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Fragment of an Analysis of a Case of Cisteria

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ABSTRACT

This article presents an imaginal case history of a presentation of cisteria as a mechanism for exploring unarticulated assumptions and unacknowledged power dynamics that undergird both the broad process of creating diagnoses, and the process of diagnosis at the individual level. Bracketed by reflections that contextualize the imaginal case study, this article aims to disrupt linear narratives regarding the production of diagnostic theory.

When I was first asked about making a contribution to this special edition, my response was an immediate and enthusiastic "yes." The levity of the title and gravity of the subject matter hit just right for me, and the possibility of getting into "good trouble" (Lewis, 2014) with Jess, Tavi, and Tobias rendered the opportunity near-irresistible. As a trans psychologist who is in intimate and extensive community with other trans people, signifiers of transgender realities are always loud in my life, but working on this article turned up the volume in unexpected—and often delightful—ways. Indeed, the volume on the gender knob is currently cranked up so high, I'm beginning to think I might be suffering from a case of cisteria-by-proxy.

In the end, the circumstances of writing this article became perhaps even more gender-y than the article itself. I also grew aware of the ways in which references and footnotes capture only a small fraction of the web of relationality that goes into writing articles such as these. While I could potentially write an article that presented my thinking as linear, coherent, and knowledgeable, the truth of these articles, like the truth of therapeutic work, is very messy. (At least it is for me. My truth might not be your truth.) This article is, then, an associative attempt to capture the messiness of the production of theory, as well as the chaotic misunderstandings that typify everyday psychotherapy, and I wanted to use the lens of cisteria to work toward these aims.

Thus, in the first section, I present a largely unedited account of my relational re/search[1] process as I move toward writing a case study focused on the phenomenon of cisteria. I enjoyed playing with how I narrate my thinking in this way, although it definitely feels rather exposing. In the second section, I move into the presentation of an imagined case history, one that I would perhaps have written as a graduate student if coming from a theoretical lens—or society—in which my formulations of gender were central rather than peripheral. Many questions—and a few concerns!—emerged in the editing process regarding the primary and secondary case histories, so let me be very clear that they are entirely fictional. No actual patients were harmed in the making of this article. In the concluding remarks, I reflect briefly on the learnings that came from engaging in these processes.

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[1] I use the slash here to indicate that my theorizing is not original, but rather a *re*lational *re*cursive search—a sifting through existing brilliance.

Section I

You can't get there from here

I mention the invitation to write this article to my partner, who is also trans, and they recommend a book I have never encountered: *Invention of Hysteria: Charcot and the Photographic Iconography of the Salpêtrière* (Didi-Huberman, 2004). Beguiled by the cover and by my partner's description, and aware of looming deadlines and my paucity of education about the psychoanalytic formulation of hysteria conceptually, I order the book right away. Once it arrives, I honor the long-standing tradition of putting it unopened on a stack of other books that I also have not opened. Some weeks later, in an emotional state that combines eagerness to read a new book with a particular form of begrudging resignation about reading a new book, I finally open it to the title page. The book that I received has been misprinted. Although the cover is the same cover that captivated me, the contents are a selection of essays about biology. The cover of a book about the social construction of hysteria encases a book entitled *Evolvability: A Unifying Feature of Evolutionary Biology?* (Hansen et al., 2023). I find myself wondering in a new way about the relationship between the social construction of gender and the biological elements of embodiment, what it would be like if they were categorically separate "books," and not a mashup of cover and contents.

This is in my mind as I call the customer service line for the bookseller and speak with a lovely person with the same high-pitched voice and rich Southern accent as my very first nesting partner. Their first names are also the same. (Yes, that ex and I are still friends.) The bookseller finds my order easily—there are very few Minshews in the United States, and the only other one I see on the Internet is a football player, which I definitely am not. The bookseller and I commiserate about having hard-to-spell last names. "That's why I had to get married," she says. I find myself debating internally whether I should tell her that she can change her name whenever she wants, that marriage is not a requirement. I also find myself wondering what our interaction would be like if we saw each other in person—if my short hair and flat chest would invite the same kinds of disclosures. I contemplate a counterfactual—what would our interaction have been like if I used my "boy voice" for the call? My fantasy is that the interaction would be brisk and efficient and lacking in psychological intimacy. Plus, my boy voice makes me sound like a Labrador. I hold my tongue on the topic of names. I regret nothing.

All of this gender semaphore takes place before I receive an actual copy of the contents of the book, and I carry forward the questions evoked by the process of receiving the book as much as the book itself. (The *books* themselves, I should say.) Certainly, the easy interpretation lingers: that the "book" is separable from the "cover" in the same way that gender is separable from genitals. But that suggests a degree of consistency about both gender and genitals, a fixed "cover" that might open to reveal equally fixed (if unexpected) "contents." This is problemed by my experiences, real and imaginal, with the book seller. I might be interpreted as a particular gender in a phone call, and yet another in a physical encounter, and both of these may be utterly separate from my own understanding of my own gender and may also have very little to do with my past, present, or future genital configuration. If my voice reveals one part of my experience, and the cut of my jeans (or genes) another, where does disclosure reside?

Although these questions feel guided by the content of the experience, they are perhaps not entirely coincidental, since, as mentioned already, I spend much of my time thinking about gender. Nonetheless, when I see an email about a reading group intended for trans analysts, I sign up and think "synchronicity!" I dust off my grad-school Jung. In doing a literature search about transpersonal psychology, I let myself get unduly excited about an article I briefly believe to be entitled "Transperson Al," but this is, alas, another misprint.

Jung began writing about synchronicity in the 1920s, and described synchronicity in various ways, but the phrase "meaningful coincidence of causally unrelated events" may have the most traction (or perhaps the subtitle "Acausal connecting principle" [Jung, 2013]). For Jung, the occurrence is largely connected to the activation of archetypes; later theorists have also discussed the focus on the interface between humans and other aspects of the natural world in Jung's clinical examples of synchronicities

(Main, 2007). A more recent case presentation asserts that "synchronicity requires open emotional and physiological borders between the self and the world" (Marks-Tarlow, 2024, p. 11). This rings true to me, and I think about the utility of both containment and porosity in the therapeutic space, and how I might carry this into my imagined case study. Marks-Tarlow calls the subject of her case study "Sabina."

The reading group for trans psychoanalysts has a date for discussing a book chapter focused on Sabina Spielrein (Tomčić & Launer, 2024). Spielrein, one of the only women associated with Vienna Psychoanalytic Society, in 1912 presented a paper fusing ideas from evolutionary biology and psychology that posited a biological, evolutionary, procreative imperative to the sex drive (Spielrein, 1912/1994). She was foundational to psychology in describing the death instinct. Nevertheless, she is largely remembered in the field (when remembered at all) as Jung's first patient and tempestuous, troublesome *femme fatale*. I consider—and reject—the notion of finally watching the mainstream movie about Spielrein, Freud, and Jung. (It came out when I was in grad school, so I have been resisting for a long time. Based solely on the trailer, I feel so resistant to it that I find myself resisting naming it here. I resist, editors insist . . . if you watch it [Cronenberg, 2011] you have only yourself to blame.) I think about the ways in which brilliant thinking often comes from the margins, perhaps because marginalized individuals are apt to find ways to try to bring factions together. Spielrein seems to have tried and seems to have blamed herself when she failed (Tomčić & Launer, 2024).

Spielrein (1912/1994) begins her paper by asserting that the sex drive brings up negative, as well as positive, feelings. She makes a biological argument for these negative feelings, asserting that the "union of [. . .] cells" (p. 156) that allows for the creation of new life is innately destructive to the individual cells that fuse together to form the new creation, and that this destruction generates anxiety. Spielrein pulls evidence from the evolutionary chain, at least as far as is convenient to her thesis, describing the literal death-by-procreation of the mayfly. (Like so many ostensibly biological arguments, it falls apart if we look at it too hard, since the ultimate progenitors of mayflies and humans alike are single-cell structures that reproduce asexually.) Some of my thinking on this gets wrapped up considering the impulse to try to fuse biology and psychology in therapy with trans people, and the ways in which psychologists and behavioral health providers are asked to stand in expertise about trans bodies that is well outside of our training. I also think about the ways in which behavioral health providers—mostly, but not entirely, cisgender behavioral health providers—insisted on taking up this mantle, as outlined in *Trans Medicine: The Emergence and Practice of Treating Gender* (Shuster, 2021).

In parts of Spielrein's (1912/1994) arguments about coming into being, however, I begin to see something trans. She writes:

> The personal psyche can only desire pleasurable feelings, but the collective psyche teaches us what we desire, what is positively or negatively feeling-toned. Therefore, we see that the collective desires living within us do not correspond to personal desires. The collective psyche wants to assimilate the more recently developed personal psyche while the ego—indeed, every part of the ego—strives for self-preservation in its present form (inertia). The collective psyche denies the present ego and, directly through this denial, creates anew. (Spielrein, 1912/1994, p. 162)

I begin to think about the ways in which trans people internalize the feeling-tone of the collective unconscious. I think about my trans friends and colleagues—how eager we are to try to please, placate, explain ourselves. I think about what got lost as we tried to become palatable to mainstream, cisgender providers, and the compounding of that loss as we started to become providers ourselves. I think of the time my dearest friend's child told my friend he could no longer call himself a tranny. "I've been calling myself a tranny since the nineties," my friend replied. "I'm not planning to stop now." I recognize myself in him. I think about another friend who, in order to transition as an adolescent, had to consent to having their genitals measured every month during development. I think about how hard this person tries to make themself palatable to cis people. I think about my own respectability and the futility of it. I recommit to the word "tranny."

In returning to Spielrein, I also consider her position that it is the disjuncture between the collective psyche and the individual ego that allows for the creation of the new, and this helps me consider the reciprocal and bidirectional nature of individual and collective change. I think about the ways in which this change can get truncated, sometimes violently, when threatened. This theme gets picked up for me indirectly, when a member of the trans analysts reading group I joined (who is also an editor of this article; hi, Tobias) makes a distinction between trans theory and queer theory and recommends an article/conversation speaking to this divide (Chu & Harsin Drager, 2019). We ponder the question of what truly trans theory would be like, but I find myself feeling like the article gets things backward. It argues that trans theory is rehashed queer theory. I find myself wondering if perhaps queer theory is rehashed trans theory. Then I wonder if I think this because I know that trans people are really good at building coalitions that later exclude us—we make space for the change in the collective psyche, and the collective psyche swallows the parts it finds palatable while rejecting the rest. In the world outside of the reading group, the federal government of the United States orders the removal of the word "transgender" from official websites (The White House, 2025). On the National Park Service website for the Stonewall Memorial, Sylvia Rivera is rewritten as someone who focused on "gay and rights" (for an overview of changes and response, see Reed, 2025). I think about how radical she was, how unapologetically trans, and how broken by anti-trans bias. In reading the new biography of Marsha P. Johnson (Tourmaline, 2025), a pragmatic realization hits hard: Many behavioral health providers, even now, would decline to provide letters of support for gender-affirming surgery for Marsha and Sylvia, pointing to their lifelong mental health concerns as evidence that they could not provide informed consent. Even if Sylvia and Marsha could obtain those letters, the women's poverty, substance use, and housing instability would probably have kept surgeons from performing surgery. The professionalization of the provision of gender-affirming care has indeed allowed some people to have greater access. And it highlights healthcare disparities and inequities in ways that are uncomfortable for those of us who have garnered access, and are now seeing it stripped away, to acknowledge.

Per Tourmaline, Rivera became unhoused at age 11—she was probably a sex worker while still in Tanner Stage 2. I think about how my government wants me to believe that it is better for a child to be an unhoused sex worker/sex-trafficked individual than on puberty blockers, and how the primary clinical and research body for governing my work might well consider me unethical if I provided letters of support for Marsha and Sylvia.

All of this feels connected to my understanding of cisteria and gives me the opportunity to reflect on what I really mean by this diagnostic framework. If I were to seriously center transitude—by which I mean a stance or attitude that truly centers transness—in psychoanalysis, how would I formulate cisteria? Of course, it would be impossible. Because psychoanalysis is rooted in cisheteronormative, white, capitalistic systems of thought, a truly trans psychoanalysis can't exist (Carter, Forthcoming; Wark, 2022). The entire endeavor would fall apart if there were no rubric for what constitutes "normalcy." Simply centering the trans psychoanalytic gaze to denormalize cis-ness does not, alas, make a true, *trans*gressive, *trans*formative psychoanalysis. "The master's tools can never dismantle the master's house" (p. 112), as Lorde (1984/2012) famously argued. But I operate as a licensed clinician in the field of clinical psychology—I can't pretend the master's tools aren't my tools. I think about one of my only cis friends—a fat, Black, disabled woman with several advanced degrees—who sometimes asks me, "then whose tools *will* dismantle the master's house?" I reflect on what it might be like to try to turn my tools to dismantling the house of psychoanalysis.

This leads me to the exercise of writing a case study as if the way in which I think about gender were typical for clinicians and society at large. I imagine what it would be like if the collective psyche held gender variability as positive, or even neutral. How would the ways in which we think about gender with our patients shift? I realize that I can't quite wrap my mind around it, but that there might be something at the edges. That this case study might apply the master's tools of psychoanalysis to an imaginal situation to create . . . not an alternative, exactly, but a mutation. I am drawing this word from Shelton and Guyotte (2024), who endeavor to build pedagogies based on theories of mutative possibilities posited by Haraway (2013) and Barad (2015). I understand mutations to be not solely

the painful, rapid change that is required of our bodyminds in the current landscape, but powerful forms of adaptability and resistance. Spaces of fusion and synthesis that allow us to survive, and also that extract a heavy toll.

Thus, I offer the following imagined case study as a mutation—an imperfect, uncomfortable, adaptive attempt to apply the tools of psychoanalysis to the diagnostics of cisteria.

Section II

Fragment of an analysis of a possible case of cisteria

In considering the proposed phenomenon of cisteria, I am reminded of my work with a patient who presented to my office describing the fixed, persistent belief that only people who were born with vaginas could be women. This patient, whom I'll call Ella, was herself a woman, and had been born with a vagina, uterus, fallopian tubes, and ovaries. Ella's menses were a domain of intense focus, and she came to our first session reporting current menstrual pain with very heavy bleeding and cramping. She rejected ibuprofen, acetaminophen, and cannabis, and resisted using a heating pad or engaging in presession therapeutic massage services, despite the availability of these generally effective interventions. Ella was tearful, and visibly uncomfortable, but persisted with the intake, reporting that she found the pain "clarifying" and describing the belief that it connected her spiritually with a long line of other people who experienced menstrual pain. This began a dialogue about the role of pain and discomfort in her theological and spiritual beliefs.

Ella reported being raised in a loosely agnostic household, but in adulthood finding a strong spiritual path within a sect that made rigid distinctions between "good/natural" and "bad/unnatural" phenomena. I was unfamiliar with the sect she described and pursued a line of gentle inquiry from a stance of genuine curiosity. She was eager to talk about her beliefs and quickly disclosed that they were partly involved in the reason for her referral: Her estrogen levels were low for someone of her age and endogenous hormonal composition, and her medical provider had been encouraging her to utilize hormonal supplementation for a number of years.

However, this supplementation was not in alignment with the teachings of her sect, as it would fall into the realm of the unnatural.

The medical provider believed that supplementation would reduce Ella's menstrual pain, increase her energy, and improve her bone and heart health over the long term, as well as easing some of the mood imbalances she was experiencing. Nonetheless, Ella had a deep fear of this intervention and continued to reject the treatment, even though this left her estrogen levels in the ranges more generally associated with significantly older ovary-bearing people. When asked by her provider about her fears, she would simply assert that those estrogen levels were her natural levels, and that she did not want to change them. Her provider, while respecting her bodily autonomy, had most recently noted a sudden decline in her already low estrogen levels, corresponding with a sharp decline in her mood, as well as self-reported social isolation, and mood management through intense exercise, which was placing strain on her already-compromised joints.

The patient was also expressing the strong desire to become a birthing parent but expressed a sense of hopelessness and futility about the process—and, indeed, conception and gestation were unlikely with her estrogen levels as low as they were. The referral note indicated that the medical provider was unsure of how to be helpful in these circumstances and wondered if Ella having the opportunity to discuss her fears of hormonal supplementation with a mental health services provider would be valuable for the patient. Ella had initially resisted mental health services, reporting no psychological distress regarding her beliefs, and exhibiting little insight into her ongoing challenges. Her situation was, however, growing increasingly uncomfortable. Her previously close relationships with her parents and siblings had grown strained, and she was turning more frequently to her religious community, including her spouse (who was also her nesting partner and proposed birthing partner), for support. This had the effect of strengthening her fears of supplementation, and also her fears of social isolation—Ella worried that if she did ultimately choose

supplementation, her community would find out, and she would be ostracized. She initially also mentioned some difficulties at work, but the full scope of this did not become clear until later.

Initially, I struggled to understand my patient's relationship to estrogen and to her reproductive system. I wondered if, perhaps, there was some ambivalence about becoming a birthing parent, and if that ambivalence was driving the hands-off approach to medical care. I also wondered if perhaps there was some unexplored masochism in her desire to fully experience the discomfort and pain of her periods, which were irregular and, as mentioned, painful. I held these hypotheses in mind during the early phase of our work and allowed my questions to be guided by my hypotheses to some extent, while also striving to remain open to a variety of possibilities.

As our work progressed, Ella began describing fantasies about "unnatural" women who use estrogen supplementation. She had a marked antipathy toward ovary-bearing women using estrogen for conditions such as polycystic ovarian syndrome, or to navigate the changes of menopause or oophorectomy, but the majority of her discomfort seemed associated with women who would be testosterone-forward without the use of exogenous estrogen, and specifically women and femme-spectrum people with penises.

Ella described a disturbing practice of attempting to listen to people urinating in the stalls of multi-user bathrooms in order to try to figure out who had a penis. She would also lurk at handwashing stations attempting to strike up conversations about "natural" and "unnatural" phenomena, based on the observations she made during these invasions of privacy and bodily autonomy. Ella reported that she had been asked to leave restroom facilities, by other patrons and even security personnel, based on the intrusive nature of her practices. She recognized that this behavior was negatively impacting her life, but she seemed unable to overcome or even contain her preoccupation. She later acknowledged that she had engaged in this practice at work, and while her work itself was excellent, she was on a support plan around her professionalism.

As Ella was describing her preoccupation, I associated to the memory of a sperm-producing individual, who identified as a man, that I had worked with some years previously. Atypically, he had refused hormonal supplementation during his birthing partner's pregnancy and thus was unable to contribute to chest feeding of the infant. The birthing parent was slow to produce milk, and the infant couldn't tolerate formula, so although my patient's community supported his embodiment choices, these choices had significant ramifications for both the infant and the birthing partner. The birthing partner opted not to reproduce with my patient again in the future and ultimately took space from the relationship and pursued deeper connection with a sperm-producing individual who *was* willing to lactate. My patient had sought therapy in an attempt to heal that rift, and to have a closer relationship with his child. Like Ella, he found it difficult to imagine that estrogen supplementation had the potential to be valuable for him.

The two cases seemed somehow connected in my mind, perhaps as they both had elements related to embodiment and the relationship between embodiment, hormonal composition, and gender. Perhaps the uncomfortable truth is that I felt some challenge—or even disgust—with the persistent delusion that hormonal composition meant something intrinsic and inalterable? I remain unsure. In any case, the two patients both identified as what is sometimes called cisgender or cissexual, although the definitions of these terms are perhaps too broad to be useful for the purposes of psychological formulation. (Trying to capture the granularity and specificity of the myriad combinations of gender and embodiment through words that describe large groups of people is a strange and uncomfortable thought experiment, is it not?) Given the pathologizing tendencies of psychology and psychiatry, any interpretation of the similarities of these cases must, of course, proceed with caution. But I began to wonder about the creation of this identity and what might lead a person to the belief they were "cisgender" or "cissexual," which I will return to in the following.

One day, Ella brought forward a dream that she asserted she had with some regularity. It involved a long sequence of searching desperately for her infant—an imaginal child that had gotten "lost" somewhere and couldn't be recovered.

In the most striking example of synchronicity (Jung, 2013) I have experienced in clinical practice, the very moment that she teared up, a seahorse in my office aquarium suddenly began giving birth, shooting out infant after infant.

"Even *she* can do it," my patient sobbed, pointing toward the seahorse.

This led me to wonder about her internalized beliefs about the relationship between femininity and reproduction, and whether perhaps her resistance to estrogen was rooted in a disavowed desire to be a seahorse-style birthing parent. Would testosterone, I wondered, be a more appropriate recommendation for her than estrogen? As estrogen was impermissible, would testosterone supplementation be an intervention that her community could accept as natural? I wasn't sure, and worried that the question might be rooted in my overwhelming desire to "fix" her problems, so I held the question, and instead offered gentle reflection about not being able to access a core desire. We quickly moved to somatic work, specifically a grounding activity, which helped bring down her nervous-system activation.

I mention her nervous-system activation because regulating her nervous system was a key part of our work together and also helped me understand one of the ways in which we were stuck in an enactment. Ella had experienced a significant stressor, in the form of extreme flooding, when living on her own for the first time in her early 20s. She and her housemates either refused to evacuate or had been unable to evacuate prior to a coastal hurricane, and she and had been stranded for almost a week before the tides receded. One friend contracted an infection in that time and had come very close to death—broad-spectrum antibiotics arrived just in time. This narrative had grown stuck and fixed in Ella's mind, and she spoke frequently about the feeling of helplessness and hopelessness in attempting to nurse her friend back to health with only rationed bottled water available to clean the wound. A wise supervisor pointed out to me that her medical provider and I kept trying to offer her a curative medicine, and she regularly rejected it in favor of insufficient treatment. Just as she could not offer her friend effective medication, her treatment providers were not allowed to offer her the medication that could potentially soothe her pain. Thus, perhaps, we experienced the anxiety and helplessness of her younger self.

Through somatic work, nonverbal holding of her traumatic experiences, and my intended stance of gentle reflection, our relationship strengthened and began to feel quite substantive. I'm sure there were times that my questions or observations felt clumsy, but she was generally quite generous in her reactions, and I could feel a reciprocal relationality beginning to blossom. But our relationship ended abruptly, for reasons I'm not entirely clear on, when we started to move more into the relational unpacking of some of her content. Even after reflection and supervision, I remain confused by the rupture, but I believe it had something to do with Ella's ideas about gender and how it relates to embodiment. I transcribe the critical moment of our last session here:

Clinician: "I don't want to in any way minimize your relationship with your body, or the relationship between your body and Spirit. I know many people who bleed monthly who have a deeply spiritual relationship to that process, and a number of people who don't bleed who have a very deep yearning for that capacity. I just want to push back a little on the felt sense of this as fixed and universal. I can tell you that, in my experience, it was *not* a good fit. The hormonal fluctuations were awful, and . . ."

Patient: "Wait, *you've* had periods?"

Clinician: "Sure, before I started testosterone. Is . . . are you ok?"

Patient (almost inaudible): "Yes, yes, just surprised."

Clinician: "I . . . I mean, I can tell I said something that upset you. I really want to know what happened. Do you think we can talk it out?"

Patient: "No! I mean. I'm not upset. I just . . . I'm sorry, I just don't think this is going to work out."

She quickly packed her things and left. I was so taken by surprise that I really didn't know how to react. I later followed up with referrals, and to ask whether she would be open to a termination session, and received a very formal reply that thanked me for my time. This felt like a significant relational wound to me, and I took the experience to my own therapy for several months.

I have worked with a number of women who produce ova and men who produce sperm, and some of them have identified with the terms "cisgender" or "cissexual." I propose that Ella (and the other individual

referenced in this history) may fall into a specific type of "cissexuality" that shares some core central features that we might think of as more difficult to work with or alongside, and that these core features might be a part of a "cisterical" diagnostic category. Presented here are some of the proposed core features. I must add a caveat, however: Although I have processed this experience in my own therapy, I'm aware of the possibility of a form of creeping countertransferential sadism in this case presentation and diagnostic framework. I know I may be attempting to extract a form of revenge on her by way of diagnosis, pathologization, and disconnection from her experience. I hope this diagnostic framework can be held lightly and used for helping rather than harming.

First, I find that this type of cissexual is generally preoccupied with what I think of as "the body as-is." There is often a disturbing lack of imaginal body (Hansbury, 2017), and thus a limited capacity for embodiment-based empathetic understanding. (I have found that this type of cissexual often struggles to understand the utility and necessity of mobility devices, for instance, unless they personally benefit from their use.) This preoccupation with "the body as-is" seems to create a narrow and rigid set of templates for the kinds of bodies that are acceptable, and a fixity of belief that only those kinds of bodies exist. (This type of cissexual struggles, for instance, to come to terms with the existence of people born with both XY chromosomes and vaginas.)

An adjacent, although separate, feature of cisteria seems to be a particular style of preoccupation with genitalia (and, secondarily, reproductive systems and secondary sexual characteristics). This seems to be rooted in a particular biologically implausible ideology—the belief that genitals, secondary sexual characteristics, and reproductive systems follow model specifications rather than exhibiting a wide range of variability. Ideas around gender subjectivity (Ashley, 2023) and physiological variability (Kamoun & Dalke, 2025) seem difficult for the cisteric to track.

Another adjacent, although perhaps separate, feature is what appears to be a difficulty in coming to terms with bodily changes, bodily transformations, and the reality of death. Both of the patients I reference here expressed some connection to their bodies as immutable. They both expressed a lot of discomfort at the prospect of their bodies undergoing significant change, adaptation, or mutation. While Ella yearned to bear children, she also expressed horror at the prospect of her body becoming "unnatural." Ella also talked frequently about body changes she might experience if she were able to get pregnant and expressed some alarming ideas about "managing" her weight during the process. She seemed disconnected from the physical and emotional transitions related to becoming a birthing parent and caregiver. The other individual discussed rejected bodily developments that could have contributed to the nurturance of his child and relief for his birthing partner, seemingly from a belief that he could avoid bodily changes associated with the birthing process. Both struggled to celebrate change and transition, including changes and transitions related to birthing, aging, and death.

Another feature that I observed is that both of these patients had very high expressed emotion when talking about gender and embodiment. These conversations never felt low-stakes or value-neutral, and I was very aware of stepping cautiously.

Not, however, cautiously enough, which leads me to my final observation about the possible diagnostic category of cisteria. (I can't stress enough, however, that this observation may be more about me as a clinician feeling hurt by a patient than it is rooted in other processes.) I've observed a certain kind of relational rigidity and a discounting of connection in individuals with this kind of presentation. At least in my experience, they have a hard time articulating the rupture, when there is a rupture, and become very distant and cold when rupture occurs. This may be more of a function of internalized whiteness (both of these patients are white, and I am also) than anything related to cisteria. On the other hand, cisteria may be more common in people with high internalized whiteness, because, as Yancy (2023) reminds us, part of the project of whiteness is to insist its own benevolence, no matter the evidence. Thus, white people with cissexualism may insist that their thinking is "natural" or "beneficent" because of their whiteness rather than their cissexuality. It would follow, then, that the presentation—spectacle?—of cisteria may be tied to whiteness, and it's difficult to disentangle directionality.

There is certainly more to be written on the function of internalized whiteness in this case study, and internalized whiteness in the proposed diagnostic criteria of cisteria, writ large. Ford et al. (2022) propose

that people who hold white identities struggle to regulate emotions when asked to consider the role of whiteness in racism, and that this difficulty with emotion regulation is a contributor to what is sometimes termed white fragility (Liebow & Glazer, 2019). Although the individuals I have tentatively diagnosed with "cisteria" struggled with the nonnormative identity of "cissexualism," perhaps our experiences of being socially centered in our whiteness, such as our white fragility, were a greater contributor to our relational rupture than their experiences of not being fully witnessed in their "cissexualism." But the diagnostic category is new, and the proposed criteria remain clumsy—a bludgeon rather than a scalpel.

I want to offer profound gratitude to my supervisors and my own health care providers, as well as my broader community of care. The mistakes in these formulations are mine alone; everything else belongs to my community.

Section III

Still there, wherever I go

The writing of this imagined case history was an exercise in the recognition of my own entrenched ideologies and embedded theologies (for a discussion of embedded theologies see Doehring, 2014; I am indebted to Sage Brown [personal correspondence] for introducing me to this concept) of both gender and the power that comes with holding a normative perspective while in a relationship with someone holding a minoritized perspective. It also provided discomfiting and unsettling moments of realization about the ease with which pathology is assigned or assumed (at least by clinicians, at least by me) when an individual is expressing a viewpoint outside of a dominant paradigm—indeed, not solely expressing a nondominant viewpoint, but living in alignment with a particular set of nonmainstream values. Exaggerated pearl-clutching about the antics of cis people is not new to me—this is a kind of thought experiment that queer and trans people I know engage in frequently, as a way of probleming the center from our well-worn place on the periphery. (Did you know that cis people raise their children to be cis!? It's a real tragedy.)

What did feel new, in stepping into an imaginal reality in which the majority of other people think about gender and embodiment like I do, was how easy it was to be dismissive of the concerns of this imaginal patient. I also became intensely aware of the psychoanalytic/psychoanalyst's defense of taking refuge in confusion. There are certainly times in which I have been legitimately confused in relationship with my patients. I also have experienced—as a patient and a therapist and in my "real life"—the experience of being legitimately confusing to people. The thought exercise of diagnosing cisteria, however, gave me the opportunity to try on taking a kind of sadistic countertransferential pleasure in a willful misunderstanding. It was surprisingly easy to step into. The "me" of the case presentation could not articulate—or even access—their hate of the patient and her perspective, and thus it became enacted through a wholesale, unexamined rejection of her worldview (Winnicott, 1994). (I am indebted to one of the editors of this paper for helping with this framing—hi, Tavi.) I found myself writing with an inability to even allow her perspective to penetrate my consciousness. It was an easy step, then, to minimize her pain, and to disavow my own contributions to it. In other word, it became easy to diagnose.

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