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PUBLISHED BY THE GESTALT INTERNATIONAL STUDY CENTER

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 Gestalt Review, 18(3):244-260, 2014

Gestalt Approaches to Gender Identity Issues: A Case Study of a Transgender Therapy Group in Oslo

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ABSTRACT

This paper is based on a case study of a transgender therapy group I facilitated in Oslo in January and February 2013. The two interlinked research questions are: How can a Gestalt therapist approach gender identity issues and transgender people in particular? What are the important experiences and changes that transgender people report from a Gestalt-inspired group? The case study particularly highlights the importance of phenomenology, polarities, and certain modes of contact, and it illustrates the practice of the former in three case descriptions and discussions. The paper concludes that Gestalt can work as a transpositive approach in accordance with a new paradigm within transgender health, the "Transgender Model." In addition to working with transgender clients, Gestalt therapists should also address gender identity issues within the larger social field, including norms and polarities on group and societal levels.

Sarah Fallon, SRAsT(D), Dip GPTI, served as Action Editor on this article.

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Introduction

In December 2012, the Norwegian association for lesbians, gays, bisexuals, and transgender people (LLH) commissioned me to facilitate a brief therapy group for transgender people. They had registered a need for complementary health services. Today, the Department of transsexualism at Rikshospitalet, a state hospital, has a monopoly on assessing and treating people with gender identity issues in Norway. Only those who are diagnosed as transsexual (F.64.0) are accepted. A large majority are rejected, many experience the meeting with the psychiatrists and health system as an affront to their dignity, and some feel pressured to lie to fit with the criteria (Miljeteig, 2011; LLH, 2012).

Van der Ros (2013), author of the first survey of living conditions and life quality of transgender people in Norway, emphasizes that the need for transrelated health care extends beyond the narrow group diagnosed as transsexual. Among the needs are guidance and different types/degrees of gender affirmation treatment like surgery and hormones. Another key finding is that there is little understanding of gender identity issues in all arenas of Norwegian society, which has consequences for transphobic discrimination and harassment, minority stress, and shame.

There is little research on transgender issues in Norway in general, even less on more specific issues such as transpositive psychotherapy, and none on Gestalt therapy and gender identity issues. Even internationally, there is a paucity of Gestalt research on this topic. Due to the need for both therapy and more research, I decided to facilitate the group and conduct a study in parallel. Presented below are research questions and methods; a summary of existing research and a theoretical starting point; selections of case material with discussions; and some final remarks.

Research Questions and Methods

This study is driven by two interlinked research questions: How can Gestalt therapy address gender identity issues, and the challenges of transgender people in particular? What are the important experiences and changes that transgender people report from a Gestalt-inspired group?

A case study approach is used that most resembles what McLeod (2010) describes as pragmatic studies, since it is based on a group that I myself facilitated. I have been concerned with reflexivity and my own role. I am a "cis-man"—the term for someone registered as male at birth, and who identifies as a man as opposed to transgender. My gender identity as well as being gay, of ethnic minority, a human rights lawyer, and a psychotherapist trained in Gestalt therapy at the Norwegian Gestalt Institute, have all influenced my

approach, the group, and the research. When some of the participants asked about my personal motivation, I shared that as a gay man I have experiences of not fitting in and of (in)visibility regarding gender and sexuality, and that I have a general commitment to social justice and personal growth.

The main data source is the group's six participants. Before the group sessions, I met with each participant individually and discussed expectations and fears, clarified what a Gestalt approach to group therapy would involve, discussed the research project, and got informed consent. We then met for six two-hour group sessions in the offices of LLH Oslo in January and February 2013.

A variety of data methods were used, including journal notes I wrote after individual meetings and group sessions; audio recordings; forms with basic client information filled in at the outset; documents in which participants identified expectations at the start; and posttherapy feedback forms, in which they identified and described important experiences and changes. The latter documents were filled in three weeks after the last session. Often clients report something other than that which therapists themselves think is important (Yalom and Leszcze, 2005; McLeod, 2010). Three weeks is not long enough to say whether the reported changes were of a more permanent nature. However, participants also had the opportunity to comment on a draft of this paper several months later.

In the analysis and presentation, I focus on incidents and processes that the participants themselves reported as particularly important, and that I myself saw as particularly important when reviewing all of the data.

Existing Research and Theoretical Starting Point

Sex and gender are central concepts in the study: "Sex is assigned at birth as male or female, usually based on the appearance of the external genitalia. When the external genitalia are ambiguous, other components of sex (internal genitalia, chromosomal and hormonal sex) are considered in order to assign sex" (WPATH, 2011, p. 222). While sex is considered to capture a biological dimension, gender is a term that refers to the cultural, emotional, and social dimensions. Gender identity can be defined as "[a] person's intrinsic sense of being male (a boy or a man), female (a girl or a woman), or an alternative gender (e.g., boygirl, girlboy, transgender, genderqueer, eunuch)" (p. 221).

Psychologists find certain general differences between men and women, consider masculinity and femininity a personality trait, and operate with several explanations (Larsen and Buss, 2010). Men, for example, are generally seen to be more emotionally stable, assertive, and aggressive. Certain theories claim that hormones are central; for example, girls with high testosterone

levels are generally seen to be more masculine. Others highlight that boys are socialized to be masculine and girls feminine; that gender stereotypes and norms are crucial.

While gender identity and expression are consistent with their sex assigned at birth for most people, this is not the case for transgender people. Transgender research refers to biological factors such as genetics and prenatal hormone levels, early experiences, and later experiences as teens or adults (APA, 2011). Strategic and normative considerations can affect which theory and explanation is chosen (Folgerø and Hellesund, 2010). For example, arguments about nature and biology win more easily in certain fora, such as within the medical establishment and public health service, than do arguments related to culture, socialization, and choice.

Someone who is registered as female at birth but perceives themself as male (and may have undergone gender affirmation treatment) is referred to as transman, affirmed man, or female-to-male (FTM). Conversely, the corresponding terms are transwoman, affirmed woman or male-to-female (MTF). Others want to be called man or woman. Still others consider themselves a third gender, male *and* female, "gender queer" or fluid, or do not want to define themselves in gender categories at all. In this study, the term transgender is used in its broadest sense to encompass all of these groups.

The World Professional Association for Transgender Health (WPATH) develops so- called Standards of Care. The sections on psychotherapy in the current Standards, Version 7 (WPATH, 2011), are largely based on the work of Fraser (2009). She describes a paradigm shift from the "transsexual" model to the "transgender" model, originating in transgender people's own experiences. The "transsexual" model considers gender as stable and binary (male, female); transgender people feel trapped in the wrong body and experience a mental pain that can only be alleviated by extensive hormonal and surgical treatment. Arguments about nature and biology are regularly employed. This is reflected in the diagnosis of transsexualism (F.64.0), and it is the approach of Rikshospitalet. The "transgender" model, on the other hand, considers gender as a continuum, in some cases fluid over time, and recognises diversity and individualized approaches. A singular explanation with reference to biology alone, for example, becomes impossible. On the basis of this "transgender" model, there have been developed not only nonpathological and transpositive understandings of transgender experiences but also transpositive, therapeutic approaches.

Though Gestalt therapists have done little research on this topic, there have been three rather recent pieces of work: Bennett (2010) presents a detailed and beautiful case in which we follow him and the transwoman "Inocencia"

on a therapeutic journey in the USA; Hawley (2011), in a British context, has written a response to Bennett; and Fallon (2012), also in the UK, describes a client who, even 25 years after gender affirmative FTM-treatment, is scared of being revealed and practices how to be a man. The findings and reflections of these authors will be referred to in forthcoming sections on case descriptions and discussions. For now, the Gestalt concepts of phenomenology, polarities, and modes of contact will be reviewed briefly, since they are of particular importance to the case descriptions and discussions.

Phenomenology is the overall method in Gestalt therapy. The focus for our exploration is the immediate, naïve perception, "undebauched by learning" (Wertheimer, 1945, cited in Yontef, 1993, p. 124). The primary data I have as a therapist include what I can observe outside myself, "the outer zone" awareness; and my own bodily sensations and emotions, "the inner zone" awareness (Stevens, 1971). I also have thoughts, including assumptions and interpretations, "the middle zone" awareness (Stevens). Adhering to a phenomenological approach, however, I may seek to "bracket off" the latter in order to experience as fully as possible what is actually happening here and now. I can get a sense of the client's experience through surrendering to dialogue characterised by presence and empathy. If what emerges is not coherent with my assumptions and interpretations, I give priority to what emerges through the dialogue. Gender identity can be seen as a phenomenon—something—as it appears in a particular person's experience. A Gestalt approach would then involve respecting this person's experience of their own gender. This is in line with most transpositive approaches and the "transgender" model. The Gestalt approach differs from therapies that treat what the client says, does, or experiences as mere appearances; and uses interpretation to find real meaning (such as strands of Freudian psychoanalysis), as well as approaches that seek to condition or program a person or group of people based on certain ideas (such as strands of cognitive behavioural therapy [CBT]).

The concept of polarities is important in the Gestalt view of the self and growth. According to this notion, different forces or sides in a person or larger system are complementary and connected rather than seen as dichotomies. Polarities are coloured by our backgrounds and experiences of ourselves. Due to "blind spots" (Zinker, 1977, p. 200) we are less aware of and identify less with—certain sides of ourselves—we may become rigid and stereotypical. Zinker mentions femininity and masculinity as an example: "If I do not allow myself to be in touch with my femininity, then my masculinity will be exaggerated, even perverse—I will be a hard, tough guy" (p. 202). Furthermore, not being "in touch" may entail intrapersonal conflict between different sides, as well as interpersonal conflict because, for example, we project a disowned side

onto another person. In this instance, the tough and hard guy may play out the inner conflict by targeting men he considers feminine. Zinker claims that "[t]he healthy person is aware of most of the polarities within him, including those feelings and thoughts which society disallows, and is able to accept himself that way" (p. 200). This occurs by uncovering the disowned sides and contacting them—"stretching the self-concept" (p. 202). By stretching one side, he claims, the other will automatically also be stretched at some point—an "'around the world' phenomenon" (p. 202). In theory, the concept of polarities seems to fit the "transgender model," which is based on the understanding of a continuum.

Contact is another crucial concept in Gestalt therapy. While some psychotherapists speak of resistances to or disturbances in contact, Wheeler (1991) emphasizes that we are always in contact with someone or something. In line with this, the Norwegian Gestalt Institute prefers to speak of different modes of contact. Wheeler further claims that the modes of contact are polarities, and we cannot say in general that some are unhealthy and others healthy; it will depend on the situation. Several modes of contact may be expected to appear in a group addressing gender identity issues; introjection with regard to gender norms is one example. The modes of contact that appeared in this particular case will be further described and discussed below.

As a starting point, it seems that the concepts of phenomenology, polarities, and modes of contact are compatible with the "transgender" model; and that Gestalt therapy can work as a transpositive psychotherapy. These notions are explored further in the following case descriptions and discussions with respect to a transgender group in Oslo.

Presentation of Group Participants

For the sake of anonymity, names and some other personal details have been changed.

Alex/Alexander: in his early 30s; of a multicultural background with a father from another European country and a Norwegian mother; defined himself as FTM without having commenced any assessment or treatment; studied at the university level. His expectations included: "experience support by hearing other people's stories, opinions, and feelings about gender and being trans"; "normalize the experience of being trans"; "communicate my own feelings about gender and being trans to others"; and "explore my own gender identity in relation to others."

Arne: in his late 20s; ethnic Norwegian; under assessment for FTM treatment at Rikshospitalet; worked at a department store. He wanted to hear about the experiences of others; he said it could be a challenge "to come out and share

and not just be quiet and observe."

Jo: in his 40s; ethnic Norwegian; had gone through gender affirmation treatment (FTM) at Rikshospitalet; had been officially registered as a male for several years; worked part-time in an NGO. His motivation to participate included supporting others; sharing own experiences; and "being social as who one is."

Julie/Olav: around 50; ethnic Norwegian; had social anxiety; lived alone and relatively isolated in a town outside Oslo; and was not working. Julie/Olav self-identified as MTF; lived as a man in public and as a woman in secret at home. Her goal was to try to be a woman in social settings. She was dressed as a woman in the initial meeting with me and in the following group sessions. After two group sessions, she quit due to social anxiety and continued her process in individual therapy.

Kennedy: in his late 30s; black; an immigrant to Norway; was registered as female at birth; had identified as bisexual and "gender queer/fluid" for a year; was not working; had few friends and acquaintances in Norway; had "trust issues." While I spoke Norwegian with the other participants, Kennedy and I spoke English during our initial meeting. I clarified that the main language in the group would be Norwegian, but that Kennedy could check if it was okay also to speak English. His expectations included: "learn more about trans life in Oslo; "try to speak more about myself (I'm a very guarded person emotionally)"; "accept that I am unique and that is okay."

Tom: in his 30s: ethnic Norwegian; in the process of gender affirmation treatment (FTM) abroad. He was sceptical with regard to participating in the group but eventually did join. In addition to meeting with me initially, he participated in one group session. He then quit, because he felt he had aggression issues he wanted to work on elsewhere.

A seventh person contacted me, who preferred to be referred to with the third gender pronoun *hin* (Norwegian equivalent of *ze*). *Ze* was not working due to a severe mental illness and had a sick mother who also took much time and energy. I sensed my heart beating faster during our meeting. I shared that I was sceptical about this person's participation, since at the onset *ze* already knew that *ze* could not participate in all six sessions; and that I had not worked much with therapy groups earlier, nor with the specific illness that *ze* had. This reminded us both of the psychiatrists who accept or reject through diagnosis, and it hurt. Eventually, we mourned together and said goodbye.

Case Description/Discussion I: He, She, and Kennedy

This first case description illustrates how a phenomenological approach can address gender identity issues. Prior to the first session, **Alex** approached me

with the consent form, wondering if he should write his "real name," and I answered that he could write both. He wrote "ALEXANDRA" in block letters. **Julia/Olav** had written "Olav." During the session, **Arne** asked how others reacted when people use "the wrong pronoun." Aware of his self-identified challenge to "come out and share," I asked if maybe he himself had some experiences he wanted to share. He said that "the wrong pronoun" happens with family, colleagues, and customers. Then he mentioned a particular instance when he was in conflict with a customer who said, "Now listen here, young man," he was totally happy. We laughed together. **Jo** said he had lived in the same building for many years, and the old neighbours still said "she" at times, adding, "But they are the ones who look ridiculous now." **Alex** asked **Julie** about the use of pronouns. She said that she lived as a man in public, but that she wanted to try to live as a woman. She was dressed as a woman in the group, and we used female pronouns. At the next session, she told us she had been shopping dressed as a woman and had decided to live as a woman full time. Soon after that discussion, **Alex** wrote me an email about "very big steps" he had taken because of the group, including: coming out to family, friends, and colleagues; undertaking a process to change his name officially; and contacting a gender clinic abroad. He signed with "Alexander." From then on, we all used the name Alexander.

Kennedy said that Kennedy preferred that people use the name as much as possible. Kennedy did not identify as man, woman, or third gender. In talking about Kennedy during a later session, I said "she," corrected myself to "he," then to "Kennedy," and apologized. "It was nice that you corrected it. That's the first time it's happened," said Kennedy with a big smile. At later sessions, Kennedy repeated that it was the first time and that it meant a lot. At the last session, Kennedy said that Kennedy was more comfortable with the whole and unique self and did not conform to the same extent as before; that Kennedy now let people know when they took Kennedy for a woman, or said "she."

A phenomenological approach—including mirroring, witnessing and validating—in connection with how each person defined themself, and in particular with the use of names and pronouns, was experienced by the participants as supportive and transformative. The group as a whole—not merely me as therapist—was rather phenomenological in that everyone, to a large extent, respected the subjective realities and experiences of the others. The episode with Kennedy, wherein I used "he" and "she" before correcting and apologising, was an accidental experiment. My apology involved a deep respect for Kennedy's gender identity as experienced by Kennedy; on the posttherapy feedback form, Kennedy reported it as a crucial event.

Bennett (2010) and Hawley (2011) confirm the importance of phenomenology in working with gender identity issues. Transpositive therapists from other traditions also emphasize the importance of the person telling their story in their own words, with another person or therapist witnessing and mirroring (e.g., Fraser [2009] cites both Devor [2004] and Lev [2004]). Within the psychodynamic approach, Fraser argues that transgender identity can be part of the authentic self; and that inattentive, incomplete, or incorrect mirroring can lead to problems. In other words problems arise, not because there is anything wrong with the person as such, but because of the tension produced in the meeting between the person and the environment. This would be in line with the overall importance Gestalt therapists attach to the wider "field" (Yontef, 1993), which in the context of gender identity has been stressed by both Bennett and Hawley. Our overall method of phenomenology should ensure that the therapeutic environment is respectful and supportive of the subjective reality and experience of the transgender client, whether that means being male, female, third gender, or something else. This respect and support may, in turn, increase self-awareness and self-acceptance.

Case Description/Discussion II: Together and Different

This second case description illustrates how certain modes of contact can appear and be meaningful in working with gender identity issues. Since introjection is explored in connection with polarity work in the next section, other modes of contact will be focussed on here.

In the first session, there was much confluence, many expressing agreement with others. There was also projection in the form of interpretations. Retroflection in the form of silences, presumably due to thinking and to participants holding themselves back, was another prominent mode of contact. During the next session, I said that **Tom** had quit because he wanted to work on aggression issues elsewhere; that it is usual in the first session to consider whether you fit in. I asked if anyone recognized this, and there was a silence. Sharing can be a counter pole to retroflection and a possible intervention; I shared that I had felt quite different as a cis-man. **Kennedy** said that Kennedy also felt quite different as queer/fluid; and **Julie** quite different as MTF. (Eventually, we spoke more English as well as Norwegian, changing between the two languages, which contributed to an increasing sense of diversity and inclusion.) I asked if others had experiences of being different. **Arne** told us how he was different at work and in life in general due to gender identity. **Alex** said his multicultural identity also made him different. **Jo** said he had been an invisible man in a woman's body before, whereas now the female in him was largely invisible. Through their differences, they had

come together in a community. I hoped, and strove to ensure, that the group could also accommodate internal differences. Being different, differentiating between oneself and others, can be a counter pole to confluence.

In a later session, **Arne** mentioned he had been thinking about how I had commented when he said “we,” “you,” and “one” when he talked about himself. I asked how that was for him, said it was not meant as criticism, and reminded everyone that the Gestalt approach was about exploring and increasing awareness, not about thought correction or reprogramming. Several participants joined in the exploration, as the confluent, projective, and deflective use of these pronouns had been rather common. “I think I have struggled so much to belong, so for me it's a bit like a confirmation that I'm a part of a community,” said **Jo. Kennedy** had a different experience: “I usually say “I” because I'm not sure if I think the same as everyone else. I don’t want to assume something about someone when that may not be the case.” The exploration in itself showed that the participants now differentiated more and took ownership of their feelings and opinions, possible counter poles to confluence and projection. **Arne** and **Kennedy** were increasingly coming out and participating, a possible counter pole to retroflection. In the posttherapy feedback form, **Arne** said that the “coming out and participating” had continued for him after therapy. “I have become a bit more comfortable about my feelings and speaking out,” he wrote; and added that he checks what others think and feel rather than merely speculating, which can be a counter pole to projection.

In summary, confluence, projection, retroflection and deflection were prominent modes of contact, particularly in the early phases. While there is often little trust, and participants seek out similarity in the first group stages (Levine, 1991; Yalom and Leszcze, 2005; Kepner, 2008), these may also be particularly relevant modes of contact for many transgender people who belong to a stigmatised minority, and who may be uncomfortable about something as visible and prominent as gender expression. For example, **Julie** lived in isolation and with anxiety; and **Arne** felt that his voice “revealed” who he was, that he was not really a man. Bennett (2010) also experienced much confluence together with his client; and Hawley (2011) writes that “[t]rans people are very prone (for perfectly understandable reasons) to live in their heads” (p. 18). As our group progressed and intimacy increased, the counter poles also made their appearance.

With increasing intimacy and exploration of confluence/differentiation, a multitude of transidentities was supported and could develop—groups where experiences could be shared and normalized; where “I” could be part of a “one,” or “we” were important, in particular when dealing with stigmatised minorities. It was also crucial to have room for differences, so that

"I" could be "I" in the meeting with others. The mixed group of transgender people—including FTM, MTF, and gender queer/fluid at different stages in their processes—worked well in that regard, as confirmed by Alexander's posttherapy feedback:

> I experienced a normalization of being trans by having a safe environment in which to explore it. The fact that the group itself was also not homogeneous was particularly positive, because I did not have to fit into a "trans standard." This experience supported me in doing what I really wanted for myself: to begin gender affirmation treatment on my own terms.

Case description/Discussion III: Military Man and Disco-Queen

This third case description illustrates how the concept of polarities can be meaningful in work with gender identity issues. At the third session, I informed the group that **Julie** had quit due to social anxiety. We processed this together, and I asked if others had similar experiences. **Jo** said that, whereas before treatment he had experienced anxiety related to not being a gender norm conforming woman, now it was related to not being a "standard man." He had a sense of loss and wanted to be able to live out the "female" more. I recognized the pressures in society, and added that for the Gestalt founders it was not an objective to adjust people to a sick society (Perls, Hefferline, and Goodman, 1951; see also Hawley, 2011). Although many categorize something as suitable for men, and something else for women, we can choose to live out several aspects of ourselves. "I would not mind having greater freedom when it comes to showing up at some party and being dressed up. If I dressed in something, it would have to be something androgynous," said **Jo**. I noticed he was wearing clothes that created for me associations with the military or wild life, and I asked if he could dress as a woman here with us. At the next session, **Jo** mentioned that he had brought some clothes he had found at home. After the break, he came in dressed in a long, colourful shirt, earrings, and sandals. The following dialogue ensued:

VK: *How is it for you to sit here with us? Have you worn these clothes before?*
Jo: *That was many, many years ago.*
VK: *Yes.*
Jo: *So, in a way it is like saying hello to an old feeling that is also a part of me. And that is probably the androgynous part.*
[Jo talked at length about his biography. At some point, my mind started to wander, and he became less visible to me in words. I wondered about a possible process of deflection. I wanted to bring us back to the group, and to

what was happening here and now.]
VK: *How is it for you here and now with us? We're sitting here now looking at you. How does it feel for you?*
Jo: *It feels like. . . it feels like a joy. Because I feel safe enough with you here. . . .*
[**Jo** continued to talk. As I listened, I became aware that he had done something that could involve anxiety, and that deflection has an important function. I checked whether it would be all right to bring in the other participants and ask them for feedback. I wanted see if he could feel seen in his wholeness, and how this might impact both him and the group.]
Alexander: *I become happy.*
VK: *You become happy.*
Alexander (turns towards Jo): *Yes. Because I get a little kick out of the clothes and the interesting cuts; and because you smiled.*
[**Arne** and **Kennedy** also shared that they became happy. **Jo** said, "I am very happy that others are happy because of this." After checking if it was OK to have more feedback, I also shared something: I described what I had seen, including Jo's smile, short beard, colourful shirt, and earrings.]
VK: *I became aware of another thing when I saw you in those clothes. Yes, here I am today, sitting in a pink sweater, and with a beard.*]
[I wanted to contribute to normalization. As a man, I choose to wear clothes that are not necessarily considered masculine. **Alexander** then added that **Jo** reminded him of a friend: "He also loves that kind of shirt."]
Jo: *Yes, no, I sometimes see some men with this style, with many colourful things, and I become happy. And then I don't understand how people can be angry and provoked when people stand out.*
VK: *So now you are being seen, Jo.*
Jo: *Yes, this queer part is what has become invisible, I guess. With my becoming so masculine, most people probably just think I'm like a standard guy. And then this queer part of me disappears.*
VK: *And now it has become visible.*
Jo: *Yes, that part is there. But I cannot show it to just anybody. Or I have not tried to. But I can make some choices later in life to show more. We'll see.*

Kennedy encouraged **Jo** to use his colourful shirts and other clothes in public as well. **Jo** said that he had some friends with whom he might be able to do so. He told us that he was, on the one hand, the colourful disco-queen we were seeing now and, on the other, a military-inspired SM-man. At this point, I engaged in some psycho-education on polarities: in particular, Zinker's ideas of "stretching the self" and the "around the world" phenomenon; and that we can be more whole and flexible when we are aware of the entire polarity. We also talked about the paradoxical theory of change (Beisser,

1970). Others participated and exchanged experiences. Kennedy was inspired to explore, accept, and express more sides of the gender identity. At the following session, **Kennedy** told us that Kennedy had bought men's shoes the week before. **Jo** shared that, before gender affirmation treatment, he felt he had had a physical urge for testosterone (i.e., a "lack" of it), but had not considered whether he could continue living as a biological female and express more sides of his gender identity. Here he differed from Kennedy. At the last session, **Jo** said that the most important episode for him was wearing his old clothes: "It was an experience rather than just talking about something"—an important characteristic of an experiential psychotherapy such as Gestalt. He felt that he had become more comfortable with his whole gendered self and did not have to be a "standard man."

This episode illustrates how polarities, gender norms, and introjection may interact. One side may be oppressed at one point in life as a woman, and the other side at another point in life as a man. Suffering can be understood in terms of the weaknesses of society—its low tolerance for gender diversity—rather than as an issue of individual pathology. This view is in line with Bennett (2010), Hawley (2011), and Fallon (2012). In our group, we recognized and explored social pressures and choice, broke gender norms in a safe setting, and explored how that felt. It was a common "chewing"—the counter pole to introjection—over the idea of how a man should be. A military-inspired SM-man could also be a colourful disco-queen. In stretching one side, **Jo** became more aware of the other side: an "around the world" phenomenon (Zinker, 1977, p. 202).

While strict and intolerant gender norms can make it difficult to choose, like Hawley (2011), to be a "feminine man" or, in the case of **Jo**, to be both a military-inspired man and a disco-queen, the episode with Jo shows that such integration would not always be sufficient. It was clear to Jo that choosing gender affirmation treatment had been about something more than norms and introjection: namely, a physical sense of lacking testosterone. For others, such as **Kennedy**, exploration and acceptance for the whole gender polarity was sufficient.

The work with polarities also had an effect on others who participated less directly. Under "Especially Important Events, Statements and Relationships" on the posttherapy feedback form, **Alexander** wrote:

> When Vikram said that one can feel one thing *AND* another thing (instead of *BUT*), which is usually seen as the opposite, this helped me to deal with the opposition between body and brain that I experience every day. Also, the feeling of being happy and angry in this process. Another important event was when Vikram talked about change,

> and how it happens when we stop trying to push ourselves to be one thing or another. Through this, I became who I want to be. The sense of safety with an open form of communication was particularly important as well, because it made me aware of how I myself am in relation to others, and that I can allow myself to be caring rather than critical in some contexts, and to be assertive in others.

Through polarity work, people can see themselves as more whole and flexible; for example, "assertive and caring," as Alexander reported. Some psychologists claim that being assertive is a typically masculine quality, while being caring is typically feminine (Larsen and Buss, 2010). Zinker (1977), too, seems to presuppose that "hard" and "tough" is masculine, while "soft" is feminine (p. 202). Because the concept masculine/feminine also has a gender normative aspect and is connected to introjection, I believe that at times it may be more appropriate to use more precise terms such as assertive/caring and hard/soft.

Alexander also mentioned "the opposition between body and brain," which may refer to the experience of oneself as a woman and a man. During the sessions, he decided to start assessment and treatment privately abroad, where it could proceed more in accordance with his own wishes. People who have undergone gender affirmation treatment may also experience something similar to "the opposition between body and brain," or otherwise feel that they are not completely at home in either gender. This may be related to their having a history of belonging to a different registered sex and gender, as was also the case for the clients of Bennett (2010) and Fallon (2012); to their feeling that the body is not always completely transformed; or to their experiencing gender identity and expression as a continuum, and sometimes fluid. All of these reasons were the case with Jo. Polarity theory and work can be meaningful in such cases.

There was also space in the group for doubt, fear, and anger in addition to counter poles like certainty, joy, and happiness. Many people probably feel doubt, fear, and other painful emotions during considerations of, and processes related to, potentially transformative changes such as gender affirmation treatment. Many transgender people feel they have to hide these feeling to convince the Rikshospitalet psychiatrists and so get the diagnosis that gives access to treatment. In the group, however, it was possible to be open; therefore the counter poles also appeared, which is considered healthier in Gestalt therapy (Zinker, 1977).

Final Remarks

This study has shown how a Gestalt therapist can approach gender identity issues. The Gestalt concepts of phenomenology, polarities, and modes of contact seem to fit well with the "transgender" model, which is based on the understanding of a continuum; and with transpositive and nonpathological approaches that give special importance to the experiences of transgender people themselves. Importantly, with regard to the last point, this paper has included references to feedback from participants about significant and meaningful experiences and changes related to gender identity issues. The "transsexual" model, however, is still the dominating paradigm within the public health sector. Offering Gestalt therapy could thus be a sorely needed complement. Research by practitioners, as well as by external academics, can happen in parallel to strengthen further the knowledge base on Gestalt and gender identity issues.

At the same time, the study shows how gender identity issues and suffering is tightly connected to the wider environment, norms, and introjections. Despite the liberal and progressive development in Norway over the last few decades, transgender people still face severe challenges, not the least a lack of tolerance for diversity. Experience, creativity, and change occurring in the confines of the therapy room will not be sustainable if the larger society constantly requires another kind of adjustment (Perls, *et al.*, 1951). Perhaps some of the intolerance is related to individuals and groups projecting and letting internal conflicts be played out interpersonally or between groups; for example, with transgender people and others who may not conform to gender norms as targets. These individuals, groups, and society-at-large also need healing for their own sake, as well as for the sake of transgender people. As Gestalt therapists, we should at least strive to communicate some of the experiences of transgender people, as well as the appreciation of diversity, to wider society. Change is required on intrapersonal, interpersonal, and societal levels.

It is hoped that this study, which includes not only academic papers but also popular papers based on them, can make a small contribution to achieving greater diversity and freedom in Norwegian society and internationally. It is also hoped that Gestalt therapists and others who work with transgender people will do what they can to bring forth necessary social change and, at the same time, develop and adhere to transpositive, therapeutic approaches.

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