Gender Dysphoria: Overview and Psychological Interventions

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20.1 Introduction

The nosography of Gender Dysphoria (GD) has recently been object of an important change. In the Statistical and Diagnostic Manual of Mental Disorders, DSM V [1], this diagnosis was separated from paraphilias and sexual disorders, becoming an independent category. The most important innovative aspect introduced by the DSM V concerns the condition known as "Gender Identity Disorder", which is now referred to as "Gender Dysphoria". The new nomenclature emphasizes the salient aspect of distress overcoming the stigmatizing definition of "disorder", previously used.

Literature reports that Gender Dysphoria (GD)—defined as marked incongruence between one's expressed gender and her/his assigned gender [2] (APA 2014)—is associated with psychological suffering characterized by anxiety, depression, impaired relationships, and suicidal ideation. The difference between one's expressed gender and her/his physical sexual characteristics is expressed by the desire to get rid of them and/or to have the primary and secondary sexual characteristics of the opposite gender. The peculiarity of this disorder is the coexistence of medical aspects (biological sex) and psychological aspects (subjective experience). Previous studies highlight that psychological risk does not derive from the gender inconsistency, but from childhood traumatic experiences in different contexts, such as family, school, and because of non-recognition of psychological and sexual identity [3]. The community non-acceptance persists in adulthood, magnified by cultural stereotypes.

Therefore, Gender Dysphoria (GD) represents the condition of partial or complete discordance between assigned sex, based on external genitalia, and the gender recognized by the brain. So, it is characterized by suffering, malaise, and stress. This existential state has an intrinsic complexity that deserves as much attention and management as the medical issues related. Therefore, in a service dedicated to GD, it is necessary to create a multidisciplinary team dealing with all aspects of the transition process. Accordingly, an elective modality of "cure" has been proposed: on the one hand, the person carrying GD is supported from a psychological point of view; on the other hand, s/he is allowed to choose how to transform his/her morphological characteristics according to his/her subjective experience of identity, through endocrinological and surgical treatments. Of

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note, Law number 164 on 14th April 1982 ("*Rules on the rectification of gender attribution*") establishes the possibility of carrying out a Surgical Sex Reassignment (SSR) and/or a change of sex at registry office even without SSR. In any case, it is permitted only after a clear diagnosis of GD has been formulated by a psychiatrist.

In Italy, the Observatory on Gender Identity (ONIG) has identified the centres able to take care of these cases throughout the national territory. Such centres must meet the criteria of Standards of Care (SOC) of the World Professional Association for Transgender Health [4], as defined by the Harry Benjamin International Gender Dysphoria Association. In fact, in all countries of the world, this Association reunited and supported people who, despite different skills, desire to develop the best possible practices and the most useful support to improve the quality of life of this population.

As a general expectation, people born with male sex identify themselves as men, while those born with female sex as women. Nonetheless, this is not what real experience teaches us and can be prejudicial if not detached from reality. In fact, a person, who experiences a so-called "Gender Variance", does not recognize him/herself in this binary system occurring at birth. He/she does not perceive the gender identity as corresponding to birth assigned sex.

In fact, while there is biological sex depending on differences in chromosome numbers and genital conformation, gender identity is a more intimate feeling of belonging to the male or female gender, or to some combination of them. Therefore, Gender Identity allows people to say: "I am a man", "I am a woman", "I am a genderqueer", regardless of the birth assigned sex.

The term *Transgender* refers to identities or gender expressions that differ from social expectations typically based on the birth assigned sex. Transgender people can have a binary gender identity (identifying themselves as women if at birth they were men or as men if at birth they were women) or non-binary (identifying themselves with subjective combination of genres). Not all people living "Gender Variance" express psychological or physical discomfort. Most of them find balance between the perception of oneself and the subjective model of relationships. On the other hand, if there is a psychological or physical distress, the so-called *Gender Dysphoria,* the person could feel the need to adapt the external reality (anatomical and personal data) to his or her emotional inner world. This is possible thanks to different interventions, including intake of feminizing or masculinizing hormones, surgical interventions, and/or modification of personal data. There are currently no data indicating a prevalence of people with gender variance. Nevertheless, there are data on the prevalence of Gender Dysphoria based on people entering specialized centres. Specifically, the World Professional Association for Transgender Health Standards of Care reported a prevalence of 1 in 11,900–45,000 for people assigned at birth to the male gender and 1 in 30,400–200,000 for people assigned at birth to the female gender.

The personal gender identity develops influenced by emotionally significant relationships and by social-educational environment, based on predisposing biological characteristics. Most of clinical and psycho-social studies agree on multifactorial nature of this process, focusing on the combined action of biological, psychological, social, and cultural factors.

20.2 Basic Concepts: Sexual and Gender Identity

To understand the experiences of Transgender people, we refer to behavioural and phenomenological markers of psychosexual development. Most of scholars refer to a tripartite model based on *gender identity, gender role,* and *sexual orientation*. Some authors also consider a further construct: *gender expression*. These components drive and guide the development of *sexual identity*. There are different definitions of *gender identity*; first, it is not a stable construct because it is acquired step by step in the entire existence and it is influenced by different experiences. The *sexual identity* consists of biological sex (male or female according to certain biological parame-

ters), gender identity (feeling male or female), gender role (adherence to the expectations of social context related to both biological sex and one's own gender identity experience), and then sexual orientation (the gender towards which the individual feels sexual attraction).

The *biological sex* is the set of all biological characteristics of being female or male (biological sex): the sex chromosomes (XY for males and XX for females), the gonads (testes for males and ovaries for females), external genitalia, and secondary sexual characteristics (development of breasts, presence of face hair, tone of the voice, etc.) which appear during the sexual development (puberty).

Gender is a more complex construct and refers to characteristics depending on cultural, social, and psychological factors that define typical behaviours for men and women. For most people, biological sex and gender identity match. The term *transgender* identifies people with gender identity other than biological sex: for example, a person born as male, but feeling female (or vice versa). The condition that gender identity differs from biological sex is known as gender incongruence. *The gender incongruence is not a disorder.* In the last edition of International statistical classification of diseases and related health problems (ICD-11), gender incongruence was declassified from the chapter of mental health and included in the chapter of *sexual health*. If psychological discomfort of gender incongruence is structured in persistent and specific symptoms with an associated alteration of the global functioning, that is Gender Dysphoria.

Epidemiological data: as previously reported, prevalence data of *Gender Dysphoria* in adults (>18 years) are collected by specialized centres. Such data are most probably underestimated because not all people with gender incongruence develop Gender Dysphoria, then not all people affected by Gender Dysphoria come to a specialized centre. The estimated prevalence of GD is 0.005–0.014% of people with biological male sex and 0.002–0.003% of people with biological female sex [5]. Therefore, gender dysphoria is more common in the MtF form with a male/female ratio of approximately 3:1. In children under 12, the male/female ratio ranges from 3:1 to 2:1; while in teenagers, over 12 years, the male/female ratio is about 1:1.7 [5]. We highlight Gender Dysphoria is independent from sexual preference, which indicates sexual and emotional attraction for a person of the same sex (homosexuality), of opposite sex (heterosexuality), or of both genders (bisexuality). Transgender people can have any sexual and sentimental orientation, for example, they can be heterosexual or lesbian, gay or bisexual.

20.3 Symptoms

Gender Dysphoria appears as malaise and discomfort towards one's body, felt as a stranger; the same sense of strangeness is experienced towards behaviours and attitudes that are typical of one's sex, within which the person does not recognize her/himself.

The first symptoms of gender dysphoria may appear from the very early years of life, 2–3 years. In studies on childhood, it was seen gender dysphoria remains until adulthood for 6–23% among males and 12–27% among females. In other words, less than a third of children, in whom gender dysphoria has been diagnosed, will maintain this condition even during adolescence. However, when gender dysphoria persists in the early stage of sexual development (puberty), it rarely disappears over time, and nearly all adolescents with gender dysphoria maintain this condition well into adulthood.

20.3.1 Children

Characteristic behaviours of gender dysphoria among children may include:

- Desire to wear clothes, use toys or take part to games typically associated to the other gender, preferring to play with children of opposite biological sex.
- Refusal to urinate as other children of the same biological sex do (standing for boys or sitting for girls).

- Desire to get rid of their genitals and want to have genitals of the opposite biological sex (for example a boy may say he wants to get rid of his penis and a girl may wish to have a penis).
- Extreme discomfort with the changes in the body that occur during puberty.

These behaviours in gender dysphoria are associated with deep suffering and distress at school and in relationships. Rather consistently, in children with gender dysphoria, anxiety and depression are common.

20.3.2 Teenagers and Adults

In teenagers and adults, symptoms may include:

- Certainty that one's true gender is not aligned with one's body.
- Disgust towards one's own genitals.
- Strong desire to get rid of one's genitals and other characteristics of one's biological sex.

It is very difficult to have or suppress these feelings, and as a result, people with gender dysphoria may present with anxiety, depression, engage in self-harm, and have suicidal thoughts.

In the Diagnostic and Statistical Manual of Mental disorders, fifth edition (DSM-5—American Psychiatric Association) details about the diagnostic criteria for gender dysphoria according to age (children, adolescents, and adults) are reported.

20.3.3 DSM 5

20.3.3.1 Gender Dysphoria Criteria in Adults

A. A marked incongruence between one's experienced/expressed gender and their assigned gender, lasting at least 6 months, as manifested by at least two of the following:
   1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
   2. A strong desire to get rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
   3. A strong desire for the primary and/or secondary sex characteristics of the other gender.
   4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
   5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
   6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

B. The condition must also be associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

20.3.3.2 Gender Dysphoria Criteria in Children

A. A marked incongruence between one's experienced/expressed gender and their assigned gender, lasting at least 6 months, as manifested by at least two of the following (one of which must be the first criterion):
   1. A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
   2. In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
   3. A strong preference for cross-gender roles in make-believe play or fantasy play.

4. A strong preference for the toys, games, or activities stereotypically used or engaged in by the other gender.
5. A strong preference for playmates of the other gender.
6. In boys (assigned gender), a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games, and activities.
7. A strong dislike of one's sexual anatomy.
8. A strong desire for the physical sex characteristics that match one's experienced gender.

B. The condition must be associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify whether a Sexual Development Disorder is present.

20.3.3.3 Gender Dysphoria Criteria in Adolescents

A. A marked incongruence between one's experienced/expressed gender and their assigned gender, lasting at least 6 months, as manifested by at least two of the following:
   1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
   2. A strong desire to get rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
   3. A strong desire for the primary and/or secondary sex characteristics of the other gender.
   4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
   5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
   6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

B. The condition must also be associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify whether a Sexual Development Disorder is present.

After confirming the diagnosis, the person affected by Gender Dysphoria must be informed about all strategies of treatments, as well as about the associated risks and the irreversibility of some of them. The symptoms described above explain the need to provide adequate responses to specific needs, bearing in mind, as we are about to clarify, the multifactorial nature of the condition of gender incongruence and of Gender Dysphoria.

20.4 Causes: Etiological Theories

The causes of Gender Dysphoria are still unclear and both psychosocial and biological factors have been implicated. Currently, the most accepted hypothesis is that both factors contribute to its development [6, 7]. Even if social factors, such as education, environment, and events of life, are of great importance in emergence of gender dysphoria, there is still no experimental evidence to support this theory.

Studies carried out on twin populations have shown that in monozygotic twins (i.e. generated by the same egg-cell and, therefore, with the same genetic makeup) the possibility of gender dysphoria occurring in both twins is higher than in heterozygous twins (generated by two distinct egg cells and therefore with 50% of the same genetic makeup). This suggests genetic factors are important in gender dysphoria. There are also numerous theories that consider the influence of sex hormones on the onset of gender dysphoria.

As established by animal model experiments, the process of sexual differentiation is not limited to the development of the genitals, but it involves the structures of the central nervous system that regulate sexual behaviours. Since the differentiation of the genitals occurs in the first 2 months of intrauterine life, while that of the central nervous system begins in the second half of pregnancy and becomes manifest in adult life, it has been hypothesized that in subjects with gender dysphoria these two processes occur in a disharmonic way. In this regard, the importance of prenatal male sex hormones, particularly testosterones, in development of male sexual identity was suggested. Indeed, some studies highlighted that low levels of testosterone in male foetuses can be associated with an increased incidence of Gender Dysphoria. Furthermore, a reduced sensitivity to testosterone and, therefore, a defective functioning of this hormone has been evidenced in MtF people.

Other studies focused on brain area differences between male and female population and suggested that cerebral architecture of individuals with Gender Dysphoria resembles the one of individuals with the same gender identity rather than those with the same biological sex, thus suggesting that non-biological factors may play a predominant role in GD genesis. The diagnosis of Gender Dysphoria requires evaluation by a mental health expert (psychologist or psychiatrist). In general, a psychologist or a psychiatrist assesses whether Gender Dysphoria criteria are satisfied, with a focus on the way feelings and behaviours develop over time, and on the family and social context (if it is present and supportive). The team also assesses all condition for differential diagnosis, i.e. a non-compliance to stereotyped gender role behaviours, or a strong desire to belong to another gender than the one assigned and the degree and pervasiveness of activities and interests that vary with respect to gender for reasons inherent to the gender role rather than identity. GD must be distinguished from Transvestic Disorder, a cross-dressing behaviour that generates sexual arousal and causes suffering and/or impairment without questioning one's primary gender. GD differs from Body Dysmorphism; the focus is on the alteration or removal of a specific part of the body as it is perceived as abnormal and not because it is representative of an assigned gender that is repudiated. It should also be distinguished from psychotic mental disorders, in which gender inconsistency can be underlying a delusional construct.

20.5 Treatment

Treatment of Gender Dysphoria aims to reduce, or remove, suffering based on teamwork of psychologists, psychiatrists, endocrinologists, and surgeons. There are standards of care proposed by the World Professional Association of Transgender Health (WPATH, [8]) and international guidelines [9] which health workers refer to. Some people with Gender Dysphoria decide to modify their body to make it more alike to how they feel, through a "*path of affirmation of gender*" that proceeds in successive phases and can include hormonal and/or surgical treatment. Treatments are not always necessary and the treatment process is not the same for all people. Indeed, the procedure is different according to real needs of the individual.

20.5.1 Treatment for Children and Adolescents

First line treatment of GD in children and adolescents is psychological intervention that must be provided by mental health experts (child psychologists and neuropsychiatrists), especially if specialized in issues related to developmental age. Psychological support allows to face current problems and provides help to reduce emotional suffering sometimes allowing for more drastic treatment avoidance.

Non-medical intervention is planned. So far, there is no consensus about the best intervention with *children* with GD, because the studies on the effectiveness of the different psychological approaches are poor and inconclusive. However, there is expert convergence on the opinion that

the aim of a clinical intervention in children with GD must be to reduce discomfort and—if present—the associated emotional difficulties. The goal is the psychological well-being of the child. The better described approach is the so-called *watchful waiting*, which has the aim to encourage people with GD to explore their gender identity for it to develop in a natural and spontaneous way, while the individual maintains a neutral attitude towards any development outcome. The aim of the clinician (psychologist and/or psychotherapist) is to inform and to train the family about GD and to support it in making decisions following a careful evaluation of costs and benefits. Major associations dealing with developmental age or transgender health, such as the World Professional Association for Transgender Health (WPATH) and the American Academy of Child and Adolescent Psychiatry, condemned all interventions aimed at identity gender modification as unethical or attempts at prevention of a future non-heterosexual orientation.

The approach to Gender Dysphoria in *adolescence* requires careful evaluation, with particular care in making differential diagnoses with other conditions in order to define individualized paths. For example, it is important to distinguish Gender Dysphoria from internalized homophobia that occurs in some adolescents who, failing to accept their homosexual orientation, may require a medical gender reassignment (GR). Depending on the cultural context, their belief system, or even stereotyped views of social arrangements, some homosexual adolescents may mistake their sexual orientation for gender identity, due to a history of borderline behaviours and cross-gender interests in childhood. First, differential diagnosis needs to exclude the "Transvestic Disorder". Transvestism mostly characterizes male adolescents who occasionally wear female clothes without a connected sexual motivation; in fact, in adolescence this behavioural manifestation can represent a phase of experimentation. Transvestic Disorder in DSM-5 is among the Paraphilic Disorders and generally occurs in males of hetero- or bisexual orientation who experience sexual arousal in wearing women's clothing associated with emotional distress. Transvestism disorder is distinguished from Gender Dysphoria because in the first case, gender identity is not in question. Gender Dysphoria must also be distinguished from "Body Dysmorphic Disorder" characterized by pervasive concern for presumed physical defects or imperfections, which are associated with repetitive behaviours in response to worries about such defects. In these cases, the modification or removal of a specific part of the body is required because it is perceived as abnormal or deformed, and not because it is attributable to the gender assigned at birth.

It is important to point out that Gender Dysphoria in adolescence is often accompanied by concomitant psychopathologies. Adolescents with Gender Dysphoria report higher levels of suicidal risk, depression, anxiety, social isolation, and bodily dissatisfaction.

The persistence of Gender Dysphoria in adolescence and the frequency of other associated psychopathologies—reactively to the condition of Gender Dysphoria—supports the importance of early intervention, including medical intervention. The guidelines of the Endocrine Society and the WPATH Standards of Care, together with the recommendations of the main national scientific societies, suggest to interrupt pubertal development with GnRH analogues (GnRHa) in adolescents with GD who meet specific criteria, i.e. an early onset of DG whose symptoms intensified during the early stages of puberty; the absence of psychosocial issues that may have interfered with diagnosis or treatment; a good understanding for the consequences of GR (Gender Reassignment) in one's existence. In addition to psychological support, the administration of GnRHa is indicated to postpone puberty when Tanner stage 2 has been reached. GnRH analogues, which are prescribed by the endocrinologist, work by suppressing the production of sex hormones, therefore they block the physical changes induced by puberty. Therefore, they allow adolescents for a longer exploration of their gender identity and the mental health experts to observe adolescents' gender identity while relieving the suffering that can come from contact with a body that develops in an unwanted direction. The effects of therapy with GnRH analogues are completely reversible:

if the treatment is interrupted, pubertal development immediately begins in the direction of biological sex. If GD persists and if specific eligibility criteria are met, it is possible to start a first hormonal GR, from 16 years onwards with the intake of cross-sex hormones (CHT). Surgery is also allowed as an extreme strategy, but better after age of 18.

20.5.2 Treatment for Adults

1. Psychological support if necessary.
2. Feminizing or masculinizing hormone treatment (cross-sex therapy).
3. Sex reassignment surgery.

In this section, we will deal with the *psychological support* provided to people with Gender Dysphoria, mentioning hormone therapy only in relation to the involvement of mental health professionals. The prerequisite for any psychotherapeutic approach can be summarized in some fundamental requirements that health professionals must apply always and in every area such as: the respect due to users with Gender Dysphoria without pathologizing the differences related to gender identities and expressions; the ability to provide adequate information about the services that transsexual, transgender and gender nonconforming people can benefit from the National Health System and, in particular, on the benefits and risks of the treatment; to guarantee personalized psychotherapeutic approaches, which are shaped on the individual needs; to facilitate the access to the most appropriate cures based on the condition of the individual. Taking charge of user with Gender Dysphoria provides for multiple paths and possibilities that the psychologist and/or psychotherapist are required to know. Indeed, some people do not feel the need to modify the somatic characteristics of their body—through medical-surgical paths of virilization or feminization—especially if capable of integrating their trans- or cross-gender experience in the gender assigned at birth. Alternatively, people may consider only a few changes in gender role or gender expression or wish to make a transition even physical in line with the change in their gender role, requiring hormonal therapies but not surgery. Finally, people may wish surgery to complete the transition process and thus alleviate dysphoria but not other non-surgical strategies. It is therefore essential for health professionals, and especially for psychologists and psychotherapists, to make an effort to deeply understand the individual's life history and support him/her in an individualized way.

In fact, treatment of gender dysphoria should always explore the different possibilities of expression of identity. Psychotherapy (individual, couple, family, or group) therefore aims: to explore gender identity, role, and expression; to alleviate the stressful impact of Gender Dysphoria and social stigma on mental health; to reduce internalized transphobia; to provide tools for the user to enhance their social network and peers; to improve their body image; and ultimately to promote resilience.

Hormone therapy can be prescribed to all people with persistent and well-documented Gender Dysphoria; who are of age (if minors it is necessary to refer to guidelines for adolescents with gender dysphoria); they must be able to make a fully informed decision and to agree with the treatment and, finally, that they do not present medical or psychological problems.

In order to start hormone therapy, no minimum time for evaluation, psychological support, or social transition is required. However, the physician prescribing sex hormones (usually an endocrinologist) has the responsibility of making sure that hormone therapy is the best way to meet the user's needs and reduce their suffering, without inducing health problems. Therefore, it is considered appropriate to provide multidisciplinary care, so that different professional skills are continuously integrated. An accurate assessment of the psychological and existential status of the person, as well as their psychosocial context of reference, is necessary.

It is good to proceed to:

1. Analysis and evaluation of the psychological motivations that led the subject to undertake his/her treatment path;

2. Analysis of awareness of achievable goals and hypothesized emotional reactions related to the realistic change of the body according to the desired identity, to any sex reassignment surgery procedures, to the functionality of the genital system;
3. Assessment of the users' ability to share with their family and social context with respect to their transition process and assessment of the resources of the family and social context to welcome and support the user.

Such a general assessment is necessary in order to have a snapshot of the personal and relational situation of the user with Gender Dysphoria and make psychotherapeutic management personalized.

However, it is important to underline WPATH recognizes that health does not depend only on clinical care, but also on a social and political climate that guarantees social tolerance, equality, respect, and the full right of citizenship. Health is guaranteed with public policies and legal reforms that promote tolerance and fairness towards all gender differences and aimed to eliminate prejudice, discrimination, and stigmatization.

A significant part of transgender people's suffering originates precisely from the stigmatization deriving from a stereotyped vision of the concept of gender along with all additional stressors, connected to the stigma of gender nonconformity, and that may negatively affect the psycho-physical health of the individual. This phenomenon, known as *Minority Stress,* affects people belonging to social categories stigmatized and subjected to excessively high levels of stress, such as those derived from violence, discrimination, and stigmatization. Stigma can certainly be defined as a social process that negatively connotes a member or a community based on its characteristics to which inferior qualities are arbitrarily attributed. Stigma can be experienced on at least three levels: structural, interpersonal, and individual. Structural stigma refers to the level of social institutions and it constitutes a barrier to access to fundamentals, such as work or care; the interpersonal stigma is a particular behavioural structure which manifests itself through verbal abuse, physical or sexual violence, or threats; the individual stigma instead refers to the feelings and emotions that the stigmatized person feels or what he believes that others think of himself. All three types of stigma are widely represented among transgender people and connected with the adverse psycho-physical health outcomes. It is evident that psychotherapy work must focus on the individual's resources to promote resilience, while being aware that structural and interpersonal aspects of the stigma cannot be eradicated with psychotherapeutic work alone.

20.6 Conclusions

The formation and definition of transgender and transsexual identity have a high specific complexity, to which environmental and cultural stigmatizations add further complexity. However, it is essential to recognize that the transgender and transsexual evolutionary path preserves the typical dynamics of any identity construction process. Therefore, in clinical work with these people, it is important to consider both the identity structure of the person and the universal evolutionary processes. Approaching transsexual people with the prejudice of an absolute diversity in the formation of the self and identity can compromise the understanding of psychological processes behind while preventing from a fully empathic relationship, that is needed in order to establish a good therapeutic alliance.

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Link to Further Information

ICD-11. Gender incongruence of adolescence or adulthood: https://www.who.int/standards/classifications/frequently-asked-questions/gender-incongruence-and-transgender-health-in-the-icd.
Infotrans: https://www.infotrans.it/.
Mayo Clinic. Gender Dysphoria: https://www.mayoclinic.org/diseases-conditions/gender-dysphoria/symptoms-causes/syc-20475255.
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