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Social and healthcare assistance needs in Italian transgender and gender diverse young adults: a qualitative study

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Abstract

Gender incongruence increasingly leads individuals to seek gender-affirming hormone therapy and surgeries. In Italy, however, general healthcare services often lack the specialization needed to address the specific needs. With a person-centered approach and a qualitative methodology, this study explores individual perspectives on promoting transgender and gender diverse people's well-being and highlights the relationship between gender incongruence, psychosocial health, and healthcare access. Seventeen participants aged 19-31 years old who experienced gender incongruence or gender dysphoria and sought medical or psychological support for hormone therapy attended a semi-structured interview processed through Thematic Analysis. Findings revealed significant barriers to adequate healthcare and social support, negatively impacting participants' well-being. Mediating factors such as peer awareness, family acceptance, and inclusive education emerged as protective. The study also discusses broader societal consequences of insufficient support and presents useful strategies to develop affirmative and inclusive practices aimed at improving access to care and psychosocial outcomes.

Keywords: transgender, gender incongruence, mental health, healthcare, social support

Introduction

Transgender and gender diverse (TGD) individuals often face unique social, psychological, and health-related challenges as they navigate their gender identity and expression within different cultural and institutional contexts. Research consistently shows that TGD people experience higher levels of stress, anxiety, and depression compared to the general population, largely due to stigma, discrimination, and limited access to affirming care (e.g., Dhejne et al., 2016; Pellicane & Ciesla, 2022; Mezza et al., 2024). Within this broader context, gender incongruence represents a significant factor impacting the general well-being, as an experience of a mismatch between an individual's gender identity and their assigned sex at birth. (American Psychiatric Association, 2013; World Health Organization,2019). Moreover, experiencing gender incongruence associated with significant distress leads to gender dysphoria, a condition associated with negative mental health outcomes, such as anxiety, depression, and suicidal ideation (e.g., Dhejne et al., 2016; Mezza et al., 2024; Pellicane & Ciesla, 2022). Transgender and gender diverse (TGD) individuals with gender incongruence or gender dysphoria often require psychological (therapy and counselling) or medical assistance (gender-affirming hormone therapy and surgeries) to navigate their gender identity and achieve optimal well-being (Capetillo-Ventura et al., 2015; Coleman et al., 2022). The World Professional Association for Transgender Health (WPATH) has developed specific guidelines (Coleman et al., 2022) that provide best practices for supporting the health, well-being, and rights of TGD individuals, which are internationally recognized and adaptable to different cultural contexts. In Italy, the National Observatory on Gender Identity (ONIG[1]) has developed a protocol (Fisher et al., 2014) specifically tailored to the Italian context, which employs a staged approach rather than following the WPATH guidelines. According to the ONIG protocol, a diagnosis of gender dysphoria is required to proceed with the medicalized gender affirmation path.

[1] Osservatorio Nazionale sull'Identità di Genere

In addition to the possible distress related to gender incongruence, TGD individuals often encounter considerable social stressors, as traditional Italian gender norms and conservative views contribute to hostile attitudes toward diverse gender identities (Ammaturo, 2019; Ciocca et al., 2020). Italy's legal framework also reinforces stigma by requiring judicial approval and psychological evaluations for both legal gender changes and access to gender-affirming surgery, making the process lengthy and challenging. The social and community networks also play a significant role in protecting or damaging the well-being of TGD people. Support from family of origin is crucial (McDonald, 2018; Wilson & Cariola, 2020), but many Italian TGD people report strained or broken relationships with family members due to a lack of understanding and acceptance (Klein et al., 2023; McDonald, 2018). Peer groups and online communities offer more stable emotional support, helping to alleviate social isolation (Cipolletta et al., 2017), especially for those who cannot access in-person support due to geographic or social constraints. Furthermore, various LGBTQ+ advocacy groups provide legal, medical, and psychological assistance and promote social inclusion through community events, education, and activism (Puckett et al., 2019; Sherman et al., 2020). Schools and universities also play a crucial role in supporting TGD students' identity, integration, and well-being. Some institutions in Italy have taken steps toward inclusivity, such as anti-bullying initiatives and LGBTQ+ staff training. Moreover, efforts to implement the Alias Career - an administrative tool in Italy that allows TGD students to use their chosen name and experienced gender within specific institutional contexts before the legal change process is completed – have been made (Bourelly et al., 2024; Mariotto et al., 2024). However, many institutions still require a formal gender dysphoria diagnosis, excluding non-medicalized TGD identities and reinforcing a pathologizing approach (Lorusso & Albanesi, 2022). Finally, media representation also contributes to the spread of negative attitudes towards TGD people. Firstly, because, despite the growing social interest in gender issues, they rarely get the visibility they deserve; and secondly, because it often frames TGD issues through a lens of sensationalism, controversy, or pathology, which can reinforce prejudices and discrimination (Billard & Zang, 2022; McLaren et al., 2021).

In Italy, although there are no precise estimates of individuals experiencing gender incongruence, the demand for specialized services is rising (Caldarara et al., 2019; Crapanzano et al., 2021). The healthcare system, however, struggles to adequately support TGD patients due to limited TGD-specific training among professionals, regional disparities in care, and funding issues (Giovanardi et al., 2020; Vicarelli et al., 2015). These challenges reduce care quality and effectiveness, contributing to adverse mental health outcomes, social isolation, risky behaviours, and decreased trust in the healthcare system (Fiorilli & Ruocco, 2019; Miller et al., 2023).

Considering these critical issues, it is essential to have an updated understanding of the experience of TGD people in relation to the support perceived, as described by individuals themselves (Cooper et al., 2020; Kausar et al., 2024; Kerr et al., 2022). This would allow to obtain significant data to improve the quality of assistance currently provided: for example, it would help to implement targeted training courses for professionals, provide personalized assistance, and adapt policies to respond to social attitude shifts towards TGD population. The positive consequences for TGD people could be varied: from the reduction of misinterpretation of symptoms, use of harmful treatments, or self-medication, to the increase of trust in social and healthcare systems and consequently their adherence to care. Despite the presence of guidelines for assistance to people experiencing gender incongruence (SOC 8; Coleman et al., 2022), the literature lacks studies with a person-centred approach and qualitative methodologies, which aim to understand individual perspectives about helpful practices in alleviating gender incongruence and monitor the functioning of gender healthcare systems in Italy. Similarly, studies investigating the experiences of young adults in the general population remain insufficient. Therefore, the aim of this study is twofold: 1) to investigate the relationship between gender incongruence, psychological health, and access to healthcare and social assistance available nationwide, and 2) to highlight the main needs, in terms of medical, psychological, and social support, for young adults with gender incongruence.

Materials and methods

Participants

The study included 17 participants aged 19-31 years old (*M* = 24.35; *SD* = 4.50). Inclusion criteria for participants consisted of being 18 years old or older and having experienced gender incongruence or gender dysphoria that led them to consult clinics or mental health professionals to obtain access to hormone therapy. Participants enrolled in the present study were drawn from two related but separate research projects that assessed the health experience of TGD persons through interviews. The two projects shared a set of questions (14) that was the focus of this analysis. Both studies had a recruitment methodology that provided contact with LGBTQ+ associations, word of mouth, and social media. At the end of the survey, participants were invited to express their willingness to participate in follow-up interviews. Those who consented and who declared in the survey to have previously consulted clinics or mental health professionals to obtain access to hormone therapy were subsequently contacted by lead researchers. Participants were not remunerated for their time; participation in the study was entirely voluntary. Participants' demographics are summarized in Table 1.

Variables	**Sample (*n*=17) n (%)**
Age (mean)	24.35 (SD = 4,50)
Assigned gender at birth	
Male	4 (23.53%)
Female	11 (64.71%)
Intersex	2 (11.76%)
Gender identity	
Transgender female/girl/woman	2 (11.76%)
Transgender male/boy/man	10 (58.82%)
Non-binary	5 (29.41%)
Occupational status	
Student	4 (23.53%)
Employees	8 (47.06%)
Working student	2 (11.76%)
Unemployed	3 (17.65%)
Highest level of education	

Middle school	1 (5.88%)
High school	8 (47.06%)
Bachelor’s degree	6 (35.29%)
Master’s degree	2 (11.76%)

Table 1. Sociodemographic characteristics of the sample

Measure

A semi-structured interview consisting of 14 questions was designed to collect data on topics such as gender identity exploration, experiences of gender incongruence, support received in the process of defining one's gender identity, and unmet healthcare needs. At the start of the interview, each participant was asked about their preferred pronouns and names. The questions were carefully crafted using gender-neutral and affirming language to honour and respect the self-determination of each participant's identity. Examples of the questions include: “What is your experience today with respect to the path of gender exploration you have taken?”; “Do you feel like you have received help from someone close to you (family, friends, partner...)?”; “What do you think the school could do to help kids with a situation similar to yours?”; and “How do you think healthcare pathways could be modified to best support a person in their gender affirmation journey?”.

Procedures

The data for this study have been collected through interviews by experienced researchers with a background in psychology and LGBTQ+ health needs. During data collection and data analysis, members of the research team engaged in reflexive discussions to acknowledge how their different gender identities, their institutional positions within predominantly cisnormative academic structures, their professional experiences as researchers and psychologists directly engaged in the clinical work with TGD clients, and their personal commitments towards inclusivity and equity in healthcare and social systems might shape the research process. These reflections aimed to identify and mitigate

potential biases and assumptions regarding gender diversity, to critically examine power relations between researchers and participants with marginalized identities, and to enhance the credibility and reflexivity of the interpretive process(Roberts et al., 2020). All subjects gave their informed consent for inclusion before they participated in the study. The study was conducted in accordance with the Declaration of Helsinki, and the protocol was approved by the Ethics Committee of the University of Bologna (n. 0132691; 17/05/2023) and the University of Padua (n. 2743; 10/07/2018). The interviews from the University of Bologna project were held online (via Zoom and Teams platform) from May to July 2023, while the interviews from the University of Padova project were held both online (via Zoom and Teams platform) and in person (at the Department of Developmental Psychology and Socialization) from December 2018 to July 2021. Interviews were reviewed and translated from Italian to English. No significant disparities emerged between the original and translated versions; minor linguistic differences were discussed and resolved collaboratively. Transcripts were then analysed using Thematic Analysis methodology (Braun & Clarke, 2006, 2023). Each interview was coded by the first author, where each code represented the participants' reflections about their personal experience or feelings. After initial familiarization with the data, codes were inductively generated and systematically applied to all transcripts. As a next step, these codes were gathered in sub-themes and then into overarching themes (e.g., Navigating Exclusion: Barriers to Recognition and Affirmation and Building Affirmation, Pathways Toward Belonging and Support), which were compared with the ones provided by other participants' interviews to identify common patterns and divergences. To enhance rigor, the coding and preliminary themes were reviewed by the other authors. Any discrepancies in interpretation were discussed until a general consensus was reached. Regular meetings among the research team promoted reflexive dialogue on how their perspectives could shape the analysis. Once general themes were defined, a summing paragraph was written for each of them. To protect the privacy of the participants, all names have been replaced with fictitious pseudonyms.

Results

Three main themes were identified that addressed the research questions in this article, under which several subthemes clustered (see Table 2).

Theme	Subtheme
1. Navigating Exclusion: Barriers to Recognition and Affirmation	a. Structural and Institutional Barriers b. Unprepared Professionals and Gatekeeping Practices c. Everyday Stigma and Social Invalidations
2. Building Affirmation: Pathways Toward Belonging and Support	a. Affirming Interactions and Social Safety b. Advocacy and Reimagining Care
3. Negotiating Safety: The Emotional Costs and Rewards of Visibility	a. Living Under Vigilance b. Avoidance and Isolation c. Finding Safety and Belonging

Table 2. Interview themes and subthemes.

1. Navigating Exclusion: Barriers to Recognition and Affirmation

1.1 Structural and Institutional Barriers

The first identified theme captures how participants experienced structural and interpersonal exclusion within the social, educational, and healthcare contexts, highlighting how the absence of institutional recognition undermines their sense of belonging and self-determination. Across narratives, exclusion was not perceived as isolated incidents but as systemic patterns that reinforced marginalization. This theme is further divided into three subthemes, which address structural and institutional barriers, unprepared professionals and gatekeeping practices, and everyday stigma and social invalidations.

Firstly, participants highlighted numerous structural deficiencies and critical issues within the healthcare and institutional systems in recognizing and addressing the specific needs of TGD individuals. This was interpreted as a fundamental misunderstanding of these needs, as well as a

reflection of the persistent marginalization and invisibilization of this population, further exacerbating barriers to equitable access to care and support. Participants denounced the lack of public healthcare services in the area, forcing the few specialized centers to handle an overload of requests: “even if they are competent, they really have too many users compared to the number of professionals available” (Lorenzo, 25 years old, transgender man). An additional consequence is that “the waiting times for hormone therapy are getting longer in the public, and those for operations are currently years as waiting lists” (Robin, 31 years old, non-binary person). Having to plan one’s social or medical affirmation journey according to timelines that are often incompatible with personal affirmation processes imposes an additional burden of stress and distress on individuals. Other structural obstacles regarded the difficult availability of drugs required for the medicalized affirmation process and the invasiveness of the clinical tools administered to assess gender dysphoria. Further structural criticalities have emerged, highlighting the inadequacy of the school system in promoting awareness and education on respect and acceptance of gender, sexual, and relational diversity. Noah criticized the content and structure of the lessons provided by their school, as partial and not representative of all the experiences beyond cis-heteronormativity.

> “One help I didn't receive was sex education in schools. (…) In primary school, it was very basic, for example: «This is the female body, this is the male body, and they will change». In middle school, however, it was a list of sexually transmitted diseases and protections. Basically, they told us: «This is all that can happen to you». (…) But everything is extremely cis-heteronormed. Contraceptive methods were mainly intended not to result in pregnancy. The fact that relationships with a purpose other than procreation could exist was not a possibility considered. Without even getting to gender identity, it's too hard to reach the next step.”
>
> Noah, 25 years old, non-binary person

Some participants also discussed the role of the Alias Career: while it serves as a strategic tool for recognizing students' right to self-determination, it is not always included in school regulations or

effectively implemented in educational practices. Additionally, as Jacopo noted, the process for activating the service remains excessively slow.

> "I would change the timing of the Alias Career. Because I understand that it could be a problem, for example, not having a certificate from a therapist, but once I present you all the correct certificates, (…) then don't make me wait three or four months! You activate it and pass me things. (…) I don't understand why it took them so long."
>
> Jacopo, 21 years old, transgender man

Additionally, the current system does not accommodate non-binary individuals, "who simply want to be able to use their chosen name in exams, etc., but cannot, because it requires changing their gender in the records as well" (Robin, 31 years old, non-binary person). Consequently, non-binary students are often forced to repeatedly disclose and explain their gender identity to have it recognized within the school environment.

1.2 Unprepared Professionals and Gatekeeping Practices

Many participants reported negative experiences interacting with the health professionals they turned to for assistance with gender incongruence or dysphoria. The most widespread problem concerns the lack of training of medical personnel regarding the specific health needs of TGD people. Noah, for example, had to explain "what is a trans person, what is a hormone treatment" to the staff of a clinic to access required gender-affirming treatments and tests. Robin reported experiencing difficulties in receiving adequate psychological support from the psychotherapists they consulted. This was due to not being provided with all the available information and treatment options.

> "Neither the first psychotherapist nor the second informed me about the international protocol. (…) It is an obligation to explain to the patient the different options for treatment, even those that you do not offer.

(…) I know many other trans people who have been given the same treatment, they have learned from me or from other trans people that there is also the international protocol."

Robin, 31 years old, non-binary person

Furthermore, many participants reported the gatekeeping role played by numerous psychotherapists responsible for assessing the presence of gender dysphoria. This often manifests through excessively lengthy evaluations, intrusive questioning, and the imposition of rigid diagnostic criteria that fail to account for individual experiences and self-identification. In addition to causing stress and discomfort in interactions with healthcare professionals, this practice frequently results in significant delays in the initiation of the gender affirmation process. Another distressing experience shared by participants involved interactions with teachers and school staff who lacked adequate training to accommodate and support the needs of students experiencing gender incongruence or dysphoria. Many participants described feeling misunderstood or invalidated when discussing their gender identity with school personnel, who often lacked the knowledge or sensitivity to provide appropriate guidance or support.

This poor awareness not only created an unwelcoming and unsupportive environment but also placed an additional burden on individuals already navigating the challenges of gender dysphoria, forcing them to constantly explain their condition.

1.3 Everyday Stigma and Social Invalidations

Beyond formal institutions, numerous episodes of explicit stigma, discrimination, or dehumanization of TGD patients by healthcare personnel, teachers, peers, or family members have been reported. For example, Marco described being verbally attacked by the doctor scheduled to examine him, who then conducted a superficial and inappropriate check-up.

Other negative experiences during medical consultations include the failure to respect the individual's gender identity, names, or pronouns, misgendering based on anatomical characteristics, and stigma toward gender-affirming surgeries. Lorenzo points out that high school and university teachers often intentionally refuse to use students' chosen names to affirm their identity in front of the classroom: "There are teachers who refuse to protect the identity of people going through a challenging period, such as adolescence" thus fostering a hostile environment and increasing the discomfort of this crucial stage of development. Many participants reported negative experiences within cis-heteronormative social contexts and peer groups, describing instances of "exclusionary dynamics" where the TGD individual was treated as "a very rare and absurd thing". These interactions often involved being marginalized, ridiculed, or made to feel like an outsider simply for expressing their gender identity, which reinforced feelings of isolation and alienation. Stress factors originating from social contexts were often exacerbated by elements of hostility within the family environment as well. Many families engaged in various forms of violence and micro-aggressions to reduce elements that were culturally incongruent with the participants' sex assigned at birth. This includes "masculinization" or "feminization" strategies with significant consequences on the development and health of participants.

> "When I was a child, both my mom and dad tried to masculinize me more. I remember some quite violent episodes. Once, my aunt, who raises various animals, made me kill a hare to make me more of a man. I was very sensitive, and that was one of the biggest traumas for me."
>
> Serena, 30 years old, transgender woman

2) Building Affirmation: Pathways Toward Belonging and Support

2.1 Affirming Interactions and Social Safety

In contrast to the previous theme, the second one focuses on experiences of validation and resilience. Participants highlighted how affirming relationships—with professionals, family members, peers, and online communities—fostered a sense of legitimacy and self-acceptance. This theme is further divided into two subthemes: affirming interactions and relational safety and advocacy and reimagining care.

First of all, some positive experiences were reported in interactions with healthcare professionals, particularly in specialized centers where staff are well-trained in addressing the health needs of TGD individuals, maintaining privacy towards their gender identity.

"The people here at xxx are all professionals, from the psychologist to the endocrinologist, who seem to be very competent compared to the average (...). For example, for the University, we had to go for swabs often, and even though I had to misgender my health card, I never received any dirty looks or perceived hostility. In fact, they all seemed very kind to me, some avoided saying «Sir» out loud when they called me, or called me only by my surname, they were careful, even the nurses at the blood tests tried to use more neutral language."

Vittoria, 29 years old, transgender woman

In some cases, the family of origin has been notably supportive and proactive, not only in relation to the individual's gender identity and journey but also in actively working to change their own attitudes and behaviours toward others. These families have made a conscious effort to educate themselves, challenge traditional gender norms, and adopt inclusive language and practices. This openness has created a safe and affirming environment for the individual, fostering a sense of acceptance and security.

"My mother is enthusiastic about it, she joined the association's parents' group, so they explained many things to her, she asked me many things. Therefore, the misinformation on her part is no longer there (...), unlike others, she even uses the neutral gender when addressing the plural."

Jacopo, 21 years old, transgender man

Interaction with the peer group plays a crucial role in meeting the health needs of TGD individuals. Most participants shared that they first came out as transgender to close friends and only later to family. This choice was driven by feelings of trust, solidarity, and a sense of recognition. Furthermore, it emerged that connecting with other LGBTQ+ individuals has a profoundly positive impact on self-esteem and self-efficacy, as these connections provide a sense of acceptance, validation, and belonging. Finally, it emerged that online environments and communities provide a safe place to find support, inclusion, and reference models. Cesare, for example, due to the lack of support from his friends, searched for online communities with TGD people to build connections and receive support. He realized that it should have gone all through social media, because "no one talked about it outside, it didn't exist".

2.2 Advocacy and Reimagining Care

Some participants proposed concrete strategies aimed at promoting TGD individuals' needs and improving the current state of care. Most of them called for a reorganization of health services to facilitate costs and timing of access and increase protocols adherence to international guidelines. Marco, for example, suggested an improvement in psychological support services to provide assistance not only in accessing the affirmation path, but also in related daily challenges and vulnerabilities to gender minority status, "which can be the Alias problem, an employer who engages in mobbing, the parent who does not accept and support the trans child, etc." Participants also asked for higher personalization of medical/surgical treatments to respond to the specific needs and expectations of each individual. Many people may not want to resort to hormone therapy and/or affirmative surgery, or they may not want to completely adhere to the canons of feminine or masculine. It is therefore necessary that healthcare professionals are ready to listen and validate patients' experiences and propose ad-hoc treatments.

“The expectations that different transgender people have regarding transition change a lot. They respond to different needs. Several transgender people I met wanted to achieve slightly different goals from transition, often they did not want to completely resemble a biological woman or man (…). This should be taken into consideration by doctors.”

Dario, 21 years old, transgender man

From several testimonies emerges the need to fight gender stereotypes and stigma and build a more positive and protective perspective on TGD identities. Noah proposes a person-oriented approach, highlighting the need for increased respect and affirmation of the individual, first of all through the “use of the right names and pronouns” within social contexts and networks. Marco also supports the spreading of awareness and education practices on gender, sexual, and relational diversity, not only to healthcare and institutional contexts, but also to social and family ones, through the construction of an open and continuous dialogue.

“Even when I was little, my parents didn't want sexuality lessons. I remember, there was the period in which in all schools, in any city or region of Italy, these activities were blocked due to protesting parents. (…) It would be nice to create meeting points where it is not the child who does the activity with the school, but the whole family.”

Marco, 31 years old, transgender man

Finally, many participants consider it essential to foster the development and dissemination of new perspectives and attitudes toward TGD individuals and the experience of gender incongruence. In Italy, the prevailing paradigm remains one that frames these experiences primarily in terms of pathology and suffering. However, Leonardo emphasized the importance of shifting this narrative, stating that “it must not be the main theme of the experience being told. There is a need to show how normal a trans person is, beyond the transition”.

3.3 Negotiating Safety: The Emotional Costs and Rewards of Visibility

3.1 Living under Vigilance

The final theme identified focuses on how the degree of perceived support shaped participants' mental health and everyday coping strategies. Experiences ranged from hypervigilance and withdrawal to the empowerment found in safe, affirming spaces. This theme is further divided into two subthemes: living under vigilance, avoidance and isolation, and finding safety and belonging.

Participants first reported an increased sense of vigilance when required to disclose or express their gender identity in contexts they perceive as potentially hostile. This heightened sense of caution is tied to a learned and internalized understanding that presenting themselves socially as TGD individuals often carries risks to their safety and well-being. As a result, they carefully weigh the pros and cons of such disclosures, evaluating whether the benefits of being true to their identity outweigh the potential harm or discrimination they may face. This constant assessment of risk creates a state of hyper-awareness that can contribute to emotional exhaustion and stress. For instance, Alex shared experiencing significant anxiety in anticipation of coming out and feeling compelled to go through with it to prevent a worsening of their distress:

"I tend to worry a lot about how others judge me, so I was very panicked about how people—especially my family—might react. But after hesitating for a while, I convinced myself, saying: 'If I don't say it now, I never will.' There's no point in waiting because keeping everything inside just makes me feel worse."

Alex, 22 years old, non-binary person

3.2 Avoidance and Isolation

The experience of discrimination led many participants to adopt avoidance mechanisms as a protective strategy. For example, Marco described how encountering misgendering and negative comments about his gender presentation in healthcare settings not only caused him significant stress but also heightened his expectations of future rejection. This, in turn, led him to neglect or even avoid further healthcare treatment, fearing additional humiliation or mistreatment. Similarly, Nicola shared how he spent "two solid years without leaving the house" to avoid exposing his body to social comparison, a coping mechanism rooted in the desire to shield himself from potential judgment. This prolonged avoidance had severe consequences for his physical health, including a notable loss of bone mass. The psychological toll of such avoidance behaviours was also evident, as they led to increased feelings of isolation, anxiety, and a diminished sense of self-worth. These coping strategies, while initially protective, ultimately contributed to both physical and mental health challenges, underscoring the profound impact that discrimination and lack of acceptance can have on an individual's overall well-being.

3.3 Finding Safety and Belonging

Finally, some participants reported experiencing a profound sense of comfort and social safety in environments where they felt validated, supported, and where their needs were understood. For Dario, the opportunity to be assisted by medical personnel who were not only capable of identifying and addressing their gender dysphoria but also attuned to their broader physical, emotional, and psychological needs was a significant factor in fostering a sense of security. Being met with professionalism, respect, and empathy allowed Dario to perceive the healthcare setting as a "safe place", where he could freely express their concerns and seek care without fear of judgment or mistreatment. This positive experience not only contributed to improved healthcare outcomes but also played a crucial role in enhancing patients' overall sense of well-being and self-worth.

“The doctors seemed absolutely prepared, with a flexible and attentive attitude, beyond the issue of gender dysphoria, even in how they interacted. They make you feel at ease; I felt comfortable.”

Dario, 21 years old, transgender man

Jacopo, moreover, reflected positively on his social experience within his high school, noting that choosing an arts-focused curriculum provided him with the opportunity to engage in a more open and receptive social environment. This setting allowed him to find not only academic fulfilment but also a space where queer identities could be expressed and celebrated. As a result, Jacopo felt supported, accepted, and empowered to embrace his gender identity and sexual orientation freely without fear of judgment, ultimately contributing to his sense of belonging and personal growth.

“I attended an arts high school, where the environment was much more flexible about these things—compared to others, let’s say. So I was always in fairly close contact with queer people, people who were part of the community, and I never had any issues expressing my sexuality and gender identity.

Jacopo, 21 years old, transgender man

Discussion

These findings offer a novel perspective on the experiences of TGD individuals in Italy, emphasizing the urgent need for a more inclusive and person-centered approach that prioritizes individual narratives and the expression of needs. Considering the results of the analyses, three different main themes emerged that describe the personal experience of perceived support towards gender incongruence or dysphoria symptoms from the healthcare and social systems. According to previous literature, this study highlighted that in Italy, TGD individuals face significant structural barriers in accessing healthcare services, including a limited and overloaded number of specialized facilities spread across the country, resulting in long travel times, waitlists, delays, and reduced quality of care

(Giovanardi et al., 2020; Vicarelli et al., 2015). Many TGD individuals also encounter difficulties accessing necessary medications and face the challenge of poorly adapted clinical tools that don't meet their specific healthcare needs. They also identified inadequate educational programs and school policies as a structural problem. Despite some virtuous examples, Italian institutions demonstrated significant resistance, not only in the context of broader discussions around gender but also in the consistent application of protocols for the Alias Career and the implementation of comprehensive sexuality education that addresses gender diversity. This fragmented approach perpetuates a hostile environment that undermines efforts to ensure equal access to education and social inclusion for all students, regardless of gender identity (Bourelly et al., 2024; Lorusso & Albanesi, 2022; Mariotto et al., 2024). Moreover, social and healthcare professionals are not trained to understand, validate, and address the specific needs of patients with episodes of misinterpretation or neglect of symptoms, inadequate consultations and treatments, and forced coming out (Marconi et al., 2024; Mirabella et al., 2023). Often, the assessment process prior to diagnosis is extended beyond the period suggested by the WPATH guidelines (Coleman et al., 2022), postponing the start of the medicalized affirmation process and damaging the physical and psychological well-being. In addition to structural challenges and the lack of training among professionals, participants also reported instances of deliberate discrimination, not limited to healthcare and educational settings but extended to social contexts as well, including peer groups and family environments. Many individuals recounted facing explicit hostility, invalidation, and exclusion. These experiences further reinforce feelings of isolation and contribute to significant emotional distress (Fiorilli & Ruocco, 2019; Miller et al., 2023; Velasco et al., 2022).

Despite numerous challenges, positive experiences also emerged in terms of support and affirmative attitudes toward participants. Some individuals reported feeling welcomed and understood when they turned to competent and empathetic psychotherapists, doctors, or teachers. Additionally, positive experiences within supportive families and queer peer groups were highlighted as crucial in alleviating dysphoric symptoms and providing guidance along the path to gender

affirmation. These findings confirm that perceived emotional and instrumental support plays a protective role against minority stressors and risk factors and is fundamental for improving positive mental health outcomes (Falak et al., 2020; McDonald, 2018; Puckett et al., 2019; Tankersley et al., 2021). Furthermore, participants expressed a significant attitude towards improving new strategies to enhance access to support. These included increasing provider training on gender-affirming care guidelines, developing personalized treatments within a non-pathologizing framework capable of addressing fluid and non-binary experiences, expanding the availability of specialized and accessible healthcare centers and professionals, and ensuring identity privacy by correctly using names and pronouns to prevent misgendering and non-consensual outing. Implementing such measures would likely improve access to care, enhance health outcomes, and mitigate the risks associated with unsafe practices (Bartholomaeus & Riggs, 2021; Boyd et al., 2022). Participants also emphasized the need to reconsider the current medical-psychiatric model applied in Italy, which requires a psychological diagnosis to access gender-affirming treatments. Instead, they advocated for the adoption of informed consent and self-determination models already implemented in other countries (Crapanzano et al., 2021; Neri et al., 2020; Spanos et al., 2021). Moreover, participants stressed the importance of introducing educational initiatives on gender, sexual, and relational diversity beyond the cis-heteronormative perspective. They also called for the implementation of affirmative measures such as the Alias Career in schools and other institutional contexts. These interventions would support the emotional development, intimacy, and self-exploration of adolescents and young adults (Lameiras-Fernández et al., 2021; Riggs & Bartholomeus, 2018), promote positive models and representations of TGD individuals (Haley et al., 2019), foster a more accepting attitude toward LGBTQ+ identities, and contribute to reducing bullying and discrimination (Eisenberg et al., 2022; Epps et al., 2023). Despite the significant mental burden associated with self-advocacy efforts, participants' proactive engagement in promoting their needs and rights may represent a crucial resource, demonstrating resilience and agency in the pursuit of systemic change (Gorman et al., 2022; Puckett et al., 2019).

Finally, this study confirms that negative experiences with healthcare professionals, educational environments, and social groups impact quality of life not only by increasing distal and proximal minority stress (Hendricks & Testa, 2012; Scandurra et al., 2017; Testa et al., 2015), including gender dysphoria (Lindley & Galupo, 2020), but also by leading participants to develop a state of anticipatory vigilance toward contexts perceived as potentially hostile. This constant state of alertness, driven by fear of discrimination or rejection, can contribute to chronic stress and psychological exhaustion (Diamond & Alley, 2022; Slavich et al., 2023). Moreover, the absence of safe and affirming social environments weakens individuals' sense of stability and trust in institutions, reinforcing patterns of avoidance, self-reliance, and low adherence to care (Fiorilli & Ruocco, 2019; Marconi et al., 2024; Velasco et al., 2022). As a result, some participants reported resorting to self-medication, non-medical interventions, or complete social withdrawal as coping mechanisms to manage body dysphoria and avoid engagement with a healthcare and social system perceived as unsupportive or even harmful. On the other hand, experiencing support and having their gender affirmation needs understood and satisfied led to a significant increase in participants' sense of security. For participants, feeling recognized and validated in their gender identity increased their perception of having access to safe spaces, reduced anticipatory vigilance, and enhanced their overall mental health, self-esteem, and willingness to engage with institutional services. This sense of security promoted greater adherence to care, increased social participation, and strengthened resilience, demonstrating the critical role of inclusive policies and affirming relationships in improving the quality of life for TGD individuals (Diamond & Alley, 2022; Sherman et al., 2020).

The study presents some limitations. First, as with all qualitative research, results cannot be generalized to the population as a whole. The symptoms of incongruence were self-reported by participants, and there is no quantitative support to confirm the person's perception. Furthermore, other demographic categories, such as disability status, ethnicity, or socioeconomic status, were not equally investigated in the two research projects. Finally, the number of participants in the categories “gender assigned at birth” and “gender identity” does not appear to be homogeneous, with a low

representation of transgender women. This contributes to having a partial picture of the TGD population. However, this study also has noteworthy strengths. The recruitment of participants took place within the general population of young adults, which makes the data particularly significant compared to the scientific literature that mainly accesses the student population. Participants mainly reported specific unmet needs, some situations in which the support received was satisfactory, and finally, suggestions for improvement. This data allow the authors to advance important considerations on the current state of gender healthcare and social assistance and to define implications for theoretical and practical contributions to the larger bodies of literature and policies on the protection of TGD people's well-being. Furthermore, the qualitative methodology and the affirmative approach allowed to foster the openness and trust of the participants in bringing their testimony. For future research, a longitudinal approach should be considered to investigate how the social and healthcare support development will satisfy participants in their medium and long-term needs. It would also be interesting to explore how belonging to different demographic categories, their salience in defining one's identity, and benefiting from different levels of privilege shape the experience of perceived support.

Conclusions

The present study investigated social and healthcare assistance needs in Italian TGD adults with a specific focus on the implications related to the support received or lacking. These findings highlight the significant barriers faced by TGD individuals in accessing adequate healthcare support in Italy, including structural obstacles, insufficient professional training, and instances of discrimination. The situation in educational environments mirrors this, as many schools fail to adopt a protective and affirmative approach toward TGD students. These challenges enhance the negative outcomes related to gender incongruence and lead to increased minority stress, psychological distress, and a lack of trust in institutions. However, positive experiences of support from healthcare professionals, family,

and peer groups demonstrate the protective role of affirming environments in promoting mental well-being and resilience. The study calls for systemic change through the implementation of gender-affirming care, inclusive educational policies, and the adoption of self-determination models to improve the overall quality of life for TGD individuals. Social and healthcare professionals should collaborate with TGD individuals to enhance understanding of their gender experiences, moving beyond stereotypes and traditional conceptions of gender.

Author Contributions

Conceptualization, F.A., M.B., M.M., P.R.; Data curation, F.A., M.B., V.D., M.M., P.R.; Formal analysis, V.D.; Funding acquisition, P.R., M.M.; Investigation, F.A., M.B., M.M., P.R.; Methodology, F.A., M.B.; Project administration, F.A., E.T.; Supervision, F.A., E.T.; Validation, F.A., E.T., V.D., M.M., P.R.; Visualization, F.A., E.T.; Writing—original draft, V.D.; Writing—review & editing, F.A., E.T., M.M., P.R.

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