



A Critical Review of Trans Mental Health Approaches


Una revisión crítica del abordaje de la salud mental trans

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Abstract: In this article we present a critical review of the psychological and psychiatric perspectives on trans mental health. We highlight how their expansion, in the form of diagnostic and therapeutic culture, has impacted everyday language and social movements, sometimes to the detriment of political action and reflection. Drawing on genealogies of feminist, queer, racialized and mad collective resistances to rethink the frameworks of meaning and response surrounding distress and madness. From this perspective, we propose trans-mad alliances as urgent and necessary, viewing them as depathologizing and anti-oppressive strategies that can expand these frameworks and translate them into social justice, transcending individualization through collectivity. We seek to reclaim the communities of affection, care and support that have historically characterized the trans collective in the face of various forms of violence and exile of cisheterosexist, racist and sanist societies.

Keywords: therapeutic culture, trans community, mad movement, critical psychology, depathologization.

Resumen: En este artículo presentamos una revisión teórico-crítica sobre las perspectivas psicológicas y psiquiátricas que abordan la salud mental trans. Señalamos cómo su expansión, en la forma de cultura diagnóstica y terapéutica, ha impactado desde el lenguaje cotidiano hasta los movimientos sociales, a veces en detrimento de la acción y reflexión política. Recuperamos genealogías de resistencias colectivas feministas, queers, racializadas y locas para re-pensar los marcos de sentido y de respuesta en torno al malestar

y la locura. Desde ahí proponemos como urgentes y necesarias las alianzas trans-locas, considerándolas estrategias despatologizantes y antiopresivas que pueden ampliar dichos marcos para que se traduzcan en justicia social, que trascienda la individualización desde la colectividad. Buscamos reivindicar las comunidades de afectos, cuidados y apoyos que han caracterizado históricamente al colectivo trans frente a las distintas formas de violencia y exilio de las sociedades cisheterosexistas, racistas y cuerdistas.

Palabras clave: cultura terapéutica, comunidad trans, movimiento loco, psicología crítica, despatologización.

Introduction

In this paper we offer a theoretical review grounded in historical and critical analysis (Guzmán Martínez *et al.*, 2021) of the psychological and psychiatric perspectives on trans mental health. We argue that the role of the psy disciplines in what is called the “clinical paradigm of gender identity” (Haraway, 1995) has left its mark on the framework of interpretation and intervention of the discomfort and mental suffering of the trans community as a result of various kinds of oppressions and violence. This paradigm, featuring theorists such as Robert Stoller and John Money, formulated the concept of gender identity as an inner reality or substance (separate from sex) which could be evaluated and measured by psy professionals. This psychologisation has now spread outside clinical settings to expand into the general culture and the everyday language we use to give meaning to our experiences and express them.

This occurs within a diagnostic and therapeutic culture where psychiatric or psychological labels and categories are increasingly used to interpret or regulate how we understand ourselves, and where it is the public itself that calls for “pathologisation from below”, seeking diagnoses that furnish an explanation for their problems (Brinkmann, 2024).

Far from the rhetoric of progress in psy theories and interventions concerning sexuality and gender, from pathologising models of transsexuality to new affirmative therapies, other pathologisations are creeping in “through the back door” as a consequence of unresolved tension between trans activism and madness. In other words, while trans depathologisation is advocated, other pathologisations and psychiatrisations derived from the mental suffering brought about by transphobic violence are accepted without hesitation. This has led to non-rejection of the biomedical or psychotherapeutic model as the

hegemonic response to the mental suffering of the trans community, supplanting the “account of oneself”, as a group, by the clinical gaze.

Our approach, rooted in the historicisation of psy violence against that which falls outside normative frameworks, holds that both the biomedical model of mental disorder and the therapeutic model of mental health are structurally harmful and potentially iatrogenic (in terms of collective mental health) ways of making sense of trans people’s (and queer people more broadly) experiences of suffering or madness. This is primarily due to their individualisation and psychologisation of suffering, and because they ignore or address in the background or independently the social context and the structural oppression behind it.

Viewed from these perspectives, the experiences of trans madness appear meaningless and in a pathological or decontextualised framework (Pilling, 2022): they are depoliticised. This does not dismantle the clinical-therapeutic institution as a control and surveillance device working for power, while hegemonic systems are perpetuated through the normalization exercises that this practice supports. Furthermore, the diverse material conditions criss-crossed by racism or classism of a large part of the trans community, symbiotically added to cissexism, are not considered. By the latter we mean a hierarchical system in which cis experiences are portrayed as natural, healthy and desirable, and trans experiences as illegitimate “others” (Radi, 2020).

In view of the above, we draw on other trans genealogies that enable us to conceive alternative and collective ways of understanding and responding to different types of suffering derived from transphobic oppression and violence: the consciousness-raising groups of radical feminism and their commitment to politicising discomfort (Guzmán Martínez *et al.*, 2021); the trans “houses or families” which have communally sustained the expelled lives of transgender people by welcoming them with love and “revolutionary street transvestite action” (Berkins, 2007; Piepzna-Samarasinha, 2019; Wayar, 2018); and finally, queer, crip and mad activism which have jointly critiqued the pathologising normalisation and medicalisation of sexual, bodily and mental diversity (Guzmán-Martínez & García-Dauder, 2023; Piepzna-Samarasinha, 2019; Rey Artime, 2017). In doing so, we appeal to the allied “trans-mad” figuration as heir to “transvestite rage”, to all the dissident struggles which have historically challenged pathologising devices, re-signified the injury and put the body on the line, underscoring the critical value of difference (Berkins, 2012).

This paper is written by three individuals situated at the intersection of trans and mad activism in the first person (plural) and comes from the concern about how diagnostic and therapeutic culture is creeping into activism just like its pathologising and individualistic tendencies. Based on a *committed articulation* (Ruiz-Trejo & García-Dauder, 2023) between activism and academia, we seek to make a theoretical contribution to studies and practices addressing trans mental health. We perform historical and critical analysis (Guzmán Martínez *et al.*, 2021), our approach is anchored in theories and actions which account in temporal terms for the development of different perspectives on trans mental health. We also explore the exercises of power and resistance which are interwoven in them. We do this by reading various kinds of documents which are relevant to the topic (mainly academic studies, reports and autobiographical texts). We conclude with proposals for alternatives which make it possible to politicise the understanding of the connection between mental suffering and oppressions so as to focus transformation and responses on its structural foundations.¹

A Reminder of Psy Violence in the Rhetoric of Progress

We are not going to take a historical tour of how Western science, and in particular medicine, have operated for the modern colonial gender system (Lugones, 2008). Psy disciplines spring from scientific racism and sexism, and through mechanisms of normalisation, disciplining and population control (Foucault, 2001) have pathologised anything that deviates from the norm or threatens the status quo. Writers such as Phyllis Chesler (2019) and Jane Ussher (1991) have examined how psychiatry has been harnessed to uphold the subordination of women, pathologising both femininity in itself and also feminist protest. In psychology, the manufacture of masculinity/femininity tests has been scrutinised as technologies of gender and sexuality control, detectors of deviations to be intervened (López-Sáez, García-Dauder, 2020). Camilo Losada (2016), for example, has homed in on the famous Minnesota Multiphasic Personality Inventory (MMPI-2) as an evaluator of cisheteronormative behaviours. Other scholars have historically addressed the pathologisation of black community protest or “sexual inversion”

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with co-productive intersections between theories of sexual and racial degeneracy (Somerville, 2000).

However, it is common to come across publications which provide a historical review of psy theories and interventions concerning sexual and gender dissidence over the last half-century anchored in a rhetoric of progress (Diamond, 2017). This review starts with the APA's pathological view of homosexuality and its consequent conversion therapies until 1973, followed by its remnant of "ego-dystonic homosexuality" (or "unspecified sexual disorder"), which pathologised the discomfort derived from the conflict between homosexuality and society (i.e., homophobia), up to the present day, when there seems to be some consensus in the psy disciplines that non-heterosexual sexual orientation is "normal".

This historical review does not always mention the protests of LGBTQ+ activists at APA meetings, nor those psychiatric patients with other diagnoses, or the alliances between survivors of psychiatry and lesbian activists. In *Still Sane* and from a clear critique of psychiatric violence as a "crucible of oppressions" (Rey Artime, 2019), Dee dee Nihera (1985: 92) pointed out:

(...) attempts to eliminate heterosexism among mental illness workers cannot be effective while the psychiatric system remains in force. Although homosexuality was deleted from the American Psychiatric Association's formal list of mental disorders in 1973, nothing has changed (...) Even if all mental illness workers informed themselves about homosexuality, violence against mad people would continue. Sexism, heterosexism, saneism, racism and classism are all facets of psychiatric oppression, but removing only one of these "isms" leaves the system's structure intact.

Nor are gender, class or racial differences in the perception of "social dangerousness" often noted: the "bad men/mad women" (Chesler, 2019) that psychiatrised lesbians while gays or transvestites (also) went to prison, or the criminalisation and psychiatrisation of racial, class or political protests (Gorman *et al.*, 2013).

When homosexuality vanished from the DSM, so-called "gender identity disorders" (GID) came into the picture, added to DSM-III with different terminology and nuances separated by age criteria. The rationale for the diagnostic label was that it would facilitate access to the desired hormonal or surgical treatment for impecunious trans people. The cost of institutional support for transition has thus been the "mental green light": the psy (psychiatric and psychological) system as an obligatory gateway with the loss of bodily autonomy and the violence of having to account for oneself (Butler, 2020). Hence all kinds of protocols were

fashioned to “work” with trans people, such as the famous *Standards of Care* (now seven editions of regulation about who does and does not have access to treatment and how).

We would highlight here how differential diagnosis in the DSM was used as a pretext to justify the presence of psychologists or psychiatrists in clinical transition processes: not only was it necessary to distinguish clinically between sexual orientation and transsexuality but also to rule out the existence of any other psychiatric diagnosis in order to validate GID. This invalidated the existence of trans people with other psychiatrised conditions. The elimination of “another mental disorder” as an exclusion criterion for transsexuality (in the latest editions of the DSM) has thus meant in recent years a new pathologisation of these experiences, generating an increasing number of additional diagnoses (anxiety, depression, BPD, suicidal ideation, etc.).

In DSM-5, GID was replaced by “gender dysphoria”, labelling not diversity per se but rather experiences of distress or suffering with society (instead of problematising transphobia) in the style of ego-dystonic homosexuality. It would appear that the DSM needs its own transition before depathologising a sexual condition (transvestite fetishism seems to follow a similar path yet to be taken). As with “adjustment disorder”, and so many other diagnoses applied to migrant populations derived from racist prejudices in the discipline, rational responses to the rejection caused by breaching the norm are pathologised and rendered meaningless (Fernando, 2017a).

The switch to dysphoria (or “incongruence” in ICD-11) is a response to collective demands to depathologise gender identities and in turn secure medical resources and funding to support transitions. Although many professionals “do not believe” in diagnosis, its necessity is advocated as a prerequisite for access to rights (Argyriou, 2023). Here too, a narrative of progress towards the depathologisation of transsexuality is presented (at least in part) and affirmative therapies (those that validate a person’s orientation or identity) come to the fore, albeit many professionals still struggle to accept that gender diversity is “normal”, let alone challenging fixed binary identities or biologicism.

There is a shift in ICD-11 from compulsory diagnosis (or real life test) to a suggestion of therapy prior to transition. Notwithstanding social criticism and some laws, the psy disciplines are reluctant to let go of their power and recognise they are dispensable. The history of enforced psy involvement in transitions has contributed to the therapeutic culture’s

focus on the trans population (particularly those who can afford it), this time in the form of recommended “accompaniment”. Furthermore, although in some countries self-identification precludes the need for psy professionals, they nonetheless assert their key role as the legitimate voice on trans children and adolescents.

In turn, the conversation on conversion therapies has resurfaced in recent years, this time as a means of correction for children and adolescents to change their early gender expression and identity. Here we revisit *The Last Time I Wore a Dress*, an autobiographical book by Dylan Scholinski (1997) in which he railed against conversion therapies and the psychiatric violence he experienced. We go back to it as a precedent for alliances between survivors of psychiatry and trans people. In so doing, we appeal not to the depathologising discourse of transsexuality centred on “we are not mad” but rather to a struggle based on the “trans-mad alliance against violence” which challenges normalisation in its various expressions (LeFrançois & Diamond, 2014). This means viewing madness as a reasonable response of resistance to transphobic violence through a politicised and not biomedical framework, one which restores agency to trans and mad people without the necessary mediation of a specialist who curbs life experiences outside the norm or has the last word in decisions about them.

The purpose of this first journey was to recover the memory of psy violence and provide an initial overview of activism as epistemic correctives (García-Dauder, 2019) as opposed to narratives of internal scientific progress. With this, we aim to question whether, in the face of trans-exclusionary positions and conversion therapies (supported by certain sectors of psychology/psychiatry and replicated by some families and the social environment), the response to trans suffering must come from the psychological disciplines themselves (and their affirmation of individual identity). In short, it is to warn about how the collective can be trapped in a psy system which both does harm and also offers itself as a last hope.

Continuities in the Medicalised Framework: New Pathologisations *through the Back Door*

As we noted in the Introduction, this paper begins with a critique of the biomedical model of mental disorder and the therapeutic and

psychologistic model of mental health. This is due to the pathologisation and individualisation of suffering as a result of transphobic violence and ignoring the social context which causes it (Boyle, 2011). As Dupuis-Vargas Latorre (2022) points out, throughout the socialisation process of the trans individuals, there is frequent referral to mental health services, which often do not seek to ensure comprehensive wellbeing but rather to prevent or correct “gender deviation”. Pathologisation thereby becomes a gender device which sustains cisnormativity.

This is compounded by unequal power relations in healthcare settings and by professionals’ deep-seated ignorance of structural oppressions together with trans, mad or racialised cultures, and therefore of potential collective responses which are not reliant on the healthcare domain. Trans mental health is often framed either in institutionalised medical settings (generally run by cis people), in many cases hostile or untrained; in private therapeutic settings or linked to LGBTIQ+ associations (even “queer psychotherapy” is offered); or based on a psychology of health where there is increasing talk of “minority stress” or “resilience”. At the same time, trans communities’ support and resistance networks are ignored alongside material and structural changes.

In contrast, comprehensive or collective mental health necessarily entails rights and social justice: decent housing and jobs coupled with the struggle against cissexism and transphobic violence (in the family, at school, in public spaces, on transport, in toilets, etc.) (Artazo, 2023). This means addressing the conditions of compulsory cisheteronormativity which underlie healthcare, exclusion and self-exclusion related to institutional violence in health settings, in this case in mental health services. Quantitative studies (when there are any) show troubling data on ignorance, deficient care or health violence against the transgender population. For example, the Spanish report *Transaludes* (Belza *et al.*, 2025) criticises medical models which make it difficult to meet the specific health needs of the group.

According to the report, 40% of trans people in this context believe that health professionals do not know how to care for them. These exclusions are the outcome of transphobic stigma and prejudice, but also of moralistic views concerning substance use or sexual practices, particularly HIV or sex work (Artazo, 2023; Pilling, 2022). Besides this, something basic is also demanded: respect for life stories and identities and active listening in early service when dealing with a health request, from the person attending at the counter (potential operators of

administrative violence) to primary healthcare and its referrals. The purpose is to avoid re-victimising an already vulnerable population.

As Ann Millet (2020) points out, de-cissexualisation of the health system is not only a matter of training professionals or developing services and roles specifically aimed at caring for trans, transvestite, or non-binary individuals; it also entails structural changes in cissexist conceptions, knowledge and practices throughout the health system (and across society at large). In mental health, changes involve more equitable power relations in health encounters and in society; listening, respecting, attending to the social context, providing support and agency from a social justice approach instead of trying to change individuals. Rather than an issue of access to health or “cultural competence” (Artazo, 2023), it is about addressing oppressive systems (immigration policies, working conditions, housing, etc.), including those in healthcare which can cause the most harm (as in the case of mental health).

In health settings, and notwithstanding the apparent depathologisation of transsexuality, life processes of transition continue to be psychologised and psychiatrised. Founded on an objective rhetoric laden with subjective judgements in assessments, “promiscuous behaviour”, “inappropriate anger” and “substance use” are pathologised along with child protection services related to mental health care (Pilling, 2022). This all comes with a lack of transparency about diagnosis, information control and a large dollop of epistemic injustice (Argyriou & García-Dauder, 2023; Fricker & Jenkins, 2017). If there is no in-depth critique of the not only biomedical but also psychologist and therapeutic framework (of the *medicalisation* of the political), the violence of the psy will resurface along with its demobilising and individualistic effect.

In *Queer and Trans Madness*, Merrick Pilling (2022) critically describes experiences and (mis)encounters of trans people with mental health professionals. Firstly, how suffering is individualised through the pathologisation of sexualities, as if the cause of discomfort or distress were to be found in dissident gender identities or expressions rather than in transphobia. This is coupled with the pathologisation of gender identity as a requirement and obligatory gateway for the validation of trans identities, apart from the binary adjustment and those surveillance tests of the experts with their time requirements (Sanz, 2024). Even when transsexuality is not pathologised, other “inappropriate” sexualities are sometimes pathologised. For example,

“promiscuity” or “indiscriminate sexual behaviour” is used in a moralistic way to support various diagnoses based on heteronormative and monogamous values (the diagnosis of BPD is a good example of this).

In biomedical and psychologistic discourse, having many sexual relationships and with different partners, or BDSM, is pathologised or interpreted and named as self-harm, as failure to self-care. Alongside this, there is further pathologisation and criminalisation of racialised sexual diversity. There are a disproportionate number of schizophrenia diagnoses in young black people (Fernando, 2017b). The migrant and precarious trans population can swing from neglect due to lack of access to health resources to over-medication, all while paying no heed to their material circumstances of labour exploitation, institutional violence due to immigration laws, absence of housing and so on.

Finally, Pilling (2022) mentions the biomedical methods of responding to crises where help is sought and admission, psychiatric medication or therapy are presented as the only alternative without addressing the context, in such a way that when these do not provide relief, other possible supports have been deactivated, even leading to involuntary or forced treatment “for your own good” which can undermine an already fragile self. This correlates with experiences publicly recounted by the trans population itself (De grietas y luces, 2025). The experience of cisheteronormative oppression thus causes discomfort and suffering, yet LGBTIQ+ people experience oppression in the very (health) system which is supposed to help them. In broader structural terms, psy practices and places of confinement end up being devices for the construction/defence of the modern subject par excellence (male, cisheterosexual, white, adult, owner, healthy/sane/able).

As a result, while groups have fought to remove trans identities from the DSM and depathologise them, the pathologising framework has crept in through the back door. As Ambrose Kirby (2014: 163) points out: “as our identities are being normalized, our resistance to transphobia is increasingly being separated from our identities and pathologized.” Therapeutic and diagnostic culture has also seeped into trans communities and what was survival and creative resistance to transphobia is increasingly placed in the individualised framework of “disorder” due to anxiety, bipolar, BPD, etc.; ironically, we might think of it as a “disorder of people who have been oppressed” (Kirby, 2014). It is a new, veiled transphobia in the shape of saneism. This alone can explain that while pathologisation for being trans is rejected, the pathologisation of

resistance to transphobia is still accepted coupled with other diagnostic labels for “extreme anger”, “self-harm”, sadness and grief, etc. (Kirby, 2014), the growing pathologisation of the affective.

Alongside this, many young people seek a psychiatric label for a variety of reasons, potentially becoming trapped in the psychiatric system (Diamond, 2014; Kirby, 2014). Neoliberal governmentality itself, and a psychocentrism which pervades common parlance, increasingly creates subjects who self-diagnose or use diagnoses as essential identities decoupled from wider social justice projects (Diamond, 2014; Rimke, 2020); this is compounded by the search for validation and the history of psy diagnosis as an endorsement.

Finally, many transgender people are in a precarious situation due to financial issues and a diagnosis can furnish them with access to rights or support (Diamond, 2014; Kirby, 2014). In other words, at the structural level, clinical validation provides access to resources which could be promoted rooted in the rationale of universally protecting basic rights. It would seem that if a diagnosis brings relief or is useful to the person it is not pathologising, or that it ceases to have pejorative effects on a social level or iatrogenic effects on a medical level. Put another way, the current overabundance of mental health discourses means that this system is the only place trans people in need of support can turn to, which may expose them to further violence.

Trans activism’s “we are not mad”, apart from pushing transsexuality away from the DSM (and theories of trans psychosis and delusions), has had the unintended effect of presupposing an unquestioned *sane* subject and moving away from the struggles of mad activism and thereby the critique of any kind of psychiatric or diagnostic category. As Kirby (2014: 170) notes: “It is not enough to take our identities out of the DSM, because somebody else’s identity is in there”.

There seems to be a growing consensus that trans identities should not be understood as a “mental disorder”, yet strategies and responses of struggle, resistance and survival are being taken out of context, individualised and pathologised. Therapeutic culture and the mental health framing of daily life, together with the boom in affirmative therapies and psychologising discourses of acceptance as a form of “resistance” against TERF discourses, has shifted the framework of intelligibility of the consequences of transphobic violence from a politicised to a medicalised one.

Like the pathological model, the affirmative therapeutic model has continued to individualise sexuality, removing it from its social and political context grounded in an empiricist, neutral, and objective paradigm. This hides the power structures and processes which generate privilege and oppression, placing the burden of responsibility on the individual. Psychocentrism thus fosters a model of individual shortcomings which overlooks social problems (Rimke, 2020).

For example, transphobia cannot be seen simply as an irrational fear in the minds of sexual majorities but rather as something produced by socio-cultural discourses and practices (Alldred & Fox, 2015; Kitzinger, 1997). Reductionism, essentialism, the ethics of personal hyper-responsibility or victim-blaming, or the “cruel optimism” of resilience (Berlant, 2020) are all part of psychocentric discourses or a widespread “psychological imagination” (Rimke, 2020).

There, sexual desires seem so personal, so “internal”, that they mutate into individual attributes not subject to social discourses and forces (which does not detract from their materiality). Therapeutic culture has normalised therapy as an unquestioned ally, even in trans-feminist groups. Therapy reinforces the confessional regime to which the trans community has traditionally been subjected, this hyper-reflexivity or having to give an account about themselves in order to explain their subjectivity. It is also about this tireless self-management (of the trans person) to gain recognition without the environment changing anything (Argyriou & García-Dauder, 2023).

Alongside this, trauma therapy has also made traction into trans or queer mental health services due to its ability “to reduce complex social justice issues into psychological symptoms, which are then thought to be curable through expert mental health treatment” (Tseris, 2017:251). In doing so, it helps to label survivors of transphobic violence and decontextualises their suffering, at the expense of neglecting its causes within a cisheteronormative system or other cultural or collective approaches to queer trauma (Cvetkovich, 2018). The lexicon of trauma depoliticises transphobic violence: by focusing on psychological harm, the material and social conditions that precede and cause distress are obviated.

From an epidemiological or public health perspective, the transgender population also appears as a group at risk of developing mental health problems, yet the risk seems to be in the dissident gender or sexuality and not in transphobia. Health psychology forgets that power and privilege

are key social determinants (Prilleltensky & Prilleltensky, 2003). Figures are provided on the high prevalence of “mental health problems” among trans people in anxiety, depression and suicide (Dhejne *et al.*, 2016; McNeil *et al.*, 2017; Millet *et al.*, 2017) and that this correlates with the impact of minority stress. But are they mental health problems or violence problems? Minority stress, stressed minorities (Riggs & Treharne, 2017), or majority oppression? What are the implications of language for the focus of intervention or potential responses? With their splitting and separation of distal-external-objective and proximal-subjective stressors, social factors emerge as contributing inputs yet not as primary targets for intervention (Riggs & Treharne, 2017; Tan *et al.*, 2019).

According to Meyer (2003), minority stress is the “excessive stress to which individuals from stigmatised social categories are exposed as a result of their often minority social position”. Subsequently, Testa *et al.* (2015) developed the Gender Minority Stress Framework (GMSF) which considers minority stressors unique to trans people (gender confusion, misgendering, non-affirmation, etc.). Yet it seems that it is minority stress which causes mental health problems, not oppression and violence. There is no structural anti-oppressive analysis but rather the social problems underlying experiences of suffering are re-individualised and psychologised.

As Riggs and Treharne (2017) contend, stress does not flow from an individual person’s social position; this would mean accepting that it is the “minority position” (or the negative consideration of one person over another) which is the cause of stress rather than structural and social oppression. In Meyer’s (2003) framework, the subjective experiences of the trans person are emphasised as proximal stressors: their negative expectations, anticipation of rejection, concealment or internalised transphobia. There is thus a shift from stress as something external to stress as a characteristic of an individual, an internalised cognition. Far from being theorised as survival mechanisms against objective conditions of oppression and violence, they are seen as internalised appraisals among minority people which generate particular stress.

Positioning stress as a purely subjective issue opens the door for “resilient actors” (Testa *et al.*, 2015) with “coping skills” while institutionalised violence, ideology and hate speech are pushed into the background. As part of this, resilience and pride of identity are presented as protective factors which can buffer minority stressors. Little is said about privilege or how whiteness or middle class status are

in themselves protective factors (Riggs & Treharne, 2017). Instead of promoting resilience, trans collective health should be directed at social change and challenging cis-heterosexist ideology.

In another exercise of co-opting and politically deflating psychology, intersectionality has even been applied to the GMSF (Millar & Brooks, 2022) without considering the different epistemological frameworks from which they come. The additive approach to intersectionality is rejected but not the positivist-empiricist and individualist model (Kitzinger, 1997), which is incapable of understanding the co-production of oppressions in the language of variables.

“Resilience” in turn perfectly embodies the spirit of therapeutic individualism which downplays social, political, historical and economic factors. The assumption that “normal” people are not privileged but rather “resilient” completely masks the inequalities, violence and social problems which contribute to human distress or success (Rimke, 2020). The idea that people who “survive and thrive” or manage to overcome “personal” problems can do so because they are “resilient” or possess a reserve of inner strength turns those who have persistent problems into morally weak or deficient individuals (Rimke, 2020).

In light of the above, we now look at other politicised frameworks of intelligibility to understand trans collective mental health.

Resistance Genealogies: Mad, Queer, Racialised

Recovering historical collective organising processes in understanding/going through discomfort and madness helps to shift from the narrow margins of possibility of psychobiomedical reductionism towards social transformation. From a feminist perspective, history is not the intellectual development of a dead past (Cruz, 2010); it re-constructs and at the same time continually transforms the present through its echoes. We recover and complexify, then, histories of resistance omitted or erased by the codes or “games of truth” (Foucault, 1996) which have formed specific knowledge about discomfort, madness and sex-gender-desire dissidence as a strategy for the construction or return of other possible responses.

In 1969, at the height of various civil rights mobilisations in the United States, Carol Hanisch (2016: 3) argued from the Women’s Liberation Movement:

The very word “therapy” is obviously a misnomer if carried to its logical conclusion. Therapy assumes that someone is sick and that there is a cure, e.g., a personal solution (...) Women are messed over, not messed up! We need to change the objective conditions, not adjust to them. Therapy is adjusting to your bad personal alternative.

This was the context in which the classic feminist slogan “the personal is political” was formulated, materialised in the organisation of feminist consciousness-raising groups where women collectivised their realities and gave them meaning by recognising power structures and relations (particularly patriarchy). In contrast to the individualisation of the “problem” mediated by a specialist, collective organisation was seen as a response to/protest about structural issues with personal effects. The consciousness-raising built among women was that “radical weapon” (Sarachild, 1973), that “uncomfortable treasure” (Cárdenas, 1970).

More than five decades on, the progressive and depoliticised expansion of discourses and practices aimed at the production of a “healthy”/“correct” individual (Foucault, 1996), such as “self-care”, “internal review”, “personal growth”, etc. (including the growing range of training/specialisations on it) have seeped into the feminist movement and other arenas of militancy, often to the detriment of collective reflection. As Laura Yustas (2022) points out: “These activities are a form of reproduction of therapeutic cultures which transforms the common sense of feminism and inserts them into a growing psychology of political action.” In contrast to the philosophy of consciousness-raising groups, with the expansion of psychologisation and therapeutic culture the political gradually becomes personal (Happonen, 2017).

Coupled with this transformation of “common sense”, the biologicist essentialism into which part of radical feminism (one of the main heirs of the women’s liberation movement) has drifted and its transexclusive positions have ultimately diverged from the depathologising legacy proposed by Carol Hanisch in 1969, shifting towards diagnostic narratives as a tool for delegitimation. Instead of “we are not messed up, we need to change the objective conditions”, it has become a defence of the pathologisation of those who do not fit into the hegemonic binary sex-gender system: for example, definitions of trans as a “delusion” reproduce not only cisexist but also saneist-ableist rationales: by using the metaphor of delusion to discredit trans, both the trans experience and the experience of madness (and thus those who have both) are discredited at the same time.

Although these feminist shifts have provoked some surprise and particular anger because they come from this sector, this is nothing new. The word “mad” used as a gendered (feminised) insult has historically marked people whose femininity “overflows” or falls outside the margins of what is acceptable according to sex-gender norms (García-Dauder & Guzmán Martínez, 2019). Yet similarly to the term “queer”, in the networks of knowledge/power and resistance the word “mad” has been re-appropriated and re-signified by the communities thus identified to trigger collective and emancipatory responses (Guzmán Martínez *et al.*, 2021).

Meanwhile, the discrediting and disparagement of the trans experience is part of a historical continuum of constructing a universal *female* subject, whose expression of femininity often predominantly fits within the white-centred parameters of femininity. As Tito Mitjans (2022) puts it: “Racist and transphobic discourses start from the same place; colonialism and all the technologies of constructing and sustaining white cisheterosexual humanity.” Likewise, he recovers statements such as those by bell hooks when she explains that trans struggles are closely related to anti-racist struggles since, for example, black cis women have been constantly exposed to masculinisation (as they do not fit the dominant model of – white – femininity) and therefore have not been fully recognised as “women”.

Likewise, the trans experience and the experience of madness have been present together with racialisation and class since the beginning of the struggles against the binary sex-gender norm. In the same year that Carol Hanisch called for the depathologisation of women’s social issues, the Stonewall protests, internationally acknowledged as a precursor to LGBTQI+ Pride, were also taking place in the United States. Racialised trans activists Sylvia Rivera and Marsha P. Johnson played a highly significant role in them. Besides Stonewall, in the 1970s and 1980s they founded and took part in various organisations together with other trans/transgender/drag people (such as ACT UP and STAR) to collectively address issues including homelessness, precariousness, lack of access to healthcare, the struggle against AIDS and racism and more (Tourmaline, 2012).

While Marsha P. Johnson is recognised by a significant part of the queer movement as a leader of the struggle against the racist cisheterosexist system, her experience with saneism and ableism is not equally well known. After her death in 1992, classified as suicide, Sylvia

Rivera (2002) noted in *Queens in Exile, The Forgotten Ones* that Marsha had had several nervous breakdowns and as a result had been affiliated to the social security on disability grounds while she was also locked up in Bellevue and Manhattan hospitals (renowned psychiatric facilities in New York). Indeed, according to Dorian Taylor (2018), this was the very reason why the New York police department refused to investigate Marsha's death as a possible murder: suicide was a sufficiently substantiated explanation as she was a madwoman. Activist Leah Piepzna-Samarasinha (2019), who recovers this part of Marsha P. Johnson's story in a text on the act of loving the legacy of mad trans women when they are alive and dead, asks: "Can we also claim this moment of queer and trans rebellion as a Mad and disability justice space? (...) I invite us to do the work of finding the disabled and neurodivergent stories in our queer and trans beloved dead" (Piepzna-Samarasinha, 2019: 60).

The unfinished work of memory proposed by Piepzna-Samarasinha is necessary for various reasons. Firstly, because the disabled, mad and trans stories have common threads or pathways as bodies that are constantly facing barriers to accessing a dignified life; bodies that are not considered sufficiently productive or re-productive for the capitalist system, which rewards excellence based on ableist oppression; bodies whose desire is questioned and pursued by the binary norms of sex and gender; bodies whose autonomy to make decisions even about themselves is, moreover, constantly denied. Secondly, it is unfinished and necessary work considering that in general such stories have not been part of the narratives of resistance or vindication of either the feminist or queer movements.

It was precisely in this sense that Judi Chamberlin (1975), a pioneer of the Mental Patients' Liberation Movement of the early 1970s (now known as the Psychiatric Users and Survivors Movement or Mad Movement), challenged feminism by questioning the analysis of psychiatric oppression. According to Chamberlin, a feminist analysis which only points to the problem of psychiatry's sexism is incomplete in understanding the oppression of women as psychiatrised. Just as the women's liberation movement tended to omit the diverse experience of women as a heterogeneous group where some were scarred by racism and class (as much or more than by patriarchy), so too in its anti-sexist analysis of psychiatry it ignored psychiatric violence itself as part of the problem and therefore of the struggle.

Nonetheless, and notwithstanding the absence of mad, disabled and/or neurodivergent perspectives in different movements, the struggles for women's liberation and the rights of the queer and racialised community were organising touchstones for the mental patients' liberation movement. Going back to Chamberlin (1975), this meant "learning as a group to free ourselves from psychiatry's redefinition of the main concerns of our life and illness, and to recognise the real and radical meaning of our protest." This learning could also be an encounter between trans and mad perspectives and struggles if we view both as responses to the pathologisation of life which not only skirts around these lives in the framework of meaning of the undesirable/expellable (of "death by exile" to quote Piepzna-Samarasinh, 2019) but also omits the necessary transformations in contexts of inequality and oppression.

Trans and mad struggles share genealogies of collective resistance that have upset the normal/pathological dichotomy in terms not only of sex-gender-desire but also of what is considered "sane"/"healthy" and "mad"/"sick". They have revealed at once the fictional character of the modern normal/abnormal binarism and its material consequences in terms of expulsion from communities and institutional violence (Berkins, 2007 and 2012).

Final Considerations: Recognising Trans Communities as a Horizon of Alternatives

In this paper we have reviewed theoretically, historically and critically the normalising power-knowledge of psy disciplines in terms of sex-gender-desire as part of a rationality which is ableist and saneist. We have traced some of the categories and frameworks of intelligibility of these disciplines as a way of eliciting a radical suspicion of the psy/medical voice as the only or the great authority in explaining our experiences and acting to address suffering. We argue that this is not only radical but also a creative suspicion insofar as it allows for displacements and expansions of the frameworks of meaning and action. Based on the journeys taken, we contend that the traditional framework of (mental) health is restricted in its ability to generate these necessary extensions since the biomedical and therapeutic models have become the experts in explaining and thus "assimilating and neutralising" alternative frameworks.

We have therefore recovered and opted for other social and politicised frameworks of intelligibility of human suffering, already

present in activism, which see it as part of the response to the diverse experiences of oppression experienced by the trans community. In these times, we forget that suffering can be much more than a “mental health problem” and instead can also be understood in political or existential terms (hence the recovery of the politicisation of discomfort and the practices of mutual support of different communities, for example). As Lohana Berkins complained about the trans privilege of the North: “Because there’s a lot of testosterone but nothing about poverty and cruelty” (quoted in Fernández, 2020).

This involves engaging critical awareness of pathologising frameworks, not just about dissident sexualities but also about what is sane/mad or what ultimately breaches or oversteps normative frameworks. To this end, we can use the trans-mad alliance as an “anti-oppressive tool that can help foster a deeper understanding of how psychiatric discourse creates and perpetuates theory and practice which pathologises, punishes and erases the human diversity that ultimately threatens the hegemonic order” (LeFrançois & Diamond, 2014: 39).

In other words, it is not only about the depathologisation of transsexuality but also about the depathologisation of our resistance to transphobia and other systems of oppression. This calls for a recovery of trans mental health in social and collective terms based on a structural understanding and analysis of cissexism and its co-production with racism or classism as well as with saneism and ableism (present in the trans community itself as in society in general). Experiences of mental suffering cannot be detached from their social, historical and political context, or some forms of oppression from others. So as opposed to “we are not mad”, we propose the trans-mad alliance against different forms of violence, considering madness contextualised as a crucible of oppressions (Rey Artime, 2019). It is not just a matter of improving or reforming mental health care services (with training for professionals, for example); this is of little use if there are no far-reaching transformations in the systems that trigger suffering and make trans lives unliveable: cissexism, but also migration policies, precariousness and exploitative working conditions, structural racism and so on.

Alongside structural changes and a politicised framework of understanding contextualised suffering, we need to think about collective and creative responses to the mental suffering which violence generates (e.g. in the style of the paths to social transformation and collective liberation of the Mad Maps) (The Icarus Project, 2015). The

response cannot amount to medicalising, therapeuticising, pathologising or psychiatrising, but rather must come from mutual support, activism, social justice, co-care and the restitution of memory and rights (Losada, 2016). Or in other words, of *LoveT* (Losada, 2016) against the orphanhood of the world; instead of seeking disciplinary responses, to think about political projects grounded in desires, corporeality and community (Ochoa, 2004). Hence we seek to reclaim the communities of affection and support systems which have characterised the trans community since its beginnings, building networks of care in response to violence. This involves a wide array of actions from securing and providing material resources, cooperative exercises, furnishing physical and emotional support through mutual support groups, affinity networks, collective living arrangements, chosen families, organising to raise money and essential supplies in various situations of precariousness, illness, layoffs, housing, performing administrative procedures, swapping hormones and information and many others (Latterra, 2024). It also means fostering the culture of mutual support in different socio-educational contexts.

As opposed to an institutionalised biomedical model which intervenes on a trans self with individual responsibility, decontextualised and restricted to personal change or recovery, empowerment or resilience (with a high risk of exposure to violence), we propose the redistribution of power, collective repair of lives and memories, political activism, connection with trans and mad cultures/arts, collective actions to sustain crises and lives, and not just survival in terms of individuality.

This also entails resistance to diagnostic and therapeutic cultures because trans people themselves are increasingly self-diagnosing or seeking diagnoses which provide explanations for their life issues. We need to create pedagogies of resistance because pathologising yourself can increase vulnerability by individualising social problems and reducing or impoverishing understanding of what is going on. With neoliberal discourses on successful trans projects based on determination, undertaking and resilience, those who fail hold themselves responsible and are ashamed instead of challenging society (Han, 2014). We need to recover and build other frameworks, such as the “queer art of failure” (Halberstam, 2018), which allow for a political “we” with the capacity for common action.

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1) Guzmán Martínez, Grecia, Pujal i Llombart, Margot, Mora Malo, Enrico and García Dauder, Dau (2021), "Antecedentes feministas de los grupos de apoyo mutuo en el movimiento loco: un análisis histórico-crítico", en *Salud Colectiva*. Doi: 10.18294/sc.2021.3274. 2) Guzmán Martínez, Grecia (2021), "Perspectivas y luchas antirracistas en el Movimiento Loco y los Estudios Locos: una revisión", in *Quaderns de Psicologia*, vol. 23, no. 3. Doi: <https://doi.org/10.5565/rev/ppsicologia.1781>. 3) Guzmán Martínez, Grecia (2020), "Fem-inismo y salud mental: discursos de politización del malestar en los inicios de la prensa feminista latinoamericana", in *Investigaciones Feministas*, vol. 11, no. 1. Doi: <https://doi.org/10.5209/infe.64801>.