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## PEER-REVIEWED ARTICLE

### A foreclosed clinic, ‘Tiresian’ clinic, and violence against trans people: Some reflections from psychoanalysis on clinical work with trans people in México

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#### ABSTRACT

This article ponders on reflections from clinical work undertaken with trans individuals in contexts of acute violence and social exclusion, conditions that permeate the vast expanse of Mexican territory. It addresses the importance of a model of clinical work required to support transgender people suffering from social violence, by examining two contrasting clinical positions based on some Lacanian frameworks: a ‘foreclosed’ clinic, and its counterpart, a ‘Tiresian’ clinic. This article explores the implications of the therapeutic setting as a safe space amid the violence suffered by trans individuals, as well as the importance of recognising the consequences of the encounter between identity and life or death decisions in environments of extreme violence.

**KEYWORDS:** transgender; foreclosure; context; language; violence

#### ON BEING TRANS IN MÉXICO AND THE ROLE OF THE CLINICIAN

Violence against trans people is of global concern. In the ongoing wave of violence, México heads the list of being the second country in the world with the highest number of registered murders of trans people (Organización Letra eSe, 2019), with over 87 homicides against trans people in 2022 (Statista Research Department, 2022). As part of the official documentation consulted by the Mexican government, the Inter-American Commission on Human Rights issued a report titled ‘Violence against LGBTI People in the Americas’ (Comisión

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Interamericana de Derechos Humanos, 2015). One alarming statistic stands out: the life expectancy of transgender individuals in the country is 35 years.

México varies in its levels of development; not all of the country finds itself in the same condition of protection and safety for trans people to thrive. As a matter of fact, only 12 states in México have criminal offences that include penalties for the attacks on trans people. Therefore, we can conclude that we are facing a vital problem which should be addressed, and one of the ways it can be approached is through the psychotherapeutic space that is provided in a clinical setting, which will also be a useful way to discuss the clinical work undertaken with trans individuals.

Coming from the idea that clinical work is always context related, it is undeniable that psychotherapeutic demands vary radically from person to person, not only regarding the singularity of the person speaking, but also from the economic, political, and sociocultural place that the person occupies and from which they speak and is spoken to. Likewise, the clinician's listening is conditioned by cultural and shared meanings, representations, and narratives, which can turn dangerous when unconscious and replicable (Freud, 1910/2012e).

Therefore, it is necessary to bring into question the quality of what reaches these particular clinical spaces and if it accounts for a great deal of well-adjusted demands to social, economic, and cultural contexts. This scrutiny is essential in light of the tangible challenges encountered by trans individuals on a daily basis, living in a country where their authenticity is intricately linked to a precarious balance between life and death. As a clinician it is crucial to be aware of this reality.

Despite taking measures aimed at providing safe spaces for trans individuals, they continue to encounter circumstances of social exclusion in the majority of contexts and situations (National Resource Center on Domestic Violence, 2015). The matter of life or death seems to play a major role in the singularities of trans people, even in those who are placed in non-violent and risk-free zones. In her work *Transgender Psychoanalysis*, Patricia Gherovici (2022a) gives an account of her clinical experience with trans people in the United States, and addresses the crucial, pivotal matter that is sex and identity reassignment for those that come to seek help. The author not only talks about the violence that trans people suffer, but rather she addresses a very singular problem regarded as fundamental and a matter of primary desire: to live as trans or to commit suicide.

Besides the economic and sociocultural constraints, trans people in México don't attend the psychotherapy spaces provided too often, perhaps partially due to the inability of many clinicians to truly listen to the disparities that being trans pose to themselves, which makes the psychotherapeutic space seem and feel like an unsafe place to these individuals.

There are, within the psychoanalytic framework, plentiful works on the importance of reformulating or reshaping the theory to take an ethical position; however, even in the light

of the emergency or reemergence of the trans topic, only few discuss the role of the foreclosed clinicians and their fault in excluding trans individuals and their particular context.

From my theoretical framework (psychoanalysis), the emergence of the trans discourse stands out prominently at a theoretical echelon within the domain of psychoanalysis (as well as in various other theoretical–clinical paradigms). This ascent provides a fertile terrain for debates, discussions, and forums, particularly in highlighting the contemporary pertinence of the subject matter. Noteworthy is the fact that its roots can be discerned in the early works of Freud (1908/2012b), who referenced Magnus Hirschfeld and his endeavours in sex reassignment surgeries, or in Lacan’s (1955–1956/2013a) role as an analyst attending to trans individuals.

The trans discourse is regarded as new although it is not. It is almost as if it had emerged at some point but detoured to its silencing, its exclusion. Perhaps what we could categorise as new is its emergence in different social contexts, where it was not evident before (or perhaps in contexts that didn’t exist before), and therefore, now we have no choice but to see it. This has led to the creation of new language or the reappropriation of signifiers that return, almost like the ominous return of the familiar that was once banished (Freud, 1919/2012d). First and foremost, it is an attempt to be able to state or to articulate something that had not been articulated before; either it occurs at the level of signifiers and enters the symbolic circuit, or is rejected (Lacan, 1955–1956/2013a). In other words, we either produce symbolic forms and spaces to accommodate what the trans population articulates as a clinical demand, or we reject them in a foreclusive manner.

A primary apprehension in engaging with patients lies in the temptation to seek refuge behind the inadequacy of theory or theoretical language in light of the resurfacing of the trans discourse. Rather than introspecting on whether we are fostering safe spaces conducive to dialogue and addressing challenges related to trans experiences, we might inadvertently assume a defensive stance. It is imperative to assess whether we contribute to inclusivity or, conversely, play a role in perpetuating exclusion within this discourse. The pervasive dominance of theoretical discourse surrounding the trans experience, encompassing aspects of gender and identity, has left scant room for conversations about the socially marginalised and mistreated trans individual—a discourse demanding a distinct narrative.

It does not seem arbitrary to me that we increasingly see a number of clinical psychologists advertise themselves as non-pathologising, inclusive, and contextualised clinicians, and it raises the question: why does it seem necessary to advertise ourselves as contextualised therapists? Isn’t the principle of clinical work precisely not to have preconceptions of the person when we ask them to share everything they have in mind? If we are not genuine while working with patients, how can we assert ourselves as safe spaces for trans individuals (groups of people that are harmed and at a constant risk of death)? One of the problems that I want to highlight here is the lack of contextualisation in the clinic and the failure to place the

clinical demands of trans individuals in a country dominated by hostility, violence, and we could even say hatred, towards this population.

## **A THEORETICAL DETOUR: THE LACANIAN PROPOSAL OF AN IMAGINARY/SYMBOLIC/REAL BODY**

Let's first address the theoretical aspect concerning the trans topic, which I believe has been the main focus serving as a screen or shield, to argue that there are not enough coordinates to guide clinical work, as if the problem were a lack of theory. Nevertheless, psychoanalysis has found an important reference on this subject in Lacan's (1974–1975) theory, and so the foundations for addressing the understanding of the trans topic have been laid for decades. Much has been written about the position of Lacanian analysis that would allow access to the understanding of a subjectivity which is not fixed in the biological body, and about the construction of theory and clinical work that does not conform to a normative binary system. In general terms, the proposal revolves around Lacan's (1972–1973/2013c) formulae of sexualisation. These formulas make a distinction between phallic jouissance and 'Other jouissance' that is not entirely phallic. A jouissance located outside the anatomical body allows us to understand that sexual difference would no longer be situated at the level of anatomy, but of discursivity. Language would then serve as the reference for differentiation (sexual and any other kind) beyond the image. In other words, there is a transition from the natural body to the discursive body.

However, what I would like to highlight here is not so much the clinical work undertaken with trans people in terms of sexuality—enough has been written about that—but the importance of this topic leading us to question the consequences of the analyst's position and listening. That is, to position oneself in terms of language, as a renouncement to that exclusion, which I think is also relevant and useful in other clinical practices and perspectives.

As for the construction of the image, which underpins subjectivity from its structure, the involvement of the biological body is undeniable (Lacan, 1949/2009a). However, the initial assumption of the image in every subject is not based on a sexed body but on the body as a unity, a whole. That is to say, what the specular image of unity projects of the other, is what causes the unity in my own image. It is more a matter of owning one's body: 'I have a body' rather than 'I have a woman's/man's body'. Initially, there wouldn't be an image reflected in the mirror endowed with sex or gender, as it would be a non-sexed image. This imaginary body (Lacan, 1949/2009a) is therefore also an imaginary and real support, and must subsequently be assumed symbolically, that is, sexually. Language will be incorporated later on; at the moment, when we are spoken to by others and along with the image of the body it will enunciate 'you're a boy/girl'.

Therefore, the body, for the human being, is an assumed body and it is not reduced to its natural experience or anatomical form. From this perspective, we find ourselves placed in a different position of listening to the other; a singular, discursive other who has assumed or is in the process of assuming the image of the body, and thereby an identity. We would undoubtedly be listening to different ways of inhabiting the real body that cease to be merely an image to give way to language. The transexual individual, for instance, reassigns their biological sex, which accounts for an entire symbolic movement preceding the real transformation, and the imaginary re-assumption comes afterward. This is why for Gherovici (2022a) it is a matter of life or death and not just a gender issue, because it traverses the body in its imaginary, symbolic, and real dimensions. It traverses the totality of the subject. Therefore, what we ultimately hear in the clinic is not nature but the signifier; in other words, we listen to difference (Lacan, 1958/2009b). This is to conduct a human clinic, and not a 'natural' or biological one.

In this regard, identifications as an imaginary component and as substance of the self (Freud, 1923/2013) are not fixed but mobile, as it can be seen clearly in trans individuals. Consequently, talking about subjective positions leads to giving up pathologising the trans subject (furthermore, encompassing myriad subjects that are categorised as psychopathological). Regarding this, Gherovici (2022b) emphasises that it is not necessary to be a specialist in the trans topic to work with trans patients. In any case, the specialists are the individuals who come into the psychotherapeutic space and assume knowledge within us, the therapists. Thus, we function as an 'echo upon their knowledge', not our own. We, in essence, lack knowing, even when equipped with a theory that elucidates the foundations of clinical work. The foundations, nonetheless, do not constitute the entirety.

## **A FORECLOSED CLINIC VS. A TIRESIAN CLINIC. WHAT ARE WE NOT LISTENING TO?**

What kind of clinical work are we taking on when listening to the discourse of transgender people living in violent contexts? The example of Rob might shed some light on what appears to be a common mistake. Rob is a young transgender woman, who sought therapy and decided to contact me. Upon arriving, Rob says to me, 'I come here because I believe that you can truly listen to me'. Undoubtedly, the inquiry regarding why I possess this capability is inherently linked to the broader question of why others might not.

After navigating through psychotherapists of diverse approaches, including psychoanalysis, Rob described how they all exhibited a willingness to listen, yet comprehension remained elusive. Some demonstrated a resistance to 'unlearn' (particularly evident in the challenges therapists faced in using neutral pronouns). 'I realised that I couldn't freely share everything I desired because it didn't seem like they genuinely listened'. It

appears unequivocally evident that trans individuals continue to feel unheard within psychotherapeutic spaces. This compels us to overtly declare our inclusivity, acknowledging that not all clinical settings are inherently so. In other words, there are (and not infrequently) clinical psychologists who exclude the trans subject and their issues.

Certainly not only have psychotherapists failed to truly listen. As the only trans individual in the city where she resides, admittance to recreational spaces created for women has been denied to Rob. An instance of such exclusion is recounted, describing the experience of pain and shame she faced in a lady's only bar, where entry was denied despite being accompanied by friends. Reflecting on this ordeal, she expresses:

In addition to how dreadful that was, it was even more dreadful to have to narrate it, and it was still more dreadful the fact that the psychologist felt more outraged because they wouldn't recognise me as a woman than when I told her they kicked me out of the place as if I was a burglar. That actually was what hurt me the most!

Friendships and a significant portion of her family have been lost, severing all ties. She articulates unequivocally that she is unheard everywhere, lacking any semblance of a safe space. 'People say things to me on the street, and I fear that something might happen to me. Sometimes I think I have to leave the city, but why should I leave?' Rob believed that she might find a safe space in the psychotherapeutic setting, only to discover that her words either 'bounce back' or are 'replaced by others'.

There seems to be an inattentiveness to certain aspects of the trans experience and the difficulties they face. I believe that a challenge in the clinical realm may lie in our behaviour resembling that of foreclosure when addressing trans issues. What is it that seems unable to be heard, and why? Referring to the term 'foreclosure', Lacan (1955–1956/2013a) mentions, 'we can only introduce things into the circuit by respecting the machine's own rhythm; otherwise, they fall into the void, they cannot enter' (p. 24). Playing with this term allows us to recognise a precarious position for clinical work. It is almost as if focusing on certain aspects of the trans experience and theorising about them, instead of aiding our work, is excluding what doesn't fit into that framework. The significant issue could be that we are hearing only what our symbolic circuit 'akin to theories' permits us to hear. This seems particularly crucial to emphasise when I hear theoretical debates about trans individuals, sometimes exclusively centred around body, gender, and identity. However, in the contextualised clinical setting here in México, the foremost theme seems to be another, one that is related to survival and security at the most fundamental level possible.

Being unable to listen is, of course, different from being unwilling to listen (or being unable due to unwillingness). Being unable to is not a form of denial (*Verneinung*, in German), as denial implies the acknowledgment of something in its negation. Denial provides a space for signifiers, as their existence is recognised even when rejected in some manner, akin to Freud's (1925/2012c) interpretation of the classic 'don't you dare think I'm talking about my mother'.

Whereas denial is an attempt at repression, foreclosure (*Verwerfung*, in German) is the absolute rejection of something symbolic because it doesn't fit in. In other words, the non-inscription of a particular signifier in the existence of the subject of language. To foreclose is to 'know nothing about the matter', 'not even in the sense of the repressed' (Lacan, 1955–1956/2013a, p. 25).

Might the therapists, then, somehow foreclose the discourse of the other? It occurs to me that, on occasion, this might be one of the challenges in the clinical setting when faced with what is deemed 'new', which, as we've mentioned, may not necessarily be so. This goes to the extent that access to the other's discourse is denied, and consequently, its subjective value is also denied. Rob chose the path of not saying everything she wanted to say because it couldn't be truly heard, meaning it would be rejected in the same manner as in other spaces. Rejecting the signifiers of the other is one of the most violent ways to act in the clinical setting. Considering that, as discussed earlier, there are theoretical foundations guiding us in listening to supposedly new information, and in the face of what has no place in theory, we must create one, following the Freudian discovery where clinical findings precede the incorporation of language to express them (Freud, 1915/2012f).

Though Lacan alludes to the exclusion of elements unable to enter the symbolic circuit as falling into the void, it is crucial to note that this does not signify the rejected is nowhere: 'Moreover, everything rejected from the symbolic order, in the sense of *Verwerfung*, reappears in the real' (Lacan, 1955–1956/2013a, p. 34). Thus, to the extent that clinical work risks foreclosing the discourse of trans individuals, the resurgence of the real manifests beyond its confines. The most authentic manifestation materialises in the form of deaths, suicides, murders, and the daily violence inflicted upon them in our country.

Furthermore, there exists a 'not all' within the trans experience. In essence, we must start by acknowledging that the challenges faced by trans individuals vary across regions. The proposition, then, would be to adopt a position that we might name the 'Tiresian' clinic.

From Ovidio's (2011) narrative, we witness the story of Tiresias, the sole character in mythology to have been both a man and a woman. Transformed from man to woman, and vice versa, as punishment for separating two copulating snakes with his staff, Tiresias can settle the dispute over which of the two sexes derives more pleasure from sexual intercourse. Endowed with knowledge of the future and the mysteries of sexuality between two antagonistic sexes, Lacan (1962–1963/2013b) positions the figure of Tiresias as a role model for psychoanalysts. Tiresias embodies a position of knowledge about sexuality beyond the limits of the phallus and its biological references. There is no signifier of being a man or a woman. A clinic in the vein of Tiresias would be a trans clinic. In essence, it transcends the biological labels, positioning itself on the side of encompassing all and listening to everything.

Listening is an opening to a new conceivable meaning, an acknowledgment of the novel or the unfamiliar without evasion. Therefore, the ability to listen without exerting violent

exclusion of the language of the trans individual doesn't necessarily require expertise in trans theory. Instead, it requires enabling the admission of the 'other' language, which authentically opposes foreclosure, no matter what. This comes with the risk of confronting our own impossibilities, encountering other realities that don't enter the consulting room unless the consulting room extends beyond itself and begins to provide those safe spaces for free expression.

Freud (1912/2012a) bestowed upon us the magnificent tool of free-floating attention, which means listening to everything and nothing simultaneously. Applying ethical principles to desire involves allowing new signifiers to emerge as unknown and making room for surprise, an authentic posture of openness to the other. 'Success is ensured when one proceeds as if at random, letting oneself be surprised by the turns, approaching them each time with naivety and without preconceptions' (Freud, 1912/2012a, p. 114; my translation). Thus, the fundamental principle of clinical work must always be to listen to the difference, not the sameness; it's to understand this not only as a sexual, identity, or gender difference but also as differences in their context and their psychic consequences. I refer to working with patients in general, irrespective of our theoretical position within it, and urging a deeper commitment to a Tiresian-style clinic. Perhaps, in doing so, it will soon be unnecessary to proclaim ourselves as non-pathologising and contextualised clinicians and to genuinely be inclusive clinical psychologists for any individual, with their subjective desires, anxieties, and fears.

## **PROVIDING A SAFE SPACE: A MATTER OF LIFE OR DEATH**

As psychologists, we run the risk of, unknowingly, exercising a form of violence against trans individuals (in a country where being trans constitutes a risk of death), by not shaping our clinical listening in the Tiresian model, but rather on the side of foreclosure. This may happen as we focus more on theoretical debates that only address a specific type of demand from trans individuals, one that unfolds in spaces where life is not at stake.

Rob's example represents a demand for clinical listening in private consultations on the trans phenomenon in a high socioeconomic context. Even in that context, Rob positions herself as at constant risk, seeking spaces she can consider safe to speak, to be heard, to unfold her fears and anxieties, and ultimately, to make life bearable in alignment with her desires. If we add the socioeconomic vulnerability to the very real risk of death, we encounter even more alarming narratives.

Mirna and Valeria, two friends and transgender women, had to flee their hometowns in Honduras because their lives were in danger. A field investigation I was conducting on violence against migrant women in México led me to meet them during their second attempt to cross the border into the United States. Eventually, I attended to them in an improvised



clinical space, irregularly, in the only feasible way given the obvious complications in their lives. Being trans, for them, meant that their desires and demands were on the side of survival itself; that is, the risk of living as trans individuals. Living as trans women could mean death; just as living could mean renouncing being trans and therefore dying in another way. Unlike Rob, their sufferings do not predominantly revolve around the inability to be heard but rather around life itself.

Valeria recalled:

We departed together to shield ourselves. In our place of origin, we suffered sexual abuse, endured forced haircuts, and had our clothing forcibly taken away because we were perceived as men. They threatened to kill us.

Once, in a shelter, they made us sleep with the men and denied us access to the women's quarters. The men behaved maliciously, touching us throughout the night. If you resist, it only gets worse, so we no longer take any action.

Honestly, I now prefer presenting myself as a man. Given everything I've been through, it's easier to navigate life as a man. I'm profoundly depressed; I used to have long, beautiful hair, but now, it's all about surviving, even if it means living as a man.

Mirna recalled:

We find ourselves in a state of poverty and lack of education, unable to afford the continuation of hormone therapy. The gradual loss of my breasts and other physical changes saddens me, not so much because of how I look, but because I don't know what will happen to me or where I will end up. I've had to resort to prostitution to survive, with men who like transvestites. My clothes are women's, even though I no longer resemble one.

I would like to see a psychologist, a doctor, a dentist, and everyone else. I would like to see a psychologist because I am sad all the time, I cry a lot, I miss my home, I am afraid, hungry, and I have no one to talk to. I can only talk to my close friend because we are going through the same thing. People treat us badly here.

Both narratives are clear in their priority in what constitutes the foundation of their desires and demands: to live. If being trans in México is condition enough to be at constant risk, the transgender migrant population are in such a vulnerable and dangerous situation, as Mirna and Valeria narrate, that life or death decisions have to be made through their journeys. Facing such terrifying experiences in order to achieve their objectives and maintain hope, their position is also clear: to choose life over their identities. The matter of identities is secondary to the matter of life, and that is what happens in such violent contexts. As Rob recalled from her last therapist, it was not that important to be acknowledged as a woman, but it is to be attacked. Being transgender most definitely does not involve the same type of dangers, experiences, and narratives; they want to be heard and properly attended to. It is then important, if not necessary and essential, to recognise how gender, identity, and violence (from both singular and social sides) cross paths in specific contexts such as México.

## CONCLUSION

I hope that our theoretical entanglements in being able to ‘listen’ to ‘the new’ do not deviate us further from real needs and lives at stake. I experienced this deviation myself while writing this text, trying to account for why I believe there is a proposal to incorporate different trans discourses into our symbolic machinery so that we can genuinely listen to them.

Discussions about theoretical elements with real implications in the lives of trans individuals, such as corporeality, sexuality, and identities, are indeed crucial. However, much more needs to be heard in spaces of extreme violence, and not explicitly pointing it out can continue leading us into the realm of excluding the speaking subject, who wants to be heard, demands safe spaces, and seeks how to live or survive in a country that pushes in the opposite direction.

It is essential to always have in mind that in violent contexts, such as the northern Mexican border, that clinical settings are not reduced for transgender people to a matter of identity, or even a matter of singularity, but also, to the fact that living as transgender represents a real threat to their lives, a major challenge in assuming a trans identity socially. The challenge for us as clinicians also rests in a constant exercising of truly listening beyond our narrow theoretical frames, of listening beyond prevailing American or Eurocentric discussions about trans issues, which might rest on radically different environments, and as a consequence, the call is for addressing all that discourse also situated in between the limits of life and death—the call is for listening beyond a ‘foreclosed’ clinic model.

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