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ORIGINAL ARTICLE

Mental health practitioners' narratives about gender transition and the role of diagnosis: A qualitative study in the Italian context

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Abstract

In many European Countries, a diagnosis is needed to access the gender transition process, which has sparked debate about whether gender variance should be equated with a psychodiagnosis. This study explores mental health practitioners' perspectives about the implications of using the diagnosis for gatekeeping purposes. Semi-structured interviews were conducted with 11 Italian mental health specialists. The personal positions and interpretative repertoires emerging from the interviews centred on three thematic areas: the diagnosis, the practitioner's role, and the clinical relationship. In relation to the development of health promotion policies, findings underscore the importance of exercising reflexivity, adhering to theory and national and/or international guidelines, and analysing people's needs to ensure that the clinical setting is an affirmative space, especially for non-binary people.

KEYWORDS
diagnosis, gender transition, interpretative repertoires, positioning, trans

1 | INTRODUCTION

In psychiatry and psychology, diagnosis has evolved in tune with the changing ethical and value system that has oriented attempts to clarify the experience of gender nonconformity, hand in hand with new knowledge and social demands regarding the growing complexity associated with gender variance. The discourse around gender-affirmative practices has recently manifested strong development. Thus, it has become necessary to promote practices and tools that not only allow assessment but also recognise all forms of gender and support change. Such an endeavour would help offset the negative psychological effects of social oppression, discrimination, and pathologisation.

In line with the foregoing, the latest version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) adopts the diagnosis of 'gender dysphoria' to identify gender nonconformity and associated distress (American Psychological Association, 2015), whereas the 10th edition of the Manual of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) still used the expression 'gender identity disorder' (World Health Organization, 1992), although this was redefined with a new category called 'gender incongruence' and moved from the 'Mental and Behavioural Disorders' chapter to the 'Conditions related to Sexual Health' chapter in the 11th edition (World Health Organization, 2018). The ICD-11 revision, therefore, eliminated the psychopathological connotations of the term 'disorder' (Winter, 2017). A discrepancy between the two manuals is seen in the use of the term 'disorder', which is currently a subject of debate despite the risk of pathologisation.

There is an abundance of international literature about the critical issues involved in gender transition and consultation (Brill & Pepper, 2008; Bryant, 2006; Burke, 1996; Currah et al., 2009; Drescher, 2013; Hilário, 2019; Hill et al., 2007; Kamens, 2011; Riggs et al., 2019). One of the major arguments in the debate revolves around whether gender variance should be equated with a psychodiagnosis for which the diagnosis is required for medical treatment and legal recognition. The recent literature has emphasised that the diagnostic process opens many doors, but also medicalises and pathologises gender nonconformity (Bryant, 2006; Jutel, 2009; Lev, 2013; Winters, 2008). Trans people, already burdened by poor

social acceptance, are thus doubly stigmatised: externally by others' normative judgement, and internally as a result of the self-attribution of a mental illness (Drescher, 2010; Fisher et al., 2017). Another risk factor for mental health practitioners is that of considering the encounter as a way of collecting data to assess a case rather than an opportunity to investigate the personal meanings for trans people (Kessler & McKenna, 1978; Rubin, 2006). Some scholars have underlined that people in transition may consequently behave as if they were reading from a script: This may be an attempt to fit into the clinician's categories, rather than to be guided in discussing needs (Gess & Doughty Horn, 2018; Gridley et al., 2016; Johnson, 2019; Skaistis et al., 2018; Spade, 2003).

Several studies have focused on the diagnostic process involved in gender transition, but there is little research on how trans people and mental health practitioners deal with gender dysphoria in the clinical setting. Some scholars have investigated trans people's negative feelings regarding the psychological pathway or consultation, and practitioners' attitude to the experience they narrate (Benson, 2013; Bettergarcia & Israel, 2018; Goldberg et al., 2019; Moe & Sparkman, 2015; Salpietro et al., 2019; Shipherd et al., 2010). Others have explored how the practitioner is represented as a 'gatekeeper' and the consultation as a hurdle to be overcome to access health services (Budge, 2015; Grant et al., 2010; Whitehead et al., 2012). The hierarchical relationship between both groups, as well as the lack of specific knowledge or ideology on the part of the clinician, have been associated with the process of discrimination, pathologisation or limitation of self-determination (Dewey & Gesbeck, 2015; Hilário, 2019; Reisner et al., 2014; Serano, 2007).

In Italy, there is little research around these themes, largely in the fields of sociology (Arfini, 2007; Garosi, 2012; Rinaldi, 2006) and clinical psychology (Cipolletta et al., 2017; Faccio et al., 2013; Neri et al., 2020; Vitelli & Riccardi, 2010). Previous sociological papers highlight the organisation of the Italian context with respect to gender transition and the critical implications related to the foundation and use of the diagnostic category and the more general legislative matter. They also underline the power dynamics related to medical and psychological practices in this field and the relevance of self-determination in the construction of gender identity. With regard to the psychological ones, they highlight the discourses, the implications and the needs of trans people with respect to gender transition processes, particularly diagnosis and gender identity construction for people who are non-binary in relation to affirming surgery.

Like other European countries that require a diagnosis, the medicalised gender transition process in Italy also hinges on the diagnosis. Furthermore, even in the absence of explicit legislation requiring a diagnosis (Ruspini, 2018), it remains the key to accessing some relevant phases and services that the transition pathway may involve. In fact, the legislation is interpreted differently by the Courts, but a diagnosis is configured as an established, although not officially required practice.

Starting from these considerations and the specificity of the Italian context, our research questions centre on: How the diagnosis is constructed by mental health practitioners involved in gender transition processes; the role these practitioners assign to the diagnosis in their practice; the implications for trans people and the practitioners who deal with their clinical issues.

What is known about the topic?

- The diagnosis of gender dysphoria is a relevant issue with regard to the risk of pathologising the gender-variant identities.
- Amongst the implications of frequent requests for psychological or psychiatric diagnosis and consultation for gender transition is that of viewing the practitioner as a gatekeeper.
- The recent guidelines for gender transition aim to promote affirmative practices of identities and reduce the risk of pathologisation.

What this paper adds?

- This paper features different narratives pertaining to the clinical practice for gender transition, with a focus on the diagnosis, the practitioner's role and the clinical relationship.
- Different narratives about the use and the implications of a diagnosis emerge: The validity of a diagnosis is questioned, a diagnosis is legitimised and validated, and a diagnosis is considered for bureaucratic purposes; gender dysphoria represents a cultural issue.
- The practitioner's role as seen in the light of the epistemological references used: The role is related to the need for objectivity; to the importance of subjectivity and the tension between a clinical and a more personal role.
- Considering the clients' perspectives, their relationship with the practitioner is contemplated as a gatekeeping relationship—a resource that could be leveraged for support; it is considered a power relationship.
- This paper discusses the implications of such narratives for clinical practice and people in transition in light of the need for gender-affirmative practices.

1.1 | Gender transition processes and diagnosis in Italy

In this contribution, gender transition processes are considered variable in terms of the steps and requirements they entail and take on different meanings based on the individual. These processes can involve a variety of steps, ranging from psychological (asking for information, support or therapy) to medical (changing one's physical attributes), as well as social and legal (changing one's appearance, name or documents; Winter et al., 2016).

The main international guidelines on clinical management of gender transition processes are provided in the World Professional Association for Transgender Health's Standards of Care for the Health of Transsexual, Transgender and Gender Nonconforming People (WPATH, 2011), and the American Psychological Association's Guidelines on Psychological Practice with Transgender and Gender Nonconforming People (APA, 2015). The guidelines take an interdisciplinary stance, and their aim is to promote and develop affirmative approaches to gender variance. These guidelines are also references for the Italian context, which includes specific guidelines, the Standards of Care for Sex Reassignment in Gender Identity Disorder, issued by the Italian Observatory for Gender Identity (ONIG). The standards share the same presuppositions about affirmative practice, and the main difference is that the WPATH do not consider psychotherapy essential.

The juridical references may vary from one country to another. In Europe, there are 34 countries where requests for the legal recognition of gender identity is subject to a diagnosis. As reported by TGEU (Transgender Europe, 2021) the exceptions are Malta, Greece, France, Ireland, Belgium, Norway, Iceland, Portugal, Luxembourg, and Denmark.

In Italy, the law (No. 164/1982) on the gender affirmation process does not explicitly state that such a diagnosis is necessary and is thus open to varying interpretations by the Courts. It includes provisions regarding the sexual assignment and changes to the name and gender marker designation on personal identity documents. At the same time, the legal framework has gone through important modifications since 1982. The legislative decree No. 150/2011 art. 31 removed the provision requiring a second ruling to obtain the final recognition of gender reassignment. The Court of Cassation (the Italian Supreme Court), in its judgement No. 15138/2015, removed the obligation to have surgery causing sterilisation as a mandatory condition to obtain legal recognition of gender identity, whilst the Constitutional Court indicated in the same year the non-necessity of undergoing surgical treatment to change one's name in official documents.

In institutional practice, however, diagnosis is still a determining factor in making decisions. This legislation established specific practices governing the different stages of gender transition processes, but it also limited how an individual's gender identity could be recognised (Connell, 2002; Ruspini, 2018; Vitelli et al., 2017). Considering this specific legal framework and the guidelines for psychological/psychiatric practice, the route to gender transition may pass through different social and professional settings.

In Italy, one of the most influential players involved in implementing practices for gender transition is the National Health System. Individuals seeking gender transition are generally required to take a series of steps: A first psychological assessment; a psychological pathway; hormone treatment and a 'real-life test' (a monitoring process forming part of the psychological pathway); any necessary legal proceedings; gender-affirming surgeries; a social reinsertion phase and a follow-up. Whilst contemplating variability and subjectivity with respect to each of these steps, the result is that medical and registry processes are closely intertwined with psychological and legal practice (Hembree et al., 2017).

The psychological pathway is an important juncture in transition processes because it is a prerequisite before the process can start, and because it follows specific international and national guidelines (Coleman et al., 2011; Wylie et al., 2013). It has both a diagnostic and a therapeutic-supportive purpose: to assess the 'dysphoric' condition and any potential psychopathological elements or gender variance and to sustain the individual during the transition (Eden et al., 2012; Lev, 2009). The route to gender transition underscores the importance of the diagnostic and psychological process for undergoing the various possible medical, social and legal transition steps, taking into consideration the peculiarities of the Italian context, the trans people' needs and the different ways of constructing gender identity and their potential implications.

1.2 | Study aims

The main research question was how mental health practitioners construct their clinical practice and what role and implications the diagnosis may have in interacting with and sharing the pathway with transgender people. In particular, we explored how a diagnosis of gender dysphoria is perceived, proposed to the clients, and used in clinical practice. We also investigated the personal and professional positions that practitioners take in relation to trans clients and the implications that the diagnosis may have on transition processes.

2 | METHODS

2.1 | Participants

The study involved 11 practitioners: 3 psychiatrists and 8 psychotherapists working in the National Health System and private practice (4 cisgender men and 7 cisgender women). All 3 psychiatrists expressed a preference for the psychodynamic perspective, 2 of the 8 psychologists defined themselves as 'psychodynamic', 2 as 'family-systemic'; 1 as 'body-oriented'; 1 as 'transcultural' and 2 as 'integrative'. They work in different regions of Italy: Lombardia, Lazio and Campania. The participants were at different stages of their practice: some had recently begun to work with people who are transitioning (ranging from a few months to a couple of years), others were active in managing different situations in this field, whilst others had left the field after many years of practice (20 years or more ago). All the participants engaged in issues and training involving gender and worked with trans clients. They were contacted by JN and recruited between March and December 2017. Some were contacted directly by email whilst others were found via a snowball sampling process supported by a Trans Centre in Milan, which suggested interested individuals. The selection criteria for the participants were that they specialised in gender transition, worked in public or private contexts and belonged to either psychological or psychiatric disciplines.

2.2 | Data collection

We used a semi-structured interview (Holstein et al., 2012) to focus on particular meanings and concrete episodes relating to clinical practice in gender transition. Interviews were conducted in the practitioner's professional office or via Skype. Participants were asked to complete an informed consent form after being informed of the aims and methods of the study. They were conducted by JN. The average interview length was 60 min, and the interviews were audio-recorded and transcribed in full. We obtained approval for the study from the University of Padua, School of Psychology ethics committee (protocol number 2070). Some orienting questions (see Table 1) explored were used as a guide for the interviews.

2.3 | Data analysis

We chose to combine two text analysis methods. The first was Discourse Analysis, which reveals not just the structures and contents, but the processes that shape our psychological and social events and perspectives (Potter, 2003). The second was Narrative Analysis (Riessman, 2008), which considers narrative modalities, the interaction between the characters in the narratives and the interviews, and the associated relational context involved in the narrative process.

Text analysis drew on two conceptual tools. Amongst the discourse, we decided to analyse 'interpretative repertoires' (Potter & Wetherell, 1987) and amongst the narrative, we analysed participants' 'positioning' (Harré & Langenhove, 1998; Riessman, 2008). These discursive and narrative processes were hypothesised in the design phase of the research and chosen following an initial analysis of the interviews. In particular, the conceptual tool of positioning was used because of its potential to explore the practitioners' interactive modalities in relation to trans clients. Interpretative repertoires were subsequently chosen based on the observation of the relevant use of metaphorical and rhetorical discursive modalities to describe, define and act in relation to diagnosis. The main interpretative repertoires were identified by analysing practitioners' use of metaphors and figures of speech, and also their way of speaking and rhetorical expressions relating to the objects of our analysis. As regards participants' positioning, we focused on analysing the identity movements they adopted in their narratives in relation to trans clients. Lastly, we considered the relational context of the interview and the wider socio-cultural setting, which provide the backdrop for certain stances and ways of describing oneself, the role of the practitioner and the trans person, and the clinical relationship.

The text analysis consisted of the following processes:

1. Exploring the interviews to recognise the linguistic elements, seeing the interview as an interactive dialogue between the participant and the researcher.
2. Outlining the linguistic elements that were shared in all the narratives.
3. Identifying the portions of the narratives relating to the interview structure, but also including dimensions of meaning that were not anticipated (e.g. non-binary gender issues).
4. Constructing analytical categories in which the discursive-narrative processes of positioning and interpretative repertoires used can be similar or extremely different. Each category is understood not only as a label that represents content or as a pivotal argument but also as a discursive-narrative configuration of reality, necessarily processual and dynamic.
5. Reviewing and defining the analysis. Once the analytical framework was defined, it was revised by including new interpretative repertoires and positionings and expanding those that were particularly original. Each repertoire or position identified was re-examined and, if necessary, recoded into new or existing ones. We aimed to be consistent within the linguistic expressions in choosing the categories and constructing the results.

3 | RESULTS

The main interpretative repertoires and identity positioning are presented below for each of the main themes considered: the diagnosis, the practitioner's role and identity, and the relationship in the clinical context.

TABLE 1 Interview questions

Orienting question	Purpose
Looking back over the years, what was your first experience with gender transition?	To collect narratives about first professional experiences in the gender transition field.
How would you describe your operational practice related to gender transition pathways?	To collect discursive and narrative processes regarding operational practices; objectives; and theoretical and operational criteria.
What do you see as the most relevant/most critical aspects of your relationship with the person in transition?	To collect discursive and narrative processes regarding the relationship with trans people, i.e. the aspects deemed most relevant and most critical (2 questions).
How would you describe the diagnostic process in this field?	To collect discursive and narrative processes regarding diagnosis and the diagnostic process and how they are used in practice.

3.1 | The diagnosis

3.1.1 | Unravelling the skein

Through this metaphor, diagnosis is connected to the ability to distinguish between clinical conditions. In this case (as three practitioners reported), diagnosis is considered as an 'independent entity', not necessarily connected to other issues that may trigger the diagnosis, for which the diagnosis must be 'revised'. Diagnosis is useful in distinguishing between personal conditions and difficulties, as emphasised by the participating psychiatrists. In some cases, the diagnostic manual (especially the DSM) is regarded as an entirely reliable tool (Box 1).

3.1.2 | I don't consider it a pathology, but the dysphoria is there

According to this interpretative repertoire, which was shared by most of the participants, the trans person's experience is not considered as a mental disorder, but is strongly characterised by 'dysphoria' that calls for clinical attention. Different arguments are advanced to support the link between 'dysphoria' and the 'suffering' experienced by the person, as proposed in the DSM-5. For example, participants emphasised that there are moments of depression, anxiety, suicide attempts, and/or challenges to others, considering them at the basis of gender dysphoria and of the request for gender transition (Box 2).

3.1.3 | The diagnosis serves, also, to ensure coverage by the national health system

Whilst it is not taken for granted that a diagnosis is necessarily valid in identifying psychopathology, it is seen as a 'useful' and 'necessary' tool that 'serves' to gain access to the different types of intervention for gender transition. The diagnosis thus seems to be spoken of in terms of bureaucratic necessity rather than—or in addition to—its supposed epistemological validity (Box 3).

It is also useful to explain that the term 'disease', which has been used by some therapists, is a common-sensical rhetorical expression to indicate a dimension of health that is not ordinary or psychopathological.

3.1.4 | Gender dysphoria as cultural illness

Gender dysphoria is also seen as an illness that springs from the eminently binary organisation of the society of which we are a part, which interprets gender nonconformity as pathological. Such repertoires arise from theoretical perspectives related to transcultural psychotherapy, which acknowledge the importance of the many ways in which cultures assign roles and status to gender nonconforming individuals. The cultural illness is presented as a specific repertoire that highlights the role of the sociocultural context in creating and maintaining the diagnosis. This is a peculiar repertoire since it represents an explicit criticism of the way in which trans people are often treated or judged in society rather than pathologising them (Box 4).

The non-binary gender dilemma

This issue and the relative positionings represent a specific subtheme of the area of the diagnosis, specifically people who are non-binary and whose needs seem to embody an impasse with respect to current mental health professional diagnostic manuals and categories, as well as their use.

3.1.5 | We can consider the non-binary condition … on a different level

Non-binary peoples' gender and needs are said to be a 'provocation' or a 'challenge' to the gender binary system, which is still a cornerstone of the Western cultural system. People who identify as non-binary are dissociated from the language and practice of transition, which is still anchored to a binary form of recognition (Box 5).

3.1.6 | The non-binary people really shake up everything

Another type of positioning connects the practitioner to non-binary people, who are said 'to shake up everything'. The dilemma that accompanies reading these narratives centres on the cultural and social processes that take a toll on the available diagnostic categories (Box 6).

3.2 | The practitioner's role and identity

3.2.1 | We must be very rigorous

This kind of positioning is often associated with terms such as 'rigour', 'validity', 'scientificity', and 'objectivity'. Subjectivity, interpreted as expressing a judgment or an opinion, is considered an obstacle that stands in the way of the rigour needed for clinical work, as well as for the psychiatric discipline (Box 7).

3.2.2 | The tension between the gut feeling and the clinical outlook…

This metaphor (used by five practitioners) expresses the tension between two important positions: in one, the practitioner is drawn towards taking the clients' point of view, confirming their request for legal recognition and actively contributing to support a demand for self-determination. In the other position, the practitioner takes a

BOX 1 Unravelling the skein

So unravelling the skein means understanding whether we are actually talking about a gender identity disorder or something else that the patient is not aware of [...] I would say that it is an entity in itself, but as always happens with humans who are not in airtight compartments, this has rather extensive connections with the depressive aspect, but I don't think there is any doubt about where the path of suffering begins, in the identity disorder and in the gender identity disorder. (Psychotherapist, private practice)

BOX 2 I don't consider it a pathology, but the dysphoria is there

And then I don't consider it a pathology... But, you know, dysphoria is certainly there, it's an expression of some form of interlocking and suffering that doesn't work. I think pathology is in any case a definition that puts the cause inside the individual and... no. Not that, but...it's a suffering yes. (Psychotherapist, private practice)

BOX 3 The diagnosis serves, also, to ensure coverage by the national health system

This is something that I always discuss with patients: the idea of the 'disease' and the fact that this diagnosis is also needed to ensure coverage by the national health system and that in any case the transition is important, and it's important not to do it alone, so I'm trying to build up the value of psychotherapy. (Psychotherapist, private practice)

BOX 4 Gender dysphoria as cultural illness

[we talk about] how gender dysphoria really is a cultural illness. In the sense that it is considered a 'disease' based on the culture, for instance, amongst the American Indians, someone with gender dysphoria would have been a shaman, and had no trouble being integrated into society [...] (Psychotherapist, private practice)

clinical perspective, which calls for evaluating how much suffering is involved and carefully weighing the implications of a gender transition path and its timing. This positioning sheds light on the attempt to separate the dimensions of subjectivity and objectivity, as well as on the role of emotional aspects in the clinical setting (Box 8).

BOX 5 We can consider the non-binary condition ... on a different level

It's a challenge, like it's narcissistic, a bit of a constant provocation towards society, in the sense that if I am different, if I don't fall into the categories that suit your common mortals, then I make my identity a challenge, being a living challenge to these categories that are so fictitious [...] (Psychotherapist, private practice)

BOX 6 The non-binary people really shake up everything

I used to have the idea that diagnosis says such and such a thing, that these are the criteria, now I find myself more and more with non-binary people, [...] who are my current challenge, because they shake up everything, in the sense that they ask for something but don't meet the DSM requirements, and then they meet others and... it's just that it's very complex (Psychotherapist, private practice)

BOX 7 We must be very rigorous

The more scrupulous you are, it's not as if when I write to the judge, I can't say it's just my opinion (laughs). [...] we must be very rigorous. (Psychiatrist, private practice)

BOX 8 The tension between the gut feeling and the clinical outlook...

I also feel a great deal of internal tension between a part of me that is more of an activist, and thus is concerned about trans people's subjectivity and rights and their need for acknowledgement and wants to help them, and the part of me that is clinical and thinks about how much harm people can do to themselves sometimes [...] (Psychotherapist, private practice)

3.2.3 | To work well, it's useful ... to abandon all these theoretical underpinnings

This kind of positioning holds that our theoretical underpinnings are always partial, incomplete, and should be set aside in favour of 'open-mindedness', 'non-judgement' and 'learning from the patient'.

An implicit part of this positioning is the idea that phenomena are complex, and they are 'difficult to categorise' and 'to generalise' (Box 9).

3.3 | The relationship in the clinical setting

3.3.1 | The disposable psychotherapist

This repertoire relates to the urgency with which the gender-nonconforming person often expresses the personal request to the practitioner, which the latter sometimes perceives as what one interviewee called 'doctor shopping', i.e. looking for a therapist who will meet the trans persons' demands. Thus, some practitioners embrace the implicit or explicit idea that changing therapists are instrumental in achieving personal objectives quickly (Box 10).

3.3.2 | People bring the criteria they know they need to bring

Another repertoire connected to the relationship and its potentially critical aspects deals with what mental health practitioners call 'ready-made answers' or 'scripts'. This interpretative repertoire is summed up by the phrase: 'people in transition bring the criteria they know they need to bring'. This is to achieve their own ends, viz., to have a medical condition certified so they can start off on the medicalised path (Box 11).

3.3.3 | From the clients' point of view, the psychologist might hinder them

Another repertoire refers to the gap between the practitioner's point of view and that of the trans person. Here, the 'ready-made answers' or other ways of approaching the issue are also related to people' expectations, intentions, or aims. In addition, there are mentions of the fear of being hindered in the transition path or judged negatively. In some cases, these narratives refer to the practitioners' awareness of their role's practical effects and potential implications (Box 12).

BOX 9 To work well, it's useful … to abandon all these theoretical underpinnings

I mean, it is useful to explore the theoretical part [...] but then with a patient it is useful, in order to work well to just abandon all these theoretical underpinnings… because really, I mean, the diversity is amazing, isn't it? (Psychotherapist, private practice)

4 | DISCUSSION

The findings provide insights into mental health practices for trans people, with particular attention to the Italian context. These practices share a common goal, as reported in the available guidelines for gender transition: To promote health and develop personal and interpersonal resources. Although this sample consisted of a few practitioners, it is possible to describe a snapshot of some of the possible discourses present within this context and advance operative reflections.

As our findings show, gender transition is defined in different ways, but all participants considered it to be a complex experience. In most cases, practitioners refer to the aims of the guidelines (APA, WPATH, and/or ONIG), which include supporting and affirming the client's experience (Korell & Lorah, 2007). Such references are

BOX 10 The disposable psychotherapist

[...] Some of the people who come here are also very determined, but then it turns out that that is not their intention and this may be a critical aspect um, the other is that… it can be to use the psychotherapist for the double purpose of having a whole series of documents and so there's a little bit of using a disposable psychotherapist, when I have all the things I need our work is finished (Psychotherapist, private practice)

BOX 11 People bring the criteria they know they need to bring

Let's say that my feeling is that this is a field where given that the person self-presents, usually bringing the criteria that they know they have to bring. [...] In fact, what is often sought is to move as far as possible from just mechanically repeating what the criteria are, and to try to get some understanding of how the person works in the broadest sense (Psychiatrist, national health system)

BOX 12 From the clients' point of view, the psychologist might hinder them

[young people] are afraid they won't be believed. And so, at the beginning, they are rather reluctant to speak, and like adults, they very often tend to tell pre-packaged stories because they start from the assumption that the psychologist might hinder them in their transition path, in their idea [...] (psychotherapist, national health system)

especially frequent on the part of practitioners working in specialised gender dysphoria centres. The first relevant element emerging from the texts with different facets is that, despite different ways of understanding gender identity and transition, all the practitioners share an affirmative approach to them in their declarations. In contrast, the element with greater variance and which has repercussions with respect to this affirmative approach is the way of understanding the diagnosis. This is, furthermore, an element in common with research in other contexts (e.g. Hilário, 2019).

With regard to the diagnostic process, the interviews indicate that the validity or guide function of diagnosis is generally not questioned. The first point that emerged is that psychiatrists consider the diagnostic process to be necessary and fundamental, whereas the other mental health practitioners believe that they help orient the path but could be set aside once the relationship is well-established.

The question of whether gender nonconformity is a pathology or not also arises in the practitioners' narratives. The answer is usually somewhere in the middle, and hinges on the level of distress and personal discomfort that can justify 'gender dysphoria' as a clinical issue.

Therefore, the relationship between affirmative orientation and the use of the diagnosis appears complex where the former is generally not questioned but, in some cases, simultaneously corroborated and made possible by the diagnostic evaluation. Trans identities and gender nonconformity are recognised in their needs, with explicit reference to an affirmative approach. However, the diagnostic category seems to still be mostly anchored to the binary of normal–abnormal.

As there are no available studies that analyse practitioners' narratives in the Italian context with respect to diagnosis, these results are particularly relevant. On the one hand, the reference to an affirmative approach is found to be in line with the international literature and guidelines; on the other hand, specific discourses about diagnosis and its use are found. These are partly shared by trans people in the same Italian context, although some disparities are also noted (Neri et al., 2020; Vitelli & Riccardi, 2010).

Some of the critical issues discussed in our literature review on diagnosis (Bryant, 2006; Currah et al., 2009; Drescher, 2013; Hilário, 2019; Hill et al., 2007; Kamens, 2011; Meyer-Bahlburg, 2010; Riggs et al., 2019) can be seen in the practitioners' narratives: The questioning of diagnosis as a tool that contributes to medicalising and pathologising gender nonconformity. Closely related to the Italian context, unlike those states where the diagnosis is not required for the change of personal data, it is possible to find the consideration of the diagnosis as a bureaucratic aspect. It brings with it to consider the diagnosis as necessary but at the same time as an aspect not central to the experience. This allows advancing some considerations not only concerning the specificity of these discursive processes and the connection with changes seen at the level of theories and guidelines in this field but also with respect to the influence of the current legislative context that still sees the need for or encouragement for diagnosis (Ruspini, 2018).

Moreover, the theoretical and disciplinary affiliation contributes to configure the diagnosis and its use in a particular way (the psychiatry/objectivist approach versus the psychology approach based on theoretical perspectives). Conversely, it is possible to note how in practice certain interdisciplinary and international theoretical and professional developments with respect to psychological practice in the field of transition are partly known but still require development in terms of management (e.g. working with non-binary people). For these reasons, diagnosis is not just configured as a theoretical and operative tool, but as a concept and practice consistent with the systems of beliefs, values and sociocultural and historical references embraced by the practitioner (Arfini, 2007; Garosi, 2012; Gergen, 2009; Hilario, 2018; Iudici et al., 2020; Neri et al., 2020; Riggs et al., 2019; Rinaldi, 2006).

With regard to the mental health practitioners' role and identity, objectivity and subjectivity were found to have a complex relationship. Especially in psychiatric practice, practitioners position themselves in favour of objectivity and neutrality, recognising that they can be subjective but rejecting anything connected with it. For psychologists, the issue seems less important, as they emphasise that subjectivity is inevitable and that they are not only aware of it but feel it can be useful. Here, it should be borne in mind that, however, much a neutral and objective approach may be sought after, phenomena are always interpreted from a specific point of view that contributes to constructing them.

Regarding the theme of role construction, several dilemmas emerged in connection with non-binary people and their needs. This issue, more than others, illuminates the idiosyncratic, social and cultural construction of gender- and body-related phenomena. Indeed, the recent guidelines contemplate such experiences as 'gender nonconformity' or 'gender variance' to emphasise gender as a continuum rather than consisting only of the two categories of female and male. The interviews indicate that non-binary experiences are regarded as critical, particularly because the diagnostic criteria do not seem to be adequate for evaluating them. The results underscore how current mental health professional guidelines for working with trans people in Italy consider people who are non-binary. Yet, in professional practice, it still seems difficult to apply these references. Vitelli et al. (2017) highlighted the variety of meanings that affirming surgery or hormonal therapy can have in the construction of identity for non-binary individuals and the need to pay attention to them in clinical practice. For these reasons, practitioners have to acknowledge the existence of non-binary conditions and respect them (Scandurra et al., 2019), but this competence is almost incompatible with the need for diagnostic reductionism (Goldberg et al., 2019; Riggs et al., 2019).

Considering the little knowledge about people who are non-binary, it seems to require further investigation by the psychological discipline, but also the legal systems suggest it. In fact, the legal recognition of the non-binary gender is present in Europe only in Malta and partially in Denmark.

This finding suggests a number of implications for clinical practice. The first regards the potential that the

diagnostic categorisation can have in reducing the possibilities of self-description, not just for the person to whom the diagnosis is applied, but also for the mental health practitioner. Whilst it is true that diagnosis can be used to 'unravel the skein', there is also the risk that it will be used as the sole interpretive criterion, leaving no room for other narrative meanings. In this sense, the extent and the implications of the binary system of knowledge that is still rooted in our culture inject further complexity into the already uncertain process whereby psycho-social phenomena are classified and defined.

The related themes of the client's urgency and ready-made answers are judged as problematic for the practitioner/client relationship, as the potential risk seems to be the shift from the trans person's aims to the practitioner's evaluative aims. The interviewees express an awareness that the trans person may fear their evaluation or be distrustful of the mental health practitioner's role: this may result in the strategy of following scripts, thus preventing the trans person's own personal aims and meanings from emerging. The risk is that the practitioner will be perceived as the expert to whom one must adapt, in a hierarchical relationship (Foucault, 1963). These critical implications also become visible in the face of other studies in the Italian context that emphasise the narratives of trans people regarding their relationship with the practitioners (Neri et al., 2020). For the practitioner, instead, taking the role of the expert may make it difficult to help create a space for sharing trans people's needs, despite the desire to promote their health and accompany them along the path to life changes.

4.1 | Limitations

The major limitation of this research is the small sample size of the practitioners involved. The specificity of the research themes reduced the field of experts in the Italian context. However, this drawback may be perceived in another way, namely, that the research and the specific results can be considered exploratory of a particular context and clinical practice and, at the same time, function as harbingers of reflections and operational proposals for affirmative practices in gender transition.

The peculiarities of and the relationships and differences between belonging to the psychiatric and psychological disciplines and public and private contexts emerging from the interviews as heterogeneous could also be further investigated.

5 | CONCLUSIONS

These results provide the basis for several pragmatic proposals for mental health practitioners who deal with gender transition, starting from the particular Italian framework. These proposals are built on the results collected in this context but also take into account the broader international framework and the guidelines' affirmative approach.

Considering clinical pathways as relational processes, historically and culturally situated (Faccio et al., 2018; Faccio et al., 2018; McNamee & Gergen, 1992), it is legitimate to emphasise the importance of the ways whereby reality is co-constructed. Likewise, it is useful that the practitioner exercise reflexivity about the specific role and personal characteristics (Lingiardi et al., 2018) and have specific competencies in gender identity, which are crucial in creating the conditions for a shared pathway starting from the trans person's identified needs (ACA, 2010; Gergen, 2009; Pawelczyk et al., 2021). Here, obstacles may arise as a result of the critical issues raised in the interviews: the use of scripts, the practitioner's gatekeeping function, or the difficulty of drawing on other relevant biographical elements (Skaistis et al., 2018).

Given the uncertainties that can accompany the diagnosis and the impossibility of ensuring an entirely objective approach (Iudici et al., 2017; Neri et al., 2020; Whooley, 2010), it is important to focus more on the complexity and the contextuality of each experience, rather than on the hypothetical ontological properties of phenomena. Understanding personal history is useful to formulate a path adapted to the individual's specific needs (Anzani et al., 2019; Brown et al., 2018). Whether this phase is necessary by law, practice, or theory or not, though the 'evaluation' may be an important step in collecting information, it is not in itself sufficient to build the relationship between the practitioner and the person in transition and ensure that it develops. Once this relationship has become hierarchical, there is a risk that it will continue to be hierarchical even after the assessment stage has ended.

These actions could help promote a new image of the mental health practitioner dealing with gender transition: A practitioner who is able to fulfil a function other than the classification and decision-making involved in the medicalisation process (Bryant, 2006). Such a practitioner would be a promoter of change and recognition of the identity the trans person desires to affirm, capable of recognising and empowering others as experts in their own history and biography, and able to accept with confidence the value of professional and personal responsibility (ACA, 2010; Faccio et al., 2020; Iudici et al., 2017; Lev, 2004; Neri et al., 2020; Salpietro et al., 2019; Vitelli & Riccardi, 2010).

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CONFLICTS OF INTEREST

The authors declare that they have no conflict of interest.

ETHICAL APPROVAL

All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional research committee (University of Padua—2070) and with the 1964

Helsinki declaration and its later amendments or comparable ethical standards.

DATA AVAILABILITY STATEMENT

Data are available on request due to privacy/ethical restrictions.

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