Supporting Wellbeing and Integration of Transgender Victims in Care Environments with Holistic Approach

DELIVERABLE 2.1

THEORETICAL BACKGROUND

TRANSGENDER CLIENTS – BASIC GUIDELINES

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Introduction

This Basic Guidelines report was compiled within the framework of the SWITCH Project (Supporting Wellbeing and Integration of Transgender Victims in Care Environments with Holistic Approach).

The aim of the Guidelines is to provide shared theoretical points of departure for the SWITCH project by defining and unifying the terms and concepts related to transgender, non-binary and intersex people and their psychological wellbeing in the three participating EU countries. Subsequently, it is proposed that such principles and suitable therapeutic approaches will be integrated in the training methodology and applied in therapeutic and medical settings. This text will serve as a basic guide used as a framework for providing informed and quality therapy and other related medical care for the target group – transgender and intersex people.

Due to low social acceptance, potential obstacles during the transition process and a high degree of discrimination against transgender and intersex individuals, this gender diverse group is exposed to long-term stress and at high risk for mental health issues. The rates of suicidal (around 60%) and self-harm (around 50%) behaviors among the transgender population are exceptionally high as compared to the general population, or even in comparison to LGB clients. Unfortunately, quality therapeutic care and support for the mental wellbeing of target group members is often unavailable or hard to access. The current theoretical guidelines and subsequent practical training will provide the methodology and tools to approach transgender and intersex clients with unbiased and well-informed support and services.

The report is intended for medical and other sectors, mental health providers and as reference material for policymakers.

1. Transgender Identity

Transgender is a term used to describe people whose gender identity differs from the sex they were assigned at birth. Gender identity is a person's internal, personal sense of being a man or a woman (or boy or girl). Some people's gender identity does not fit neatly into those two choices. For transgender people, the sex they were assigned at birth and their own internal gender identity do not match (GLAAD, 2018).

How Many Transgender People Are There?

There is no major consensus on the number of transgender people. Clear statistics are lacking for several reasons, including the fact that many trans people are not out (both pre- and post- transition).

In the past, estimations were primarily based on the data sourced from health professionals indicating the number of people who had undergone sex reassignment surgeries or were undergoing hormone treatment. Other estimations were based on the number of people who had obtained legal gender recognition. However, such estimates fail to take into account the transgender people who do not undergo reassignment surgeries or other health treatments.

According to different surveys, the number of trans people is reported as being between 0.3% and 1-4% (Amnesty International, 2014).

Medical Diagnosis

The United Nations' health agency approved a resolution to remove "Gender Identity Disorder" from its global manual of diagnoses, which, according to Human Rights Watch, will have a liberating effect on transgender people worldwide (United nations, 2019). In the newly-revised version of the WHO's International Classification of Diseases (ICD-11), "Gender Identity Disorders" have been reframed as "Gender Incongruence." Gender Incongruence is defined as a marked and persistent incongruence between a person's experienced gender and assigned sex. Gender nonconformity is now included in a chapter on

sexual health, no longer listed among mental health disorders (WHO, 2019).

This progress is in line with efforts to depathologize transgender and gender non-conforming people and their situations.

Coming Out

We can distinguish two phases of coming out: internal and external. It is not uncommon that some transgender clients spend years or even decades before they decide to come out publicly.

The realization that one is a transgender person can take anywhere from a few moments to several decades. Transgender people usually have inkling early on in their lives that their assigned gender feels out of sync with their social role, or feel physically uncomfortable. The self-realization process is extremely complicated. A gender-questioning person may be triggered into intense denial or, in response to social constraints, ignore the signs pointing toward their transgenderism, whether consciously or unconsciously.

Transgender people vary greatly in choosing whether, when, and how to disclose their transgender status to family, close friends, and others. The prevalence of discrimination and violence against transgender people can make coming out a risky decision. Fear of retaliatory behavior, such as being banished from the parental home, can influence a transgender person's decision not to not come out to their families at all, or wait until they have reached independence in adulthood. Parents who are confused or rejecting of their transgender child's newly revealed identity may treat it as a "phase" or attempt to convert their children back to "normal."

Research conducted in 2018 in the Czech transgender community by the Czech organization Transparent z.s. indicated that the least positive reactions to coming out were from parents (44% of negative reactions; 28% of positive reactions came from fathers and 36% from mothers). In contrast, the most positive reactions were from friends (73% of positive reactions), followed by romantic partners or spouses (62%) (Pavlica et al., 2018).

Scientific data regarding health professionals' attitudes indicate that it cannot be assumed that professionals will provide adequate and empathetic care. According to Chapman et al. (2012), LGBT families seeking health care for their children can be reluctant to reveal their sexual orientation to health professionals, as they do not trust that they will be cared for in the same way as heteronormative families. This reinforces the importance of using holistic care models focused on the care of the person and the characteristics of each family system. (Chapman et al, 2012).

Jenner (2010) states that it is necessary to advance in the revision of health care protocols and adapt them to the needs of this population. For this author, caring for transsexuals requires knowledge of anatomical reassignments, the effects of hormone therapy, and also cultural sensitivities particular to the specific gender identity community. The quality of healthcare can be determined by the importance given to cultural sensitivity, institutional policy change, and professional integrity. (Jenner et al., 2010).

Carlström and Gabrielsson (2020) studied transgender clients' experiences of encounters with healthcare staff. The study concluded that it is important to recognize that transgender people are deeply vulnerable and their dignity is often violated when receiving medical care. For this reason, Carlström and Gabrielsson insist that health personnel can play a central role in facilitating and empowering transgender clients. Healthcare professionals can contribute in restoring and up- holding transgender people's trust in health care by accepting trans clients' identities and focusing on their healthcare needs. (Carlström et al, 2020).

According to Sedlak, Veney and Doheny (2016), although issues about transgender individuals (TIs) are now being more openly discussed in the general public, healthcare providers often express feeling uncomfortable in interacting with TIs because they have not been educated in the care of TIs and their care is often based on insensitive stereotyping. (Sedlak et al, 2016).

Transition

Trans identified clients often intend to undergo a process of transition, which means acquiring the visual characteristics, physical features and social roles to align with a person's gender identity. This can be divided into three components:

- Physical – hormone replacement therapy (HRT), surgical changes (sex reassignment surgery – SRS or gender reassignment surgery – GRS).
- Legal – change of legal gender marker and legal name.
- Social – change of name and pronouns; adjusting one's visual appearance; performing the desired gender role.

Social Transition

The most difficult aspect of the transition process is the social aspect. Social change means a trans person must shift visibly and publicly from one gender role to another. They may experience a change in social status; for example, trans women may find that the pay rates in their profession are reduced. Expectations from others may change as well. The older a person is and the more social roles they play, the more complicated the transition. In extreme cases, a person may find themselves in social isolation.

As mentioned above, it is recommended that transgender clients have sufficient access to professional psychological support during this period.

Legal Transition (Legal Gender Recognition)

30 countries in Europe have stringent legal procedures, and there some that expressly demand that trans people be diagnosed with a psychological disorder and otherwise assessed by mental health professionals, undergo sterilization and other medical interventions and get divorced or be single, before being permitted to change their name and obtain legal gender recognition. All of these procedures are costly and time consuming, and many are questionable in their efficacy. Gender recognition has ramifications beyond being an administrative act: it is

essential for many trans people to be able to live a life of dignity.

Such arbitrary and potentially discriminatory requirements, or a lack of legislation altogether, mean that in practical terms trans clients have no protection and may be harmed in the various processes; for instance, many trans people in those countries must carry documents that do not match their gender identity, and must use these documents daily for self-identification purposes in every social sphere. This leaves trans clients powerless in choosing when and how to out themselves, and vulnerable to bullying, discrimination, violence and more in their daily activities such as going to work, going to the post office, shopping or seeing a dentist. The requirement of forced sterilization is invasive, inhuman and unjust, removing trans clients' self- determination and autonomy and potentially causing mental strain for one who still hopes to be a parent, not to mention potential complications in surgery, unnecessary health problems and further hormonal shifts. The requirement to be divorced or maintain single status (even when the trans client's spouse is in agreement and supportive of the gender change) can break up families and destroy a trans client's primary support network. All of these processes may threaten a trans client's job security or professional experience, given the lengthy time necessary to absolve all of the steps.

Such arbitrary and unfounded requirements violate a person's dignity, physical integrity, right to form a family, and right to be free from degrading and inhumane treatment. Some progressive countries offer a model of self-determination (Belgium, Denmark, Ireland, Luxembourg, Malta, Norway and Portugal) where applicants can be formally acknowledged in their preferred gender without a requirement to satisfy medical, civil status or age preconditions.

Physical Transition

This is the most visible part of the transition, and for most people a symbol of or synonym for transition as such.

Not all trans people are automatically interested in all available surgical interventions – in general, the stronger the dysphoria, the greater the interest in surgeries. Each country legislates transition differently, so

we recommend that you familiarize yourself with the procedures in your country. In any case, the process must begin with a personal decision to transition, prompted by the feeling that one's gender identity does not match the cultural norms/roles attributed to the sex they were assigned at birth.

In some countries, a diagnosis and a number of medical examinations (endocrinology, internal, psychological, etc.) should be made prior to HRT or SRS. An integral part of the diagnosis is the so-called Real-Life Test, in which a person must practice living in the gender role with which they identify for some time before undergoing SRS. This experience may cause trans people additional stress.

After HRT, a person starts to change physically (and often mentally), which is associated with frequent coming out experiences and risks such as losing one's job, conflict with family, friends or acquaintances, and more. It is recommended that the person in transition have enough support around themselves (good friends and/or some professional psychological help) during this period.

As noted above, in some countries (e.g., the Czech Republic) those who want to change their gender legally must still undergo forced surgical sterilization.

Gender Reassignment Surgery (GRS) includes Feminization and Masculinization surgeries.

An anatomy that is typically gendered female may require one or a set of feminization surgeries, including orchiectomy, vaginoplasty, feminizing augmentation mammoplasty, facial feminization surgery, reduction thyrochondroplasty (tracheal shave), and voice feminization surgery, among others.

An anatomy that is typically gendered male may require one or a set of masculinization surgeries, including chest masculinization surgery (top surgery), hysterectomy, phalloplasty, metoidioplasty, and crotoplasty.

Transphobia

Transphobia is a term used to describe the intense dislike of or prejudice against transgender, gender diverse and intersex people. Transphobia can manifest itself in two main ways: active (intentionally acting against gender diverse people) or passive (not recognizing or allowing for the fact that gender variance exists) (Young Scot, n. d., Galop, n. d.).

It can take time for others around the trans person to become accustomed to using the new pronouns. Mistakes are understandable, but deliberately denying a trans person's identity by using the wrong pronouns ("misgendering") or previous name ("deadnaming") is a form of transphobia which can have proven negative psychological effects on the trans person. Transphobia also manifests in discrimination, such as preventing a trans person to use the bathroom or refusing them services or work based on their trans identity. More severely, transphobia can lead to hate speech or even violent hate crimes. Every year, numerous transphobic attacks and murders of transgender people are reported globally. Lack of prosecution in such cases, the rise of intolerant, extremist socio-political movements and laws enacted against transgender rights directly and indirectly endanger the lives of trans people. Lack of official support networks can compound this experience.

Gatekeeping

Gatekeeping happens most commonly in the medical field, where doctors can control the pace of a transgender client's transition, or deny it altogether. Arguments by medical gatekeepers are based on the belief that transgender people are not capable of determining their own identities and must undergo months or even years of therapy before being allowed to transition. Some gatekeepers assert that psychological diagnoses or issues are grounds to delay or deny transition. Trans clients' psychological problems are often caused by their body dysphoria and the stress of going through life feeling they are in the wrong gender, so their lack of power in the transition process may further negatively impact their mental health.

Such gatekeeping is a form of transphobia, as the medical establishment's insistence on expertism denies trans clients' authority in their own lives. Transition, overall, is not a simple, easy or pleasant process. Feminine men, masculine women and others who may think that their lives would be easier as "the other" gender don't transition. Those who do choose to transition act from a deep need and long, complex consideration (Wikipedia, n. d.)

1.1. The Difference Between Transgender and Intersex People

Intersex

We have established that transgender means that one's gender identity is incongruous with the sex they were assigned at birth. Intersex means a person is born with any of a number of biological attributes that do not fit the specific definitions of female or male. Some intersex people experience gender dysphoria and identify as transgender as well, for instance when they have been socialized as one sex and gender and find during puberty (or earlier) that they exhibit attributes of "the other" gender in addition to or instead of those of their assumed sex and socialized gender

Definition of Intersex

Intersex is an umbrella term relating to a variety of situations in which a person is born with biological attributes that do not fit the typical definitions of female or male. For example, a person who appears to be female on the outside may have mostly male-typical anatomy on the inside; a girl has a large clitoris, or no vaginal opening, or a boy is born with a small penis, or with a divided scrotum so that it looks like labia. One may be born with mosaic genetics, with a mix of her XX and XY chromosomes (Intersex Society of North America, n. d.).

Intersex is a general term used to describe a wide range of natural bodily variations. In some cases, intersex traits are visible at birth while in others, they are not apparent until puberty. Some chromosomal intersex variations may not be physically apparent at all (Office of the High Commissioner for Human Rights, 2015).

How Common Are Intersex People?

Up to 1.7 % of human births (1 in 60) may be intersex, including variations that may not be apparent at first. Babies with genitals that cannot easily be classified as male or female may number approximately 1 in every 1,500 (Fausto-Sterling, 2000).

Intersex Medical Interventions

Since the 1920s, surgeons have attempted to "remedy" an increasing array of conditions. In the 1950s, a team of medical specialists at Johns Hopkins University (USA) developed what has come to be called the "optimum gender of rearing" system for treating children with intersex variations. The Hopkins team believed that any child could be made into a "real" girl or boy with early gender assignment, altering their bodies and convincing them and their parents to believe and act in accordance with the gender assignment. As the Hopkins model spread throughout the developed world, surgeons performed cosmetic genital surgeries on intersex children without their consent, believing this was necessary and efficacious (Wikipedia, 2020).

Unfortunately, in many countries, babies with ambiguous genitals are still forced to undergo surgery in order to be legally recognized as either female or male, even though for most, the condition is not life-threatening. It is said that for surgeons, it is easier to "dig a hole" than "build a pole," so the majority of intersex babies are assigned female at birth. Few countries have yet provided for the legal recognition of intersex people (Germany, Austria, NZ, Australia, Malta, India and Canada).

The legal recognition of intersex people concerns, firstly, their access to the same rights as other men and women; secondly, their right to request to administrative corrections to legal documents when their original sex assignment is found inappropriate; and thirdly, while opt-in schemes may help some individuals, legal recognition is not about the creation of a third sex or gender classification for intersex people as a population, but about their self-determination (Asia Pacific Forum of National Human Rights Institutions, 2016).

2. Basic Terms and Definitions

Sex – a strictly biological definition, based on certain sets of physical features, typically separated into the categories of 'Male' and 'Female.'

Sex Assigned at Birth – sex assigned at birth refers to the sex (male or female) attributed to a child at birth by medical personnel based on certain sets of physical features (genitalia, chromosomes, gonads, hormones, etc.). May also be referred to as birth sex, biological sex, or natal sex.

Gender – socially or culturally constructed roles that people in a society identify with based on their gender identity; such roles vary historically and geographically and are associated with certain physical appearances, expressions, and expectations.

Gender Identity – a person's interpretation and categorization of their own gender, finding a comfortable definition of oneself, expressed through interactions with other people.

Trans(gender) Person – someone whose gender identity is incongruous with the sex they were assigned at birth. The terms 'trans' and 'transgender' are used exclusively as adjectives.

Trans(gender) Woman – a woman who was born with male sexual characteristics, assigned- male-at-birth (AMAB) and does not identify with the social role of a man. Trans women are sometimes also referred to as MtF (male-to-female), although this term oversimplifies the process.

Trans(gender) Man – a man who was born was born with female sexual characteristics, was assigned-female-at-birth (AFAB) and does not identify with the social role of a woman. Trans men are sometimes referred to as FtM (female-to-male), although this term oversimplifies the process.

Transsexual – a historical term, today widely considered outdated, related to the previous medical diagnosis of transsexualism which was replaced by the diagnosis of "gender incongruence".

Transsexualism, transsexuality – a medical diagnosis falling under

mental disorders, coded F64.0 in the previous versions of the International Classification of Diseases (ICD). This diagnosis has been replaced by that of Gender Incongruence, no longer classified as a mental disorder, but a condition related to sexual health.

Gender Incongruence – a medical diagnosis which will replace Transsexualism/Gender Identity Disorder in the ICD as of 2022. It indicates the shift in the perspective away from the category of mental disorder and focusing on the social aspect of the transgender condition in addition to the physical one.

Cis(gender) Person – a person whose gender identity aligns with the sex they were assigned at birth – e.g., a person who was assigned male at birth, was raised as a man and considers himself a man.

Intersex – a general term used for a variety of conditions in which a person is born with biological attributes that dot not fit the specific definitions of female or male.

Non-binary, Gender-diverse, or Genderqueer – those whose internal sense of gender falls outside the gender binary (feminine/masculine); Non-binary people are extremely diverse in terms of their identities and may be fluid or fixed in terms of their gender; these may include:

- **Bigender** – a person whose identity shifts between feminine and masculine depending on the context or situation.
- **Genderfluid** – a person whose gender identification shifts or changes.
- **Androgynous** – a person whose identity is neither feminine nor masculine, presenting a gender either mixed or neutral.
- **Pangender** – a person whose identity is made up of all gender identities.

Agender – a person who does not have a personal sense of gender identity.

Genderless – a person who does not identify with any gender.

Gender Non-conforming – a person whose gender expression does not

conform to societal expectations of feminine or masculine.

Two Spirit – a person who fulfills the roles of both genders; traditionally used in Native American cultures, but the term is being also used as an umbrella term for "third genders" in other cultures.

Transvestite, Cross-dresser, Drag Queen/King – falls outside the contemporary understanding of 'transgender,' as it denotes a person who prefers or the clothing styles and gender expression of another gender or who dresses as another gender for personal enjoyment or performance.

Dysphoria – negative feelings associated with one's physical features, experienced by most trans people to a greater or lesser extent.

Transition – the process of acquiring the visual characteristics, physical features and the social role that is in accordance with a person's gender identity:

- **Physical** – hormone replacement therapy, surgical changes, sex reassignment surgery – SRS, or gender reassignment surgery – GRS.
- **Legal** – change of legal gender marker and legal name, other gender markers such as digits in national identification numbers indicating gender.
- **Social** – change of name and pronouns; adjusting visual expression; performing the desired gender role.

SRS, GRS – sex reassignment surgery, gender reassignment surgery.

HRT – hormone replacement therapy during transition.

Real-Life Test (RLT), Real-Life Experience (RLE) – common medical requirement for trans clients to prove they are able to live in their authentic gender role. It may range in duration from a couple of months to years. While for many people this practice may be beneficial, for some others it poses unnecessary risk and stress.

Legal Gender Recognition – the official procedure to change a trans person's name and gender identifier in official registries and documents such as their birth certificate, ID card, passport or driving license. In some countries, it's impossible for a transgender person to have their gender

recognized by law. In other countries, the procedure can be long, difficult and humiliating.

Passing – being perceived and accepted by other people in a manner consistent with one's own gender identity.

Misgendering – referring to people using the wrong pronouns or gendered language (may happen by mistake, carelessness or seeking confrontation); connected with **Deadnaming** (using someone's old name).

Self-determination – the inherent right to declare one's own gender and make choices to self- identify in one's own authentic way of expression.

Transphobia – the fear or hatred of trans people, often expressed in the form of verbal or physical attacks (insults, confrontation, assault).

Gatekeeping – any requirement which controls access to resources for transgender people; often used in regards to medical and legal transition, where there are strict formal requirements trans clients must fulfill in order for one's transition to be acknowledged medically or legally.

Depathologization – a process involving an official shift in perspective, in which the range of transgender identities are no longer considered pathological conditions/medical disorders in need of healing but acceptable health and behavior choices, in which trans and non-binary people are respected as agents of their own identities.

Gender-questioning – a person who may be questioning or exploring their gender identity and whose gender identity may not align with their sex assigned at birth.

3. General Recommendations for Providers in Contact with Transgender Clients

As the first point of contact during the process of transition and legal gender recognition, healthcare providers play a crucial role in the ensuing development and wellbeing of transgender and intersex clients. It is therefore alarming to see how often healthcare providers (including trans-specific providers) are reported as acting in ways that are unsupportive of or detrimental toward their transgender and intersex clients. According to the findings of a Research Survey on the Hopes and Fears of Trans People in the Czech Republic conducted by Transparent z.s., the most harassment, discrimination and degrading treatment against transgender clients was perpetrated by care providers. A quarter of respondents (25.1%) listed negative and degrading experiences with professionals who provided some form of care (medical professionals, psychologists, sexologists, clergy, etc.) only followed by ill treatment and discrimination at schools (24.3%), from family and close people (21.3%), at the workplace (12.8%), in the public space (8.1%), by police (5.3%), etc (Pavlica et al., 2018). It is therefore very important to provide recommendations directly relevant for care providers in general and trans-specific healthcare in particular.

Transgender clients should be given the space to articulate their identities on their own terms, without being forced to fit categories in which they do not feel they belong. Priority should be placed on respecting and understanding each transgender person as an individual, and special attention should be devoted to the inclusion of non-binary gender and sexual identities, sending a clear message that transgender people will not be discriminated against or denied resources on the basis of identifying outside a strictly binary gender system.

Medical transition should not be treated as a prerequisite for asserting a valid trans identity within the realm of medical transition; multiple options, rather than a single normative trajectory, should be acknowledged as viable.

No medical treatment or procedure should be a prerequisite for legal

gender recognition, including but not limited to HRT, top surgery, surgical or non-surgical sterilization, or genital surgery.

Qualified doctors, medical personnel, and medical students should be systematically supported with regular professional development and education on trans issues, including an awareness of international developments in this field.

Health care providers should make an effort to ask about transgender clients' preferred names and pronouns, rather than assuming them from legal documents alone.

Transgender clients should be permitted to choose their own names, without the current requirement for a gender-neutral form even for those who would prefer a clearly masculine or feminine form.

The option to undergo any treatments, including HRT and/or transition surgeries, should remain recognized as medically necessary for those transgender people who wish to undergo them, preserving the current funding situation. Choosing to undergo one treatment (e.g. HRT) should, however, not be taken as automatic consent to other treatment (e.g. any surgery) unless desired by the individual. Rather than making funding for HRT and surgeries contingent upon the definition of transgender status as a disorder, transgender people should be supported in the decisions they make about their own health. It should be noted that there are many health-related circumstances such as pregnancy, childbirth, parental leave and need for child benefits, which are not classified as pathological states, yet qualify the person to receive financial assistance from the state. The fact that such financial support is available reflects the value placed on each circumstance by society and the state. The same principle can apply to bodily self-determination in general. Access to specific treatments should also be considered as separate from the issue of legal gender recognition.

Healthcare professionals are advised to closely observe international developments that tend towards the depathologization of trans identities in the medical field (actively endorsed by the medical organization WPATH), and towards making legal gender recognition contingent on self-identification rather than on approval by a regulatory body or

on any particular medical procedure in the legal field.

3.1 Involved Professionals' Knowledge and Awareness

The Ethical Principles of Psychologists and Code of Conduct (APA, 2010) include gender identity as one factor for which psychologists may need to obtain training, experience, consultation, or supervision in order to ensure their competence (APA, 2010).

It is important for psychologists to engage in continuous training on issues related to identity and gender expression as a foundation for an affirmative psychological practice because of the high level of societal ignorance and stigma associated with Transgender and Gender Non-conforming (TGNC) people, ensuring that psychological education, training, and supervision is affirmative, and does not sensationalize (Namaste, 2000) exploit, or pathologize TGNC people (Lev, 2004).

Precisely because most psychologists have received little or no training on the LGBT population and do not feel educated in the matter (APA, 2015), expert colleagues are called upon to implement and disseminate continuing education and training practices, helping to fill these gaps.

It is essential, first of all, that psychologists who receive training in this field develop a non- judgmental professional attitude towards people who experience different gender identities and expressions from their own. It is important to increase the awareness of cisgender privilege, anti-trans prejudice and discrimination, host panels inviting gender expansive people to offer their personal perspectives, or include their narratives in course readings (ACA, 2009).

According to the ACA, ALGBTIC Competencies for Counseling Transgender Clients, as can be seen from the context of helping relationships, psychologists should have more knowledge regarding the following points:

- Physical aspects (e.g., access to health care, HIV, and other health issues).
- Social aspects (e.g., family/ partner relationships).

- Emotional aspects (e.g., anxiety, depression, substance abuse).
- Cultural aspects (e.g., lack of support from others in their racial/ethnic group).
- Spiritual aspects (e.g., possible conflicts between their spiritual values and their family's).
- Stressors, e.g., financial problems as a result of employment discrimination (ACA, 2009).

It is important to provide training spaces in which healthcare professionals can train their own intrapersonal and interpersonal skills to:

- Identify and visualize their own culture of belonging, values and principles, to manage prejudices or stereotypes.
- Know and properly apply communication models that promote empathy and a relationship of trust with trans and intersex people, to prevent violence in health care practices and health care protocols that currently exist.

3.2. Development Through the Life Cycle

Professionals who work for the wellbeing of transgender people (Psychologists, Psychotherapists, Psychiatrists, Counselors, Sociologists, Educators) are encouraged to update themselves on the relevant literature (APA, 2015) and to consider the peculiar characteristics of each of the different stages of the life cycle in the following groups:

Children

Because gender nonconformity may be transient for younger children in particular, the psychologist's role may be to help support children and their families through the process of exploration and self-identification (Ehrensaft et al., 2012). Additionally, psychologists may provide parents with information about the potential long-term trajectories children may take in regard to their gender identity, along with the available medical interventions for adolescents whose TGNC identification persists (Edwards-Leeper et al., 2012).

Adolescents

In working with adolescents, it is important to consider some conditions that can better guide the intervention:

- Some adolescents don't have a strong history of childhood gender role nonconformity or gender dysphoria.
- Some of these adolescents may have withheld their feelings of gender nonconformity out of a fear of rejection, confusion, conflating gender identity and sexual orientation, or a lack of awareness of the option to identify as TGNC.
- Parents of these adolescents may need additional assistance in understanding and supporting their children.

Elderly Clients

Intervention with the elderly should take into consideration their bio-psycho-social needs, both in terms of their social contexts (isolation/exclusion) and offer support in dealing with their psychological experiences of shame, guilt and internalized transphobia, respecting their freedom in the manner in which they choose to come out.

At a biological level, it is necessary to support the evolution of the client's own identity or gender expression at any age, recognizing the fact that these paths were often not accessible or practicable in previous stages of life.

3.3. TreatingTransgenderClients

In Brief: General Recommendations

1. **Believe** – all identities are valid;
2. **Respect** – not only tolerate, but respect gender variance and expression;
3. **Support, empower** – create safe spaces, communicate, befriend;
4. **Protect** – protect trans clients and encourage respect for them, even in

their absence.

- Never assume someone's gender based on the ways they dress or express themselves. Unless you know for certain, it is better to use gender-neutral language, or ask discreetly.
- Respect the client's preferred name, even if it is different from the name in their legal documents.
- Use the client's preferred pronouns or gendered language and remind others to use them too, even in their absence.
- Believe and respect the ways in which the person refers to themselves.
- If the client wishes to keep their gender identity a secret, do not discuss it with other people.
- Secure easy access to restrooms and gendered facilities – ask trans clients which ones they prefer to use and ensure that they will be safe using them.

What Name and Pronoun to Use?

For some transgender clients, the use of their birth name can cause anxiety, for others it is a part of their life history that they want to leave behind. Respect the name a transgender person is currently using. If you happen to know a transgender person's birth name (the name given to them when they were born, but which they no longer use), don't share it. Sharing a transgender person's birth name and/or photos of them before their transition without their permission is an invasion of privacy.

In the event you don't know which pronoun a person uses, if you can, first listen to the pronouns others use to address that person. If you must ask, start with your own pronouns. For example, "I'm Dan, I use he and him pronouns. And you?" Use that given pronoun to address that person and encourage others to do the same. It may happen that you unintentionally use the wrong pronoun: simply acknowledge your mistake, apologize, then let it go and move on (GLAAD, 2018).

After Coming Out

Revealing one's trans identity to someone is deeply personal. It takes

trust and courage to talk about gender identity or gender transition. The best-case scenario is probably to: 1) ask what questions, if any, are acceptable for you to ask; and 2) acknowledge that, while your questions may originate in innocent curiosity, the trans person may choose to end the discussion at any time they may feel uncomfortable. This makes it easier for the trans person to maintain privacy and integrity.

Ask Intimate Questions Only When Necessary

It is inappropriate to ask any client, both cisgender and transgender, about their genitals. The same applies to "the surgery" or their surgical status – whether they are "pre-op" or "post-op". If they want to share such information, they will decide to do so (GLAAD, 2018).

Know Your Own Limits

If you don't know a relevant piece of information when caring for a transgender client, it is always better to ask. Making assumptions or saying something that may be incorrect can in some cases be hurtful. You can also find helpful resources online where you can learn more (GLAAD, 2018).

4. Applicable Psychotherapeutic Approaches

An estimated 38.2% of European Union citizens (200 million people) suffer from emotional distress due to mental disorders. Among transgender people, for example, in a sample of 573 transgender women, 64.2% were depressed or suffering from mood disorders (n=96, 31.6%), suicidal and non-suicidal self-injury (n=50, 16.5%), and anxiety disorders (n=44, 14.5%) (Reisner et al, 2016). These mental disorders include anxiety disorders (14.0%), insomnia (7.0%), major depression (6.9%), somatoform disorders (6.3%), alcohol and drug dependence (>4%), ADHD (5%) in the younger population, and dementia (up to 30%, depending on age) (EAP, 2020). The suicide attempt rate among transgender people ranges from 32% to 50% across European countries (Virupasha et al, 2016).

Traditional verbal approaches make up the bulk of the counseling and therapeutic methods used in these cases, however, body-based and holistic approaches embracing a comprehensive concept of the personality are also advised, and may better meet transgender clients' needs. Mental health providers must comprehend the biological and socio-psycho-spiritual dimensions of the human being, to prevent reductionism during counseling and therapy.

Transgender clients deserve accessibility to high quality mental health care. They have a right to be informed about options for counseling or therapy treatment. Transgender clients can be vulnerable when seeking mental health services, and there are many models, including "bottom- up" (body based: sensations, neurobiological, emotion-aware approach), "top-down" (brain based: cognitive, linguistic, educational approach) or mixed approaches that can facilitate healing, according to clients' needs and the desired benefits.

The most important factor in treating transgender clients is that the mental health care provider be gender-affirming in their approach, meaning that they do not question the validity of the trans client's self-determination or pathologize the trans client, and that they support the client in exploring the themes the client brings to the counseling or

therapy without judgment (PROUD, 2015).

4.1. Holistic Approaches, "Top-Down" and "Bottom Up" Models

Of the "top-down" models, popular approaches include Humanistic models:

Psychodynamic Therapy: Psychodynamic therapy is an in-depth form of talk therapy drawing on and extending the theories and principles of psychoanalysis. Psychodynamic therapy is not focused specifically on problems or behavior, but on painting an image of the client's lifelong experience, situating the client's place in and relationships with the world.

The client narrates their own story, examining how their past experiences, particularly those in childhood, and the learned at that time, may continue to influence their current patterns of behavior, emotions, choices, and relationships. (Psychodynamic Therapy, 2020).

Gestalt Therapy: In Gestalt Therapy, developed by Fritz and Laura Perls as another alternative to psychoanalysis, the therapist works with the client, mainly through conversation, exploring the here and now. The name alludes to the concept that life's meaning is more than just the sum of its parts. Clients can work through their current experiences by reenacting them with the therapist, while the therapist brings the client back to the present moment. Gestalt Therapy is a non-judgmental and non-pathologizing model which assumes that psychological disorders stem from hidden desires, needs, memories which will arise when the client is prepared to face them and find healing. (Amendt-Lyon et al., 2020).

Person-centered (Rogerian) therapy: Person-Centered counseling/psychotherapy was the first talk therapy based on empirical research conducted by its founder Carl Rogers. This therapy was originally conceived as non-directive and grew into a non-hierarchical model in which the therapist believes in the client's innate actualizing tendency to find and fulfill their own potential.

Person-centered therapy is based on this trust of the client's autonomy and ability to self-heal when met by a therapist who holds a safe space

in which the client can process. The therapist offers their own authenticity (congruence), empathy, and acceptance (unconditional positive regard) toward the client. It is a non-pathologizing therapy, believing that clients' beliefs, emotions and actions are reasonable responses to their experiences. (Wistreich, 2020).

Cognitive and Behavioral Approaches

Cognitive Behavioral Therapy (CBT) and **Affective Cognitive Behavioral Therapy** (ACBT) can be used as supportive modalities for short-term behavioral retraining in response to social anxieties, OCD, self-harm and other more extreme issues which cause the client severe restrictions in daily functioning.

Cognitive Behavioral Therapy (CBT) is a form of psychotherapy focused on how our thoughts affect how we feel and act.

It is a structured, directive and educational model which is usually short-term with a goal of changing a client's emotional responses so that they can shift behaviors. While the therapeutic relationship is important for the training to be effective, is it not the focus of the collaboration. CBT is an educational model using the Socratic Method and Inductive Method. Clients have exercises to do at home.

CBT is a broad umbrella term which includes Cognitive Therapy, Dialectical Behavioral Therapy, Rational Behavior Therapy, Rational Emotive Behavior Therapy, and Rational Living Therapy, among others. (National Association of Cognitive Behavioral Therapists, 2020)

Many transgender clients can benefit from more holistic, "bottom-up" body-mind based psychotherapeutic approaches, because they are dealing with specific issues around their bodily sensations, body image, hormonal changes, daily physical experience in the world, and often feel a disconnection between who they believe they are and what the mirror or society reflects back at them. The integration of attachment theory and neuroscience opens up extensive possibilities in psychotherapeutic and counseling interventions.

Expressive Arts Therapies (EXA) go beyond traditional verbal psychotherapy. approaches. EXA focus on sensitivity and responsiveness to the

needs of the diverse needs of clients. EXA use creative outlets as a means of connecting with the self, exploring one's concerns through the art form, and finding diversity and new coping skills through self-expression. EXA can be especially helpful for clients who have difficulty verbalizing or conversing about their experiences, thoughts and emotions. Expressive Arts Therapies include Art Therapy, Drama Therapy, Poetry or Bibliotherapy and Storytelling, Play Therapy, Music Therapy, Drumming Therapy, Dance /Movement Therapy. EXA can be used with individuals and groups. EXA can aid transgender clients in unlocking and processing deeper issues and building resilience.

Somatic /Body-Mind/ Trauma Informed Therapies

Somatic modalities are holistic therapies involving the body in accessing deeper wisdom that cannot be accessed with talk therapy. Trauma therapies focus on working with the client in a way that carefully and safely processes the trauma experience. Many transgender clients have experienced trauma through their journeys to finding their identities, and as their bodies are central to that journey, somatic and trauma-focused therapy may help them learn to cope with the complexity of their situation.

Trauma may begin as acute stress from a perceived life-threat or as the end product of cumulative stress. Both types of stress can seriously impair a person's ability to function with resilience and ease. Trauma may result from a wide variety of stressors such as accidents, invasive medical procedures, sexual or physical assault, emotional abuse, neglect, war, natural disasters, loss, birth trauma, or the corrosive stressors of ongoing fear and conflict (Levine, 2020).

Body-mind therapies are based on the development of the individual. Methods focus on sensorimotor learning and reconfiguration of past historical experience, the creation of new experiences, and engaging neuroplastic learning, allowing for the establishment of new neurological pathways and new mental maps.

Somatic Psychology offers key concepts that include:

- **Grounding**: Grounding is actively sensing the body, feeling one's

connection to the earth and staying in the present moment to decrease anxiety.

- **Cultivating Somatic Awareness:** Working with breath and tension patterns that are held just under our conscious awareness. When we bring awareness to our physical sensations, we create change.
- **Staying Descriptive:** We can go into the client's somatic experience in detail – naming sensations with descriptive words that note temperature, movement, pressure.
- **Deepening Awareness:** We can deepen the experience by gently amplifying the sensations (patterns, tension) we have noticed, but in such a way that it is not overwhelming.
- **Resourcing:** We can enable clients to find resources in themselves - body memories of moments in which they felt safe and strong. They learn to observe and remember the sensations that happen in their bodies when they feel calm, relaxed, peaceful.
- **Titration:** This awareness helps us notice where we hold tension in the body. Titration, used in Somatic Experiencing (Peter Levine) and Sensorimotor Psychotherapy (Pat Ogden and Kekuni Minton), is a way of discharging that tension slowly and progressively, alternating our attention between feeling the distress and feeling safe and calm.
- **Sequencing:** When we release the tension, we can feel shifts in our sensations and emotional states, breathing, etc. bringing us further along a healing path.
- **Movement and Process:** Somatic therapies look at our postures, gestures, and use of space to read the story the body is telling about our experiences.
- **Boundary Development:** Focusing on the here and now empowers us to stay responsive to our needs and develop clear boundaries. Limits allow us to recognize and speak "yes" or "no" in a way that feels protected and strong.
- **Self-Regulation:** Neuroscience strongly informs somatic therapies about how we respond to life stressors and traumatic experiences.

The research emphasizes the value of staying cognitively embodied in the midst of big emotions or sensations.

When we can feel our bodily sensations, we can learn to temper our emotional intensity. (Schwartz, 2017).

Somatic Therapy

Modern somatic approaches incorporate polyvagal theory, Biosynthesis, Bioenergetics, EMDR, meditation, mindfulness, neuroplasticity, and much more.

Polyvagal Theory introduced a new perspective on the relationship between the Autonomic Nervous System (ANS) and behavior. The ANS was identified as a "system." The neural circuits involved in the Autonomic Nervous System's regulation were identified, and autonomic reactivity was understood to be adaptive within the context of the phylogeny of the vertebrate autonomic nervous system (Porges, 2007). The Polyvagal Theory identifies the three circuits of the tenth cranial vagus (wandering) nerve, which respond to safe, potentially dangerous and life-threatening circumstances (Cherland, 2012). The Parasympathetic Nervous System (survival – the oldest, reptilian system) is a passive feeding and reproduction system creating a metabolic baseline of operation to manage oxygen and nourishment through the blood. Its dorsal vagal pathway is responsible for shutdown or freeze states. The Sympathetic Nervous System (danger/fight or flight, a newer, limbic system) is a more sophisticated set of responses, enabling us to respond to threat, feeding, and reproduction via limbs & muscles. The Social Engagement System (thriving – the most modern system) supports massive cortical development, enabling maternal bonding (extended protection of vulnerable immature cortex processors) and social cooperation (language and social structures) via facial functions.

Biosynthesis represents a holistic and humanistic approach in somatic psychotherapy. The basic starting points for this work include the connection between the client and therapist and mutual mirroring of mental and physical processes. Biosynthesis trusts the client's healthy potential for growth and harmony and making connections between the

internal and external selves. Biosynthesis works with bodily expression, emotions and thoughts, including insights and inner images, sexuality and spirituality. The client explores their networks of relationships with others, especially the earliest family bonds, development beginning pre-birth. Biosynthesis works symbolically as well as with the body to tap into these memories. (European Association for Psychotherapy, 2019, Biosynthesis Therapy, 2020).

Bioenergetics is a way of understanding the personality through the body and its energetic processes. Alexander Lowen developed Bioenergetics as the study of the human personality in terms of the energetic processes of the body. Lowen created the psychotherapeutic body-mind model Bioenergetic Analysis (BA) to aid clients in living fuller lives. This work begins with the body's basic functions – breathing, motility, feeling, and expression, investigating any restrictions found there, whether physically in the body, emotionally in the feelings, and intellectually in the understanding. BA believes in the body's ability to heal itself, and it is unique in that it combines an analysis of personality and character with body techniques and physical exercises to recognize and release chronic muscular tension, which it sees as a necessary step to work through blocks in feelings, behaviors, and attitudes. (Lowen Foundation, 2020).

Eye Movement Desensitization and Reprocessing (EMDR) Eye Movement Desensitization and Reprocessing (EMDR) is a psychotherapeutic treatment designed by Francine Shapiro, which aims to alleviate the distress associated with traumatic memories. Adaptive Information EMDR therapy aids clients in accessing, processing and resolving their traumatic memories. EMDR therapy helps clients release stress and physical responses, as well as renegotiating negative belief patterns. During EMDR therapy, the client remembers emotionally disturbing material in brief sequential doses while simultaneously focusing on an external stimulus directed by the therapist – lateral eye movements. Other stimuli including hand-tapping and audio stimulation can be used. EMDR therapy uses a three-pronged protocol: (1) first the client processes the troubling past events by linking the memories with new adaptive information; (2) the triggers are desensitized when the

triggering circumstances are targeted; (3) imaginal templates of future events are incorporated, to assist the client in acquiring the skills needed for adaptive functioning. (EMDR Institute, 2020).

The NeuroAffective Relational Model (NARM), developed by Laurence Heller, is a nondirective and noninvasive approach to treat attachment, relational and developmental trauma. Using both top-down and bottom-up approaches, NARM uses mindful inquiry to explore the client's identity and unify the biological and psychological development while focusing on tracking the client's felt sense in the body and supporting nervous system re-regulation. (Heller, 2019).

Pesso Boyden System Psychomotor (PBSP) emphasizes the early attachment experience, working with developmental patterns. Created in 1961 by Albert Pesso and Diane Boyden-Pesso, PBSP is the most advanced therapeutic system available for emotional re-education or reprogramming. PBSP uses techniques to help clients identify emotional deficits and create new memories. These new memories provide symbolic fulfillment of the basic developmental needs of place, nurture, support, protection and limits. Many aspects of PBSP theories and techniques have close parallels in recent neuroscience findings about mirror neurons, empathy, morality, and the impact of language on the theory of mind (Pesso PBSP International LLC, 2011).

Seeking Safety (Najavits, 2002) is an evidence-based model that can be used in group or individual counseling. It was specifically developed to help survivors with co-occurring trauma and substance use disorder and, crucially, in a way that does not ask them to delve into emotionally distressing trauma narratives. Thus, "safety" is a deep concept with varied layers of meaning – safety of the client as they do the work; helping clients envision what safety would look and feel like in their lives; and helping them learn specific new ways of coping.

Seeking Safety stays in the present, teaching a broad array of safe coping skills that clients may never have learned if they grew up in dysfunctional families or may have lost along the way as their addiction and trauma spiraled downward. All of the Seeking Safety coping skills apply to both trauma and addiction at the same time – providing integrated

treatment that can help boost motivation and guide clients to see the connections between their trauma and addiction issues (Najavits, 2019).

4.2. Self-Help Methods, Support Groups and Counseling

There are many modalities which trans clients can use on their own, such as:

Meditation is the intentional and self-regulated focusing of attention to relax and calm the mind and body. The practice of meditation has been scientifically proven to modify various physical and psychological states (e.g. increased cerebral blood flow; reductions in metabolic activity, heart and respiratory rates, blood pressure, oxygen consumption, and muscle tension; decreased depression and anxiety symptoms).

Mindfulness is suspending judgment and intentionally bringing one's attention to internal and external experiences in the here and now. This may include awareness of sensations, thoughts, bodily states, consciousness, emotions, or the environment. Mindfulness asks us to be open to possibility. It can be practiced through meditation, movement, sensory awareness, etc. (Edenfield, T., & Saeed, S., 2012).

Trauma-Sensitive Yoga (TCTSY) is an empirically tested clinical intervention for complex trauma or chronic, treatment-resistant post-traumatic stress disorder (PTSD). TCTSY is also informed by Trauma Theory, Attachment Theory, and Neuroscience. TCTSY uses the main elements of hatha yoga, creating specific shapes and movement with the body. These forms are practiced in a way that empowers and strengthens the yoga practitioner's relationship to their body. TCTSY emphasizes the participants' reference to felt sense in the process, allowing the participants to restore their connection of mind and body and cultivate a sense of agency that is often compromised as a result of trauma (TCTSY, 2020).

PTSD symptoms have been shown to be significantly reduced by yoga practice, comparable to well-researched psychotherapeutic and psychopharmacologic approaches. Yoga may improve traumatized individuals' functioning and coping skills because they learn to tolerate a

variety of physical and sensory experiences related to fear and helplessness and to increase their emotional awareness and affect tolerance. (Van der Kolk, 2014).

Mental health support groups are another option for transgender clients. Peer-to-peer support groups from within transgender and intersex communities, particularly, can be invaluable, especially in cases where the public healthcare system does not adequately provide sensitive and well-informed help and support. Self-help groups may be organized by a professional facilitator or by transgender and intersex people themselves for those who seek a feeling of belonging or need urgent advice and help. In order to encourage participants to open up and share their experiences, the groups must offer unbiased and sensitive facilitation, safety and security of the members, and confidentiality agreements. Participants are empowered by the non-hierarchical and non-pathologizing environment, which also fosters community building, trust, friendships and collective resilience. As indicated by the Research Survey on the Hopes and Fears of Trans People in the Czech Republic, peer-to-peer support groups (not guided by a sexologist) ranked highest in transition-related services among transgender respondents (92.2% satisfaction), followed by support from friends, the healthcare system and private psychotherapy: (78.4% psychotherapeutic care beyond that required for transition-related examinations and 68.7% psychological care during transition-related examinations) (Pavlica et al., 2018).

Other useful body-based therapies and modalities include Body-Mind Centering, Compassionate Inquiry, Continuum, Focusing, The Hakomi Method, NeuroAffective Touch, Somatic Experiencing, Somatic Attachment Therapy and more. In many European cities, clients can locate self-help practices such as those mentioned above with a specific focus on serving trans and intersex people.

4.3. Principles of Client-Centered Care

- Working step-by-step.
- Client knows their own needs best.

- Safe and confidential communication.
- Respectfully exploring options.
- Search for access points to client resources, verbalization, imagination, creativity, movement-oriented approaches and activities, expressive therapy (art therapy, drama therapy, dance therapy, music therapy, etc.).
- Accepting and working with the client's apprehension.

Characteristics of the Strengths-Based Affirmative Psychologist

- Has moved away from anti-trans prejudice to being cognizant of and sensitive to gender diversity; values & respects differences.
- Is aware of transphobia & transnegativity; recognizes cisgender privilege.
- Is aware of institutional & social barriers to success.
- Is comfortable with differences that exist between themselves and their clients.
- Is aware of their personal values and biases and how they impact gender minority clients.
- Understands intersecting identities; TGNC is only one part of identity (Ervin, A. n.d.)

Making Clinical Sites More Transgender Accessible

- Include all genders on patient health data forms.
- Introduce gender-variant affirming signage, artwork and medical information displays in reception areas and examination rooms.
- Educate all staff about how to affirm a patient's gender identity and welcome all clients.
- Provide clients with unisex restrooms.
- Ask the transgender individual which pronoun they prefer (Selix et al, 2016.)

4.4. Domains of Wellbeing

The domains of wellbeing can help in counseling practice to promote increased satisfaction and quality of life.

Table1

Existence	Belonging	Adaptability	Inclusivity	Development
Me and my body I take care of myself and my appearance I choose between healthy and unhealthy lifestyles	**My place in the world** I see myself as a part of the living environment. I feel safe in school, at work, or on the street.	**Everyday life** I accept my body as it is and work with my feelings around my appearance I have a job; I am a student or have work to do	**Wholeness** Each of my parts is integral to the whole I fully use my resources	**Courage** Showing courage, I respond to challenged and keep working on myself I have the potential to continue growing throughout my life.
Me as a person I am independent I have an idea about my future	**My place among people** I am valued - others appreciate me and I am respected I have friends	**My free time** I take part in sports and leisure time activities I meet with people and spend my free time with them	**Wholeness** Including shared leadership Integrating aspects of personality through the body and mind.	**Passage of life** My life passes until it ends

Me and my soul	**My place in society**	**Living independently**	**Meaning**	**Spirituality**
I believe in the future I believe that my life has meaning	I am able to take care of myself and accept medical and social services In my free time, I participate in community activities	I plan my work I can manage my problems	My life has meaning and I am aware of my uniqueness and interrelatedness	I am aware of my connection with myself, others, nature and the universe

5. The SWITCH Project's Mapping of the Best Therapeutic Practices in Three Partner Countries

"Supporting Wellbeing and Integration of Transgender Victims in Care Environments with Holistic Approach" (SWITCH) used an orientational in-depth interview to map the best therapeutic practices in the three partner countries. The respondents were selected therapists with long-term experience in providing therapy and counseling services to transgender, non-binary and intersex people in the Czech Republic, Italy and Spain. Eight therapists from the Czech Republic, five from Italy and six from Spain participated in the interview.

The aim of the interview was to determine the needs and barriers found in psychological and psychotherapeutic services in practice with trans, non-binary and intersex people in the individual partner countries. The interview was composed drawing on the 25 topics defined in the "Seeking Safety" handbook, directed mainly at clients suffering from trauma and PTSD (Najavits, 2002, 2009).

With informed consent and an in-depth interview, we obtained information about therapy practices in the three partner countries. The interview was distributed in English and accompanied with a translation in the respective native language of each country (Czech, Spanish, Italian) for the sake of accuracy. The information provided in English was analyzed, summarized and evaluated. Despite the small number of respondents and the potential for linguistic inaccuracy, the responses are an important qualitative indicator for good practice, providing a range of therapists' experiences and recommendations.

The resulting information can be used to enhance the therapeutic methodologies and standards for working with trans, non-binary and intersex people in the individual countries and as an inspiration for further research work. Additionally, the data can also serve for development and educational purposes. A detailed summary for each participating country is available as Appendix 1.

Generally corroborated principles of good therapy and counseling practice in the three partner countries:

- Comprehensive, respectful and non-hierarchical approach, addressing clients ethically.
- Education and awareness-raising of experts and trans people and others.
- Application of ethical principles for all clients; non-pathologizing, destigmatization.

Selection of the most important topics in therapeutic practice

The most common topics encountered by therapists in their practice, in hierarchical order:

Table 2

Spain	**Italy**	**Czech Republic**
Healthy relationships	Emotional pain	Safety, trust and support from others
Asking for help	Creating meaning and assumptions	Emotional pain
Emotional pain	Healthy relationships	Healthy relationships
Taking care of yourself and your health	Asking for help	Acceptance by family, friends and school
Community and community resources	Honesty	Acceptance by society and at work
Discovering and exploring	Integration of split self	Concerns about not having one's identity understood
Triggers	Acceptance by family, friends and school	Coming out
Respecting one's own time	Appearance	Physical dysphoria and appearance
Physical dysphoria and appearance	Acceptance by society	Considering official transition
Considering official transition	Loneliness, possibilities of socializing	Stress in public space
Acceptance at work	Stereotypes and expectations from others	Stress from social situations

Acceptance by society	Sexual orientation/asexuality	
Concerns about not having one's identity understood	Depression and anxiety	
Surgical interventions	Concerns about not having one's identity understood	
Coming out and acceptance by family and friends	Stress from social situations	
Possibilities of socializing, loneliness	Fulfilling binary social roles of men/women	
Stereotypes and expectations from others		
Problems at work, securing employment		
Discrimination at work and other spheres of life		
Impact of hormone therapy on mental health		

The least common topics encountered by therapists were faith vs. identity, compulsory divorce, addictions and intersex issues.

Psychological, biological, environmental and social, as well as work-economic barriers vary according to age group and life necessities of the individuals. General topics relevant to clients in the three countries fall within the sphere of biological barriers relating to prevention of illness and health complications or risks. Low self-esteem and self-confidence and minority stress are the most common psychological barriers, along with stereotypes and prejudices and integration of the body and the mind. Inaccessible psychological support, lack of therapists covered by healthcare insurance. Lack of specialized trainings for experts, education for families, in the workplace and at schools, poor consciousness-raising. Barriers in environment and society were defined as lack of

information and education, discrimination and violence. Barriers in the work- economic sphere included prejudices, discriminating work conditions, unequal opportunities and legislative requirements during transition.

Risks in relation to mental health manifest themselves primarily in the following areas:

Spain: Depression; frequent mood swings, feelings of despair, fear of rejection, fear of the impossibility to create healthy relationships with others, effects of bullying, self-harm and thoughts of self-harm, suicidal behavior, anxiety, somatization, substance abuse, eating disorders, mistrust in society, resistance and rejection of majority society, isolation.

Czech Republic: stress from unmet needs manifests mainly in depression; anxiety (especially social anxiety); repetitive feelings of despair; mood swings; compulsive thoughts resulting in OCD-like rituals. Some mention of eating disorders; self-harm; somatization; anger and aggression; alcohol and drug abuse. Relationship problems, staying in dysfunctional relationships, social isolation and loneliness are also mentioned. Risk of misdiagnosis (e.g.: Borderline Personality Disorder).

Italy: Anxiety, somatization, depression, frequent mood swings, emotional dysregulation, feelings of despair, fear of rejection, feeling of otherness, stigmatization, self-harm and thoughts of self-harm, suicidal behavior, substance abuse, gambling, mistrust in society, resistance and rejection of majority society, and isolation.

6. Conclusion

The difficult context of gender incongruence, transition and legal gender recognition in Europe (and beyond) requires an in-depth introduction to the current concepts and an insight into both the theoretical and practical background of well-informed, high quality care. The key to the wellbeing of transgender and intersex population does not only rest on the status of the European landscape. The aim of this Basic Guidelines report is to navigate the context and provide a common ground for subsequent activities within the framework of the SWITCH Project (Supporting Wellbeing and Integration of Transgender Victims in Care Environments with Holistic Approach).

The project's scope spans three participating countries, whose experts cooperated on the Report, yet it provides a relevant and valuable reference for those who work with transgender and intersex people elsewhere in Europe and beyond. The therapy tools and methodology outlined herein are intended as a resource to further educate healthcare providers as to how to take a sensitive, unbiased approach to trans-specific care. These health services are often the gateway to trans clients' legal gender recognition and social affirmation of their true identity. With respectful and trans-informed healthcare, providers can contribute to supporting trans clients in leading safe and dignified lives.

In addition to healthcare and mental health specialists, this report can serve as a resource for educators and policymakers, thus having broader implications in the sphere of gender recognition and the rights of transgender and intersex people.

Appendix – Mapping Best Therapy Practices in Three Partner Countries

CZECH REPUBLIC

The SWITCH project solicited five professional counselors/therapists from the Czech Republic who provide counseling services and psychotherapy to people from the transgender / non-binary / intersex community.

The numbers of clients for individual practitioners varied, numbering from several clients to several dozen. The most frequent and trans men slightly predominated over trans women. There were very few non-binary clients, almost none, and practitioners had no intersex clients.

The therapeutic methods used with this clientele were varied, but no one worked within only one model; therapists often had a diversified approach. Some practitioners (two) utilized psychoanalytic or psychodynamic models, one used art therapy, another humanistic psychotherapy, and the rest worked with several methods, including drama therapy and body-oriented therapy. One expert provided only on-line counseling, not therapy services.

All of the practitioners obtained data about their clients mainly through interviews, less often using formal tools. Open communication was considered most important, along with a non-directive and respectful approach. The most frequently mentioned ethical standards included: addressing the client using their preferred name and gender, being open towards any changes and developments related to the preferred name and gender, not pathologizing the issue of being transgender.

The topics most frequently brought by trans clients to counseling/therapy were safety, support from others, setting boundaries in relationships, emotional pain, community and community sources. Addiction, on the contrary, was the least common topic.

The list of 25 main topics is defined in the handbook "Seeking Safety," which focuses on working with trauma and PTSD.

The following part asked specifically about topics relating to trans, non-binary and intersex identified clients, the most frequent of which was "acceptance by friends and family," followed by coming out, acceptance in Czech society, stress in public spaces, acceptance at work, concerns about their identity being misunderstood, physical dysphoria and issues

around their physical appearance, considering official transition, and the topic of hormonal therapy and its effects on mental health. The least common topic was the issue of intersex identity, followed by compulsory divorce and faith versus identity. The above list of topics is based on the experience contained in the final report Concerns and Wishes of Trans People and on the practices of Transparent z.s.

All experts agreed that the needs and requirements of clients differ at different stages of life. Children and adolescents deal mainly with acceptance by their parents and at school.

Adults face issues primarily with work and family relationships and adapting to a new life role. The practitioners stated that they had no experience with senior clients. One noted that for the elderly, there is a high risk of loneliness, and need for special services for seniors (and a risk that they would not be respected) as well as contact with peers with similar experiences.

According to the experts, the long-term stress from non-fulfillment of trans clients' needs can manifest in the following: depression, anxiety (especially social anxiety), repetitive feelings of despair, mood swings or obsessive thoughts leading to rituals similar to those with OCD. Some mentioned eating disorders, self-harm, somatic manifestations, anger and aggression, alcohol and drug abuse. They also discussed their relationship issues, such as maintaining non-functional relationships, social isolation, and loneliness.

One practitioner stated that some clients were diagnosed with Borderline Personality Disorder, but that the symptoms which would warrant such a diagnosis, in the practitioner's view, were likely a "consequence of long-term frustration, fear and tension."

Practitioners' conclusions related to working with trans, non-binary and intersex clients:

"For the vast majority of clients, it is crucial to have the option to go to therapy that is open and accepting of them, enabling them to set the limits of therapy themselves, and covered by their insurance scheme. All, especially younger clients, would appreciate support with their family relationships."

"The provided expert practices (sexology, although endocrinology is also covered) are primarily rooted in a purely medical approach which is normative and outdated, incoherent and thus uncontrollable. We are lacking affordable (not only financially), professional and therapeutic support.

There is no expert discourse which would create a friendly environment (experts' reactions are also normative, no matter how well-intentioned, and therefore degrading)."

ITALY

The SWITCH project solicited five professional counselors/therapists from Italy who provide counseling services and psychotherapy to people from the transgender / non-binary / intersex community.

The numbers of clients for individual practitioners varied, numbering from several clients to twenty or thirty. The most frequent counseling and therapy clients were trans people, and trans men slightly predominated over trans women. There were very few non-binary clients, almost none, and practitioners had no experience with them at all. Practitioners had the least amount of experience with intersex clients.

The therapeutic methods used with this clientele were varied, but no one worked within only one model; therapists often had a diversified approach. Some practitioners (3) primarily used work with family psychotherapy within a systemic or psychodynamic approach. Some mentioned Body Psychotherapy, art therapy and imagination therapy, guided meditation, work with emotions, dramatherapy (psychodrama and role playing), narrative psychotherapy, positive psychology approaches, and family mediation.

All of the practitioners obtained data about their clients mainly through interviews, less often using formal tools. Tools were used to identify more serious mental problems and suicidal risk, and projective methods (character drawing, family). One practitioner mentioned monitoring medical records and using a structured interview inspired by Kernberg. One practitioner stated that when psychodiagnostics were required beyond the scope of the clinical interview, they used tests focused on personality structure, particularly the comprehensive MMPI II questionnaire. However, one of the other therapists mentioned that he did not use MMPI, because in his view, the masculinity index in the questionnaire was not fitting and should be revised. One of the therapists stated that they cooperated with a psychiatrist when they needed a more detailed assessment of the client's mental state.

One practitioner specifically noted literature on trauma (Michele Giannantonio, 2003-2009, v.

2.1 Da Giannantonio, M. (2009). Psicotraumatologia. Fondamenti e strumenti operativi. Torino: Centro Scientifico Editore). Two therapists reported using the Italian version of the American Psychological Association's recommendations to work with transgender * people (APA, 2015: Guidelines for psychological practice with transgender and gender nonconforming people. American Psychologist, 70 (9), 832-864. http://dx.doi.org/10.1037/a0039906). The recommendations have been translated into Italian and are available at https://psicamp.it/index.asp?page=psicologia-transgender-linee-guida.

The most important recommendations for working with trans people were:

The need for specialized training in working with LGBT+ people for healthcare professionals and other disciplines, networking of necessary services and interconnection of care. Cultivating a relationship with LGBT+ communities to overcome societal prejudices and LGBT+ people's defenses. Focus on possible barriers to access to care, on issues of possible discrimination and violence.

The main ethical principles mentioned were: observance of the same ethical rules as when working with any other clients, sensitive listening and respect, non-judgmentalism, non-pathologizing transgender issues (but timely detection of possible mental disorders). Adherence to the APA ethical principles.

In the questionnaire, practitioners indicated the following topics as appearing most frequently when working with trans clients:

- Emotional pain
- Meanings and assumptions
- Healthy relationships
- Asking for help
- Sincerity
- Reintegrating a split self

The least commonly mentioned topics were addiction, support from others (others in recovery), post-traumatic stress disorder, indications of

safety and danger.

The list of 25 main topics is defined in the handbook "Seeking Safety," which focuses on working with trauma and PTSD.

In another questionnaire, focusing specifically on the topics of trans, non-binary and intersex clients, the most common topics were the following (top to bottom from most to least frequent):

- Acceptance by family, friends, school
- Physical appearance
- Social acceptance
- Loneliness, need for socialization
- Stereotypes and social expectations
- Sexual orientation/asexuality
- Depression and anxiety
- Fears around others not comprehending identity
- Stress from social situations
- Fulfilling the role of man/woman

The least mentioned topics were compulsory divorce and faith versus identity. The above list is based on the experience contained in the final reports Concerns and Wishes of Trans People and the practices of Trans-parent z.s.

The topics of depersonalization and time / adaptation to a new role were also mentioned.

The psychological needs of both trans women and trans men included support in the transition process, adaptation to a new role, support when feeling fearful or doubtful of their "new body" or new sexuality. Support in the integration of the psyche and body, help when distrusting of others and overcoming traumatic experiences caused by conflicts with one's loved ones (parents and family). In trans men, support for "feel- ing like a man" despite their ongoing menstrual cycles and other physi- ological processes. Non-binary people need support especially in an- choring oneself in one's own scheme, to support their definition of identity

which society does not consider. Therapists usually do not have enough experience with psychological needs in intersex people. All of the groups mentioned a need for listening and support.

With regard to special pedagogical needs, the need to support trans * persons in restoring confidence in other people and to support self-awareness and increase self-confidence is mentioned. Encourage them not to perceive their role as men / women according to the expectations and prejudices of the environment, but according to themselves. The education of the environment of trans people is also mentioned. With regard to non-binary and intersex people, society has almost no information.

The most common economic and employment needs are the requirement for non-discriminatory working conditions, the issue of job search and lack of job opportunities, and the issue of prostitution among trans-women / men.

The following were identified as barriers and critical areas:

1. Physical/biological barriers for trans people – previous diseases complicating transition, transition defined only by physical aspects, poorly trained medical staff and care, rejection or misunderstanding by medical staff and distrust and rejection of health care. Body traits and biological markers determining gender were also noted.
2. Psychological barriers for trans people – confrontation by society and its expectations, feeling threatened, prejudices against trans people (and social distrust of trans people), experiences of discrimination, stigma, shame, loneliness, emotional pain. Feeling of incompleteness, feeling that they are not perceived as a "real man / woman." Issues of parenthood and reproduction, internalized stereotypes. For non-binary people, a lack of awareness of issues in society, incomprehension, struggling with the requirements of defining their gender, depression and frustration.
3. Barriers in labor/professional sphere: discrimination against trans * people in general working conditions, prejudices, discrimination due to the ongoing transition process, more difficult to achieve economic / financial independence, difficulty in finding work corresponding to

one's education and experience.

4. Barriers in society: generally, less tolerant and uninformed environments, including health professionals, as well as official obstructions to transition, a time lag in legal recognition of identity, misunderstanding, discrimination and prejudice, a lack of information, intolerance or lack of understanding regarding non-binary people.

All experts agreed that the needs and requirements of clients differ at different stages of life.

Children deal mainly with acceptance by their parents and at school; education for parents and educators is necessary. Children also need support with self-acceptance.

Adolescents face the issues of early hormone blockers in adolescence and the initiation of the transition process, socialization and relationships with peers, the need to find "their" group, feelings of guilt and inability to live up to the expectations of society and the environment, feelings of rejection. Adolescents need guidance on setting boundaries in relationships, in supporting their identities, and in establishing client-therapist relationships.

Adults face issues primarily with living life to the fullest, self-realization, acceptance in society, confirmation of their identity and understanding of "who I am." According to one of the experts, there are also young adults who, due to family pressure, have not been able to work with their identities and only require a "certificate of gender dysphoria" without gaining access to psychotherapeutic work. Practitioners reported a lack of experience with senior clients. However, they noted a need to improve the reputations of older trans people, to support them in their choices and decisions based on their needs and not on societal expectations. Due to age, seniors may feel less bound by the rules in which they lived their previous lives and decide to change.

According to the experts, the long-term stress from non-fulfillment of trans clients' needs can manifest in the following: Anxiety, somatization, depressive states, frequent mood swings, emotional dysregulation, feelings of hopelessness, fear of rejection, feeling of otherness, stigmatization, self-harm or thoughts about it, suicidal behavior. Substance abuse,

gambling.

Distrust in society, defiance and rejection of the majority society, isolation.

Finally, experts' comments included an emphasis on the need to work with trans people's families and their acceptance, understanding and non-pathologizing trans identities.

SPAIN

The SWITCH project solicited six professional counselors/therapists from Spain who provide counseling services and psychotherapy to people from the transgender / non-binary / intersex community.

The numbers of clients for individual practitioners varied, numbering from several clients to several hundred. The most frequent counseling and therapy clients were trans people, and trans men slightly predominated over trans women. Non-binary clients numbered significantly lower, or practitioners had no experience with them at all. The practitioners had the least amount of experience with intersex clients.

The therapeutic methods used with this clientele were varied, but none worked within only one model; therapists strove for a diversified approach. Most therapists (4) primarily used a cognitive-behavioral approach, others (3), also mentioning gestalt psychotherapy. Narrative psychotherapy, and family mediation were mentioned. In two cases, affirmative LGBT+ psychotherapy was mentioned.

All of the practitioners obtained data about their clients mainly through interviews, less often using formal tools. Some mentioned tools used to identify more serious mental problems (e.g. BDI) or risk of suicidality, questionnaires focused on relationship and attitudes (Adult Attachment Questionnaire, TREC Belief and Attitudes Scale).

Two practitioners cited The World Professional Association for Transgender Health Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People (WPATH standards of care guide, available at https://www.wpath.org / publications / soc), as the main resource for information. Publications on psychotherapeutic work (e.g. Theory of Personal Constructs, Kelly, 1995 or Rational Emotive Behavioral

Therapy, de Lega, Sorribes, Calvo, 2017) were also noted. A reference was made to legislation from 2007 relating to legal gender recognition and change of name.

The most important recommendations for working with trans people were:

Maintaining a comprehensive, non-directive and respectful approach. Therapists should be aware of their own belief patterns and attitudes towards LGBT + people, and should decentralize heteronormativity in their approach. Active listening and refraining from evaluation as much as possible. The need to train health professionals and other fields as to how to work with LGBT + people, networking among necessary services and interconnection of care.

The main ethical principles mentioned were: maintaining the same ethical rules as when working with any other clients, addressing the client in their preferred gender, and above all, refraining from pathologizing transgender issues.

In the questionnaire, practitioners indicated the following topics as appearing most frequently when working with trans clients:

- Healthy relationships
- Asking for help
- Emotional pain
- Taking good care of oneself and your health
- Community resources
- Discovering and exploring
- Coping with triggers
- Respecting one's own time

The least common topics were meanings and assumptions, post-traumatic stress disorder, addiction, and change in thinking.

The list of 25 main topics is defined in the handbook "Seeking Safety," which focuses on working with trauma and PTSD.

In another questionnaire, focusing specifically on the topics of trans, non-binary and intersex clients, the most common topics were the following

(top to bottom from most to least frequent):

- Body dysphoria and the theme of appearance
- Considering official transition
- Acceptance at work
- Acceptance by society
- Concerns related to not having one's identity understood and accepted
- Surgeries and their quality
- Coming out and acceptance
- Acceptance by family and friends
- Possibilities of socialization, loneliness
- Stereotypes and social expectations
- Problems at the workplace/finding a job
- Discrimination
- Work and other spheres of life
- Concerns about acceptance at work
- Hormonal therapy and its effect on mental condition

The least common topic was intersex, followed by compulsory divorce and faith versus identity. The list above is based on the experience contained in the final reports Concerns and Wishes of Trans People and in the practices of Transparent z.s.

Among other topics mentioned by the respondents were: "Anger that I was born this way," sadness and feelings of unfairness, transitioning at a later age, acceptance by family including grandparents, problems at school environment, finding a partner and disagreements and relationships and couple therapy. Parents of transgender children often look for biological explanations.

The psychological needs in both trans women and trans men included acceptance of one's identity and one's body, support in coming out in the family and at work, in overcoming fear from rejection, issues of

parenthood, fighting public prejudices (trans women associated with prostitution) and discrimination, finding romantic/sexual partners, friends, self-fulfillment. Also, the issue of depression, anxiety, social phobia, self-harm, internalized transphobia. For non-binary people, the needs focused on support, especially in not being recognized by society, their needs not being recognized and visible, anchoring oneself in one's own scheme, finding one's own path, support in managing frustration and working with emotions.

Therapists were noted as usually not having enough experience with intersex clients' psychological needs.

Education on trans identities was reported necessary, particularly the need to educate pedagogical staff, students and teachers, and teaching society not to stigmatize and pathologize transgender people. Education geared toward trans people should focus in particular on making them aware of their rights and opportunities. There is a specific need to educate society on non-binary and intersex identities, including health and education professionals.

The respondents' most common economic and employment needs were lack of non-stigmatization in job search and job interviews and safe and non-discriminatory working conditions. The conditions for the formal change of name and identity must be changed, the current rules were considered discriminatory. The issue of non-binary people should be included in legal documents. Other needs included the need for understanding, the possibility of gender self-determination and more trained professionals working with this topic.

The following were identified as barriers and critical areas:

1. Physical/biological barriers for trans people – lack of health monitoring and prevention, previous diseases complicating transition, poorly trained medical staff and provision of care conditional upon transitioning. Health problems related to the use of hormones. Low quality of surgical procedures.
2. Psychological barriers – low self-confidence, minority stress, feeling threatened, living in a society with prejudices against trans people (and distrust of trans people in society), fear of rejection, experience

of discrimination, feeling incomplete, concerns about effects of hormones on the psyche. In trans women, experience with degradation to the object of sexual desire, attributing the role of a prostitute, trans men are not considered "real men." Issues of parenthood and reproduction. Internalized stereotypes. For non-binary people, lack of awareness of issues in society, experience of misunderstanding.

3. Barriers in labor/professional sphere: worse conditions for entering the labor market, lack of job-related stability, insufficient support in education and potentially dropping out of school leading to a more difficult position on the labor market, the effect on job opportunities or discrimination around the transition process and the change of trans people's legal documents and names, social transphobia.
4. Barriers in society: legal conditions of transition – for example, the requirement of two years of hormone use before a person can officially change their name and documents, surgery not covered by health insurance, the length involved in the whole process and legal procedures. Intolerant and uninformed environments, especially outside large cities, trans people are degraded and misunderstood.

All of the experts agreed that the needs and requirements of clients differ at different stages of life. Children deal mainly with acceptance by their parents and at school; education for parents and educators is necessary. Adolescents face the issues of early hormone blockers in adolescence and the initiation of the transition process, adequate medical care, communication, and parents' acceptance, socialization and relationships with peers, self-harm and suicidal behavior.

Adults face issues primarily with support in the labor market, acceptance at work and support from friends, and mainly healthcare and possibility of transitioning regardless of age and emerging issues of discrimination and insufficiently enforceable legislation against intolerance and discrimination. Senior clients have a high risk of loneliness, there is not enough information about this issue within the services for the elderly (and a risk of not respecting their identity and needs), and that hormonal and surgical treatment should be available regardless of age. Attention should be paid to aging trans women who have a history in or are actively engaged in prostitution.

According to the experts, the long-term stress from non-fulfillment of trans clients' needs can manifest in the following: depressive states, frequent mood swings, inability to experience happiness, feelings of hopelessness, fear of rejection, fear of inability to form functional relationships with people, expression of the effects of bullying, self-harm or considering self- harm, suicidal behavior. Anxiety, somatization, substance abuse, eating disorders/issues with food intake were also mentioned, as well as distrust of society, defiance toward and rejection of majority society, isolation.

Finally, experts' comments included an emphasis on respect toward trans people, support of further education of experts in care profes- sions with regard to the topic and support of enhancement of the quality of life of trans persons, an expression of support for them and their families, and the need to enact legal changes to ensure trans people's rights and dignity.

References

1. ACA ALGBTIC Transgender Committee. (2009) ALGBTIC Counseling Transgender Clients. Retrieved November 10, 2020, from https://www.counseling.org/Resources/Competencies/ALGBTIC_Competencies.pdf
2. Amendt-Lyon, N., Spagnuolo Lobb, M. (n.d.). Description of Gestalt Therapy. Retrieved November 10, 2020, from https://www.eagt.org/joomla/index.php/2016-02-25-13-29-31/description-of-gt
3. American Psychological Association. (2015). Guidelines for Psychological Practice with Transgender and Gender Nonconforming People. American Psychologist, 70(9), 832-864. doi.org/10.1037/a0039906) https://www.apa.org/practice/guidelines/transgender.pdf
4. Amnesty International. (2014). The State Decides Who I Am, Lack of Legal Recognition for Transgender People in Europe, retrieved November 10, 2020 from https://www.amnesty.eu/wp-content/uploads/2018/10/the_state_decides_who_I_am.pdf
5. Asia Pacific Forum of National Human Rights Institutions. (2016). Promoting and Protecting Human Rights in relation to Sexual Orientation, Gender Identity and Sex Characteristics. Asia Pacific Forum of National Human Rights Institutions. ISBN 978-0-9942513-7-4.
6. Carlström, R., Ek, S., & Gabrielsson, S. (2020). 'Treat me with respect': transgender persons' experiences of encounters with healthcare staff. Scandinavian Journal of Caring Sciences.
7. Center for Trauma & Embodiment at Justice Resource Institute, About. (n.d.). Retrieved November 10, 2020, from https://www.traumasensitiveyoga.com/about

8. Chapman, R., Zappia, T., & Shields, L. (2012). An essay about health professionals' attitudes toward lesbian, gay, bisexual and transgender parents seeking healthcare for their children. Scandinavian Journal of Caring Sciences, 26(2), 333-339.
9. Cherland E. (2012). The Polyvagal Theory: Neurophysiological Foundations of Emotions, Attachment, Communication, Self-Regulation. Journal of the Canadian Academy of Child and Adolescent Psychiatry, 21(4).
10. Edenfield, T., & Saeed, S. (2012). An update on mindfulness meditation as a self-help treatment for anxiety and depression. Retrieved November 10, 2020, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3500142/
11. Edwards-Leeper, L., & Spack, N. P. (2012). Psychological evaluation and medical treatment of transgender youth in an interdisciplinary "Gender Management Service" (GeMS) in a major pediatric center. Journal of homosexuality, 59(3), 321-336.
12. Ehrensaft, D. (2012). From gender identity disorder to gender identity creativity: True gender self child therapy. Journal of homosexuality, 59(3), 337-356.
13. Galop (n.d.). Transphobia. Retrieved November 10, 2020, from https://www.galop.org.uk/transphobia/
14. GLAAD (2018). Transgender FAQ. Retrieved November 10, 2020, from https://www.glaad.org/transgender/transfaq
15. Institute, Inc. (2020) What is EMDR? Retrieved November 10, 2020, from https://www.emdr.com/what-is-emdr/
16. Intersex Society of North America (n. d.). What is intersex? (n.d.). Retrieved November 10, 2020, from https://isna.org/faq/what_is_intersex/

17. Ervin, A. (n.d.). The Ethics of Working with Ground Rules Transgender and Gender. Retrieved November 10, 2020, from https://cdn.ymaws.com/www.papsy.org/resource/collection/C954A5EF-F25C-4505-A0EA-25C6047A068D/W16_Ethics_of_Transgender.pdf

18. Fausto-Sterling, Anne (2000). Sexing the Body: Gender Politics and Construction of Sexuality. New York: Basic Books.

19. European Association for Psychotherapy. (2019). Biosynthesis Therapy. Retrieved November 10, 2020, from https://www.europsyche.org/approaches/biosynthesis/

20. Heller, L. (2019). Introduction to the NeuroAffective Relational Model [NARM]. Retrieved November 10, 2020, from https://drlaurenceheller.com/narm-introduction/

21. Heller, L. (2019). What is NARM? Retrieved November 10, 2020, from https://narmtraining.com/what-is-narm/

22. Jenner, C. O. (2010). Transsexual primary care. Journal of the American Academy of Nurse Practitioners, 22(8), 403-408.

23. Lev, A. I. (2004). Transgender emergence: Understanding diverse gender identities and expressions. Retrieved May, 1, 2018.

24. Levine, P. (2020). What Is Somatic Experiencing? Retrieved November 10, 2020, from https://traumahealing.org/about-us/

25. Lowen Foundation, (n.d.). What are Bioenergetics? Retrieved November 10, 2020, from https://www.lowenfoundation.org/what-is-bioenergetics

26. Najavits, L. (2019). Seeking Safety: A Model to Address Trauma and Addiction Together. Retrieved November 10, 2020, from https://www.rehabs.com/pro-talk/seeking-safety-an-evidence-based-model-to-address-trauma-and-addiction-together/

27. Namaste, V. (2000). Invisible Lives: The Erasure of Transsexual and Transgendered People. University of Chicago Press, Chicago.

28. National Association of Cognitive Behavioral Therapists. (n.d.). What is Cognitive-Behavioral Therapy (CBT)? Retrieved November 10, 2020, from https://nacbt.org/whatiscbt.htm/

29. Office of the High Commissioner for Human Rights. (2015). A step forward for intersex visibility and human rights. Retrieved November 10, 2020, from https://www.ohchr.org/EN/NewsEvents/Pages/Astepforwardfor-intersexvisibility.aspx

30. Pavlica, K. et al. (2018). The Fears and Hopes of Trans People. Prague: Transparent, z. s.

31. Pesso PBSP International LLC, 2011. Retrieved November 13, 2020, from https://pbsp.com/.

32. Porges, S. W. (2007). The polyvagal perspective. Biological psychology, 74(2), 116-143.

33. Platforma pro rovnoprávnost, uznání a diverzitu z.s. (PROUD). (2015). Report on Trans People and Their Experience Health Care and Legislation in the Czech Republic. Prague: PROUD.

34. Psychology Today (n.d.). Psychodynamic Therapy. Retrieved November 10, 2020, from https://www.psychologytoday.com/us/therapy-types/psychodynamic-therapy

35. Reisner, S. L., Poteat, T., Keatley, J., Cabral, M., Mothopeng, T., Dunham, E., Holland, C. E., Max, R., & Baral, S. D. (2016). Global health burden and needs of transgender populations: a review. Lancet (London, England), 388(10042), 412–436.

36. Seeking Safety (2020) http©2020 Treatment Innovations www.treatment-innovations.org and www.seeking-safety.orgs://www.ncbi.nlm.nih.gov/pmc/articles/PMC1868418/

37. Sedlak, C. A., Veney, A. J., & Doheny, M. O. B. (2016). Caring for the transgender individual. Orthopaedic Nursing, 35(5), 301-306.

38. Selix, N. and S. Rowniak. 2016. "Provision of Patient-Centered Transgender Care." Journal of Midwifery and Women's Health. 61(6):744-751. Retrieved from https://onlinelibrary.wiley.com/doi/abs/10.1111/jmwh.12518

39. Schwartz, A. (2017, December 19). Somatic Therapy: Dr. Arielle Schwartz. Retrieved November 12, 2020, from https://drariellеschwartz.com/somatic-therapy/

40. TCTSY. (n.d.) What Is Trauma-Sensitive Yoga? About. Retrieved November 10, 2020, from https://www.traumasensitiveyoga.com/about

41. The International Focusing Institute (n.d.). What Is Focusing? Retrieved November 10, 2020, from https://focusing.org/felt-sense/what-focusing

42. The Young Scot Card (n.d.). What is transphobia? Retrieved November 10, 2020, from https://young.scot/get-informed/national/what-is-transphobia

43. United Nations. (2019). A major win for transgender rights: UN health agency drops 'gender identity disorder', as official diagnosis. Retrieved November 10, 2020, from https://www.un.org/sustainable-development/blog/2019/05/a-major-win-for-transgender-rights-un-health-agency-drops-gender-identity-disorder-as-official-diagnosis/

44. Van der Kolk B., Stone, L., West, J., Rhodes, A., Emerson, D., Suvak, M., & Spinazzola, J. (2014). Yoga as an adjunctive treatment for posttraumatic stress disorder: A randomized controlled trial. The Journal of clinical psychiatry, 75(6), 559-565.

45. Virupaksha, H. G., Muralidhar, D., & Ramakrishna, J. (2016). Suicide and Suicidal Behavior Among Transgender Persons. Indian journal of psychological medicine, 38(6), 505–509.

46. Wistreich, N. (n.d.). What is the Person-Centred Approach? Retrieved November 10, 2020, from https://www.the-pca.org.uk/about/what-is-it.html

47. Wikipedia. (n.d.). Transphobia. Retrieved November 10, 2020, from https://rationalwiki.org/wiki/Transphobia

48. Wikipedia. (2020). History of intersex surgery. Retrieved November 10, 2020, from https://en.wikipedia.org/wiki/History_of_intersex_surgery

49. World Health Organization (WHO). (2019). The ICD-11 Classification of Mental and Behavioural Disorders. Genève, Switzerland: World Health Organization.

50. World Professional Association for Transgender Health (WPATH). (2011). Standards of Care (SOC) for the Health of Transsexual, Transgender, and Gender Nonconforming People. Retrieved November 10, 2020, from https://www.wpath.org/publications/soc