DOI: 10.5281/zenodo.21079440
Original paper
Received: 20. 7. 2025
Accepted: 16. 1. 2026

Annual Review of Critical Psychology
Volume 22,
Special Issue -
Yugoslav Critical Psychologies

Jelena Vidić

FROM SEX REASSIGNMENT TO MEDICAL GENDER AFFIRMATION – A CRITICAL REVIEW OF THE WORK OF THE BELGRADE SEXOLOGICAL TEAM

Abstract

Although various aspects of the lives and health of transgender people have been the subject of study by different scientific disciplines for decades, medicine has undoubtedly been the most prominent among them. From the beginnings of the medicalization and psychopathologization of gender diversity within psychiatry, through the development of hormonal treatment and surgical procedures and the search for the perfect candidate who would fit into a pre-defined treatment, medicine and mental health sciences have come a long way. Today we are witnessing the depsychopathologization of gender diversity. Current guidelines set the goal of gender affirmative medicine as achieving the best possible physical health and psychological well-being of gender diverse people, and medically gender affirmative treatment is individualized and adapted to each individual person.

The aim of this paper is to offer one possible view of the history of gender affirmative medicine in our region. The Belgrade Sexological Team began its work in 1986, only seven years after the publication of the first version of the international guidelines for working with transgender people. Seven years later, the publication *Polni identitet i promena pola* (Gender Identity and Sex Reassignment) (Rakić et al., 1993) was published, as an important testimony to the Team's practice at that time and its theoretical foundations.

Given the long history of gender affirmative medicine in our region, the aim of our paper was to analyze those parts of the publication that fall within the domain of psychology and psychiatry. We used a combination of deductive and inductive analysis as the dominant approach. The four themes we focused on were: Defining Gender Diversity, Medical Treatment of Gender Diversity, Gender Diversity and the Environment, and Ethical Considerations. By comparing the Team's work with the leading guidelines of that time, we showed that the practice was in line with the international standards of the period. In the final part of the paper, we examined the practice and guidelines of that time in the context of the contemporary approach, with special emphasis on indications for treatment and the search for the "true transsexual."

Keywords

Belgrade Sexological Team; transgender; medical gender reassignment; gender affirmative approach

Jelena Vidić, Docent,
Department of Psychology,
The Faculty of Media and Communications,
Belgrade, Serbia
jelena.vidic@fmk.edu.rs
0000-0001-5844-2651

Citation:
Vidić, J. (2026). From sex reassignment to medical gender affirmation – a critical review of the work of the Belgrade Sexological Team. *Annual Review of Critical Psychology,* 22.
https://doi.org/10.5281/zenodo.21079440

CC BY NC ND

Introduction

The scientific field dealing with various aspects of the lives and health of people whose gender identity differs from the sex assigned at birth — today referred to as transgender and gender-diverse people — has undergone intensive changes at the beginning of the 21st century. After the establishment of this field in the 1920s, a turning point was the publication of Harry Benjamin's study *The Transsexual Phenomenon* (Benjamin, 1966), followed by the founding of the "Harry Benjamin International Gender Dysphoria Association" in 1979[1], which that same year published the first edition of the *Standards of Care for the Health of Transgender and Gender Diverse People, under the title The Hormonal and Surgical Sex Reassignment of Gender Dysphoric Persons*. The number of studies in this field gradually increased, bringing changes in approach. Alongside the depsychopathologization of gender diversity as a key change in mental health sciences, which brought significant changes in treatment and a shift toward a gender affirmative approach[2] (Hidalgo et al., 2013), the field has in recent years been increasingly viewed as interdisciplinary. In addition to various branches of medicine, it now encompasses legal sciences, as well as knowledge from sociology, anthropology, cultural studies, literature, and queer theory. Apart from the increase in empirical data, an important contribution to the development of this field has been made by the strengthening of the activist movement for improving the position of transgender people, which has enabled them to unite and reach a clearer articulation of the demands and needs of the transgender community (Stryker, 2007).

If we compare transgender medicine of the 1960s and 1970s with today, we notice several significant changes. After decades of treating gender diversity as a mental disorder,[3] the professional community today largely considers gender diversity "a common and culturally diverse human phenomenon that should not be judged as inherently pathological or negative" (Coleman et al., 2022, p. 56). Along with calls for depsychopathologization and destigmatization, the exclusively binary understanding of gender is being abandoned, and gender is instead viewed as a spectrum (APA, 2015). Changes in the nosological status of gender diversity are occurring simultaneously with changes in treatment itself: instead of seeking the ideal candidate who will go through pre-defined steps of the "triadic therapy" with the aim of complete "sex reassignment", healthcare today is expected to be adapted to the individual needs of each person. Treatment *may* include, among other things, hormone therapy and surgical interventions, voice and communication therapy, hair removal, primary healthcare, reproductive and sexual health services, and mental health services. Healthcare workers are expected to enable gender diverse people, through their activities, to "optimize overall physical health, psychological well-being, and self-fulfillment" (Coleman et al., 2022). Depsychopathologization also brings a change in the

[1] This association would change its name to "World Professional Association for Transgender Health" (WPATH) in 2007.

[2] The characteristics of a gender affirmative approach are a non(psycho)pathological view of gender diversity, recognizing and acknowledging gender fluidity and the cultural context, and instead of biological essentialism (and midway determinism) in the understanding of how gender identity is developed, we consider the complex interplay of biological, psychological, social and cultural factors.

[3] Psychopathologization of gender variance brought with it the stigma of mental illness, that is, placing the gender diverse person in the role of a psychiatric patient, followed by the loss of autonomy in the patient and the paternalizing stance of the doctor.

role of the psychiatrist and psychologist: from "gatekeepers" who search for suitable candidates for medical gender affirmation, the emphasis today is on informed consent and collaborative relationships between the transgender or gender-diverse person themselves and mental health professionals.

On the other hand, despite significant changes in the understanding of gender diversity and in the guides and guidelines for working with gender diverse people, research shows that transgender and non-binary people still face numerous difficulties when in contact with healthcare workers. Some of these difficulties – such as being addressed in the wrong gender or with the wrong name[4], expectations to fit into cisheteronormative[5] expectations of healthcare workers, prolongation of access to treatment, denial of treatment, and even verbal insults — come from medical staff. Others, such as the lack of hormone therapy, long waiting lists for specialists, or a shortage of trained professionals, can be seen as structural barriers (Berrian et al., 2024; Vidić, 2020; Smiley et al., 2017). Non-binary people are in a particularly disadvantaged position, as gender stigma is even more pronounced toward them. This is reflected in their socio-economic position, physical and mental health, access to various services, and even greater exposure to transphobic violence in different contexts, including cisnormative expectations and negative reactions from medical workers (McCann et al., 2021; Burgwal et al., 2019).

Almost four decades ago, gender affirmative medicine began to develop in the territory of former Yugoslavia. The Belgrade Sexological Team was formed in 1986, seven years after the publication of the first version of the *Standards of Care*. Its members included psychiatrists Zoran Rakić and Jovan Marić, endocrinologists Dragoljub Slijepčević and Svetlana Vujović, and surgeon Sava Perović. The first so-called sex reassignment[6] operation was performed in 1989. Although the Team's composition has changed somewhat in the meantime, continuity in its work has been preserved to this day. It is interesting, precisely in light of misunderstanding and even rejection by the medical community, that the work of the former Belgrade Sexological Team (today the Belgrade Team for Gender Identity), despite its recognition in international circles,[7] only received legal grounding in 2012 with the establishment of the Republic Expert Commission. The Commission was initially called the Republic Expert Commission for the Treatment of Transsexual Disorders, and in 2017, at the request of non-governmental organizations, it was renamed the Republic Expert Commission for Transgender Conditions. This means that the work of this group of doctors (whose composition changed and expanded over the years) was not recognized by the state and the competent medical body for almost a quarter of a

[4] This practice is within transgender community called deadnaming.
[5] Under cis/heteronormative society we refer to the society in which cisgenderness exists as a gender norm, and heterosexuality as a sexual norm. Cisgender persons are those in whom there is no discrepancy between the gender assigned at birth and their gender identity, expression and role, and heterosexual persons are those who feel sexual, romantic and erotic attraction toward persons of the opposite sex. In traditional patriarchal societies, the sexual and gender norm often go hand in hand, which is why the terms cisnormativity or cissexism are frequently used.
[6] In the languages of former Yugoslavia the term that was officially in use in medicine is "promena pola" which means "sex change".
[7] For the portrayal of a trans male's experience in navigating state and private institutions in Serbia, see Nord (Nord, 2018)

century.[8]

In 1993, the Belgrade Sexological Team published the publication *Polni identitet i promena pola* (Gender Identity and Sex Reassignment) (Rakić et al., 1993). This volume represents the first professional medical publication in our region that deals with the issue of transgender and gender diverse people. It is a valuable testimony to the first years of the Team's work, the people who approached them, and the understandings of gender diversity and the process of "sex reassignment" at that time. Therefore, the aim of our paper is, through an analysis of the publication, to offer a presentation of the theory and practice of gender affirmative medicine in our region[9] in the first years of its development. In addition, we want to consider the views and experiences presented in this volume in the context of the dominant professional positions and guidelines in the international framework at that time, and to critically examine it in light of the contemporary understanding of gender diversity.

Analysis of the Publication

Methodological Approach

For the analysis of the publication, we used a combination of comparative analysis and thematic analysis. Before beginning the analysis, we defined three themes to follow: The Concept and Definition of Gender Diversity; Medical Treatment of Gender Diversity; and Gender-Diverse People and the Environment. We then examined the text, identified lower-order themes, and categorized the material accordingly. Due to our psychological education,[10] we selected the main themes with the desire to focus on those connected with mental health sciences, which have undergone the greatest changes during the decades of development in this field. A fourth theme — Ethical Issues Related to Gender Diversity — was added to the analysis beyond the initial plan, as a useful example for illustrating the negative attitude toward gender diversity within the medical community.

After presenting the views and practices from the publication, we offered a comparison

[8] It is our view that this fact should be understood within the context of the overall negative relationship towards gender diversity, not only at the level of society at large, but also within the medical community. In a traditionally patriarchal society such as we have in Serbia, gender norms hold great value and importance, and from that stems a high degree of prejudice and discrimination toward gender diverse persons, as well as a low level of awareness (for research related to healthcare workers, see Vidić, 2020). This is evident not only at the institutional/structural level (first and foremost in the lack of necessary legal regulations), but also at the level of individual psychology. Unfortunately, all the larger studies in Serbia so far have mostly examined attitudes toward LGBT persons, without discriminating between people of a non-normative sexual orientation and gender identity (for example, the yearly studies done by the Commissioner for Protection of Equality's office). Regardless, they all point consistently toward a high degree of social distancing and discrimination toward LGBT persons; for data on the monitoring of discrimination and hate crimes against transgender persons see Vidić, 2015; for more recent data, see the website of the "Let it be Known" organization (*Da se zna* in Serbian, www.dasezna.lgbt)

[9] The Team was formed during the existence of the Socialist Federal Republic of Yugoslavia, and the publication were published after its desintegration, in the Socialist Republic of Yugoslavia.

[10] For ten years, the author was part of a Belgrade NGO working in the sphere of protection of rights of LGBTQIA persons, providing psychosocial support.

with the leading professional guidelines of the time, as well as with the characteristics of the contemporary approach, with emphasis on the ways of conceptualizing the phenomenon of gender diversity and in treatment models. As reference guidelines for past and contemporary practice, we used the appropriate versions of the *Standards of Care for the Health of Transgender and Gender Diverse People* of the Harry Benjamin International Gender Dysphoria Association (HBIGDA), later the World Professional Association for Transgender Health (WPATH).[11] Special focus in the comparative analysis was placed on the critical examination of indications for treatment, i.e., the search for the "perfect candidate" for medical gender affirmation. As we have already emphasized, for decades psychiatrists and psychologists had the role of "gatekeepers" in the process of gender affirmation.

Structure of the Publication

The publication *Polni identitet i promena pola* was published in 1993 in Belgrade by BIGZ, as a special edition in the *Scientific Works* series. The authors were members of the Belgrade Sexological Team: psychiatrists Zoran Rakić and Jovan Marić, endocrinologists Dragoljub Slijepčević and Svetlana Vujović, and surgeon Sava Perović. The publication has a total of 265 pages and is divided into two parts, with eight and ten chapters respectively. The first part is titled "Identity in Sexual Behavior" and consists of eight chapters: 1. Introduction to the Problem; 2. Sexual Behavior; 3. Disorders in Sexual Behavior; 4. Developmental Course of the Study and Treatment of Transsexuality; 5. Differential Diagnosis of Transsexuality; 6. Etiological Considerations of Transsexuality; 7. Clinical Picture of Transsexuality; and 8. Treatment of Transsexuality. Chapters five and six were written by psychiatrist Jovan Marić, while the remaining chapters were written by psychiatrist Zoran Rakić.

The second part – Sex Reassignment – deals with specialized endocrinological and surgical considerations of topics related to gender diversity. It contains the following chapters: 9. Embryogenetic Characteristics of Sexual Development; 10. The Testis; 11. The Hypothalamus and the Pituitary Gland; 12. The Ovary (author: endocrinologist Dragoljub Slijepčević); 13. Other Organs Important for Sex; 14. Disorders in Gonadal Development; 15. Pseudohermafroditismus masculinus et femininus – transsexualismus (endocrinologist Svetlana Vujović); 16. Sex Reassignment by Surgical Means – General Part; 17. Sex Reassignment by Surgical Means – Special Part (surgeon Sava Perović); and the final, eighteenth chapter, Legal, Ethical, and Social Implications of Sex Reassignment (psychiatrist Jovan Marić).

As a criterion for analysis, we took the chapters dedicated to topics from the field of psychology and psychiatry, which are located in the first part of the publication. Due to the importance of ethical issues, we also refer to the last chapter, dealing with that topic, as well as chapter 15. When citing parts of the text, we indicated the author of the chapter, the year of the publication, and the page number in parentheses.

Notes on Terminology and Definitions Related to Gender Diversity

[11] The Harry Benjamin International Gender Dysphoria Association changed its name into the World Professional Association for Transgender Health in 2007.

At the beginning of our considerations, we face the issue of terminology, which has changed significantly over the past few decades. The World Professional Association for Transgender Health, instead of the previously used terms *transsexualism* and *transvestitism*, recommends the phrase "transgender and gender-diverse people" as a formulation that, in a non-pathologizing and non-gender-normative way, encompasses people whose gender identity or expression differs from the gender assigned to them at birth (Coleman et al., 2022). This phrase is used to emphasize the existence of numerous and diverse gender identities, expressions, and experiences, all of which have in common that they differ from those expected in a given society on the basis of assigned sex. Some of these fall within a binary understanding of gender, while others lie outside of it[12] (APA, 2015). Furthermore, gender diversity is today depsychopathologized, meaning that the diversity of gender identities and expressions is considered a normal characteristic of the human species. Thus, in ICD-11 (WHO, 2019), there is a code for *gender incongruence*, but it is no longer in the chapter on mental, behavioral, and neurodevelopmental disorders, but in the chapter on Conditions Related to Sexual Health. DSM-5 (2013) removes the diagnosis of *gender identity disorder* and instead introduces the diagnosis of *gender dysphoria*, which can be applied not to gender diversity itself, but to people who experience intense distress due to the difference between assigned sex and their experienced gender.[13]

On the other hand, the publication we are reviewing were written at the beginning of the last decade of the 20th century, so they deal with the phenomenon of transsexuality as a form of "disorder in sexual behavior," i.e., a "typical disorder of gender identity." The authors refer to the classifications valid at the time: the third version of the *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association (DSM-III-TR, APA, 1987) and the tenth version of the *International Statistical Classification of Diseases and Related Health Problems* of the World Health Organization (ICD-10, WHO, 1992), which had only just come into force. In both classifications, gender diversity was categorized as a mental disorder under the diagnosis of gender identity disorder, i.e., transsexualism as its most pronounced form. A similar stance was held by the Harry Benjamin International Gender Dysphoria Association.

At that time, the term "sex reassignment"[14] ("*promena pola*") was in use in professional circles. Based on this, one might mistakenly conclude that these interventions actually change sex. Today, we therefore speak of gender transition, confirmation, and affirmation, i.e., gender affirmative medical and/or surgical treatments (Coleman et al., 2022).

Another important terminological difference is the way gender identity is determined. In the second half of the 20th century, including the time when the analyzed publication were written, the primary determinant of identity was the sex assigned at birth (so-called male or

[12] The American Psychological Association depicts gender as a spectrum in its guidelines (APA, 2015)
[13] Here we can observe a similar course of depsychopathologization as in the same-sex sexual orientation, where after the diagnosis of homosexuality has been abandoned, the diagnosis of ego-dystonic homosexuality appears as a "transitional alternative" in DSM-III in 1980, only for it to be abandoned as well in the subsequent version of the manual.
[14] As we have already stated, the more precise translation would be "sex change".

female transsexual). Sexual orientation was also determined on the basis of that sex. For example, when the authors write about a homosexual male transsexual, they actually mean a person assigned male at birth whose gender identity is female and who is attracted to men. By "female heterosexual transsexual," they mean a person assigned female at birth whose gender identity is male and who feels attraction to men. Today, we take the person's gender as the primary determinant of gender identity. Thus, by (transgender) women we mean people whose gender identity is female, while a (transgender) man is a person whose gender identity is male. In this change in determination, we see a shift from an essentialist biological determination of identity to a psychological one, in which the person's right to self-determination is key.

Definition of Gender Diversity – Transsexuality as a Mental Disorder

Defining Concepts Related to Gender and Sex

Gender diversity has been the subject of study by medicine and mental health sciences for a century and a half. Starting from the second half of the 19th century, several authors described people whom we would today call transgender and gender-diverse (Krafft-Ebing, 1886; Havelock Ellis, 1900/1938; Hirschfeld, 1910). At that time, there was still no clear distinction between the concepts of sex, gender (including gender identity, role, and expression), and sexual orientation (Weeks, 2019). Here we will first present the definition of the concepts key to considering gender diversity, which entered the history of psychiatry and medicine precisely through work with transgender and intersex people[15] (Germon, 2009). In the next section, we will consider the definition of gender diversity itself.

The definition of basic concepts is found in the chapter "Sexual Behavior," which includes subsections dedicated to the definition of the concepts of sex, sexual drive (and within it gender and sexual orientation), and gender role. The authors view not only sex, but also gender and sexual orientation as biological categories and consider them within the framework of sexual drive, as aspects of psychic life that have a bodily, i.e., biological basis.

"*...(Gender) represents a verbal projection of a deep experience in a person. Gender existed even when man did not yet know how to speak, when there was no grammar. Gender is a biological creation.*" (Rakić, 1993, p. 13)

However, biological determinism in the understanding of gender is part of the author's broader understanding of the biological:

"*Biological is not only of the body, but of everything that is alive, and the spiritual belongs to this realm as well.*" (p. 6)

In the further consideration of the development of gender identity, Freud's theory of psychosexual development is presented in more detail, and Stoller's concept of core gender

[15] In addition to Robert Stoller and Richard Green, another important name is that of John Money, who in his work with intersex children, particularly in the case study of David Reimer, tried to find support for the view that gender identity is formed mostly under the influence of environmental factors (for criticism of his work, see Butler, 2024; Colapinto, 2021).

identity is mentioned (Stoller, 1968). In defining the concepts, Lief's definition of sex, gender, and gender role (Lief, 1978) and Levine's model of gender identity, which consists of gender identity, sexual orientation, and sexual intention (Levine, 1989), are also cited. In accordance with the views of that time, the definition of sex and gender is binary. Since "the bodily sexual dimorphism of humans is also transferred to the dimorphism of sexual behavior" (Rakić, 1993, p. 20), there is no description in this volume of people whose gender identity is non-binary.

Alongside the consideration of psychoanalytic theory and biological factors as determinants of sex, gender, and sexual orientation, Rakić points out that cultural determinants are important for *gender roles*,[16] in such a way that "the acceptance of a certain type of cultural pattern by an individual depends on the innate mental substrate (biological characteristics) onto which the cultural pattern can be grafted" (Rakić, 1993, p. 29). Thus, here too we can see the primacy of the biological and innate, which cultural factors can modify to a certain extent.

Transsexuality as a Disorder of Identity in Sexual Behavior

In the first half of the 20th century, doctors began to use various terms to describe gender diversity, which later entered official medical terminology. Hirschfeld is considered the first to use the term transvestitism (Hirschfeld, 1910); Cauldwell first used transsexuality (Cauldwell, 1949), followed by Harry Benjamin (Benjamin, 1966), while Fisk introduced the concept of gender dysphoria (Fisk, 1973).

In the publication, transsexuality is viewed as "*the most severe form of disorder of identity in sexual behavior*" (Rakić, 1993, p. 6). Although the entire sixth chapter is dedicated to etiological considerations of transsexuality, the possibility of its psychogenesis, along with genetic and endocrinological influences, the authors are quick to emphasize early on, in the introductory chapter, that it is a disorder based in the biological. Rakić states that it is "*precisely the immutability of such mental content and its continuous manifestation toward the environment*" which represents the main diagnostic criterion of transsexuality (Rakić, 1993, p. 115), in contrast to other disorders in mental content that generally have a changeable character. The fact that it is "*a disorder in the deep mental layers, in the layers of the sexual drive*" (ibid.) is used as an argument against treatment aimed at removing transsexual aspects of identity[17], and in support of the view that the reverse path — adjusting the body to the gender identity — is the treatment of choice.

In addition, the publication contain a chapter dedicated to the differential diagnosis of transsexuality in relation to homosexuality, transvestitism, fetishism, adolescent conflict, and psychosis, as well as a chapter on the clinical picture of transsexuality with clinical examples, in which distinctions are made according to sex and according to sexual orientation. These considerations, as well as the definition of the concepts of sex and gender, their grounding in the

[16] For gender role, the author states that the expression "sex role" will be used in the text, seeing how that expression is "amenable to the ear and accepted here", while the expression "gender role" is "new and sounds foreign" (Rakić, 1993, p. 20). In the rest of the paragraph Rakić lists the ten characteristics of gender roles according to John Money.
[17] That is, against so-called conversion therapy.

biological and drive-related, and sexual and gender dimorphism, are in line with the medical model and the official psychiatric stances of that time, so we will not reconsider them again. We will address the issue of the relationship between sexual orientation and gender identity in the context of the approach to sex reassignment treatment later in the paper.

Medical Treatment of Gender Variance

Indications for Treatment – "True Transsexuals"

The first sex reassignment surgeries in Serbia were performed at the beginning of 1989, three years after the founding of the Team and the first patients who entered follow-up. After the first surgeries, the number of people approaching the Team increased; however, transgender women constituted the majority of patients. The authors explain this imbalance by the availability of treatment: "*After the start of sex reassignment operations for male transsexuals, their frequency in seeking help in the doctor's office has noticeably increased*" (Rakić, 1993, p. 91). Three years later, there was a change in the gender structure: "*After the start of sex reassignment surgeries for female transsexual persons, the frequency of such persons seeking help in the doctor's office has noticeably increased*" (ibid.). By 1993, the ratio of transgender women and transgender men approaching the Team had almost balanced.

In the first six years of the Team's work, more than 100 people who approached the Team due to "gender incongruence" went through the diagnostic procedure, of whom 90 received the diagnosis of transsexualism. Of these 90 people, 78 met the condition of being "homosexual transsexuals" and were included in further follow-up and analysis. These were primarily young people: the average age at which they approached the Team was 22.5 years, with transgender young men being somewhat older than transgender young women. Of the total sample, 62% had access to treatment (33% were in the process of hormone replacement therapy, and 29% had undergone gender affirmation surgeries), while 38% were "not yet indicated," i.e., they were in the psychotherapeutic process or "waiting for better life conditions." The authors also provide data on education, religion, and the structure of the primary family and conclude that there are no data that would be significant in terms of differences between these patients and the general population.

The principles according to which the Belgrade Sexological Team operated at that time are listed in the subsection titled "Indications for Sex Reassignment". As we will see, the indications and their fulfillment are assessed by the doctor, while the necessity of such criteria is explained by *the complexity of the demands of real social life* and the fact that sex reassignment treatment is complex, long-term, and demanding.

The ideal candidate for this process is a person in whom "*there is only a transsexual identity, without pronounced mental complications in the patient or the presence of severe real-life circumstances in which the patient lives*" (Rakić, 1993, p. 127). More serious mental disorders are not considered a contraindication, but they can be an aggravating circumstance, and

it was deemed necessary to bring them under control first.

The second condition relates to the person's material and social reality, i.e., "*the ability to support themselves materially and to adapt to social reality*" (p. 127). This also implies the so-called real-life test, i.e., the condition that the person, before starting medical treatment, lives full-time in their gender for a certain period.

An additional requirement set by the Team, which we do not find in other guidelines, is that sex reassignment is not indicated without prior consultation with the patient's primary family (which could further develop into family therapy). The Team emphasizes that this condition is *appropriate for our locale*. Although not stated explicitly, we assume that this refers to the characteristics of family functioning in our locale and a higher degree of family connectedness (including prolonged cohabitation) compared to some other countries, such as the USA. Also, given the age, the majority of patients were younger people who often lived with their family of origin, which further supports this condition. However, the requirement for consultation, and even for obtaining the consent of family members, remained part of the practice in subsequent years, which for some people resulted in multi-year delays in starting treatment (Vidić et al., 2022).

Transsexuality and Sexual Orientation

As we saw in the section on indications, the sexual orientation of a transgender person can be one of the criteria for denying access to treatment. This means that people whose sexual orientation, after going through the gender alignment process, would be homosexual are not approved for treatment. Since they take anatomical sex as the starting point, members of the Belgrade Sexological Team call these people non-homosexual transsexuals. In the first six years of the Team's work, 12 such people approached (compared to 78 homosexual ones), which they consider an indicator of their lower representation in the population. However, the authors did take a critical stance toward this interpretation, referring to the fact that the initial trend of fewer approaches by people assigned female at birth was interpreted in the same way, only for it to later turn out to be a misconception. Just as the beginning of the Team's work led to an increasing number of people approaching them, so the rejection of "non-homosexual transsexuals" from treatment probably led to them seldom approaching the Team. The further fate of these people remained unknown. "*When such patients realize that they will not be accepted for sex reassignment treatment, they lose motivation to continue contacting the doctor for a longer time in order to possibly receive some other type of help*" (Rakić, 1993, p. 104).

Gender Diversity and the Environment

Transgender and gender-diverse people, by their very existence, come into conflict with the gender norm as one of the basic norms of the Western world, which is why they are one of the social groups exposed to discrimination and various forms of violence. In the publication of the Belgrade Sexological Team, difficulties in the family, interpersonal relationships, and the wider social environment are recognized, but they are not interpreted using any theoretical concept.[18]

[18] Here we refer to the concepts such as stigmatization, marginalization, prejudice and discrimination, etc.

In the second chapter, Rakić views the position of transgender people in a cisheteronormative society through the prism of the "reality of the majority" and its relationship to being different. He states that the vast majority of "*normal people do not tolerate sexual dimorphism*[19] *in the behavior of one person*" (Rakić, 1993, p. 31), that "*cultural tradition does not tolerate intermediary forms or unclear norms in behavior*" (Rakić, 1993, p. 20), and that gender diverse people can only find understanding and acceptance within the framework of medicine. He further problematizes the choice a transgender person faces in a cisnormative society: since relationships with others are of *existential importance* for a human being, the "*unhappy individual tries to realize the patterns of the majority in sexual behavior, but such effort is reduced to acting out the gender role that is expected of them*" (Rakić, 1993, p. 31). Since it is an act, and not authentic behavior, such a state is not sustainable, and the person surrenders to their "*authentic gender role (...) because there is no other choice*" (ibid.), i.e., they are faced with biological forces *they cannot resist*, which are in opposition to society's demands for gender-normative behavior.

Non/Understanding, Non-Acceptance, and Rejection by the Environment

Alongside the position that gender diversity is a mental disorder, the authors emphasize on several occasions that transgender people face numerous difficulties in everyday relationships that are a source of suffering and mental health problems, and they clearly separate these difficulties from the phenomenon of gender diversity itself.

"*A transsexual person faces the fact that people from their immediate environment do not understand them, avoid them, or even openly reject them on a daily basis.*" (p. 119)

In the publication, these difficulties in the interpersonal sphere are identified as a secondary level of the disorder[20] that "*further disrupts mental health*" (p. 117), but which is not a primary or necessary feature of gender diversity. The understanding of the higher prevalence of mental difficulties among transgender people as a consequence of misunderstanding, rejection, and violence by the environment served two decades later as one of the arguments in favor of the depsychopathologization of gender diversity (e.g., Robles et al., 2016; Olson et al., 2015).

The need for the environment to accept and recognize their identity is particularly pronounced in young people in relation to their family of origin.

"*For a young transsexual person, recognition of their identity has the meaning of recognition of their existence.*" (Rakić, 1993, p. 118)

In the context of considering the dynamics between a young transgender person and their parents, the authors emphasize the importance of working with parents, which has remained one of the key tasks of mental health professionals in working with young gender-diverse people to

[19] By this we mean that a person exhibits gender-typical behaviors that differ from those expected of their assigned gender, i.e. that they "openly exhibit some variations of hermaphroditic behavior" (Rakić, 1993, p. 31)

[20] Rakić cites the subjective experience of gender incongruence as the first level of the disorder.

this day (Coleman et al., 2022). Puberty is the period when gender dysphoria usually intensifies and becomes visible, which, along with all other manifestations of adolescence, leads parents to be "*in most cases inclined to accuse their child of unusual and inappropriate behavior*" (Rakić, 1993, p. 119). The psychiatrist's task is to help them recognize that this is not the child's defiance or whim, and the framework that enables this is viewing gender diversity (transsexuality) as a mental disorder.

"*Through the psychotherapeutic process, parents overcome this phase and come to the realization that much in people's behavior cannot be shaped by upbringing and their own will, and especially not a disorder such as transsexuality.*" (p. 120)

Here, the understanding of gender diversity as a disorder that is not a matter of choice nor under the person's voluntary control, but a force stronger than them, can be beneficial in that it frees the person from guilt and responsibility for their (unwanted) difference, and requires the environment to take a compassionate stance, as toward any other patient who is not guilty of the condition they are in.[21]

In this subsection, there is also Table 1 titled "Parents' Relationship Toward the Child". It shows that only 41% of the patients of the Belgrade Sexological Team at that time were truly accepted by their parents, 38% had declarative support, while one fifth of the people (21%) were openly not accepted by their parents. The data that parents accept transgender sons more often than daughters is explained by the fact that "*in the clinical picture of female transsexual persons, greater adaptability to reality, i.e., more sociable behavior is observed than in the clinical picture of male persons*" (p. 121). The authors (especially Marić) are inclined to view this difference in the context of biological differences between men and women. However, this expressed difference can also be interpreted in the context of our patriarchal society and the way women are perceived in it. Since sons are traditionally valued more than daughters in patriarchal culture, being a transgender child whom parents perceive as a son has a different meaning compared to the transgender child they believed to be female. In addition, peer (and wider social) violence toward people who violate gender norms is much more pronounced toward boys, young men, and men perceived by society as feminized than toward girls, young women, and women who exhibit masculine behavior (Matsuzaka & Koch, 2019).

Alongside the consideration of difficulties caused by misunderstanding, declarative acceptance, or open rejection, the authors explain (and even justify) the negative attitudes of the environment. Thus, they state that the environment sees the person's insistence on being accepted in the experienced gender as "*senseless and unachievable*" and places it in the category of "*immoral and crazy*" (Rakić, 1993, p. 118). Responsibility for getting out of these difficulties is placed primarily on the transgender person – they must accept the (im)possibilities of their environment to accept them, i.e., they should understand the (cisnormative) "*people around them*

[21] Here we refer to Parsons's examination of the role of patient, whose four most important aspects are the exclusion of a person from everyday responsibilities, the belief that the person is not responsible for the state they are in, the requirement that the person accepts their own illness and that the existing state (of illness) is undesirable, and that the person wishes to recover from it, as well as cooperate willingly with medical professionals in that process (Parsons, 1993).

who are different from them" (ibid.) and that "*they often behave toward the environment with reactions similar to how the environment behaves toward them*" (Rakić, 1993, p. 119). Therefore, the authors consider that building or renewing the capacity to establish good relationships with the environment is one of the main goals of psychotherapy, and family and friends are included in the psychotherapeutic process depending on their motivation. Many studies also speak about the importance of a supportive environment (Bowling et al., 2020; McCann et al., 2021); however, elements of the attitude that it is the responsibility of the transgender person to earn the favor and acceptance of their loved ones through their own effort can also be understood in the context of unequal power relations within the process of stigmatization (Link & Phelan, 2014).

The importance of relationships with the environment is one of the factors that the Belgrade Sexological Team uses to assess the outcome of hormonal-surgical gender alignment interventions. Of the 20 people who had gone through this process by the time of the publication of the publication, 60% describe their relationship with the environment after the process as satisfactory, and 40% as unsatisfactory. The other two indicators of successful outcome used by the Team are the relationship toward bodily appearance, where 80% of patients express satisfaction, and the relationship toward the "changed sex", with which all respondents are satisfied. As we can see, the relationship with the environment is the area in which the smallest degree of satisfaction is expressed, compared to the other two indicators. In interpreting these results, Rakić states that the treatment fully meets the expectation of reducing gender incongruence, while the expectation that the (known) environment will significantly change its attitude toward them and recognize and accept them in accordance with their identity often remains unfulfilled. Therefore, Team members consider that the best solution would be for people to "*continue to live in a new environment with new personal documents after sex reassignment*" (Rakić, 1993, p. 58), i.e., in an environment where their transgender past is not known.

Ethical Considerations

The last chapter in the publication is dedicated to the legal, ethical, and social consequences of sex reassignment by psychiatrist Jovan Marić. We decided to include it in the analysis because we consider it a good presentation of some of the prejudices toward gender-diverse people that existed among some members of the Team, which are in contradiction with some other parts of the publication themselves, as well as with contemporary professional positions. Here we will focus on the presentation of ethical and social consequences.[22]

In the subsection dedicated to ethical topics, Marić considers the justification and gravity of the process of medical gender alignment and highlights the question of whether therapists and psychiatrists "*are entirely aware of what is good for another person, for our patient*" (p. 255). While today this dilemma is considered through criticism of the role of psychiatrists and psychologists as "gatekeepers", Marić questions the justification of the interventions themselves. "*Do we know at all, completely, to the last consequences, to the last neurotransmitters and receptors, what a mental disorder is, what a personality disorder is that we label as*

[22] It is important to note that already in this publication the issue of legal recognition of gender identity is considered, while the issue itself became legally regulated in Serbia only in 2019.

transsexualism (...)" (Marić, 1993, p. 255). In the continuation of the text, he further problematizes the process of medical sex reassignment as the treatment of choice by comparing it with the once-accepted lobotomy, and then refers to Money's research, which shows "*increased incidence of antisocial behavior and prostitution among male transsexuals*" (Money, 1972, according to Marić, 1993, p. 255). The next ethical dilemma is the person's right to decide whether to inform their partner of their transgender past, and he wonders whether the doctor thereby becomes "*an accomplice in deception*" that could be grounds for annulment of marriage (Marić, 1993, p. 256). It seems that the very choice of dilemmas is quite sensationalist, and that the author takes the perspective of the cisnormative system, omitting what we would consider the phenomenology of the other person, which is necessary in psychiatric practice. Also, although Marić views gender diversity exclusively from the position of a society that wants to preserve the existing cisnormative order, he excludes the contribution of social factors from the interpretation of some statements – for example, he interprets the data on prostitution by referring to (naive) biological reductionism ("*probably the male model of behavior in sexual activity remained present somewhere*", p. 256) and sees it as a form of confirmation of the new identity, while he does not mention problems of poverty, homelessness, and social marginalization that contribute to engaging in sex work.[23] While his colleague psychiatrist Zoran Rakić shows understanding for the complexities of the position of transgender people in many places, this perspective seems to be missing in Marić, which constitutes a significant difference between the chapters written by these two authors.

Medical Violence

Although the chapter on ethical issues does not mention the necessity of informed consent and ensuring anonymity when using various materials obtained during work with patients, it is important for us to discuss this here. Transgender people in Serbia have spoken on several occasions about situations that we would identify as medical violence,[24] and one example is found in this publication. Namely, in the chapter "Pseudohermaphroditismus masculinus et femininus – transsexualismus" by Svetlana Vujović, there are photographs of naked people, while in other, later studies we find testimonies of people that photographing was done without their informed consent (Vidić et al., 2022; Zulević, 2012). In addition, on some of the photographs, the faces of the photographed people are visible, and without any concealment. More than twenty years later, the author of the chapter republished these photographs, with minimal concealment of identity (a thin black strip over the eyes), in her chapter in the publication *Transseksualizam. Multidisciplinarni fenomen* (Duišin & Đorđević, 2016). The publication (and even the collection) of material for which a person has not given appropriate consent, as well as photographs that make it possible to determine the person's identity, is contrary to the Law on the Protection of

[23] An additional problem with positioning trans women as promiscuous and as sex workers (while the text entirely omits numerous and varied difficulties that transgender and gender diverse persons are facing) is the fact that this perpetuates one of the prejudices about trans women and their sexuality. The subject of trans women as sexual predators is present to this day in the debates on the use of public restrooms, locker rooms, safe houses, but also prisons. For more information on research in Serbia see Zulević (2012).

[24] By "medical violence" we refer to situations in which medical workers use their power and authority in a way that directly or indirectly compromises the dignity, rights or well-being of the patient.

Patients' Rights of the Republic of Serbia and can be characterized as medical violence.

Discussion

Since the presentation of different understandings of the origin and development of gender identity and gender diversity significantly exceeds the scope of this paper, we will focus on the issue of indications for treatment, the search for the "true transsexual," and then briefly touch on the relationship between a person and their environment through the prism of stigmatization. Also, as we have briefly discussed the issue of depsychopathologization of gender diversity in the first part of the paper, we will not return to it specifically.

Indications for Treatment

When it comes to indications for treatment, the Team's practice at that time was, with the exception of the condition of consulting the family, in line with the then-valid *Standards of Care for the Health of Transgender and Gender Diverse People* of the Harry Benjamin International Gender Dysphoria Association. These indications, as well as the very concept of treatment, are grounded in biological essentialism and the reproduction of cisnormativity, with the aim of ensuring the finding[25] of an appropriate candidate who would fit well into cisnormative society. Common to the first four versions of the *Standards of Care*[26] is the emphasis on criteria that a person must meet in order to have access to standardized hormonal-surgical treatment. The treatment consists of three steps: assessment by a mental health professional, hormone replacement therapy, and surgical interventions. For starting replacement hormone therapy and surgical treatment, the consent of a mental health professional is required: one recommendation letter for hormone treatment, and the consent letter of two psychiatrists for surgical intervention. For psychiatric consent, the following conditions had to be met: at least two years of prior existence of gender dysphoria that can be confirmed by a third party (or psychiatrist); real-life experience[27] (at least three months for starting hormone replacement therapy, and twelve months for surgical interventions); and mandatory psychotherapy (minimum three or six months). As we can see, the assessment of a mental health professional is a condition for access to hormonal-surgical treatment, and the *Standards of Care* explicitly state that interventions on the patient's personal request (without fulfillment of additional conditions) are contraindicated.[28]

Although the stringency of the criteria is explained by the gravity, risks, and irreversible effects of the interventions themselves, their uniformity, insensitivity to context and individual differences, as well as the requirement for mandatory psychotherapy, resulted in the role of

[25] But also shaping that candidate – through the requirement of obligatory psychotherapy.
[26] SOC 1 (1979), SOC-2 (1980), SOC-3 (1981), SOC-4 (1990)
[27] Real-life experience refers to living in the desired gender, i.e. social transition, as a requirement for starting the procedure of medical gender reassignment. Although this requirement was introduced to diminish the likelihood of a person regretting their medical interventions, as they would have gained the experience of living in the desired gender, this practice can be problematic (unsafe, even) for persons who do not have the adequate support: their old environment can react to the perceived change with violence, the person does not have the matching documents, nor a support network to leave the old environment and start their life somewhere else in their new identity.
[28] That is, they are unadvisable (or even prohibited) due to *possible damaging or undesired effects*.

mental health professionals as "gatekeepers," delays in starting treatment, and the search for the "true transsexual," which has now been abandoned.

The Myth of the "True Transsexual" and Fitting into Cisnormative Society

The search for the "perfect candidate" is characteristic of the first decades of the development of transgender medicine. Harry Benjamin also wrote about this in the book *The Transsexual Phenomenon* (Benjamin, 1966). Following Kinsey's scale of sexual behavior, he creates a seven-point scale of "sexual orientation," according to which he classifies people assigned male at birth into transsexuals, transvestites, and normal men.[29] Benjamin writes that indications for surgery must be carried out with great caution, that a psychiatric assessment is necessary to rule out the possibility that gender dysphoria is the result of psychosis or emotional instability rather than a fixed identity, that the person has the intellectual capacity and emotional stability to understand the consequences and limitations of medical interventions, and that there is no other way to enable the person to have a happier future (Benjamin, 1966, p. 60). Benjamin also notes that it is important for the person (physically and psychologically) to be able to live relatively successfully in their gender identity, i.e., to successfully "pass" as a real woman/man, with the caveat that in several cases access to treatment was granted ("*with or without my consent*") to trans women who were "more than six feet tall or had a dense black beard" (Benjamin, 1966, p. 36).[30]

Within these requirements, we can also view the exclusion from the process of people with homosexual orientation, which was also the practice of our Team. Although the first four versions of the *Standards of Care* do not explicitly mention the issue of sexual orientation, from the definition of the "true transsexual" in the fifth version (Levine et al., 1998) we see that the candidate, after going through the process, should be heterosexually oriented.[31] Given the period to which the analyzed publication refer, the condition of heterosexuality can rather be understood as the influence of Benjamin's later positions than as adherence to the then-valid version of the *Standards of Care*. Also, when considering this criterion, we should keep in mind that homosexuality ceased to be diagnosed as a mental disorder only in the tenth version of the ICD (WHO, 1992), and that, accordingly, some earlier studies assessing the effectiveness of treatment on quality of life treated homosexual orientation as one of the indicators of poor adjustment (Fleming et al., 1980). Although the practice of the Belgrade Sexological Team at that time was in

[29] Benjamin also includes in his study persons who were assigned female gender at birth, but points out that they were less present in his practice. The improvement of penis reconstruction techniques has increased the number of trans masculine persons who approach gender clinics (Rakić, 1993), and there is a significant increase in both transgender and gender diverse persons who approach our Team in the last couple of years (Duišin et al., 2017).

[30] In Benjamin's case we can observe a change in the attitude toward gender diversity, from the initial openness and seeing gender variance as a spectrum, along with a phenomenological and non-pathologizing approach, to an increasing insistence on binarity and "passing" (i.e. cisnormativity), but also heteronormativity through the exclusion of same-sex oriented persons. For more information see Ekins (Ekins, 2005), and Schaefer and Wheeler (Schaefer & Wheeler, 1995).

[31] In the fifth version the "true transsexual" is described as a person who consistently exhibits identification with the opposite sex throughout their life, does not feel any sexual arousal when putting on clothes typical for the opposite sex, and who (based on their anatomic sex) has no heterosexual interests whatsoever.

line with the contemporary professional positions, today we undoubtedly consider it discriminatory. This reminds us that the very psychopathologization of gender diversity (but also of non-heterosexuality), and then the practice of conditioning access to treatment with the expectation of good social adjustment, can be viewed as a form of institutionalized gender stigma (Herek, 2007), but also as yet another indicator that psychiatric diagnoses and practices are not morally and politically neutral, but that medicine is often in the service of preserving the existing social order (Drescher, 2010; Conrad & Schneider, 1992; Jutel, 2011).

Therefore, although the requirement for adjustment to social reality (which at the same time implies that the person is a "true transsexual") also has the function of confronting the person with the reality of life in their (new) role and the difficulties that arise from it,[32] we must not lose sight of the fact that at its core there is also a demand for gender-normative behavior, i.e., fitting into the prevailing norms of cisnormative society. That this is the case is confirmed by the practice of denying access to treatment to people who do not fit into the gender dimorphism of identity, role, and expression.

This also conditioned the specific role of mental health professionals as "gatekeepers," and in accordance with the power relations arising from the medical model – health care professionals are the ones who make the decision about access to treatment, and it is up to the person to meet the requirements placed before them. Here, the power of health providers was further contributed to by the ongoing psychopathologization of gender diversity, from which it follows that opposite the doctor stands a person with a diagnosis of a mental disorder; this brings with it an additional loss of autonomy and setting the expectation that the doctor's authority must be accepted, since the doctor knows better than the person themselves what is good for them. Also, the role of "gatekeeper" was at the same time the role of guardian of the social order, because consent was given only to those for whom it was deemed would fit well into the demands of cisnormative society. Both components of this approach have been criticized by the transgender community, which has led to significant changes in the newer versions of the *Standards of Care*. An additional reason for criticism of this model is the consideration of the power position of mental health professionals in the context of medical violence – both structural, by viewing the position of the gender-diverse person within the medical system, and at the individual level, through various examples of abuse of that power directed against the well-being and dignity of the person and preventing them from exercising their rights as a user of healthcare.

The search for the "true transsexual" as the prototype of the person who will benefit most from medical gender alignment was first criticized in the fifth version of the *Standards of Care* (WPATH, 1998). Namely, over time it turned out that patients who do not fit the ideal prototype rarely approach doctors,[33] and that many people who did fit the description of the "true transsexual" achieved this by giving inaccurate information during conversations with psychiatrists, in order to secure access to treatment by presenting themselves as the "ideal"

[32] An additional difficulty is the issue of legal gender recognition, i.e. the (im)possibility of changing their first name and gender denomination in personal documents, which was not possible before the genital operation took place.
[33] This issue is also taken into consideration by our Team.

example from professional literature (WPATH, 1998; Burke, 2011). This speaks volumes about the difficulties and complexities of the position of transgender and gender-diverse people within the medical system — they faced double stigmatization there as well, the stigma of a psychiatric patient and the stigma of a violator of gender norms, and facing them were mental health professionals as guardians of social norms and authorities whom they had to convince to give them consent for access to treatment. The abandonment of the search for the ideal candidate and the emphasis on adapting treatment to the person occurs in the sixth edition of the *Standards of Care* and is further elaborated in the next two versions.

Change in Approach – From Seeking an Appropriate Candidate to Seeking an Appropriate Treatment

From the sixth version of the *Standards of Care* (WPATH, 2001), a change in approach is noticeable, with the search for the ideal candidate who could enter the medical process falling by the wayside; instead, the process itself is adapted to the individual needs of the person, and the decision-making process about entering the process is viewed more as collaborative. Within these changes, partial access to interventions is enabled for the first time, i.e., the condition that people entering the process must accept both hormone replacement therapy and surgical procedures is abandoned (see for example Hage & Karim, 2000, Vidić et al., 2022). This gradually opened space for the inclusion of gender-diverse people whose needs differed from those previously expected, as well as for greater individualization of treatment.

A huge step toward individualization and depsychiatrization of treatment is represented by the seventh edition of the *Standards of Care* (Coleman et al., 2012), whose ideas are further elaborated in the eighth edition (Coleman et al., 2022). In them, the difference between gender dysphoria and gender diversity[34] is emphasized, and the adaptation and individualization of treatment to the needs of the person themselves is insisted upon. The decision on hormone and surgical treatment is primarily the decision of the person themselves, as are all other decisions related to healthcare. This also implies a change in the role of mental health professionals: although the requirement for obtaining their consent remains, it is emphasized that it is the transgender person who makes the decision about the desired treatment, while the mental health professional should help them prepare for it as well as possible. Instead of mandatory psychotherapy and psychiatric assessment of the success of the real-life test, the letter of recommendation is now based on the assessment of the professional that the client is psychologically ready for further treatment, which implies that they are informed about the treatment, that their expectations are clear and realistic, and that possible mental health problems have been brought under control,[35] i.e., on the assessment that the person is able to give informed consent. In addition, mental health professionals should help the person to be practically ready as well: to discuss with them how to secure financial resources for medical interventions, how to gather information about doctors from the team and decide with whom they want to collaborate,

[34] Differentiating between gender dysphoria and gender diversity is an important step toward the depsychopathologization of transgender and gender diverse people, since it clearly emphasizes that not all gender diverse people will necessarily have gender dysphoria.
[35] Hence, mental disorders are no longer a contraindication for medical gender reassignment.

and how to plan postoperative care. As we can see, the relationship between the professional and the transgender person is more collaborative than paternalistic here. On the other hand, since the mental health professional still performs an assessment of gender dysphoria and the person's overall functioning, such practice is not fully in line with the informed consent model and gender affirmative care required by part of the activist community (Cavanaugh, Hopwood & Lambert, 2016). Also, the question remains open as to why this type of assessment is still required for gender affirmative interventions, but not for other treatments and surgical interventions that can also significantly modify the body (but do not violate gender norms).

When it comes to the changes that occurred in the work of our Team in the following period, the past decade saw an increase in the number of approaches to the Team in general, as well as a higher number of non-binary people who want to enter the process of gender affirmation (Duišin et al., 2017). Psychiatric-psychological assessment by one psychiatrist as a condition for starting hormone replacement treatment, or two psychiatrists and an endocrinologist for genital surgical interventions, is a practice that the Belgrade Team for Gender Identity still adheres to today, except that the conditions for obtaining recommendation letters are less restrictive and there is, in principle, greater openness to the individual needs of gender-diverse people. Unfortunately, this positive change occurred significantly after it appeared in the fifth, sixth, and seventh versions of the *Standards of Care*. From informal communication with organizations working with transgender and gender-diverse people in Serbia, we learn that the Team's doctors are more open to the individualization of treatment, i.e., adapting treatment to the needs of the person.

Also, the official establishment of the Republic Commission in 2012, the adoption of amendments to the law that enabled two-thirds of the costs of surgical gender affirmation to be covered by the Republic Health Insurance Fund, and then their application in practice, contributed to greater clarity and standardization of gender alignment treatment and eliminated some of the difficulties that existed during the 1990s and 2000s.[36]

Transgender and Gender-Diverse People in a Cisgender Society – The Problem of Stigmatization and Mental Health

Today, in order to understand the life situation of transgender people, it is important to take into account the difficulties arising from negative reactions of the family and close environment and socially based discrimination and violence. Numerous studies around the world, as well as studies conducted in our country, point to a high degree of exposure to psychological, physical, and sexual violence, both from known environments (family, peer groups, work environment, in partner relationships) and in public spaces, in the media, and on social networks (for example, James et al., 2024; James et al., 2021; Evje et al., 2024; Robles et al., 2016; Bockting et al., 2013, Testa et al., 2012; Grant et al., 2011; Turner et al., 2009; Clarke et al., 2010). Experiences of rejection, discrimination, and violence further affect mental and physical

[36] For more information, see Zulević (2012) and Vidić and Bilić (2022).

health in a negative way,[37] including a higher prevalence of anxiety, depression, suicidality, and psychoactive substance abuse; they also affect the socio-economic status and overall well-being of gender-diverse people, and lead to unfavorable outcomes compared to the cisgender population (Santos et al., 2025; Evje et al., 2024; Liu et al., 2024; Marzetti et al., 2024; Hajek et al., 2023; James et al., 2021; Hughto & Reisner, 2021; Smiley et al., 2017; Bockting et al., 2013; McNeil et al., 2012; Grant et al., 2011). As the members of the Belgrade Sexological Team also recognize, these difficulties are a consequence of an unfavorable social position (or, as they call it, "secondary level of the disorder"), and not characteristics of gender diversity itself. Studies that investigate the relationship between mental health difficulties and exposure to violence (Hughto & Reisner, 2021; Robles et al., 2016), as well as those that point to the protective effect of family and environmental support on the mental health of gender-diverse children, speak in favor of this position (Olson et al., 2016).

The unfavorable position of transgender and gender-diverse people in society and the accompanying mental health difficulties can also negatively affect their socio-economic position. Data from a large American study show that 34% of respondents live in poverty, 18% are unemployed, 30% have been homeless during their lives, and 11% have been forced to leave work or been fired for being transgender (James et al., 2024), which further affects mental health. The results of research in Serbia confirm these findings: in one pilot study, 37% of the interviewed transgender and gender diverse people declared that they lived in households whose incomes were somewhat insufficient or completely insufficient to support their monthly expenses, and 20% described their financial difficulties as serious; only a quarter of the respondents from the same sample stated that they were not subjected to discrimination or suffered violence in their school years due to their gender identity (Vidić, 2021). Another study, which involved transgender and non-binary persons from five European countries, reveals particularly troubling information on mental health in Serbia: 86% of the respondents seriously contemplated suicide at some point of their lives, 74% of whom had done so on more than one occasion (Smiley et al., 2017).

Legal gender recognition (i.e., obtaining documents with a different, appropriate gender/sex marker and chosen name) largely determines the everyday life of transgender people, including remaining in the education system, the possibility of employment, and functioning in various situations where it is necessary to show documents. For several decades the practice of changing personal data was not legally regulated, which resulted in an uneven practice and misuse (Zulević, 2012); since 2019, this practice has been legally defined, but also medicalized, i.e. requiring verification from a doctor – the person who wishes to change their personal data needs to have been in hormone treatment for at least a year, or to have gone through surgery.[38] Apart from having great practical significance, research points to the possibility of legal gender recognition having a positive effect on mental health as well (Puckett et al., 2024; Dechants et al.,

[37] Including the availability and access to general and transspecific healthcare, where they also encounter anti-trans prejudice.

[38] For a more extensive review of the position of transgender and gender diverse people in Serbia see Vidić and Bilić (2022).

2022; Scheim et al., 2020).[39]

Negative Attitude Toward Gender Diversity Within the Medical Community

The Belgrade Sexological Team, in the first years of its work, recognizes that transgender and gender-diverse people encounter misunderstanding and rejection not only from their closest environment and wider society, but also within the medical community. The negative attitude is manifested in two ways: one is the denial of the existence of the phenomenon itself, when doctors who have no clinical experience in this field "*succumb to the influence of cultural guidelines and perhaps doubt the very existence of this type of disorder, and thus the effectiveness of one complex and long-term therapeutic process*" (p. 260). In addition, a negative attitude toward gender diversity is seen in its status as a mental disorder, which in its extreme form implied complete rejection of medical gender alignment and insistence on (conversion) psychotherapy (see Socarides, 1964, Limentani, 1979). The Belgrade Sexological Team criticizes both positions and points out that pharmacotherapy and psychotherapy directed exclusively at the secondary level of the disorder do not address gender diversity itself. Despite the tendency of increased openness of the Team towards individualized treatments and educating new experts in this field, gender diverse persons in Serbia are facing the problems of gender stigma, discrimination and violence to this day, both in their social environment and within the medical context. Apart from prejudice and a lack of knowledge on gender affirmative healthcare among the general practitioners (Vidić, 2020), a study which involved members of the self-help trans group pointed to the problem of gender binarism even among some of the members of the current Team (Vidić and Bilić, 2022).[40] It is important to mention the research of Jelena Zulević as well (2012), since it brings forward the testimonies of transgender people who have tried to enter the process of medical gender affirmation and legal gender recognition during the 90s and the 00s, and includes various examples of discrimination and violence.

Even though some circles still harbor similar doubts, the research data unequivocally state that hormonal and medical gender affirmation has a positive overall influence on the mental health and everyday functioning of a person (Verbeek et al., 2020; Dhejne et al., 2015, Bränström & Pachankis, 2019, de Vries et al., 2014). These procedures are aimed at diminishing gender dysphoria and allow for greater quality of life in an appropriate gender (Coleman et al., 2012, 2022). Some of the benefits coming from these interventions are connected to the affirmation of gender of a person by their environment; in those persons for whom the interventions allow for "passing as" and obtaining legal acknowledgment of gender, the treatment also reduces the likelihood of being exposed to violence and discrimination, enabling us to see the extent to which medical, psychological, social, but also legal transition are intertwined and important for the quality of life of gender diverse persons. Preliminary results of a large American study confirm the importance of social transition (79% of the respondents claim that they are a lot happier in their life after the transition, and 15% that they are somewhat happier), hormone replacement therapy (84% a lot happier, 14% somewhat happier), surgical interventions (88% a lot happier,

[39] This information becomes especially important in view of the turn of some countries (USA in particular) towards conservative policies based on biological essentialism.
[40] This paper offers an extensive overview of the position of transgender people in Serbia.

9% somewhat happier) (James et al., 2024).

Of course, when considering these results, we must not lose sight of the fact that transgender and gender diverse persons are a heterogeneous group, whose attitude towards medical and surgical interventions may differ greatly. While some people wish to go through hormonal-surgical gender adjustment in order to blend more fully with the binary cisheteronormative matrix, others want only partial interventions, and others still no medical interventions at all. All of this speaks to the importance of individualized treatment (Hage & Karim, 2000), and the opennes to understanding the needs of non-binary, i.e. gender diverse persons as a particularly marginalized section of this already highly marginalized group (Burgwal et al., 2019; Richards et al., 2016; Taylor et al., 2019).

Conclusion

The history of the study of gender diversity, both in the world and in Serbia, clearly indicates the manyfold influence of social norms on the lives of individuals. Cis and heteronormativity are present not only in general social attitudes, but also in the history of medical classifications, medical (and psychological) practice, and legal regulations. Social norms also determine the choice of questions that different scientific disciplines will deal with, the ways in which those questions are posed, the choice of research methods and techniques, as well as the ways in which the results will be interpreted. These are not only questions that remain within the framework of scientific work – instead, they guide medical practice, legislation, and social attitudes, and are thus reflected in the lives of gender-diverse people.

Trans-affirmative medicine has a multi-decade history in our region. The publication *Polni identitet i promena pola* of the Belgrade Sexological Team, published in 1993, was written in accordance with the professional guidelines valid at that time and represents valuable testimony to the practice of our doctors and its theoretical foundation. Gender affirmative medicine is a field that even today is known to only a small number of doctors, and which was additionally marginalized at the time; however, the analysis of the parts of the publication dealing with psychological-psychiatric considerations shows that our Team was up to date with the leading professional standards of the time. Biological essentialism in the understanding of gender diversity, its psychopathologization, as well as the search for "true transsexuals" who would be granted access to treatment – which have now been abandoned – are a reflection of the time in which the Team worked. However, in some places in the text, a critical attitude toward what is considered scientific truths and a call for caution in premature conclusions are noticeable, because it is a field that is still developing and the way in which it is practiced significantly shapes what we consider knowledge. Although there is no critical consideration of the role of psychiatrization of gender diversity as a means of social control and preservation of the cisgender order, the authors criticize the misunderstanding and rejection that their patients encounter and show an empathetic attitude toward the complexity of the life situations of the people they work with.

In addition to significant changes within scientific disciplines dealing with gender and gender diversity – depsychopathologization of gender diversity, an increasing number of studies

that clearly speak in favor of the importance of the affirmative approach and individualization of treatment – in the previous decade, the topic of gender diversity has found itself at the very center of public debates. Such (we would say – completely unwanted and negative) popularity has been contributed to by the strengthening of the anti-gender movement, which, in its fight against the so-called gender ideology, sees the very concept of gender as the main enemy (Zaharijević and Lončarević, 2022; Gergorić, 2020; Kuhar & Zobec, 2017; Bilić, 2022; Vidić and Bilić, 2022). The anti-gender movement views the very notion of gender as dangerous and false, describing gender theories as a form of indoctrination, aimed particularly at the most vulnerable groups – children and young people – with the goal of destroying the traditional family system, social values and norms. The activities of the movement focus on denying the preservation and promotion of gender equality, sexual and reproductive rights and the rights of LGBTIQA people.

Sadly, anti-gender activities are present in Serbia as well, with one of the examples being the demand to remove the units that deal with sex and gender from biology textbooks.[41] In spite of an increasing body of research which confirms the benefits of the psychological, social, legal and medical transition, some activities of the anti-gender movement have also been focusing on denying access to gender affirmative medicine and proclaiming the entire field non-scientific, which can impact the lives of gender diverse people, as well as further research and practice, in a dramatic, negative way. This is why we wanted to present the beginning of the development of gender affirmative medicine in our country in this paper, highlight its continuity, point out the similarities and differences with the contemporary approach, and consider it in the light of contemporary research, as a testimony for the generations of practitioners and researchers to come.

References

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: Author.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

American Psychological Association. (2015). Guidelines for Psychological Practice with Transgender and Gender Nonconforming People. *American Psychologist, 70*(9), 832-864. doi: 10.1037/a0039906

Arnoldussen, M., Steensma, T.D., Popma, A. *et al.* Re-evaluation of the Dutch approach: are recently referred transgender youth different compared to earlier referrals?. *Eur Child Adolesc Psychiatry*, 29, 803–811 (2020). https://doi.org/10.1007/s00787-019-01394-6

Benjamin, H. (1966). *The Transsexual Phenomenon*. Dusseldorf: Symposium Publishing

Berrian, Kedryn, Marci D. Exsted, Nik M. Lampe, Sayer L. Pease, and Ellesse-Roselee L. Akré. 2024. 'Barriers to Quality Healthcare among Transgender and Gender Nonconforming Adults'. Health Services Research n/a (n/a). https://doi.org/10.1111/1475-6773.14362.

[41] Strucno-misljenje-interdisciplinarne-komisije.pdf, accessed on August 19, 2025.

Bilić, B. (2022). (Post)socialist gender troubles: transphobia in Serbian leftist activism. In: Bilić, B., Nord, I. & Milanović, A. (eds.) Transgender in the post-yugoslav space. Lifes, Activism, Culture. Bristol: Policy Press.

Bockting, W. O., Miner, M. H., Swinburne Romine, R. E., Hamilton, A., & Coleman, E. (2013). Stigma, mental health, and resilience in an online sample of the US transgender population. *American Journal of Public Health, 103*, 943–951.

Bockting, W. O., Miner, M. H., Swinburne Romine, R. E., Hamilton, A., & Coleman, E. (2013). Stigma, mental health, and resilience in an online sample of the US transgender population. *American Journal of Public Health, 103*, 943–951.

Bowling, J., Barker, J., Gunn, L. H., & Lace, T. (2020). "It just feels right": Perceptions of the effects of community connectedness among trans individuals. *PLOS ONE, 15*(10), e0240295. https://doi.org/10.1371/journal.pone.0240295

Bränström, R., & Pachankis, J. E. (2019). Reduction in mental health treatment utilization among transgender individuals after gender-affirming surgeries: A total population study. *American Journal of Psychiatry, 177*(8), 727–734. https://doi.org/10.1176/appi.ajp.2019.19010080

Budge, S. L., Adelson, J. L., & Howard, K. A. S. (2013). Anxiety and depression in transgender individuals: The roles of transition status, loss, social support, and coping. *Journal of Consulting and Clinical Psychology*, 81, 545–557.

Burgwal, A., Gvianshishvili, N., Hard, V., Kata, J., Garcia Niento, I., Orre, C., Smiley, A., Vidic., J. & Motmans, J. (2019). Health disparities between binary and non-binary trans people: a community-driven survey. *International Journal of Transgenderism*, 20(2-3), 218-229.

Burke, M. (2011). Resisting pathology: GID and the contested terrain of diagnosis in the transgender rights movement. In: McGann, PJ. & Hutson, J. (eds). *Sociology of Diagnosis. Advances in Medical Sociology*. Vol. 12, 183-210, Emerald Group Publishing Limited.

Cauldwell, D. O. (1949). Psychopathia transexualis. In R. Ekins & D. King (Eds.), Pioneers of transgendering: The popular sexology of David O. Cauldwell. New York: International Journal of Transgenderism.

Cavanaugh, T, Hopwood, R., Lambert, C. (2016). Informed consent in the Medical Care of Transgender and Gender-Nonconforming Patients, *AMA Journal of Ethics*, 18(11), 1147:1155.

Clarke, V., Ellis, S., Peel, E., Riggs, D. (2010). *Lesbian, Gay, Bisexual, Trans and Queer Psychology. An Introduction.* Cambridge: Cambridge University Press.

Colapinto, John (2001). As Nature Made Him: The Boy Who Was Raised as a Girl. New York: HarperCollins. ISBN 978-0-06-019211-2. OCLC 42080126.

Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., ... Zucker, K. (2012). Standards of care for the health of transsexual, transgender, and gender-nonconforming people, version 7. *International Journal of Transgenderism, 13*(4), 165–232. https://doi.org/10.1080/15532739.2011.700873

Conrad, P. and Schneider, J. (1992). *Deviance and Medicalization. From Badness to Sickness*. Expanded edition, with a new afterword by the authors. Philadelphia: Temple University Press.

de Vries, A. L. C., McGuire, J. K., Steensma, T. D., Wagenaar, E. C. F., Doreleijers, T. A. H., & Cohen-Kettenis, P. T. (2014). Young adult psychological outcome after puberty suppression and gender reassignment. *Pediatrics, 134*(4), 696–704. https://doi.org/10.1542/peds.2013-2958

DeChants, J. P., Price, M. N., Green, A. E., Davis, C. K., & Pick, C. J. (2022). Association of updating identification documents with suicidal ideation and attempts among transgender and nonbinary youth. International Journal of Environmental Research and Public Health, 19(9), 5016. https://doi.org/10.3390/ijerph19095016.

Dhejne, C., Vlerken, R. V, Heylens, G. & Arcelus, J. (2015). Mental health and gender. dysphoria: A review of the literature. *International review of Psychiatry, 28*(1), 44-57.

Drescher, J. (2010). Queer Diagnoses: Parallels and Contrasts in the History of Homosexuality, Gender Variance, and the Diagnostic and Statistical Manual, *Archives of Sexual Behavior*, 39, 427–460.

Duišin i Đorđević (ur.) (2016). *Transseksualizam: multidisciplinarni fenomen*. Beograd: Beogradski centar za urogenitalnu rekonstruktivnu hirurgiju.

Duišin, D., Barišić, J., Stojanović, B., Kojović, V., Bižić, M., Vujović, S. & Đorđević, M. (2017). „Transgender Health Care in Serbia". Contemporary Trans Health in Europe: Focus on Challenges and Improvements. 6–8 April 2017, Belgrade, Serbia.

E. Coleman, A. E. Radix, W. P. Bouman, G. R. Brown, A. L. C. de Vries, M. B. Deutsch… J. Arcelus (2022) Standards of Care for the Health of Transgender and Gender Diverse People, Version 8, International Journal of Transgender Health, 23:sup1, S1-S259, DOI: 10.1080/26895269.2022.2100644

Ekins, R. (2005). Science, politics and clinical intervention: Harry Benjamin, transsexualism and the problem of heteronormativity. Sexualities, 8(2), 152–168. https://doi.org/10.1177/1363460705050858

Ellis, H. (1910/38). *Studies in the psychology of sex* (Vol. 1). New York: Random House. (Original work published 1900)

Evje, J., Fluit, S., & von Soest, T. (2024). Transgender people experience more discrimination and violence than cisgender lesbian, gay, or bisexual people: A multilevel analysis across 30 European countries. *International Journal of Transgender Health.* https://doi.org/10.1080/26895269.2024.2440856

Fisk, N. M. (1973). *Gender dysphoria syndrome: The how, what and why of the disease*. In D. Laub & P. Gandy (Eds.), *Proceedings of the Second Interdisciplinary Symposium on Gender Dysphoria Syndrome* (pp. 7–14). Palo Alto, CA: Stanford University Press.

Fleming, M., Steinman, C., & Bocknek, G. (1980). Methodological problems in assessing sex-reassignment surgery: A reply to Meyer and Reter. *Archives of Sexual Behavior, 9*(5), 451–456. https://doi.org/10.1007/BF02115944

Frojd, S. (1969). O seksualnoj teoriji. Novi Sad: Matica srpska.

Frost DM, Meyer IH. Minority stress theory: Application, critique, and continued relevance. Curr Opin Psychol. 2023 Jun;51:101579. doi: 10.1016/j.copsyc.2023.101579. Epub 2023 Apr 6. PMID: 37270877; PMCID: PMC10712335

Gajin, S. (2012). Model zakona o priznavanju pravnih posledica promene pola i utvrđivanja transeksualizma Prava trans osoba–od nepostojanja do stvaranja zakonskog okvira.

Beograd: Centar za unapređenje pravnih studija.

Gergorić, M. (2020). Antirodni pokreti u 21. stoljeću. *Anali Hrvatskog politološkog društva, 17*(1), 149–167. https://doi.org/10.20901/an.17.07

Germon, J. (2009). *Gender. A genealogy of an idea.* Palgrave Macmillan New York https://doi.org/10.1057/9780230101814

Grant, J.M, Mottet, L.A., Tanis, J., Harrison, J., Herman, J. & Kesiling, M. (2011). Injustice at every turn. A report of the national transgender discrimination survey. Washington: National Center for Transgender Equality & National Gay and Lesbian Task Force, preuzeto sa: https://www.thetaskforce.org/wp-content/uploads/2019/07/ntds_full.pdf

Greta R. Bauer, Margaret L. Lawson, Daniel L. Metzger (2022). Do Clinical Data from Transgender Adolescents Support the Phenomenon of "Rapid Onset Gender Dysphoria"? The Journal of Pediatrics, Volume 243, 224-227, https://doi.org/10.1016/j.jpeds.2021.11.020.

Hage, J.J., Karim, R.B. (2000). Ought GIDNOS get nought? Treatment options for transsexual gender dysphoria. Plastic and Reconstructive Surgery, 105, 1222-1227.

Hajek, A., König, H.-H., Buczak-Stec, E., Blessmann, M., & Grupp, K. (2023). Prevalence and determinants of depressive and anxiety symptoms among transgender people: Results of a survey. *Healthcare, 11*(5), 705. https://doi.org/10.3390/healthcare11050705.

Handler, T., Hojilla, J.C, Varghese, R., Wellenstein, W., Satre, D.D. and Zaritsky, E. (2019). Trends in Referrals to a Pediatric Transgender Clinic. Pediatrics, 144 (5) e20191368; DOI: https://doi.org/10.1542/peds.2019–1368

Harry Benjamin International Gender Dysphoria Association. (1979). *Standards of care: The hormonal and surgical sex reassignment of gender dysphoric persons*.

Harry Benjamin International Gender Dysphoria Association. (1980). *Standards of care: The hormonal and surgical sex reassignment of gender dysphoric persons* (2nd ed.).

Harry Benjamin International Gender Dysphoria Association. (1981). *Standards of care: The hormonal and surgical sex reassignment of gender dysphoric persons* (3rd ed.).

Harry Benjamin International Gender Dysphoria Association. (1990). *Standards of care: The hormonal and surgical sex reassignment of gender dysphoric persons* (4th ed.).

Herek, G. (2007). Confronting Sexual Stigma and Prejudice: Theory and Practice. *Journal of social issues*, Vol. 63 (4). https://doi.org/10.1111/j.1540-4560.2007.00544.x

Hidalgo, Marco A., Diane Ehrensaft, Amy C. Tishelman, Leslie F. Clark, Robert Garofalo, Stephen M. Rosenthal, Norman P. Spack, and Johanna Olson. 2013. "The Gender Affirmative Model: What We Know and What We Aim to Learn." Human Development 56 (5): 285–90. https://doi.org/10.1159/000355235

Hirschfeld, M. (1910/1991). *Transvestites: The erotic drive to cross-dress* (M. A. Lombardi-Nash, Trans.). Amherst, NY: Prometheus Books. (Original work published 1910)

Hughto, J. M. W., & Reisner, S. L. (2021). A systematic review of the effects of transphobic discrimination on mental health. *Social Science & Medicine, 279*, 113961. https://doi.org/10.1016/j.socscimed.2021.113961 (doi.org in Bing)

Institut za javno zdravlje Srbije „Dr Milan Jovanović Batut". (2010). *Međunarodna statistička klasifikacija bolesti i srodnih zdravstvenih problema: Deseta revizija, Knjiga 2 – Priručnik za upotrebu*. Beograd: Institut za javno zdravlje Srbije.

James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2021). *The report of the 2015 U.S. Transgender Survey.* National Center for Transgender Equality.

James, S.E., Herman, J.L., Durso, L.E., & Heng-Lehtinen, R. (2024). Early Insights: A Report of the 2022 U.S. Transgender Survey. National Center for Transgender Equality, Washington, DC.

Jutel, A. (2011). Sociology of Diagnosis: A Preliminary Review. U: McGann, PJ. & Hutson, J. (eds). *Sociology of Diagnosis. Advances in medical sociology*, Vol. 12, 3-32 Emerald Group Publishing Limited.

Krafft-Ebing, R. von. (1886/1999). *Psychopathia sexualis: With especial reference to contrary sexual instinct: A clinical-forensic study* (B. King, Ed.). Burbank, CA: Bloat Books.

Kuhar, R., & Zobec, A. (2017). The anti-gender movement in Europe and the educational process in public schools. *Center for Educational Policy Studies Journal, 7*(2), 29–46. https://doi.org/10.26529/cepsj.168

Levine, S.B. (1989). Gender identity disorders of childhood, adolescence and adulthood. In: Kaplan, H. & Sadock, B. (eds.). Comprehensive textbook of psychiatry. Baltimore: William & Wilkins.

Lief, H.I. (1978). Introduction to sexuality. In: Freedman, M. A., Kaplan, H.I,, Sadock, J. B. (eds). Comptehensive textbook of psychiatry, second edition. Baltimore: William & Wilkins.

Limentani, A. (1979). Transsexualism: A clinical and theoretical overview. *British Journal of Psychiatry, 134*(6), 552–559. https://doi.org/10.1192/bjp.134.6.552

Link BG, Phelan J. Stigma power. Soc Sci Med. 2014 Feb;103:24-32. doi: 10.1016/j.socscimed.2013.07.035. PMID: 24507908; PMCID: PMC4451051.

Liu, M., Patel, V. R., Reisner, S. L., & Keuroghlian, A. S. (2024). Health status and mental health of transgender and gender-diverse adults. JAMA Internal Medicine. Advance online publication. https://doi.org/10.1001/jamainternmed.2024.2544.

Marzetti, H., et al. (2024). Discrimination, victimization, and suicidal ideation among transgender adults. *Journal of Affective Disorders.*

Matsuzaka, S., & Koch, D. E. (2019). Trans feminine sexual violence experiences: The intersection of transphobia and misogyny. *Affilia: Journal of Women and Social Work, 34*(1), 28–47. https://doi.org/10.1177/0886109918790929

McCann, E., Donohue, G., & Brown, M. (2021)**.** Experiences and perceptions of trans and gender non-binary people regarding their psychosocial support needs: A systematic review of the qualitative research evidence. *International Journal of Environmental Research and Public Health, 18*(7), 3403. https://doi.org/10.3390/ijerph18073403

McCann, E., Donohue, G., & Brown, M. (2021)**.** Experiences and perceptions of trans and gender non-binary people regarding their psychosocial support needs: A systematic review of the qualitative research evidence. *International Journal of Environmental Research and Public Health, 18*(7), 3403. https://doi.org/10.3390/ijerph18073403.

McNeil, J., Bailey, L. Ellis, S., Morton, J. & Regan, M. (2012). *Trans Mental Health and Emotional Wellbeing Study 2012*. Scottish Transgender Alliance; TREC, Traverse; Sheffield Hallam University, TransBareAll.

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual

populations: Conceptual issues and research evidence. *Psychological Bulletin*, *129*, 674–697. doi:10.1037/0033-2909.129.5.674

Money, J. (1972). *Man & woman, boy & girl: Gender identity from conception to maturity*. Johns Hopkins University Press.

Nord, I. (2018). Routes to gender-affirming surgery: navigation and negotiation in times of biomedicalization. In: Griffin, G. & Jordal, M. (eds). Body, Migration, Re/constructive Surgeries. Routledge. https://doi.org/10.4324/9781351133678

Olson KR, Durwood L, DeMeules M, et al. (2016). Mental Health of Transgender Children Who Are Supported in Their Identities. Pediatrics, 137(3).

Parsons, T. (1951). *The Social System*. London: Routledge.

Puckett, J. A., Price, S., Dunn, T., Kuehn, K., Kimball, D., Hope, D. A., Mocarski, R., Juster, R.-P., & DuBois, L. Z. (2024). Legal gender affirmation, psychological distress, and physical health issues: Indirect effects via enacted stigma. Sexuality Research and Social Policy. Advance online publication. https://doi.org/10.1007/s13178-024-00971-y

Rakić, Z., Marić, J., Slijepčević, D., Vujović, S., Perović, S. (1993). Polni identitet i promena pola. Beograd: BIZG.

Richards, C., Bouman, W.P., Seal, L., Barker, M.J., Nieder T. & T'Sjoen., G. (2016). Non-binary or genderqueer genders. *International Review of Psychiatry*, 28(1), 95-102, DOI: 10.3109/09540261.2015.1106446

Robles, R., Fresan, A., Vega-Ramirez, H., Cruz-Islas, J, Rodrigues-Perez, V., Dominguez-Martinez, T., Reed, G. (2016). Removing transgender identity from the classification of mental disorders: a Mexican field study for ICD-11, Lancet Psychiatry, 3: 850–59.

Santos, G.-M., McFarland, W., & Wilson, E. C. (2025). Prevalence and correlates of sexual intimate partner violence among trans women in the San Francisco Bay Area. *Frontiers in Global Women's Health.*

Schaefer, L. C., & Wheeler, C. C. (1995). Harry Benjamin's first ten cases (1938–1953): A clinical historical note. *Archives of Sexual Behavior, 24*(1), 73–93, https://doi.org/10.1007/BF01541990

Scheim, A. I., Perez-Brumer, A. G., & Bauer, G. R. (2020). Gender-concordant identity documents and mental health among transgender adults in the USA: A cross-sectional study. *The Lancet Public Health, 5*(4), e196–e203. https://doi.org/10.1016/S2468-2667(20)30032-3.

Scheim, A.I., Restar, A.J, Zubizarreta, D., Lucas, R., Wilson Cole, S., Everhart, A., Baker, K. E., Rodriguez, M. I. (2025). Legal gender recognition and the health of transgender and gender diverse people: A systematic review and meta-analysis, *Social Science & Medicine,* Vol 38, 118147, https://doi.org/10.1016/j.socscimed.2025.118147.

Simić, J. (2012). Medicinsko-pravni aspekti transseksualnosti - u susret priznavanju pravnih posledica promene pola u Srbiji. Pravni zapisi, vol. 3, br. 2, str. 299-322, https://doi.org/10.5937/pravzap3-2954

Smiley, A., Burgwal, A., Orre, C., Summanen, E., Garcia Niento, I., Vidić, J., Motmans, J., Kata, J., Gvianishvilli, N., Hard, V. and Kohler, R. (2017). *Overdiagnosed but Underserved. Trans Heathcare in Georgia, Poland, Serbia, Spain, and Sweden: Trans Health Survey*.

TGEU

Smith, E., Jones, T., Ward, T., Dixon. J., Mitchel, A., Hilier, L, (2014) *From Blues to Rainbows. The mental health and well-being of gender diverse and transgender young people in Australia*. Australian Reserach Centre in Sex, Health and Society, La Trobe University and University of New England.

Socarides, C. W. (1964). *The overt homosexual*. Grune & Stratton.

Stoller. R. J. (1968). Sex and gender : on the development of masculinity and femininity. New York: Science House

Taylor, J., Zalewska, A., Gates, J.J. & Millon, G. (2019). An exploration of the lived experiences of non-binary individuals who have presented at gender identity clinic in the United Kingdom. *International Journal of Transgenderism*, 20(2-3), 195-204

Testa, R., Sciacca, L., Wang, F., Hendricks, M., Goldblum, P., Bradford, J., Bognar, B. (2012). Effects of violence on transgender people. *Professional Psychology: Research and Practice*. *43*(5), 452-459.

TGEU - Trans Rights Map za 2025. godinu

Turner, L., Whittle, S., Combs, R. (2009). *Transphobic Hate Crimes in the European Union*. London: Press For Change.

Verbeek, P., Zadeh, S., & van der Meulen, R. (2020). *Transgender care in Europe: A comparative analysis of policy and practice*. European Journal of Public Health, 30(5), 845–850. https://doi.org/10.1093/eurpub/ckaa123

Vidić, J., Stanković, B., & Džamonja Ignjatović, T. (2022). Iskustva medicinske tranzicije transrodnih osoba u Srbiji: Od afirmacije identiteta do institucionalnog nasilja. *Sociologija, 64*(3), 401–427. https://doi.org/10.2298/SOC2203401V

Vidić. J. & Bilić, B. (2022). Transgender and non-binary persons, mental health and gender binarism in Serbia. In: Bilić, B., Nord, I. & Milanović, A. (eds.) *Transgender in the post-yugoslav space. Lifes, Activism, Culture*. Bristol: Policy Press.

Vidić, J. (2021)**.** Položaj i potrebe transrodnih i rodno nebinarnih osoba u Srbiji. *Psihološka istraživanja, 24*(1), 75–99. https://doi.org/10.5937/PSISTRA24-27858

Vidić, J. (2020). *Transrodnost u Srbiji u 21. veku – Pilot studija o informisanosti i iskustvima zdravstvenih radnika o procesu prilagođavanja pola*. Engrami, 42(2), 6–22. https://doi.org/10.5937/engrami41-28757

Vidić, J. (2015). *Prekinimo ćutanje! Izveštaj monitoringa diskriminacije i zločina iz mržnje nad trans* osobama*. Beograd: Gayten-LGBT, Centar za promociju LGBTIQ prava

Viks, Dž. (2019). Šta je istorija seksualnosti? Novi Sad: Mediterran.

Will the cycle of violence ever end? TGEU's Trans Murder Monitoring project crosses 5,000 cases - TGEU - Trans Europe and Central AsiaTGEU – Trans Europe and Central Asia

World Professional Association for Transgender Health. (1998). *Standards of care for gender identity disorders* (5th ed.).

World Professional Association for Transgender Health. (2001). *Standards of care for gender identity disorders* (6th ed.).

Zaharijević, A., & Lončarević, K. (2020). Rod i ideologija: o pobuni protiv jednakosti. U: T. Várady & M. Pajvančić (Eds.), *Rodna ravnopravnost – od jednakih prava do jednakih mogućnosti* (str. 29–44). Beograd: Srpska akademija nauka i umetnosti.

Zucker, K. J. (2017) Epidemiology of gender dysphoria and transgender identity. *Sexual Health* 14, 404-411. https://doi.org/10.1071/SH17067

Zulević, J. (2012). Istraživanje problema transeksualnih osoba u sferama školstva, rada i zapošljavanja, zdravstvene zaštite i državne administracije. U: Gajin, S. (ur.). Model zakona o priznavanju pravnih posledica promene pola i utvrđivanja transeksualizma. Prava trans osoba – od nepostojanja do stvaranja zakonskog okvira. Beograd: Centar za unapređenje pravnih studija.