and 'neutralises' it, transforming it into 'alpha elements' made up of positive emotions and content which are no longer 'frightening' and are finally manageable by the child's psychic apparatus to 'build thoughts'; the child in turn 'reintrojects' these finally manageable emotions and positive experiences into him/herself, and uses them to start autonomously developing a psychic apparatus capable of supporting the genesis and development of his/her own mental apparatus.

Using other words, and describing the process of *reverie* according to a well-known and concise formula which clearly represents the thoughts expressed in this regard by Bion, 'a mother receives anguish and gives peace'.

Therefore, according to Bion, analogous to what happens in the relationship between a child and a mother when the latter exercises her 'alpha function', psychoanalysis and the analytic relationship also activate a mental functioning capable of withstanding the impact of emotions and thus enable an evolutionary change of the mental apparatus. The concrete body, in the

here and now of the psychoanalytic session, is considered by Bion as a potential for thought in the making, as 'a thought waiting to be thought', whereas the role of analysts in favouring the birth of a thought through their own and their patients' bodies can – metaphorically – be assimilated to that of the midwife who contributes to the 'coming into the world' of a child about to be born.

If we take as inspiration the thought of Ludwig Von Bertalanffy according to which 'every organism is a system, *i.e.*, a dynamic order of mutually interacting parts and processes' (Von Bertalanffy, 1952, pg. 317), it is evident that not only the individual 'mind-body units' of the mother and the child on the one hand, and of the analyst and the patient on the other, but also each 'field' created by their mutual interaction, are to be considered as 'complex systems' and therefore interpreted on the basis of contributions from all these authors in the psychological/psychoanalytic field, as well as through the principles indicated by the so-called 'Theory of non-linear dynamic complex systems' (Von Bertalanffy, 1952; Von Foerster, 1981; Seligman, 2005; Parisi, 2021).

The 'therapist-patient' dyad is in fact a whole in which both components are, in turn, two further complex systems united by a regular relationship of interaction and mutual interdependence. As a result of this process of continuous 'co-construction' of the care relationship which reverberates and produces changes within both the 'subject-patient' and the 'subject-analyst', today's Psychoanalysis of the Relationship is no longer characterised, as was the case in early Freudian psychoanalysis, as a 'treatment of the human soul' that therapists exercise towards their clients, but as a continuous variation of the internal arrangements of both based on the so-called 'principle of mutuality'.

The role of the emotions experienced through the two 'mind-body units' of the patient and the analyst, in their reciprocal action and interaction, can thus give rise to a practical technique of psychoanalysis which, in my opinion, can be concrete and effective with a variety of types of persons who wish to go down the psychotherapeutic route, including, in particular, transgender persons.

Indeed, there is no doubt that for the latter, their relationship with their body and with the personal experiences generated from it, and is absolutely central with regard to their behaviour as a whole, and their overall psychophysical balance, and forms the basis of the above-mentioned 'double bonds' at the root of their emotional problems and their existential difficulties.

Through a relationship based on mutual, true 'informed consent' and a course of therapy based on trust – the same trust that the child places in his own 'good enough' mother who exercises the function of reverie for him – a trust that concretely enables the transgender patient to transform into 'alpha elements' those 'beta elements' which the two aforementioned 'double bonds'

systematically transmit (and which form the basis of distress or, in any case, of malaise and existential issues), a path of psychological support and psychotherapy for transgender persons can effectively, in my opinion, not only help them get free from the 'double double bind' in which they frequently find themselves entangled, but above all prevent and avoid even more serious psychological problems – depersonalization, somatic symptoms or even dissociation – to which a prolonged exposure over time to the stress induced by this extremely confusing condition certainly exposes them.

As Gabriele Lenti (2020) states in this regard, 'Feeling one's body comes from the love one feels for oneself: when destructive tendencies manifest themselves there is depersonalisation, the body 'scatters all over the place', its most intimate experience is distorted, becoming alien. Significant somatic symptoms such as migraine, dyspnea, and dizziness appear, and the idea that one's body exists as a separate element may emerge and grow.

Onto the affective scene, the impression of not existing may emerge, the subject loses the contours of their image; they feel they are losing consistency and no longer recognise themselves. We often talk about disappropriation of the body and the phenomenology becomes complicated, but at the same time leaves intact the stability of the deep ego beyond the bodily ego [...] Mental faculties, as Meynert has indicated, remain intact during an episode of depersonalisation; this happens because it is not a matter of schizophrenic fragmentation or paranoid delirium but of an experience closely linked to the phenomenic dimension of the body' (Lenti, 2020, p. 60).

The search for new alpha elements that can replace the beta elements from these persons' bodies, as well as replace the often 'unthinkable' conflicts derived from them, represents, in my opinion, a sort of 'highway' through which a relationship can be built with the outside world, based on the harmonious integration of the affirmation of one's 'true self' and respect for the principle of reality. The new 'thinkable thoughts' represent the constituent elements of the human psyche on which, little by little, and over time, more complex and more stable systems can be built. Their preeminent presence in the psychic apparatus of each of us – and transgender persons in particular – should represent, in my opinion, one of the main objectives to be pursued by psychological and psychotherapeutic interventions.

Conclusions

Since the inception of Clinical Psychology and Psychiatry, individual inclinations towards transgenderism have generally been considered manifestations of a mental disorder. This interpretation has certainly been diluted

over time, but even today (unlike in the mid-1970s and the concept of 'homosexuality') it is not completely obsolete.

As a consequence, many psychotherapists still believe that those who manifest these inclinations need some kind of 'treatment' that will lead them to a level of mental functioning that is no longer connoted in a 'regressive' and 'psychopathological' sense but oriented towards a more or less theoretical 'normality'.

In recent years, however, we have witnessed a vast and in-depth debate which no longer places the 'scientific' and 'objectifying' vision at the centre of psychotherapy, and whose main objective would appear to be the overcoming of a condition of mental malfunction, but rather the attainment of a subjective state of well-being based on overcoming both the conflict between assigned gender and the gender authentically perceived by the subjects themselves, and the conflict deriving from the stigma and consequent malaise that these persons experience from family and the social and interpersonal contexts in which they are immersed. In practice, this requires a complex process based on multiple elements, and one of the 'knots' to undo still appears to be the one constituted by the as-yet incomplete overcoming of the concept of 'diagnosis' when referring to this specific subjective condition.

For example Jack Drescher (2010), a member of both the DSM-5 working group on sexual disorders and gender identity, and the ICD-11 working group on sexual disorders and sexual health stated:

'The guiding principle in medicine is first, do no harm […]. The harm of maintaining the diagnosis is stigma, and the harm of removing it is the potential loss of access to care.

According to Drescher, the dual stigmatization of being transgender and being diagnosed as having a mental disorder creates a doubly critical situation which contributes to creating a 'stalemate' situation for many that is not easy to surmount.

The crucial issue, according to this author, still remains that of the human rights of transgender persons which are violated the instant their manifestations of 'Gender variance' are labeled as symptoms of a 'mental disorder'. For this reason, any type of 'diagnosis' within this process of taking charge and assuming responsibility should be 'depathologised', in the same way as for homosexuality in 1973 by the DSM and in 1990 by the ICD.

The avoidance of a 'psychopathological diagnosis' could have several immediate positive repercussions:

1) First, it could constitute a powerful and potentially successful argument in those legal cases which challenge the denial of financial coverage for the necessary treatment of transgender persons of any age.
2) As a result, it could prevent insurers from denying access to treatment

for transgender persons struggling with inadequate private and public funding sources for psychological, medical, and surgical treatment.

3) Finally, the acquisition of economic coverage could allow access to a global system of treatment based on the unconditional acceptance of the patient's person, on the pursuit of their subjective psychological well-being respectful of that of others and, finally, on the affirmation and concrete attainment of the gender they actually aspire to.

In this respect, Crapanzano *et al.* (2021) noted:

> *'It is clear, in this context, the extent to which it is desirable to formulate and adopt models and approaches which can on the one hand facilitate 'coming out', which do not constitute an obstacle for the transgender person, and which are as welcoming and respectful of the specific needs of the individual as possible, but which, at the same time, guarantee maximum protection of psychophysical health. The identification and adoption of the most suitable model to satisfy the complex and varied needs of the transgender population could certainly be of great help in overcoming distress, reducing the high risk of suicide, and guaranteeing a good quality of life these persons'.*

In my opinion, these are objectives that the psychotherapist community and other 'helping professions' have been pursuing for some time and whose achievement today appears more than ever before a concretely attainable goal, in our country, but above all internationally.

Glossary

Terms relating to gender issues that are commonly used and widespread today:

- **Cisgender:** term describing persons whose birth-assigned sex aligns with both their gender identity and their gender expression.
- **Coming-out:** expression originally used in the English language, but now also widely used in Italy, to indicate the decision to openly declare, or in any case not to hide from the outside world, one's sexual orientation or gender identity. It should not be confused with 'outing' (see below).
- **Gender dysphoria:** clinically significant distress or impairment related to gender incongruence, which may include a desire to change primary and/or secondary sexual characteristics, and which is defined in the DSM-5-TR as arising from a marked inconsistency between lived/expressed gender and assigned gender lasting at least 6 months characterised by the presence of specific symptoms. Not all transgender or gender-different persons suffer from gender dysphoria.
- **Gender expression:** the outward manifestation of a person's gender, which may or may not necessarily reflect their internal gender identity, and which essentially concerns how they present themselves to the world relative to their gender based on traditional social expectations. A

person's gender expression cannot always be superimposed on the gender identity that is actually presented; rather, it represents the way in which persons present themselves, the clothes they wear, the accessories, the hairstyle, any cosmetics, the voice/speech patterns, mode of conversation, and physical characteristics.

- **Gender non-conforming:** an 'umbrella' term which includes many nuances and possibilities regarding a person's gender identity; it describes subjects with gender identities and/or expressions that are not rigidly defined. It also includes persons who identify as belonging – simultaneously and/or alternately – to multiple genders or who identify as genderless. (Italian uses expressions such as: *genere diverso*, *genere non conforme*, *non-conformità di genere* or other similar expressions).
- **Gender identity:** the subjective psychological sense of one's gender that a person exhibits, *i.e.*, a person's inner feeling of being a girl/woman, a boy/man, a combination of both, or something else, including not having any gender. The latter may correspond, or not correspond, to the sex assigned at birth.
- **Nonbinary:** a term used to define persons whose gender identity is neither girl/woman nor boy/man.
- **Outing:** the English word outing is used in Italian to indicate the practice of making a person's sexual orientation or gender identity public without their consent. It clearly differs from the so-called 'coming out' (see above), which is a voluntary act of revealing one's own sexual orientation or gender identity. The meaning of the term outing, used in Italian, is not limited to the sphere of sexual habits and inclinations but also refers to the making public of a private fact concerning someone who would rather the fact were not known (for example, concerning that person's political orientation or religious beliefs).
- **Assigned gender at birth:** a person's demographic designation as 'female', 'male' (or, more rarely, as 'intersex'), based on anatomy (*e.g.*, external genitalia and/or internal reproductive organs), and/or to other biological factors (*e.g.*, sex chromosomes). 'Sex' and 'gender' are often terms used interchangeably in this regard, but in reality, they are distinct entities. It is, therefore, increasingly good practice to distinguish between sex, gender identity and gender expression, in order to risk making assumptions about one of these characteristics based only on knowledge of the others. The sex actually assigned at birth is sometimes abbreviated to the acronym AMAB (assigned male at birth) or AFAB (assigned female at birth).
- **Sexual orientation:** term which describes the types of individuals a person is emotionally, and/or physically attracted to. Each human being can, for example, be attracted only or almost exclusively to persons of the opposite sex (defined in this case as heterosexual*),* but can also be

attracted only or almost exclusively to persons of the same sex, and be defined homosexual (we also use the terms gay males or lesbian women). A person can manifest attraction (alternately and simultaneously) towards persons of both genders (defined as bisexual), towards any person of any gender (and is defined as asexual) or towards any other type of person, even of a gender which is not defined (in this case, the term pansexual is usually used).

- **Transgender:** generic term describing persons whose gender identity aligns not with the sex assigned to them at birth, but with that of the opposite sex.

REFERENCES

American Psychiatric Association (2022). *DSM-5-TR. Manuale Diagnostico e Statistico dei Disturbi Mentali*, *quinta edizione, revisione del testo*. Tr. it.: Milano: Masson, 2023.

Baranger, W., Baranger, M. (1961-2), *La situazione analitica come campo bipersonale*. Milano: Cortina, 1990.

Bezoari, M., Ferro, A. (1989). Ascolto, interpretazioni e funzioni trasformative nel dialogo analitico. *Rivista di Psicoanalisi*, 35(4): pp.1015-1051, 1989.

Bion, W.R. (1961). *Experencies in groups and other papers*. London: Tavistock Publications, 1961 (Tr. it.: Esperienze nei gruppi. Roma: Armando Editore, 1970).

Bion, W.R. (1962). Apprendere dall'esperienza. Roma, Armando, 1972

Bion, W.R. (1963). Gli elementi della psicoanalisi. Roma: Armando, 1979.

Bion, W.R. (1965). Trasformazioni. Il passaggio dall'apprendimento alla crescita. Roma: Armando, 1973.

Bion, W.R. (1967). Analisi degli schizofrenici e metodo psicoanalitico. Roma: Armando, 1970.

Bion, W.R. (1970). Attenzione e interpretazione. Roma: Armando, 1973.

Bion, W.R. (1996). Cogitations-Pensieri. Roma: Armando, 2010.

Corrao, F. (1986), Il concetto di campo come modello teorico. In: *Gruppo e Funzione analitica*, VII, N.1, Gennaio/Aprile 1986.

Crapanzano, A., Carpiniello, B., Pinna, F. (2021). Approccio alla persona con disforia di genere: dal modello psichiatrico italiano al modello emergente basato sul consenso informato. *Riv Psichiatr* 2021; 56(2): 120-128.

Drescher, J. (2010) Trans-sexualism, gender identity disorder and the DSM. *J Gay Lesb Ment Health*, 2010; 14: 109-22.

Drescher, J., Cohen-Kettenis, P.T., Reed, G.M. (2016). Gender incongruence of childhood in the ICD-11: controversies, proposal, and rationale. *Lancet Psychiatry* 2016; 3: 297-304.

Ferro, A. (2009). Transformations in dreaming and characters in the psychoanalytic field. Int. *J. Psychoanal.*, 90: 2009-2030.

Ferro, A., Basile, R. (a cura di) (2011). *Il campo analitico*, Roma: Borla, 2011.

Freud, S. (1919). Il perturbante. *Opere*, 9: 81-114. Torino: Boringhieri, 1977.

Freud, S. (1922*)*. L'Io e l'Es. *Opere*, 9: 467-520. Torino: Boringhieri, 1977.

Gallese, V., Migone, P., Eagle, M.N. (2006). La simulazione incarnata: I neuroni specchio, le basi neurofisiologiche dell'intersoggettività ed alcune implicazioni per la psicoanalisi. In: *Psicoterapia e scienze umane:* 2006, XL, 3: 543-580. Milano: Franco Angeli, 2006.

Istituto Superiore di Sanità (2021). Disforia di Genere. In *ISSalute: Informarsi, conoscere, scegliere*. Roma: Portale dell'Istituto Superiore di Sanità, 26 Aprile 2021. Indirizzo web: https://www.issalute.it/index.php/la-salute-dalla-a-alla-z-menu/d/disforia-di-genere

Kohut, H. (1984). How Does Analysis Cure*?* Chicago: Univ. of Chicago Press (trad. it.: *La cura psicoanalitica*. Torino: Boringhieri, 1986).
Lacan, J. (1936). Le stade du miroir. Théorie d'un moment structurant et génétique de la constitution de la réalité, conçu en relation avec l'expérience et la doctrine psychanalytique. Relazione presentata al *Fourth International Psychoanalytic Congress* a Marienbad, 1936.
Lenti, G. (2005). Al di là del principio di entropia. Alcune riflessioni su psicoanalisi e complessità. Roma: Armando Armando editore, 2005.
Lenti, G. (2020). Un vivo fascio di garofani rossi. Ricerche psicoanalitiche sulla poetessa Antonia Pozzi. Roma: Europa Edizioni, 2020.
Lenti, G. (2021). Complessità e campo psicoanalitico*. Scritti*. Roma: Europa Edizioni, 2021.
Merleau-Ponty, M. (1945). Fenomenologia della percezione. Milano: Il Saggiatore, 1965.
Organizzazione Mondiale della Sanità (2018). ICD-11, versione informatizzata in lingua Inglese, 2018. Indirizzo web: https://icd.who.int/en
Parisi, G. (2021). In un volo di storni. Milano: Rizzoli, 2021.
Seligman, S. (2005). Le teorie dei sistemi dinamici come meta-inquadramento della Psicoanalisi. In: *Ricerca Psicoanalitica*, Anno XVIII, n. 3, pp. 309-343, 2007.
Sterba, R. (1934). Das Schicksal des Ichs im therapeutischen Varfharen. *Int. Z. Psychoanal*., 20: 66-73 (Trad. it.: Il destino dell'Io nella terapia analitica. *Psicoterapia e Scienze Umane*, 1994, XXVIII, 2: 109-118).
Stern, D.N. (1985). The Interpersonal World of the Infant. New York: Basic Books, 1985. (trad. it.: Il mondo interpersonale del bambino. Torino: Bollati Boringhieri, 1987).
Von Bertalanffy, L. (1952). Teoria generale dei sistemi. Milano: Mondadori, 1971
Von Foerster, H. (1981). Observing systems. Seaside, Ca. Intersystems Pubblications, 1981. (Trad. It. *Sistemi che osservano*. Roma: Astrolabio, 1987)
Winnicott, D.W. (1949). L'intelletto e il suo rapporto con lo Psiche-Soma. In: *Dalla Pediatria alla Psicoanalisi*. Firenze: Martinelli, 1975.
Winnicott, D. W. (1958). Dalla Pediatria alla Psicoanalisi. Firenze: Martinelli, 1975.
Zucker, K.J. (2017). Epidemiology of gender dysphoria and transgender identity. In: *Sexual Health*, 2017 Oct, 14(5):404-411.

Conflict of interests: the author declares no potential conflict of interests.

Ethics approval and consent to participate: not required.

Received: 3 March 2023.
Accepted: 31 October 2023.

Licensee PAGEPress, Italy
Ricerca Psicoanalitica 2024; XXXV:791
doi:10.4081/rp.2024.791