Language of self-definition in the disorders of identity

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Summary

The present paper takes into consideration the centrality of language for body definition and its relationship with the process of identity construction. Moving from the psychiatric, socio-linguistic and phenomenological perspectives, I focus on the role of the awareness and experience of one's own body as the original anchors of the developing sense of self. Indeed, two paradigmatic examples are provided as particular clinical conditions to highlight the role of language on the body in shaping one's identity: the so-called eating and feeding disorders and gender dysphoria. I consider them as two examples of psychopathology of post-modernity, and in some ways as two disorders of self-identity, in which language changes and innovations mirror the fluidity of cultural transformations and their impact on the body. Taking a Sartrean perspective, we might view these disorders as manifestations of a disturbance of lived corporeality, more specifically the predominance of one dimension of embodiment, namely the 'lived-body-for-others'. Indeed, in both conditions the external reality of the body and the inner subjective perception do not match, preventing a harmonious relationship between the internal representation of the body and the body itself, which results in a consequent feeling of estrangement within oneself.

Key word

Self-identity • Corporeality • Eating disorders • Gender dysphoria • Sexual identity

The issue of self-definition

The very moment a person attempts to define him- or herself can be considered as the connectedness of the general and the individual, under discontinuous conditions. We generally think about identity when it is no longer assumed, but questioned. With the term identity, a sameness is claimed which either in the very moment of description is already overtaken by discontinuity or which is eschatologically projected into the future. Therefore, the moment a person thinks about self-definition, he or she suddenly "becomes" conscious of how other persons represent themselves. This process can vary according to different contexts, social and cultural influences, as well as according to different aims and objectives.

For example, when I attempt to find a job, I generally refer to my work experience and qualifications. Many countries do not allow job seekers to report their age, biological gender or family characteristics, because they are supposed to be irrelevant (but rather discriminatory) to an individual's professional competence. However, during political elections candidates often describe their private profile; for example, they may talk about their families and therefore provide implicit information about sexual orientation. From a different perspective, there are also persons who first speak about their professional roles when they want to introduce themselves to a person they like, in order to mirror or suggest their hierarchy of personal values.

Only recently in the contemporary history of philosophy has the concept of self-identity been viewed as a central epistemological construct. Friedrich Schelling first conceptualised his system of absolute identity in his work, "Representation of My System of Philosophy" [1 2]. Drawing on this first conceptualisation, Sigmund Freud's use of the term *ego-identity* opened the road to many sociological and socio-psychological identity theories. According to Erikson's theory [3], *ego-identity* is fully developed after adolescence, when a person experiences him- or herself as a unique individual (personal identity, self-likeness, and continuity of the person in time), while, on the other hand and at the same time, as belonging to a particular social group (group identity, constancy of the symbols of a group despite fluctuations in group membership). Regardless of diverse critical commentary and modifications in psychoanalysis and psychotherapy, Erikson's concepts have found extremely wide prevalence and recognition, and they have continued to prove useful as a heuristic model in concrete psychotherapeutic work.

In the present paper, I will take into consideration the way self-identity is defined according to one's own language:

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how we communicate who we are to the others and to ourselves. From a historical point of view, the relationship between the process of identity construction and language has been considered in various sociolinguistic theories, including those developed by Bourdieu [4 5] and Giddens [6]. Their research is concerned with the ways in which individuals use language to co-construct their everyday worlds and, in particular, their own social roles and identities and those of others. In this regard, it is important to mention the concept of *social identity*, which includes participant roles, positions, relationships, reputations and other dimensions of social personae, which are conventionally linked to epistemic and affective stances [7]. *Social identity* is multiple and varied, describing individual representations that embody particular social histories built up through and continually recreated in one's everyday experiences [8]. Moreover, it is acknowledged that individuals belong to varied groups and so take on a variety of identities defined by their membership in these groups. In our use of language, we represent a particular identity at the same time that we construct it. One of the more prominent positions on social identity is Anthony Giddens's theory of structuration [6]. According to Giddens, individual agency is a semiotic activity, a social construction, 'something that has to be routinely created and sustained in the reflexive activities of the individual'. In our locally occasioned social actions, we, as individual agents, shape and at the same time are given shape by what Giddens refers to as social structures. In our actions, we draw on these structures and in so doing recreate them and ourselves as social actors. The repeated use of social structures in recurring social practices in turn leads to the development of larger social systems, 'patterns of relations in groupings of all kinds, from small, intimate groups, to social networks, to large organisations' [6].

Shifting to a phenomenological perspective, Jean Paul Sartre (1905-1980) offers another major contribution to the concept of identity. In *Being and Nothingness* [9] he defines two types of reality that lie beyond our conscious experience: the being of the object of consciousness and that of consciousness itself. The object of consciousness exists "in-itself," that is, in an independent and non-relational way. However, consciousness is always consciousness "of something", so it is defined in relation to something else, and it is not possible to grasp it within a conscious experience: it exists "for-itself". When I make who I am the object of my reflection, I can take that which now lies in my past as my object, while I have actually moved beyond this. Sartre says that I am therefore no longer who I am. Similarly with the future: I never coincide with that which I shall be. First, the past corresponds to the facticity of a human life that cannot choose what is already given about itself. Second, the future opens up possibilities for the freedom of the for-itself. The coordination of freedom and facticity is, however, generally incoherent, and thus represents another aspect of the essential instability at the heart of the for-itself.

Sartre's philosophy defines the process of self-structuration across life by drawing on the progressive consciousness of one's own lived corporeality. From a phenomenological perspective, there is a distinction between lived body (*Leib*) and physical body (*Koerper*), or body-subject and body-object. The first is the body experienced from within, my own direct experience of my body in the first-person perspective, my self as a spatiotemporal embodied agent in the world; the second is the body thematically investigated from without, from a third-person perspective, for example as viewed by natural sciences such as anatomy and physiology [10 11]. The body can be apprehended in the first-person perspective as the body-I-am. This is the cenesthetic apprehension of one's own body, the primitive experience of oneself, the basic form of self-awareness, or the direct, unmediated experience of one's own 'facticity', including oneself as 'this' body, its form, height, weight, colour, as well as one's past and what is actually happening. First and foremost, we always have an implicit acquaintance with our own body from the first-person perspective. The lived body turns into a physical, objective body whenever we become aware of it in a disturbing way. Whenever our movement is somehow impeded or disrupted, then the lived body is thrown back on itself, materialised or 'corporealised'. It becomes an object for me. Having been a living bodily being before, I now realise that I have a material (impeding, clumsy, vulnerable, finite etc.) body [12]. In addition to these two dimensions of corporeality, Sartre emphasised that one can also apprehend one's own body from another vantage point, as the body when it is looked at by another person. When I become aware that I, or, better, my body is looked at by another person, I realise it can be an object for that person. Sartre calls this the 'lived-body-for-others'. "With the appearance of the Other's look", writes Sartre, "I experience the revelation of my being-as-object". The result is a feeling of "having my being outside (…) [the feeling] of being an object". Thus, one's identity becomes reified by the gaze of the other, and reduced to the external appearance of one's own body.

Neurobiological perspectives have also focused on the awareness and experience of the body as the original anchors of our developing sense of self [13]. The mind continues to mature until it can represent and reflect upon its own contents. Ultimately, the self becomes abstracted from the body and is intellectualised as the self-conscious mind, but the felt self and its body background continue to frame whatever is the current focus of attention. During the developmental period every person structures

his or her own primitive form of self-identity around the progressive building and discovering of the *body image*. Indeed, although there is no definite consensus on the concept of *body image* [14] it has become clear that the body image is neither completely innate, nor completely constructed out of experience and learning. Body image has been defined as the picture of the body that is formed in the mind [15] or 'a system of perceptions, attitudes and beliefs pertaining to one's body' [14]. This concept must be clearly differentiated from the *body schema*, the 'system of sensory-motor capacities that function without awareness or the necessity of perceptual monitoring' [14]. The phenomenological concept of *lived body* must also be differentiated from the body image, as the immediate experience of one's body (the layer of kinesthetic sensations), and not a representation of it [10 11 16-18]. The lived body is my own direct experience of my body from a first-person perspective, of myself as a spatiotemporal embodied agent in the world.

Self-definition and psychopathology: what are the disorders of identity?

Moving from this theoretical background, in the present paper I will take into consideration the central role that language plays in body definition in order to show how this relates to the construction of identity. We do not use language as solitary, isolated individuals giving voice to personal intentions; rather, we 'take up a position in a social field in which all positions are moving and defined relative to one another' [19]. Social action becomes a site of dialogue; in some cases it is the site of consensus, in others, that of struggle. In choosing among the various linguistic resources available (and not so available) to us in our roles, we attempt to mould them for our own purposes and thereby become authors of those moments.

In order to integrate the phenomenological with the sociolinguistic position on the role of language on identity, I will consider two different human conditions: the so-called eating and feeding disorders and gender dysphoria. I offer these as two examples of psychopathology of post-modernity, in some ways as two disorders of self-identity, in which language changes and innovations mirror the fluidity of cultural transformations and their impact on the body. In the next paragraphs, I will explain in greater depth the reasons for considering these conditions from these different points of view.

Eating disorders (EDs) are complex and severe psychiatric syndromes, "characterized by severe disturbances in eating behavior" [20]; however, abnormal eating behaviours can also be seen as the final result of specific cognitive and emotional disturbances related to the body and to the way it mediated the shaping of self-identity [21 24]. Conversely, Gender dysphoria (GD) persons are characterised by a strong and persistent identification with the opposite sex, discomfort with one's own sex and a sense of inappropriateness in the gender role of that sex [20]. GD subjects experience a cognitive state in which their physical body contrasts with their self-perceived identity [25], and which can be a source of deep and chronic suffering [26]. Transgender persons perceive their gender identity as incongruous with their body, and therefore experience the desire to develop a gender role consistent with their gender identity.

In both EDs and GD, the process of self-identity construction is in some way impaired and the representation of the body is the battleground of their affliction. From a Sartrean perspective, we might hypothesise that EDs and GD represent two different manifestations of a disorder of lived corporeality, more specifically, a predominance of one dimension of embodiment, namely the 'lived-body-for-others'. Indeed, in both conditions the external reality of the body and the inner subjective perception do not match, and the harmonious relationships between the internal representation of the body and the body itself has not been achieved, which results in a consequent feeling of estrangement within itself [27].

What other features might EDs and GD share? In both, many authors argue that the main psychological disturbances are impairments in overall identity development and the failure to establish multiple and diverse domains of self-definition. Indeed, they both tend to develop during the uncertainty of adolescence. As clearly described by the psychoanalyst Domenico Di Ceglie [27], during this period the attention is directed toward new questions about the body, gender and the self. These questions are accompanied by a comparison of one's own body with others'. This process should not be categorised as pathological, but rather as a physiological stage of indeterminateness. Indeed, there is no adolescent who is not learning about his/her body shape or about the nature of masculinity or femininity, and who is searching for some inner sense of self as male or female. The questions about the body are intimately related to the nature of relationships with others, the degree to which we are coherent with others. In other words, they concern the issue of distinctiveness. In finding the answers to these questions, adolescents build a sense of self and mark their own identities in a way that makes sense to themselves.

Gender identity represents a person's private sense, and subjective experience, of his or her gender [28]. Its significance is related to acceptance, the desire belonging to a category of people: male or female. Gender membership is a fundamental component of our general identity, and provides a sense of continuity of the self. The uncertainty of gender definition across adolescence combined with

the pressure of Western societies for clear categorisation that matches with the anatomical body, results, in GD persons, in a strong sense of non-pertinence and extraneousness from the world around them. It has been suggested that psychopathology may be the consequence of difficulties in coping with these feelings [29], social stigma [30], or rejection by family and friends [31], rather than from a primary psychiatric illness.

From a psychodynamic perspective, Ilde Bruch [32] suggested that the dissatisfaction with the body image that characterises persons with EDs reflects a maladaptive 'search for selfhood and a self-respecting identity' (p. 255). Stern [33] emphasises that feeding is a vital activity for the construction of the self, as it serves as a framing environment and allows face-to-face contact with the caregiver via the phenomenon of 'affective attunement', an essential step toward the development of a narrative self and a sense of identity. Also, within the cognitive model, self-concept is defined as a set of knowledge structures about the self that originate from the cognitive products of the person's interaction with the social world. These aspects are important for the development of self-schemas that shape the individual's social interactions [34].

Defining oneself through the gaze of the other: body dimensions and eating behaviours

According to many psychological theories, persons with EDs are characterised by a dysfunctional system for evaluating self-worth. Whereas most people evaluate and define themselves on the basis of a variety of domains of life (e.g. the quality of their relationships, work, parenting, sporting ability etc.), people with EDs judge themselves largely, or even exclusively, in terms of their body shape as well as their eating habits, and their ability to control weight [35]. In recent studies, which advance the phenomenological perspective mentioned above, Stanghellini et al. [36 37] demonstrate that the core psychopathology in EDs is related to a dimension of embodiment named 'lived-body-for-others'. According to these findings, persons with EDs experience the body first and foremost as an object being looked at by another, rather than cenesthetically or from a first person perspective. They always express feelings of extraneousness from their own body; this is related to attempts to define themselves through pathological behaviors such as starvation or fixated checking of objective measures. Such strategies may operate as kinds of coping strategies aimed at being able to experience the self in some way for those who are unable to feel themselves cenesthetically.

The dimension of experiencing oneself through the gaze of the other and defining oneself through the evaluation of the other have been compared to the concept of *public consciousness*. Public self-consciousness, as opposed to private self-consciousness, includes all those qualities of the self that are formed in other people's eyes. In fact, persons with ED have a tendency to think of those aspects of the self that are matters of public display, rather than attending to more covert, hidden aspects of the self, e.g., one's privately held beliefs and feelings [38].

Indeed, the language adopted by persons with EDs to define themselves is often exclusively based on terms regarding objective evaluation of their body, such as *large* or *thin*, *fat* or *slim*, the way dresses fit around their body, or the proportion of space their bodies occupy in a room. In most cases, the terms *fat or slim* transcend objective measures and regard the moral value of the persons: *fat* means lacking control of ones' instincts, of little worth, and weakness. The use of the word *hunger* is often present in the speech of persons with EDs to express their difficulty in defining their emotions (*alexithymia*) and sensations, which, again, they perceive as extraneous and dangerous. In the diaries of persons with EDs we can find expressions such as: "I came back home after a terrible day where it all went wrong… I realised I have an irresistible hunger…". The quality of food transcends its association with taste and can be viewed as a dysfunctional way to express and modulate different emotions: salty and full-bodied foods seem to predominate in moments of anxiety, while the sweet, warm, soft or liquid prevail in conditions of sadness: "I want the food that I swallow to be something cuddly… sweet after so many things to love…" [39]. The term *pleasure* reported in their diaries often does not have anything to do with what we generally consider as pleasure, because it is generally equated with the reduction of emotional distress. That is, "pleasure" often arises in these disorders from anesthetic conditions regarding emotions and visceral sensations, or, in persons with anorexia nervosa, from the perception of hunger during starvation periods.

Concepts of control, starvation and loss-of-control binge eating have taken on different meanings according to the cultural and historical context. In fact, in ancient Greek and Roman cultures – which identified balance as the highest value for a person – the ideal for eating was that of measure, the absence of voracity [40]. On the contrary, in Celtic and Germanic cultural traditions the *big eater* was considered as a positive and valiant person [41]. In the Germanic mythology and poems of chivalry, the image of the brave warrior was even that of a strong man, greedy, insatiable, able to swallow huge quantities of food and beverages [42]. Relevant differences also existed between the Mediterranean and Continental Europe, as demonstrated for example by opposite rules across the monastic orders. The monastic rules in North Europe were harsh and strict, marked by fasting and penance, while in the South (those developed by Benedict of Norcia, for ex-

ample) were characterised by a greater sense of balance closer to the Roman culture [43]. During the medieval time, *binge eating* was in fact a privilege of the nobility, in light of widespread constant fear of hunger [42]. Regarding semantic and moral values, while nowadays the notion of *fat* among persons with EDs is synonymous with weak, incompetent and inefficient, in the Middle Ages *fat* was something desirable: a "fat cheese offered to Charlemagne was described as something delicious" [44]. The term *fat* also had a positive connotation in aesthetics and even in politics. Being *fat* was a sign of wealth and nutritional well-being; so it meant not only beautiful, but also rich and powerful: for example, in the Florence of the Middle Ages, the upper class was called *popolo grasso* (fat people) [42]. The value of thinness as a symbol of efficiency and productivity appeared only in the eighteenth century, especially in relation to the emergence the bourgeoisie and Puritanism, as opposed to old Europe [45]. Gradually, industrialisation allowed access to adequate food consumption for a wider population. Therefore, the notion of the "binge" lost the positive meaning, and the fear of hunger was replaced by the fear of loss of control [46].

Nowadays, it is important to consider the role of language and symbols adopted by the media, and their effects on the pathogenesis of EDs. Not only do the media glorify a slender ideal, they also emphasise its importance, and the importance of appearances in general, and they glorify slenderness and weight loss and emphasise the importance of beauty and appearances [47]. A number of studies have documented the trend of increasing thinness in Playboy centerfolds, Miss America contestants and fashion models between the 1950's and the 1990's [48 49]. The multi-billion dollar beauty industry depends on a strong emphasis on the value of beauty and appearances for women, because this supports a consumption-based culture in which the answer for any problem can be achieved by purchasing advertised products for improving one's appearance [50]. In another survey, middle-aged women were asked what they would most like to change about their lives, and more than half said "their weight" [51]. The pervasive body dissatisfaction is so widespread in Western countries that authors coined the term 'normative discontent' [52]. The role of media in the development of body dissatisfaction and eating disorder symptomatology was supported by a recent naturalistic experiment conducted in Fiji [53]. Until recently, Fiji was a relatively media-naïve society with little Western mass-media influence. In this unique study, the eating attitudes and behaviours of Fijian adolescent girls were measured prior to the introduction of regional television and following prolonged exposure. The results indicate that following television exposure, these adolescents exhibited a significant increase in disordered eating attitudes and behaviours.

How are these epidemic phenomenon related to identity? Nordbø et al. [54] maintain that pathological eating behaviour represents a tool for achieving a new identity. Skarderud [55] showed that to some persons with EDs, changing one's body is a tool to become another person. They want to change, and changing one's body serves as both a concrete and a symbolic tool for such ambitions. Thus, shaping oneself is a 'concretised metaphor', establishing an equivalence between a psychic reality (identity) and a physical one (one's body shape). As suggested by Surgenor et al. [56], looking into the different ways persons with EDs construct the self has strategic implications for the therapeutic endeavor.

Which gender am I?

Gender membership is a fundamental component of our general identity, and it provides a sense of biographical continuity of that identity. *Gender identity* refers to an individual's sense of self as male or female, and it usually develops by age three, remaining stable over the lifetime [28]. For most people, it is congruent with biological or anatomical sex, the sense of being male or female. Indeed, gender identity has been conceptualised in a bipolar, dichotomous manner with a male gender identity at one pole and a female gender identity at the other. However, there are individuals who have uncertain or confused gender identity or who are transitioning from one gender to the other, who do not fit into this dichotomous scheme. The extreme of this continuum is represented by *gender dysphoria (GD)*, defined as the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender [20]. For GD persons, the primary source of suffering is the sense of dissonance with the gender assigned to one's anatomical sexual characteristics.

The GD condition highlights the dichotomy and the contradictions of the post-modern society between a physical reality (anatomical body) and the mental reality (gender identity) [57]. Therefore, a main issue in this topic is what makes us males or female. For those persons who are not clearly classified as *he* or *she*, the Western world has coined the word *transgender*. Indeed, the natal anatomic view of gender has been the mainstream view in most developed countries. According to this perspective the determinant of our sex identity is based on our external anatomy, and persons should grow up with a gender role that matches their anatomy, and those who deviate from these "rules" are seen as mentally disordered.

Western psychiatry considers GD to be a psychiatric disorder by pointing out that it is rare, and it represents abnormality [57]. The only treatments that are typically considered in Western countries are hormone therapy

or surgery. However, a large proportion of transgender persons want to live in their actual condition without undergoing any medical or surgical intervention [58]. While the recognition of GD as a disorder may allow access to state insurance and medical services, as well as legal protection against discrimination, most transgender persons see themselves not as disordered but rather as part of human diversity. GD persons often state that their minds are fine but that they were born into wrong bodies, and their mental problems are the consequences of reactions from family, friends, and society.

Contrary to the anatomical position, the psychosocial perspective maintains that the sex category into which we are placed at birth is simply a first guess as to what identity we will later assume, and that it is possible to grow up with a gender that does not match that original sex category [57]. Therefore, "transgender" should be considered as an aspect of human diversity rather being considered disorder, deviance, or at worst depravity. The conflict between these two perspectives is a serious matter of concern for transgender persons, involving the discrepancy between identity and the name written in a passport, social welfare rights, marrying and parenting rights, and even the search for a job.

The anthropological perspective allows us to consider the ways in which culture shapes and is itself shaped by the activities and understandings of people, from the most intimate of bodily concerns to the most global of economic systems. Indeed, there are different ways in which sexuality and gender are understood in other cultures and, in so doing, can underscore the importance of disengaging concepts of sex from those of gender [59]. This topic highlights the importance of the social context in shaping our understanding of gender as something that is not given, but rather learned. In many parts of the world male and female are not seen as the only possible gender identities, and need not to be regarded as mutually exclusive. Indeed, some peoples recognise the possibility of a third gender, and in Western societies, until the late eighteenth century, popular and medical science assumed that there was only one gender. This interpretation suggests that gender identity may be a more important marker of personhood and self-identity than anatomical sexual identity. However, when it comes to how to respond to individuals whose gender role and identity is manifestly discrepant with their physical bodies and appearances, most groups or societies are at a loss. So fundamental is the need for clarity about who is male and who is female that those who demonstrate apparent uncertainty (or indeed express a perplexing certainty) are viewed with alarm [60].

There is no universal patterning of tasks or behaviours according to sex. For example, in some societies men may adopt more nurturing kinds of behaviour than women, while women adopt more aggressive roles [61]. An interesting example is represented by *Hijras* in India, a religious community of men who dress and act like women and for whom commitment to the role of *hijra* is signified through their impotence as men, an impotence usually achieved through the act of castration. As children they often have interest in playing with girls, with wearing female rather than male clothing and using eye make-up. Gilbert Herdt notes that central to *hijra* identity is their in-betweeness, their being neither man or woman is what being *hijra* is [62]. The idea that a person's identity arises out of his/her sense of who he/she is and how he/she presents to the world is more widespread in those countries that are least influenced by Judeo-Christian or Western psychiatry. Among them is Thailand, which is overwhelming Buddhist [63].

Languages reflect how the issue of gender identity is differently managed across cultures. For example, Thai language fails to distinguish between sex and gender. One word, *phet,* says it at all. The word is so versatile it can even be used for "sexuality". Moreover, Thai culture allows for the possibility that there may be more than two sexes and genders; thus, for example, the common term for transgender is *phet tee sam,* the third gender [57]. On the contrary, the linguistic consequences of the anatomic view are evident in the English-speaking world. For example, male to female persons are generally called transsexual males or male transgenders, regardless of their perceived female identity. Indeed, many male to female persons refer to themselves as transgender females and not males. A first consequence of this linguistic discrepancy is marriage: even though male to female persons are often attracted to males they may not be able to marry them, since in a number of Western countries this qualifies as same-sex marriage and is illegal. Moreover, transgender persons may find it difficult to get a job simply because their gender identity and appearance or papers fail to match. In Italy, the anatomic perspective is so strong that to get a new "legal" gender identity, persons must undergo genital reassignment surgical intervention. In other words, they must sterilise themselves to adopt an (official) gender identity that resembles their perceived identity. Also, transgender persons can be victims of the anatomical perspective, as many say that they are "born transgender" but are now male or female.

The conflict between the two views (natal anatomical versus psychosocial) is now more evident as in the names given to the surgical operations in which a person's genital are removed [57]. In English, the mainstream name is "sex reassignment surgery". The connotation is one of moving away from the sex that one properly belongs. In contrast, many transgenders talk about "sex confirmation surgery", the connotation being moving towards the sex one always should have been.

The anatomic view is so represented in Western culture that the less-informed public finds it difficult to distinguish between gay and transgender persons. Considering sexual orientation, the anatomic view allows saying that male to female persons should be considered as homosexuals. However, a male to female person who is attracted to men generally feels female, and may have felt so as long as she can remember, often predating any feelings of sexual attraction. Conscious that her attraction towards men is consistent with her feelings of identity, she sees herself as heterosexual. She probably sees her partner's attraction to her in the same light, as indeed he might.
One of the contributions that work on transgenderism can offer to sociolinguistics and anthropology is a focus on the relationship between language and the lived body. *Transgenderism* contributes to an affirmation of the permeability of gender boundaries. Several studies have been performed regarding the language of transgender persons and the adoption of stereotypical speech, that is, a way of speech that helps produce the appearance of appropriately sexed corporeality. For example, it has been noted that transgender females generally use more tag questions (i.e. questions appended at the end of a statements, like "this is silly, isn't it?) and the so-called "empty adjectives" like lovely and precious [64]. On the other hand, transgender males are told to use a certain aggressive style and to tell people what they want instead of asking it, to help them pass as men. Another example is represented by the linguistic innovations of Dana International, an Israeli transgender pop diva. It has been argued that Dana is a "significant linguistic innovator" whose lyrics transcend any one language, in much the same way she transcends any sex as she tries to maintain gender ambiguity. Moreover, there many words that have been invented and adopted by many transgender persons to define themselves, including *gendertrash, spokensherm* and *genderqueer*. Words such as *femisexuals*, *mascusexuals, transhomosexuals* have also been coined, demonstrating great creativity in the language of transgender persons [64]. These examples suggest an attempt among transgender people to transcend grammatical gender and reconfigure language to express their subjectivities and desires.

Conclusion

According to the different perspectives presented herein, language impacts the experience and definition of the body, which is related to the construction of identity. Both GD and EDs are conditions in which the process of self-identity construction is interfered with by a profound uneasiness toward one's own body. They both thematise the relationship among language, body and identity, as they are ways in which people feel a disturbance of the implicit connection between leib, koerper and body-for-others, and this causes disturbances in identity. Societal and cultural norms and values, particularly as expressed in language and symbols, may exacerbate this identity split and the distress felt by such individuals, by limiting the opportunities for self-expression: in EDs, this is by having a limited definition of beauty and ideal body; in GD, this is by limiting gender to either male or female.
However, differences do exist between these conditions, especially in the way language represents a kind of solution. In EDs, the definition of the body can offer a kind of "materialised metaphor" that may be used to shape identity. GD people may try to exit the confines of typical language either by creating their own labels or by using language in a unique or individualised way. Therefore, in some way GD people are finding creative and constructive ways out of their situation, expanding the possibilities for language and identities, and overcoming the limitation of socio-cultural traditional models. On the contrary, persons with EDs remain entrenched in the limitations of their corporealised language, which limits the expression of their own identity.

Conflitct of interests
None.

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