Mental health practitioners' positioning toward the diagnosis in gender transition

Introduction

The ways of meaning the experience of gender variance have changed significantly across different socio-cultural contexts and historical periods, and also the diagnostic criteria used to frame the phenomenon have been modified a lot over time.

In psychiatry and clinical psychology the diagnosis has evolved in tune with the change in the ethical and value system that has oriented the attempt to clarify and consider the experience of gender nonconformity, hand in han with the new knowledge and social demands respecting the growing complexity related to the gender variances.

The currently-adopted diagnostic category in the DSM-5 is that of "gender dysphoria", it is used to identify particular forms of gender nonconformity and the related distress (APA 2013, 530), while the ICD-10 still uses the expression "gender identity disorder" (WHO 1992). Despite this, the authors of the latter manual have recently published their intention to replace it with a new category called "gender incongruence" willing to eliminate the psychopathological connotation associated with the term "disorder" (Winter 2017). Also in light of the discussion about the diagnostics both inside and outside the academic world, the need for undergoing assessment criteria remains a crucial point in gender transition.

There is an abundance of literature about the critical issues deriving from this (Kamens, 2011; Brill e Pepper, 2008; Hill, Rozanski, Carfagnini, e Willoughby, 2007; Lev, 2005; Moser e Kleinplatz, 2005; Perrin, 2002; Burke, 1996; Sedgwick, 1991; Currah, Green, e Stryker, 2009; Bryant, 2008, Meyer-Bahlburg, 2010; Drescher, 2013). One of the most relevant debate arguments is the equation of the gender variance condition with a mental disease together with the need for the clinical certification (provided on the base of the diagnosis) in order to undergo the medical treatment and the legal recognition. Entering the question in more details, it has been put in evidence by recent

literature that the diagnostic process represents a passepartout, but also the inexorabile mean of medicalysing and pathologysing the gender nonconforming variance experience (Bryant, 2011; Jutel, 2009; Lev, 2013; Winters, 2005; Langer and Martin 2004; Vitelli et al., 2013); it should also be remembered that the diagnosis of gender dysphoria may guarantee or prevent not only the surgical sexual reassignment procedures, but also the hormone treatments and the broader psychological pathway (Dewey 2008; Bryant 2011). The condition of gender variant, already weighted down by poor acceptance in the social context, is thus exposed to a double stigma: the external derived from the normative judgement of common people, and the internal one, linked to the self-attribution of being a person suffering for a mental disease (Pleak et al., 2009; Grant et al., 2011; Drescher, 2012). Another critical issue, in this case for the clinical researchers and for practitioners, is that related to the difficulties in collocating the diagnosis within the Diagnostic Manuals. Among the options there are the link with endocrinology, urogenital issues, rare diseases and with psychology or psychiatry (Bockting, 2009; Drescher, Cohen-Kettenis & Winter, 2012; Valerio e Fazzari, 2016). Remaining on the side of clinicians, an additional risk factor is that to consider the encounter as a way to collect data to assess a case, as if it were a test to be passed rather than an opportunity to investigate a history and personal meanings in relation to which the transition is the mere precipitate (Kessler and McKenna 1978; Rubin 2006). Some authors have emphasised that people in transition may consequently take the diagnosis for granted and behave during the clinical exchange as if reading from a script: their aim might be to satisfy the clinician's expectations and to fit into the professional's categories, rather than to take the opportunity to be guided in the discovering of the implications related to the transition, as benefiting from a special aid (Spade 2003; Johnson 2019). This shifts the centre of gravity of the encounter towards cultural archetypes of masculinity and femininity, but also of the gender binarism, to which these people must adapt in order to give their diversity an acceptable name instead of shedding light on their own particular interpretation of how they feel to be, for example, a man or a woman.

Despite the several studies on the diagnostic process and the psychological pathway involved in gender variance situations, little research has been conducted on how trans people and psychologists or psychiatrists view and deal with the diagnosis of gender dysphoria in the clinical context. Some authors have underscored trans people's negative experiences and perceptions of the psychological pathway, and of professionals' approach to their situation (Benson 2013; Shipherd, Green, and Abramovitz 2010; Bettergarcia and Israel 2018). Others have explored how the professional is represented as a gatekeeper, and the consultation as an imposition (Whitehead et al. 2012; Budge 2015). The implications of the power imbalance between people in transition and clinicians with a view to maintaining social control have been described as a crucial component of pathologizing processes (Dewey and Gesbeck 2015; Serano 2007).

In Italy, this area has been studied in a handful of works, more in the fields of sociology (Arfini 2007; Garosi 2009; Rinaldi 2006) than in clinical psychology. Vitelli (Vitelli et al., 2017) found that, although some trans people express the need to undergo gender affirming surgery, many of them do not identify with a binary gender categorisation. While the centrality of the genitals and the importance of surgery seem to decline over time because of gender variance, surgery continues to be an important goal. All this makes understanding the need for a diagnosis, like the demand for surgery, more debated, especially inasmuch as concerns the relationship between nonbinary gender identification and the paradoxical need for modification of corporeal and sexual characteristics, which effect seems to confirm and take for granted the binary gender condition.

The questions that moved our research concern: how the diagnosis is constructed by mental health practitioners actively involved in gender transition pathways in the national health system, in terms of resources and limits; the role they attribute to the diagnosis within the gender transition pathways; the implications for trans people and for practitioners managing their clinical issues. As our aim was to address the subjective perspectives of psychologists, psychiatrists and psychotherapists, we approached these questions by means of a qualitative research based on semi-structured interviews with 11 mental health practitioners in northern and central Italy.

Italy is characteristic in that the diagnosis strongly influences the accessibility of the various phases of the medicalised path of gender transition. It is not specifically required by law, but necessitated by the everyday institutional practices of courts, hospitals, and other services involved in gender transition.

Gender transition and the diagnosis of gender dysphoria in Italy

The international guidelines on intervention in gender transition processes were developed by the World Professional Association for Transgender Health (WPATH 2011) and the American Psychological Association (APA 2015) for the health of transsexual, transgender and gender nonconforming people. The guidelines take an interdisciplinary stance with a view to promoting affirmative approaches to experiences of gender variance and the need for change in gender identification. The diagnostic process is configured as a way to discriminate between conditions of gender variance and gender dysphoria, as the latter entails a clinically-relevant distress. Unlike other guidelines (such as the Standards of Care for Sex Reassignment in Gender Identity Disorder issued by the Italian Observatory for Gender Identity [ONIG]), the WPATH does not consider psychotherapy essential.

The normative and juridical references may vary from one country to another. In Europe, for example, there are 34 countries where requests for the legal recognition of gender identity is subject to a diagnosis of gender dysphoria (Pezzini 2012); the exceptions are Malta, Greece, France, Ireland, Belgium, Norway and Denmark. In Italy, the need for such a diagnosis is not explicitly stated in the text of the law (n. 164/1982) on sexual reassignment, which is open to various interpretations by the courts, but the diagnosis is still a decision-making factor in institutional practice.

Together with Germany, Italy was one of the first Countries in Europe to have introduced a proper legislation and to have formalyzed the opportunity of medical treatments for gender transition, then the legitimization of this process and of transsexual and transgender. This implied the need to establish specific norms and practices governing the different stages of the gender transition process,

defining and limiting the recognition of an individual's gender identity (Connell 2002; Vitelli, Scandurra, Pacifico et al. 2017). The Italian law contains norms concerning sexual assignment and defines gender transition as a modification of the sex and name attributed to individuals in their personal identity documents, connoting it as a medical issue.

The route to gender transition may pass through different areas of opportunity and social settings, including hospitals, courtrooms and operating rooms, but also associations, workplaces, body care places, and virtual spaces. In Italy, one of the most influential players involved in implementing norms and practices relating to gender transition is the National Health System, through its various medical, endocrinological, psychological and psychiatric professionals. Their operativity is based on a specific technical-scientific knowledge, structured in a multidisciplinary perspective. Individuals wishing to embark on the path of gender transition are generally involved in a series of steps: a first contact with a mental health professional, including a psychological assessment; a psychological pathway, hormone treatment and a "real-life test" (a monitoring process forming part of the psychological pathway), any necessary legal processes, sexual reassignment, a social reinsertion phase, and a follow-up.

In the various phases of the process, the psychological pathway is considered important partly because it is always demanded, and it adheres to specific international and national guidelines (Coleman, Bockting et al. 2011; Wylie, Barrett et al. 2013), and partly because it is an essential step before the transition process can start. It has both a diagnostic and a therapeutic-supportive purpose: to assess the "dysphoric" condition and any psychopathological elements prompting the request to change gender; and to sustain, accompany and monitor the individual during the transition (Lev 2009; Eden, Wylie et al. 2012). This approach underscores the importance of the diagnostic and psychological support process, as well as the different ways of interpreting and constructing identity and gender, and their potential implications.

Theoretical background

The study moves from a postmodern paradigm, and from the theoretical perspectives of Symbolic Interactionism (Mead 1934; Blumer 1969) and Social Constructionism (Gergen 1985) which allow to focus on the interactive processes at the roof of the co-construction of phenomena and to recognize in the diagnosis its social rather than natural foundation. The different processes aimed at generating the sense of self and gender identity are here considered as multiple and mutable, historically and culturally situated and connected to the dimension of the discourse and narratives of doing and performance in every context of daily life (West and Zimmerman 1987; Denzin 2003; Goffman 1988; Butler, 2004; Bornstein, 1994; Prosser, 1998). The narrative and discursive processes used to describe events and phenomena contribute to create them, also lending them an ontological status, as in the case of gender. The same applies to the diagnosis of gender dysphoria, that constitutes not just a nosographic category, but also reflects the cultural and normative values that permeate the social representation of a phenomenon, since they contribute to building it.

Study aims

The aim of this research was to explore the narratives about how mental health practitioners construct their practice, and what meanings the diagnosis of gender dysphoria may have in their narration of the transition process. In particular, we tried to shed light on how a diagnosis of gender dysphoria is perceived, proposed to the clients and used. We also investigated what personal and professional positions practitioners take in relation to transgender clients and the possible implications that the diagnostic matter has on the whole transition path. Results are presented on the basis of the three main investigated themes:

1. The diagnosis
2. The practitioner's role and identity
3. The relationship between the expert and the trans-person

Our findings should contribute to our understanding not only of how the diagnosis of gender dysphoria is defined by transgender people, as widely discussed by the recent literature, but also of

how it is interpreted and used or debated by clinical psychologists and psychiatrists, and what other meanings or challenges it may have and implies. The goal is to shed light on practitioners' experiences and narratives and their different ways of constructing and signifying gender identity and gender variance, also referring to personal values and beliefs and not just to the professional and technical know-how.

Methods

Participants

This research involved 11 practitioners: 3 psychiatrists and 8 psychotherapists operating in public and private contexts. Among them, there were 4 men and 7 women. Practitioners' theoretical orientations were: all 3 psychiatrists expressed preference for psychodynamic perspective, 2 of the 8 psychologists defined themselves as "psycho-dynamic", 2 "systemic-familiar"; 1 "corporeal"; 1 "transcultural" and 2 "integrated". They operate in different regions of Italy, such as Lombardia, Lazio and Campania. Participants were in different stages of their practice: some were at the beginning of their practice in gender transition, others were active in this field managing different situations and others were not operating anymore after many years of work. All of them were specialized or engaged in gender and/or sexual orientation and practices issues and trainings.

All participants were contacted by one of the authors (JN), a woman, after a period of participant observation in a self-help group for transgender people setting over a period of 8 months, through direct or suggested contacts by them. All participants agreed to take part in the study after seeing a presentation on the goals and methods of the inquiry, some of them were contacted by email while others were intercepted by means of a snowball sampling process (Hudelson 1994), supported by a Trans Center in Milan, which suggested other potentially interested individuals.

Concerning the role of the authors in preparing this paper: substantial contributions to the conception or design of the work, the acquisition, analysis, and interpretation of data was provided by the second

author (EF). The draft of the paper was done by the first author (JN), while the second (EF) revised it critically for the final version to be published.

Data collection

We used a particular form of semi-structured interview (Castiglioni and Faccio 2010), considered not just as a tool, but as an interactive process between interlocutors who co-construct a text in a given research field, and as a narrative practice (Holstein et al. 2012). We opted for episodic interviews (Flick, 2007) to focus on particular meanings and concrete episodes relating to psychological or psychiatric practice in gender transition, while leaving room for any other relevant issues to emerge in the dialogue. Interviews were mainly conducted in the practitioner's professional or clinical study or online via Skype. Interviews were audio recorded and transcribed in full. Participants were asked to complete an informed consent form immediately after being informed of the aims and methods of the study. An academic ethical committee approved the study.

Data analysis

Given the aims of the inquiry, we chose two main text analysis methods. The first was discourse analysis, which reveals not just the structures and contents but especially the complexity of texts and the processes that shape our versions of the world, actions and events, and our "mental" life (Potter 2003). The second was dialogic-performative analysis (Riessman, 2008), which also includes into the analysis the researcher in the interaction, the setting and the social circumstances of its production and interpretation to integrate the analysis of the narrative processes.

Two conceptual tools were chosen for the text analysis. Among the primary discursive elements, we opted to focus on interpretative repertoires, meaning the lexicon or set of metaphors used to define and assess actions and events that are generally available in a given cultural setting, and serve as frames for interpreting experiences (Potter and Wetherell 1987). Finally, among the narrative elements, we also analyzed participants' positioning. The positioning construct is a conceptual tool

used to explore how identity is constructed and negotiated in narratives and discourses between people. It can be defined as a process of attributing parts or fluid roles to speakers in the discursive construction of personal stories (Harrè and Van Langenhove 1999; Riessman 2008).

The main interpretative repertoires were identified by analyzing participants' use of metaphors and figures of speech, and also their way of speaking and rhetorical expressions relating to the objects of our analysis. Concerning participants' positioning, we focused on analyzing the identity movements they adopted in their narratives in relation to transgender clients. The interactive 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, were considered as well.

Results

For each one of the main themes considered by the episodic interview (the diagnosis, the practitioner's role and identity and the relationship in the clinical context) the main interpretative repertoires and identity positioning emerged are presented below.

1. **The diagnosis**

The process of diagnostic evaluation emerged from the interviews as an essential phase or process in the clinical work in the field of gender transition and it has been differently described by each mental health professional operating in different professional contexts. Such argument highlights non only the professional's operative modalities but also his epistemological and personal system of reference. The interpretative repertoires emerged are different and they might be linked by the meta-metaphor "Diagnosis as Personal Sufferance". In some cases, le discursive modalities used by the participants imply a causal relation or a correlation between the clinical entity and its implications, while in others, the clinical entity is intended as consequence of other factors.

"Loosening the skein"

Through this metaphoric expression the diagnosis is connected to the capacity of distinguishing between clinical conditions such as the depressive disorder (often associated by some participants), or of representing a specific clinical condition itself. In this case (as referred by three professionals) the diagnosis is considered as an "independent entity", not necessarily connected to other problems that may trigger the diagnosis, for those, on the contrary, the diagnosis must be "revised".

Diagnosis is useful to distinguish between the person's conditions and problems, as underlined in particular by psychiatrists in this research. In some cases, the diagnostic manual (especially the DSM) is not retained an instrument you can completely rely. The so called diagnosis is considered a specific entity, starting point for an evaluation that can be modified during the process, as highlighted by psychologists and psychotherapists in this research.

Interesting is the position of who sustain that the diagnosis can be made only at the end of the process itself.

"then loosening the skein means understanding whether we are actually talking about a gender identity disorder or other 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 great connections with the depressive aspect, but from where the path of suffering begins, I believe there is no doubt, in the disorder of identity and in the disorder of gender identity. If they are other triggers then the therapy brings them out and corrects the diagnosis as you go, the diagnosis is constantly reviewed and revised. […] You can formulate the diagnosis at the end and not at the beginning, at the beginning it's just a frame that guides you not to get too confused between one thing and the other". (N., psychotherapist in private context)

"quindi **sciogliere la matassa significa capire se effettivamente stiamo parlando di un disturbo dell'identità di genere o altro di cui il paziente non è consapevole** […] io direi che **è un'entità a se stante** ma come sempre succede con gli esseri umani che non sono a compartimenti stagni, questa ha piuttosto grandi connessioni con l'aspetto depressivo, **però da dove inizi il percorso di sofferenza credo che non ci siano dubbi, nel disturbo dell'identità e disturbo dell'identità di genere**. Se sono altri gli inneschi allora la terapia li fa emergere e correggi la diagnosi strada facendo, la

diagnosi è costantemente rivedibile e rivista. […] la diagnosi la puoi formulare alla fine e non all'inizio, all'inizio è solo una cornice che ti guida **per non confondersi troppo tra una cosa e l'altra**". (N., psychotherapist in private context)

"I do not consider it as a pathology, but the dysphoria is present"

According to this interpretative repertoire thai s shared by most of the participants, the trans person "condition", in the different linguistic expressions used to define it, is not considered as a mental disorder or a psychiatric pathology, but (it is often used the adversative conjunction that changes the meaning of the previous proposition) è strongly characterized by a "dysphoria", a "sufferance", a "discomfort" that requests clinical attention, a psychological path or support.

Different argumentations are brought to support the link between "dysphoria" and "sufferance" experienced by the person, as proposed in the DSM-5, for example is emphasized the presence of moments of depression, anxiety, suicide attempts, isolation and/or challenge to the others, considering them at the basis of gender dysphoria, rather than the contrary. This "fundamental sufferance" is named as dysphoria and is the axle from the request of change moves and then the contact with the psychological and medical staff.

"And then I don't consider it a pathology… But, you know, surely dysphoria is there, it's an expression of how to say some form of interlocking and suffering that doesn't work. And it's not just a question of diagnoses for doctors or to charge for insurance, because if you come to ask someone to be operated on, to medicalize your body, to alter, to intervene etc., then it means that something... You don't like it that way, but it's not good for you, not for me that is in the sense (smiles) […] I think pathology is a definition anyway that puts the cause inside the individual and… no. That no. Ehm… but… a suffering yes, in the sense (smiles) the idea of the catch comes to me for that". (V., psychotherapist in private context)

"**E allora non la considero una patologia… però, come dire, sicuramente la disforia c'è, è un'espressione di come dire qualche forma di incastro e di sofferenza che non funziona.** E non è solo una questione di diagnosi per i dottori o per far pagare l'assicurazione, perché se vieni a chiedere a qualcuno di essere operato, di medicalizzare il tuo corpo, di alterare, di intervenire eccetera **allora vuol dire che qualche cosa... Non ti va bene così, ma a te non va bene così,**

non a me cioè nel senso (sorride) […] **credo che patologia sia una definizione comunque che mette la causa dentro l'individuo e… no. Quello no. Ehm… però… una sofferenza sì, nel senso (sorride) l'idea della fregatura mi viene per quello**" (V., psychotherapist in private context)

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

The diagnosis of gender dysphoria is not accepted o taken for granted in its utility and validity in the relation with the psychopathology, but it is counted as an instrument that "serves" and that is "useful" and "necessary" to access to the different types of intervention for gender transition, discourse that is also brought in the meetings with trans clients. In this way, it seems to emerge an exception of bureaucratic necessity rather than or in adjunct to the supposed epistemological validity of the diagnosis.

"This is something that I always discuss with patients: the idea of the disease and about the fact that this diagnosis is needed to ensure also coverage by the national health system and that however the transition is important and make it accompanied, so I'm trying to build up the value of psychotherapy. […] some people totally reject this aspect of the diagnosis but that is I also refer a little to the element of reality, this is the situation here we have to stay in this, we try to make it as sensible as possible in short, no?" (T., psychotherapist in private context)

"è una cosa che tematizzo questa sempre con i pazienti rispetto all'idea della malattia e rispetto al fatto che **comunque questa diagnosi serve per garantire anche una copertura da parte del sistema sanitario nazionale** e che comunque la transizione è importante e farla accompagnati, la psicoterapia ha un valore enorme, quindi cerco di costruire il valore della psicoterapia. […] alcune persone rifiutano totalmente questo aspetto della diagnosi però cioè **io rimando anche un po' all'elemento di realtà, questa è la situazione qui dobbiamo stare in questa, cerchiamo di renderla il più sensata possibile insomma no?"** (T., psychotherapist in private context)

"Gender dysphoria as cultural illness"

Gender dysphoria is also meant as an illness that moves from the organization of the society in which we are insert, eminently binary, that therefore associates pathological meanings to gender non conformity. This kind of repertoires takes shape in accordance to theoretical perspectives related to

the transcultural psychotherapy (Nathan, 1996; Devereux, 1978), that recognize and valorize the diversity of ways in which different cultures attribute peculiar roles and status (sometimes very respected) to the protagonist of this condition. The shapes of gender variance are not intended as pathological in itself, but this very qualification would be the product of the perception and the attribution of diversity by the dominant society.

"T: […] I think it is not a mental illness and then we also talk about the related aspects, that is, the depressive aspects, the abuses, rather than the anxiety, as these are actually the symptoms caused by gender dysphoria. [we talk about] how gender dysphoria really is a cultural disease. In quotes.

interviewer.: in what sense a cultural illness?

T: in the sense that it is considered disease based on culture, what do I know among the American Indians the person with gender dysphoria before was a shaman, was quietly integrated into society because they spoke of the third spirit to say but even now, and so obviously the suffering that a person with gender dysphoria experiences is much less because he feels a context around him that recognizes him, that gives him a status that... you're okay with that, right?" (T., psychotherapist in private context)

"penso che non è una malattia mentale e poi si parla anche degli aspetti correlati, cioè degli aspetti depressivi, degli abusi, piuttosto che l'ansia, come queste siano in realtà i sintomi causati dalla disforia di genere. [parliamo di] **quanto in realtà la disforia di genere sia proprio una malattia culturale**. tra virgolette.

J.: in che senso una malattia culturale?

T.: eh nel senso che è considerata malattia in base alla cultura, che ne so tra gli indiani d'America la persona con disforia di genere prima faceva lo sciamano, veniva integrata tranquillamente nella società perché si parlava del terzo spirito per dire ma anche adesso, e quindi ovviamente la sofferenza che esperisce una persona con disforia di genere è molto minore perché sente un contesto intorno a sé che lo riconosce, che gli dà uno status che... ti va bene così no? […]". (T.)

The cultural illness is configured as a specific repertoire that highlights the role of the socio-cultural context in the creation and the maintenance of the diagnosis.

The practitioner's role and identity

In concern to the professional identity, the analysis underlines some personal and professional aspects about the practice of the role, enucleating a series of elements of tension and complexity in this field. The latent dimension along which the emergent positions might be placed, expands between the two semantic polarities of "objectivity" and "subjectivity". They are two extremis of a continuum often present into the discourses related to the process of construction of knowledge and methodologies, as well as into those related to the ordinary practices in the field of psychiatry and psychology. From one hand, the tendency is to position itself within the side of the professional who must maintain a role as neutral and objective as possible in front of the other and of the evaluation. In the other hand, it is possible to position itself within the side that includes and comprehend the own subjectivity in the work without deny it.

"the rigor must be tightened"

This kind of positioning is often associated with terms such as "rigor", "validity", "scientificity" and "objectivity". The aspect of subjectivity, interpreted as the expression of a judjement or a personal opinion, is considered as an obstacle and in contradiction to the necessary rigor for the clinical work, as well as for the psychiatric discipline related.

"How to say more you are righteous (smiles), it is not that when I transcribe to the judge... I cannot say it is my opinion (laughs). To me that the judge does not ask my opinion, but also in that case I have to explain to the judge in very simple words, it is very difficult that the judge ask your opinion or however you have to prove it is absolutely understandable... […] the rigor must be tightened". (D., psychiatrist in private context)

"Come dire più si è ligi (sorride), non è che quando io trascrivo al giudice... non posso dire è una mia opinione (ride). A me che il giudice non mi chiede una mia opinione, **ma anche in quel caso io devo spiegare al giudice in parole molto semplici, è molto difficile che il giudice chieda il tuo parere o comunque devi dimostrarlo è assolutamente comprensibile...** […] **il rigore dev'essere mooolto stretto** [...]" (D.)

"The tension between the gut and the clinical feeling…"

Through this metaphor (shared by 5 practicioners) the tension between two important positions is made explicit: one position would assume the client's point of view, accept and confirm the request of legal and right recognition, actively contributing in furnishing help and support to a legimitate request of selfdetermination and the other, that of the clinical practitioner, that would evaluate some kind of sufferance and evaluate carefully the implications of a gender transition path and its timing. This positioning permits, not only to shed a light on the attempt to separate between dimensions related to subjectivity and objectivity, but also the role played by emotional aspects in the clinical context.

"[...] instead in this thing here sometimes, I also feel so much of an internal tension between a part of me that is more activist, that therefore has in mind the trans subjectivity and rights and need of knowledge and that wants to be a support, in that direction there and the clinical part that is the part of me that is clinical and that has in mind how much people can hurt themselves sometimes, that is in the sense (laughs) that... and that so, how to say... They help each other, they stick together, but they also fight a lot, that is sometimes I feel a bit in the middle here (laughs) […] there is also a thing of belly that is in the sense, that then... there are some cases where you have the feeling, that of the belly takes over either one or the other". (V., psychotherapist in private context)

"[...] invece in questa cosa qui alle volte, **sento tanto anche una tensione interna tra una parte di me che è più attivista**, che quindi ha in mente la soggettività trans e diritti e bisogno di conoscimento e che vuole essere un supporto, in quella direzione lì **e la parte clinica cioè la parte di me che è clinica e che ha in mente quanto la gente si possa fare del male da sola certe volte, cioè nel senso (ride)** che... e che quindi, come dire... **Si aiutano a vicenda, si tengono insieme, però litigano anche tanto cioè delle volte mi sento un po' nel mezzo ecco (ride) […] c'è anche una cosa di pancia cioè nel senso, che poi... ci sono dei casi in cui hai la sensazione, cioè di pancia prende il sopravvento o l'uno o l'altro**". (V.)

"To work well, it is useful… to abandon all these theoretical references"

This kind of positioning is used in concern to the belief and the attempt to set aside our theretical reference, always partial and never exhaustive, in virtue of a "open-mindedness", a "non-judgement", and of "learning from the patient". Implicit for this positioning is the conception of the phenomenon

as complex, and in particular, of the transition or the so called “gender dysphoria” that is defined as “hardly categorizable” and “hardly generalizable”.

“perhaps the personal element, how to say, is useful paradoxically... how to say it is useful to deepen the theoretical part, then even if one is also inserted inside [a center or specialized association] there are always articles and things, etcetera... but then with a patient it is useful, in order to work well ehm, to abandon just all these theoretical references... because really, perhaps in this area more than perhaps in other areas, Um... I found a casuistry that’s actually a crazy diversity, right? […] so when you are there with the patient maybe more in this area it is useful to abandon the theories and get close to the patient [...]” (L., psychotherapist In private context)

“forse l'elemento personale, come dire, è utile paradossalmente... come dire è utile approfondire la parte teorica, poi anche infatti se uno è inserito anche all'interno [di un centro o associazione specializzata] ci sono sempre articoli e cose, eccetera... **però poi con un paziente è utile, per lavorare bene ehm, abbandonare proprio tutti questi riferimenti teorici**... perché veramente, forse in questo ambito più che magari in altri ambiti, ehm... ho trovato una casistica in realtà cioè di una diversità pazzesca no? **[...] quindi quando sei lì con il paziente forse più in questo ambito è utile abbandonare le teorie e avvicinarsi proprio al paziente** [...]” (L., psychotherapist In private context)

1.1 The non-binary gender dilemma

The main element of strain and complexity is situated by all practicioners into the delicate issue of non-binarism, so the difficulties related to the definition and the evaluation of this always more visible and present “reality” and of the forms of gender variance which do not fit in the traditional gender categories of man and woman. The positions connected to this theme can be placed along a continuum characterized by two semantic polarities: “from distancing to disrupting the diagnostic criteria”. The point of reference for the evaluation of this kind of narratives remains the diagnostic dimension so the current available criteria for the pracrticioner and for the field of gender transition: from one hand, the independence from this narrative from the medicalized gender transition and from the other hand, the calling into question the current diagnostic criteria.

“We can consider the non-binary condition… on a different level”

Non-binarism is associated to a “challenge” or a “provocation” in front of a gender binary system, still cornerstone of the western cultural system. In this way, people who define themselves as non-

binary, are dissociated from the language and the practice of the transition that are still today anchored to a binary ways for the recognition, trying to highlight perceived paradoxes or evaluation difficulties in front of the interlocutors' narratives.

"we have to get to... describe what you feel according to a language that is that of the transition path, so the definition of non-binary is on a different plane, it's an interpretation, an idea that you have of what it means... […] Challenge to, how to say, narcissistic a bit of constant provocation towards society, in the sense that if I am different, if I do not fall into the categories that suit you eee common mortals, then I make of my identity, the point of challenging, of being a living challenge of these categories that are so fictitious. [...] In the sense, and not binary we can leave... on another plane no? [...] (V., psychotherapist in private context)

"dobbiamo arrivare a... descrivere quello che provi secondo intanto un **linguaggio che è quello del percorso di transizione, quindi la definizione del non-binario è su un piano diverso, è un'interpretazione, un'idea che tu hai di cosa vuol dire ehm...** […] **Di sfida verso, come dire di, narcisista un po' di provocazione costante verso la società, nel senso che se io sono diverso, se io non rientro nelle categorie che vanno bene a voi eee comuni mortali, allora faccio della mia identità, il punto di sfidare, di essere una sfida vivente di queste categorie che sono così fittizie. [...] Nel senso, e il non binarismo lo possiamo lasciare... su un altro piano no?** [...] (V., psychotherapist in private context)

"The non-binary persons really unsettle everything"

Another positioning connects the practitioner to the non-binary people who are defined as people who unsettle everything. The dilemma that accompanies the read of these narratives and biographical self-definition includes the view on the cultural and social processes that take a toll the available diagnostic categories. To this narrative modality is linked the conception of a complexity that must be valorized in some ways and requests to question the own values and systems of meaning in order to comprehend the experiences of people in transition, non-binary or not.

"[...] And then if I had just the idea that diagnosis says this, the criteria are these now I find myself more and more with people of nonbinary gender, who define themselves so, who are putting me, are my current challenge, because they upset just everything, in the sense that they ask one thing but do not have the requirements of the dsm then they have others and... it's just that it's very complex, it's all very complex... this remains eh, the complexity always remains (laughs)". (T., psychotherapist in private context)

"[...] e poi se prima avevo appunto l'idea che la diagnosi dice questo, i criteri sono questi adesso **mi ritrovo sempre di più con persone di gender non binario, che si definiscono così, che mi stanno mettendo, sono la mia sfida attuale, perché sconvolgono proprio**

tutto, nel senso che chiedono una cosa ma non hanno i requisiti del dsm poi ne hanno altri e... è solo che **è molto complesso**, **è tutto molto complesso**... questo rimane eh, **la complessità rimane sempre (ride)".** (T., psychotherapist in private context)

2. The relationship in the clinical context

Another relevant semantic category emerging from the interviews is connected to the relationship that is co-constructed in the clinical context between the practitioner and the client. These repertoires are related to the meta-metaphor "the relationship between points of views": changing che point of observation (that of the practicioner or that of the trans person), there is the tendency to highlight the need to do not take for granted the person's rhetorical expressions or narratives or, the person's point of view and the peculiarities such as the concern for the avaluation.

"The throwaway psychotherapist"

This kind of repertoires is associated to the discursive configuration related to the urgency and the hurry with which the person often expresses the personal request to the practitioner, that is some times perceived by them as related to the phenomenon of change and substitution of the psychotherapist. Some practitioners embrace the implicit or explicit theory for which the change of the therapist would be instrumental to obtain personal objectives in short time. This kind of modality is also defined in one interview as "doctor shopping", that is the research for a therapist who can confirm and satisfy the people in transition's requests.

"there are people who come here also very determined, but then it turns out that that is not their intention and this may be a critical aspect erm, the other is that... can be use the psychotherapist for the double need to have a whole series of documents and so there's a little bit the use of the psychotherapist disposable, when I have a little bit everything is finished our work... and then it becomes difficult to pass the message to the patient that there is the need to work for a little longer duration because even from the hospital, by the doctor is said that even the psychologist is useful at this stage, this may be a critical aspect..." (L., psychotherapist in private context)

"ci sono persone che vengono qui anche molto determinate, ma poi si scopre che non è quella la loro intenzione e questo può essere un aspetto critico ehm, l'altro è che... può essere utilizzare lo psicoterapeuta per la doppia necessità di avere tutta una serie di documenti e quindi c'è un po' l'utilizzo dello psicoterapeuta usa e getta, quando ho un po' tutte le cose è finito il nostro lavoro... e quindi li diventa

difficile far passare il messaggio al paziente che c'è la necessità di lavorare per una durata un po' più ampia perché anche dall'ospedale, dal medico viene detto che anche lo psicologo è utile in questa fase, questo può essere un aspetto critico..." (L.)

"The person brings the criteria he/she knows he/she must bring"

Another repertoire connected to the relationship and its possible critical aspects is related to the defined "ready-made answers" or "scripts" by mental health professionals. The interpretative repertoire is represented by the phrase: the person in transition brings the criteria he/she knows he/she must bring. This to obtain the personal scope, that is to start the medicalized path through the certification of a pathological condition.

"we can say that my feeling is that this is a field where as the person presents himself, usually bringing the criteria that he knows he has to bring (smiles) is so then because the scope is very spoiled by the fact that he joins a medical-dimensionlegal and a clinical dimension, the two things go very together, there is a request and it is known that the people who are considering can facilitate or not, um, the interventions. In fact, what is often sought is to move as far as possible from the mechanical repetition of what are the criteria, trying to understand a little bit how the person works in the widest sense and then understand in short if there was a deep reflection on what is the between quotation marks the symptom that is carried or vice versa is the result of impulsivity or product of something else. ehm... the impression is that we need to make a lot of eye […]" (A., psychiatrist in public context)

diciamo che la mia sensazione è che questo è un campo dove siccome la persona si auto presenta, solitamente portando i criteri che sa che deve portare (sorride) è così poi perché l'ambito è molto viziato dal fatto che si unisce una dimensione medico-legale e una dimensione clinica, le due cose vanno molto assieme, c'è una richiesta e si sa che le persone che stanno valutando possono facilitare o meno ehm, gli interventi. di fatti quello che spesso si cerca di fare è spostarsi il più possibile dalla ripetizione meccanica di quelli che sono i criteri, cercando di capire un po' come funziona la persona nel senso più ampio e quindi capire insomma se c'è stato una riflessione profonda su quello che è il tra virgolette il sintomo che viene portato o se viceversa è frutto di impulsività o frutto di qualcosa di altro. ehm... l'impressione è che bisogna farci molto l'occhio [...]". (A.)

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

A different kind of repertoire implies a dislocation from the practitioner's point of view which includes that of the trans person. In this way, also the "ready-made answers" or other ways to approach or narrate, are related to people' expectations, intentions or scopes. Among them, we can find those related to the fear of being hinder or negatively judged in the path.

"[...] At the base [people] are afraid not to be believed. And so at the beginning they are rather reluctant to speak, very often as adults tend to tell preconceived stories because they start from the assumption that the psychologist might hinder them in their transition path, in their idea. usually in fact the first 4 meetings are the most difficult [...]" (O., psychotherapist in public context)

"[...] **alla base i ragazzi hanno paura di non essere creduti.** e quindi all'inizio sono piuttosto restii a parlare, molto spesso come gli adulti **tendono a raccontare storie preconfezionate perché partono dal presupposto che lo psicologo potrebbe ostacolarli nel loro percorso di transizione, nella loro idea.** di solito infatti i primi 4 incontri sono i più difficili [...]" (O.)

The exercised power by the mental health professional is considered critical: "it is a power that must be managed carefully". It is associated to this narrative modality, in some cases, the awareness and the reflection about the decisional and pragmatic effects by the own role and its potential implications.

Discussion

According to these results gender transition is defined in different ways, but from all the participants it is considered a complex experience. In most cases, practitioners refer to the contents of the guidelines (APA, WPATH and/or ONIG) in concern to the scopes of the path, that are the support and the affirmation for the client's choice and request (Korell and Lorah, 2007). The explicit reference to guidelines is especially frequent for those who work in the public institution and in the specialized center for gender dysphoria. In general terms, it can be said that where in the work (and also the diagnostic process) uncertainties could emerge, the tendency is to refer most of all to the supervision with other colleagues, so to the guidelines and the institutional references that orient the clinical practice.

Concerning the central theme of this inquiry, that is the diagnostic process, we can notice from the interviews that the diagnosis is generally not questioned in its validity or guide function but varied are the ways to interpret and use it, along with the corresponding evaluation procedure. The first main difference emerged, concerns the value attributed to the use of the category and the diagnosis process, retained necessary and fundamental from psychiatrists, while for the other mental health professionals it is considered a contribute to orient the path ant that could be set aside once the relationship is well-established.

From the professionals' narratives the question about the relation between pathology and normality emerges; the answer is usually placed in the middle and it is explicated through the dimensions of the sufferance and the personal discomfort such as to justify "gender dysphoria" as a clinical problem.

Some of the principal critical aspects underlined from the literature revision on the diagnosis (first part of the article) are recognizable into the professionals' narratives: the questioning of the diagnosis as an instrument that contributes to develop processes of medicalization and pathologization of experiences, the stigma that may accompany the diagnosed persons and the difficulty to situate the diagnosis into the diagnostic manuals.

Diagnosis is not just configured as a theoretical and operative tool, but it represents a concept and operative practice consistent with the systems of beliefs, values and socio-cultural and historical references to which also the practitioner appeals (Salvini, 2009; Gergen, 2009).

For what concern the identity and the mental health professional role, it can be found how objectivity and subjectivity are situated in a complex relationship: the objective e neutral attitude is often pursued into the clinical context, while the subjectivity, mainly intended as a personal judged is feared and moved away or kept under control. Especially in the psychiatric practice the expert position favors objectivity and neutrality for the own work, refusing what it can be connected the own subjectivity while recognizing its existence. For the psychological field this appears less relevant, where the awareness and the utility of the inevitable subjectivity is highlighted. In this case, we can underlined that despite the ambition for a neutral and objective approach, there is always a point of observation from where we read the phenomena and that contributes to confer them meaning (Maturana and Varela, 1970), so to construct them, as it has been underlined by some interviewers highlighting the role of the clinician to reach a diagnosis.

Regarding the theme of the role construction, some notable dilemmas emerged converging into the phenomenon of "non-binary gender". This issue, most of all, consents to highlight the idiosyncratic, social and cultural construction of the gender and body related phenomena. Such as experiences, also defined as "gender nonconforming" or "gender variance" in order to underline the concept of gender

as a continuum and not just a construction by the two categories of woman and man and the distancing from the binary classification forms are indeed already contemplated into the recent guidelines. Starting from the interviews, it has emerged how these experiences in the clinical context are retained critical, in particular for the fact that they seem exceed the diagnostic criteria and that the latter result inadequate for the evaluation.

The results permit di advance some reflections about the possible implications for the clinical practice. The first regards the potential that the diagnostic categorization could reduce the possibilities of self-description, not just for the person to which the diagnosis is referred but also for the mental health professional. If it is true that diagnosis can be used for "loosening the skein" and clarify the situation, it brings the risk to be used as unique criterion and lens for observation avoiding space for other narrative elements and meanings. In this sense, furthermore, the extent and the implications of a binary system of knowledge still eradicated in our cultural context, produces more complexity into the already uncertain process of classification and definition of the psycho-social phenomena.

The related themes of urgency and ready-made answers from the client's point of view, are described as problematic aspects in the relationship, attributing this to the fact that the center of gravity of the path seems shifted on the professional's evaluative scopes rather than on those of the trans person.

There is awareness among the interviewers around the fact that the tarns person in transition may fear the evaluation and may express diffidence towards the role of the mental health practitioner: the strategy to put in place predefined discourses, or the explicit critique, might be the precipitation, pain the possibility to let emerge or share personal and different exigencies and meanings. The risk is that the practitioner is perceived and act as the expert to which one should adapt, serving the hierarchical relationship (Iudici and De Aloe, 2007; Foucault, 1963). From the other hand, for the professional the assumption of a role of the expert may take over, pain the difficulty to contribute to the creation a space with shared objectives and specific person's exigencies, despite the temptation to promote health and to accompany the person along the path and the possible changes in life.

Conclusions

The research results consent the individuation of some operative and pragmatic proposals, qith particular attention to the clinical context and the professionalities that exercise into it:

1) Starting from the assumption that clinical and therapeutic pathways can be considered as interactive and relational processes, historically and culturally situated, within which meanings, symbols and descriptions of self are co-constructed, in front of shared goals (McNamee and Gergen, 1992), it is legitimate to emphasize the importance of the ways of co-construction of reality, which guarantee the sense of experience and which should not never be shifted on one of the interlocutors. Relevant is the exercise of reflexivity by the practitioner, crucial in order to help create the conditions for a shared pathway starting from the research of the person in transition's exigencies (Mizock e Lundquist, 2016; Gergen, 2009). This may, however, limit some of the critical issues raised from the interviews with regard to the pre-defined responses or the professional *gatekeeping* function, or the difficulty of putting in place other relevant biographical elements in the attempt to adhere to the psychologist/a or psychiatrist's knowledge and categories, considered as the most useful choice at that particular moment.

2) Given the uncertainties that can accompany the diagnostic process and the impossibility of relying on an objective approach (Wakefield and First, 2003; Whooley, 2010), it is important to stress the opportunity of focusing not so much on the hypothetical ontological properties of the phenomenon of gender variance or gender dysphoria but on complexity, the particularity and contextuality of each experience and biography.

The understanding of personal history implies the willingness to formulate a path adapted to the peculiarities of the individual (Brown, Kucharska, & Marczak, 2018; Anzani et al., 2019). In it the phase of "evaluation" may represent an important step in order to collect elements about the person, however, it cannot bind to itself the construction of the relationship and the evolution of it. Once the

hierarchical relationship between the practitioner and the person in transition has been established, there is in fact the risk that it will remain so even after the assessment phase.

In this regard, meetings, training or collaborations between professionals and operators of the centers and trans associations could be particularly productive even in the specificity of roles and functions. Such an action would allow the collection and analysis of other narratives and meanings related to trans experience for how they are produced within contexts unrelated to the logic of the diagnostic imperative, laying the foundations for a rigorous adaptation of clinical practice to the socio-cultural and meaningful changes that accompany the concept of gender (Hansmann, 2008; Israel e Tarver; 2003; Lev, 2004).

3) These tracks could help to promote a new image of the mental health professional dealing with gender transition, able to express, both in the two-way relationship and at the social level, a function other than the classification and decision objectives typical of the medicalization process (Bryant, 2011). A promoter of change and recognition of the desired identity, able to confer on the other the role of expert of his own history and biography, and able to accept with confidence the value of their professional and personal responsibility (McNamee, 2018).