Who has the worst attitudes toward sexual minorities? Comparison of transphobia and homophobia levels in gender dysphoric individuals, the general population and health care providers

A. D. Fisher · G. Castellini · J. Ristori · H. Casale · G. Giovanardi · N. Carone · E. Fanni · M. Mosconi · G. Ciocca · E. A. Jannini · V. Ricca · V. Lingiardi · M. Maggi

Participants completed the Modern Homophobia Scale (MHS) and the Attitudes Toward Transgendered Individuals Scale (ATTI) in order to assess attitudes toward gay men and lesbian women and toward transgender individuals, respectively. In addition, GDs completed the Gender Identity/Gender Dysphoria Questionnaire (GIDYQ-AA) and ATTI to measure, respectively, gender dysphoria levels and internalized transphobia. Religious attitudes were evaluated by means of the Religious Fundamentalism Scale (RFS), and Discrimination and Stigma Scale (DISC-12) was used to measure perceived discrimination.

Abstract
Purpose To date, few studies have addressed attitudes toward transgender individuals. In addition, little is known about health care providers' (HCP) attitudes toward sexual minorities. The aim of the present study is to compare attitudes toward homosexual and transgender individuals between gender dysphoric individuals (GDs), general population controls (C) and HCP.

Methods A total of 310 subjects were considered, including 122 GDs (63 transwomen and 59 transmen), 53 heterosexual HCP (26 males and 27 females) and 135 C.

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Results (1) Men showed significantly higher levels of homophobia and transphobia when compared to women ($p < 0.001$); (2) perceived discrimination was higher in lesbian women compared to gay men and in transwomen compared to transmen ($p < 0.001$ and $p < 0.05$, respectively); and (3) religious fundamentalism was associated with both homophobia and transphobia (both $p < 0.001$).

Conclusions Our results underline the need to promote awareness and acceptance of the sexual minorities, who are more at risk of discriminatory attitudes, which are strongly dependent on religious precepts and dogma.

Keywords Transphobia · Homophobia · Gender dysphoria

Introduction

Historically, stigma has been defined as a strong disapproval toward those characteristics that an individual possesses, or is believed to possess, that are considered socially inappropriate [1, 2]. The recognition of these characteristics leads to the stigmatized individual being deeply devalued in particular social contexts [3–5].

More recently, the concept of stigma has been reframed in order to deepen the sociocultural processes and structures that sustain it, as well as the factors that cause variability in how it is experienced and expressed [6, 7]. As a consequence, stigma is now divided into three interacting levels (social, structural, and internalized) accounting for the multifaceted forces that influence this sociocultural and subjective process [8].

Lesbian, gay, bisexual, and transgendered (LGBT) individuals represent sexual and gender minorities particularly at risk of substantial stigmatization because their sexual orientation or gender identity or expression fails to conform with heteronormative and/or gender-normative cultural expectations [9]. Robust connections were found among sexual stigma, religiosity [10, 11], and sexism [12, 13]. In particular, homophobia and, by extension, transphobia may be driven by the crossover of religious fundamentalism, with a tendency to rigidly adhere to traditional gender role ideology [14]. Whereas homo- and bisexuality are related to sexual orientation, transgenderism is an umbrella term describing individuals whose gender identity, expression, or behavior can differ from those typically associated with their assigned gender [15]. Concerning sexual stigma, homophobia describes negative attitudes toward individuals who do not conform to a stereotyped sexual orientation (i.e., non-exclusive heterosexual people) [16] and transphobia toward those who differ from common standards of gender dichotomy or society’s gender expectations (i.e., feminine men, masculine women, cross-dressers, or transgender persons) [17]. Both homophobia and transphobia can range from mild fear and feelings of discomfort to a strong disgust toward the stigmatized person [18]. The application of these feelings and attitudes by a person belonging to these sexual minorities are, respectively, called internalized sexual stigma [18] and internalized transphobia [19, 20].

Three components of sexual stigma have been described [21]: (1) perceived stigma, referring to the awareness of being a possible target of discrimination (anticipated stigma); (2) experienced stigma or the actual manifestation of violence and discriminatory behaviors; (3) and self-stigma, referring to the adoption of a stigmatized view of oneself and usually characterized by feelings of shame, hopelessness and a loss of self-esteem [22].

Several studies have examined the degree of homophobia in heterosexual individuals [14, 23–32] and the degree of internalized sexual stigma in homosexual individuals [33, 34]. In particular, high rates of perceived and experienced stigma have been reported by lesbian women and gay men [27–31]. Perceived stigma seems to be associated with negative consequences with respect to physical and mental health in sexual minorities [31, 35], as well as with low self-esteem [36].

Concerning transphobia, different studies showed that also transgender individuals reported frequent experiences of violence and discrimination, which they ascribed to their belonging to a sexual minority group [37–41]. There is some evidence to support the idea that, among sexual minorities, transgender people are the most stigmatized, as they clearly violate the rules concerning gender roles [38, 42–44]. However, there is an objective lack of empirical data on the actual dissemination of the stigma suffered by this population [9]. Stigma suffered by transgender people has a negative impact on self-esteem, social relationships, coping behaviors, and general health [39, 45]. It affects transgender people on different levels (structural, interpersonal, individual) in several critical domains, such as employment and health care [46]. Transphobia is also involved in the high rates of suicidal tendencies observed among transgender persons [45, 47].

With respect to the association between religion and prejudice, several studies have shown that people who are religious fundamentalists, those who attend religious services on a regular basis, and individuals who belong to conservative religious entities are more likely to express sexual prejudice than are their peers [48, 49]. Among these groups, the strongest association with sexual prejudice seems to belong to religious fundamentalism [50]. Contact with lesbian women and gay men was found as a moderating factor on the negative impact of religion on sexual stigma [51].

Finally, with regard to sexism as a predictor of sexual stigma, research has shown that, in general, heterosexual men have more negative attitudes toward gay men and lesbian women [52] than women. The negative attitudes may be part of men’s deeper conformity to traditional gender belief systems [53].
Despite the negative psychological and social impact of sexual stigma, to date no studies have simultaneously analyzed levels and correlates of homophobia and transphobia in the general population and in health care providers (HCP). Moreover, studies addressing differences in terms of perceived discrimination levels between lesbian women, gay men, and transsexual people are missing. Finally, to our knowledge, the presence of homophobia in gender dysphoric populations has never been evaluated.

Aims

The aims of the present study were: (1) to evaluate attitudes toward homosexual and transgender people and religious fundamentalism in gender dysphoric persons (GD), in lesbian women and gay men, and to compare them with general population controls (C) and HCP; (2) to evaluate levels of perceived discrimination in the same populations; (3) to establish possible correlates (e.g., psychopathology levels, politic beliefs, religious education) of homophobia, transphobia, and religious fundamentalism in the considered groups.

Methods and main outcome measures

Study design

The study was conducted at the Sexual Medicine and Andrology Unit of the University of Florence and at the Department of Dynamic and Clinical Psychology, Sapienza University of Rome. A consecutive series of people referred to the Florence Gender Clinic and diagnosed with GD from December 2013 to February 2016 was enrolled. Patients were compared to a group of general population controls (C) and HCP both recruited by means of an advertisement in the University Hospital, at the Department of Developmental and Social Psychology and at the Department of Dynamic and Clinical Psychology of Sapienza University of Rome.

C and HCP men were asked to participate as controls in a study assessing levels of transphobia and homophobia characteristics, and they underwent the same assessment described below for GD individuals.

Study procedures were fully explained during the first routine visit and prior to the collection of data; after that, the patients were asked to provide a written informed consent.

The study protocol was approved by the Institution’s Ethics Committee. Patients provided their written informed consent to participate in the study.

Participants

A total of 310 subjects of similar age (mean ± SD age = 33.60 ± 10.35 years, F = 1.67, p = 0.116) were considered, including 122 GD (63 transwomen and 59 transmen), 53 heterosexual HCP (including medical doctors, nurses, laboratory technicians, 26 natal males, and 27 natal females), and 135 C (66 natal males and 69 natal females).

Diagnosis of GD was based on formal psychiatric classification criteria and performed through several sessions with two different mental health professionals specializing in GD. Diagnosis was made according to DSM-5 criteria [15].

Assessment

Participants completed the Modern Homophobia Scale (MHS) [54, 55] and the Attitude Toward Transgendered Individuals Scale (ATTI) [9] to assess attitudes toward gay men, lesbian women, and transgender individuals, respectively. In addition, GDs completed Gender Identity/Gender Dysphoria Questionnaire (GIDYQ-AA) [56, 57] and ATTI to measure, respectively, GD and internalized transphobia.

Religious attitudes were evaluated with the Italian version of the Religious Fundamentalism Scale (RFS) [58, 59]. The Italian version of the Discrimination and Stigma Scale (DISC-12) [60, 61] was used to measure perceived discrimination, and the Italian version of the Symptom Checklist-90-Revised (SCL-90 R) [62, 63] to assess psychopathology. Finally, Liebowitz Social Phobia Scale was used to evaluate social phobia levels.

The Modern Homophobia Scale (MHS) [54, 55] is a multidimensional scale assessing three dimensions of homophobia: deviance, personal discomfort (or socializing), and institutional homophobia. The MHS includes two subscales: one concerning attitudes toward lesbians (MHS-L with 24 items) and the other concerning attitudes toward gay men (MHS-G with 22 items). Both subscales were assessed using a 5-point Likert-type scale, ranging from 1 (do not agree) to 5 (strongly agree). Items were coded so that high scores reflected higher homophobic attitudes.

The ATTI is a 20-item scale evaluating transphobia levels [9]. Each item is a 5-point Likert scale (1 = strongly agree, 2 = agree, 3 = neither agree nor disagree, 4 = disagree, and 5 = strongly disagree). Higher scores denote strong negative feelings and behaviors toward transgendered individuals.

The Discrimination and Stigma Scale (DISC-12) is a 36-item structured interview developed to measure discrimination experienced in the last 12 months [60, 61]. Participants’ responses were rated with a 4-point Likert scale (0 = no difference, 1 = a little different, 2 = moderately different, and 3 = very different). The scale was adapted.
in order to assess discrimination related to sexual orientation and gender identity. In particular, homosexual and GD people were asked about discrimination perceived because of their sexual orientation or gender identity, respectively. Higher scores indicate more severe experiences of discrimination.

The Religious Fundamentalism Scale (RFS) is a 12-item scale assessing religious fundamentalism [58, 59]. Each item is rated on an 8-point scale (−4 = very strongly disagree, −3 = strongly disagree, −2 = moderately disagree, −1 = slightly disagree, +1 = slightly agree, +2 = moderately agree, +3 = strongly agree, and +4 = very strongly agree). Items 2, 4, 7, 9, 10, and 12 are worded in the contrary direction, and their scoring key is therefore reversed. Higher scores indicate higher levels of religious fundamentalism.

The Gender Identity/Gender Dysphoria Questionnaire (GIDYQ-AA) is a 27-item questionnaire evaluating GD [56, 57]. Each item is rated on a 5-point response scale, with the past 12 months as the time frame. The response options were Always (coded as 1), Often (coded as 2), Sometimes (coded as 3), Rarely (coded as 4), or Never (coded as 5). Lower scores are associated with higher levels of GD [56, 57].

The Symptom CheckList-90-Revised (SCL-90-R) is a measure of the psychological state using question items that ask, on a 5-point scale, how much a certain problem has bothered the subject over the past 7 days, allowing nine primary symptom scales and three global indices of distress to be derived [62, 63].

Social phobia was measured through the Liebowitz Social Phobia Scale [64], a 24-item questionnaire divided into two subscales. Each item is first rated on a 4-point Likert-type scale (0 = none, 1 = mild, 2 = moderate, and 3 = severe) indicating fear felt during the situations, and then the same items are rated again on a 4-point Likert-type scale regarding avoidance of the situation (0 = never, 1 = occasionally 1–33 %, 2 = often 33–67 %, and 3 = usually 67–100 %). Higher scores reflect higher levels of social phobia. In order to obtain an Italian version of the Liebowitz Social Phobia Scale, a process of translation, back-translation, and semantic concordance evaluation has been performed independently by two bilingual translators, who were experienced psychiatrists and English native speakers.

Sexual orientation was investigated through genotypic sex of a current partner, referred sexual orientation, and referred masturbation fantasy, as previously reported [65].

Moreover, in order to explore economic status (ES), a specific standard question was used. Responses were rated with a 4-point Likert-type scale (0 = low income, 1 = sufficient income, 2 = well off, and 3 = wealthy). Education level and employment status were assessed through standard questions with a 4-point (0 = primary school diploma; 1 = middle school diploma; 2 = high school diploma, and 3 = university or higher degree) and a 6-point Likert-type scale (0 = self-employed, 1 = employee, 2 = homemaker, 3 = unemployed, 4 = retired, and 5 = student), respectively.

Religious beliefs were investigated with a specific question (0 = I do not have a religious belief and 1 = I have a religious belief). In particular, individuals were asked about their attendance at religious services with responses rated on a 4-point Likert-type scale (0 = I do not attend religious services; 1 = I attend only for the main festivities; 2 = I attend about once a month, and 3 = I attend about once a week). Furthermore, religious education, relevance given to religion in daily life, adherence to religious precepts, and influence of religion on sexual behavior were explored all with responses rated on a 4-point Likert-type scale (0 = not at all; 1 = a little; 2 = enough; and 3 = a lot).

Finally, individuals were asked to define their political beliefs through a standard question rated on a 6-point Likert-type scale (0 = extreme left wing party; 1 = center left wing party; 2 = center party; 3 = center-right wing party; 4 = extreme right wing party; and 5 = no political party).

**Statistical analysis**

Continuous variables were reported as mean ± standard deviation, or median and quartiles, for non-normally distributed variables, whereas categorical variables were reported as percentage. A univariate analysis of variance (ANOVA) was used to compare the continuous variables among groups. Post hoc paired contrasts with Tukey’s B test were performed for the pairwise comparison among the groups. The Chi-square test was used for categorical variables. Independent sample test was also adopted for dichotomous comparisons of continuous variables. Pearson’s correlation was used to evaluate the associations between different variables. Finally, linear regression analyses were performed in order to adjust the aforementioned correlations for age. All analyses were performed using SPSS version 20 (SPSS Inc., Chicago, IL, USA).

**Results**

1. Clinical and sociodemographic characteristics of the samples studied.

The sociodemographic and clinical characteristics of the samples included are summarized in Table 1. Of the 122 GD individuals included, 63 (51.6 %) were transwomen, and 59 (48.4 %) transmen. The entire GD sample reported sexual attraction exclusively toward natal sex (heterosexual sexual orientation). Among the
C group, 38 males (hem-C) and 40 females (hef-C) reported exclusive heterosexuality and 28 males (hom-C) and 29 females (hof-C) homo- or bisexuality. No one among the HCP group reported homo- or bisexuality. Groups showed significant differences in terms of political beliefs ($p < 0.0001$), with transmen reporting a more liberal position than other groups ($p < 0.05$). Education level was also different among groups ($F = 15.78$, $p < 0.0001$), being higher in HCP people when compared to GDs and both hem-C and hef-C. In addition, ES was higher in hem-C vs. the rest of the sample ($p = 0.02$). Moreover, significant differences were found in terms of employment status. In particular, transwomen, when compared to other groups, were more often unemployed, while hem-C were more often retired and hef-C were more often students (all $p < 0.05$). Regarding religious

### Table 1 Sociodemographic characteristics of the sample

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<tbody>
<tr>
<td><strong>Age (years), mean ± SD</strong></td>
<td>33.1 ± 11.5</td>
<td>33.2 ± 7.3</td>
<td>29.9 ± 9.8</td>
<td>33.7 ± 10.1</td>
<td>28.8 ± 5.3</td>
<td>31.4 ± 5.6</td>
<td>32.4 ± 11.5</td>
<td>28.8 ± 8.7</td>
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<td><strong>Years of education, mean ± SD</strong></td>
<td>14.2 ± 3.8</td>
<td>17.0 ± 2.5</td>
<td>17.1 ± 2.2</td>
<td>17.4 ± 1.6</td>
<td>15.9 ± 2.5</td>
<td>15.7 ± 3.2</td>
<td>13.0 ± 3.6</td>
<td>12.7 ± 3.3</td>
<td>&lt;0.0001</td>
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<td><strong>Employment % ($n$)</strong></td>
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<tr>
<td>Self-employed</td>
<td>33.3 (13)</td>
<td>42.3 (11)</td>
<td>13.5 (5)</td>
<td>3.7 (1)</td>
<td>16.7 (5)</td>
<td>35.7 (10)</td>
<td>21.4 (13)</td>
<td>12.3 (7)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Employee</td>
<td>33.3 (13)</td>
<td>30.8 (8)</td>
<td>27.0 (11)</td>
<td>66.7 (18)</td>
<td>50.0 (14)</td>
<td>28.6 (8)</td>
<td>25.0 (16)</td>
<td>40.4 (24)</td>
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<tr>
<td>Homemaker</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>5.4 (2)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>1.8 (1)</td>
<td>0 (0)</td>
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<tr>
<td>Unemployed</td>
<td>0 (0)</td>
<td>19.2 (5)</td>
<td>16.2 (6)</td>
<td>14.8 (4)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>39.3 (25)</td>
<td>21.0 (1)</td>
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<tr>
<td>Retired</td>
<td>11.2 (4)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
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<tr>
<td>Student</td>
<td>22.2 (8)</td>
<td>7.7 (2)</td>
<td>37.8 (15)</td>
<td>14.8 (4)</td>
<td>33.3 (9)</td>
<td>25.0 (7)</td>
<td>12.5 (8)</td>
<td>26.3 (16)</td>
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<td>Economic status % ($n$)</td>
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<td>Low income</td>
<td>0.0 (0)</td>
<td>26.9 (7)</td>
<td>27.8 (11)</td>
<td>4.3 (1)</td>
<td>16.7 (5)</td>
<td>21.4 (6)</td>
<td>26.4 (17)</td>
<td>16.1 (10)</td>
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<td>Sufficient income</td>
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<td>53.8 (14)</td>
<td>47.2 (19)</td>
<td>47.8 (13)</td>
<td>45.8 (13)</td>
<td>46.4 (14)</td>
<td>50.9 (32)</td>
<td>69.6 (40)</td>
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<td>Well off or wealthy</td>
<td>55.6 (21)</td>
<td>19.2 (5)</td>
<td>25.0 (10)</td>
<td>47.8 (13)</td>
<td>37.5 (10)</td>
<td>32.1 (9)</td>
<td>22.6 (14)</td>
<td>14.3 (9)</td>
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<td>Religious beliefs, % ($n$)</td>
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<tr>
<td>No religious beliefs</td>
<td>39.3 (15)</td>
<td>42.3 (11)</td>
<td>43.2 (17)</td>
<td>60.9 (16)</td>
<td>51.9 (15)</td>
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<td>48.1 (30)</td>
<td>61.4 (36)</td>
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<td>60.7 (23)</td>
<td>57.7 (25)</td>
<td>56.8 (23)</td>
<td>39.1 (11)</td>
<td>48.1 (13)</td>
<td>21.4 (6)</td>
<td>51.9 (33)</td>
<td>38.6 (23)</td>
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<td>Political beliefs, % ($n$)</td>
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<tr>
<td>Extreme left wing party</td>
<td>0.0 (0)</td>
<td>7.7 (2)</td>
<td>13.5 (5)</td>
<td>4.3 (1)</td>
<td>11.1 (3)</td>
<td>25.0 (7)</td>
<td>9.3 (6)</td>
<td>6.3 (4)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Center left wing party</td>
<td>42.3 (16)</td>
<td>38.5 (10)</td>
<td>56.8 (23)</td>
<td>56.5 (15)</td>
<td>59.3 (17)</td>
<td>60.7 (18)</td>
<td>24.1 (15)</td>
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<tr>
<td>Center party</td>
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<td>19.2 (5)</td>
<td>0.0 (0)</td>
<td>4.3 (1)</td>
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<tr>
<td>Center-right wing party</td>
<td>26.9 (10)</td>
<td>15.4 (4)</td>
<td>0.0 (0)</td>
<td>8.7 (2)</td>
<td>3.7 (1)</td>
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<td>9.3 (6)</td>
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<tr>
<td>Extreme right wing party</td>
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<td>0.0 (0)</td>
<td>5.3 (3)</td>
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<tr>
<td>No political party</td>
<td>11.6 (5)</td>
<td>19.2 (5)</td>
<td>29.7 (12)</td>
<td>26.2 (7)</td>
<td>25.9 (7)</td>
<td>10.7 (3)</td>
<td>51.7 (33)</td>
<td>55.0 (32)</td>
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Statistics: univariate analysis of variance (ANOVA) for continuous variables and Chi-square test for categorical variable

Hem-C heterosexual males from the general population control group, mHCP male health care providers, Hef-C heterosexual females from the general population control group, fHCP female health care providers, Hom-C homo- and bisexual males from the general population control group, Hof-C homo- and bisexual females from the general population control group, MtF GD male to female gender dysphoric persons, FtM GD female to male gender dysphoric persons
beliefs, 59.4% (n = 184) were agnostics/atheists, 37.1% (n = 115) Christians (of which 114 Catholics and one orthodox), 2.6% (n = 8) Buddhists, 0.6% (n = 2) Hindus, and 0.3% (n = 1) Jews.

2. Comparison between groups in terms of religious fundamentalism, homophobia, and transphobia levels.

Groups showed significant differences in terms of religious fundamentalism (according to RFS score, \( F = 2.59, p < 0.02 \)). Transwomen and hem-C more often have a high score in the fundamentalism scale, whereas fHCP group reported the lowest level (Fig. 1a).

When compared to the rest of the sample, hem-C and mHCP showed significantly higher homophobia levels, according to MHS score, than the rest of the entire sample (\( F = 14.01, p < 0.001 \), Fig. 1b). In addition, considering MHS subscales, hem-C and mHCP showed also significantly more negative attitudes toward both lesbians (MHS-L) and gay men (MHS-G) compared to the other groups (\( F = 22.30, p < 0.001 \) and \( F = 42.18, p < 0.001 \), Fig. 1c, d, respectively).

A similar pattern was observed when transphobia levels were considered, including only C and HCP groups in the analysis. In fact, heterosexual males from the C and HCP groups showed significantly lower levels of ATTI compared to homosexual and heterosexual females of C and HCP samples (\( F = 19.58, p < 0.001 \) (Fig. 2).

3. Levels of perceived discrimination in GD, lesbians, and gay men.

Perceived stigma (DISC-12 scale) was found to be significantly higher in the hof-C vs. hom-C group (\( t = 3.48, p < 0.001 \), Fig. 3a) and in transwomen vs. transmen (\( t = 2.15, p = 0.03 \), Fig. 3b).

All the aforementioned results were confirmed after adjusting for religious fundamentalism.
4. Correlates of religious fundamentalism, homophobia, and transphobia levels.

Fundamentalism (RFS) was positively associated with more conservative politic beliefs \((r = 0.156, p < 0.001)\). When items regarding personal religiosity were considered, religious fundamentalism was associated with higher attendance at religious services \((r = 0.425, p < 0.001)\), more strict religious education \((r = 0.346, p < 0.001)\), and adherence to religious precepts \((r = 0.313, p < 0.005)\).

Considering transphobia and homophobia levels, fundamentalism (RFS) was significantly associated with a lower tolerance toward both homosexual and transgender people \((r = 0.447\) and \(r = -0.412,\) respectively, for MHS and ATTI; all \(p < 0.0001)\). Moreover, both homophobia (MHS) and transphobia (ATTI) were significantly associated with a higher attendance at religious services \((r = 0.429, r = -0.324,\) both \(p < 0.001)\) and higher influence of religion on sexual behavior \((r = 0.285, p < 0.02,\) and \(r = -0.312, p < 0.05,\) respectively, for MHS and ATTI). Considering psychopathology, MHS was positively correlated with paranoid ideation and psychoticism SCL-90-R subscales \((r = 0.205, p = 0.01,\) and \(r = 0.31, p = 0.006,\) respectively). No significant correlations were found between other SCL-90-R subscales and MHS. Finally, no significant associations were found between transphobia and homophobia levels with age, educational level, economic status, and strict religious education.

When only GD population was considered, internalized transphobia (ATTI scale) was found to be significantly correlated with fundamentalism (RFS, \(r = -0.433, p < 0.001,\) Fig. 4a) and homophobia levels (MHS, \(r = -0.488, p < 0.001,\) Fig. 4b). Moreover, perceived stigma (DISC-12) was significantly correlated with Liebowitz Social Anxiety Scale \((r = 0.264, p < 0.01,\) Fig. 4c), as well as with fear Liebowitz subscale \((r = 0.285, p = 0.01),\) even though Pearson’s coefficient was relatively small, given the small
sample size. Finally, internalized transphobia (ATTI scale) was significantly correlated with levels of gender dysphoria (GIDYQ-AA, \( r = -0.288, p < 0.0001 \)).

All the aforementioned associations were confirmed at multiple linear regression analyses, after adjusting for age and educational level.

Discussion

This study compared the attitudes toward transgender and homosexual people in sexual minorities, attempting to find social and psychopathological correlates of these dimensions.

The main results of the present study were as follows: (1) men showed significantly higher levels of homophobia and transphobia when compared to women; (2) perceived discrimination was higher in lesbian women compared to gay men and in transwomen compared to transmen; and (3) religious fundamentalism was associated with both homophobia and transphobia.

Consistent with previous research, men scored significantly higher than women on both homophobia [66, 67] and transphobia levels [68]. One interpretation of these findings could be that more negative attitudes toward lesbian women, gay men, and transgender persons are not directly related to homosexuality and transgenderism per se, but to a more general adherence in men to traditional gender roles [12, 13]. In line with this, it seems that the comparison with non-traditional gender manifestations (including gender identity, gender roles, or sexual orientation) could trigger men’s anxiety about their masculinity, which, in turn, is likely to promote both transphobia and homophobia [68]. Our results also confirm previous research about the presence of stigmatizing attitudes against gay men, lesbian women, and transgender persons among health care providers [69, 70]. In our sample, male health care providers were, besides heterosexual male controls, the most homophobic and transphobic. Providers’ prejudice about sexual orientation may contribute to health care disparities among sexual minorities, affecting the quality of patient-provider communication [71]. In particular, in the case of transsexuals, these attitudes—including refusal of care and harassment or violence in medical settings [69]—could be notably critical, considering the frequency of transsexuals’ contact with public hospitals (e.g., psychometric and clinical evaluations). Therefore, they are probably in a highly vulnerable condition, in which contact with informed, empathic, and welcoming professionals could provide psychosocial support and prevent psychological distress and other poor outcomes for general health [37, 40].

Regarding perceived discrimination, lesbian women resulted significantly more affected as compared to gay men. This result may appear, at a first glance, surprising. In fact, different studies have reported that gay men experience more acts of external homophobia (e.g., verbal and physical abuse) than lesbian women [72, 73]. However, a recent meta-analysis reported that gender did not moderate internalized homophobia levels and, thus, the greater experience of externalized homophobia in gay men cannot be translated into higher levels of internalized homophobia [74]. The different figure observed in the present study may be the consequence of not conforming to social expectations related to the female gender role of lesbian women. These are of relevance in a heteronormative and family-based culture such as the Italian context [75].

We also observed that MtFs reported higher levels of perceived discrimination compared to FtMs. This could be
explained by considering that a loss of masculinity in natal males is usually less acceptable than masculine traits and behaviors in natal females [65, 76]. Moreover, the higher levels of perceived discrimination observed in both lesbian women and MtFs may be also reinforced by the strong discrimination that women still suffer, on different levels, in the Italian context. In addition, we found an association between internalized transphobia and gender dysphoria levels (even though the coefficient was small); this finding highlights the importance of poor social acceptance in exacerbating the distress experienced by GD persons that tend to have a more stereotypical gender view. As a further confirmation of the consequences of homophobia in GD persons, we found a significant association between internalized homophobia and psychopathology, as well as between perceived discrimination and social anxiety.

Finally, consistent with previous studies, our results confirmed that religious fundamentalism is moderately associated with both homophobia and transphobia. This seems to be in line with the current Italian situation where the attempts to expand civil rights to homosexual couples and families still clash with the outrages of political sections strongly influenced by the Catholic Church [75]. Furthermore, it is interesting that in MtFs internalized transphobia was significantly highest according to levels of religious fundamentalism.

Several limitations to this study should be noted. The study used a convenience sample from specific geographic locations. Convenience individual samples can be justified by the difficulty in identifying members of minority groups as eligible for participation in a study, but in the case of HCP, a randomized and interdisciplinary nature of HCP samples may be helpful in defining target educational and training interventions. Moreover, the measures used were all self-reported, thus eliminating the opportunity to detect implicit attitudes toward sexual minority groups that exist beyond conscious awareness or control. In addition, the GD sample was not representative of all GD subjects because an unknown proportion of these subjects had not undergone professional assessment. Finally, the weakness of some correlations could be due to the relatively small sample size.

In conclusions, this framework implies the need to promote awareness and acceptance of these categories of people that seem to be more at risk and to oppose the discriminatory tendencies of our culture, strongly dependent on religious precepts, dogma, and gender roles. Particular attention should be placed on the health care provider training, to ensure that all people receive dignified medical assistance that is respectful of individual rights.

Compliance with ethical standards

Conflict of interest The authors declare that they have no conflict of interest.

Ethical approval The study protocol was approved by the Institution’s Ethics Committee.

Informed consent All patients have provided their written informed consent to participate in the study.

References