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ORIGINAL ARTICLE

A qualitative study on minority stress subjectively experienced by transgender and gender nonconforming people in Italy☆

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Summary A great amount of quantitative research has largely demonstrated that transgender and gender nonconforming (TGNC) people experience high rates of minority stress, against which they are able to exercise resilience and to use adaptive strategies buffering the negative effects of stress on health. Notwithstanding, qualitative investigations on how TGNC people subjectively experience minority stress are still scarce. This study aims at exploring the subjective experiences of minority stress through a focus group with 8 Italian TGNC individuals (5 male-to-female, 2 female-to-male, and 1 genderqueer; M = 25; SD = 5). Narratives were analyzed through the deductive thematic analysis. The analysis generated four main categories: (1) family rejection; (2) visibility of the body; (3) negative effects of family violence on health; and (4) integration of TGNC identity. Results offer an in-depth exploration of minority stress processes in TGNC people, as well as the impact of stress on health and adaptive strategies to face with stigma. Suggestions for clinical practice are discussed.
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Introduction

Transgender and gender nonconforming (TGNC) people are those whose gender identity is not fully congruent with the sex assigned at birth. TGNC people live systematic violence and oppression throughout their lives due to their gender nonconformity (e.g., Bradford et al., 2013, Lombardi, 2009), being at risk of developing negative health outcomes, such as anxiety, depression, and suicide ideation or attempts (Bockting et al., 2013, Bradford et al., 2013). From this perspective, researchers are increasingly focused on understanding psychological and social processes, which lead social stigma to affect mental health of TGNC people (Amodeo et al., 2015, Scandurra et al., 2017a). One of the theoretical frameworks aimed at exploring the negative impact of stigmatizing events on mental health of minority groups is the minority stress theory (MST; Hendricks and Testa, 2012, Meyer, 2007).

The MST assumes that minority people experience stress due to persistent social stigmatization. Within the context of the individual environmental circumstances, Meyer (2007) conceptualized both distal and proximal stress processes. Distal processes are objective stressors independent of the individual, while proximal stressors are dependent on the individual because they are linked to one's own feelings, thoughts, and actions. Both processes are located on an environmental continuum, in which different stressors act. From distal to proximal processes, the stressors are:

- stressful objective and chronic events and conditions (prejudice events, such as interpersonal violence, employment discrimination, or problems in accessing to healthcare setting);
- expectations that these events will happen and subsequent surveillance (perceived stigma), and;
- internalization of negative societal attitudes (internalized stigma).

In addition to stressors, the MST also highlights the role of protective factors in buffering the effects of minority stress on mental health, such as social connectedness, resilience, or group cohesion (e.g., Detrie and Lease, 2007, Frost, 2011, Scandurra et al., 2017d). Thus, stress, resilience, and coping strategies interact and predict the development of mental health problems.

MST was originally applied to lesbian, gay, and bisexual people, and only recently has been theoretically and empirically applied to TGNC people (Bockting et al., 2013, Hendricks and Testa, 2012, Testa et al., 2015). It is noteworthy that qualitative investigations on how TGNC people subjectively experience minority stress are still scarce especially within the Italian context. Thus, through the lens of the MST, a qualitative research was carried out to explore narratives of a group of Italian TGNC people participating in a focus group. Before reporting results, a brief theoretical introduction to the TGNC experience of minority stress will be provided, as well as a brief overview of the Italian context within which TGNC population live.

Minority stress in TGNC people

Regarding the most distal stressors, the prejudice events, evidence indicates that TGNC people experience high levels of violence and discrimination. To this end, Lombardi et al. (2011), in a population of 402 TGNC people, reported that 59.9% of the sample suffered from violence and abuse, and that 37.1% suffered from economic discrimination; overall, 47% were assaulted in some way during their life-time. Again, Bradford et al. (2013), in a sample of 350 TGNC people, reported that 41% suffered from transgender-related discrimination and that the most associated factors were geographic context, being female-to-male (FtM), belongingness to an ethnic minority group, low socioeconomic status, younger age at first transgender awareness, lack of health insurance, history of abuse, substance use, and low levels of community connectedness and family support.

Previous research reported that psychological problems were caused by stressful experiences suffered by TGNC people. For instance, Lombardi (2009), in a sample of 90 TGNC people, reported that transphobic events were associated with depression and anxiety. Bockting et al. (2013), in a sample of 1.093 TGNC individuals, reported that social stigma was associated with depression, anxiety, and somatization. Shipherd et al. (2011), in a sample of 97 male-to-female (MtF) TGNC people, reported that 98% suffered from at least one traumatic event, and that 91% suffered from multiple traumatic events; among them, 17.8% reported post-traumatic stress disorder symptoms, while 64% reported depressive symptoms.

Compared to distal stressors, less research has been aimed at assessing the impact of proximal stressors on TGNC health. To this end, as regards the perceived stigma, Beemyn and Rankin (2011) reported that more than half of their sample ($n = 3.474$) declared that they hid their gender identity to avoid intimidation. Similarly, Testa et al. (2012) stated that TGNC people do not report violence to the police and do not have access to medical and mental health services due to the fear of being victimized again. Instead, the most proximal stressor, that is internalized transphobia, can be defined as a discomfort with one's own TGNC identity due to the internalization of societal negative gender expectations (Bockting, 2015). Perez-Brumer et al. (2015) reported that internalized transphobia increased the likelihood of attempting suicide, while Scandurra et al. (2017b) found a positive association between internalized transphobia and both anxiety and suicide ideation. Furthermore, in a recent study by Scandurra et al. (2018a), it was found that internalized transphobia mediated the relationship between prejudice events and negative mental health outcomes, and that this relationship was positively buffered by high levels of resilience.

As regards the latter point, within the MST, there is evidence that TGNC individuals use adaptive strategies to buffer the effects of both distal and proximal stressors on health (Pflum et al., 2015, Singh et al., 2011, 2014, Testa et al., 2014). For instance, Singh et al. (2014) found that community connectedness and social support can reduce the levels of internalized transphobia, and Pflum et al. (2015) found that social support ameliorates the negative distress caused by prejudice events.

Data presented in this paragraph show that MST is a useful framework to understand psycho-social processes leading social stigma to affect TGNC mental health. Recent evidence demonstrated that the MST is a suitable framework to understand how social stigma affects health in Italian TGNC people (e.g., Amodeo et al., 2018b, Scandurra et al., 2017e).

The Italian context for TGNC people

The Italian context is not highly supportive for TGNC population (e.g., Cussino et al., 2017). For instance, Italy has only recently established, thanks to a sentence of the Court of Appeals promulgate in 2015, that the gender reassignment surgery must not be considered a prerequisite for modifying one's own legal gender status, thus removing the previous mandatory sterilization. Moreover, Italy has not yet promulgated an anti-discrimination policy to protect TGNC people from social stigma and hate crimes. To this end, a European study by Turner et al. (2009) aimed at mapping hate crimes in Europe, in a sample of 2.669 TGNC people, found that Italian TGNC individuals experienced the highest percentage (51%) of transphobic verbal comments. In the same vein, in a study analyzing the causes of transphobic murders in Europe between 2008 and 2013, Italy was classified as the European country with the second highest rate of transphobic hate crimes, after Turkey (Prunas et al., 2014).

The few studies that have assessed the effect of minority stress on the health of Italian TGNC people seem to confirm that such a population is at a risk of experiencing stigmatizing episodes which, in turn, can affect mental health (e.g., Amodeo et al., 2015, 2018b, Scandurra et al., 2017d, 2017e). Indeed, Scandurra et al. (2017a), in a sample of almost 150 Italian adult TGNC people, found that both distal (i.e., anti-transgender discrimination) and proximal (i.e., internalized transphobia) stressors were associated with depression, anxiety, and suicide ideation. Furthermore, in their study, Scandurra et al. (2017a) found that support from family and resilience were able to buffer the negative effect of stressors on health. On the other hand, negative health outcomes have been found also in a sample of TGNC adolescents (Fisher et al., 2017).

As specifically regards resilience, a study by Amodeo et al. (2018b) aimed at assessing the efficacy of an empowerment-based group training program in increasing resilience levels in a small group of Italian TGNC youths, highlighted that resilience is a fundamental coping strategy to face with stigmatizing episodes. Summarizing their results, Amodeo et al. (2018b) defined resilience in TGNC individuals as ''the ability to define one's own gender identity and to generate the subjective sense of having a specific gender identity, thus self-recognizing and accepting one's own trans identity'' (p. 13).

Notwithstanding these findings, to our knowledge no previous studies have qualitatively investigated how Italian TGNC individuals subjectively experience minority stress and how they cope with it.

The current study

The current study aims at qualitatively exploring how minority stress is subjectively experienced in a small group of Italian TGNC individuals participating in a focus group. Given the literature on stigma and coping in TGNC people and informed by the MST, the main questions which guided this study were:

- How do TGNC individuals subjectively experience social stigma towards them?
- What impact does the social stigma have on TGNC individuals' health?
- How do TGNC individuals cope with societal stigma?

Table 1 Socio-demographic characteristics of participants ($n = 8$).

Pseudonym	Age	Gender identification	Sexual orientation	GAF[a]
Denise	30	MtF	Straight	Yes
Christine	21	Genderqueer	Queer	No
Rachel	28	MtF	Straight	Yes
Sophie	25	MtF	Straight	No
Philip	22	FtM	Straight	No
Carl	26	FtM	Straight	No
Allison	20	MtF	Straight	No
Angela	28	MtF	Lesbian	No

[a] GAF: Gender affirmation surgery; MtF: female-to-female; FtM: female-to-male.

Method

Participants and procedures

The present study involved 8 Italian TGNC participants, born and living in Naples, a city of Southern Italy. Considering the gender identification, 7 of them self-identified as transgender, specifically 5 MtF and 2 FtM. Only 1 self-identified as genderqueer and was female-assigned-at-birth. As regards the gender affirmation surgery, only 2 participants underwent genital surgery, while all of them, with the exception of the genderqueer participant, were taking hormones. Participants aged from 20 to 30 years old ($M = 25$; $SD = 5$). Finally, as for sexual orientation, 6 self-identified as heterosexual, 1 as lesbian and 1 as queer. Socio-demographic characteristics of participants described above are reported for clarity in Table 1. In order to protect the identities of participants, pseudonyms are used throughout the manuscript.

Participants were recruited through the involvement of personal contacts of the fourth author of the current work, who is well known within the local TGNC community for his long experience in the advocacy for TGNC rights. Thus, through a snowball sampling procedure, potential participants were sent a presentation letter of the study, in which objectives and methods were described in detail. In the letter, inclusion criteria to take part in the focus group were also reported, that were:

- self-identifying as a TGNC person;
- being aged between 20 and 30 years;
- being born and living in Naples.

Before being included in the group, participants who voluntarily decided to take part in the study were invited to

a meeting for the presentation of the study. The meeting was conducted by the second and fourth authors of the current work. In that occasion, a preliminary screening to exclude severe psychiatric disorders was performed with the participants' informed consent. Following the methods adopted by Amodeo et al. (2018b) in a study aimed at assessing the efficacy of a group training program in increasing resilience levels in TGNC youths, the current screening contained questions about perceived well-being (e.g., ''All things considered, how satisfied are you with your life as a whole nowadays?''), symptoms of depression (e.g., ''Have you ever had a spell of feeling down or depressed?''), and suicidal thoughts (e.g., ''Have you ever seriously thought of ending your own life?''). All participants attending the meeting were recruited, as the screening showed no severe psychiatric disorders.

The focus group was not conducted by the same authors who managed the initial meeting, in particular because they were well known to some of the participants. Thus, to avoid potential interferences on the research process (e.g., influence of the previous knowledge on answers, social desirability, etc.), the focus group was conducted by the first author of the current work who did not know any participants and had a certified experience in TGNC issues and in conducting focus groups. During the focus group, all participants were informed again about the aims of the study and the researcher presented himself as both psychologist and expert in research on TGNC issues. In the informed consent, the importance of answering honestly, the non-existence of right answers, the right for each participant to leave the group at any time, and the anonymization of the participants' identity in case of scientific publication were stressed. All participants gave consent to report their narratives in a scientific manuscript.

All data were collected in accordance of the General Data Protection Regulation 679/2016 and the study was designed to respect all principles of the Declaration of Helsinki on Ethical Principles for Medical Research Involving Human Subjects. Collected data were stored in a database accessible only to the principal investigator, the first author of the current article, who masked participants' identities through pseudonyms before sharing data with other researchers.

Focus group

One semi-structured focus group lasting two hours was conducted by the first author of the current work, as expert in group conduction and TGNC research issues. It was audio-recorded with the informed consent of participants and transcribed verbatim. The focus group was conducted so that all participants had the opportunity to express their thoughts. As we were interested in exploring social stigma processes towards one's own TGNC identity and coping mechanisms used to face with it — i.e., dimensions occurring within collective and social systems (Brown, 2010, Scandurra et al., 2017c) — focus group was considered more suitable than individual interviews. Indeed, as suggested by Hughes and DuMont (2002), contrary to in-depth interviews, focus groups specifically provide insights about both psychological and social processes that occur in specific cultural groups, shedding light on their social realities.

In this study, informed by the MST, the focus group included 4 semi-structured questions, as follows:

- distal stressors (''What kind of stressors, such as discrimination, violence, abuse, did you experience in your life due to your gender nonconformity?'');
- proximal stressors (''How do you think these experiences influenced the perception you have of yourself as a TGNC person?'');
- effect of stressors on health (''What effect do you feel that these experiences have had on your well-being as a TGNC person?) and;
- coping strategies (''How did you cope with these experiences?'').

Questions were the product of a reflexive comparison between all researchers involved in the study. Beyond the semi-structured questions, we had to ask other questions for different reasons, such as to bring out latent discourses, to guarantee the same participation to all participants, or to obtain more and detailed information about a specific discourse.

Data analysis

As we were interested in qualitatively exploring the effect of social stigma on TGNC participants' health and coping strategies using a clear theoretical framework, i.e. MST, data were analyzed through a deductive thematic analysis, that helps the interpretation of identifiable themes and patterns of behavior (Braun and Clarke, 2006). According to Braun and Clarke (2006), the analysis of the focus group transcripts consisted of five main stages, each of them performed by two independent raters (the first and the last authors of this work) to guarantee validity. They discussed to find agreement on divergences and differences in each stage.

In the first stage, an initial detailed reading of the materials served to familiarize with data. In this stage, researchers took notes about their initial thoughts and highlighted concepts or phrases considered as significant or interesting on the basis of MST. In the second stage, the transcript was re-read several times so that it was possible to generate initial codes, that serve to identify a feature of the data. In the third stage, initial codes were transformed into potential themes. Thus, different codes were combined to create an overarching theme. In the fourth stage, themes were refined and evaluated on the basis of their internal homogeneity (i.e., the data collated within each theme adhere together in a meaningful way) and external heterogeneity (i.e., there are clear and identifiable differences across individual themes). In the fifth stage, themes were clustered into categories to which a name was attributed. Subthemes were also identified.

Results

The deductive thematic analysis allowed to cluster themes identified into 4 main categories, as reported in Table 2. The results are presented with extracts from the dataset to support each category.

Table 2 Themes and related subthemes identified through the deductive thematic analysis.

Theme	Subthemes
1. Family rejection	a. Family rejection and pain b. Family rejection and genderism
2. Visibility of the body	a. Persecutory body b. Body and intimacy
3. Negative effects of family violence on health	a. Violence and sexual health b. Violence and depressive symptoms
4. Integration of TGNC identity	a. Pride b. Community connectedness

Family rejection

Most of participants told different stigmatizing episodes (e.g., verbal or physical abuse, difficulty in finding a job, etc.), that were experienced in diverse contexts (e.g., school, workplace, healthcare systems, etc.). Notwithstanding, in rethinking about them, all participants agreed that the most significant stigmatizing episodes were those experienced within the family of origin, in particular when they were children. For example, Denise (30 yo, MtF), had this to say:

> I was violated as a child every time I was forced to do something. I didn't like it but I had to behave as boy. I felt abused. I was born transgender and it was terrible. I loved to have long nails, but my terrible neighbor told my mother ''Why these long nails? He's not a girl, he's a boy!''. And my mother violently hit me to educate me. I gave the Barbie doll to my sister, but just because I could have used it in secret. So, I missed the chance to play with other children. I felt a sense of loneliness, emptiness and sadness. I lacked a piece and this piece is still lacking! I suffered from every kind of violence. I suffered from harassment. I suffered from everything. I could live my life only in my fantasy. The dolls were in my mind, I was female in my mind, everything was in my mind and only in my loneliness.

This is a clear statement about the first subtheme, or rather the pain TGCN individuals may live if the family of origin is rejecting towards their own gender nonconformity (e.g., Koken et al., 2009). The impossibility for gender nonconforming children to share their thoughts and feelings about the gender nonconformity itself, or their needs to be recognized as a gender nonconforming child, might create, as in the case of Denise, a great sense of loneliness (Bochicchio et al., 2019), leading the child to feel to be free of expressing his/herself only in the mental world.

A second subtheme identified in the dataset is the action of genderism within family. Genderism is an ideology that perpetuates the negative evaluation of people who do not identify as cisgender; such an ideology leads to believe that nonbinary people are anomalies (Hill, 2003). To this end, Rachel (28 yo, MtF) stated:

> My mother didn't allow me to wear skirts before undergoing surgery, because people would have thought that I had something dangling under my skirt and it was frustrating for her. I wore a skirt for the first time a couple of years ago. I had started to think that my problem was my legs.

This statement sheds light on the shame that a parent may feel if a son or a daughter does not match the social binary gender expectations. The last sentence (i.e., ''I had started to think that my problem was my legs'') shows that feelings of shame coming from a genderist belief might be internalized. Furthermore, the social pressure coming from genderism seems to lead to perceive surgery as a solution which enables TGNC individuals to conform to the binary view of gender, preventing a more subjective self-identification development which, as known (e.g., Vitelli et al., 2017), might be very diverse and often unhook from the genital surgery. As a further evidence of this ''social cage,'' it is interesting how Allison (20 yo, MtF) answered to the Rachel's narrative:

> Beyond the personal distress, you have to add the distress lived in your family. It's very heavy, or better extremely heavy. This totally impacts your behaviors, attitudes... this makes your life a hell, a cage!

Visibility of the body

In talking about proximal stressors (i.e., perceived stigma and internalized transphobia), narratives of participants were organized around the role of their body. As suggested by Vitelli (2014, 2015, 2017, 2018), the body represents the symbolic and material place where the TGNC identity expresses itself to others. Indeed, most TGNC people need to change their body in order to adapt it to the image they have of themselves. The body-image of TGNC individuals represents the interface between subjective internal identifications and social norms related to femininity or masculinity, and this makes the look of the Other very significant for TGNC people. Nevertheless, if, on the one hand, the other's gaze is important for the identity stabilizing process, on the other hand, the other is established as a constant source of threat. As Sophie (25 yo, MtF) had to say:

> Society tends to idealize. Thus, if you are a real man or a real woman, it will be more welcoming just because your body gives you the shape society wants. That's the reason why a transgender person who does not match this binary conception of bodies is constantly targeted. Continuous, inquisitive looks! I everyday live inquisition on my skin.

This statement clearly shows that one's own body might become persecutory for some TGNC individuals who feel themselves constantly looked by others. This might have a heavy price in psychological terms, as it can cause shame and self-hatred if internalized, or rather internalized transphobia (e.g., Bockting, 2015, Scandurra et al., 2018a). The discomfort that the internalization of societal normative gender expectations, in other terms the internalization of the look of the Other, is well shown by Carl (26 yo, FtM) in his narrative:

> I love soccer and I've always had the season ticket. Now, on my card it's written C. [female name], but my picture shows a boy with bear. I also saved 40 Euros on the subscription for women reduction. I knew that I would have changed my IDs at the end of the championship and I asked to pay the whole price, the one for men. They didn't allow me because I had to respect the law. I had many problems to have access twice. The first time, after some talk, I managed entering. The second time, instead, I suffered so much. I had the same problem. They didn't let me in. People in the queue kept on looking at me. Full of anger I screamed: ''If you want a prove, put your hand in my slip!''. So, he told me to wait and went away, going on looking at me. I screamed again ''Have I to take off my pants? Don't you have enough?''. These people take off your clothes with their eyes. You cannot have an idea of the violence I saw in those eyes. Those eyes kill you because they make you ashamed of yourself. I hated myself and my identity in that moment.

A related subtheme identified in the dataset is the relationship between the body and intimacy. Being the body visible, most TGNC individuals are immediately recognizable as TGNC and this may cause stress and discomfort (Radix et al., 2017). Indeed, visible TGNC individuals experience higher rates of discrimination compared to those who pass for cisgender person (Grant et al., 2010, Reisner et al., 2015). Even when TGNC individuals are not immediately visible because they pass for cisgender person, they may avoid overt discrimination, but may experience high levels of anxiety due to the fear of disclosure (Sevelius, 2013, Vitelli, 2017). A significant statement about the relationship between body and intimacy was by Angela (28 yo, MtF):

> I can't have an intimacy about my life. I can't have a space and a time to decide to whom and when reveal my identity. I simply must to disclose it to everybody, differently from a gay male who can have his time and choose to disclose himself to a parent first, to a brother later, and so on. A transgender person has not this possibility, because she/he has to face with somatic changes. Body is central, fundamental and visible. It steals your intimacy. I would have liked to make a peaceful path, in harmony with my time. But it hasn't been possible, because body doesn't leave you privacy.

Negative effects of family violence on health

This theme was connected, but differentiated, to the first one (i.e., ''family rejection''). Indeed, in asking about the effects of stressors on health, all participants answered thinking about their most significant stigmatizing episodes, that were those experiencing within their family of origin. The first subtheme identified was the negative effect of family violence on sexual health. Many participants asserted that the family rejection affected how they experience their body in sexual relationships. The effect of such violence on sexual health is well shown by Rachel (28 yo, MtF) in her narrative:

> Just 3 years ago I felt proud of showing my body on the beach and I published on Facebook some pictures of me. I wondered where the need to hide my body from men comes from. Today, I answer that it comes from the abuse I suffered from when I was a child, when I was forced by my parents to play karate because it would have made me more masculine... I saw all those dicks in the locker room... I saw dicks everywhere and for me it was a violence. That's the reason why I've many difficulties in being even touched by a man. I could have sex for the first time only 3 years ago. For me, having sexual intercourse was terrible. Male hands on my body were an abuse for me.

This statement clearly shows that rejecting one's own gender nonconformity may have detrimental effect on health and well-being. Notwithstanding that, as reported in previous research (e.g., Amodeo et al., 2018a, Scandurra et al., 2019a, 2018a) prejudice events have a negative effect on health through the action of proximal stressors, such as internalized stigma. It seemed to us that the narrative reported above clearly illustrate such a mediation mechanism, as family violence negatively affected sexual health through the action of body shame, that is associated with internalized stigma (Greene and Britton, 2012, Wiseman and Moradi, 2010) and that seems to be caused by violence.

A second subtheme was identified in the development of depressive symptoms as a result of the family rejection, as well explained by Philip (22 yo, FtM).

My father always told me

> ''you are not a boy, you are a girl and you must behave like that''. I loved male games, like football, robots, and so on. My father did not allow me to play with these games and I did not understand why. I simply liked them. So, for years, I thought I was not worthy of his love. I felt down. I saw my friends' fathers... they were not like mine. They loved their children. I felt like I was missing a piece. I've always wondered if it was this that pushed me to eat until becoming overweight. And the more I ate, the more other classmates, especially during the middle school period, made fun of me. I did not sleep at night when I was a child. I was really bad!

This statement clearly deals with the depressive feelings that may be developed when children are not recognized by parents in their needs and desires. It is probably that eating problems represented an expression or a correlate of a depressive mood. It is noteworthy to highlight the vicious circle on which Philip sheds light: family violence seemed to cause depressive symptoms that, maybe, were expressed through eating problems which, in turn, caused other violence (i.e., bullying in school). This seems to confirm the detrimental effect that family violence may have on children and, in a chain reaction, on adolescents.

Integration of TGNC identity

In talking about strategies to cope with stigmatizing episodes, the discourses of participants were organized around the process of TGNC identity integration within their Self, in particular around pride feelings and community connectedness, that were the two subthemes identified.

TGNC identity development represents a very complex process constituted by different stages (e.g., Devor, 2004, Lev, 2004). This process is not linear and can assume specific characteristics, leading to different outcomes. Both Devor (2004) and Lev (2004) assigned a central role to pride feelings toward TGNC identity, specifically in the latter stages of their TGNC identity development models. Lev (2004) affirmed that pride is a dimension which indicates a sense of identity integration, and this is well explained by Angela (28 yo, MtF):

> I bring always my condition, my body, with myself, together with my story. Making people proud of themselves is necessary, because they do not have to reject what they are... they have to love their body even if it negatively impacted their story. Most MtF transgender people reject themselves. They have to fight for what they are. They have to fight in society, to make it aware of their identity. Today, when I meet new people, I don't mind anymore to disclose my identity, because others have to understand that we are similar, but also different. We are all human beings.

Another statement which clearly deals with pride dimension is that by Christine (21 yo, genderqueer):

> My sister didn't want to call me with my new gender-neutral name. She went on calling me with my original female name. But I had the courage to tell her and my dad ''call me C. [new name] ... this is my real identity''. I felt very proud of myself. I'm very proud of my identity!

The identity integration process seems to be strongly facilitated by the community connectedness (i.e., the second subtheme individuated), as reported by Sophie (25 yo, MtF):

> In the past, I felt my transgender condition as similar to a handicapped one. I felt like lacking a part of me, as if I had not an arm. Today, I feel different... I have understood that I have both arms. And I have understood this since I had the courage to seek help from a local association. I came into contact with other people like me and we became friends. Now, I feel a whole!

This statement sheds light on the protective role of peer groups which can be seen as a form of familial support that most participants did not receive during their childhood. Indeed, using the metaphor by Sophie, peers seem to act as a lacking arm, allowing to feel oneself more integrated and, as a result, increasing the levels of self-acceptance.

Discussion

The purpose of this work was to qualitatively analyze the subjective experiences of minority stress in a group of Italian TGNC individuals through the lens of the MST. The deductive thematic analysis generated four themes: family rejection, visibility of the body, negative effects of family violence on health, and integration of TGNC identity.

Although differentiated, the themes which have been presented separately should be seen as interrelated dimensions of a psycho-social process — i.e., the minority stress — which postulates that stress mediates the relationship between social status and health of sexual and gender minority groups (Hatzenbuehler, 2009). In the case of TGNC people, the minority social status is represented by gender nonconformity itself.

The first theme individuated (i.e., family rejection) showed that gender nonconformity is stigmatized very early, often during childhood. This is in line with previous studies, which highlighted that non-TGNC siblings receive greater support than TGNC ones (Factor and Rothblum, 2007) and that mothers and fathers are among the main perpetuators of psychological harassment (Gerini et al., 2009). Furthermore, scientific literature highlights different means through which family stigma can be manifested, that are physical, verbal and sexual assault, or less overt means, such as lack of emotional support (Factor and Rothblum, 2007; Grossman and D'Augelli, 2006), as in the case of participants of the current study. Family rejection resulted to be also strongly associated with genderism that, as reported above, is an ideology which perpetuates a negative evaluation of gender nonconformity. As suggested by Hill and Willoughby (2005), ''genderism is both a source of social oppression and psychological shame, such that it can be imposed on a person, but also that a person may internalize these beliefs'' (p. 534). This is in line with what participants of the current study reported. Indeed, participants clearly expressed that their gender nonconformity caused shame feelings in their parents and that they ended up feeling ashamed of themselves, internalizing those beliefs. In this complex process, it seems that the only solution to adapt oneself to the normative gender expectations is to undergo genital surgery, in order to solve the gender nonconformity itself.

The second theme individuated (i.e., visibility of the body) seems to be a direct derivative of the first theme, because the body of TGNC individuals is not conforming to the societal expectations about femininity and masculinity. Indeed, body is in the foreground for TGNC people (Amodeo et al., 2018b), as they experience an incongruity between the given body and the body they would have for feeling themselves (Lemma, 2013). The incongruity TGNC individuals suffer from leads others to constantly look at them, in particular at their body, and this may lead TGNC people to live their own body in a persecutory way (Vitelli, 2015). As Lemma (2013) suggested, this process may start very early, in childhood, a period in which the others looking at the body are the parents. Thus, ''inquisitive looks'', as reported by one participant of the current study, may be internalized, causing shame and self-hatred (i.e., internalized transphobia), as well as a perception to be constantly visible to others (i.e., perceived stigma), regardless of whether one is truly visible or not. This is probably the reason why participants of the current study felt that their intimacy was violated.

The latter point — the relationship between body and intimacy — is somehow related to the third theme individuated (i.e., negative effects of family violence on health). Indeed, participants expressed two main health dimensions

they felt to be affected by family violence (i.e., sexual health and depressive symptoms). Analyzing narratives, it seemed to us that this effect was not direct, but mediated by proximal stressors, in particular by internalized transphobia. This is in line with a recent theoretical framework which represents an extension of the MST, that is the psychological mediation framework (PMF; Hatzenbuehler, 2009). The PMF, recently applied quantitatively to both TGNC (e.g., Breslow et al., 2015, Scandurra et al., 2018a, Testa et al., 2017) and lesbian/gay (e.g., Amodeo et al., 2018a, Liao et al., 2015, Schwartz et al., 2016) population, sheds light on psychological pathways linking stigma-related stressors to negative health outcomes, assuming that proximal stressors of the MST act as mediators between distal stressors and health. It seems to us that participants of the current study specifically highlighted the role of internalized transphobia as a mediator between family rejection and health, in particular depressive symptoms and sexual health. As regards the effect of violence on depressive symptoms, previous studies already found this relationship (e.g., Scandurra et al., 2017a, Testa et al., 2015). As for the effect of violence on sexual health, we are not aware of studies specifically focused on this association. This result seems to be strictly interrelated to the visibility of the body, as the body represents one of the fields in which sexuality is experienced. Indeed, as reported above, the body may become persecutory for TGNC individuals, as they are often visible and recognizable. This may lead some TGNC individuals to develop internalized transphobia which, in turn, may affect positive relationships with others, even in sexual terms. Thus, it is plausible to hypothesize an association between social stigma, visibility of the body, and sexuality. Future studies should explore both qualitatively and quantitatively this hypothesis.

As regards the last theme (i.e., integration of TGNC identity), our results indicated that TGNC individuals tend to cope with stigma through both internal (i.e., pride feelings) and external (i.e., community connectedness) resources. These resources lead TGNC individuals to integrate their own TGNC identity within their Self, promoting a process of self-affirmation and self-acceptance that, on the basis of the MST, may buffer the negative effects of violence on health. As suggested by two very known theoretical models, pride is the latter stage of the TGNC identity development process (Devor, 2004, Lev, 2004). Specifically, Devor (2004) intended pride both in politically and personally terms, while Lev (2004) reported that pride is a dimension indicating a sense of identity integration. Both authors considered pride as a dimension able to buffer the effects that shame and social stigma may have on health. On the same line, participants of the current study expressed that pride allowed them to feel comfortable in disclosing their TGNC identity to others, and this may be interpreted as a buffering resource in the face of shame and persecutory feelings. On the other hand, participants of the current study highlighted the fundamental role of peers and community connectedness in promoting a process of identity integration. This is in line with previous studies which highlighted that family as a primary support network is often inaccessible to TGNC people and, for this, they often find a support source within TGNC community itself (e.g., Carroll et al., 2002).

Limitations

The main limitation of the current study concerns the local level of participants, who were recruited in a unique city of the Southern Italy. This cannot allow to generalize our results to the Italian context. Furthermore, due to the small number of participants, we cannot explore the differences on how MtF, FtM, and genderqueer participants subjectively experience minority stress. Future studies should consider exploring such potential differences through focus groups that are homogenous with respect to gender identities. Notwithstanding, the explorative and qualitative nature of the study allows looking at these limits as relative.

Implications for clinical practice

This study has important implications for clinicians who work with TGNC individuals. The MST, indeed, was developed to understand those dimensions related to the mental health of sexual and gender minorities that are dependent on social contexts and on the internalization of societal attitudes. As suggested by Hendricks and Testa (2012), it is necessary that clinicians, within counseling and/or psychotherapy interventions, assess deeply the different dimensions of minority stress.

The results of the current study shed light on subjective experiences of minority stress which TGNC individuals may do during their life course. The detrimental effect that family rejection may have on health through the action of internalized transphobia should lead clinicians to address their psychological interventions to mitigate the psychological distress coming from the negative self-image which may result from stigmatization. As we showed, stigmatization may affect sexual health leading to feeling of shame and self-hatred, as well as cause depressive symptoms. Applying the PMF, an efficient clinical work should be addressed to proximal stressors, as they link violence to negative health outcomes. Thus, clinically working on internalized transphobia, on the fear of disclosing one's own TGNC identity, on the persecutory feelings about one's own body, may result in a relief and, in turn, may promote an identity integration process that buffers the effects of stigma on health (Scandurra et al., 2019b).

At the same time, given the complexity of clinically working on such deeply encysted dimensions, clinicians should pay attention to those aspects linked to social support and resilience. To this end, Meyer (2007) highlighted the efficacy of the group and community dimension in buffering the effects of stressors on mental health. This is undoubtedly also true for TGNC people. Thus, clinicians should consider using, beyond an individual approach, a group approach, as the group has the potential to facilitate mirroring and empowerment processes (Amodeo et al., 2017, Esposito et al., 2017, 2018, Scandurra et al., 2018b).

Both at individual and group level, it is fundamental that clinicians provide affirmative counseling and psychotherapy interventions which are respectful and supportive of the identity and life experiences of TGNC people (Korell and Lorah, 2007). Currently, TGNC people may encounter other sources of stigma within mental health services, and this

represents a powerful and common barrier for this population (American Psychological and Association, 2015). As suggested by McCann and Sharek (2016), TGNC people meet specific mental health needs, encountering distinct challenges due to their gender expression and identity, such as access to appropriate services and treatments, and the responsiveness of providers, as well as the provision of family support. Mental health providers should be aware of this, having the ethical obligation of providing a competent and informed answer to their clients.

Conclusions

The present study might be considered a qualitative exploration into the minority stress subjectively experienced by a group of TGNC individuals. Our study shows that TGNC individuals, although representing a resilient community able to face with societal stigma, still experience rejection due to their gender nonconformity, and this rejection starts very early, during childhood. Early experiences of rejection seem to set in motion the complex process of minority stress which, starting from distal stressors, may come to affect mental health and well-being. This should lead to implement psycho-social interventions, as well as social policies, aimed at changing the negative socio-cultural views on gender nonconformity, promoting a less genderist cultural view and helping families in supporting gender nonconforming children in their identity developmental paths.

Disclosure of interest

The authors declare that they have no competing interest.

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