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RESEARCH

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Promoting the health of gender variant children in Italy: Parents' experience with supportive networks

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Abstract

Objective: The aim of this research was to explore the ways in which Italian parents of gender variant (GV) children construct their experience of seeking medical–psychological support and their experience with local services.
Background: We refer to gender variance in minors as the process of identification with a gender, other than the one assigned at birth. Parents taking care of their GV children often search for professional support to better understand them and promote their overall well-being. International research has shown that parents often meet health professionals who are ill-equipped to support them.
Method: We interviewed 26 parents in Italy with children who are GV. Through discourse analysis, with a focus on Harré's discursive positioning, we discuss how throughout their experience, parents have turned to information from professionals who were mostly uneducated about gender variance, and therefore, unable to help.
Results: A mostly adequate support was received when the parents eventually turned to specialized services for transgender and GV people; however, the fundamental source of support and empowerment is the informal relational network of services and "gender" families.
Conclusion: Parents' reports show that in Italy, health professionals and services addressing gender variance are highly heterogeneous and patchy, thus necessitating a specific training for professionals on the needs of transgender people.
Implications: This study is particularly important in the current context of the medicalization of children who are GV, as it offers valuable insights into the experiences of

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families navigating the complex and often stigmatized world of gender identity development.

KEYWORDS

adolescents, family diversity, gender development, gender differences, health and health-related issues, mental health issues

INTRODUCTION

The term *gender variant children* is used by clinicians to indicate those minors who have a subjective sense of gender identity and/or preferences regarding clothing, activities, and/or playmates that are different from what is culturally normative for their assigned sex at birth (American Psychological Association [APA], 2022; Gray et al., 2016). Through what they express verbally and behaviorally, as early as the age of 2–3, these children question the notion of gender and the implicit expectations of parents, family members, and people they meet in school or in everyday life (Coolhart et al., 2018; Drescher & Byne, 2012). Such questioning can be experienced very differently from child to child and can undermine the parent–child relationship. Furthermore, the way in which the family signifies gender variance affects how a child's needs will be understood, thus resulting in different actions that may, in turn, involve different professionals.

With this study, we explored realities of families with gender variant children in Italy, with a focus on the parental role. Only recently, in the Italian context, have gender identity and minors been discussed more openly. From the scientific perspective, research on the subject is still limited, especially considering the services aimed at families. In the Italian context, the approach to gender diversity is still moralistic and conservative. Italy is among the top countries in Europe for the number of transphobic hate crimes (Prunas et al., 2015): In the period from 2008 to 2020, 42 homicides of transgender people have been registered. Furthermore, from an institutional perspective, there are no laws that protect LGBTQ+ people from stigma and discrimination. For example, the laws regulating the change of registry and documents do not include minors, are outdated, strongly binary, and stuck to the need for the surgical "correction" of sexual characteristics. The aim of the research was to explore the ways in which parents of gender variant children construct their experience of seeking support, if needed, and their experience with formal or informal local services.

Background

In the literature, a high incidence of internalizing disorders (mostly anxiety and depression; Fisher et al., 2017; Steensma et al., 2014), eating disorders (Weiselberg et al., 2019), and self-injurious behavior or suicidal ideation (Connolly et al., 2016) is reported for these children and adolescents identifying as gender variant (GV). During puberty, many GV minors experience severe distress and rejection of their biological sex due to breast growth, menstruation, the onset of pubic hair, or changes in voice that motivate the urgency to start hormonal therapies or medical–surgical interventions (Wallien & Cohen-Kettenis, 2008). Such symptoms are often identified with gender identity dysphoria (*Diagnostic and Statistical Manual of Mental Disorders*; 5th ed.; *DSM-5*; APA, 2013), although some authors argue that they are not the cause of unease but a consequence of specific social conditions (Castro-Peraza et al., 2019; Davy & Toze, 2018; Dhejne et al., 2016). Several studies (Campbell et al., 2015; Valentine & Shipherd, 2018) have shown that the discomfort found in transgender people does not reflect the experienced gender incongruence, but rather reflects social stigma connected with negative reactions from family, friends, and society in general.

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McQueen (2014) argued that during the advancement of formal and informal knowledge, the rhetoric in which transgender people are associated with having a "wrong body" has strongly rooted. Indeed, in history, the discourse on "diverse" gender identities and on their psychological or medical–surgical approaches was pervaded by an intrinsically problematized vision over the course of the last century and a half. Indeed, in the second half of the 19th century, nosographic classification systems were created to frame those phenomena considered psychopathological and the object of treatment by medical science and psychiatry (Bryant, 2006). From the beginning, homosexuality, transsexuality, and transvestism have been considered disorders and their existence questioned the fundamental heteronormative and binary cultural conceptions of gender identity. The term *transsexualism* appeared for the first time as a diagnostic label in the *International Statistical Classification of Diseases and Related Health Problems (ICD)–9th Edition* (World Health Organization, 1975), whereas in the *DSM*, diagnoses for gender identity were introduced in the third edition of 1980 as *transsexualism* and *childhood gender identity disorder*, initially included among psychosexual disorders. The diagnoses of *gender identity dysphoria* (APA, 2013) and *gender identity incongruence* (*ICD-11*; World Health Organization, 2019) have undergone several modifications over the years, demonstrating how knowledge in this area is precarious, spoiled by prejudices and crossed by different lines of thought (Davy & Toze, 2018). Only in recent times, a fluid and nonbinary conception of gender identity, not anchored to corporeal domain, has been affirmed (Horowicz & Giordano, 2021).

A few useful considerations stem from the clinical context, in which several authors (Castro-Peraza et al., 2019; Suess Schwend et al., 2018) discuss the legitimacy and usefulness of the diagnosis regarding gender identity in minors. Because there is no general benefit nor any medical treatment is provided in the prepuberal period, only a strong risk of stigma and ostracism for the child remains (Valerio & Fazzari, 2016). The World Professional Association for Transgender Health (WPATH) published the *Standards of Care*, which describes the best practices for health professionals to care for transgender people in a shared manner by assisting and supporting children and their families (Coleman et al., 2012). It is agreed that working with the family is essential to effectively support transgender children and adolescents (de Vries & Cohen-Kettenis, 2012; Di Ceglie & Thümmel, 2006).

Understanding how children and adolescents who are GV live in their own body is not easy, and sometimes it requires conversations that may result in misunderstandings, suffering, and family conflicts. As noted by Simons et al. (2013), family support is crucial for the safety and health of the GV minor, but often the families themselves must manage an experience connoted by uncertainty and concern (Gregor et al., 2015). Frequently, parents of GV minors are faced with a situation characterized by "not knowing" what the child is going through (Gregor et al., 2015; Sharek et al., 2018). They do not know how to behave, how to make decisions in everyday life (Riley et al., 2013), and they express concern about their child's safety (Hill & Menvielle, 2009).

Only recently, the research has begun to address the experience of those parents who have implemented varying educational approaches to care for their child, often consulting a medical or psychological professional to get support. However, it was highlighted that parents have difficulties in finding health professionals prepared on gender matters, especially with respect to minors. Research has emphasized the need for support and the lack of adequate answers to both parents and children (Johnson & Benson, 2014; Kuvalanka et al., 2017; Pyne, 2016). It has also been highlighted that in health-care contexts, there are forms of stigma and discrimination against transgender people and their families, who may feel unsafe and grow distrust in health professionals (Kuvalanka et al., 2014; Merryfeather & Bruce, 2014). In a recent study in Italy, Fortunato et al. (2020) found that the interviewed pediatricians and psychologists claimed to have little or no knowledge about GV, however, they affirmed willingness to learn about these topics. Many professionals, including the ones in larger cities, have stated that they are not aware of the existence of specialized centers, highlighting the lack of a collaborative network model among professionals.

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Other research has indicated that families must travel long distances or move to access specialized care and to live in areas with more accepting communities (Platero, 2014). It has also been found that health professionals often maintain their personal theories, unsupported by scientific evidence, that a GV identity is determined by parents' behavior, such as apprehensive, symbiotic mothers or absent or slightly masculine fathers (Fortunato et al., 2020). While becoming "experts," parents develop coping strategies and improve their own agency to better support their children and make difficult decisions, sometimes even deviating from the health specialist's advice (Platero, 2014). Based on GV minors' difficulties and the abovementioned parental issues, with this study, we intend to explore the Italian reality, with a focus on the parental role.

The status of services in Italy

In Italy, the main association in the field of transgenderism is the National Observatory on Gender Identity (ONIG). It was founded in 1998 and consists of multidisciplinary teams of physicians, psychiatrists, psychologists, and activists. ONIG began caring for transgender children and their relatives in 2008, and currently, the centers for minors are located in seven Italian cities. The association also published its guidelines about the undertaking based on international protocols and on the recommendations from the WPATH. The model provides only psychological paths for children and does not provide for any medical intervention. In adolescence, along with the psychological support for the child and for the family, it is possible to access pharmacological treatments. Psychological interviews are provided to collect history and administer questionnaires, aimed at analyzing the user's demand and evaluating the "actual presence of discomfort" of gender identity. The team takes on the responsibility of informing the child and the family about the procedure, with particular attention to the school environment and the social context. On the national territory, health centers or organizations are not affiliated with ONIG, and they carry out activities such as help desk, counseling, psychological care, and support for the medical transition for transgender people. Presently, the organization of services in Italy does not seem adequate to meet the new needs of families. In some municipalities and regions, there are no specific services able to meet the requests for assistance of parents and GV minors, and the presence of competent specialists is "not adequate" and with many areas "entirely without support" (Massara, 2019).

Theoretical background

The research was conducted using the assumptions of the interactionist paradigm (Cahill, 1980; Mead, 1934; Salvini & Dondoni, 2011). In this perspective, scientific knowledge is conceived as necessarily linked to a theoretical framework that is situated, relational, and evolving within historical, geographical, and cultural contingencies (Salvini, 1998). Interactionism conceives the individual as an agent who, through symbolic and linguistic processes, gives meaning to his or her own experiences and organizes his or her own conduct (Iudici & Fabbri, 2017; Romania, 2012). This framework places great emphasis on the personal and interpersonal contexts in which GV children are situated, as they shape the meaning and evolution of their experiences. Learning the beliefs of family members, teachers, and classmates can help us understand how children with gender variance might perceive themselves. Gender identity is understood as an inherently relational construct and as an articulated system of different ways of configuring lived reality in continuity with one's own biography (Neri et al., 2022; Iudici et al., 2020; Iudici & Verdecchia, 2015).

From the interactionist point of view, the interest for this research was placed on observing and describing how parents interact with their children with gender variance and services in search for support. One of the main ways to capture interaction between people is through

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discourse studies. In qualitative studies, this area of study has developed strongly over the past 4 decades (Fairclough, 2013; Van Dijk, 2014; Wodak & Meyer, 2015). In our work, we have opted for the study of discursive positioning. This theory was first proposed by Davies and Harré (1990) to study and understand how minors with GV and their relatives position themselves or are positioned by others in social interactions and has been then developed by several authors (Harré, 2015; Harré & Moghaddam, 2003; Kayı-Aydar, 2019; McVee et al., 2021).

Positioning is defined as "the discursive process whereby people are located in conversations as observably and subjectively coherent participants in jointly produced storylines" (Davies & Harré, 1999, p. 37). It is used to grasp the ways in which rights and duties are distributed, assumed, rejected, and defended in the plot of daily interactions, depending on the moral domains of reference, in this research regarding minors with GV and their parents. Moreover, narrative lines are considered the fundamental organizational structure of speech used by people to make sense of their experiences. Storylines are embodied in discursive practices that reflect the meaning of the world and how it is interpreted from the perspective of whom we consider ourselves to be (Harré, 2015). Hence, whether something is possible to do or not is based on the positioning assumed or underwent by those who speak within a specific normative and institutional framework.

METHODS

Participants

The participants were recruited with the help of two activists for transgender people's rights who shared the proposal of the research project both to known parents and to a private Facebook group of families related to the LGBTQ+ world. Participants voluntarily applied and were contacted by the researcher to present the project, answer any questions, and organize meetings for the interviews. To participate in the research, it was required for the participants to be the parent of a minor whose felt gender identity differs from the given one; the presence of a gender dysphoria diagnosis was not required.

The research involved 26 parents including 14 females, 11 males, and one person who identified as nonbinary. Only one parent for each family of GV children accepted to take part to the research and was enrolled for the interviews. Of these, 25 are biological parents and one exerts the parental role being married to the biological parent. Their ages range from 37 to 62 years, average age being 47.5 years.

Data collection

For data collection, we used the semistructured interview (reported in Table 1), a widely used method in qualitative research (Willig, 2001). By using this tool, one can access, through nondirectional questions, the symbolic and experiential universe of people as they understand it (Flick, 2009; Wengraf, 2001). The usefulness of this methodology is especially evident in gender studies because the same term may not have the same meaning for the researcher and for the different respondents, as the meanings of words depend on the use, on the context, and on the relationship in which they are stated (Corbetta, 2003; Fylan, 2005).

Participants signed an informative document regarding the purpose of the research and were granted anonymity and privacy protection. The interviews were conducted in person and in Italian as it is the mother tongue of all the participants, were recorded with a voice recorder, and were later transcribed verbatim and translated in English. Overall, the interviews were conducted during a period of 2 months and each one lasted from a minimum of 40 to a maximum of 50 minutes. The research project was validated by the Ethics Committee of the University of Padua.

TABLE 1 Interview track

Objectives	Semistructured interview
To explore, through parents' accounts, the state of professional knowledge and practices in dealing with gender variant minors' needs and formal or informal services in Italy	1. Did you search for professional support to care for your gender variant child? If so, to what kind of support did you turn to? 2. What are the services and professional networks available in Italy that are specific for transgender children's health? How did you find out about them? 3. To your knowledge, are there other forms of support for gender variant children and their families? Can you share some examples?
To describe the ways in which parents of gender variant children construct their experience of seeking support to care for their gender variant children	1. Can you describe your experience with health professionals (pediatricians, physicians, psychiatrists, psychologists, etc.) that you turned to: what was their understanding of transgender people's health and their approach to your and your child's requests? 2. What was your experience? 3. What helped you as a parent? 4. What difficulties did you encounter?

TABLE 2 Codex criteria for analysis

Discoursive level	Specific positioning
Language used	Metaphors, rhetoric, speech acts (e.g., complaints), verb tenses, expressions used, interpretations, and implied and assumed meanings (the "unspoken").
Moral/regulatory prescriptions	The rights and duties that each person implicitly or explicitly assumes or suffers.
Macrothemes	The plots of the subjects' narratives, within which are the subtopics, which would be the positions assumed by the subjects.

Data analysis and coding

To perform the analysis of the interviews, theoretical references drawn from the discursive positioning theory were used. The interviews were read and analyzed separately by the two authors in pencil and paper mode, coded by the criteria in Table 2. The results of the first coding were discussed, and subsequently revised jointly. A first reading of each interview was made individually to observe the ways in which the respondents' speeches were deployed according to the theoretical assumptions. Subsequently, the answers to each question were organized based on the similarities of the salient positionings produced in the different experiences. Through a constant back-and-forth movement between the texts and the extracts of the encoded data, we have identified the main positionings, which were then systematized in conceptual dimensions to describe and observe them (McVee et al., 2021). These criteria were used to describe the main discursive placements.

Positioning of oneself and others can be implicit or explicit and forced or unforced. People can position themselves actively, but they can also be positioned according to the positions of others. The different ways through which people position themselves allow us to understand how they see the world and make sense of their own experiences. In our analysis, we go in search of what discourses people use about the situation triggered by our questions, that is, the type of subject positioning. The results represent a generalization of positionings, which is therefore useful for understanding how parents interact with respect to the delicate situation experienced by their children, especially with respect to services.

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For instance, one of the interviewees told how their child's gender identity was denied by the specialists through the linguistic practice of misgendering, despite the warnings given by family members about the proper gender and name to use:

> With the fact of the attempted suicide, you enter with the neuropsychiatrist and there, nothing was said about Marco as a male, we said that we called him Marco, they continued until this year, then for a year and a half, to call him Maria, to talk to him as a female.

From the text we can gather a positioning of parents based on subordinate, powerless, and disadvantageous interaction in the face of an institutional and professional role.

RESULTS

The answers obtained from the interviews were organized into three main macrothemes: (a) request for professional support from psychologists and psychiatrists (positioning of not knowing; positioning of asking for expert enlightenment; positioning of feeling judged and not understood); (b) request for support to specialized centers (ONIG); and (c) request for support to informal networks and associations.

Request for professional support from private psychologists and psychiatrists

The positioning of not knowing and the psychological and psychiatric hypothesis

The parents' positioning is to feel initially bewildered and disoriented; they experience that they have no idea what has happened to their child. Parents described a state of disquiet because of the difficulty in interpreting their child's attitudes. The first questions are what's wrong with the child? Why are they doing this? Such questions are initially taken to psychologists and psychiatrists, thus implicitly identifying GV as a matter of expertise in those fields. This suggests that the initial doubts and uncertainties are transformed into assumptions of illness or disorder that would justify the idea of turning to those very figures.

A mother of an 8-year-old girl said, "At first we were scared, we lacked the lenses to see, we didn't understand anything, and we didn't know what to do, how to deal with the situation, then we said, let's go to someone, so we went to the psychologist."

> A mother of a 9-year-old girl said,
> My husband and I were speechless, obviously we were missing things, then we understood why. Anyway, we couldn't understand the reasons for this change in the child, then as we went on, we got a little worried and then we started to speculate, it could be just a game let's say so passing, but then it didn't pass and finally we said: maybe she's sick, then we went to the psychiatrist to see if there were more serious problems.

Positioning of asking for expert enlightenment

The central positioning of most parents is to hope for a competent response regarding how to interpret their child's situation.

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In some cases, the health-care provider has been able to provide the parent with adequate responses, both in terms of the willingness to listen to them and in the provision of the relational tools or understanding to handle the situation. This is the case with parents who have prepubescent children; in fact, they come to psychologists seeking support in exercising their parental role and to receive guidance and feedback on their actions, but do not seek psychological help for their child. The expressions "point by point," "he listened to me," "we found a place to think," and "lifeline" indicate a full acknowledgement of the professional encountered and delineate an interaction based on asking questions to the professional, as can be captured in the two responses below.

The mother of a 7-year-old GV child stated,

> The psychologist I turned to has been … bare, raw, precise. She clarified in an hour everything that my son was. First, she listened to me, then she answered me point-by-point and said: "Look, your son is not homosexual, your son is something else." She really gave me a starting point, since my husband and I fell into the void, we finally found a place to stop, to think.

The mother of a nonbinary child of 7 years, referring to the psychologists at a specialized health service, said,

> For me, they were a table of salvation because, at a time when I didn't know any other family and no other child with a profile like that, everything I saw was online and it was like a very abstract field. The decisions to make were daily.

In some cases, the positioning takes on a moral significance, so the interaction is based on the request in the right–wrong pole, as evident in another mother's response about the first request she made to the psychiatrist:

> The child told me, "I want to wear a skirt." I didn't know if I had done right or wrong. Instinctively, I would have made him wear a skirt. I wanted to be cautious and understand from those who knew the phenomenon better than I did what the right approach was.

Conversely, several parents reported encountering professionals, psychologists, and psychiatrists, even developmental specialists, who showed a total lack of experience with GV identities. In some situations, the parents, faced with the incompetence of the experts, took on the role of an informant themselves and provided them with informational material on the subject.

The mother of a GV teenager claimed,

> At the psychiatrist, when the gender variance thing came out, I also brought a guide that explained what gender variance during developmental age actually is. She didn't even read it and when I told her she had to contact the school because G. wanted to start the social transition. She said, "I don't know how to do it, I don't know how to behave so I'm sorry, I don't know."

The mother of a 7-year-old nonbinary child reported her first contact with a psychologist:

> The paediatrician recommended us to go to this psychologist who was a super good person, from the point of view of treatment and the approach, but she had no idea what she was doing, she just didn't know the phenomenon at all. She gave us advice

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> on everyday life, which we appreciated because yes, it is good that a child plays with his dad … but from the point of view of his preferences, nothing changed.

A professional role that is mentioned by many parents is the pediatrician, who is usually the first person to be contacted to better comprehend a child's health. Many interviewed parents have turned to pediatricians who proved to be unprepared on the subject or could not suggest other professionals to turn to and considered the situation to be just a "passing phase." In this case, many parents needed to educate their pediatricians, some of whom were willing to learn and gain further experience on the topic. A parent reported what they were told by their pediatrician: "Our paediatrician said: 'He's a fancy kid, he'll be an artist, don't worry.'"

The parent of a GV teen described her experience with psychiatrists in the public sector: "Practically, [in] all public structures, as soon as you touch upon the question of gender dysphoria, it is a little like they withdraw, as if it was too complex and they don't get into it, as if a person's psyche was separated."

Positioning of feeling judged and not understood and those who undergo a pathologizing or correctionalist interpretation

Several parents reported not only the rejection to address gender issues from their professional support but the very denial of the child's identity. In the narrated experiences, hospital psychiatrists whom the families approached expressed an explicitly hostile attitude toward GV and did not acknowledge the minor's expressed identity, which was also claimed by the parents. This occurred with openly refusing to concord pronouns and names with the appropriate gender and using the name given at birth. Sometimes, they explicitly denied that the child could truly be transgender, dismissing it all as a phase and belittling the situation of psychological malaise.

A mother said that she often had arguments with health-care professionals and social workers scared her. She told how the staff of the Local Health Authority reacted when she turned to them in fear of the child's self-harming:

> A. used to leave me notes: "Mom, I'm afraid to kill myself." A. cuts himself and I call these Local Health Authority morons: "He cut himself again, what should I do?"
> "Oh ma'am, they do it! These kids do it, it happens. It hurts, but they do it!" At some point, I rebelled against everything.

In this exchange we see a different interpretation of the severity of the problem, on one hand the mother's fear of her son's threat to kill himself, and on the other the interpretation of self-harm as a psychiatric symptom.

A parent said that she had spoken to a renowned psychologist and sexologist when the child was 3 years old. The psychological treatment was performed by this professional as a reparative therapy, in which the parents were seen as the cause of the development of a GV identity, as the parent recounted:

> We were questioned above all, then the grandparents or whatever figure that revolved around L. was studied concerning the faults. The father had to take him to play soccer, L. didn't like it. All the pink toys she had, the pots, the little things, her father had to break them with a hammer together with L. So, this experience with this psychologist, for me, but also for the father was very exhausting, frustrating, I didn't like it. If I think of someone who hurt me, I think of this psychologist.

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In this narrative, we describe a fault-finding approach directed toward the child or family members, aimed at identifying the causes of a behavior that is deemed problematic a priori. Similarly, another mother discussed the attitude of a public psychiatric service for children toward GV:

> Dysphoria was never mentioned, ever. For them [the psychiatrists], we were looked after by the ONIG Centre and so, for them, it was borderline depression. Depression last year, borderline this year. Stop, two separate things. I said, "How can they be two separate things if it's the same person?"

In this case, she referred to having received two different diagnoses at two different times. In the first year that she referred, her son was diagnosed with depression; in the second year, he was diagnosed with a borderline problem. In our research experience, this tends to occur when the reality of children with GV is unknown. This finding confirms other studies regarding not only the pathologization of GV youth, but also the attempt to administer conversion therapies to GV children (Gray et al., 2016; Kuvalanka et al., 2014; Pyne, 2016).

The request for support to specialized centers

Many parents reported that they ended up being followed by multidisciplinary teams at the ONIG centers, after having the most inadequate, if not harmful, experience with private or public health professionals. The parents report that they immediately felt welcomed in the ONIG centers where the legitimacy of the child's identity was not questioned. Children were asked what they wanted to be called, what their needs were, and they were also involved in the information and decision-making processes about their treatments. Reaching the ONIG centers was fundamental to being acquainted with other "gender" families, as the mother of a 7-year-old GV child told us:

> At ONIG Center we found group support, very strong, you no longer feel alone. You no longer feel alone because you realise that there are so many children, just a few have come out. That's why he's fine at [ONIG Center] and he says: "Mom, I go to ONIG Center, I can be who I am." Yes, he can be who he is.

The parents highlighted a few critical issues about the services' organization, the approach, and/or about how ONIG guidelines are implemented. Whereas some of the services, meetings, and therapeutic paths are also provided for other family members, this is untrue for many other health services. Some of the parents complain about the lack of assistance for GV minors' siblings who may need to be supported as well. The parent of a GV teen stated, "What I personally feel is that there is great support for the main character, great support for the parents, otherwise there is nothing."

Parents contrapose the legitimization of the GV child with the services dedicated to them. One of the parents reported that he "has developed a very guilt-ridden attitude toward the ONIG approach, believing it to be potentially harmful and schizophrenic in that it supports the child inside the home and inhibits the expression of his empowerment outside." This expression is meant to highlight precisely the contrast between attention to the child and his or her legitimacy in the center and an absence of attention to the next phase, which is that of transition.

For some, the time frame is considered excessively slow and prolonged because of the standard psychological assessment pathways. As much as the parents are aware that evaluations should rule out potential psychological and medical risks in line with protocol guidelines, at the

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same time they find it very harmful not to respond quickly to their children's needs. One parent with a 16-year-old son said,

> And then there are these endless tests, long to fill out, no one says what they are for, what their function is, it seems like an endless bureaucracy that never ends, and then you don't know who has to decide, when they have to decide, and in how long. And meanwhile, the kids suffer because puberty is still a source of anxiety and discomfort for most of them.

The positioning of the parents is that of being in a permanent wait-and-see condition.

In addition, ONIG centers in different cities have different ways and times to obtain diagnosis and access to treatment; in fact, some parents decide which center to go to, according to their inclinations and needs. One parent of a pubertal-age boy said, "Another problem concerns the distance to the ONIG Center, which is not facilitating for some of us. This requires travel from one region to another and a considerable expenditure of time and money."

Parents consider which center or facility to choose for transition based on their financial resources. One parent said, "I am one who switched Centers, I was in contact with other parents and I learned that hormone treatment is much faster at that center." Someone else, however, preferred not to let their child know that access to transition is easier in another city without a thorough psychological evaluation. Another respondent preferred to go to another region to avoid meeting acquaintances and disclosing to them why she was in the hospital.

This highlights how contextual and random factors influence and shape a situation that is poorly regulated and is often driven by the common sense of individual actors, professionals, and institutional figures. The parent of an adolescent explained,

> There were very long waiting times, decisions that they did not make. Even for the blockers, they were very reluctant, that is, they had to understand, they had to do this and that, they had to analyse. I just don't know, after two years, they didn't have a diagnosis yet. Even the fact that they said he could get over it. It was handled as if it was a disease. What is it, a cold that you get over?

Several parents believed that the approach and the path of taking charge, provided with numerous in-depth tests and medical–psychological evaluations, suggest an iatrogenic and pathological notion of gender variance. In addition, the interviewees argued that psychological therapies should not be mandatory but should be undertaken if the child or the parent deems it necessary. The mother of a teenager, who was followed by an ONIG center for her teen's transition, said,

> They always make you feel a little ill, in the sense that you are, but I think this is very Italian, there are so many investigations, so many tests, you have to go to the neurologist, then to the psychiatrist, then to another one. So, I continue a bit to defend myself, from this, from the idea that in any case they are people who must be … not "medicalised," because I do not want to say that it is so, but … They should be assisted when they feel the need, not regardless of.

As the ONIG centers are part of an association that receives little and uncertain funding, some parents think that the operators may not be able to support transition due to the fear of backlash from the public opinion, which could result in the loss of political funding. As argued by Cromwell (1999), "transsexual" discourses are constructed and controlled by medical and psychological operators who "diagnose, classify, regulate and produce transsexual bodies" (p. 136).

Based on the accounts collected in this part of the research, we emphasize that the perception of gender identity in minors and their families can be significantly influenced by the level

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of expertise that professionals (such as doctors and psychologists) possess regarding the specific topic. When mental health professionals are not well-informed about new phenomena like gender identity, there is a risk of failing to recognize the unique aspects of the experience and mistakenly attributing it to some other psychiatric disorder. This misidentification can lead minors to perceive themselves as ill, which may result in behaviors such as self-rejection or self-harm, as reported in the literature (Prunas et al., 2015).

The strength of shared experience: Request for support to informal networks and associations

A common feature of the parents' reported experiences is that they referred not only to institutional health specialists as points of reference, but most of the parents agreed upon considering "informal" figures as fundamentally important to helping them manage GV.

Many parents told that finding the blog of an Italian mother, who shares her experience of parenting a GV child, was essential in navigating their experience. In many cases, the blog became the first "anchor" for parents who were searching for answers on the web: "The first person we turned to is [blogger mother], not an expert, a doctor or the paediatrician. For sure, the first message we sent was to her because we saw the blog."

Over time, the blog formed a network of families. This group, mostly virtual, appears to be crucial in the parents' discourses. Hence, the parents became the junctions of the support network "from below": They share information and personal experiences, provide support, and organize themselves to confront the institutions. Another parent said,

> It's as if a help network was formed. There is a help that is very deep, in an informal way. Within WhatsApp, within Messenger. With another mother we never got in touch, except from the online group. We share our experiences, we keep in touch via Messenger, for anything, we have each other.

Another key figure in the parents' experiences is an activist administering a help desk in a northern city, which is funded by private donations and regional subsidies. This help desk was suspended at the time of the interviews due to a lack of funds. The activist at the help desk provided advice and specialists' contacts, which also allowed the families to receive economic benefits. Among the offered services, self-help groups were particularly relevant for both parents and the children. A parent said,

> I must say that, first of all, we went to this self-help group and there I realised many things, many realities of life and … I didn't suit there as a person, but it helped us a lot, it helped me to understand T. even more and to understand his discomfort in certain situations, that maybe I didn't understand.

DISCUSSION

The data show that parents of GV children experience different emotions throughout their experience. The first stage is one of uncertainty and restlessness in which the feeling of not knowing and not being able to help their child prevails. The way they cope with this feeling is to seek help from an expert, almost always from a psychological or psychiatric area. Sometimes, the request is based on the hope of knowing something other than what one knows; sometimes it has a moral significance, that is, it is aimed at understanding whether one is doing right or wrong. This places the parents in the position of assuming a disorder anyway.

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With a few exceptions, the interviews with parents revealed that most psychologists, private psychiatrists, or public pediatricians have no experience in dealing with GV. Some of these professionals also showed a disengaged attitude toward the problem, downplaying it as a passing phase or a child's tantrum and often suggested parents take their time. This is a finding that corroborates other similar research (Fortunato et al., 2020; Johnson & Benson, 2014; Pyne, 2016). Several parents stated that they were more knowledgeable than the specialist and needed to educate the specialist themselves, and this finding is also found in the literature (Gregor et al., 2015; Pullen Sansfaçon et al., 2015; Platero, 2014).

The positioning of those who hypothesize a disorder underlying their children's GV behaviors and the notable presence of professionals not trained to deal with the experience of a GV child leads one to think that there may be many diagnostic misunderstandings, that is, the psychologist does not recognize the issue and therefore interprets it as something else or the parent does not know the issue and is looking for explanations. These positionings can lead to a GV child's experience not being recognized and therefore can severely hinder their development and identity affirmation (Pollitt et al., 2021) and make them vulnerable (Gridley et al., 2016; Wren, 2002).

The existence of ONIG centers and psychological support have been crucial for the parents of children, especially adolescents, whose different identities have finally been legitimized by institutions. However, parents say that within the ONIG centers, there is a tendency to manage the children's situation with a bureaucratic approach that becomes iatrogenic.

Consistent with protocol assessment procedures, psychodiagnostic tests are performed with children, who must also be followed by psychologists. Psychological treatments are often considered unnecessary by the parents or children themselves and are seen as an imposition that makes them feel "controlled" and renders the procedures as tools that seek an individual psychological or psychiatric problem at any cost.

In reference to these discourses, it might be useful for the centers' practitioners to describe the reasons for this wait, making it more shareable to manage time and manage a wait that in the minds of children and their parents can turn into a serious personal problem or the idea that there are adverse political forces. The relationship with health experts noted a difference between the parents with prepubertal children and those with pubertal children. In fact, the former's parents come to the centers seeking support in the exercise of their parental role, to receive guidance and feedback on their actions, and do not seek psychological help for their child. As for the parents of adolescents, their relationship with services is related to the issue of the transition procedure, which is perceived as an urgency due to the passage of time and the development of hormonal changes.

Over time, psychologists and psychiatrists assume a predominantly utilitarian function, given their gatekeeping role in the access to hormone treatments. In the long run, this situation can lead to a delegitimization of psychologists and psychiatrists as they become a tool for access to transition rather than actual help. Again, it might be useful to go into the meanings of the use of the tests so as not to make the position of the test takers passive. Once again, managing the interaction between the clinician and the user turns out to be crucial.

At first, many parents trusted the specialists, believing that they might be more experienced on the matter, merely because of their institutional role. As time passed and as they listened to their child's expressed needs, the parents realized that they must find more specific support and not settle for the initial answers. The parents, some of whom were already supported by psychiatrists or in contact with private or school psychologists, thus turn to additional "informal" figures, in search of support, such as friends or acquaintances in contact with the LGBTQ+ community or activists. The first connections are made and allow the evolution and implementation of the relational network composed of "gender" families. Such a network functions as an interactive hub in which experiences, advice, support, and, most importantly, reliable specialists' contacts are shared.

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Thus, a kind of rift has been created between service providers and the informal network, which in the medium and long term may lead to a delegitimization of the services if they fail to innovate by responding to the new needs involving GV children. A significant lack of regulation and organization was also found in both the public and private sectors, a finding also confirmed by another research study (Giovanardi et al., 2020). This has allowed private citizens, parents, and transgender people to organize to compensate for these deficiencies.

Meeting and listening to the viewpoints of transgender people in self-help groups are recognized as fundamental opportunities to become acquainted with transgender people, overcoming prejudices and common sense. On one hand, the direct testimony of the life experiences of people who have transitioned is functional to surpass many stereotypes and prejudices. On the other hand, some interviewees specified that they did not "suit" in the self-help groups, where the transgender adults reported painful life experiences.

In addition, the developmental and identity needs of transgender children are likely to be significantly different from people who began the transition in a different life stage or many years ago, in different historical–cultural contexts, as reported by Dierckx et al. (2017).

Limitations

One of the limits of the research is the small number of participants. In line with the average sample of qualitative research available in the literature on this topic, it is sufficient given the qualitative and exploratory character of the study. Another limitation of this research was the variation in the participants' knowledge on the topic of gender variance. A few participants were a part of an informal group of parents of GV children, a subculture, and are in contact with each other. Moreover, some of them have been living with this experience for some years and have developed a particular attitude toward the topic.

All participants were White and of European Union nationality. It would be interesting to study parents from non-European countries to understand how cross-cultural differences may configure gender deviance and whether gender identity discourses are different and more inclusive. Such a study could shed light on how cultural norms and beliefs shape attitudes toward gender, and how they differ from Western notions of gender identity. In certain non-European cultures, for instance, gender may be conceptualized as a more flexible and dynamic construct, potentially affording greater space for the acceptance and integration of nonbinary gender identities.

Implications

This research is an early qualitative paper aimed to understand the experiences related to GV identities in the Italian context. The interviews have brought to light the experiences of Italian parents of GV minors, subjects on whom research is almost nonexistent to date.

This research has allowed us to collect narratives about experiences with health professionals, who were mostly described as "not helping" or "frustrating." Not being able to find answers, support, or worse, being in contact with nonacceptant or hostile health professionals, can become very problematic for parents who wish to promote their child's identity and health. These interviews demonstrate how gender identity variance is part of an entrenched process of medicalization and problematization of the identity experience, which is explicitly condemned by many parents. In this way, the discourse on the health of the transgender person is anchored to the medical discourse and the attendance of medical clinics and to the psychiatrist's consent to obtain the diagnosis, even for those who do not experience the discomfort that gender dysphoria presupposes (Neri et al., 2020).

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Facing a topic that is subject to prejudice and ignorance may exacerbate the mission of promoting a child's identity toward the goal of health and personal fulfilment. The literature has widely highlighted how an accepting and supportive family context is of fundamental importance for the psychological well-being and health of the child (Ashley, 2020; Bhattacharya et al., 2021; Faccio et al., 2020; Kuvalanka et al., 2017; Turchi et al., 2022). Rather than focusing on the gender identity of the child and on the search for elements related to possible psychopathologies, the attention from a psychological point of view should reconfigure itself toward the development of the interactive, communicative, and operational skills of the parent. This cannot occur without promoting, at a scientific and cultural level, projects aimed at depathologizing identity experiences beyond gender binarism (Iudici & Orczyk, 2021), and it should be aimed at enhancing individual differences as a resource for the community rather than as a deviance to blame and inhibit.

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