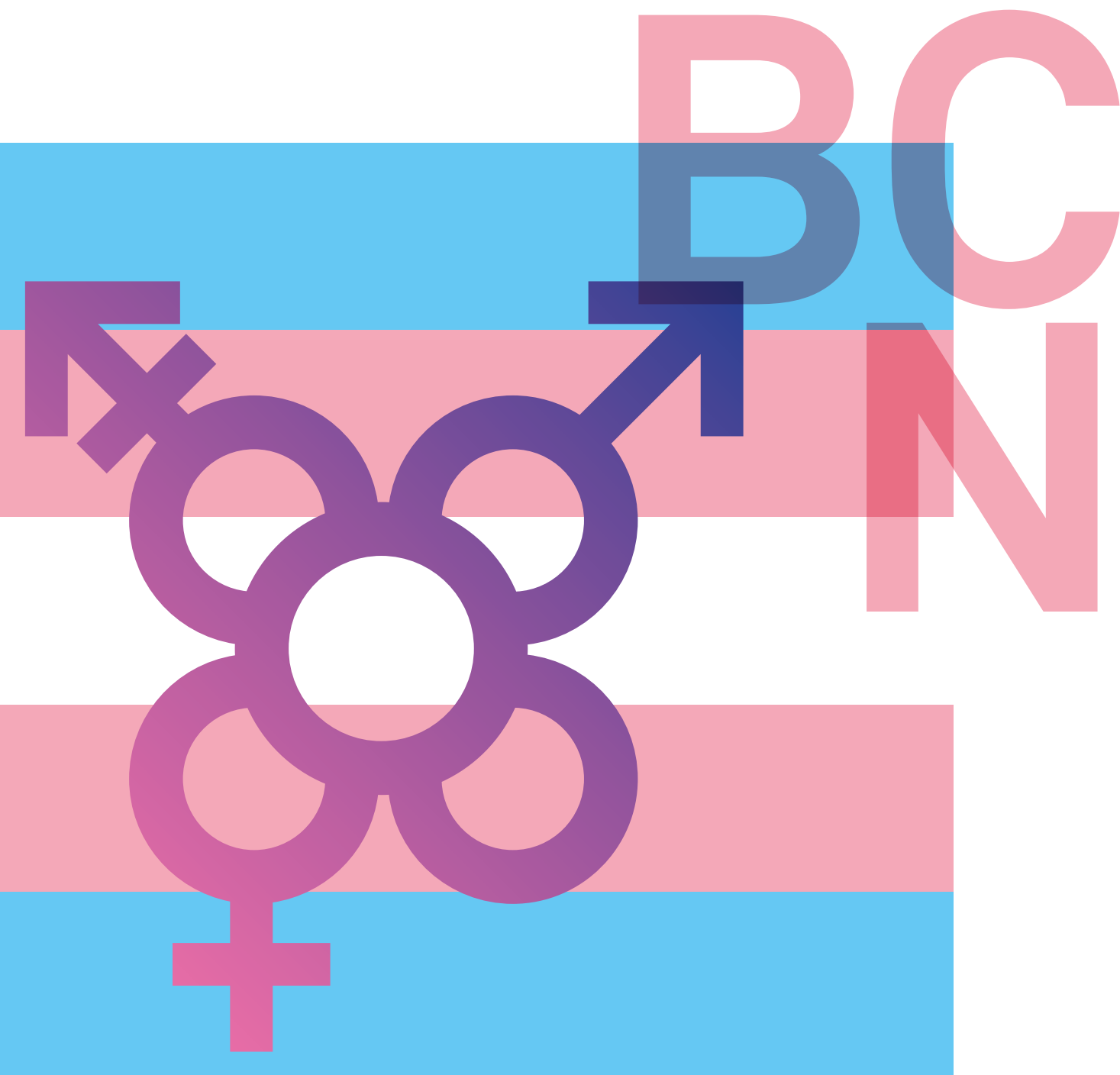


Report on support and assistance model for trans people in the city of Barcelona



**Area of Citizen Rights,
Participation and Transparency**

Department of Feminism
and LGBTI Affairs

**Report on support and assistance
model for trans people in the city
of Barcelona**

Barcelona, April 2016



**This publication forms part of the roll-
out of the 2016 - 2020 Municipal Plan
for Sexual and Gender Diversity**

Measures for LGBTI Equality

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1. INTRODUCTION AND GENERAL FRAMEWORK

This report is in response to the assignment carried out by the Councillor's Office for Feminism and LGTBI Affairs of Barcelona City Council to assess to what extent the health needs of trans people or people with gender variance are covered, and to draw up a support and assistance model for these city residents.

On the one hand, we have prepared an assessment of the public healthcare system in the city of Barcelona, taking into account the experiences of similar services, in order to form some recommendations aimed at implementing a healthcare model that is non-pathologising and inclusive.

On the other hand, we have defined the basic lines for creating a municipal comprehensive care service for trans people. This service must focus on psychosocial and community aspects and not just health-related issues, which is what is currently happening in Catalonia.

This report has been coordinated by Cristina Garaizabal, a psychologist with experience in supporting trans people since the end of the 1980s, and has been drawn up by Cristina Garaizabal; Jordi Mas Grau, sociologist and anthropologist specialising in trans studies, and Dr Rosa Almirall and Soraya Vega, gynaecologist and psychologist respectively, professionals from the Trànsit public service, who have essentially taken care of the health-related recommendations.

A meeting was held with trans organisations (ATC, EnFemme, Espai Trans, Chrysallis, Generem! and Grup de Famílies de Persones Trans) in order to gather their opinions and be able to use their ideas and requests.

Advice was also requested from trans people and/or experts in LGTBI matters, such as Andreu Agustí, Gerard Coll-Planas and Miquel Missé, who reviewed the report and contributed their ideas. We also coordinated with Nuria Gregori, as she has coordinated a diagnostic report on intersex people, and there are a number of issues the two subjects share.



1.1 Diversity of trans people. From the pathologising model to the depathologising model

Transsexuality appeared as a medical category during the 1950s to identify people whose gender identity did not correspond to their biological sex. In order to correct what was considered to be a pathological condition, biomedicine developed therapeutic protocols that established hormone treatment and sex reassignment surgery as the treatment to be followed by all transsexual people. For a long time, doctors publicised this treatment as the only way possible for a trans person¹ to occupy a normal position in the exclusive gender binary system. Initially, however, the hormone-surgical therapy was not unanimously accepted by the professional community, as the majority considered it more appropriate to provide psychotherapeutic care aimed at correcting the transsexual desire of the patient.²

In order to address the criticisms and to socially and scientifically legitimise the hormone-surgical treatment, various diagnostic criteria were created to determine which people were truly transsexual. "Transsexualism" was incorporated as a psychiatric category into the third edition of the DSM (1980), the most influential manual worldwide that classifies mental disorders and is developed by the American Psychiatric Association (APA). Almost at the same time, homosexuality was declassified thanks to the pressures from the gay and lesbian movements, which had been calling for the depathologisation of homoerotic desire. In the fourth edition of the DSM (1994), the term "transsexu-

alism" was replaced by the category of "gender identity disorder". In the fifth and most recent version of the manual (2013), the phenomenon is currently categorised as "gender dysphoria".

The psychiatric categories used to define transsexuality, with their corresponding diagnostic criteria, have not only been used to decide who accesses treatment; they have also conditioned how trans people see themselves and how society understands the phenomenon. At an individual level, a diagnosed person may internalise the view that their condition is abnormal. At a social level, a diagnosis of a psychiatric disorder facilitates discrimination and stigma. The psychiatrisation of transsexuality acts as a powerful tool to legitimise our gender system, as all those people that reject gender assignment³ are considered to have a pathological disorder that needs psychiatric treatment.⁴

Nevertheless, Foucault points out that these categorisations have ambivalent effects, as not only do they have a repressive or controlling function, but they may also lead to a "reverse affirmation", i.e. a use of these categories with unconventional, transgressive purposes by the categorised people themselves. In this sense, the diagnostic categories (such as homosexuality, transsexuality, transvestism and intersex), created to strengthen the social control over sexual and gender minorities, can turn into self-affirmation policies that question the very sex and gender system that is

- 1 Throughout this text, we will use the word "trans" as an umbrella term that includes all gender-variance identities and expressions (transsexual, transgender, crossdresser, etc).
- 2 Billings, Dwight and Urban, Thomas (1998), "The Socio-Medical Construction of Transsexualism: An Interpretation and Critique", to José Antonio Nieto (comp.): *Transsexualidad, transgenerismo y cultura*, Madrid: Talasa, pp. 91-116.
- 3 We understand that "gender assignment" refers to the gender that the person is assigned at birth according to their genital morphology. A direct correlation has been established in our societies between sex and gender (as per the equations: man = male, woman = female).
- 4 Nieto, José Antonio (2008), *Transsexualidad, intersexualidad y dualidad de género*, Barcelona: Edicions Bellaterra.

trying to control them. The fights, advocating and achievements of the LGBTBI movement are a good example of this.

In 2009, numerous associations from all over the world, led by the trans groups in Barcelona, joined the Stop Trans Pathologization (STP) international campaign, requesting that transsexuality was removed from the mental disorder manuals (the DSM and the CIE developed by the WHO). Apart from the depathologisation of transsexuality, the Campaign also aims to ensure free access to hormone treatment and surgery, without the need for psychiatric counselling, public healthcare cover that respects the diversity of these citizens, recognition of all trans identities and the fight against institutional and social transphobia.⁵ This international movement considers that being trans is another way of building gender identity and that it is just as valid and legitimate as any other. Consequently, it cannot be treated as a disease, disorder or abnormality. From this depathologising perspective, it is understood that gender identity is an inalienable right of a person, who has to be the one to decide at all times what therapy they themselves need without having to be subjected to a psychiatric evaluation.

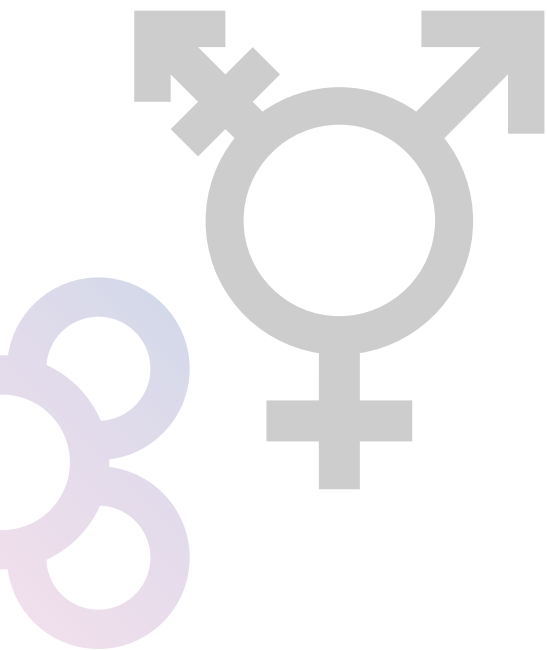
In fact, a large portion of the community of care professionals that work with trans people consider the depathologising model to be the most appropriate, but there are few that apply it through to the end. Depathologisation means removing the evaluation carried out by psychologists and psychiatrists, and replacing it by "informed consent". This involves more than the signing of a form by the user before embarking on any treatments: it means granting the full decision capacity to the person, while the health professional offers all the information available to the user and supports them - whenever the person want this - during the subjectification process.

On the other hand, it has to be considered that trans people are not a homogeneous group. The diversity among them means that it cannot be assumed that they all need the same care or the same resources. There are those that feel they are the "opposite gender" to the one assigned at birth, those who do not identify with the normative models of male and female, those who are confused, those who are very clear that they do not feel that their assigned birth gender is the right one, but are not sure how to find personal satisfaction and balance, etc. Similarly, the needs of trans people in relation to healthcare services vary hugely depending on their personal characteristics, the level of suffering developing a non-normative gender identity entails, their body experiences, the ideas they have on gender, their expectations regarding the transition, how they want to go through the transition and how far, etc.

⁵ <http://www.stp2012.info/old/es/objetivos>.

As a result, not all trans people want to have an operation or obtain the body effects resulting from hormone treatment. Furthermore, apart from hormone-surgical treatment, there are a series of treatments linked to promoting health that are particularly significant for these citizens, such as gynaecological care or analyses to control the effects of the hormone therapy. As a result, the public health network professionals, and particularly those in primary healthcare, need to have adequate information and training so that they can meet the requirements of this diverse group of citizens, whether through direct assistance or referring them to specialised services.

Finally, the care of trans people should not always be under medical services, which is what currently occurs in Catalonia. Due to extreme social transphobia, these people experience daily violence, discrimination and exclusion, which must be combated in different areas (work, legal, education, etc.) In this regard, it is necessary to create a municipal comprehensive care service that focusses on the psychosocial and community aspects, capable of acting on the different axes of inequality and guaranteeing the fundamental rights of trans people.



1.2 Legal framework

At the end of the 20th century, various international political authorities and organisations demanded a change in the model in terms of the conceptualisation, care and recognition of trans people. The UN General Assembly declaration on gender identity, sexual orientation and human rights (2008),⁶ the resolution of the European Parliament that endorsed the UN declaration (2011),⁷ the Yogyakarta Principles on the Application of International Human Rights Law in relation to Sexual Orientation and Gender Identity (2007)⁸ and the report on human rights and gender identity by the European Commission of Human Rights, Thomas Hammarberg (2009)⁹ request the elimination of psychiatrisation of transsexuality and they emphasise that free expression of gender identities must be understood as a basic human right. From this perspective, it is considered that the rights of trans people may be violated if two of the main pillars of the biomedical paradigm are maintained: the consideration of transsexuality as a mental disorder and the need for psychiatric evaluation as a requirement to access hormone and surgical treatment for body modification.

Along the same lines, in 2012 the Parliament of Catalonia made a request¹⁰ in an institutional declaration for transsexuality to be excluded from the mental disorder catalogues and for the equality and dignity of trans people to be recognised. Furthermore, the approval of Act 11/2014, defending the rights of LGBTI people,¹¹ offers the necessary regulatory framework to build a non-pathologising care model that respects trans diversity. The Act aims to guarantee comprehensive care to transgender people under equal conditions and the participation of the person in the decision-making (Art. 16). It also specifies that transgender people should be able to obtain what is established by the law without any need for a gender dysphoria evaluation¹² (Art. 23).

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6 https://www.oas.org/dil/esp/orientacion_sexual_Declaracion_ONU.pdf.

7 <http://www.europarl.europa.eu/sides/getDoc.do?pubRef=-//EP//TEXT+TA+P7-TA-2011-0427+0+DOC+XML+V0//ES>.

8 <http://www.refworld.org/cgi-bin/texis/vtx/rwmain/opendocpdf.pdf?reldoc=y&docid=48244e9f2>.

9 http://www.genrespluriels.be/IMG/pdf/Human_rights_and_gender_identity.pdf.

10 http://www.parlament.cat/web/activitat-parlamentaria/declaracions-institucionals/index.html?p_format=D&p_id=115596163.

11 http://portaljuridic.gencat.cat/ca/pjur_ocults/pjur_resultats_fitxa/?documentId=672704&action=fitxa.

12 Remember that "gender dysphoria" is the diagnostic category that refers to transsexuality in the most recent version of the DSM.

The well-being of many trans people also depends on the legal requirements to access the change in name and gender in official documents and registers. The administrative recognition of gender identity is a vital tool for combating transphobia and guaranteeing equal opportunities, as an ID document that does not reflect the identity of the person may lead to problems when accessing the job market, public services, leisure centres, and so on. In 2007, the Spanish regulatory law for changing the gender of people in official registers was approved,¹³ excluding the obligation of the person to have had genital reassignment surgery in order to access the register change¹⁴ (Art. 4.2). Nevertheless, it is essential to submit

a "gender dysphoria" psychiatric evaluation (Art. 4.1.a) and to undergo hormone treatment for at least two years (Art. 4.1.b). These requirements violate some international declarations and reports, such as the Yogyakarta Principles and the Hammarberg report, which underline that nobody should be obliged to undergo medical treatment to obtain the legal recognition of their gender identity. In this regard, the laws in Argentina (2012),¹⁵ Denmark (2014)¹⁶ and Malta (2015)¹⁷ do not demand any therapy requirement to access the change of gender and name, as they are based on the principle of self-determination of one's own gender and the right to body integrity.

¹³ http://www.boe.es/diario_boe/txt.php?id=BOE-A-2007-5585.

¹⁴ Before the Act was approved, all registry changes were processed in the courts. The Supreme Court maintained the firm position of demanding hormone and surgical treatments for reassigning the primary and secondary sex characteristics in accordance with the desired gender.

¹⁵ http://www.tgeu.org/sites/default/files/ley_26743.pdf.

¹⁶ http://www.ft.dk/RIpdf/samling/20131/lovforslag/L182/20131_L182_som_fremsat.pdf.

¹⁷ <http://justiceservices.gov.mt/DownloadDocument.aspx?app=lp&itemid=26805&l=1>

1.3 Healthcare protocols and models for trans people

The Standards of Care (SOC) drawn up by the World Professional Association for Transgender Health (WPATH) have become the care protocol of reference all over the world. The content has been revised various times and the most recent version (the seventh) was published in 2011.¹⁸ This version gathers together some of the demands from political organisations and trans associations, which is a clear difference to the previous editions. Some of the most notable new additions are as follows:

1. It is considered to be a flexible guide that should be adapted according to the context, the care teams and systems, and the needs of each trans person.
2. It recognises the diversity of gender expressions and accepts the existence of different therapy options.
3. It urges healthcare professionals not to impose a binary vision of gender and to increase their knowledge of identities and expressions of gender variance.
4. It accepts that any healthcare professional with knowledge of behavioural health and gender matters will participate in all the phases of the treatment process (which also includes primary healthcare professionals).
5. It insists that the well-being of trans people not only depends on good clinical care; it also requires a social and political environment that guarantees their rights and full citizenship.

While there are a great variety of healthcare models for trans people at an international level, most of them are based on either of the two existing major paradigms: pathologisation and informed consent. Many European countries, including Spain, have healthcare services that use a standardised therapy itinerary that makes psychiatric evaluation an obligatory requirement to access treatment. Meanwhile, some parts of Canada and the USA have implemented a care model based on informed consent. In this model, the task of the healthcare professional is to offer information, support and advice suited to the needs of each trans person during their change process.¹⁹ The person has the final word over all the decisions made, which means that the diagnostic evaluation is eliminated and the treatment is adapted to the different time scales and expectations.

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18 WPATH (2011). *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*. http://www.wpath.org/uploaded_files/140/files/SOC%20-%20Spanish%20v2.pdf.

19 Spanish Network for Trans Depathologisation (2010), *Guía de buenas prácticas para la atención sanitaria a personas trans en el marco del sistema nacional de salud*. <http://www.aldarte.org/comun/imagenes/documentos/STPpropuestasanidad.pdf>.

1.4 Comprehensive care centres: experiences of other countries

Understanding that the well-being of trans people not only depends on good health care, but also on their full social inclusion and no transphobia experiences, some public administrations and NGOs have set up comprehensive care centres that go beyond health care. There is a wide disparity of models in terms of management, financing, services offered and the profile of the staff working in these types of centres. In addition, in the majority of cases, these are programmes for trans people that are integrated into LGBT centres. In recent times, however, centres

and programmes specifically for these citizens have been set up in Colorado (USA),²⁰ British Columbia (Canada)²¹ and the United Kingdom.²² Despite not having the information necessary to make a detailed assessment of these centres, we can point out the main services that they offer: reception (online, telephone and onsite), information on health resources, mutual help groups, socialisation spaces, educational activities for teachers, students and public service staff, legal and employment advice, cultural and awareness initiatives, and so on.

²⁰ The Gender Identity Center. <https://www.gic-colorado.org/>.

²¹ Transgender Health Information Program. <http://transhealth.vch.ca/about/vision-mission>.

²² Gender Identity Research and Education Society. <http://www.gires.org.uk/what-we-do>.

2. ASSESSMENT OF THE HEALTHCARE SITUATION IN THE CITY OF BARCELONA FOR TRANS PEOPLE

2.1 Methodology

In order to analyse the situation of trans people and the specialised healthcare services in the city of Barcelona, as well as to draw up some recommendations and guidelines to define a comprehensive care service, several data collection techniques have been used. The assessment of the Gender Identity Unit (UIG) and of Transit has been carried out using data obtained through the PhD thesis of Jordi Mas, *Subjetividades y cuerpos gestionados. Un estudio sobre la patologización y medicalización del transgénero* [Managed subjectivities and bodies. A study of the pathologisation and medicalisation of transgender].²³ In this research study, carried out in Catalonia between 2010 and 2014, 41 trans women and 13 trans men were interviewed, as well as 10 healthcare professionals who work with these citizens (7 of whom work or have worked in the UIG and 2 in Trànsit). Furthermore, a discussion group was organised with 7 trans women, a participatory observation was carried out at events organised and/or aimed at trans people, and an online forum in Spanish was also observed. In order to analyse Trànsit, data and statements collected from the professionals working there were used: Rosa Almirall (gynaecologist) and Soraya Vega (psychologist). It should be pointed out that, during the preparation of this report, we contacted the UIG on various occasions in the hope of interviewing the people who worked there, but they declined.

We also went to a Generem! association meeting to make note of their opinions, and a meeting was organised with the majority of the trans organisations in the city (ATC, EnFemme, Espai Trans, Chrysallis and Generem!) in order to discuss the first draft of the report and to debate their suggestions and requests. Even though the Association for Parents of Gay, Lesbian, Bisexual and Transsexual Children (AMPGIL) could not attend the meeting, they sent their contributions by email. Ramon Escuriet and Anna Rubio, officers from the Department of Health of the Generalitat regional government of Catalonia, were interviewed in order to gather data on the healthcare service for trans people.²⁴ Finally, trans people and/or experts in LGTBI matters gave their opinions, such as Andreu Agustí, Gerard Coll-Planas and Miquel Missé.

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²³ http://diposit.ub.edu/dspace/bitstream/2445/64043/1/JMG_TESIS.pdf.

²⁴ All the data referring to the UIG have been provided by the Department of Health of the Generalitat regional government.

2.2 The Gender Identity Unit of Hospital Clínic in Barcelona²⁵

In the Spanish state, each autonomous region makes the decision to include genital reassignment surgery in their portfolio of complementary health services. Due to the Generalitat regional government of Catalonia's decision to finance this type of surgery, since 2008 CatSalut has officially recognised the Gender Identity Unit (UIG) of Barcelona's Hospital Clínic as the unit of reference and referral for the care of trans people living in Catalonia.²⁶ The UIG is part of the Adult Mental Healthcare Centre of the same hospital and it is made up of a multidisciplinary team: a clinical psychologist, two psychiatrists, a child-youth psychologist and psychiatrist, two endocrinologists, a gynaecologists, two plastic surgeons and administrative support professionals. The care is organised around the so-called "triadic therapy", which involves the following three phases: real life experience,²⁷ hormone therapy and sex reassignment surgeries.

549 people were attended to in the Unit between 2000 and 2009. While 32 sex reassignment operations were carried out in 2010, this figure has dropped considerably due to the policies to reduce healthcare spending. The data provided by the official bodies (Ministry of Health and CatSalut) confirm this decrease: there were 15 surgical procedures in 2012, one less than in 2011.²⁸ The drop in the number of operations has resulted in a significant increase in waiting times, which has led to many complaints by the users. The waiting time in 2012 was between three and five years, depending on the type of surgery, a waiting time which has been extended even more now due to budget cuts.

The UIG is based on an authorisation model, whereby access to hormone and surgical treatment depends on the decision of a mental healthcare professional. All trans people who want to initiate the process to modify their body in the UIG must undergo a diagnostic evaluation by the clinical psychologist and a psychiatrist. To carry out the diagnostic evaluation, the professionals make use of the psychobiography prepared by the user during the medical appointments, the criteria established in the DSM-5 and a set of psychometric tests (such as the Minnesota Multiphasic Personality Inventory).

²⁵ The original name of this service was the Gender Identity Disorder Unit (UTIG).

²⁶ Doctors of Hospital Clínic were already attending to trans people voluntarily and unofficially since the 1980s.

²⁷ Real life experience is a diagnostic confirmation tool that consists in the trans person adopting an appearance in accordance with their gender identity. This is one of the most controversial aspects of the therapy, as the numerous associations consider that it obliges the trans person to develop highly stereotyped gender roles.

²⁸ Moreno, Cristina (23 April 2013): "The transsexual collective, victim of the healthcare expenditure adjustments despite the promises of the PP political party". *Público.es*. <http://www.publico.es/actualidad/454215/el-colectivo-transexual-victima-de-los-ajustes-sanitarios-pese-a-las-promesas-del-pp>.

According to our analyses of the interviews conducted with the users,²⁹ the UIG prioritises the care of those people that are most similar to the ideal of transsexuality created by biomedicine.³⁰ Therefore, those people that reject their assigned birth gender and have strong feelings against their genitals, who are heterosexual and who, at the time of the first interview, have adopted the appearance of being socially connected to the target gender and request genital surgery, tend to obtain the evaluation during the first two protocol appointments and get quick access to hormone treatment. On the other hand, people who do not fit in with this ideal often find that their evaluation can take up to month, or that their request to access treatment is in fact rejected.

In terms of hormone treatment, the majority of users interviewed positively valued the fact that the Catalan public health system finances and supervises this treatment. In some cases, however, they complained that the UIG offers a treatment that is too standardised that is not adapted to the variety of needs and expectations of trans people. The

most negative evaluations were from people that wish to limit the taking of hormones for various reasons: they don't want to be a stereotype, or they want to carry out minimal body changes, so that they continue to pass unnoticed in an environment where people are not aware of their reality, or, in the case of trans women, because they actively use their penis during sexual relations.³¹

As for sexual reassignment surgeries, the UIG accepts that not all trans people want to undergo genital surgery (vaginoplasty in the case of trans women and phalloplasty or metoidioplasty in the case of men).³² This is not the case, however, with two of the main surgeries for trans men: the hysterectomy (uterus and ovary removal) and mastectomy (breast removal). In this regard, some trans men that want to keep these sexual characteristics criticise the fact that the UIG pressurises them to have the operation. These people complain that the UIG seeks the maximum body transformation of the person so that there is no ambiguity regarding the two socially legitimate genders.

²⁹ For more information, see the annexe on the statements of trans people in relation to the Hospital Clínic UIG.

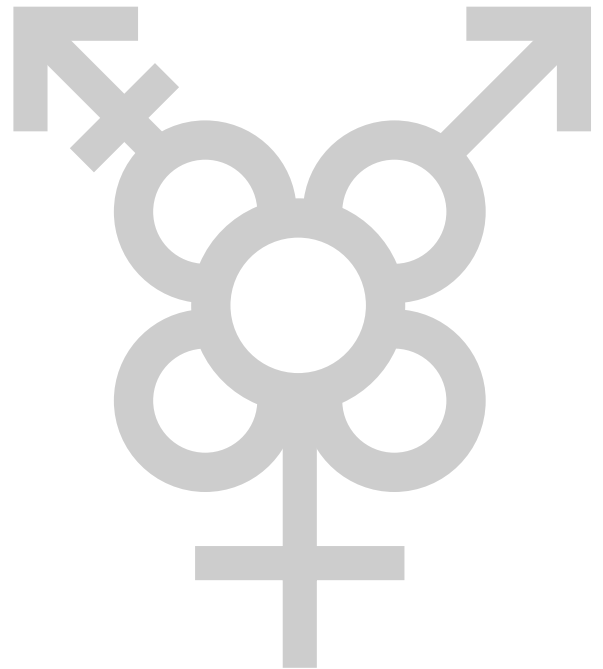
³⁰ During the interview that we conducted with the technical staff from the Department of Health, we were told that the Department has urged the UIG to draw up some criteria regarding the prioritisation and management of the waiting lists for hormone and surgical treatment. However, they were not able to confirm whether or not it had been drawn up.

³¹ In this last case, the main component that they want to avoid is cyproterone acetate (marketed under the brand name Androcur), an anti-androgen that decreases erection and orgasm.

³² Phalloplasty is a technique where a neopenis is constructed using skin from other parts of the body (abdomen, groin, leg or forearm) and metoidioplasty consists of giving the shape of a micropenis to the clitoris that has developed thanks to hormone therapy.

To sum up, the evaluation of the service user who receives care at the UIG depends largely on their body and identity project. Those that are closer to the transsexual archetype tend to see the diagnostic process as a simple procedure in order to access the treatment, they rate the care given by the community of mental health professionals positively, and they consider that the hormone and surgical care is appropriate as it meets their expectations of maximum body transformation (although they complain about the long waiting times). Nevertheless, those with a heterodox life story, who wish to keep some of the sexual characteristics of their assigned gender and who explore

areas of identity that are not the standard male-female pairing, consider that the UIG does not attend to their needs adequately. This is actually a violation of Article 16 of the Catalan law on the rights of LGBTI people, as the public health system is not offering care under equal conditions and is limiting the participation of the person in the decision-making. Meanwhile, all the trans organisations contacted in order to produce this report (Associació de Transsexuals de Catalunya, EnFemme, Espai Trans, Chrysallis and Generem!) coincide in considering that this service needs to be re-addressed in order to establish non-pathologising and more comprehensive care.



2.3 The Trànsit service of the Catalan Healthcare Institute.

Trànsit started up in 2012 on the personal initiative of a gynaecologist and a midwife with the basic goal of promoting the health of trans people (pap tests, mammograms, prevention and detection of STDs, etc.) This type of care is not usually offered in UIGs (which focus on the hormone-surgery process) or in primary healthcare centres (as the majority of professionals are not aware of the needs of these citizens). Subsequently, it was decided to extend the offer of services with the prescription of hormone treatment as well as its assessment and supervision, and a new line of care was implemented: psychotherapeutic support by two psychologists who work part-time. The initial idea of Trànsit was to offer care to trans people residing in the city of Barcelona (it provides its services in the CAPs (primary healthcare centres) of Manso and Numància), but there are currently many requests from all around the Catalan region. However, there is presently no agreement between Trànsit and CatSalut, as the health care of trans people lies exclusively with the UIG.

Nowadays, Trànsit seeks the following goals: 1) Support trans people during their entire identity and body construction process; 2) support the people close to them (family members, friends, partners and teachers); 3) raise awareness among healthcare, education and media professionals about the trans reality; 4) train healthcare professionals so that they can attend suitably to the requests of trans people; 5) write up the medical and psychologist reports that are legally necessary to access the gender and name changes in registries. In order to achieve these goals, Trànsit is divided into two interrelated services: Trànsit-AM, to attend to medical matters, and Trànsit-AP, to provide therapeutic support.

Trànsit - Medical Support

In Trànsit-AM, it is considered that the decision to start body modification treatment should not have to be pre-empted by a psychiatric evaluation. It is understood that health care is a collaborative process between professionals and trans people that ought to focus on the needs and expectations of the person at all times. In this service, the person's life story is actively listened to in relation to their identity construction process and the questions that they might have throughout the process. The support received by close family and loved ones, and by the education and work spheres are also studied. In terms of hormone treatment, the information and advice required is offered from a non-binary view of gender and recognition of the diversity of trans subjectivity and bodies. This means respecting the decision of the person at all times in relation to the type and time frame of the hormone treatment. The person also decides if they wish to be referred to Trànsit-AP so that they themselves or those close to them can receive psychotherapeutic support. Trànsit-AM also promotes the referrals of trans people to mutual help and support groups.

Trànsit - Psychological Support

In Trànsit-AP, psychotherapy is not considered to be a cure or evaluation technique for any type of mental disorder; it is an intervention that facilitates the personal growth and development process of the person's psychic autonomy. The care in this service is organised around the following guidelines: 1) Support in psychosocial aspects of the person always has to be at the request of the person themselves; 2) the health-care professional is an information, advice and support provider; the final decision lies with the person and only the person; 3) support has to be provided during the identity construction process, respecting and strengthening the person's subjectivity; 4) the autonomy of trans people has to be reinforced during their transition process; 5) the expression of gender is diverse and unique to each individual and has to be considered as such.

The fact that Trànsit has opted for a care model based on informed consent means that this service has become a place of reference for all those who want to receive non-pathologising health care. There are people who go to Trànsit with more normative identity and body projects, but also those that do not wish to attend the UIG because they do not want to undergo the standardised treatment. This could be, for example trans women that want to adjust the hormone treatment to suit their needs, or trans men that do not want to undergo a mastectomy or hysterectomy (surgeries that are considered to be essential in the UIG).. Basically, people that do not fit the prototype of the transsexual person taken as the reference in the UIG.

Care model summary/table

	UIG	Trànsit
Definition of transsexuality/transgender	Gender identity disorder (GID) / gender dysphoria DSM-5.	Another expression of gender diversity.
Theoretical model	Obligatory psychological/psychiatric evaluation. Differential evaluation based on the DSM-5.	Informed consent. Psychotherapeutic support at the request of the person.
Definition of the problem	The professionals evaluate the person's identity. The transition treatments can only be accessed with the evaluation. Standardised protocol for everybody.	Only the person can define their own identity and their therapeutic needs after receiving objective information. Each person has their own individual journey of transition.
Method	Authority to permit or refuse the person access to hormone and/or surgical treatment.	Provide access to the transition treatments actively listening to the needs of each person.
The medical or therapeutic professional	The professionals lead the process. Standardised protocol for everybody.	Professional capable of active listening and adapting the treatments to the needs of each person with ongoing collaboration.
The user	Patient of a service / passive agent.	Capable of receiving information and making decisions according to their needs / active agent.
Conclusions	Model based on transsexuality as a disorder. It creates an issue that needs a solution and, sometimes, excludes people that do not respond to the model created by biomedicine.	Depathologising model, based on the concept of identity as a human right. More comprehensive model of all types of trans people.

Care service data

Service	Trànsit	UIG
Waiting time/first appointment	Trànsit-AM: 1-7 days Trànsit-AP: 3 weeks	No data available
Waiting time first care/hormone treatment	87 % HT on first appointment	No data available
People excluded from hormone treatment	0	No data available
Total no. of people attended to	Trànsit AM: 442 (October 2012 - January 2016) Trànsit AP: 111 (May 2013 - January 2016)	1,045 (2000 - 2014) 321 (2012 - 2014)
Referral to the UIG 2015	Trànsit AM: 26 Trànsit AP: none (everyone is told about the service)	
First psychology/psychiatry appointments	101	No data available
First hormone treatment appointments 2015	171	No data available
Second psychology/psychiatry appointments 2015	558 total appointments in the therapeutic process (maximum: 10 appointments per person/family)	No data available
Second hormone treatment appointments 2015	520	No data available
Therapy support group attendees 2015	Total: 43 people (three editions: 2013/2014/2015)	No data available
Number of mastectomies 2015		49 (2008 - 2014)
Number of vaginoplasties 2015		70 (2008 - 2014)

2.4 Minors with non-normative gender

We have recently been helping to create awareness about a sizeable number of minors and adolescents that express various identities and do not meet the gender orders that have been assigned to them at birth. If we recognise that the trans fact is another form of development of gender identity, just as legitimate as the others, and not a disorder, we can see that amongst these minors, there is a large variety of experiences, occurrences and behaviours. Nevertheless, these people often have to face social pressure and numerous types of discrimination because they don't adapt to the gender norms.

When a situation like this arises in a family, alarm bells go off and there is great concern: concern for the minor's happiness, because the parents don't know how and what they are dealing with, because they find it difficult to support certain gender expressions when they know that they are not socially accepted with normality, etc. In the best case scenario, when they accept the forms of expression of their son or daughter without any difficulty, they are unsure of the best way to support them and to build up their self-esteem. Among other things, this is due to the well-known fact that while we live in a society that prides itself on individual liberty, people who are different continue to be punished socially. Sexual and gender diversity are not considered to be social assets, and direct and indirect discrimination occurs frequently.

Mothers, fathers, healthcare staff and teachers wonder what to do when a girl or boy feels that their gender is different from the gender assigned to them at birth or when they demonstrate behaviours, tastes or play games that do not correspond to those they should be developing socially. This diverse reality needs to be addressed properly to determine the exact needs of these people and how to deal with them and their environment. Legitimising the desires of the minor, putting the family's mind at rest, reducing the gender labels in primary and secondary schools, and working in schools to promote respect for sexual and gender diversity are important tasks for minimising pressure and discrimination.

From the healthcare point of view, the most recent version of the Standards of Care (WPATH, 2011) opens the door to starting hormone treatment during puberty in the case of people who, throughout their lives from when they were young children, express a strong desire to represent a gender other than the one assigned, provided there is total agreement between the medical team and the minor's guardians. As there is no international consensus on the aptness of giving treatment to minors, there are some limitations according to the Tanner Stages, the scale that defines the development of primary and secondary sexual characteristics. The Standards establish that girls and boys have to be at least in Stage 2 (10-13 years of age) to receive a reversible treatment that stops pubertal development. Once they are 16 years old, they can start cross-sex hormone therapy. As regards sex reassignment surgeries, the Standards establish that the person must be the legal age of majority established in each country.

Care provided to minors in the Gender Identity Unit of Hospital Clinic

In Hospital Clínic, minors with gender diversity are attended to by the Psychology and Psychiatry Service for Children and Adolescents (SPPIJ), which keeps in constant contact with the UIG. If the professionals consider it appropriate, therapy with puberty blocker hormones is provided to minors who are in Tanner Stage 3 (11-13 years of age). If the minor accepts the changes well and continues to want body transformation, they can start taking sex steroids at 15-16 years of age. The SPPIJ comments that it is very important to be careful in the diagnostic evaluation of children as the majority of "gender dysphoria" evaluations in childhood do not persist as time passes. With regard to the care of younger children (who don't receive any type of pharmacological therapy), parents are made aware that they are not to repress the desires and behaviours of their children and to offer them personal development spaces, while at the same time protecting them from possible conflictive situations with people in their environment, such as school peers. If it considers it appropriate, the SPPIJ can contact the education centres to explain the minor's situation and thereby facilitate their educational integration.

Trànsit - Psychological Support. Care provided to families of minors with gender diversity

The support given to minors (up to the age of 15) with gender diversity at Trànsit AP is directed at the families of these children and adolescents, as this centre does not have a specific child psychology service. The first appointment is conducted with the parents and/or extended family of the minor, depending on what the adults decide. In 90% of cases, these appointments are only conducted with the parents. The most frequent request is for information about how to act when a diverse gender expression by the minor is detected. In these cases, clear information about gender diversity is offered, emphasis is placed on the importance of supporting the child or adolescent in their identity construction process and respecting what they need without expressing prejudices. The advantages and disadvantages of making the social transition during childhood are also discussed. It is possible that the fear and the burden of the responsibility felt by the parents as they make decisions on their child's health are addressed in subsequent appointments, as well as the frustration and fear of having to challenge a system that discriminates. Furthermore, ways of communicating the diverse identity of their child to those around them are also explored. Information is also provided about existing resources, such as family support associations (Chrysallis and Grup de Famílies de Persones Trans), as socialisation is key to combating the anxiety caused by these situations.

Trànsit - Medical Support. Health care of trans minors

Apart from the support given to the families of trans minors, Trànsit- AM gives advice on the possible therapeutic actions that can be carried out on the onset of puberty:

- Let the pubertal process take its course while looking out for any signs that the body changes are upsetting the minor, all the time reinforcing their self-esteem. The future advantages of not stopping the pubertal changes also need to be pointed out (reproduction, sexuality, understanding the biological fact).
- Do not let the pubertal changes take their course using puberty blockers, while explaining the advantages and disadvantages of this treatment.
- Start hormone treatment for the target sex when the pubertal changes are already very evolved and cause discomfort, or after the age of 15 in the case of having opted for the use of puberty blockers.

The decision on which path to take is made by the parents together with the trans minor, advised by the Trànsit-AM professional on the possible advantages, disadvantages and unresolved questions in the health care of trans minors. Medical reports are also offered so that these minors are treated in accordance with their gender identity, which helps their socialisation in the areas of education, health, leisure, etc.

Data on minors attended to in the health services

		Trànsit-AM	Trànsit-AP	UIG
All minors attended to		41 (November 2012 - January 2016)	11 families (Total appointments 30)	74 (2008 - 2014)
	4-11 years	6	6	
	12-14 years	7	0	
	15-17 years	25	5	
First appointments minors 2015		26	6	No data available
	4-11 years	6	2	
	12-14 years	4	0	
	15-17 years	16	4	
Waiting time/ psychological care			3 weeks	No data available
Waiting time/ first medical care		1-4 days		No data available
Waiting time/ start blockers		*		No data available
Waiting time first care/hormone treatment 12-17 years		16/28** start HT on first appointment 6/28 (1-3 months) 6/28 don't start		No data available

* Two minors are in treatment with blockers given in other centres.

** Two minors have started hormone treatment in another centre.

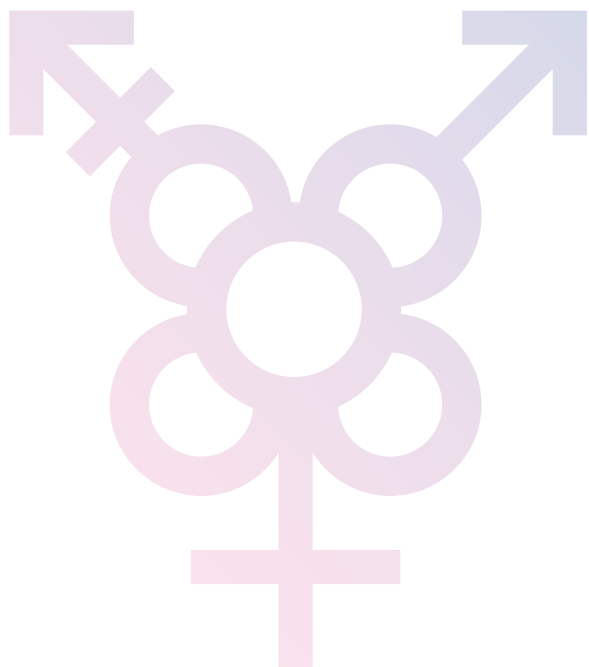
3. RECOMMENDATIONS FOR THE EFFECTIVE RUNNING OF THE PUBLIC SERVICES AIMED AT TRANS PEOPLE

In this section, a series of specific actions and recommendations are proposed to enable the municipal public services to attend to the needs of trans people appropriately, guaranteeing their rights and contributing to the fight against transphobia. We understand that these recommendations put to the City Council must be transmitted to the Generalitat regional government of Catalonia in order to guarantee that the healthcare services throughout the Catalan region attend to these citizens appropriately.

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3.1 Guarantee comprehensive, non-pathologising health care

The healthcare services need to attend to trans people with a depathologising and humanist approach, considering the trans condition as an expression of diverse gender and not as a disorder. To achieve this, the following recommendations are put forward:

- The Barcelona Health Consortium should prompt a debate with the interested parties (without forgetting the trans organisations) on the existing healthcare models.
- The community of primary and specialised healthcare professionals needs to have minimum competences in gender diversity and transition processes, and should at all times respect the subjectivity, autonomy and decision-making capacity of the person.
- It is essential to shift from the model based on a psychiatric evaluation to informed consent, understanding the latter to be a process where the person voluntarily receives information, advice and support, and is ultimately responsible for their decisions.
- The care from the healthcare professional must be personalised and should take into account the possible variants of intervention: hormonal, surgical and psychotherapeutic care, just one of these, or none at all.
- The care should go beyond the hormone and surgical treatment. The health promotion services for these citizens should be fostered (gynaecological care, cardiovascular risk evaluation, prevention of STDs, etc.) as well as certain specialised services (such as speech therapy for feminising the voice).
- The professional staff have to help the trans person connect with peer networks as an element of integration and reinforcement of the process itself. This is why minimum knowledge of the associative network and the social networks existing in their region is so important.
- Healthcare protocols including care to minors have to be developed.
- The Generalitat regional government of Catalonia needs to draw up a strategic comprehensive healthcare plan for trans people to be implemented in the Catalan region for 2016-2020, which takes into account the prevention/promotion of health and care during the transition processes. This plan must be based on the concept of informed consent and should be linked to the primary healthcare services.
- It is necessary to assess the possibility of carrying out a pilot of the plan in a municipal healthcare centre.

3.2 Promote actions to combat transphobia and foster respect for gender diversity

The extreme discrimination associated with the gender identity of trans people impacts on their quality of life and that of their families, it restricts their access to rights and resources, and makes the personal autonomy and social integration process difficult. To counteract this problem, Barcelona City Council should:

- Develop information and awareness campaigns/programmes and campaigns to raise the visibility of the trans experience and the effects of transphobia, aimed at public service staff.
- Become involved in the organisation of public awareness-raising campaigns to raise awareness of the reality and problems of this group of people.
- Give support to the collectives in their fight to reform laws that attack the rights of trans people (such as Act 3/2007, on changing gender and name).
- Maximise the initiatives to raise awareness of and promote trans culture that are carried out in the city using a permanently updated trans virtual agenda.
- Achieve more involvement and commitment from the Catalan Media Corporation (CCMA) regarding the broadcasting of the trans fact using a destigmatising approach with respect for diversity.
- Finance the preparation of reports and studies that look in detail at the needs of trans people (childhood, adolescence, ageing, physical changes, etc.) in order to improve the implementation of public policies.
- Promote inter-administrative collaboration so that each Administration promotes the fight against transphobia within the scope of their competences.

3.3 Promote coordinated actions between the different social, education and healthcare services in relation to the trans fact during childhood and adolescence

The childhood and adolescence stages are ages of risk for the development of the identity of people that present non-normative or different gender roles to those that society distinguishes according to the assigned gender. Within what we today call "trans minors" there are a large variety of situations, which range from curiosity to explore the different gender expressions to the conviction of belonging to a gender different to the one assigned. In order to guarantee the well-being of children and adolescents with these needs while respecting their identity, a series of measures needs to be followed:

- Guarantee that the minor is treated according to their perceived identity in education and healthcare centres, and not according to the assigned gender. This recognition should take place without the guardians needing to present a psychiatric evaluation.
- Organise awareness courses for teaching staff.
- Prevent gender labelling in schools, by proposing that the changing rooms, bathrooms, clothes, etc. are not structured according to the sex and binary system of genders.
- Promote learning actions among primary and secondary school pupils on respect for gender diversity.
- Draw up action protocols in education centres that have trans students or with gender diversity.

3.4 Promote actions for active community insertion of trans people

It is important to encourage the active participation of trans people as city residents. The appropriate conditions need to be generated to increase the empowerment and skills of this population, and, to this end, the following is recommended:

- Guarantee that, in all municipal administrative processes, the trans person is treated according to the name they have chosen, even if they have not changed their name in the register. It is also recommended that, provided the law so permits, the municipal documents and registers should respect the desired name and gender.
- Encourage people to join associations and promote the public and social participation of trans people and their families.
- Ensure that the public policies of the City Council, bearing in mind the new Catalan law on the rights of LGBTBI people, have an intersectional consideration of the trans fact (taking into account variables such as ethnic group, age, gender, cultural and economic capital, etc.)
- Recognise the trans organisations as an element of active support and participation in the designing of public policies and strategies.
- Promote the mutual help groups directed both at trans people as well as their families.
- Design action strategies aimed at the families of trans people in order to promote an outlook based on the free expression of identities, which challenges binary and normative gender stereotypes.

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Especially during the transition process, but not exclusively, many trans people have problems living and developing in normalised environments: adolescents who have to leave home due to lack of understanding from their families, people who lose their job when they initiate the transition, people who don't find work because they don't have official documentation with the desired name and gender, elderly people who have to go to a retirement home where they cannot express or develop their identity, etc. In this sense, it is important that Barcelona City Council stands as a fundamental pillar when guaranteeing that the basis needs of these people are met.

3.5 Promote initiatives to foster the labour market insertion of trans people

One of the fundamental keys to the social integration of any person is their insertion into the workplace. This is of particular significance in the case of trans people, as they are one of the collectives that suffer most from labour market exclusion. Having a decent job does not only guarantee income for carrying out their life projects (including non-financed treatments); it is also an essential tool for empowerment and assertiveness. Taking into account the study carried out by Miquel Missé and Gerard Coll-Planas³³ on the existing resources for the labour market insertion of trans people in the city of Barcelona, the following recommendations are made:

- Implementation of a guidance, training and labour market insertion plan for the trans population with positive discrimination measures to facilitate the hiring of trans people, particularly in the public sector.
- Training and awareness-raising for companies in order to avoid situations of discrimination against trans people.
- Give special attention to sex workers. In this regard, two types of measures are proposed: 1) Foster the empowerment of sex workers and combat occurrences of violence and stigmatisation; 2) promote career guidance and training for people who want to give up prostitution. To do this, it would be necessary to establish a protocol with the active participation of trans sex workers, taking into account that giving up being a sex worker could not be enforced as a condition for attending these training courses.

³³ Missé, Miquel, and Coll-Planas, Gerard (2015), *Trans-Lab. Avaluació dels recursos d'inserció laboral de les persones trans a la ciutat de Barcelona [Evaluation of the resources for the labour market insertion of trans people in the city of Barcelona]*.

3.6 Improve and promote comprehensive care of trans elderly people in their habitual and residential environment

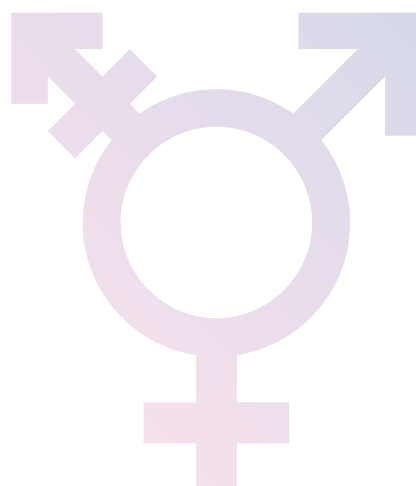
It is very important to take special care of trans elderly people, as they have lived quite a large portion of their life in an extremely transphobic socio-political context, completely unrelated to their needs and requests. The particular social vulnerability attached to ageing (solitude, poverty, dependence) is seen to be worsened in the case of trans people if the social and healthcare services do not jointly develop plans to promote the well-being of these people, to fight against exclusion and to prevent their invisibility and stigmatising treatment. As specific measures, the following are put forward:

- Promote actions that lead to the recognition and repair of the persecution and violence that they have suffered.
- Create awareness of and respect for the identities of trans elderly people, especially in retirement and day centres, where often they cannot express their identity.
- Strengthen the relational networks in order to combat solitude and loneliness.
- Promote studies on the specific needs of this target population.

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4. GUIDELINES FOR DEFINING THE COMPREHENSIVE CARE MODEL FOR TRANS PEOPLE

4.1 Trans Support and Reception Service

In order to implement the recommendations and actions of the previous section, it is considered necessary to create a Trans Support and Reception Service within the LGTB Municipal Resource Centre of Barcelona. Nowadays, there are different resources in the city of Barcelona for the trans population,³⁴ the majority of which are included in more extensive programmes and initiatives aimed at LGTB citizens. The advantage of this form of organisation is that it makes use of already existing resources and offers an integrated outlook on gender diversity, but there is also the risk that the specific needs of trans (often the "T" becomes blurred when acting under the acronym LGTB) people are not duly attended to. Furthermore, Missé and Coll-Planas point out that in the city of Barcelona:

The main shortfall detected if we observe the map of resources in detail is the absence of a service that offers comprehensive quality resources and information, which are not specialised in a single field. Very diverse services are offered, but we consider that a specific space is needed that provides quality information that follows the connecting thread of the rest of the services. Currently, the healthcare services (both Trànsit and the Gender Identity Unit) are the ones that take on these general requests for information about the subject.³⁵

Along the same lines, this report suggests creating a comprehensive care space for trans people in the city of Barcelona, outside the context of health care and with a socio-community perspective, which may provide an outlet for some of the recommendations made above and the actions required to accomplish them. In this Trans Support and Reception Service, connected to the LGTB Municipal Resource Centre, trans people could receive quality information and specific services.

The Trans Support and Reception Service needs to work closely with the existing trans association network in the city, and with the group of public services, in order to refer the users that require it to the specialised resources. The work coordinated with the rest of the services should also serve to identify the main gaps existing in the care for trans people and to promote the initiatives that have already proven to be effective. In order to guarantee that this comprehensive service responds to the requests of these citizens at all times, it is recommended that a Monitoring Committee is created, i.e. a body that is in charge of promoting the joint evaluation and exchange of opinions between the community of professionals and the trans organisations.

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³⁴ See Barcelona City Council (2014), *Guia de recursos per a persones trans de la ciutat de Barcelona*. http://w110.bcn.cat/DretsCivils/Continguts/Multimedies/GUIA_RECURSOS_TRANS.pdf.

³⁵ Missé and Coll-Planas, *op. cit.*

The main goal of the Service must consist of improving the quality of life of trans people and their families, but it must also act to facilitate understanding among the general public of the trans reality and its destigmatisation. That is the only way to address the issues that hamper the well-being of these people: social transphobia caused by a rigid, binary gender system. Next we propose the basic guidelines and the functions that this multicare service should include:

- 1. Reception.** Actively listen and pay attention to the requests of the people to refer them to the necessary resources. In order to work from a perspective of support between equals, a duly trained trans person needs to be the one to carry out this task.
- 2. Information.** Apart from the on-site information given to people who come to the Service, it is important to create a trans space on the LGTB Resource Centre website, with specific information for these citizens which also permits online queries. It is also recommended that a telephone helpline service is promoted (e.g. establishing a timetable for calling specialised professionals) for people that don't have easy access to the internet or who prefer anonymity. Finally, we consider it important to offer employment advice due to the discrimination suffered by these citizens in this area. In particular, information should be provided about positive discrimination measures in terms of active policies for trans people, as well as the different initiatives implemented by the different municipal services, other competent administrations and organisations specifically in relation to employment for trans people (social clauses, employment plans, employment training with professional certificates, youth guarantee programmes and so on).
- 3. LGTB Document Centre.** It is necessary to maximise awareness of the trans subject using bibliographies, audiovisuals, resources for education on diversity, links to studies and relevant works, activist group actions, etc.
- 4. Socialisation and cultural promotion.** For trans people, safe spaces where they can mix with equals are fundamental, especially during the transition process. These spaces, which may be generic or for people and specific issues (adolescents, trans women, elderly trans people, family members, partners, etc.) should have the participation of experts in the trans subject and creating group dynamics. It is recommended that existing initiatives are stepped up (such as the Espai Obert Trans/Intersex).³⁶ It would also be necessary to maximise leisure and recreation spaces where trans adolescents feel secure and can freely express their identity. Special attention needs to be given to the situation of trans elderly people to find out their needs and thereby offer comprehensive care. Finally, artistic and cultural creations that increase the visibility of the trans reality should be promoted in order to help create a social imaginary that respects diversity and fosters the desire for non-normative identities and bodies.

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36 <http://espaitransintersex.blogspot.com.es/>

- 5. Support and mediation.** Support is of particular importance during the beginning of the transition, given that in this stage the person has to decide where and when to come out according to the perceived identity, and this has to occur in safe spaces. In this sense, it may be important to include a mediation process if the trans person and/or their emotional environment face conflicts with the social environment (at school, work, with members of their own family or their cultural/religious group, at the retirement homes for the elderly, and so on).
- 6. Special relationship with education centres and those responsible for education policy** in order to not only facilitate conflict resolution when the minor demonstrates non-normative gender roles, but also to reduce binary gender labels (different services for girls and boys, bathrooms and dressing rooms, clothes, etc.) and to cultivate an education in values that respects diverse forms of being. Specific activities that the Service could develop could include training courses for teachers, workshops with students, LGTB talks in education centres, advice on coeducation topics to challenge gender binarism, etc.
- 7. Legal advice.** Coordinate this Service with the legal advice that is currently offered in the LGTB Resource Centre, while guaranteeing that the professional in charge has the necessary training to deal with all the issues that affect trans people (like changing their name and gender in the official register).
- 8. Psychological support and advice.** Given the specific nature of the trans subject, it is important to have specific psychological advice, which should be differentiated from therapy. This support and advice would consist of a maximum of six sessions and would only be at the request of people experiencing identity conflicts who are not sure what these are due to and what they mean. Clarifying the wishes and personal conviction of a person is a task which, to be successful, must be carried out by a professional that avoids closed mindedness and dares to delve into the vicissitudes of the wishes, taking responsibility for the uncertainties that this could entail. This support should help to establish whether or not transsexuality is the only problem, or if there are other factors that require therapy; considering the pressure of being "different"; differentiating between sexual orientation, non-identification with the dominant male and female models and the desire or conviction to belong to another gender; work on the negative connotations of the trans reality that the person may feel on the inside; help to clarify the image of the trans reality in the life of the user; explore the risks of the transsexual process with the user; work out together how they can express their gender identity in safe spaces and provide the necessary skills to face the problems and harassment caused by social transphobia; draw up psychological reports at the request of the users. If deeper personality problems are detected, due to transphobia or other inter-related issues, the person would be referred to a specific service.

9. Support for the families of trans minors or minors that break away from gender norms through the creation of groups with the families where they can express their anxieties and doubts; advice to enable them to negotiate with schools to ensure their children can be treated in accordance with their perceived gender; the creation of workshops or training spaces to break away from gender binary schemes; psychological support so the wishes and interests of the minor can be legitimised without repressing the expression of their subjectivity. This task needs to be carried out by staff who are qualified professionally and with expert knowledge of the trans subject, from a depathologising perspective.

10. Community and awareness-raising work aimed at all citizens about the trans reality, sex and gender diversity and the effects of transphobia, at all times with the participation of the trans organisations. This community work would consist of promoting specific activities (awareness-raising campaigns in the style of the last municipal campaign against gender-based violence, conferences, workshops, exhibitions, film screenings) and also of giving support to the actions carried out by trans and LGTB groups. As part of the community work, it is important to offer workshops to raise awareness and the visibility of the socio-affective and gender diversity of trans elderly people in retirement homes and places where these citizens usually socialise. These workshops, aimed at the elderly and the community of professionals, are an important psychoeducational tool, as residential and day centres are rarely sensitive to the special, medical and psychosocial needs of trans elderly people.

11. Training for different professional and social collectives on the trans subject, delivered by experts (similar to what the City Council did in the case of gender-based violence). Given the vulnerability of these citizens in terms of harassment and discrimination, the people who work in the municipal services must have the appropriate training to treat these people with respect and to guarantee their rights.

12. Research. Promote and finance research on the trans reality, giving priority to those whose aim is to analyse transphobic violence in Barcelona. In this sense, it is important to search for information, incorporating an intersectional outlook, on the psychosocial and health needs of trans elderly people with the goal of planning psychological, social and medical interventions. Of particular interest is the analysis of the loss of social networks and the fear of showing themselves to be trans people.

Service Staff

Some of these actions may be carried out by the staff working in the LGTB centres, such as legal advice, the documentation service, etc. In this case, however, it should be guaranteed that these staff have the necessary training to adequately attend to the trans population. For the other tasks, it would be necessary to hire specific staff (and assess whether they should be full-time or part-time). The recruitment of trans people is considered to be particularly significant, especially in the case of the person who carries out the first reception meeting, who needs to have the appropriate training to carry out this task, and also the community work. We also think it is necessary to hire a psychologist with experience in the trans subject and a social work/education professional. One of these people should coordinate what is carried out in the service and ensure that the needs of trans people are attended to as required by the services shared with the LGTB Centre and by the rest of public services. It is also recommended that the Municipal LGTB Resource Centre prioritises the recruitment of trans people at risk of social exclusion.



4.2 Comprehensive healthcare service. Recommendations for the Barcelona Health Consortium and the Department of Health of the Generalitat

As has been already mentioned, two interrelated services are needed to carry out all the actions: the Trans Support and Reception Service for the psychosocial and community aspects, and a service (like Trànsit) dedicated to health, which should be reinforced and recognised by the Department of Health of the Generalitat as a centre that facilitates the roll out of regional health care for trans people all over Catalonia. Among the functions that need to be carried out by this Service are:

- Coordination of all the professionals that may have contact with these people such as primary care doctors, nurses, endocrinologists, gynaecologists, plastic surgeons, urologists, paediatricians, and so on.
- Coordination with the plastic surgery services in the event that surgical interventions are required. One of the surgical services would serve as a reference point for the more highly complex interventions (vaginoplasty, vocal cord operations, etc.)
- Designing of protocols to establish the intervention strategies and therapeutic plans (task that must be carried out by a multidisciplinary team).
- Designing, programming and implementation of training for healthcare staff on the needs and specific issues relating to trans people.

As regards the health care roll-out throughout the Catalan region, it is proposed that the Generalitat regional government of Catalonia creates eight care centres for trans people (two per province) located in the primary healthcare centres. Each centre should have two healthcare professionals (one could be a specialist in family medicine, endocrinology, gynaecology or paediatrics; and the other a nurse or midwife), a psychologist, a social worker, an administrative officer and a consultant (the hiring of trans people would be prioritised).

These professionals would receive theoretical and practical training delivered by the Comprehensive Healthcare Centre for trans people in Barcelona. In this way, when they finished their training, they could then train others in their regions, as they would have the same skills as their counterparts in Barcelona (and they could always consult or refer the most complex cases to the reference centre). Once the roll-out has been completed, all the healthcare professionals should have the minimum training required to attend to and duly refer any trans people that attend their services.

ANNEXE 1.

STATEMENTS OF TRANS PEOPLE IN RELATION TO THE HOSPITAL CLÍNIC UGI

Below are some statements given by trans people who follow or have at some time followed the diagnostic and therapeutic process in the Gender Identity Unit of Hospital Clínic in Barcelona. All the data has been taken from the PhD thesis *Subjetividades y cuerpos gestionados. Un estudio sobre la patologización y medicalización de las personas trans*, [Managed subjectivities and bodies. A study of the pathologisation and medicalisation of transgender]³⁷ by Jordi Mas. In order to protect the anonymity of the people interviewed, false names have been used while respecting the real gender.

1. Assessments of the pathologising paradigm and the diagnostic process

The majority of the users of the unit reject the categorisation of transsexuality as a mental disorder and they use the same logical argument that most of us would use; that to have a disorder, the person has to be imbalanced or crazy:

“I have an organised life, I am mature, My work has paid for my studies and my flat. I do not have mental problems, I am not imbalanced. Well, if they want to give me a subsidy for it...” (Andrea).

“I do not agree that it (transsexuality) should be in a psychiatric manual because we are not crazy. And obviously the fact that it falls within the field of psychiatry socially, it is like we are ill.” (Dani).

Nevertheless, there are people who defend keeping transsexuality in the mental disorder manuals for fear of losing public funding of the treatment. It should be borne in mind that, in many countries, both the public health system and private insurance companies finance the hormone-surgical treatment because it is not elective, and this consideration is based largely on the fact that transsexuality is classified as a mental disorder:

“While I don't like the way they consider us to have mental illnesses, I don't think that now is the time to have these debates. We have to be very careful about what we say because they are closing down operating theatres all over the place.” (Jon).

It is noted that, during the diagnostic evaluation, some users reformulate their life stories so that as much as possible it fits in with the transsexual ideal and they can start treatment as soon as possible:

“The main thing was when on the second or third appointment, the psychologist asked me if I had ever thought about having relations with a man (as Elena had stated that she was a lesbian). And I said, “I wouldn’t dismiss the idea, because anything can happen in life. It’s possible. Time will tell”. And this gave her more of a reason to send me for endocrine treatment. I said this so that she would accept me and help me [...] If I hadn’t said it, she would have quickly sent me away and all that.” (Elena).

“Whenever there was a typical trick question, I always gave the answer that the doctors wanted to hear. Otherwise, you don’t get what you want.” (Hans).

Some of the people interviewed that reject the classification of transsexuality in the manual consider the diagnostic process to be part of the formal procedure to access body modification treatment:

“I find that a psychiatric check-up is like a friendly chat: “Hi, how are you?” “Well, today I did this and that and went to such and such a place”.” (Julia).

Others consider the diagnosis to be a positive tool to discard any pathology that may be confused with transsexuality. They also emphasise the treatment received and the role of the mental health professionals when they offer information of interest (“they are the ones who call the shots” —Dani—) and give support during the hormone-surgical process:

“Of course. Everything involves going through an external process. When you have to fill out a form, you have to go through someone. So it’s the same thing. So, there are people that say: “A doctor should not decide my life for me”. Sorry, but prosecutors decide it for you, a judge decides if you have to go to jail, a lot of people make decisions for you. So, who cares if a doctor, just another person, decides something that’s going to be definitive? And maybe during the therapy, he or she will say: “Look, think about it”. We have to go through the process, even if just minimally. It’s like cancer therapy, I don’t know: a diagnosis has to be made, analyses have to be done. Because if they give you an injection that goes wrong, you die. It’s the same thing: if they cut something that they’re not supposed to remove and then you die, the doctor goes to jail.” (Jennifer).

“Very good. [The UIG professional] has always supported me. Not because she is a psychologist, but because she has done more than a psychologist; she knows all about my girlfriend (who has had serious personal problems), and she is the first person that has said to me, “Bring her along some day. I will talk to her”. In my opinion, [the UIG professional] is more than a psychologist. She is a person doing her best to help transsexuals.” (Marcos).

However, the pathologising and medicine-based discourse may cause the trans person to adopt a view of themselves that is pathological and abnormal, taking in the biological discourse of the doctor:

“Basically, just like some people are born with physical problems, like they are missing an arm or a leg, we are born the wrong sex, and this sex is developed at odds to what we really are.” (Bego).

“And I read the clinical evaluation and it really is a physical disease that requires, for the person's well-being, hormone and surgical transformation. Requires, meaning that there is no option.” (Núria).

On the other hand, there are also very critical opinions amongst the users on the obligation to obtain the evaluation. They are people that state that they are fully aware of what is going on with them and what they are looking for, so they are disgusted that they have to be examined by a professional and prove their true feelings:

“I think it is absurd, totally absurd, because I have always been clear about this. I don't think that I need to be, how should I put it, analysed. I often felt analysed. They asked me questions that I thought were totally ridiculous [...] I was thinking, “I have come here, I am sitting here with you now because it is the only solution, but if there were more options then I wouldn't be here. I think it is absurd because I know how I feel” [...] To tell the truth, I don't like going to a place to prove what I am because in reality, you [to the interviewer] don't go anywhere to prove that you are a man, do you? [...] I find it quite ridiculous that a transsexual should have to go to a place... And what is most ridiculous

of all is that the place is a centre for mental problems.” (Andrea).

The most critical voices against the evaluation are from those that “stray” from the paradigm of transsexuality. The professional staff of the UIG recognise that people that are closer to the transsexual ideal (rejection of assigned gender since childhood, distress with genitals, stereotypical adoption of the target gender, heterosexual desire, wish to undergo surgery) constitute, in the words of a UIG professional, an “easy diagnosis” and they usually reach this diagnosis after the two protocol appointments (it is true, of course, that there is follow-up later on). However, there are people with heterodox identity and body projects that find that the evaluation process can go on for months, or they may not even be given the diagnosis. This is the case of Tere, who went to the UIG at the age of 45, and that of Clara, who explains that she dropped out of the UIG after months of arguments with the professionals:

“I think that I went to my first appointment dressed as a guy, because when I decided to take the step, I was talking to Montse. And I said, “I think that I will go dressed as a guy on the first day so that they don't confuse me for a transvestite” [...] I was shocked when I got to the Clínic because I honestly thought that they were going to be nicer. I had it clear in my head that I was going to be completely sincere [...] But I was also sure that I wanted to take this step [...] And yet when I got there, I was totally sincere and there was no empathy whatsoever [...] In the first evaluation, [The UIG professional] she said that she did not think that I was a transsexual, that I was more like a transvestite [...] And yes, obviously they have to discard the wrong cases. But I mean, supposedly you have studied and have qualifications in this and you are able

to detect stuff. Well, a psychologist or a psychiatrist need to have the necessary data. Not to say as soon as they see me, "You are transsexual and you don't need to say anything", But crikey, I explain it to you and you can take the time that you need, but don't tell me on the first appointment that I don't seem to be transsexual." (Tere).

"I am a monster for [the UIG professionals]. They didn't quite say it to me, but they made it very clear. I got various readings from these meetings: I am a monster and I assert my right to be a monster. I have asserted my right to play with cars and play football since I was small and to be the most girlie girl in the world [...] They want clichés; they want people integrated in society that are not a nuisance; they want women who are perfect housewives and tied to the kitchen sink; they want this type of transsexual woman. Anyone that doesn't fit into this box is a monster." (Clara).

One of the aspects of the evaluation that gets the most criticism is the "real-life test", i.e. the trans person adopts the appearance socially bound to the gender they identify with. With regard to this matter, some trans people think that this is a tool that reinforces gender stereotypes, while they demand their right to decide on the type of masculinity or femininity they wish to represent in society,

"What do I have to do? Wear high heels in the shower? [...] And what happens if my behaviour is masculine? How many women are masculine? Do I have to spend all day long painting my nails? [...] A doctor cannot determine what I am like. A doctor can determine a disorder, but not my characteristics. A doctor cannot determine my level of femininity." (Jennifer).

In addition, other people (mainly trans women) point out that it is quite complicated to adopt the appearance of the target gender without having initiated hormone therapy and be included by those around you in the gender that you wish to represent. Not getting recognition lowers the person's self-esteem and can expose them to social transphobia:

"When you start the transition and you go outside dressed as a women, you are no more than a man dressed as a woman and everybody looks at you. The phenotype does not help at all, and you feel very insecure. You really suffer until you finally learn how to be secure in yourself. That's why I don't think that the real-life test should be enforced. At most, it should be done when the person has obtained some characteristics of the opposite sex from the hormones. Nobody will say anything to a transsexual guy who wears trousers. But if a girl puts on a skirt or dress, with no breasts and signs of a beard, everyone will stare at her [...] I had plenty of character and was a strong person, but there are a lot of people who aren't and they suffer a lot; they feel like a clown." (Montse).

2. Hormone treatment

The majority of UIG users positively evaluate the endocrinological care received. However, there are some who think that the Unit requires they adopt a stereotyped image:

“The doctors tend to prescribe more medication. They want the sex change to be 100%. They don't want intermediate states and they try to convince the transsexual person to go through the whole process [...] We tend to be more self-taught. There are even transsexuals that don't take hormones; they did for a while, but then they lost their sexual desire or whatever, they wanted to function or whatever, and now they don't take the hormones.” (Mónica).

And some of them actually defend taking the hormones their own way, as they consider that they have the knowledge and experience to do that:

“A [medically] guided hormone treatment and taking the hormones your own way will be the same thing if you have been advised correctly. The doctor is not going to prescribe you something that doesn't... Having the advice, you are going to do the same thing. There's no mystery to it really.” (Gema).

Furthermore, some people do not like being subjected to the physical examination required by all people before starting the treatment in order to rule out being intersex:

“Did you feel uncomfortable with the endocrinologist?”

A bit... because the first day he told me to take my clothes off and he touched my penis, etc. I was a bit shocked as I really didn't see what they would gain by touching my penis; I suppose just to check that there is no problem, but I found it quite shocking.” (Ana).

3. Sex reassignment surgery

Some trans people strongly criticise the fact that some medical sectors have publicised the surgical procedures as a type of master key to enter the domain of gender normality:

“The sex/gender system is incredibly well armed. If it were easier to escape, people wouldn't even undergo surgery. Why would someone undergo surgery for an operation that is life-threatening, if they could get out of it? If they do it, it is because they really don't see any other way out. And we are not judging people who have the operation; the problem is this crap society that we live in so that someone feels they need to have the operation just to be happy. I mean, you prefer to adapt to society, rather than society adapting to you. I understand it, but it gives me a lot to think about.” (Luis).

“Science has sold us the operation as something idyllic, when it is really far from that. They keep saying that we will be women, that we will be accepted. That society will accept you because you have been castrated is a lie, it's nonsense. I am not against the operation, but I recommend a trial period beforehand, a sex trial period. It is necessary to have sexual relations first to realise that the operation is not necessary.” (Mónica).

All in all, women that reject their genitalia firmly desire feminisation surgery. They believe that it would be the final step towards creating what they consider to be a discrepancy between their gender identity (what they perceive as innate and true) and their body (seen as wrong, strange, alien): "the operation will mean that my whole body is in harmony with the real me" (Jennifer); "the operation will make my body fit in with who I really am" (Jessica). This conviction that surgery will fix the disharmony between the mind and body creates such a strong desire to undergo surgery that the fear of post-surgery complications takes second place:

"When I went into the operating theatre, I had already accepted that I might die if things didn't go well, or that I may never again feel sexual pleasure, but I didn't care. I just wanted them to get rid of my penis..." (Montse).

"I always say the same thing to my family and friends, "If something goes wrong during the operation, please don't cry or feel bad or anything, because I will have died the happiest woman in the world, the happiest in the world, because I will have died realising my dream." (Pilar).

The case of trans men is different. While some of them reject their birth genitals, the vast majority don't wish to undergo phalloplasty due to the numerous risks and post-surgery problems associated with this surgical technique:

"Not until it is totally fine [phalloplasty], I don't want it. I will do mastectomy. But phalloplasty, not until it is totally fine, I don't want it, because I don't want to have a penis that happens to measure 8cm and has no sensitivity, not to have sexual relations...Because I wouldn't feel any pleasure and it would just be for using the toilet." (Pedro).

"At the moment, no, because why would I want to have a...? Why would I self-destruct my own body? Take skin from my forearm just so that it doesn't work and to look like I have been through the mill, or a mince meat grinder... No, thanks. Now if they tell me that there is a new technique that works, I would do it. But not for the moment, because I am not going to risk harming my body." (Hans).

In the case of trans men with a stronger body rejection, hysterectomy and mastectomy are the most sought-after surgeries:

“But I would get my breasts removed first as they are the most obvious [...] So, when the hormones take effect, I will have the problem of a beard, and the voice and body of a man, and I will go to the beach, take off my t-shirt and “Surprise!” (Pedro).

“It was more to do with the breasts, it was the breasts...My genitals are not something that I obsess about the way I was obsessed with my breasts [...] Genitals are only seen by the person that I sleep with. Nobody else knows what I have or don't have, so it really doesn't bother me.” (Marcos).

In relation to a hysterectomy, the UIG professionals state that it is absolutely necessary for avoiding possible health problems, such as tumours, while Trànsit professionals point out that it is not necessary to remove healthy organs, and that regular gynaecological check-ups are a good way of controlling the gonads. If a trans man does not want to have periods, Trànsit professionals recommend endometrial ablation (destroy the lining of the uterus), a less aggressive technique (that does not require incisions) rather than a hysterectomy. In this regard, there are men that are bothered by the fact that the UIG insists on the need for a hysterectomy:

“I think that a hysterectomy at the age of 25 is super aggressive, I think it is crazy [...] There are lots of different opinions, but the Clínic claims that it is absolutely necessary. The endocrinologist told me that I have to do it. He said, “I won't insist, but you need to get our head around it”. I find it shocking that a doctor would force you to undergo an operation that you don't want [...] They say that you could get cancer, but obviously I can get check-ups every six months and if I get cancer, then we can take it out.” (Marc).

ANNEXE 2. PRESENTATION OF THE TRÀNSIT SERVICE³⁸

1. Goals

1. Support trans people in their needs and decision-making with regard to their perceived identity:
 - » Listen actively to their account of their identity, the support they receive from those around them, and the needs and doubts they may have at any given time.
 - » Inform, initiate or adjust the hormone treatments; give advice on surgical treatments; and carry out preventive and health promotion activities.
 - » Offer psychotherapeutic support to trans people when they voluntarily request it: in moments of doubt, respect their identity or need for support when making decisions at any time during the transition process.
 - » Carry out therapeutic groups for trans people as a complement to the therapeutic process and/or as a socialisation space during the transition process.
2. Support those in the trans people's immediate environment (including support for families and loved ones, education centres and their workplaces.)
 - » Provide information on different identities, the changes and beneficial and adverse effects of the hormone and/or surgical treatments to the family and loved ones of the trans person.
 - » Write up reports explaining the transition process for primary and secondary schools, universities, the workplace, professionals, etc. that facilitate their integration into the perceived gender.
 - » Advise health professionals (psychologists, psychiatrists, doctors, endocrinologists, etc.) on the different identities and support they need to give to the trans person during the transition process.

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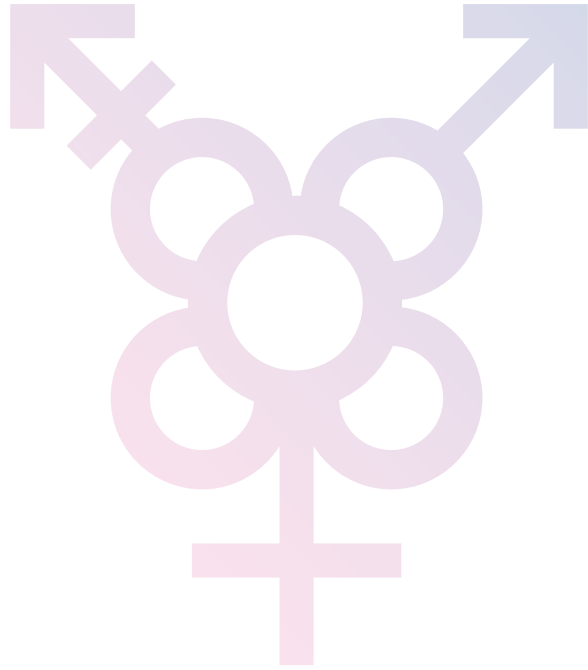
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³⁸ Report drawn up by Soraya Vega (Trànsit-AP) and Rosa Almirall (Trànsit-AM).

3. Raise awareness among healthcare, education and media professionals about the reality and needs of trans people, giving a perspective free from stereotypes and prejudices:
 - » Clinical sessions in healthcare centres, psychologist associations, etc.
 - » Talks to school committees, parent associations, etc.
 - » Interviews with the media.
4. Train healthcare professionals so that they have adequate knowledge of the transition processes and can give appropriate care.
5. Write up medical and psychological reports as required by law in order to change the name and gender to the perceived gender in all identification documents.

2. Population

The service is aimed at trans people who are interested in using the trans psychotherapeutic and/or medical service, as well as their families and partners, irrespective of whether the requests are made by the person themselves, by the family or by both.



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3. Care model in Trànsit

Trànsit was set up in October 2012 by a gynaecologist. The main mission of this service is to promote the health of trans people in the region. In May 2013, it extended its service provision by starting up a new line of care, psychotherapeutic support, under a psychologist. From here on, it is necessary to use two names to differentiate the two services: **Trànsit-AM**, to attend to all medically-related queries, and **Trànsit-AP**, which responds to the psychological and therapeutic needs.

Trànsit-AM Promoting the health of trans people

The healthcare provided to trans people in Trànsit-AM is inspired by a model based on the community and fostered by trans people. This model, which was described earlier on in this document, began in Canada in 2003, and has been developing healthcare and clinical protocols for trans people since 2006. It is thereby considered that the decision to start treatment is a collaborative process between professionals and trans people, focusing on the needs and expectations of the person, and which only requires the valuation of the chances of socialisation in the perceived gen-

der and obtaining informed consent. As a result, any primary healthcare professional with a certain amount of expertise in identity matters can facilitate this decision-making process, informing, educating, guiding and supporting these people during all the stages of the process.

In our service, we promote the referral of trans people to therapy support groups made up of trans people, and individual psychotherapeutic support if desired, but with psychologists, who we call "transpositive therapists".

Trànsit-AP Psychotherapeutic support

The theoretical basis of the intervention provided for in the Trànsit-AP model is based on the epistemological premise of constructivism. Each event is constructed in different ways for each person depending on numerous variables that are in constant interaction. As a result, human activity is understood as a global process of construction of meaning and the human being as an organism whose main activity is to construct the events in which it finds itself (including itself, others, suffering and symptoms) (Feixas, 2012).³⁹

This framework assumes a proactive view of the human being that regulates its psychological processes according to what is consistent with the system created up to then. Therefore, it is understandable that a person finds conflict when having to make the self-concept compatible with their personal values during the decision-making process.

One of the authors of reference that introduce the concept of conflicts as a synonym of psychopathology is Manuel Villegas with his theory of moral development. This theoretical approach understands psychopathology as the "psychological suffering caused by the incapacity of the human being to feel, think and act freely due to entrapment or conflicts in their own needs, passions, duties or relations, or because of losses

or failures in their existence" (Villegas, 1981). From this point of view, therapy is not considered to be a technique for curing or diagnosing any kind of mental illness; it is an intervention that facilitates the personal growth process or the conversion into an autonomous person, like a call to the authenticity of existence. In other words, a "method aimed at promoting better self-knowledge and development of psychological autonomy, sufficient for assuming and freely developing one's own existence" (Villegas, 1981).

Constructivism has adopted the narrative as part of more general psychotherapeutic evaluation and intervention models. The narrative model in this constructivist psychotherapy makes sense, as it is used as a tool to help trans people increase their knowledge about their own operating rules, significantly extending flexibility in reference to daily experiences, and to try to deconstruct the discourses associated with the reason for consultation in order to construct more empowering narratives, free of restrictions. In this sense, the use of constructivist narrative therapy is similar to the strategic approaches and the standard "solution focused therapy", given its marked preference for the rapid change of the more immediate patterns associated with the reason for the consultation.

³⁹ *El constructivismo* [inedited text]. Guillem Feixas Viaplana, 2012.

3.1. Basic guidelines for the care provided to trans people in Trànsit

Trànsit-AM. Basic guidelines for the healthcare of trans people

The care of trans people in Trànsit-AM is based on actively listening to their life story in relation to their identity, their needs and doubts at the time they receive the care; evaluation of the support they receive with their decisions from their family and loved ones and their education and work environment, and respecting the decisions they make in terms of the type and pace of the hormone treatment; and evaluation of health promotion and prevention measures and of the personal decision as to whether or not they or the people around them wish to receive psychotherapeutic support.

The main points worked on in Trànsit-AM healthcare are:

- Evaluation of the suitability and need for hormone transition treatments, and if changes are necessary, in trans people who already follow these treatments and do regular analytical and medical check-ups.
- Starting hormone transition treatments and regular analytical and medical check-ups.
- Preventive actions relating to the sexual and reproductive health of trans people - prevention of cervical and breast cancer, reproductive advice, prevention of sexually transmitted infections, advice on life-styles (toxic substances, food, exercise, etc.).
- Virtual advice by email in response to the queries of trans people.
- Referral to the Gender Identity Unit of Hospital Clínic for people that want to be referred.

Trànsit-AP. Basic guidelines for the psychotherapeutic support of trans people

The stigma and discrimination suffered by trans people in society today means that there is a high risk of suffering and psychological distress and is subject to special and specific attention by society as a whole and by health professionals in particular.

At Trànsit-AP, we have drawn up some guidelines that we apply and which should be used to guarantee quality care and the legal protection of trans people. These guidelines are inspired by, are consistent with and respect the ethical principles and the code of conduct proposed by the American Psychological Association.

This approach also includes those people who, having a diverse gender expression, do not need any psychological, hormone or surgical treatment.

- Psychosocial support for the person always has to be at their request.
- The healthcare professional provides information, advice and support during the personal process of the trans person. The final decision lies with the person themselves and nobody else.
- It is necessary to give support during the identity construction process, respecting and maximising subjectivity.
- The autonomy of trans people has to be maximised during their transition process.
- Gender expression is diverse and unique to each person and must be understood from this perspective. The guidelines have to be at the service of the people and not the other way round; that is why it is necessary that the care is personalised and without prejudices, taking into account all the possible variants of intervention: hormone therapy, surgery, psychotherapy, a combination of two, all or none.
- Sexual orientation and gender diversity are independent but interrelated concepts.

The minimum skills required by the psychotherapeutic support professional are summarised below:

- Degree in psychology and, preferably, a master in therapeutic intervention with a constructive or gender perspective, or specialising in sexuality.
- Minimum training and/or experience required in psychotherapeutic support for trans people from a constructivist and humanist perspective that treats the person as a person and maintains a therapeutic relationship of expert to expert.
- Broad vision of gender: gender understood as a personal construction of one's own identity - unique, diverse and exclusive to the person.
- Conception of transsexuality as just another expression of diverse gender. It is not possible to diagnose something that is not considered to be an illness. This position guarantees the depathologisation of transsexuality and diverse expressions of gender.
- Perspective of the need for a social change that facilitates integration and recognition of the diverse genders as an element that enriches culture and society and allows us to advance in the conception of the human being.

Other activities of the Trànsit-AM and Trànsit-AP services

- Producing medical/psychological reports during the stage in which, for imperative legal reasons, there is a discrepancy between the physical appearance and the details on the ID (DNI) card:
 - » to facilitate the person's socialisation in the perceived gender
 - » so that in healthcare services, these people are named and treated in accordance with their perceived gender, and are provided with the required medical check-ups and treatments
 - » for the social environment (primary and secondary schools, universities, workplace, libraries, sports centres, etc.) so that their registers and membership cards use the changed name of the trans person.
- Producing medical/psychological reports for the change of name and gender on the birth certificate and, later on, in all official documents.
- Exchange of opinions with healthcare professionals - professionals from the fields of psychology and psychiatry, psychopedagogy, family medicine, endocrinology -, social workers, community and social educators, prison staff, etc. that attend to trans people in complex situations.
- Provide information on how Trànsit operates to different non-governmental organisations and associations (Stop Sida, Acathi, Generem!, Chrysallis, Fundació Enllaç, Àmbit Dona Prevenció, APIP, etc.) and design referral structures.
- Awareness sessions, courses and workshops and training for healthcare professionals (gynaecologists, midwives, primary care teams, psychologists, nursing assistants, healthcare administrative staff, etc. in relation to gender identity, transition processes, body changes, beneficial and adverse effects of hormone and/or surgical treatments and repercussions on their environment of socialisation in the perceived gender of the trans person.
- Advice to students conducting research projects on transsexuality in lower and higher secondary school, undergraduate final year projects, masters final projects and PhDs.
- Awareness-raising to bring about the normalisation and acceptance of different gender identities as part of the broad spectrum of human diversity, with participation in medical seminars and collaboration with the media (interviews with magazines, radio, television, etc.)
- Help the trans person connect with peer networks as an element of integration and reinforcement of the integration process. On this point, the importance of the professional's knowledge of regional resources must be highlighted in terms of the trans social network and their connection with these to facilitate and ensure referral to the appropriate person and place.
- Information, advice and support for loved ones, in education and professional life, etc.

Coexistence with other intervention models. The case of the UIG in Barcelona

The appearance of Trànsit in October 2012 marked a before and after in the health panorama of trans people in Barcelona, in Catalonia and possibly in the rest of the Spanish state. This initiative to promote the health of trans people complements the public service offered to trans people up to the present day, exclusive property of the UIGs - units with a team of professionals that offer multidisciplinary and integrated transsexual treatment according to established protocols.

The healthcare and psychological intervention model that characterises the UIGs is based on the psychological evaluation of transsexuality, which consists of carrying out a series of tests that help to diagnose transsexuality. The most important stage would be the complement of the DSM-5 and CIE-10 criteria. Once the psychological evaluation has been completed and after having confirmed the diagnosis of gender dysphoria, *the trans person can access hormone treatment*, with an appointment with an endocrinologist, and the psychotherapeutic intervention during the initial hormone-taking stage is based on the so-called "real life experience".⁴⁰

The application of these protocols means that many people that label themselves as trans are not accepted by the UIGs. At this vital time that is so important and decisive, where the support of the healthcare professional is so fundamental, these people who are considered "doubtful" are not attended to at all.

In this context, Barcelona is experiencing a major upswing in trans activism, which has led to a notorious international movement that fights for the depathologisation of trans people.

At an international level, from an exclusively professional viewpoint, different campaigns were carried out against the publication in May 2013 of the new version of the (*Diagnostic and Statistical Manual of Mental Disorders*) DSM-5. The platform for the Boycott of DSM-5 (Boycott DSM-5), made up of activist groups from various disciplines such as medicine, psychology and social work, and the American Psychological Association have expressed their concern regarding the reliability, validity and classification accuracy of the DSM-5. In the same vein, the British Psychological Association - BPS) requested a change of paradigm in mental health, publicly declaring its opposition to the biomedical model for understanding mental disorders.

In the face of these criticisms of the evaluation systems, there are still many people in the professional and research field, and also patients, that defend their use. The UIGs are one of these establishments, despite the complaints made by their users in relation to the intervention model they are currently using.

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40 Asenjo-Araque, Rodríguez Molina, García-Romeral, López-Moya and Becerra-Fernández, 2011.

3.2 Care framework in Trànsit

Professionals:

Trànsit –AM started up in October 2012 by a gynaecologist who progressively increased her hours according to demand. Trànsit -AP was established in May 2013 by psychologist Soraya Vega within the framework of a collaboration agreement with the University of Barcelona, and in January 2015 was joined by Diana Zapata. The former works ten hours a week while the latter works five.

Referral:

The people who come to both Trànsit-AM and Trànsit-AP are referred by external collaborating agents, such as Generem!, Chrysallis, EnFemme, Acathi, el Casal Lambda, l'Espai Trans, la Fundació Enllaç, Àmbit Dona Prevenció, l'Associació de Mares i Pares de Gais, Lesbianes, Bissexuals i Transsexuals, and other professionals; the social networks; or the recommendations of other trans people or healthcare professionals. Trans people or their loved ones are referred from Trànsit-AM to Trànsit-AP when they consider psychotherapeutic support to be necessary at any time during their transition process (20%). 57% of people attended to in Trànsit AP are referred from Trànsit-AM, and trans people are referred to Trànsit from Trànsit AP when medical support is believed to be necessary in their processes.

The contact is by email: Trànsit-AM: transit.bsn.ics@gencat.cat, and Trànsit-AP: transitapsico@gmail.com.

Setting:

Trànsit-AM: The care is offered on the sixth floor of CAP Manso or the third floor of CAP Numància (primary health-care centres), depending on the person's preferences, at a time agreed between the professional and the person from Monday to Wednesday, 8am - 8pm, and Thursday and Friday, 8am - 3pm.

Trànsit AP: The sessions are carried out on the sixth floor of CAP Manso, in the psychologist's office, on Monday and Wednesday afternoons.

The care has a maximum duration of ten sessions and there is one session every two weeks.

Trànsit-AM: healthcare methodology

At the first appointment, the person's life story is examined in relation to their identity, as well as their current situation and corresponding needs, and their wishes regarding body changes. The knowledge of loved ones (family and friends) and the education and/or work environment of the person's situation are evaluated, including the support they received from all of these. At the same time, how much the person knows about role models or trans people is also evaluated.

A clinical history is drawn up that includes any family history of cardiovascular risk, hormone-dependent cancers and osteoporosis, life styles (toxic substances, food, exercise, etc.), any previous physical or mental disorders and *bullying*, physical assaults, sexual abuse and attempts or ideations of self-harm.

Finally, a reflection carried out on the impact of transition treatments on sexual response so that the person can adapt their treatment to the desired sexual response.

In addition, the following advice is provided:

- Prevention of sexually transmitted infections, reproductive possibilities and contraception where necessary.
- Different treatment options, different transition time-scales, the chronology of reversible and irreversible expected changes, and short and long term adverse effects. This allows for personal choice as to whether to start the treatment, type and dosage, or modification of the dosage if the person is already undergoing treatment.
- The impact of transition treatments on sexual response so the person can

adapt their treatment to the desired sexual response.

- Surgical treatments, understanding that no surgery is necessary from a medical point of view in any transition process.
- Possible preventive activities: prevention of cervical and breast cancer, smoking cessation advice, prevention of risk of osteoporosis, etc.
- How the UIG works and the possibility of monitoring and surgical procedures in this unit financed by the public health service. Referral if the person so wishes.
- Care for family and friends if the trans person believes that this care will lead to better support.
- The Trànsit-AP service for the trans person or their loved ones if they request psychotherapeutic support. Referral if requested.
- Resource networks for trans people: EnFemme, Generem!, Chrysallis, referents trans, Espai Obert Trans/ Intersex, Cultura Trans, Grup de Famílies de Persones Trans, Barcelona Trans Ocupació, etc.

They are informed of the possibility of maintaining virtual contact to resolve any queries, and a follow-up appointment and analytical control are agreed. Reports are drawn up for the education and work environments, the family doctor, etc. which explain the transition process in order to make socialisation in the perceived gender easier. Medical reports are also written up for changing the name and gender in the official documents in the cases of people that meet the legal requirements.

[Trànsit-AP: individual psychotherapeutic support methodology](#)

Amongst the diverse narrative techniques and strategies used, there is a self-written report (diaries, structured self-observation tasks), emotional recognition and focusing exercises, session agendas, reframing and reformulating resistances such as maintaining systemic coherence, life project history, completion rituals and summaries, etc. (Neimeyer and Mahoney, 1995; Guidano, 1991; 1995; Neimeyer, 2001).

The change process experienced in therapy can be described in the following stages:

Stage 1: Reception stage. The reception of the therapist has to comply with a deep and real sense of interest, respect and acceptance of the other which constitutes the basis of a special type of professional relationship and therapeutic alliance. During this stage, the Trànsit-AP model is introduced, as well as the goals of the therapy and actual tasks of the psychotherapy that will be carried out. The therapeutic relationship begins, expressed through mutual respect and trust, and through the verbalisation and acceptance of a shared commitment to the process, which is formalised through the signing of a collaboration contract.

Stage 2: Exploration stage. Work is carried out to clarify the person's requirements, what they want to work on, what bothers them, what they want to achieve with the therapy. The basic techniques used are the genogram and life line with a gender identity perspective.

Stage 3: Expression/compression stage.

This is the central stage of the therapeutic strategy. It includes different important episodes for bringing about change in the well-being of the trans person: immediate reconstruction of the trans experience, background reconstruction of the trans experience, relationship implications of the trans experience, recovering the desire for what they want to be as opposed to what they are supposed to be and what people expect from the person (conflict between the egocentric and the allocentric) and integration of the trans identity.

Stage 4: Resolution/closing stage.

The therapy is completed by looking back at the aspects that have helped most in the process, which have strengthened their identity and provided anchors that will carry them through the rest of their life.

Group therapy support methodology

The support group is formed around a life condition common to all the people participating, which is their definition as a person with a diverse, non-normative identity.

This group experience was set up with the intention of giving support to trans people during their transition process to reduce the fear, anxiety and isolation that they may feel when they go through the transition. The only way for them to feel better in this sense is by joining a satisfactory social network. This is one of the major functions of the therapy group for trans people.

The group acts as a platform for expressing fears of family abandonment or their partner leaving them once they have made the transition or when the fact that they are a trans person is made public.

The basic mechanism used in these groups is the universality of the trans reality, cohesion and vicarious learning. The development of new coping mechanisms and new behaviour strategies to deal with transphobia is promoted.

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4. Evaluating the model

The positive evaluation of the Trànsit-AM care model can be seen from the words of thanks of different people attended to in our service:

“As our sessions come to an end, we are definitely much clearer now on everything and we would again like to thank you for all your help and for helping us to understand our child a bit better; you know how confused we were at the start.”

“Thank you so much for everything, Rosa, and we will stay in touch. I have been waiting just to give you the good news; to be honest, the paperwork was very slow and tedious, but I got there in the end:))))).”

“Thankyou from the bottom of my heart, I don't think that I can express just how happy I feel, so when you see me, you will see the huge smile that I now go around with every day.”

“I am very happy with the way you treated me and if anyone ever has any questions, people who are unsure, I will recommend your services. You do so much for us!”

“I send you a very strong colourful hug, I often think about you.”

“Thank you for everything, Rosa. Every time I come to Trànsit, I feel cared for and cherished. I give you 10/10 for patient care, don't change a thing. I will continue the treatment just as we have been doing it. You can let me know when the next appointment is.”

“As you can imagine, thanks to you this week has been very important for me, one of the most important in my life. By giving me the chance to go ahead, I have become more sure about everything and some of my "fears" and "complexes" are fading away.”

“Thanks again for everything and have a nice day.”

“I'd like to take this opportunity to thank you for supporting us in the fight for trans normalisation.”

Below are some qualitative evaluations made by people who have completed the therapeutic process in Trànsit-AP:

“It has made me think, question..., put my emotions and priorities in order, and this has shown me the need to evolve as a person and to make the most important decision in my life.”

“It has helped me to improve communication and my relationship with my family in relation to the transition, to learn more about myself thanks to the experience of the therapist, in a safe place where I can express myself in terms of my transition. Very kind.”

“To become more familiar with this new world and not be so afraid. It is a space where you find the experience of the therapist, strength and support.”

“I have been able to create a secure space inside me, to reassure myself, to discover my own stumbling blocks, to be patient with myself and my processes, understand them, look after myself. A space where I have found flexibility, a crutch when I've fallen, a bodyguard, guidelines after getting to know me.”

“Learn how to feel free just being me. Identify my chains. Work on my fears of being transsexual in a society that frowns upon it. It has helped me prepare to talk with my family and to explain who I am.”

“I have reflected hard on who I am. This has helped me to decide, as I had no other options if I wanted to be myself. It has been very important to analyse the type of masculinity I wanted to experience, to rethink masculinity and integrate my femininity. I have gone from rage to non-aggressive euphoria.”

“I have been able to clarify my doubts about who I am, my sexuality, identity and possible therapy routes. Now I know who I am.”

5. Empirical approaches. People attended to in Trànsit-AM (October 2012 – August 2015)

375 people actually came to Trànsit, 38 of whom were referred to Trànsit-AP and 29 of whom were attended to exclusively in Trànsit-AP. 36 people asked for an appointment but then did not turn up, and 52 received advice via email.

Care for trans women

224 trans women were attended to, 10 of whom were minors. Of the 214 adult trans women, 131 were already undergoing hormone treatment, with self-treatment (111) and controlled treatment in the UIG (16) or with a private endocrinologist (2), and 2 had completed their socialisation as women without ever having had hormone treatment.

- Trans women who have been undergoing hormone treatment for over two years or have socialised as women in all aspects of life by their first appointment: 94 women

These women are between 21 - 67 years of age. Of this group of trans women, 59% are immigrants, the majority being from Central America. 49% of those who have been socialising as women in all aspects of their life for over two years are sex workers, and 21% of them receive government benefits, even though 43% of them have university qualifications. 20% of their parents, 77% of their children and 30% of the people in their workplaces do not know about the transsexuality of these women or do not accept it, and 43% do not have a stable partner.

It should be pointed out that 42% confirm substance abuse, 24% have needed long-term psychological and/or psychiatric support, 15% have been victims of bullying and/or sexual abuse and 4 trans women have attempted self-harm (8 attempts in total).

This data shows just how socially vulnerable this collective is.

- Trans women who have been undergoing hormone treatment for less than two years or have socialised as women in all aspects of life by their first appointment: 37 women

These women are between 20 - 59 years of age. 53% are immigrants, the majority being from Central America or South America. 23% are sex workers and 14% receive government benefits, even though 36% have university qualifications. 50% of their parents, 100% of their children and 67% of the people in their workplaces do not know about the transsexuality of these women or do not accept it, and 52% do not have a stable partner.

It should be pointed out that 30% confirm substance abuse, 25% have needed long-term psychological and/or psychiatric support, 6% have been victims of bullying and/or sexual abuse and 2 trans women have attempted self-harm (4 attempts in total).

This data shows just how socially vulnerable this collective is.

In all these cases, the risk factors of the treatment were evaluated according to the family and personal medical history and life-styles, the benefits/risks of the hormone treatments were assessed and the treatment readjusted when necessary, offering tests (blood tests, bone densitometry, mammograms, etc.) according to the situation, and reports were provided for their socialisation in the perceived gender as well as information on resources for trans people.

- Trans women who have never undergone hormone treatment and/or have not socialised as women in all aspects of their life by their first appointment: 83 women

Of the 214 adult trans women, 83 had not initiated any hormone treatment and 69 started it on their first appointment in Trànsit. In all these cases, the risk factors of the treatment were evaluated according to the family and personal medical history and life-styles, the benefits/risks of the hormone treatments were assessed, information was provided on the expected body changes, and treatment dosages were established according to their expectations regarding the transition process, establishing the frequency of medical controls and blood tests. They are between 18 and 67 years of age. 3% are sex workers and 25% receive government benefits, even though 53% have university qualifications. In this group of trans women who are mostly locals (71%), the lack of knowledge of their situation among those in their social circles is notable: Only 50% of their parents are aware, 13% of their children, 44% of their friends, 54% of their partners and 11% of people in their workplace. 46% do not have a stable partner.

It should be pointed out that 25% confirm substance abuse, 35% have needed long-term psychological and/or psychiatric support, 10% have been victims of bullying and/or sexual abuse and 3 trans women have attempted self-harm (3 attempts in total).

This data shows just how socially vulnerable this collective is.

In all these cases, advice was offered to the person's loved ones, psychological support was given, they were provided with the contact details of resources for trans people and reports were written up for their healthcare professionals, education and work environment.

- Trans girl minors

None of the 10 trans girl minors started the treatment on the first appointment. Their ages range from 7 to 17 years. In all of these cases, advice was given to the trans person (over 12 years of age) and to all the parents about transsexuality; measures were put in place to facilitate the well-being of the person and their socialisation process in the perceived gender; psychological support was offered; contact details were provided of resources for trans people and their families; and reports were provided for their healthcare and education professionals, and direct advice given to their educational environments.

Care for trans men

122 trans men were attended to, 14 of whom were minors. Of the 108 adult trans men, 36 were already undergoing hormone treatment, with self-treatment (16) and controlled treatment in the UIG (19) or with a private endocrinologist (1).

- Trans men who have been undergoing hormone treatment for over two years or have socialised as men in all aspects of their life by their first appointment: 18 men

These men are between 21 - 51 years of age. 89% are locals. 7% receive government benefits, 93% are self-employed or employed and 39% have university qualifications. 17% of their parents, 100% of their children, 20% of the people in their workplace and 7% of their friends are not aware of their transsexuality or do not accept it. 17% do not have a stable partner.

It should be pointed that 66% confirm substance abuse, 8% have needed long-term psychological and/or psychiatric support, 17% have been victims of bullying and/or sexual abuse and no trans man has attempted self-harm.

This data shows that this collective is socially vulnerable, but a lot less than in the case of trans women.

- Trans men who have been undergoing hormone treatment for less than two years or have socialised as men in all aspects of their life by their first appointment: 19 men

These men are between 19 - 51 years of age. 67% are locals. 14% receive government benefits and 75% have university qualifications. 37% of their parents, 100% of their children and 7% of the people in their workplaces do not know about the transsexuality of these men or do not accept it. 17% do not have a stable partner.

It should be pointed that 40% confirm substance abuse, 26% have needed long-term psychological and/or psychiatric support, 17% have been victims of bullying and/or sexual abuse and no trans man has attempted self-harm.

This data shows that this collective is socially vulnerable, but a lot less than in the case of trans women in the same situation.

In all these cases, the risk factors of the treatment were evaluated according to the family and personal medical history and life-styles, the benefits/risks of the hormone treatments were assessed and the treatment readjusted when necessary, offering tests (blood tests, bone densitometry, pap tests, mammograms, etc.) according to the situation, and reports were provided for their socialisation in the perceived gender as well as information on resources for trans people.

- Trans men who have never undergone hormone treatment and/or have not socialised as men in all aspects of their life by their first appointment: 71 men

Of the 108 adult trans men, 71 had not initiated any hormone treatment and 49 started it on their first appointment. In all these cases, the risk factors of the treatment were evaluated according to the family and personal medical history and life-styles, the benefits/risks of the hormone treatments were assessed, information was provided on the expected body changes, and treatment dosages were established according to their expectations regarding the transition process, establishing the frequency of medical controls and blood tests. These men are between 18 - 50 years of age. 14% receive government benefits, 40% are self-employed or employed, 30% are completing their education and 29% have university qualifications. The majority are locals (85%). It should be pointed out that only 60% of their parents, none of their children, 46% of their friends and 90% of the people in their workplaces know about their transsexuality. All of the trans men who have a partner know about it and accept it. 50% do not have a stable partner.

It should also be pointed out that 35% confirm substance abuse, 49% have needed long-term psychological and/or psychiatric support, 20% have been victims of bullying and/or sexual abuse and 2 trans men have attempted self-harm (3 attempts in total).

This data shows that this collective is socially vulnerable, but a lot less than in the case of trans women.

In all these cases, advice was offered to the person's loved ones, psychological support was given, contact details were provided of resources for trans people and reports were written up for their healthcare professionals, education and work environment.

- Trans boy minors

None of the 14 trans boy minors started the treatment on their first appointment. These trans minors are between 4 - 17 years of age. In all of these cases, advice was given to the trans person (over 12 years of age) and to all the parents about transsexuality; measures were put in place to facilitate the well-being of the person and their socialisation process in the perceived gender; psychological support was offered; contact details were provided of resources for trans people and their families; and reports were written up for their healthcare and education professionals, and direct advice was offered to their educational environments.

6. People attended to in Trànsit-AP with individual support (May 2013 – October 2015)

Since the service was set up in May 2013, up to October 2015, a total of 67 people have been attended to in individual therapy processes.

The 67 people who have had individual therapy have between them had a total of 387 individual sessions. The maximum number of sessions that a person receives is 10, and the minimum is 1, always at the request and decision of the person. The average number of sessions per persons is 6.

57% of the people attended to by Trànsit-AP are referred by Trànsit; i.e. first of all, the person requests an appointment to receive information about hormone treatment or trans health matters, and at the same time they require the psychotherapy service to work on an issue related to the transition: internalised transphobia, living with their body without the transition, exploring their diverse identity, exploring sexual relations in-depth; requests to meet a need with an **individual dimension**, an intrapsychic aspect..

The trans person that accesses individual therapy tends to be a person that questions their own identity - the first day of the session they prefer not to be labelled in the gender variable - , aged between 21 and 25 who is studying at university.

The remaining 43% are recommended by users of Trànsit-AP or by the social organisations within the region that work for trans people: associació Generem!, Chrysallis, EnFemme, Acathi, el Casal Lambda, l'Espai Trans, Joves Trans de Barcelona, etc.

Of these 43% that approach Trànsit-AP directly (29 people), 62% ask to be referred to Trànsit to make a query related to the hormone treatment process and 100% have started a transition process with hormones. It is a very dichotomised collective in all the analysed variables. In terms of levels of studies, 56% have university qualifications and the rest have a basic educational level. As regards age, 56% are under 35 years of age and the rest are above 35 (the highest percentage is among people aged 46-50 years). More than half (61%) do not have a stable partner. In reference to origin, 50% were born in Catalonia, and the rest elsewhere (Cantabria, South America and Morocco).

The most common requests from people meeting this profile are about whether or not it is a good idea to start the process, taking into account the cost it could entail at a professional, partner and family level: their relationships with the people closest to them (family, partner and friends), catastrophic anticipation associated with the transition, fear of social and family rejection, and feelings of blame for feeling trans; i.e., requests to meet a need with a **social dimension**, interpersonal in nature.

Studying the request is a fundamental stage in the psychotherapeutic process and it means understanding what the person is saying, explaining who says what to whom and when, and with what purpose.

As already specified, there are basically two types of requests in Trànsit-AP, depending on whether the need to be met is of an **individual nature**, regulated by desires and needs coming from internal pressure, or of a **social nature**, regulated by social norms and relationships, by external pressure.

Requests with an **individual dimension** can be catalogued as unspecific and intrapsychic. They are related to the need to clarify one's own identity: the person comes to seek support and guidance to understand and face up to their own problems related to their *self*, to their gender identity. Some examples taken from conversations in therapy sessions and which are direct transcripts demonstrate this fact:

“I need to clarify how I feel so that I can be certain and reassure myself about my decision to make the transition, or to find out if I am making a mistake somewhere along the line. I need help to form my internal discourse, one that I can explain to myself and to others in order to externalise my feelings and to accept them...” (CIS Woman, 32 years old).

“I can't figure out which label I fall under: man, transvestite, transsexual woman...” (CIS Man, 55, crossdresser).

“I am uncertain about my identity.” (W CIS, 50, lesbian queer).

“I want to be certain or to reassure myself; know that I am to be able to accept all the consequences. Before anything else, I need to get rid of this uncertainty so that I can live without this constant obsession about myself and just concentrate on living. Because I am not sure of the image I have of myself. After trying to work it out in many different ways, I am not sure if I consider myself to be a man or a woman. Or maybe I am not brave enough to face up to it. Because whenever I have felt sure about it, in the end I have convinced myself that I was a man.” (M CIS, 29).

“Because I don't feel happy with myself or with the others. I have always had the feeling, but especially in the last two years, that I should have been a boy, which means that I am transsexual. I want to feel good about myself and to carry out day to day activities without feeling uncomfortable, and to do others that, out of fear, I have never been able to do.” (W CIS, 21).

“Because I want to feel better about myself. I feel quite lost and confused. Find out what I can do to change myself physically and how I see my body, and how I think about identities so that I can make my own (because I feel like I don't know where to go).” (W CIS, 33).

“Define my gender identity and be clear about what steps to take so that I can have a satisfactory and stable life.” (M CIS, 55, crossdresser).

“I don't know if “being a girl” physically speaking would make me happy... Sometimes, I think that it would be the best solution, but then I also sometimes think that it would just trigger a load more serious problems.” (M CIS, 24).

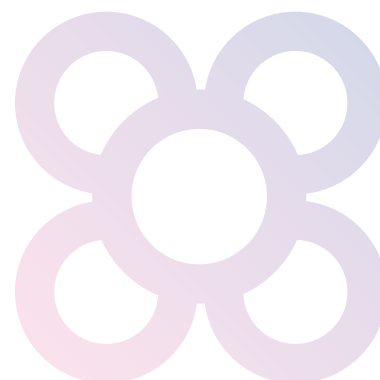
The requests that correspond to the **social dimension** can be catalogued as specific interpersonal requests. They are related to concern about being accepted by the other for being trans and communicating to the world who I am.

“Having the security and empowerment to not be afraid to express the way I am to my family. I don't know how to set about telling my family about my identity, the way I think and the way I live. This makes me sad and frustrated, I don't live coherently, I push them away because I am frustrated that I have to live playing this role; to avoid this, I don't live it.” (W CIS, 28, male trans).

“Face up to my family and tell them who I am. Show the world what I am like.” (M CIS, 38, female trans).

“Help with the process when explaining it to my parents.” (W CIS, 20, male trans).

“Help me to deal with the difficult family relationships with the whole issue of my transition.” (M CIS, 20, female trans).



7. People attended to in therapy groups (October 2013 – October 2015)

The therapy group space is led by two psychologists: Soraya Vega and Diana Zapata. This space has been gaining more and more ground every year since October 2013, when it set up its first group, attended by 14 people. In 2014, 9 people participated in the group and in October 2015, its third year, there was a considerable increase in participation with 23 people enrolled.

As regards the gender with which the group participants identify, there was a change from a female trans majority (12) in 2013 to a male trans majority (12) in its third year, which started in October 2015.

One of the aspects highlighted by the participants in these groups is the fact that they consider it a space where they can talk freely about how they feel in terms of gender. They underline the distinctive and positive fact that it is a space where the attitudes regarding how gender is understood are flexible and diverse, and this means that you can call yourself what you want without being judged. This year, there are two people that are not sure what to call themselves and two more that consider themselves to be gender fluid, something that increases the number of participants and makes the group more heterogeneous in terms of the diversity of gender to which they belong.

Each person works on their own experience in the group therapy. The group acts as a sounding board, facilitating the expression of emotions among its members, by working together. It gives us the chance to bring into play what happens during our daily lives, so that we can become aware and responsible for what happens to each and every one of us. Furthermore, the group helps us to recognise the way we come across to others and to explore hidden or rejected aspects of our personality. Group work

speeds up the effectiveness of therapeutic processes.

The aims of the therapy group are:

- Work on accepting gender difference.
- Place the focus on their life stories by telling them in the first person and giving sense to the fact of being people dedramatising and revitalising the trans choice.
- Contribute to reducing stigmatisation, opening up meeting spaces to strengthen interpersonal relations, and to combat social exclusion and isolation.
- Reinforce the strength of each member of the group as a product of their own experiences, as well as feedback that helps them to share their experience with the other group members.
- Universalise the experience of living as a non-normative gender through group reflection and individual experiences.
- Create social support networks and synergies to combat personal isolation.

Common issues addressed in the group and transcribed literally

“Help me to solve mental conflicts and problems regarding who I am.”

“How to deal with violent situations, discrimination and transphobia in daily life and to come through them successfully. Feel supported.”

“Get the strength to face the transition, be given a nudge because I can't do it on my own.”

“Talk about the physical and psychological changes caused by the hormone treatment taking into account personal characteristics.”

“Help the other group members with my own experience of the transition.”

“Share information about trans social networks /how to change your name?”

“Depathologise trans. Have a space where I can deal with what is happening to me without the fear of being judged.”

“Come to a space when I can meet with other people like me, who understand what I'm talking about.”

“Become more secure as a person.”

“Meet new people, socialise, share personal and unique stories.”

“How to tell the family, friends and relatives?”

8. Other types of care at Trànsit-AM and Trànsit-AP

Care provided to the close family and friends of trans people

62 close family and friends of trans people (parents, grandparents, aunts and uncles, partners and friends) were attended to in Trànsit and 15 in Trànsit-AP.

Reports for changing the name and gender on the birth certificate

67 medical reports have been written in Trànsit and 51 in Trànsit-AP.

Reports to facilitate socialisation during the transition period when the name and gender cannot yet be changed on the ID card (DNI)

- Reports for changing the name on lists in primary and secondary schools, universities, health centres, libraries, sports centres, etc.: **38**.
- Reports for primary care doctors and nurses to facilitate greater access to medical control and treatment: **108**.
- Other reports (summer day camps, plane journeys, etc.): **30**.
 - » Advice on projects in lower and higher secondary school, undergraduate degrees, masters, PhDs: **16**
 - » 28-hour courses for professionals of the Sexual and Reproduction Healthcare unit (ASSIR) of Barcelona: **108 professionals**

- » Clinical sessions for primary healthcare teams: **150 professionals**
- » Participation in seminars and workshops for healthcare professionals: **2**
- » Training for psychologists: **45 professionals**
- » Raising awareness among school professionals: **85 professionals**
- » Media intervention: **6 magazines, 1 radio programme, 2 radio programmes and two documentaries**
- » Participation in trans activism seminars: **6**
- » Coordination with prison healthcare services: **1**
- » Coordination with special education services: **2**
- » Coordination with social workers: **3**
- » Coordination with psychologists and psychiatrists: **10**
- » Courses for trans people in non-governmental organisations: **3 courses** with 38 attendees
- Volunteer training courses for non-governmental organisations: **2 courses** for volunteers from Stop Sida with 54 attendees

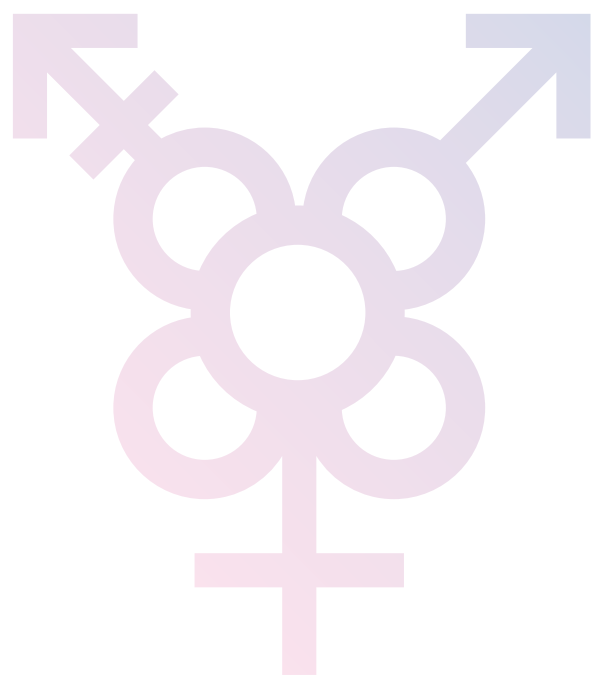
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