

TRANSEXUALIZING PROCESS IN THE SUS: QUESTIONS FOR PSYCHOLOGY FROM THERAPEUTIC ITINERARIES AND DEPATHOLOGIZATION

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ABSTRACT. This qualitative, descriptive and exploratory research conducted in the Away from Home Treatment (Tratamento Fora de Domicílio [TFD]), in Cuiabá, Brazil, aimed to raise reflections on the therapeutic process itineraries of trans people in the search for the Transsexualizer Process (Processo Transexual [PT]). Three transgender men, two transgender women and one transvestite woman participated. They were aged between 21 and 32 years. Data were collected through semi-structured interviews and analyzed using Content Analysis. The results show that trans people follow different itineraries, looking for institutionalized or informal services (trans sociality networks) to affirm their gender identities. Obstacles related to pathologization, reception, continuity of care, resolution and reference in the care network of the Transsexualizer Process stand out. Important critical points were observed in social, endocrinological and psychological care. The pilgrimage by health services was marked by constant institutional discrimination, allowing for the understanding of how the health system is organized concerning the care of these people, listing issues for the work of Psychology, in this field, from a perspective of the experience and materiality of gender.

Keywords: Transsexualizer process; therapeutic itineraries; trans people.

PROCESSO TRANSEXUALIZADOR NO SUS: QUESTÕES PARA A PSICOLOGIA A PARTIR DE ITINERÁRIOS TERAPÊUTICOS E DESPATOLOGIZAÇÃO

RESUMO. Trata-se de uma pesquisa qualitativa, descritiva e exploratória, realizada no Tratamento Fora de Domicílio, na cidade de Cuiabá-MT, Brasil, que objetivou levantar reflexões sobre os itinerários terapêuticos de pessoas trans, na busca pelo Processo Transexualizador. Participaram três homens trans, duas mulheres trans e uma mulher travesti, com faixa etária de 21 a 32 anos. Os dados foram coletados por entrevistas semiestruturadas e analisados mediante análise de conteúdo. Os resultados mostram que

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essas pessoas trans seguem trajetórias diversas, procurando serviços institucionalizados ou informais (redes de socialidade trans), para a afirmação de suas identidades de gênero. Destacam-se entraves atinentes à patologização, ao acolhimento, à continuidade do cuidado, à resolatividade e à referência na rede de atenção do processo transexualizador. Observaram-se importantes pontos críticos na assistência social, endocrinológica e para a psicologia, sendo a peregrinação pelos serviços de saúde demarcada por constantes discriminações institucionais, permitindo a compreensão de como o sistema de saúde se organiza em relação ao atendimento dessas pessoas, elencando questões para o trabalho da psicologia, nesse campo, a partir de uma perspectiva da experiência e materialidade do gênero.

Palavras-chave: Processo transexualizador; itinerários terapêuticos; pessoas trans.

PROCESO TRANSEXUALIZADOR EN EL SUS: CUESTIONES PARA LA PSICOLOGÍA DESDE ITINERARIOS TERAPÉUTICOS Y DESPATOLOGIZACIÓN

RESUMEN. Esta es una investigación cualitativa, descriptiva y exploratoria realizada en el tratamiento fuera del domicilio en la ciudad de Cuiabá, Brasil, que tuvo como objetivo plantear reflexiones sobre los itinerarios terapéuticos de las personas trans en la búsqueda del proceso transexual. Participaron tres hombres trans, 2 mujeres trans y 1 mujer travesti de 21 a 32 años. Los datos fueron recogidos a través de entrevistas semiestructuradas y fueron analizados mediante el Análisis de Contenido. Los resultados muestran que estas personas trans siguen caminos divergentes en busca de servicios institucionalizados o informales (redes sociales trans) para afirmar sus identidades de género. Se destacan los obstáculos relacionados con la patologización, acogida, la continuidad de la atención, la resolución y la referencia en la red de atención del Proceso Transexualizador. Se observaron puntos críticos importantes en la asistencia social, la endocrinología y la psicología, en que la peregrinación por los servicios de salud es delimitada por la constante discriminación institucional que permite comprender cómo se organiza el sistema de salud en relación con la atención de estas personas que señalan los problemas para el trabajo de la Psicología en este campo desde una perspectiva de experiencia y materialidad de género.

Palabras clave: Proceso transexualizador; itinerarios terapéuticos; personas trans.

Introduction

This article aims to raise reflections on the therapeutic itineraries of trans people residing in Cuiabá-MT, having as a central point the production of health care, based on the Transsexualizer Process (Processo Transexualizador [PT]), in the Unified Health System (Sistema Único de Saúde [SUS]), and the questions that the therapeutic itineraries pose to Psychology. To achieve this goal, it was necessary to understand how trans people operate in the meshes of the process and their maneuvers to ensure specific demands, since the way of living, outlined by the context in which each person is inserted, produces differentiated care itineraries that are relevant for a more comprehensive

understanding in health. Throughout the article, we use the expression ‘trans people’, as a more inclusive linguistic strategy, by referencing identities in their varied relationships with gender identities, thus avoiding the essentialisation of the experience due to a generic noun that is routinely allocated in a pathologizing bias, either by the narratives of society and the State or the medical-legal discourses (Teixeira, 2012).

In this sense, medical, legal, psychiatric and psychological knowledge, while not depathologizing trans identities effectively, contribute to the maintenance of mental pathology, under the rubric of transsexualism (1980) inscribed in the *Diagnostic and statistical manual of mental disorders*, later transforming into a Gender Identity Disorder (1994) or Gender Dysphoria, most recently (2013) (Favero & Machado, 2019). Tenório and Prado (2016) point out that the pathologization of trans identities has been historically endorsed in a bias of knowledge-powers hierarchy, guided by hegemonic gender normativities and refusing to know the experiences, subjectivities, trajectories and demands of trans people. There is a gap between the sciences, such as hegemonic Medicine and Psychology, from the world experienced by trans people, reducing them to stereotypes, with the pretense of classifying, diagnosing and pathologizing them.

In June 2018 (World Health Organization [WHO, 2018]), the World Health Organization moved the diagnostic category of transsexuality as a mental disorder, defining it as a “[...] condition related to sexual health [...]”, which still reveals the maintenance of the psychopathologization of transgender experiences, even though it was an outstanding achievement in terms of movement. In Brazil, Resolution nº 1 (Resolução nº 1, 2018) of the Federal Council of Psychology emerges as a pioneering milestone for the struggle and defense of the depathologization of genders and sexualities, as it summons the category within its field of action and other assistance, guiding professionals in the area towards an ethical, depathologized action aimed at eliminating transphobia and prejudice directed at trans people. Despite this, the Resolution still faces resistance to implementation, in constant negotiation and social struggle with compulsory cisgenderism, which acts as a strategy to normalize bodies and ways of living. Thus, it is essential to (re)know the strategic movements used in the trajectories and itineraries of trans people, who, for the most part, act from a perspective of re(ex)istance of life and in the face of escape solutions found to avoid spaces in which they are known to suffer violence. The aim here is to invert the “[...] logic of the hierarchy of knowledge and its forms of power over the control of life” (Tenório & Prado, 2016, p. 44), to consider trans knowledge about health and body, from two aspects: Transsexualizer Process and (De)pathologization of Trans Identities.

The concept of therapeutic itinerary is adopted here to describe and analyze individual and sociocultural health practices in terms of the paths taken by trans people, who are located outside cisheteronormativity, to meet health needs that are uniquely expressed. According to Alves (2015), throughout the history of the social sciences, the concept has received different meanings and names: ‘illness behavior’, ‘illness career’, and ‘therapeutic itineraries’. These terms emphasize how social actors seek answers and solutions to health needs.

Since the 1950s, studies called ‘illness behavior’ have focused on identifying the behavior of people or social groups in health services. It was called ‘career of illness’ when the focus was the sequential process of practices that a person considered ‘sick’ developed to seek a therapeutic solution. From the 1980s onwards, research on ‘therapeutic itineraries’ broadened the analytical scope and paid more attention to the

existence of different medical conceptions about treatment and disease. Research on therapeutic itineraries addresses themes primarily in three disciplinary fields (anthropology, sociology and social psychology) and is predominantly guided by qualitative methodologies (Alves, 2015).

Approaching these more recent works, Cabral, Hemáez, Andrade and Cherchiglia (2014) point to therapeutic itineraries as a valuable resource for apprehending singularities in health care and attention processes, which seems to us more interesting for the proposed objective as “[...] they refer to a succession of events and decision-making that, having as an object the treatment of the disease, builds a certain trajectory” (Cabral et al., 2014, p. 4434). In everyday use, the term ‘therapeutic’ can be linked to illnesses and diseases, so it deserves to be explained that the use made throughout the text is the production of health. This caution is vital since trans experiences are just some of the different forms of gender identities and not a pathology-disease allocated in persecutory health, based on individualizing choices (Castiel & Dardet, 2007). Research on therapeutic itineraries makes it possible to walk between singularities and the homogenizing representation of trans bodies, to initiate ruptures in the automatic linguistic predominance that imprisons bodies and subjectivities.

Notes on the transsexualizer process

In 2008, due to social movements, the Transsexualizer Process in SUS was conquered and instituted by Ordinance nº 1.707 and nº 457 of August 2008, expanded by Ordinance nº 2.803 on November 19, 2013, ensuring comprehensive health care for trans people. Currently, the SUS service network for the Transsexualizer Process has ten services that are enabled and in operation, through local initiatives (Brasil, 2017), in addition to some established outpatient clinics that are in the process of being equipped in certain states: Hospital das Clínicas de Uberlândia (MG), Instituto Estadual de Diabetes e Endocrinologia do Rio de Janeiro, Centro de Referência e Treinamento IST/AIDS de São Paulo, Hospital de Clínicas da Faculdade de Medicina (USP), Hospital Universitário Pedro Ernesto (UFRJ), CRE Metropolitana de Curitiba (PR), Hospital de Clínicas de Porto Alegre (UFRGS), Hospital das Clínicas de Goiânia (UFG), Hospital das Clínicas de Recife (UFPE) and Hospital Universitário Cassiano Antonio de Moraes (UFES).

Since services are not available in all Brazilian states and there are no referral services in the region of residence of the person, this is done through Away from Home Treatment - TFD - which is responsible for the forwarding of the person for access to a referral institution. In general, the path of the SUS Transsexualizer Process through the reference regions presupposes access by primary care (priority gateway) for diagnosis that pathologizes the trans identity, interdependent on multidisciplinary follow-up for at least two years. After this process, the person can start in outpatient clinics and referral hospitals, following the generational criteria – minimum age of 18 years old for hormone therapy and 21 years old for surgical procedures, if he/she desires (Brasil, 2013, 2015, 2017).

In force, Resolution nº 2.265 (2019) reduced the minimum age for surgical procedures from 21 to 18 years old. An essential difference between the new text and the previous one is that the updated one starts to contemplate specific issues, such as the interruption of the production of sex hormones at puberty, which is still considered experimental, and cross hormone therapy (a form of hormone replacement in which the

sex hormones and other hormonal medications are administered to trans people, for feminization or masculinization), which were previously unforeseen (Resolução nº 2.265, 2019).

When the search takes place outside the region of the reference services, the itinerary to be followed implies opening a request process via TFD to follow the steps of the itinerary provided for in said ordinances. However, the person can advance the diagnosis stage via a report and multidisciplinary follow-up for two years, entering primary care, or doing it through private channels, if he is in socioeconomically favorable conditions, waiting only for the approval of the process through TFD, for referral to outpatient and hospital procedures in reference services.

Thus, the report combines restrictive power for some accesses in health and progress in the Transsexualizer Process in SUS. Besides, the Ordinance recommends that the gateway is through primary care. However, this is presented in a distanced way in practice since many professionals are unaware of these ordinances and guidelines, denying care in advance from their beliefs. So, the user needs to use other itineraries to find the paths capable of helping to guarantee his/her rights, as can be seen in the interviews.

According to Rocon, Sodré and Rodrigues (2016), the history of transsexualizer procedures in Brazil is marked mainly by the judicialization and medicalization of demand. Thus, it is essential to question what has supported the (in)comprehension of the trans experience by medical-legal knowledge expressed in regulations, resolutions and ordinances and the consequences of health care. Has the normalizing and regulatory bias been efficient in guaranteeing access to health for all trans people? Furthermore, why is psychopathologization a crucial requirement for access to the Transsexualizer Process? We cannot forget that the Federal Council of Medicine (Conselho Federal de Medicina [CFM]) reinforces the classification of a transsexual patient, conceived as mentally ill and potentially suicidal, establishing diagnostic categories for the assessment of the 'true transsexual' (Rocon et al., 2016; Favero & Machado, 2019). Although the regulations authorize the Transsexualizer Process and institute it, in health care, the inconsistency of a gender life outside the lines of binarism, in which bodies become intelligible through their genitals, remains unacceptable and over-coded by nosographic categories (Bento & Pelúcio, 2012).

It is worth mentioning that, even though the guideline establishes the age of 18 years old for outpatient services, such as hormone therapy, many trans people have already conditioned their transition and use of hormones through informal means (trans social networks) long before that age, under the risk of illness or death, due to the difficulty of accessing the health services necessary to make the changes, as already pointed out in other studies, such as those by Rocon et al. (2016) and Favero and Machado (2019), mentioned in this research. However, this has called for revisions in this protocol, which has been implemented timidly since the CFM Resolution nº 2.265/2019.

In Mato Grosso, health care for the trans population, specifically about the Transsexualizer Process, is within the competence of the TFD, via the Cuiabá Regulation Center (Regulator Complex), linked to the Mato Grosso State Health Department (Secretaria de Estado de Saude de Mato Grosso [SES-MT]). The procedure authorization process, carried out through regulatory action, is based on pre-established protocols. The Regulation Center previously authorizes the procedures. This authorization is granted by a team of authorized physicians, guided by the protocols. It aims to ensure orderly access,

respecting clinical criteria of users' needs and availability of the offer. The Transsexualizer Process's authorization procedures are time-consuming, with a long waiting list, resulting in drop-outs or non-referral to competent units for continuation. In this sense, as emphasized by Rocon, Sodré, Zamboni, Rodrigues and Roseiro (2018), the struggle for the universalization of the Transsexualizer Process, from a depathologizing perspective, is closely related to the implementation of the SUS and the ethical and political values of health reform, which is counter-hegemonic, so that the integrality of care, equity, social participation and the autonomy of trans people over their bodies and lives can be reinforced, thus paving the way for a Psychology that cares without pathologizing (Prado, 2018).

Psychology and the transsexualizer process

Since 1997, when the regulation of surgical procedures for transgenitalization began, Psychology has been part of the multidisciplinary team of the Transsexualizer Process (Resolução nº 1.482, 1997). However, this process is governed by biomedical rationality, with the multidisciplinary team subject to and submitting to the ordering of practices framed by diagnosis and medical procedures. It should be noted that processes of normalization and control have historically characterized the links between Psychology and the dissident sexualities and genders of cisheteronormativity, based on a search for the 'true transsexual' (Borba, 2016; Bagagli, 2016), which perpetuate a relation of the profound need for hormonal and surgical interventions, based on gender binarisms (Mattos & Cidade, 2016).

It is in a field of power and dispute that Psychology finds itself when it problematizes and opposes the pathologization of gender identities, for it is addressed diagnostically, in the context of health care for trans people, as it is mainly subordinated to pathologizing, technical and objectifying norms to subjective demands (Mattos & Cidade, 2016). An example of the place reserved for Psychology, in this process, is the compulsory prescription of psychotherapy for two years, as part of the Transsexualizer Process, a requirement that Psychology fulfills in a normative way, in most cases, instead of using the space of two years for transfeminist subversion. As an ethical-political horizon for Psychology, Transfeminism implies questioning, even the standardization that requires two years of the psychotherapeutic process. A transfeminist view presupposes thinking about care focused on health and other domains, such as Human Rights and Public Policies (Mattos & Cidade, 2016; Favero & Machado, 2019). In the disputes and conflicts, Psychology professionals participate in the social mortification of trans people when they conceive the difference as a clinical demand and relegate people who do not fit a classic psychopathological profile of gender to the margins. The reports prepared by psychologists are expected to attest that the person experiences 'symptoms' for at least two years (Favero & Machado, 2019). Thus, it can be seen that the performance in Psychology is still oriented to a learning process on how to act with a 'real transsexual', as pointed out by Borba (2016).

Through a descriptive systematic literature review, aiming to identify the discourses on transsexualities that circulated and impacted the scientific production of Brazilian Psychology, in the period from 1997 to 2015, Pacheco (2017) found several works focused on a practice in Psychology centered on the psychopathological diagnostic investigation and authorizing for interventions in the body. Besides, the author observed that the compulsoriness of psychotherapy did not seem to be a problematized issue by some

works, in the same way, that she realized that it was not, also, for the CFP, from the analysis of the *Technical note on the transsexualizer process and other forms of assistance to trans people* (Conselho Federal de Psicologia [CFP], 2013) and the lack of public positioning against this compulsory clinic defined by the CFM, suggesting an attempt at conciliation (Pacheco, 2017).

In this sense, a paradox arises to be overcome. As referenced in the CFP Technical note (2013), the objective of psychological assistance is to promote the autonomy of users. However, the CFP is not opposed to the compulsory nature of Psychotherapy for two years and that this is a pre-requirement for carrying out the transgenitalization. How can Psychology contribute to the autonomy of trans people if it captures for itself the power to legitimize or deny gender identities through technical reports? Therefore, it is appropriate to advocate for a transautonomy expressed in effective changes in the institutional requirements for diagnostic confirmation, as Favero and Machado (2019) pointed out. Few depathologizing initiatives of psychological care, even if the criteria established in the regulations are safeguarded, manage to become effective and, when they do, they face internal and external resistance to services (Murta, 2011).

Method

Semi-structured interviews were conducted with three trans women and three trans men, around the Federal University of Mato Grosso (UFMT) at Cuiabá Regulation Center - MT, from May to August 2016, following the parameters of the Ethics Committee in Research with Human Beings from the Humanities Area at UFMT. The research was approved by Opinion 1.487.878 and CAAE 53595615.7.0000.5690. The interlocutors signed the Free and Informed Consent Term, respecting the voluntary decision to participate in the research and guaranteeing anonymity, changing the social names to names of gods and goddesses of the Greek pantheon. Access to the investigation's participants occurred through an initial mapping in Cuiabá Regulation Center and organized collectives - LGBT - of the UFMT in Cuiabá - establishing network research.

Thematic content analysis was used to read data (Bardin, 2011). This type of method foresees three primary phases: 1) pre-analysis, 2) the exploration of the material, and 3) the treatment, inference, and interpretation of results (Bardin, 2011). In the pre-analysis, the material underwent a floating reading to make it operational, systematizing the initial ideas to allow its categorization in the exploration phase. Subsequently, it was possible to constitute the thematic categories and units from the empirical data in the material exploration phase to interpret and make inferences.

In the analysis, three categories were constructed based on the interview script and the analysis of the narratives: a) Decision and Search for the Transsexualizer Process (Identity processes, trans network, social imaginary, first place sought, self-hormonization); b) Difficulties and Access to the Transsexualizer Process (place of access, receiving treatment, institutional discrimination, social support, quality and types of services sought until care is taken, referrals made) and c) Performance of Psychology professionals (practices in the care team and assistance policies provided for by the Transsexualizer Process).

The profile of the trans research participants has the following characterization: three trans men, two trans women and a transvestite. Four have incomplete higher education, and two have completed higher education. They are 21 to 32 years old, defining two of them as heterosexual, two as bisexual and two as pansexual. Three

classified themselves as black and three, white color. Regarding occupation, two are unemployed; two are employed – Nurse/Public Servant – and two are studying: Undergraduate Student/Postgraduate Student.

Results and discussion

We descriptively analyze the itineraries of trans people in the search for health care. A wide range of crossings and assemblages leads to diversified movements in the care network, making the trajectories visible in the face of the few available resources, since, in Cuiabá, the Transsexualizer Process is carried out via TFD, that is, users are referred to surgeries in other states. The itineraries are better represented in Table 1.

Table 1. Protocol, itineraries and strategies - Transsexualizer Process (PT) in SUS

PT protocol in SUS	Apollo	Athena	Artemis	Aphrodite	Dionysus	Zeus
Pathological report/diagnosis to follow the next steps	He obtained the report by private means (UNIMED – health insurance)	She searched for and obtained the report by SUS	She did not seek a report to start PT	She sought and obtained the report from the SUS, as her family wanted to understand what she had.	He did not seek a report to start PT	He did not seek a report to start PT
Via Reference Hospitals and Outpatient Clinics	He did not seek the PT due to difficulty at work	She looked for the PT through SUS via TFD.	She did not look for the PT because she heard that it was difficult and that in Cuiabá, there were no services, only TFD.	She sought the referral service in Brasília to start psychological therapy and hormone therapy	He did not look for the PT, knowing the complexity of the service.	He did not look for the PT, knowing the lack of service in Cuiabá and the complexity of the TFD.
18 years old for Outpatient Procedures (Psychotherapy, social assistance and hormone therapy)	Psychotherapy got through Unimed. Hormone therapy, at first, was carried out by informal means (trans social networks) due to the refusal of endocrinologists	At first, she had access to hormones through informal means (trans sociality networks) until she underwent PT in the SUS and got it through an endocrinologist.	At the recommendation of Athena, she got the hormones through informal means (trans social networks) and in pharmacies. Afterward, she looked for a psychologist to help her accept herself better.	She underwent hormone therapy through informal means (trans sociality networks) due to the difficulty with endocrinologists to perform such care	He underwent hormone therapy through private health insurance, in addition to psychiatric follow-up to deal with other issues.	He only performed hormone therapy through informal means (trans sociality networks), as recommended by Apollo.
Preoperative (multi-professional follow-up required for at least two years).	There was no multidisciplinary follow-up for PT but to deal with other issues.	She performed multi-professional care through private channels initially and later through TFD.	There was no multidisciplinary follow-up for PT but to deal with other issues.	She was followed up for PT.	There was no multidisciplinary follow-up for PT but to deal with other issues.	He did no type of multi-professional follow-up.
21 years old for surgical procedures (Transgenitalization and implantation or removal of prostheses/breasts)	He has not undergone surgical procedures but is interested in having a mastectomy	She performed surgical procedures - transgenitalization	She did not perform surgical procedures.	She did not perform surgical procedures. She is on the waiting list.	He did not perform surgical procedures.	He has not undergone surgical procedures but is interested in having a mastectomy

Postoperative (follow-up required for another year).	Not applicable	She did not return for a post-surgical follow-up.	Not applicable	Not applicable	Not applicable	Not applicable
Via Cuiabá Regulation Coordination Via TFD MT	Not applicable	The regulatory center referred her to the reference hospital in Goiânia to carry out the entire process	Not applicable	Not applicable	Not applicable	Not applicable

Source: Prepared by the authors.

In the following subtopics, we highlight some aspects of the itineraries followed by the interlocutors in this process.

Decision and search for the transsexualizer process

All the research participants reported that, since childhood, they had difficulties in the process of gender transition due to lack of support and recognition by society, represented by the lack of family, interpersonal, political nuclei, formal and informal institutions, plus transphobic and gender violence that are present, as Apollo unburdens, "Society is not humanized, they forget that trans people, above all, are people" (Apollo, 25 years old)

The narratives of the trans men interviewed support a search for redirecting trajectories, whenever possible, looking for the answer to care for their health, often in private services. From the first attempt, they perceive a barrier in the service, which starts with their identification, disregards the social name and gender identified and accentuates disapproval. Such results have already been found in other works such as Cerqueira-Santos, Calvetti, Rocha, Moura, Barbosa and Hermel (2010). However, they adopt care tactics, such as, for example, simulating a heterosexual couple in a gynecological consultation, "So, what I do, when I need to go, I call my best friend, ask her to call me by my registered name, when she is called to be assisted, she gets up, and I go after her, like a couple, you know? Then it is acceptable, right?" (Apollo, 25 years old).

Dionysus, when pointing out some of the difficulties in respecting the social name, draws attention to the process of affirmation of trans identities, which is often felt as "[...] a mess that can be pleasant, if there are no attempts to control standardization" (Dionysus, 28 years old). This report is in line with what Apollo and Zeus narrate about the Transsexualizer Process in Cuiabá, "Despite being a capital, Cuiabá is not prepared to assist trans people in any health area. I found it very difficult to find treatment here" (Apollo, 25 years old). Regarding health care for transgender people, "There is none. It is non-existent" (Zeus, 21 years old).

Apolo tried to seek the Transsexualizer Process after difficulties with safe hormone therapy protocols initiated by informal means (trans sociality networks),

You don't know what you're applying; it's made in Paraguay (a Brazilian expression saying something is not original). Sometimes it's mineral oil you're applying, and you don't know it. Because it's oily so that they can put any kind of oil. [...]. I know I can't do that, but what am I going to do? Am I going to run out of hormones? The same way it hurts me if I take it, the same way it hurts me if I stop suddenly, you know? (Apollo, 25 years old).

On the other hand, because he was in constant contact with Apollo, Zeus chose not to seek the Transsexualizer Process when he knew about the difficulties experienced by Apollo.

Unlike trans men, trans women sought the Transsexualizer Process, despite obstacles. They reported that, since childhood, they had confronted a conception of gender designated by the cis-heteronormative matrix, as stated by Athena, "At first, it is confusing, because you don't accept yourself and, later, your soul starts to fit into your body. After that, it's a kiss of light [...]" (Athena, 31 years old). About this transition process, Artemis narrates her experience:

The transition period is the most challenging [...] People look at you like, what is it? What the hell? You are this or that. And you have to change a lot, your clothes, you have to change your whole wardrobe. [...] And then I met Athena again, and then she said, Artemis, do you want to know about the medicine? I said, Yeah, I want to know about the medicine. [...] Then she said, Look, what the doctors tell me is this one. [...] Is it Estrogen? Yeah, It's estrogen. [...] Then I started to buy (Artemis, 24 years old).

In this way, we noticed that, before the transition itself, the processes of searches and itineraries were already underway. Some participants were already undergoing hormone therapy through informal means (trans sociality networks) and were attending psychological therapy, either through the private service or through the public service, to comply with the requirements of the transsexualizer protocol and advance some paths.

Vergueiro (2015) indicates the importance of the sociality network, as it is through it that (re)existences are inscribed in a system that starts from the binary cisgender perspective to decide, from medical knowledge, about the life processes of trans people. The trans interlocutors of this research understand that health is built in different spaces, especially in the trans network. This definition goes beyond the view strictly linked to illness processes, restricted to health institutions, without denying them. In reality, the rare situations in which institutionalized health services appeared in these people's itineraries did not meet their expectations and demands and were considered inadequate by them. Thus, we observe a gap between what is stated in the public health text and the practices in the services.

It is also important to note that the construction of the bodies of trans people is crossed by the production of subjectivities that resort to knowledge already built in the experiences of other trans people, as, for example, concerning the taking of hormones, body modification and, consequently, the affirmation of their gender identity. These are processes that, in general, are conducted without the follow-ups required by this type of intervention to reduce the risks and harms to the health of this population (Bento & Pelúcio, 2012; Brasil, 2015). It is also worth noting that the medical procedures of hormonization and body modification are not always the strategies chosen in the affirmation process. According to Bagagli (2016), it is not biology that talks about gender identity but the subject.

Thus, the construction of bodies is connected to producing a subjectivity that works in transit, in the production of genders, with a particular subversion. However, they are sometimes loaded with suffering due to pressures for normalization. The consolidation of a health care practice that is highly focused on the production of care is relevant because trans experiences require thinking about a policy of experience, since they are multiple

experiences, and it is urgent to implement strategies that allow these people to continue producing their knowledge, create other spaces of care.

Difficulties in accessing and following the transsexualizer process

All participants reported difficulties accessing the Transsexualizer Process, which involved the complexities and bureaucratization, location, available resources, institutional discrimination and lack of referral. Athena, the only participant who carried out the entire Transsexualizer Process through TFD, highlighted that she sought the process so as not to die unhappy,

I saw that it was different. I felt the need to want to be a woman, but it really came out during adolescence. Then, I saw that I couldn't flee anymore from this situation [...] That's why I went to have the surgery because I couldn't relate to men. I couldn't, like, take my clothes off [...] these things, so it was super important. (Athena, 31 years old).

Despite all the struggle undertaken by Athena to make the process effective, and the awareness of the role of the State about the integral health of trans people, her social place occupied demonstrates the dimension of the realization of this conquest and right, "Like, it looked like you won the Mega Sena (It is the largest lottery in Brazil, organized by the Caixa Econômica Federal bank since March 1996) [...] Oh, I can't believe it... It was the biggest news in the world. Going to college in addition to surgery!" (Athena, 31 years old).

However, the *giant lottery* proved to be a pilgrimage and submission to unsatisfactory accommodation conditions to carry out the procedure in another state. After the financial resource was approved, she was referred to the reference hospital in Goiânia, with insufficient financial support for quality accommodation. What support network did Athena count on, staying in a hostel in the post-surgical process?

The accommodation is in hostels. They give you a very symbolic amount, a minimal amount. You can't survive very well there. You stay in a hostel; you don't eat very well and the ticket, the only good thing, that I really appreciate, well, was the question of the ticket (Athena, 31 years old).

Aphrodite, a participant who started the process in Brasília-DF, where she lived before moving to Cuiabá-MT, is still waiting for the surgical procedures on the waiting list. The participant said that she sought the reference service of the Transsexualizer Process to start psychological therapy and hormone therapy,

I never had an endocrinological follow-up because the two times I looked for an endocrinologist to see, they said they didn't want to prescribe such medicines for me because they could cause many problems for me in the future, and they would have prescribed them for me [...] So, well, I had a lot of trouble (Aphrodite, 32 years old).

When portraying difficulties similar to Aphrodite in the hormonization process, Apollo pointed out that, to have access to hormone therapy with medical follow-up (safe hormonization requires measurements, through periodic blood tests), he needed to resort to his private health insurance plan after embarking on informal networks. However, the participant pointed out that he first underwent hormone therapy through informal means (trans social networks) because he could not find endocrinologists willing to assist him. Five endocrinologists he sought care for refused it, claiming that they did not understand

this procedure and did not want to get involved. The protocol of the Transsexualizer Process, in force, contemplates transsexual men and the demands for hysterectomy, mastectomy, neophalloplasty surgeries, in addition to hormone therapy, among others.

Athena sees, in the Transsexualizer Process, a long and slow, bureaucratic and unpleasant path, which has the effect of normalizing and prescribing sexual practices,

The process lasted about five years. And my professor in college said to me; he said, To do the sexual adjustment surgery, you have to be 25 or older. Me, guys, what a joke! I'm going to start having sex after 25 because the transsexuals themselves, the zero ones they talk about, the true transsexuals, who have difficulties, and that's why they do the surgery as they can't relate to men due to their organ. [...]. Imagine the blow that it won't be for this woman to lie with the man, have sex with him, have confidence, and be with him and not feel bad for using, for showing her organ (Athena, 31 years old).

The participant addresses difficulties in the postoperative period and how this experience was painful, depending on the procedures and techniques adopted. According to the interviewee, she only used the acrylic mold for vaginal dilation in the first few months, moving on to another one of inferior quality,

When I changed the mold, I had another mold. It didn't go in so deep; it didn't do it right because the material was terrible. It reduced to 15 cm deep. So, it was horrible. I remember once I went to insert the mold inside her [...], she made a poof, isn't that what it's like when you break the hymen? [...] Okay, something ruptured, blood started coming out, blood. So, like, it's super important that you're moving that orifice to maintain the depth (Athena, 31 years old).

As Vergueiro (2015) and Bagagli (2016) assert, for the medical system, from the point of view of guaranteeing the rights of trans people to access services, they are placed, sometimes as invisible, sometimes as usurpers, since the pathologization of their 'medical condition' necessarily passes through the endorsement of psychiatric and psychological reports, to determine whether it is true transsexuality. In this way, we can say that the TFD, which is a procedure guaranteed by the SUS to its users, necessarily passes through this sieve, being the trajectory in which transphobia operates, because the medical-legal contexts impose on trans people the category of SUS sub-users.

Psychology in the transsexualizer process

From the participants' narratives and therapeutic itineraries regarding the Transsexualizer Process, it was possible to visualize how these people perceived Psychology in this area to summon this discipline to self-criticism concerning the care and assistance provided to this population, which predominantly works based on diagnostic categories, as Aphrodite argues,

Even then, I questioned myself about my sexuality, whether I were bi, straight, homo. What was I? So, well, I had already seen since I wasn't a typical transsexual either. Got it? So, on the day of my final interview with the psychologist, who is the holder of the power, right, who will give the visa for my surgery, and that's when I failed (I wasn't approved) for the first time I went through this test, right? I spent a year in therapy, and she said that I didn't fit in the trans case because if I had bisexual tendencies, that wasn't a woman thing (Aphrodite, 32 years old).

This form of care, subordinated to the institutional requirements of diagnostic and pathological confirmation of gender, will reflect on the decision to go through the PT or not,

as can be seen in Chart 1, in addition to also influencing the continuity of this follow-up, as discussed in the other categories. Therefore, the concepts of health disease need to overcome the biomedical logic to give rise to specific and distinct ways of thinking and acting in the world. After all, diagnoses do not only assess anatomical/physio/psycho/pathological structures: they are crossed by the representation of the norm in specific sociopolitical contexts (Bento & Pelúcio, 2012).

The space for the Away from Home Treatment, where part of the Therapeutic Itineraries narrated by the interlocutors of the research, is mainly focused on expertise to discover/produce, through practices, the 'true transsexual' (Borba, 2016; Bagagli, 2016). The power to judge the veracity of an experience, which is materialized in TFD, updates the psychiatric/psychological/expert power in the form of an alleged therapeutic intervention, worth repeating what Foucault (2006) commented on psychiatric power,

[...] first of all, a particular way of managing, of administering, before being liketherapy or a therapeutic intervention: it is a regimen, or rather, it is because it is and to the extent that it is a regimen that a certain number of therapeutic effects are expected from it – isolation regime, regularity, use of time, a system of measured needs, obligation to work, etc. (Foucault, 2006, p. 218).

Apolo reports how the psychologist who attended him confused gender identity and sexual orientation, the secularity of the profession and moralization, referring him to a church,

I spent four months going to meetings with her [psychologist], and I noticed that she confused gender identity with sexual orientation. She even introduced me to a Catholic church group called Anchorage. I don't remember how to write the name of the group of gays and lesbians within the church and how they articulate themselves. And I tried to tell her. But I'm not a lesbian. At the time, I identified myself as a hetero trans man. I only related to women, and she said, No. But this is for homosexuals, the sex (Apollo, 25 years old).

In Aphrodite's therapeutic itinerary, Psychology was requested by the user to 'give explanations to the family' as to the reasons why the participant 'was the way she was': a trans person. She reported that from the moment she was diagnosed via a pathologizing report, her family relationship improved significantly, since, from that moment, she was understood as a 'TRANStornada' (it is a 'word game' in Portuguese that means 'she may indicate a mental disorder condition') person, which led her to be in favor of pathologization, for a time course:

One of the things they asked me a lot was, But why? Why are you like this I said, Grandma because I don't know, you know? I won't know why I was born this way. I've felt this way since I was little, so I won't know why, you know? [...] When I arrived at my family with this medical report, everything changed. Gosh! She is sick. Now we understand. It's here, oh! Gender Disorder! It's her disease! And then it facilitated all the acceptance of my family. At the time, it was just that this was a burden for me [...] That heavy weight led me to be in favor of pathologization. Because, man, one of the greatest sufferings of all of us, trans, is precisely this. The loss of family contact (Aphrodite, 32 years old).

It appears that, for Aphrodite, the diagnosis, even with all the stigmatizing and pathological bias, was also a controversial way of promoting health care in the family context. Artemis, in turn, described psychological counseling as a space for questioning the process, surgeries, experience and gender norms that cross it,

I was talking about this with the psychologist, and she said: We'll see with time if you really want to do it. I've always felt the need to do the reassignment because it's a way to feel better, more of a woman. But I've heard so many transsexuals saying that they don't need it to feel more like a woman, that we need to work on this with ourselves (Artemis, 24 years old).

Thinking about the professional practices of Psychology, in the context of health promotion for trans people, leads us to the need to consider the epistemological, ethical, aesthetic and conceptual, micro and macropolitical, intersubjective and sociocultural crossings that are present in the Transsexualizer Process, converging on practices that strengthen the rights and citizenship of this part of the population, which routinely continues to face barriers, stigmas and invisibility in health care (Sales, Lopes, & Peres, 2016; Pocahy, 2016). In fact, in the Transsexualize Process, what is emphasized, including in the naming, is the genitalia. In contrast, it is precisely necessary to understand that

[...] a vast amount of other tasks is required. These include raising funds; getting personal support, postoperative care, legal documentation; finding housing; dealing with relationship crises; dealing with workplaces or getting work; dealing with bodily changes; getting social recognition; dealing with hostility. Any of these factors can become central (Connell & Pearse, 2015, p. 217).

As Bento and Pelúcio (2012, p. 576) state, questioning the protocol of the Transsexualizer Process, "[...] in the terms in which it has been implemented, is to face the pathologization of gender and place it in the arena of debate, situating it as a scientific, and therefore historical, category, which means also considering its political character". In this sense, indeed, for some trans people, the therapeutic clinic is essential, especially when there is room for transautonomy. Therefore, the time of therapy and the right not to undergo psychological treatment as part of the Transsexualizer Process should also be preserved. A psychological practice guided by the production of health attentive to the uniqueness of therapeutic itineraries is fundamental to avoid the pathologization of the expressions and gender identities of trans people.

In line with a perspective of psychological care based on the experience of trans people, Prado (2018, p. 49) highlights that it is necessary to see the depathologization from the notion of materialities since depathologizing/de-diagnosing and no-assisting/abandoning are not concepts and synonymous words. "Quite the contrary, it is putting health care in place of co-responsible care. [...] On the contrary, to depathologize is to realize that there is a diversity of body, gender, sexuality and this legitimate diversity has historical and biographical singularities that need to be taken care of".

Final considerations

The therapeutic itineraries taken by trans people in the search for health care and the Transsexualizer Process revealed paths that range from referral services to informal means (trans sociality networks), including private services. Some points were reported as obstacles in the health itineraries: institutional discrimination, bureaucratization and complexities of the policy of the Transsexualizer Process, pilgrimage through various health institutions and professionals, delay in referring the initial care service to the reference service, lack of reception of the demands, thus resulting in the abandonment of

following the policy protocol, to resort, therefore, to informal means (trans sociality networks).

It is from a perception of the Transsexualizer Process not centered on the surgical procedure that the professional practice of Psychology must be rethought because the participants narrate a series of factors related to their gender affirmation, which, in their majority, move from the field of medical intervention to social relations, including family, interpersonal and loving relationships, labor market, education, housing, discrimination and legal documentation, as determinants of well-being and autonomy of therapeutic itineraries. In this field, health care needs to be strengthened so that the work with the user is guided by a bias capable of bringing him together as a protagonist in the production of his health process.

In this scenario, the participants call on Psychology for an effective depathologizing action that is not based on norms and social diagnoses of gender but production of health. Care practices cannot be equated with the violent practices that affect trans bodies and lives, reported throughout the research. The search for the Transsexualizer Process is part of a path of affirmation of ways of living gender identities and sexualities. The itineraries are tortuous due to the difficulties faced during this process, with no report, among the people interviewed, that institutionalized transphobias produce health.

As one of the professions involved in issuing mandatory reports for authorization of procedures in the Transsexualizer Process, psychology is crossed by an ambivalent character since this practice gives it decision-making power. Thus, we agree with the demands of the people interviewed in the sense of asking from Psychology care practices that are attentive to the diversity and difference in the ways of living genders and sexualities, seeking interventions from the scope of materiality and the trans experience for more integral care besides the ongoing struggle for the depathologization of trans identities. And, in a near-future horizon, to act for the emancipation of trans users who live their gender identities, the Transsexualizer Process, live their life.

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