

FROM GENDER-AFFIRMING CARE TO TRANS-AFFIRMING CARE: Trans Youth
Discourses of Healthcare Access

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A dissertation submitted in partial fulfillment of
the requirements for the degree of

Doctor of Philosophy

University of Washington
2020

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Program Authorized to Offer Degree:
Nursing

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Abstract

FROM GENDER-AFFIRMING CARE TO TRANS-AFFIRMING CARE: Trans Youth Discourses of Healthcare Access

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Transgender youth in the United States face intersecting forms of societal marginalization and discrimination that places them at higher risk for disparate health outcomes compared to their cisgender peers. Access to care is known to improve long-term health outcomes among transgender adolescents, yet existing studies demonstrate that few youth receive transgender-affirming services. The overarching goal of this study was to better understand the healthcare-seeking experiences of transgender youth under 18 (both with and without parental support), highlighting how youths' perspectives might challenge existing ideas in health research and practice about what constitutes equitable access to care in this population. The present study was comprised of three interrelated analyses. The first analyzes the discursive framing of contemporary transgender youth in the existing healthcare literature by applying discursive analytic methods to a small, purposely assembled sample of 10 articles in which ideas about the diagnosis and treatment of transgender youth are presented, discussed, and evaluated. The second utilizes discursive analytic methods and principles of community-based participatory research to analyze data from interviews with self-identified transgender youth between the ages of 13 to 17 (n=11) and parents of transgender youth (n=6) to better understand how youths' transgender identity and legal status as minors impacted their ability to access health care or influenced the quality of care they received.

Youth participants were invited to participate as members of the data analysis team. Two of the 11 youth participants served as data analysts. The third and final analysis integrates the perspectives of 8 additional trans youth who participated in a focus group regarding access to care for transgender minors and utilizes discursive analytic methods to evaluate how notions of age, consent, and autonomy influenced youth's ability to access care and their inclusion in informed consent processes. Findings from this study suggest that a shift in research paradigms is needed for sufficiently addressing the health disparities facing trans youth, especially those most likely to experience inequitable access to care, particularly poor transgender youth, transgender youth who lack parental support, and transgender youth of color.

Dedication

This dissertation is dedicated to the memory of Lou Sullivan, who died from complications due to AIDS in San Francisco, California on March 2, 1991.

“When people look at me I want them to think – there’s one of those people...that has their own interpretation of happiness. That’s what I am”.

-Lou Sullivan

Acknowledgments

My deepest gratitude and respect to the nineteen young people that volunteered their time and shared their experiences with me. To everyone that made the time to meet with me and talk with me, that invited me into their homes, that offered me food, that spent time and energy communicating with me to arrange interviews or answer follow-up questions over e-mail – thank-you!

To the people in Seattle and beyond that supported the logistics of this research project and made time to share your perspectives, offered feedback, made space for me, and made connections at varying stages of this project: Chris Brown, Nicholas George, Sasha Duttchoudhury, John Farley, Morgan Darby, Aidan Key, Eyva Winet, Genya Shimkin, Kendra Liljenquist, Britt Murphy, and Jeremy Miller. To all of the individuals at schools and organizations throughout the Seattle-Tacoma area who helped me secure safe interview space to meet with youth when they chose to interview without their parents present. To Diana Tordoff – for being a witness, an ally, a co-conspirator, a teacher, and a friend. To April Clark, Robin Hardwick, and Will St. Pierre Nelson – for taking a chance on me and agreeing to be part of the analysis and manuscript development phases of this project. Dean Weiler – for the gift of your incredible artistic talent, which brought the experiences and perspectives of participants to life at presentations and conferences; your work engaged people in a way that I would never have been able to do without your illustrations! To Billy Rosa – for entering my life at the exact moment I needed you and for being a witness and a mirror during the dissertating stage of this process.

To the members of my committee – Drs. Ira Kantrowitz-Gordon, Doris Boutain, Marieke van Eijk, and Helene Starks – for your steady support throughout my doctoral experience, for your thoughtful feedback, for contributing your insights, experiences, and expertise, and for being my pacers. To Dr. Amanda Swarr – for your encouragement early in the process of this research. To Dr. Selina Mohammed – for taking the time to meet with me, listen to me, and think with me at pivotal points over the last three years.

This research was made possible by generous funding and support from the Robert Wood Johnson Foundation Future of Nursing Scholars Program. To Heather Kelley, Amanda Bastelica, Samantha Fotos, and Drs. Julie Fairman and Kathy Dracup – for believing that I was valuable and helping me navigate the highs and lows of this process. Additional funding support was provided by the Washington Institute for the Study of Inequality and Race and University of Washington School of Nursing Hester McLaws Nursing Scholarship, for which I am grateful.

To my mother and my brother, Betti and Mikey Shook, for always saying ‘I Love You’, particularly when it hasn’t been easy.

Over the last three years, when I envisioned the moment I’d finally sit down to write the acknowledgements of this dissertation, I always thought the exact right words would come to me, that I’d have the words to properly thank each of you for the invaluable contributions you’ve made to my life. I thought it would feel like the closing of a chapter, one that I opened fifteen years ago when I ‘crossed over’...for lack of a better way of putting it. In many ways it has felt exactly like I expected and not like that at all. In alphabetical order: Amy Alikhani, Marcia Benjamin, Renee Byrd, Joseph Canarelli, Dresden Carvalho, Cathy Johnson, Megumi Iwasa, Augustus Klein, Tim Matheson, Shafer Mazow, Kevin Miles, Tracy Montauk, Elizabeth Nicholson, Deanna Pusatier, Gaelen Stevens-Nelson, and Kelly Storck – you are my queer family, the family I made from scratch. I was never alone in this process because each of you was with me...helping me to cross over ...over, and over again.

To my partner Kevin Custer, love of my life – Thank-You...for “traveling down the road of life with me”. As the Reverend Doctor Douglas Harrison says: “The dissertative spouse is a singular thing to live through.” We made it love! Forward always.

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Chapter One

Introduction

The past decade has witnessed rapid growth in programs that address the health and wellbeing of transgender (henceforth, trans) youth. Paralleling (or perhaps propelling) an explosion of scientific publications in the past five years, the United States has witnessed the opening of over 30 adolescent clinics that specialize in providing “gender-affirming care” to trans youth (often called “gender clinics” or “transgender clinics”)¹, as well as a series of historical funding announcements from the National Institutes of Health indicating their interest in funding “research addressing the medical, sociological, psychological and structural causes and consequences of transgender and gender nonconforming identities.”² While extant studies overwhelmingly demonstrate that transgender youth face unique challenges accessing healthcare services and health information³⁻⁸, particular types of transgender experiences have and continue to be privileged in research and scholarship, with most literature regarding transgender youth focused on individuals who seek binary gender transition⁹.

Access to trans-affirming care is known to improve long-term health outcomes among transgender youth in the U.S., yet existing studies demonstrate that few youth receive these services³⁻⁸. Research suggests that the majority of trans adolescents and adults become aware of their transgender identity during pre-pubescence, with one study suggesting that 60% of trans individuals felt that their gender was ‘different’ before the age of 10¹⁰⁻¹². While some trans youth articulate their gender identity to parents/guardians as young as three years old, current data on trans youths’ experiences suggest that the average age adolescents share knowledge of their self-determined gender is 17 years old^{11,13}. It is likely that some adolescent youth who may come to identify as transgender later in life do not currently have language or social models to express their gender identity, lack parental support and/or safe environments in which to disclose their transgender status, or lack the type of healthcare access necessary for receiving a transgender-related diagnosis (e.g., gender dysphoria) which is required to accomplish medical gender transition before the age of 18 (if such intervention is desired at all).

Among the studies that have explored barriers to care, researchers have generally recruited participants from within existing clinical samples and often give notable attention to the experiences and opinions of parents and legal guardians^{7,14-17}. However, these experiences represent only a small subset of trans youth, in large part because of limited inclusion in research of trans youth under age 18, both with and without parental support. While parental consent is a hallmark of pediatric research ethics, especially for vulnerable children, requiring parental consent for participation in research among trans youth likely contributes to the narrow view and agenda about which health services are needed and important in this population¹⁸. Additional structural level factors contribute to inequity in access to appropriate trans-affirming medical care for trans individuals generally and are likely to be exacerbated in the case of youth because of their status as legal minors. These include geographic disparities in the availability of qualified medical and mental health providers willing and able to offer appropriate care, fear of discrimination from members of the health care community, and disparities in health insurance coverage that render certain procedures and interventions unaffordable for many¹⁹⁻²².

Furthermore, biomedical approaches to transgender phenomena tend to gender identity as an individual aspect of selfhood. Often the terms that are used in research and clinical practice to delineate trans populations from their cisgender peers (i.e. language used to construct particular individuals as gender non-conforming) are often the same terms that “reinscribe the limitations of gender as a social construction that constitutes the pathologization of gender nonconformity”²³. Considering the power relations within which transgender individuals have been constructed as “other” in relation to the taken for granted cisgender norm – and youths’ legal status as minors – a paradigm shift is needed for sufficiently addressing the health disparities facing trans youth, particularly poor youth, youth who lack parental support, and youth of color²⁴.

The overarching goal of this dissertation is aimed at addressing this gap in the existing literature and at better understanding the experiences of transgender youth when seeking and navigating healthcare (both with and without parental support), highlighting how youths’ perspectives might challenge existing

ideas within health research – and healthcare practice more generally – about what constitutes equitable access to care in this population. Data for this study were taken from multiple sources; therefore, specific aims were targeted at particular data sources.

Specific Aims

Aim 1: Analyze the discursive framing of contemporary trans youth in the extant healthcare literature (e.g., medicine, psychology, nursing, social work). Paper 1/Chapter 2, “Gender Affirmation and Contemporary Trans Youth: A Critical Discourse Analysis,” analyzes the discursive framing of contemporary trans youth in the existing literature. We applied discourse analytic methods to a small, purposively assembled sample of 10 articles where our analysis was aimed at addressing the theoretical question of how the present model of care reinforces discourses of normativity, what types of trans youth are likely to have access to specialized pediatric gender clinics, and the possibility that the existing model of specialized care for trans youth is likely to exacerbate existing inequities in the U.S. healthcare system.

Aim 2: Describe the narratives of healthcare access among trans youth ages 13 to 17. Paper 2/Chapter 3, “Transgender Youth Talk About Access To Care: Results from the Trans Youth Health Experiences Study” utilizes discursive analytic methods and principles of community-based participatory research to analyze data from interviews with self-identified transgender youth between the ages of 13 to 17 (n=11) and parents of transgender youth (n=6). Youth participants were invited to participate as members of the data analysis team. Two of the 11 youth participants served as data analysts. Three youth participant-researchers are currently collaborating on manuscript development. Our analysis was aimed at better understanding how youths’ transgender identity and legal status as minors impacted their ability to access care or influenced the quality of care they received.

Aim 3: Understand the role that consent plays in regulating access to care for trans youth. Paper 3/Chapter 4 utilizes the existing qualitative data set from the Trans Youth Health Experiences Study, integrates the additional perspectives of 8 trans youth who participated in a focus group regarding access

to care for trans minors, and focuses on how notions of age, consent, and autonomy influenced youths' ability to access care and their inclusion in informed consent processes.

We conclude by discussing implications for future research and practice as well as relevance to the field of nursing.

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Chapter Two

Gender Affirmation and Contemporary Trans Youth: A Critical Discourse Analysis

Abstract

While significant research has been undertaken in recent years to address the health inequities facing transgender youth as well as potential interventions for alleviating these disparities, limited attention from within the health sciences has been paid to the possible role that discourse plays in producing ideas about who is or is not a transgender child as well as what health resources should be leveraged on their behalf and under what conditions. In this article, we undertake a critical discourse analysis of the existing literature on trans youth health and health care by closely examining ten exemplary texts. Our analysis was primarily concerned with better understanding the discursive processes through which trans youth have been constructed as a new, at-risk social category, as well as how talk about trans youth health functions to produce a dominant discourse regarding the health and health care needs of contemporary ‘gender non-normative’ youth. We identified three overarching discourses present across each of the 10 texts we analyzed. These included *discourses of gender non-normativity*, *discourses of risk*, and *discourses of gender-affirmation*. Discourses of gender non-normativity centered on the notion that transgender youths’ particular sex/gender configurations are misaligned or incongruent, set trans youth apart from their cisgender peers, and produced the logic that establishes diagnostic criteria for gender dysphoria. Discourses of risk took place within broader narratives of distress among trans minors, as well as the potential for biomedical intervention, and centered on the notion that intervention is justified in order to prevent future negative health outcomes. Discourses of gender-affirmation were framed in terms of benevolence and rescue and functioned to obscure the role that health care practices – and the biomedical discourse they enact – have played throughout history in the construction and regulation of ‘transgender’, as well as the construction and regulation of sex/gender more generally. Together, discourses of gender non-normativity, risk, and gender affirmation found across the 10 scientific articles we analyzed combined to produce a dominant, overarching discourse of gender abnormality or pathology, which situated ‘transgender’ within biomedical discourse as always already fractured. This discourse produces ‘transgender youth health care’ as a medical subspecialty, perpetuates ideas about transgender embodiment as anomalous, and works to reinforce sex/gender norms that produce the logics upholding

the binary gender segregation of social and institutional practices throughout the United States. We suggest that future research regarding the health and health needs of trans youth under age 18 center the perspectives of these youth, both with and without parental support, and consider their perspectives as critical to ensuring the equitable, accurate, and ethical production of knowledge regarding their care and wellbeing.

Introduction

In a relatively short period of time, during which diagnostic language associated with transgender phenomena has changed rapidly¹, contemporary transgender (henceforth, trans) youth have come to be regarded as a vulnerable and medically underserved population with unique health needs – in large part because of their age. Consequentially, there has been a proliferation of scientific research regarding the health and health care needs of trans youth in the last decade, particularly within the previous five years. A growing body of literature emerging from within the health sciences (e.g., medicine, nursing, social work, and psychiatry and behavioral science) has begun to address the significant health disparities facing trans youth, as well as emerging models of healthcare aimed at improving health outcomes and overall quality of life among trans youth²⁻¹⁵. While significant research has been undertaken to address the health inequities facing trans youth as well as potential interventions for alleviating these disparities, limited attention from within the health sciences has been paid to the possible role that discourse plays in producing ideas about who is or is not a transgender child as well as what health resources should be leveraged on their behalf and under what conditions. In this article, we undertake a critical discourse analysis of the existing literature on trans youth health and health care by closely examining ten exemplary texts. Our analysis was primarily concerned with better understanding the discursive processes through which trans youth have been constructed as a new, at-risk social category, as well as how talk about trans youth health functions to produce a dominant discourse regarding the health and health care needs of contemporary ‘gender non-normative’ youth. We consider how the discursive framing of trans youth health and health care primarily in terms of gender-affirmation is likely to occlude the experiences of trans youth under 18 who lack parental support or access to specialty medicine, as well as individuals whose experiences of gender transcend binary categories of boy/man or girl/woman but who do not receive a transgender-related diagnosis as children or adolescents.

A Brief History of the Present

Historically, gender non-normativity among children and adolescents has been pathologized and was treated as a mental illness for decades. Scientific interest in the identification and treatment of gender non-normative children gained popularity during the 1960s and '70s among researchers and clinicians studying what they perceived as a mental health crisis of feminine boyhood during the post-World War II era¹⁶⁻²⁷. While gender variance had long been of interest to practitioners of medicine and psychology, a number of factors contributed to the reconstruction of the meanings attached to gender variance at this time, particularly regarding gender-variant boys¹⁹. As Bryant has previously documented, these factors included 1) a crisis of White masculinity in the period following World War II^{28,29}, 2) the rise of psychological understandings of personal issues and public concerns^{30,31}, 3) the disruption of conventional gender roles during the Depression and World War II, 4) increased visibility of LGBTQ+ communities, and 5) the construction of transsexuality as a “new social subjectivity and medical-psychological issue”^{19(p25),32}. Gender non-normativity – often also frequently referred to as gender non-conformity – was established as a pathological condition in need of a cure. Goals of treatment aimed to align children’s gender expression with existing social norms. Discussions of gender-variant boys at this time were often framed as discussions about gender variant children more generally, where the ultimate goal was the identification of “pre-homosexual” children. Although research was simultaneously being conducted regarding masculine or non-normative girl children, Sedgwick has argued that the early focus on gender non-normative boys was likely a function of the historical privileging of masculinity over femininity³³.

By the 1980s, a new psychiatric diagnosis – Gender Identity Disorder in Childhood, or GIDC – was introduced into the third revision of the Diagnostic and Statistical Manual. Until recently, GIDC was defined as “a strong and persistent cross-gender identification” combined with “evidence of persistent discomfort about one’s assigned sex or the sense of inappropriateness in the gender role of that sex”^{34(p576)}. For many years, GIDC and the treatments associated with it were debated by scholars in

medicine and psychology, scholars of gender and sexuality, and transgender community activists^{33,35-44}. Critics of GIDC and its treatments argued that the diagnosis operated to enforce normative conceptions of masculinity and femininity, pathologize homosexuality, and situate particular social ‘problems’ as aspects of individual pathology¹⁹. It was not until 2012 and following years of controversy – over 30 years after the establishment of GIDC as a diagnostic category – that the World Professional Association for Transgender Health¹ (WPATH) declared in its 7th edition publication that medical and psychiatric treatment aimed at changing gender identity and expression were no longer considered ethical⁴⁵. In 2013 the GIDC diagnosis was removed from the fifth edition of the *Diagnostic and Statistical Manual for Mental Disorders (DSM-5)*⁴⁶ and replaced with “gender dysphoria,” and the diagnosis for children was separated from that for adults^{19,47}. According to the American Psychiatric Association, this change in the diagnostic language associated with transgender phenomena signaled a shift in the understanding of ‘transgender’ as a diagnostic category previously characterized by “cross-sex identification” to one primarily understood as an issue of “gender incongruence”^{1,48}.

While some researchers and clinicians continue to advocate for ‘conversion’ or ‘reparative’ treatment models that reinforce normative gender expression and seek to prevent transgender identity^{49,50}, the prevailing contemporary model of healthcare aimed at treating gender non-normative, gender non-conforming, and/or transgender youth – the gender-affirmative model of health (GAMH) – increasingly positions gender variance as a part of human diversity⁵¹⁻⁵⁵. The gender-affirmative model holds that “gender variations are not disorders, gender may be fluid and not binary, and gender development is multifaceted, involving biological, developmental, and cultural contexts”^{56(p166)}. This shift in treatment models and goals has predominantly been regarded by researchers and clinicians as a paradigm shift – from gender pathology to ‘gender affirmation’ and harm reduction^{42,43}. By 2014, upwards of thirty child

¹ The World Professional Association for Transgender Health is an international, multidisciplinary, professional association whose mission is to promote evidence-based care, education, research, advocacy, public policy, and respect in transsexual and transgender health. Standards of care for the treatment of transsexual, transgender, and gender-nonconforming people were first published in 1979.

& adolescent gender clinics had been established at pediatric hospitals and healthcare systems throughout the United States⁵⁹. Additionally, pediatric medical and mental health providers often provide similar services in private practice or public health clinics where providers are frequently regarded as pediatric gender specialists. In 2015 the National Institutes of Health awarded \$5.7 million for a five-year, multicenter study – the first in the United States – aimed at evaluating the long-term outcomes of medical treatment for transgender youth at four academic medical centers in Los Angeles, San Francisco, Chicago, and Boston⁶⁰. Most recently, in 2018, the American Academy of Pediatrics issued its first-ever policy statement supporting a gender-affirmative care model for youth who “do not conform to social expectations and norms regarding gender”^{61(p1)}. The policy statement reviews current concepts related to the provision of medical and mental health services for transgender minors and provides “suggestions for pediatric providers that are focused on promoting the health and positive development of youth that identify as transgender while eliminating discrimination and stigma.”

While significant advances have been made to support the health and wellbeing of transgender and gender non-conforming youth, we find that transgender bodies, identities, and experiences continue to be defined and diagnosed in terms of their non-normativity – as individuals who “do not align with traditional notions of masculinity and femininity”⁶², “[who] display incongruence”⁶³, and who “depart from the cultural norms and expectations implied by their assigned sex at birth”⁶⁴. Particular types of transgender experiences have been – and continue to be – privileged in research and scholarship, with most literature on transgender youth health focused on individuals who seek binary gender transition (e.g. transition ‘from one gender’ to ‘the other gender’)⁶⁵. The narrow focus in previous research on biomedical intervention as the essence of transgender youth health produces at least three detrimental effects.

First, it is likely to marginalize individuals whose experiences of gender over the course of their lifetimes may not fit into binary categories of boy/man or girl/woman. Second, it constrains notions of transgender health to those embodied experiences that relate only to gender crossing. For example, health equity and health disparity in this population have largely come to be defined in terms of access to

pubertal suppression, cross-sex hormones, and “gender-affirming” or “gender-alignment” surgeries within the context of binary gender transition⁶². Third, it constructs gender transition – whether socially or medically situated – as an event with a distinct beginning and end and as a treatment – an intervention – that can be evaluated in relation to other markers of health and illness such as depression, anxiety, substance use, and suicidal ideation^{66–68}.

To some extent, these issues have been explored in bioethics literature regarding hormone treatment of children and adolescents diagnosed with gender dysphoria and have centered on notions of health equity, access, and distribution of health resources. With regard to the foundational bioethics principle of justice (“the equal distribution of benefits and burdens among social groups”), access to care is currently inequitable⁶⁹. Franklin, for example, has argued that researchers and scholars find additional pathways for addressing the social determinants of health among trans youth⁷⁰. The limited focus on particular medical technologies (e.g., puberty blockers, hormones, and surgeries) is insufficient for addressing the significant health disparities facing trans youth, particularly poor trans youth, youth who lack parental support, and trans youth of color who are likely to experience inequitable access to healthcare more generally⁷⁰.

Methodology

Discourse Analysis

Discourse analytic theory and methods were utilized to conduct our analysis. Discourse analysis (DA) arises from within linguistic studies, literary criticism, and semiotic, performative theories of language⁷¹. A discursive approach to research explores language as a “form of action”⁷² and seeks to understand how individuals and institutions use language to create and enact identities and activities⁷¹. DA is operationalized and conceptualized differently by different disciplines, and there is no agreed-upon approach or set of analytic steps considered uniform to discourse analysis. While linguistics focuses on the function and structure of words and phrases, critical social theory takes a different approach and looks at language as a social practice, taking into consideration the *context* of language use (e.g., within the

context of a scientific body of knowledge on a particular subject; for example, transgender youth health)⁷³. Discourse analytic methods are often used to examine structural inequalities in healthcare, communication in healthcare contexts, health policy, and power dynamics in health service provision.

The term “discourse” is used variably by scholars conducting discourse analyses but generally refers to multiple and different ways of understanding the world⁷⁴. Rather than merely mirror or represent reality, discourses make things happen and bring things into being; they construct social reality⁷⁵. Dominant discourses, for example, work to promote viewpoints and uphold ideologies that codify existing power relations, hierarchies, and social structures⁷⁶. We adopted a Foucauldian definition of discourse in which the word discourse refers to “practices that systematically form the objects of which they speak”^{77(p15)}. Foucault was primarily concerned with discourse, power, and how social identities – what he termed “subject positions” – are constructed. Foucault’s work was directed at entire systems of thought or “knowledge systems”⁷⁸ (e.g., medicine, religion, psychology, law) and was concerned with the dynamics through which individuals become – or are forced to become – institutionally recognizable types of subjects (e.g., ‘real transgender youth’). A discourse in Foucauldian terms is a body of knowledge that both constrains and enables what, in any given historical moment, we can write, speak, think, or ask about a given social object or practice⁷⁵. Discourse makes it possible to think some thoughts and not others, as well as empower some speakers and disqualify or invalidate others. A Foucauldian approach to discourse analysis examines the institutional and societal discourses that enable and constrain individual action at a particular moment in time⁷⁹. This is different from discursive psychology, for example, a form of discourse analysis that focuses on how individuals engage different discourses to pursue personal goals⁸⁰.

Critical Discourse Analysis

Critical discourse analysis (CDA) is a form of DA that focuses specifically on the role that language plays in producing power structures and inequity – as well as opportunities for improving the conditions under which the marginalized suffer. Researchers who utilize CDA are interested not just in

how people use language, but in how discourse is linked to power⁸¹. According to Foucault, discourse produces power as well as knowledge. As such, Foucauldian-informed CDA is often employed to examine the experiences of individuals and communities whose perspectives have been suppressed or obscured by the relations of power, what Foucault called “subjugated knowledges”⁸². Sutherland et al. write, “Foucault conceptualized power as pervasive, socially distributed, and discursive, rather than as a tool consciously used by individuals or groups. Power is not something that people possess – instead, it circulates throughout social relations and constitutes people into certain kinds of subjects suitable to a prevailing political order”⁸³. We took up a *critical* discourse perspective in that our analysis was particularly focused on the power relations within which transgender individuals have been constructed as “other” in relation to the taken for granted cisgender norm. As such, we understood ‘transgender’ not as a predetermined category into which identities or bodies are inherently formed or ‘ready-made,’ but as a shifting discursive category produced through medical, legal, and cultural practices over time^{84,85}. According to Willig, “Foucauldian discourse analysts focus on the availability of discursive resources within a culture [or particular time period] – something like a discursive economy – and the implications of this for those who live within it”^{79(p130)}. In the present analysis, we focused specifically on understanding how ‘transgender’ is constructed and evaluated in the existing scientific literature on transgender youth health, as well as how power – circulating as ‘expertise’ – operates to produce a dominant discourse that guides the provision and regulation of health care for contemporary transgender minors.

CDA differs from other methodological approaches to research in that it determines its site(s) of interest in advance, and follows a different and critical approach to problems⁸². “Critical,” which can be traced to the influence of the Frankfurt School or Jurgen Habermas, refers to a particular relationship to the data in which analysis takes an explicitly political stance⁸². Critique is aimed at making visible the interconnectedness of institutions and everyday life. CDA projects are bound together by a particular approach to research – and a focus on self-reflection of scholars doing research – rather than by a solitary theory or methodology. Wodak suggests that “theory as well as methodology is eclectic: both are

integrated as far as it is helpful to understand the social problems under investigation”^{82(p29)}. However, the concepts of power, history, and ideology are each central in all CDA⁸². Issues prominent in research projects that employ CDA include gender issues, issues of racism, media discourses or other dimensions of identity that have become important in contemporary discussions. CDA can be helpful in identifying what discourses obscure about the ways that institutions participate in the generation and regulation of norms, or what Foucault termed “the mechanics whereby [a discourse] becomes produced as a dominant discourse”^{77(p17)}.

Critical Trans Theory

Critical trans theory, or transgender studies, is an interdisciplinary field concerned with both material conditions and representational practices and pays particular attention to the interface between how trans individuals are represented in dominant discourse (i.e. in the existing scientific literature on trans youth health) and how the politics of representation impact their everyday lives. Like other socially oriented interdisciplinary fields of inquiry such as disability studies and critical race theory, transgender studies is concerned with addressing questions of “embodied difference” and analyzes how such differences are transformed into social hierarchies – systems of power – that “operate on actual bodies, capable of producing pain and pleasure, health and sickness, punishment and reward, life and death”⁸⁶. Critical trans theory calls into question the epistemological framework that approaches gender as a system for connecting two supposedly stable and naturally occurring biological sexes (male and female) with two fixed and normative social categories (man and woman)⁸⁶. Transgender studies treat the immense body of scientific literature on transgender phenomena – dating back to the nineteenth century in Europe and the United States – as its archive⁸⁶. Where relevant, we have integrated the perspectives of critical trans scholars whose work has addressed the role of discourse in the construction and regulation of trans subjectivity. Our aim in including the perspectives of critical trans scholars was to bring the fields of gender and sexuality studies and health research into conversation and further validate and contextualize our findings. Our analysis is situated within a particular historical moment during which scientific and

popular representations of trans youth have been made hyper-visible via neoliberal configurations of risk, prediction, measurement, intervention, and outcome. As Stryker and Aizura write, “as trans subjects become ‘countable,’ we also become vulnerable to new modes of biopolitical regulation, including the increasingly tight management of precisely what combination of surgical and hormonal bodily transformations are required to legally define a person’s sex and transgender status”^{87(p7)}. The politics of recognizability have particularly salient consequences for trans youth who experience health and seek healthcare services as individuals who are not granted the autonomy or authority of knowledge to make decisions about their bodies and health without parental permission because of their status as legal minors.

Methods

Selection of Documents for Analysis

This study involved the collection and analysis of existing scientific literature in which ideas about the diagnosis and treatment of transgender youth are presented, discussed, and evaluated. We conducted an initial search of PubMed using the search terms “gender affirming healthcare youth.” Our search was limited to articles published in English within the previous ten years and included ages birth to 18 years. This initial search yielded a total of 58 articles. We then reviewed article titles and abstracts and excluded articles not specifically relevant to transgender youth health in the United States (i.e., articles relevant to transgender adult populations or transgender youth outside the United States). The terms ‘gender non-conforming youth’ and ‘transgender youth’ were often used interchangeably. Therefore, articles that did not include ‘transgender youth’ in the title or abstract but did include ‘gender non-conforming youth’ were included. This resulted in a total of 24 articles, each of which addressed transgender youth health in some capacity. Topical areas varied and included issues related to fertility preservation, ethical considerations in the treatment of trans youth, predictors of suicidal ideation, attempt, and risk, binary gender categorization in health care systems and electronic medical records,

barriers to HIV prevention services for trans youth, barriers to care more generally, and broad overviews concerning the diagnosis and treatment of transgender or gender non-conforming youth.

Of these 24 articles we narrowed our search to a total of 10 articles, each of which met the following criteria for inclusion in our analysis:

- Provided a definition of ‘the transgender child’
- Discussed etiological factors of gender identity disorder of childhood/gender dysphoria as well as prevalence estimates of transgender individuals in the United States
- Outlined gender identity development
- Outlined mental health issues among trans youth and associated treatments
- Discussed medical treatment options and gender transition (also frequently referred to as ‘gender-affirmation’), with many also addressing surgical interventions
- Addressed clinical practice guidelines and recommendations, as well as research priorities related to the care of transgender minors.

These ten articles do not represent all of the dynamics relevant to the diagnosis and treatment of transgender youth, nor are they reflective of all emerging healthcare practices that practitioners employ in their work with transgender young people. However, together they provide substantive content on which we were able to evaluate and analyze the dominant discourse that inscribes and enables the notion of contemporary ‘transgender youth health’ and the provision of health services aimed at addressing the health and healthcare needs of trans youth in the United States today. Given the labor-intensiveness of discourse analysis and the need to validate findings with textual examples, many discourse analyses examine a relatively small amount of text, frequently as few as one or two interviews or other texts such as media texts⁸⁸. The ultimate collection of 10 articles is briefly outlined in *Table 1*.

Data Analysis

We applied discourse analytic methods to a small, purposively assembled sample of 10 articles. A discursive approach to these texts provided a framework for exploring how language serves as a “form

of action”⁷² through the production and reproduction of a particular set of ideas and norms iterated and reiterated in health sciences literature regarding transgender youth health and health care⁷¹; “the state of the science”. Specific to our analysis, this regarded the processes whereby gender non-normativity was discursively produced in the literature, particularly among child subjects, and the potential impact that discourse has on the provision of health resources for trans minors. We were also interested in how prevailing ideas about gender-affirming care might obscure or render invisible certain historical processes or social issues related to the provision of health services and interventions for these youth.

We utilized Willig’s framework for CDA using a Foucauldian perspective to guide the analytic process⁷⁹. After reading through the texts to develop familiarity, the focus of our analysis was the examination of the texts for discourse, i.e. “practices that systematically form the objects of which they speak”^{77(p15)}. We first analyzed the various ways in which discursive objects (what Willig calls “objects of study”) were constructed relating to the aims of our study (e.g., how were ‘transgender youth’ or ‘gender-nonconforming youth’ constructed within the texts?). Next, we examined the transcripts for differences between and across constructions of the discursive object. For example, in what ways did authors frame transgender youth health in terms of the dominant discourse of gender-affirming health care or gender-affirmation? This stage of the analysis sought to identify the various discursive constructions of transgender youth health within broader, system-level discourses; for example, biomedical discourse, risk discourse, cisgender discourse.

We then focused on a closer analysis of the discursive contexts in which the different constructions of trans youth and their health needs took place. Willig asks, “What is gained from constructing the object in this particular way at this particular point within the text?”^{79(p174)}. For example, transgender youth were often framed as children who “display incongruence”⁶³, “do not align with traditional notions of masculinity and femininity”⁶², and who “depart from the cultural norms and expectations implied by their sex assigned at birth”⁶⁴. What is gained from constructing transgender youths’ particular sex-gender configurations as misaligned or incongruent in the scientific literature regarding their health and health needs? We then identified various subject positions and how discourses

constructed particular subject positions. Subject positions are about the creation of subjectivities, which speakers can take up as well as place others within. In the case of transgender youth, if ‘transgender’ is the object of study, what types of transgender youth subjectivity are constructed as legitimate, diagnosable, and thus appropriate sites of intervention?

We then examined the relationship between discourse and healthcare practice by systematically exploring the ways in which discursive constructions and the subject positions contained within them facilitate or foreclose opportunities for action within the healthcare context. This entailed exploring how discourse plays a normalizing and regulatory role and reflecting on how discourses encourage certain ways of relating and discouraging others. Our final stage of analysis focused on exploring the relationship between discourse and subjectivity. How does discourse shape how the health needs of trans youth have come to be understood, what health resources are deployed on their behalf, and under what conditions?

Results

We identified three overarching discourses present across each of the ten texts we analyzed. These included *discourses of gender non-normativity*, *discourses of risk*, and *discourses of gender-affirmation*. Discourses of gender non-normativity centered on the notion that transgender youths’ particular sex/gender configurations are misaligned or incongruent, set trans youth apart from their cisgender peers, and produced the logic that establishes diagnostic criteria for gender dysphoria. Discourses of risk took place within broader narratives of distress among trans minors, as well as the potential for biomedical intervention, and centered on the notion that intervention is justified in order to prevent future negative health outcomes. Discourses of gender-affirmation were framed in terms of benevolence and rescue and functioned to obscure the role that health care practices – and the biomedical discourse they enact – have played throughout history in the construction and regulation of ‘transgender’, as well as the construction and regulation of sex/gender more generally.

Discourses of gender non-normativity

Across each of the texts we analyzed, transgender youth were defined in terms of atypicality and non-normativity. Phrases such as “not typical” and “does not align” situated trans children as fractured beings who come to the attention of biomedical authority in need of observation and repair. For example, Chew et al. defined ‘transgender’ as “a term used to describe an individual whose inner gender identity differs from their sex assigned at birth”⁸⁹. While authors varied in how they defined or described transgender, consistent across the texts was a focus on atypicality⁶³ and misalignment⁶⁷. This construction of difference between one’s “inner” gender identity and sex assigned at birth operated to position ‘transgender’ as an individual aspect of selfhood characterized by a “mismatch” between body and mind that is unique to transgender individuals.

“This mismatch can cause distress and functional impairment, resulting in gender dysphoria or what was previously termed ‘gender identity disorder’.”⁸⁹

Gender dysphoria – which replaced ‘gender identity disorder’ in the *Diagnostic and Statistical Manual for Mental Disorders (DSM)* in 2013 – is presently defined as “clinically significant distress (of at least six months duration) related to the *incongruence* between one’s affirmed or experienced gender and one’s assigned or natal gender”⁹⁰. This notion of mismatch or misalignment is central to the diagnostic criteria that both constrain and enable how and under what conditions trans youth are able to access particular health services and interventions (e.g., puberty blockers, hormones, and surgeries). When youths’ gender expression or identity transgresses or deviates from that which is traditionally associated with their sex assigned at birth, they are called upon – as are transgender individuals more generally – to disclose or explain to family, medical professionals, and the law a sense of sex/gender incongruence consistent with existing diagnostic criteria for gender dysphoria¹³. In this sense, youth must effectively display or perform ‘symptoms’ of a sex/gender mismatch in order to be deemed legitimately ‘transgender.’ In Foucauldian terms, we can understand this as a form of confession, where such

confession makes “cross-gender” identification and the potential distress related to it real or true⁹¹; it brings ‘transgender’ into reality.

Hildago et al. construct the differentiation of non-normative gender expression – that which is said to characterize ‘feminine boys’ or ‘masculine girls’ – from gender identity – that which is said to characterize ‘real trans youth’ – as a mechanism for making accurate diagnoses.

“By differentiating gender expressions from gender identities, we have a tool for sorting out children who are insistent, persistent, and consistent in their affirmation of a cross-gender identity from those children who are either asserting or exploring gender-nonconforming expressions within acceptance of their natal gender assignment”^{92(p286)}.

The experience of gender dysphoria was constructed across texts as a motivating factor prompting trans youth and their families “to seek care to understand their gender nonconformity or physically transition to their affirmed gender”^{93(p1185)}. In order to receive a diagnosis of gender dysphoria, which is required before youth can access biomedical interventions such as pubertal suppression or “cross-sex” hormones (access which is also predicated on parental permission) youth must “persist” in their transgender identity. Those youth who continue to experience gender dysphoria during adolescence – the ‘persisters’ – are said to constitute a ‘really trans’ group.

“There have been efforts to identify factors to differentiate prepubertal children who will persist in their transgender identity during adolescence and adulthood versus those who will desist. In a study of 53 adolescents in the Netherlands, those who persisted versus desisted in their gender identity had similar gender variant expression in childhood. Yet, those who experienced increased dysphoria in adolescence, starting between 10 and 13 years, were more likely to have a stable transgender identity”^{94(p85)}.

Notably, the use of “sex assignment” versus “gender assignment” varied across texts, which we interpret as a function of the changing construction of both sex and gender over time. While gender variance is increasingly talked about in the literature on trans youth health as a part of human diversity, in

the texts we analyzed, discourses of gender non-normativity were consistently invoked to separate normative gender identity and expression from non-normative gender identity and expression. The ‘persistence’ of gender dysphoria was constructed across texts as a fundamental quality of a “stable transgender identity”^{94(p85)}, where the separation of ‘persisters’ from ‘desisters’ ensures accurate diagnoses and justifies intervention upon what would otherwise be considered a normal and healthy body. Castaneda has argued that this construction of persistence is part of the process whereby trans child bodies are “converted in legitimizable ways into the subject[s] of treatment”^{1(p264)}.

Discourses of gender non-normativity also frequently operated in the texts via the construction of binary gender (i.e., male vs. female, girl vs. boy), where transgender was classified and legitimized in the context of “cross-gender” behaviors and identification. The construction of binary gender operated within a broader discourse of cisnormativity, or cisgenderism discourse. Cisnormativity is the epistemological framework that approaches gender as a system comprised of two supposedly stable and naturally occurring ‘biological’ sexes – male and female – with two fixed and normative social categories – man and woman⁸⁶. For example, in a 2014 article describing endocrine considerations for transgender youth, the author invoked binary notions of gender through talk about a male-assigned-at-birth child who “insisted on a girl’s name and the use of the female pronoun and [who] would only wear girls’ clothing”⁹⁵.

Historically, cisgender bodies and experiences have been centered as the norm in research and medical practice. The term cisgender refers to persons whose sex assigned at birth is said to align with their gender identity. Cisgender bodies are discursively situated as aligned, congruent, and natural. As such, ‘transgender’ is discursively constructed as fundamentally misaligned and incongruent. The construction of binary gender renders particular names, pronouns, clothing, and genitalia ‘female’ versus ‘male’ and is central to the discursive production of transgender as a diagnostic category, as well as a site of medical intervention⁹⁶. Wiseman and Davidson argue that the construction of binary gender creates a number of difficulties in its operation for trans youth⁹⁷. Firstly, the construction of binary gender divides

acceptable expression into two discreet categories: masculine and feminine. This may lead young people to seek to alter their bodies in order to make them seem ‘natural’ to themselves or others. Secondly, the demand for persistence contributes to the idea that “authentic”⁹⁸ transgender children’s feelings and behaviors are predictable. Wiseman and Davidson note that young people may actually experience “a great deal of uncertainty and fluidity, both temporal and contextual”^{97(p530)}. The need for trans youth to be certain about gender may function to silence grief and uncertainty to oneself and others. This need for certainty or persistence is part of a broader discourse of identity formation – of which Erikson’s stage theory of personality development is one example⁹⁹ – that calls youth to ‘discover’ who they are in adolescence, as if identity beyond adolescence is fixed and enduring.

Discourses of gender non-normativity within the texts we analyzed approached ‘transgender’ as always already broken or ruptured, and thus established medical intervention as central to transgender health. Through this logic, ‘transgender’ becomes a condition to be intervened upon and monitored. As Castenada has previously argued, the term ‘transgender’ does not itself “implicate a need or desire for medical diagnosis, intervention, and treatment. [However], medical discourse uses the term ‘transgender’ in ways that consistently implicate medical treatment”^{1(p263)}. Across the texts we analyzed, emphasis was placed on lack of congruency within the self rather than on the regulating institutions (e.g., medicine, psychology, law, family) that make sex/gender assignment and reinforce and regulate traditional gender norms and roles. Trans youth health interventions are thus figured as necessary, reasonable, and justifiable through the production and reproduction of a set of ideas that link sex/gender ‘mismatch’ with persistent distress. While this narrative may accurately represent the lived experiences of some trans youth, it is unlikely to reflect the true diversity of experiences among youth. In some cases, it may operate to pressure youth to produce narratives of distress consistent with existing diagnostic criteria for gender dysphoria rather than promote the articulation of a multiplicity of trans experiences and identities.

Discourses of Risk

Across the texts we analyzed, talk about embodied distress (e.g., gender dysphoria) among trans youth, as well as the potential and legitimacy of intervention, was situated within discourses of risk. Trans youth were figured as occupying a liminal space between childhood and adulthood, and between man and woman, where puberty represented a pivotal and precarious moment in time – a potential ‘turning point.’ In this way, so-called ‘trans puberty’ was constructed as somehow riskier than cisgender puberty. Prepubertal trans children’s ability to “pass as their affirmed gender” (i.e., to be perceived as cisgender) was said to be “aided by the fact that they have not yet developed secondary sex characteristics”^{94(p87)}. Puberty – “the life stage characterized by the development of secondary sex characteristics”^{94(p87)} – was discussed by Shumer et al, for example, under the subheading “Sex Differentiation and Normal Puberty”^{94(p87)} in terms of so-called “male” versus “female” puberty and “incentives” for pubertal suppression were discussed in binary terms regarding male-to-female and female-to-male individuals. In this way, so-called trans puberty was figured as not only risky but inherently abnormal.

While authors frequently noted the limitations of previous research studies regarding health outcomes among trans children and adolescents (including instrumentation of binary measures of gender, reliance almost exclusively on parent report, and failure to incorporate measures for addressing the role that social stigma plays in producing disparate health outcomes among trans youth) they invariably leveraged these data to ground discussions related to the need – if not imperative – for body-level intervention (e.g., pubertal suppression, hormones, and surgeries). For example, Vance et al. contextualize the health needs of “gender nonconforming youth” within the broader context of risk for “a number of adverse mental health and medical outcomes, including anxiety, depression, suicidality, oppositional defiance, lower school performance, non-suicidal self-injury, drug-abuse, and alcohol abuse”^{93(p1187)}. Indications for pubertal suppression and “cross-sex” hormones immediately followed a

call for mental health professionals to help transgender youth “find pathways to live authentically in the genders they know themselves to be”^{93(p1187)}. This particular logic of risk for poor health outcomes hinges upon the notion that gender non-normativity is somehow inherently painful or distressing and that gender non-normativity is a symptom of a so-called gender inauthenticity, i.e., transgender is situated as less authentic than cisgender and interventions for alleviating distress among trans youth are aimed at bringing body, self, and gender into alignment through medical intervention.

Discourses of risk also worked to link ‘untreated’ gender dysphoria with disparate health outcomes and thus situated gender dysphoria as an inherent risk for poor health outcomes that must be intervened upon. However, any linkage between gender dysphoria and medical intervention is, in fact, poorly understood. A 2018 systematic review of hormonal treatment in young people with gender dysphoria, for example, found that while hormones “were observed to be associated with significant improvements in global functioning, depression, and overall behavioral and/or emotional problems,” hormone treatment “had no significant effect on symptoms of gender dysphoria”^{89(p15)}. It is possible that trans individuals may experience gender dysphoria over the course of their lifetimes, whether or not they seek and are able to access medical intervention. Authors suggest that the continued presence of gender dysphoria is “not surprising” given that hormone treatment “cannot be expected to lessen one’s dislike of existing physical sex characteristics” nor “desire for the physical sex characteristics of their preferred gender.” This notion of gender preference evokes the concept of choice and obscures the social and institutional forces that contribute to the production of disparate health outcomes among trans youth (whether or not they seek and are able to access medical intervention), as well as both the material and discursive production of the sex/gender categories ‘male’, ‘female’ and ‘transgender’.

Across many of the texts we reviewed, authors invoke the suffering of transgender adults in order to justify intervention in the lives of trans youth. Health disparities and inequities among adult trans individuals were framed as avoidable risks. This worked to create a sense of urgency about when and how to intervene upon the bodies of gender non-normative youth¹⁰⁰. Shumer et al., for example, write:

“Transgender persons continue to be disproportionately affected by bias, persecution, and harassment, and have alarmingly high rates of depression, anxiety, self-harm behaviors, and suicidality. A staggering 41% of transgender adults have attempted suicide”^{94(p85)}.

Discourses of risk were largely dominated by discussions about how to reduce the likelihood and extent to which one’s future becomes a ‘transgender future’ and hinged upon what Sadjadi has previously termed “the familiar trope of the abject trans person”^{100(p257)}. Relevant to this construction of trans futures as risky and trans individuals as abject is Lamble’s analysis of Transgender Day of Remembrance events intended to memorialize individuals killed due to anti-transgender hatred or prejudice (e.g., transphobia). Lamble argues that by positioning violence experienced by trans people as specifically anti-transgender violence, remembrance events reduce the complexity of circumstances in which “poverty, institutionalized racism, inadequate healthcare, sex-worker stigma and a punitive justice system contribute to particular gender variant people being far more vulnerable to violence”^{101(p30)}.

Similar narratives of depression, anxiety, self-harm, and suicidality played out in the texts we analyzed regarding trans youth health. Health outcomes were defined in terms of success or failure, where successful outcomes were about crossing over a socially constructed gender border at a particular time in one’s life, thus establishing a kind of ‘early intervention.’ Discourses of risk also functioned to establish trans puberty as a kind of medical emergency. Physician-anthropologist Sahar Sadjahi has likened this particular construction of risk in the lives of trans youth to the way that ‘natural’ disasters in Africa, for example, are often portrayed: “No one is responsible, but emergency aid is morally mandated”^{100(p257)}.

The types of trans bodies that have become possible in an era of pubertal suppression and the notion that ‘early intervention’ will function as an effective risk-reducing therapeutic construct two types of trans embodiment and fix puberty as the site of divergence⁹⁶. Discourses of risk identified in the texts we analyzed worked to figure contemporary trans youth as different, somehow more successful (e.g., more likely to ‘pass’ as cisgender) than transgender adults and elders ‘of the past.’ Additionally, discourses of risk invariably operated with an overarching biomedical discourse, which supported the

imperative to intervene upon the individual body rather than upon the regulating institutions (e.g., medicine, psychology, law, family) that perpetuate and regulate the gender norms that construct transgender as characterized by non-normativity, misalignment, and incongruence. In this sense, discourses of risk in the texts we analyzed worked to obscure the social and institutional processes whereby trans individuals are disproportionately impacted by violence in American society.

Discourses of gender affirmation

The notion of “gender affirmation” that is central to the gender-affirming model of health “refers to an interpersonal, interactive process whereby a person receives social recognition and support for their gender identity and expression”^{102(p2)} and was introduced into the scientific literature most prominently with Sevelius’ 2013 article titled “Gender Affirmation: A Framework for Conceptualizing Risk Behavior Among Transgender Women of Color.” However, as Sevelius notes, the idea of gender affirmation was used by researchers prior to 2013 and was previously referred to by a variety of terminologies including ‘gender validation’¹⁰³, ‘transgender identity affirmation’, ‘identity support’, ‘gender identity affirmation’^{104,105}, and ‘gender construction’¹⁰⁶. Development of this framework was based on the existing literature regarding adult transgender women at the time and “integrates objectification theory, a theory that has been primarily explored in the context of women’s body image and eating disorder research with the Identity Threat Model of Stigma from social psychology literature”^{102(p3)}. Sevelius argues that gender affirmation is not unique to transgender individuals but may come more easily to non-transgender individuals, who may feel pressure to conform to rigid notions of masculinity and femininity, but whose gender identity is said to ‘align’ with the gender they were assigned at birth.

Across the texts we analyzed, the authors used ‘gender-affirming’ as a descriptive term to qualify health care models, approaches, or interventions. Frequently, the authors utilized the phrase ‘gender affirmation’ to describe trans-specific interventions. For example, the use of hormones among trans youth was constructed as uniquely gender-affirming, i.e., “gender-affirming hormones”^{12(p118)}. Testosterone, for example, is a hormone that has frequently been utilized in sport to enhance athletic

performance but is not characterized by the qualifiers “cross-sex” or “gender-affirming” in the ways that it is when used among some transmasculine individuals to facilitate medical gender transition. Once regarded as “sex reassignment” surgeries, surgical interventions for youth have similarly been discursively refashioned as “gender-affirming surger[ies]”^{63(p424)}. Youth who seek and are able to access particular health interventions (namely puberty blockers, hormones, and surgeries) were talked about in the texts as “affirmed males” and “affirmed females,” thus differentiating them from their cisgender peers. Discourses of gender affirmation served to further naturalize the cisgender body and erased the fact or possibility of trans child bodies outside the scope of biomedical interpretation and intervention. Across the texts we analyzed, trans youth bodies and experiences came to be defined in terms of “gender diversity”⁹³, “gender creativity”⁹², and “gender affirmation” only in the context of their difference.

Discourses of affirmation functioned as an aspect of a broader biomedical discourse and operated to conceal the ways in which health care practice(s) and biomedical discourse often work to produce and regulate ideas about what is natural, normal, and healthy. The biomedical model of medicine – which originated in the mid-19th century – defines health as freedom from disease, pain, or defect and connects that which is “healthy” with that which is “normal.” The biomedical model of health focuses on physical processes, generally does not take into account social factors or individual subjectivity, and does not consider diagnosis – which ultimately affects treatment and treatment access, or what we might think of as the *regulation of treatment* – as a result of complex negotiations between provider and patient¹⁰⁷. By obscuring the role that health care practice(s) and biomedical discourse have played and continue to play in the construction and regulation of ideas about what is natural, normal, and healthy, we found that discourses of gender affirmation situated ‘gender-affirming care’ as a ‘new’ approach to the transgender patient. However, studies in the formation of “gender identity disorder of childhood” as a diagnostic category (which was discussed in more detail in the introduction of this article) – presently called “gender dysphoria” – demonstrate that research historically aimed at the treatment of children whose genders departed from their sex assigned at birth “promised to potentially solve the problem of adult transsexuality through preventing its development in the first place”^{19(p26)}. Discourses of gender

affirmation were contingent on the notion that contemporary trans youth are a new social category figured as somehow different than trans adults.

Within the context of trans youth health specifically, the gender-affirming model defines “gender health” as “a child’s opportunity to live in the gender that feels most real or comfortable to that child”^{92(p286)}. As we found with discourses of risk, the authors evoke the concept of individual choice. This notion of individual choice operated to obscure the complex social and institutional forces that reinforce the production and regulation of gender normativity vs. non-normativity, as well as how trans youths’ legal status as minors may impact their abilities to “live in the gender that feels more real or comfortable.” Invoking risk discourse Hildago et al., for example, situate this notion of a child’s ‘gender opportunity’ against a backdrop of risk for poor health outcomes – “including depressive symptoms, low life satisfaction, self-harm, isolation, homelessness, incarceration, posttraumatic stress, and suicide ideation and attempts”^{92(p286)} – where ‘opportunity’ suggests the possibility of avoiding future negative health outcomes that characterized adult trans populations in the texts we analyzed. Across texts, authors suggest that their goals involve ‘listening to the child’ but overwhelmingly failed to address the power dynamics present in research and practice related to trans youth and their health needs – particularly authors’ social positions as ‘experts’ and the relative lack of inclusion in the research of trans youth under age 18, both with and without parental support. We found that discourses of gender affirmation in the text actually worked to reinforce binary constructions of sex/gender as well as the need to bring one’s body into ‘alignment’ with that which has been naturalized and normalized throughout history (e.g., the cisgender body). Discourses of gender affirmation operated, in part, through the erasure of gender non-normative young people’s bodies that throughout history, have been violently intervened upon via processes of white supremacy, coloniality, medical experimentation, and norm production, as well as through the notion that gender-affirming models of care are a radical reorientation to ‘transgender’ as an object of medical-scientific regulation and intervention rather than situating the notion of gender affirmation within its broader historical context as an extension of the reparative therapies of the past¹⁰⁸.

Discussion

Together discourses of gender non-normativity, risk, and gender affirmation functioned to construct the health and potential of trans youth as fundamentally intertwined with an imperative for psychological evaluation and biomedical intervention. The construction of gender non-normativity, risk, and gender affirmation across the ten scientific articles we analyzed combined to produce a dominant, overarching discourse of gender abnormality or pathology, which situated ‘transgender’ within biomedical discourse as always already fractured. This discourse produces ‘transgender health’ as a medical subspecialty, perpetuates ideas about transgender embodiment as anomalous, and works to reinforce sex/gender norms that produce the logic upholding the binary gender segregation of social and institutional practices throughout the United States. As the dominant or prevailing discourse on transgender youth health, these combined interrelated discourses of gender non-normativity, risk, and gender affirmation render trans youth as legitimately and intelligibly diagnosable and treatable within a cisnormative paradigm of health and health care. “In such a framework,” writes transgender scholar and activist Julia Serano, “[transgender] bodies, identities, perspectives, and experiences are continuously required to be explained and inevitably remain open to interpretation”¹⁰⁹.

Discussions of youths’ ‘gender-related’ distress and the potential for future negative health and social outcomes situate trans youth as appropriate sites for therapeutic intervention. Discourses of risk operated in the texts we analyzed to reinforce the notion of gender dysphoria as the defining characteristic of trans experience as well as legitimize a diagnostic category that has been contested by transgender individuals and practitioners of health care for decades. Discourses of risk related to trans youths’ health and health needs were consistent with neoliberal rationalities of health, which rely heavily on broader discourses of risk and that have historically privileged and naturalized the white cisgender body. In an alternate interpretation of distress among trans youth, Katrina Roen argues that distress might be better understood in the context of trans youths’ relationship to norm-maintenance as “the normative cruelties that structure the embodied and gendered experiences of trans youth”^{110(p1)} – both a kind of symbolic violence (“that is done through the maintenance of the gender binary and that is produced as normal and

natural”^{110(p3)}) and as material violence (“that is done daily in the life of anyone for whom binary gender feels far from normal or natural, and may not feel at all comfortable or achievable”^{110(p3)}).

Discourses of gender affirmation, particularly as they related to childhood and adolescence, and which were heightened in the texts we analyzed as talk about trans youth as “affirmed females” and “affirmed males” produced a certain set of ideas about what constitutes a desirable, successful, and healthy transgender life. This notion of gender affirmation early in one’s life becomes established as a new model of healthcare, doing something new for the project of gender by producing outcomes – bodies – that somehow address the root causes of health inequity among trans people more generally^{67,68}. As trans scholar Eric Plemons has previously noted in his 2017 book *The Look of a Woman*, particular methods, models, and interventions (e.g., the gender-affirming model of health) come to be seen over time as “trans therapeutics” and thus inform what also comes to be socially and medically legible as a good trans subject¹¹¹.

Critical-discursive attention to the existing literature on the health and health care needs of contemporary trans youth demonstrates that a pediatric trans therapeutic which situates cis-passability (i.e., one’s ability to ultimately pass as cisgender rather than be recognizable as transgender) as a successful outcome of gender-affirming intervention dictates what is or is not possible for bodies to do and to be, and particularly in the case of child subjects, locates specific moments in time, ‘windows of opportunity,’ in which one must act accordingly in order to avoid foreclosing the possibility of living a “normal, happy life.” The notion of “gender health” central to this model – “a child’s *opportunity* to live in the gender that feels the most real or comfortable”^{92(p286)} – is wrapped up in neoliberal logics of self-configuration that establishes healthcare as a commodity whose consumption is solely about individual choice. This assumption of health presupposes that “authenticity” can be performed safely for all trans subjects and expects that happiness and the capacity for success will result from gestures toward aligning one’s body with that which has been naturalized throughout history – the white cisgender body. Discourses of risk and gender affirmation establish pubertal suppression as an ideal intervention that also construct today’s transgender children as passive, ‘at-risk’ subjects in desperate need of expert biomedical

attention. Situated as an emergent social category, contemporary trans children must be figured as somehow categorically distinct from past and present representations of what is or is not a transgender adult, or more specifically – what is or is not a *successful* transgender adult.

The possibility of pubertal suppression and ultimately, cis-passability, come to define the success of trans life in terms of one's ability to blend into a racialized binary categorization system of sex and gender and operates as what Sara Ahmed has termed a "happiness script." "Happiness scripts could be thought of as straightening devices, ways of aligning bodies with that which is already lined up"^{112(p91)}. Happiness scripts are part of how norms are created and how vulnerability and security are distributed and are often intertwined with narratives of appropriate stages of development and achievement through one's lifetime. "[They] speak a certain truth: deviation can involve unhappiness"^{112(p91)}. This notion that a particular kind of gender-affirming healthcare in which young people can express their gender(s) "with freedom from restriction, aspersion, or rejection"^{92(p286)} – one largely predicated on biomedical intervention and achievable only through particular types of healthcare access – inevitably privileges white, middle-class youth with parental consent and access to particular kinds of healthcare services as the ideal happiness projects.

We have explored how discourses of non-normativity position trans youth as fractured subjects in need of integration, as well as how discourses of risk situate individual bodies as ideal sites of intervention (rather than through consideration of the complex power relations that make trans youth – particularly poor trans youth, youth under 18 who lack parental support, and transgender youth of color – most likely to experience disparate health outcomes). We have considered how discussions regarding a particular model of health – the gender affirmative model – occlude the diversity of trans childhoods and perpetuate a kind of medical logic that continues to render some bodies more valuable as potential success stories than others. Pubertal suppression, and "gender-affirming" hormones and surgeries operate as both discursive and material risk reduction strategies. They function to produce the notion that gender transitions are always intelligible to biomedical authority, that gender transitions have distinct beginnings and endings, and they situate a particular category of child as valuable sites of cultural capacity¹¹³.

Contemporary notions of gender-affirming healthcare establish particular biotechnologies as what Eric Plemons has called “‘real me’ intervention[s].” ‘Real me’ interventions are aimed at making “authentic identities visible”^{111(p153)}. On the cusp of the so-called “transgender tipping point”¹¹⁴ – in an era of pubertal suppression that coincides with the proliferation of trans individuals in popular culture and media representations, the Trump administration’s plan to redefine sex and gender¹¹⁵, and ongoing legislative discussions about where and how particular trans bodies should or should not be allowed to take up space^{116,117} – we might consider how the creation of a new form of specialty medicine – gender affirming healthcare for youth – functions to uphold a kind of symbolic and material capital and erases trans youth who continue to grow up in radical and revolutionary ways, even as their bodies are marked for erasure, exclusion, and marginalization. As sociologist Tey Meadow has previously suggested, “trans is [no longer] just an identity; it’s an industry”^{118(p5)}.

There are limitations to this analysis. It has been argued that research employing CDA does not adequately “bind” to the data. To address this issue, we have used excerpts and direct language from the ten texts we analyzed in order to demonstrate how the discourses we identified were present within the data. As we have previously noted in the methods section of this article, the ten articles we analyzed do not represent all of the dynamics relevant to the diagnosis and treatment of contemporary transgender youth. However, we believe that together they provide substantive content on which we were able to evaluate and analyze the dominant discourse that inscribes and enables the provision and regulation of health services aimed at addressing the health and healthcare needs of trans youth in the United States today. Given the rapid pace at which scientific publications related to the health and health care needs of trans youth have proliferated, particularly within the previous five years, we acknowledge that the discourses we have identified are dynamic and ever-changing. These discourses shape and shift over time as trans individuals are placed within them by broader social and institutional forces and/or take them up in order to access particular healthcare services. We also acknowledge that our social positions as transgender individuals have directly influenced the collection and analysis of data during this study by enhancing attention to the mechanisms by which trans bodies, identities, and experiences are rendered

intelligible or illegitimate within a binary categorization system of sex and gender that is defined by cisgender perspectives, values, and interests. We suggest that future research regarding the health and health needs of trans youth under age 18 center the perspectives of these youth, both with and without parental support, and consider their perspectives as critical to ensuring the equitable, accurate, and ethical production of knowledge regarding their care and wellbeing.

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Table 1.1. Final sample of documents relevant to the health of transgender/gender non-conforming youth

Title	Year	Author(s)	Brief Outline
Management of the Transgender Adolescent	2011	Olson et al.	Describes medical intervention to "achieve gender/body congruence" and "affirmative" mental health therapy to minimize negative health outcomes and maximize "positive future" for transgender adolescents (p. 171)
The Gender Affirmative Model: What We Know and What We Aim to Learn	2013	Hildago et al.	Outlines the gender affirmative model of health as well as knowledge in the field regarding psychosocial development of gender-nonforming children (p. 285)
Approach to the Patient: Transgender Youth: Endocrine Considerations	2014	Rosenthal	Reviews existing studies on biological underpinnings of gender identity, epidemiology of "transgenderism", current clinical practice guidelines for transgender youth, and limitations to "optimal" care (p. 4379)
Psychological and Medical Care of Gender Nonconforming Youth	2014	Vance et al.	Describes "general approach to and management of gender-nonconforming youth" (p.1186)
Transgender and Gender Nonconforming Adolescent Care: Psychosocial and Medical Considerations	2015	Guss et al.	Highlights recent literature concerning the psychosocial and medical care of transgender and gender non-conforming adolescents, focusing on applications for general practitioners (p. 421)
Research Priorities for Gender Nonconforming/Transgender Youth: Gender Identity Development and Biopsychosocial Outcomes	2016	Olson-Kennedy et al.	Summarizes research focused on prevalence and "natural history" of transgender/gender non-conforming youth as well as outcomes of recommended clinical practice guidelines (p. 172)
Transgender Youth: current concepts	2016	Rosenthal	Reviews terms and definitions relevant to gender non-conforming youth, biologic determinants of gender identity, clinical practice guidelines for transgender youth, "challenges to optimal care", and research priorities (p. 185)
Advances in the Care of Transgender Children & Adolescents	2016	Shumer et al.	Defines terminology in the field of transgender youth health, describes what is known about gender identity, outlines current mental health disparities relevant to transgender youth, addresses current guidelines regarding medical treatment of transgender minors, highlights barriers to care, includes case examples (p. 80)
Hormonal Treatment in Young People With Gender Dysphoria: A Systematic Review	2018	Chew et al.	Reviews evidence for the physical, psychosocial, and cognitive effects of gonadotropin-releasing hormone analogs (e.g., puberty blockers), gender-affirming hormones, antiandrogens, and progestins on transgender adolescents (p.1)
Caring for the transgender adolescent and young adult: Current concepts of an evolving process in the 21st century	2019	Agana et al.	Provides current concepts and evaluation and management of transgender youth patients with an emphasis on hormone therapy (p. 304)

Chapter Three

Transgender Youth Talk About Access to Care: Results from the Trans Youth Health Experiences Study

Abstract

The purpose of this study was to better understand the healthcare-seeking experiences of transgender youth under age 18 and how youths' transgender identity and legal status as minors impacted their ability to access care or influenced the quality of care they received. Access to care is known to improve long-term health outcomes among trans youth in the U.S., yet existing research demonstrates that few youth receive trans-affirming health services. There is limited research on the healthcare-seeking experiences of transgender youth under 18, in part because of intersectional power dynamics related to age and gender, and because of limited representation of trans youth under age 18 in research, both with and without parental support. Discursive analytic methods and principles of community-based participatory research were used to analyze data from interviews with self-identified transgender youth between the ages of 13 to 17 (n=11) and parents of transgender youth (n=6). Youth participants were invited to participate as members of the data analysis team. Two of the 11 youth participants served as data analysts. We identified three sets of discourses across interview transcripts – *discourses of normativity*, *discourses of temporality*, and *discourses of access*. Discourses of normativity centered on youths' experiences seeking a transgender-related diagnosis (e.g., gender dysphoria) and were prevalent in the talk about goals of care. Discourses of temporality encompassed the role that waiting played in participants' narratives of health care access, as well as how risks and benefits were framed in terms of less or more permanent intervention. Discourses of access centered on how youth and families were able to find pathways around or pathways through the barriers they encountered in pursuit of health services and interventions. Each of these discourses were present across multiple layers of healthcare practice. Findings from this study highlight the processes by which contemporary trans youth are made intelligible or recognizable in healthcare contexts, as well as processes by which they are erased or excluded from institutional and medical knowledge and practice. Together discourses of normativity, temporality, and access influenced when and in what ways study participants were or were not able to access healthcare services, and their abilities to access adequate and trans-affirming care were often facilitated or impeded by parents. These

data highlight power dynamics present in clinical interactions – particularly when parents are present or when youth lack parental support entirely – that impact how trans young people present themselves and self-censor their experiences in order to ensure their safety and access to care.

Introduction

Transgender (henceforth, trans) adolescents in the U.S. face intersecting forms of societal marginalization, discrimination, and stigmatization and are disproportionately impacted by disparate health outcomes¹⁻⁴. The term *transgender* represents a diverse group of individuals within and across populations and has been used throughout history to describe individuals whose embodied experience of gender over the course of their lifetimes does not fall into binary categories of boy/man or girl/woman. It is used most commonly as an umbrella term that is intentionally broad and refers to individuals “who were assigned one gender at birth based on their genitals, [and] who feel that this is a false or incomplete description of themselves”⁶⁰. The language utilized to describe transgender bodies and experiences has changed throughout history as ideas about sex and gender have changed⁵⁻⁹.

Access to care is known to improve long-term health outcomes among trans youth in the United States, yet existing research studies overwhelmingly demonstrate that few youth receive trans-affirming health services^{4,10-14}. Previous research has identified multiple structural level factors that create barriers to care for trans individuals. These include geographic disparities in the availability of qualified medical and mental health providers willing and able to offer appropriate care, fear of discrimination from members of the health care community, and disparities in health insurance reimbursement^{15-19,20}. In response to these inequities, the past decade has witnessed a rapid growth in research and programs that address the health and wellbeing of trans children and adolescents. Increasingly, transgender healthcare is provided to youth in specialized gender clinics within pediatric academic-medical centers²¹, and there has been a rapid increase in scientific publications in the previous five years related to the health and wellbeing of trans youth.

Among the studies that have explored barriers to care for trans youth specifically, researchers have generally recruited participants from within existing clinical samples, and often focus on the perspectives and experiences of parents and caregivers.^{13,22-25} A 2017 study exploring the health concerns of trans youth and their parents found that the number of youth endorsing concerns about gender-

affirming hormones was significantly higher than the number of parents.²⁶ Overall, trans youth were concerned with issues related to transitioning, whereas parents were more concerned with safety and acceptance. Additional research has demonstrated a difference in youths' interest in gender transition versus parents' willingness to support gender transition in their children and has noted that parents often fear harassment, peer rejection, physical harm, and transition regret, which may lead parents to resist their child's gender transition.²⁷ It is likely that existing studies regarding access to care represent only a small subset of trans youth, in part because of intersectional power dynamics related to age and gender, and because of limited representation of trans youth under age 18 in research, both with and without parental support.

Further complicating this lack of representation of trans youth under age 18 in research are underlying beliefs about gender that can influence how research is approached, what questions are asked, and how transgender identities are constructed. These beliefs, or discourses, are a function of cisnormativity. Cisnormativity is the epistemological framework that approaches gender as a system comprised of two supposedly stable and naturally occurring 'biological' sexes – male and female – with two fixed and normative social categories – man and woman²⁸. Historically, cisgender bodies and experiences have been centered as the norm in research and medical practice. The term cisgender refers to persons whose sex assigned at birth is said to align with their gender identity. Cisgender people are discursively situated as aligned, congruent, and natural. As such, 'transgender' is discursively constructed as fundamentally misaligned, incongruent, and uniquely requiring affirmation. Approaches to investigating transgender health issues have tended to treat gender identity and expression as individual aspects of selfhood. Thus the very terms used to construct particular individuals as transgender or gender nonconforming are often the same terms that reinscribe the limitations of gender as a social construction that constitutes the recognition and pathologization of gender nonconformity²⁹.

Particular types of trans youth experiences have been privileged in research regarding access to care, with most studies focused on individuals who seek binary gender transition³⁰. Consequently, existing research regarding access to care for trans youth has been limited to issues pertaining to the

accessibility of particular interventions – namely, pubertal suppression, and gender-affirming hormones and surgeries. In order to receive these services, youth must first receive a diagnosis of gender dysphoria, which is presently defined in the DSM-5 as “clinically significant distress (of at least six months duration) related to the incongruence between one’s affirmed or experienced gender and one’s assigned or natal gender”³¹. Biomedical and ethical justification for the provision of these interventions to trans youth with diagnoses of gender dysphoria have primarily centered on narratives about “risk” and the prevention of depressive symptoms, and self-injurious and suicidal behaviors, which are all significantly higher among trans youth.^{13,32}

Despite the many health disparities facing trans youth and the problems they encounter in receiving equitable care, little is known about how youth under 18 seek and experience health care and how they are able to garner support for their identities in healthcare contexts. It is possible that framing trans youth healthcare services primarily in terms of access to pubertal suppression, and gender-affirming hormones and surgeries may render invisible the range of healthcare needs and interests of other trans youth. In particular, it may erase the experiences of youth who lack parental support or who may not receive a transgender-related diagnosis (i.e., ‘gender dysphoria’) in childhood or adolescence. To our knowledge, no prior research studies have explored trans youths’ (ages 13 to 17) perspectives of health care access, particularly when parental consent was not a prerequisite for research participation.

In this article, we describe the results of a qualitative study that examined the role that intersectional power dynamics related to trans youths’ age and gender played in both constraining and enabling access to care. The purpose of this study was to 1) better understand the processes whereby gender non-normativity is discursively produced in the healthcare context (particularly when one is a child and not legally granted the authority to make decisions about one’s own body), 2) understand the impact of discourse on young people’s ability to access health resources, and 3) understand how youths’ transgender identity and legal status as minors influenced the quality of care they received.

Methodology

Discourse Analysis

Discourse analytic theory and methods guided this study. Discourse analysis (DA) arises from within linguistic studies, literary criticism, and semiotic, performative theories of language³³. A discursive approach to research explores language as a “form of action”³⁴ and seeks to understand how individuals and institutions use language to create and enact identities and activities³³. DA is operationalized and conceptualized differently by different disciplines, and there is no agreed-upon approach or set of analytic steps considered uniform to discourse analysis. While linguistics focuses on the function and structure of words and phrases, critical social theory takes a different approach and looks at language as a social practice, taking into consideration the *context* of language use (e.g., within the context of health care)³⁵. Discourse analytic methods are often used to examine structural inequalities in healthcare, communication in healthcare contexts, health policy, and power dynamics in health service provision.

We adopted a Foucauldian definition of discourse in which the word discourse refers to “practices that systematically form the objects of which they speak”^{36(p15)}. Foucault’s core concerns were discourse, power, and how social identities – what he termed “subject positions” – are constructed. Foucault’s work was directed at entire systems of thought of “knowledge systems” (e.g., medicine, religion, psychology, law) and was concerned with the dynamics through which individuals become – or are forced to become – institutionally recognizable types of subjects (e.g., ‘real transgender youth’). A discourse in Foucauldian terms is a body of knowledge that both constrains and enables what, in any given historical moment, we can write, speak, think, or ask about a given social object or practice³⁷. Discourse makes it possible to think some thoughts and not others, as well as empower some speakers and disqualify or invalidate others. A Foucauldian approach to discourse analysis examines the institutional and societal discourses that enable and constrain individual action at a particular moment in time³⁸. This is different from discursive psychology, for example, a form of discourse analysis that focuses on how individuals

engage different discourses to pursue personal goals³⁹. We consider the embodied experience of trans young people as knowledge essential to the analysis of transgender health and fundamentally necessary for understanding the political dynamics that influence their ability to access healthcare services. Disqualified throughout history via the pathologization of trans bodies, these knowledges – what Michel Foucault called “subjugated knowledges” – are the kind of knowledges trans people have about their embodied experiences *and* about the relationship of discourse to the regulation of gender as a social category.

Critical Discourse Analysis

Critical discourse analysis (CDA) is a form of DA that focuses specifically on the role that language plays in producing power structures and inequity – as well as opportunities for improving the conditions under which the marginalized suffer. It is often employed to explore the experiences of those subjugated by the relations of power⁴⁰. Issues prominent in research projects that employ CDA include gender issues, issues of racism, media discourses, or other dimensions of identity that have become important in contemporary discussions. Critique is aimed at making visible the interconnectedness of institutions and everyday life. We took up a *critical* discourse perspective in that our analysis was particularly focused on the power relations within which transgender individuals have been constructed as “other” in relation to the taken for granted cisgender norm, and we consider the relationship between language and power in transgender young people’s encounters within the healthcare context.

Methods

Recruitment

We recruited trans youth ages 13 to 17 in the Seattle-Tacoma area of Washington State for participation in one-on-one interviews about their experiences seeking and navigating a variety of healthcare services. Inclusion criteria were self-identification as transgender or non-binary, age 13 to 17 at the time of the interview, English-speaking, and having sought care in the Seattle-Tacoma area. ‘Transgender’ was conceptualized as an aspect of identity, experience, or history and was irrespective of

medical intervention. Given that the majority of research studies with trans youth have recruited participants from within existing gender clinics at academic-medical centers where participants are already engaged in care, we utilized recruitment strategies that would reach youth outside existing clinical samples. Flyers with information about this study and how to contact the researchers were posted electronically via online social media and social support groups. Hard copy materials were distributed at local organizations that serve youth (both LGBTQ+ specific and not) as well as at LGBTQ+ youth advocacy and community organizing events. Five participants heard about the study through LGBTQ+ student listservs/flyers, two from transgender community listservs/flyers, one from an LGBTQ+ youth advocacy workshop, one via online social media, 1 through a psychotherapist referral, and 1 participant reported hearing about the study via word of mouth.

Ethical Considerations & Waiver of Parental Permission

Ethical approval was obtained from the University of Washington Institutional Review Board. A waiver of parental permission was obtained that permitted the enrollment of transgender youth under age 18 with and without parental involvement or consent. While parental consent is a hallmark of pediatric research ethics, especially for vulnerable children, requiring parental consent for participation in research among trans youth may be contributing to the narrow view and agenda about which health services are needed and important in this population⁴¹. Many trans youth may not have disclosed their trans status to their parents or guardians *because* disclosure might put them at risk for parental harassment, abuse, or even expulsion from the home. Additionally, not all trans youth are currently living with their legal guardians precisely because their legal guardians or parents are not supportive of their gender identity. For these youth, contact with legal guardians could compromise youth's physical or emotional wellbeing. This is a very vulnerable segment of the larger population of trans youth who are most susceptible to health inequities and inadequate or inaccessible healthcare services, and who are capable of providing valuable data on how lack of support from parents/caregivers affects their experiences navigating healthcare services. Thus, excluding this segment of the population from participating in this study

because of the inability to obtain parental consent, would have prevented the research team from understanding and meeting their unique needs. Furthermore, “instinctively situating young people, under the age of 18, as unable to participate in research [about their lives] infantilizes them and limits rather than empowers their autonomy”⁴². Given the stigmatization that often surrounds one’s trans status, trans young people may be better informed than their parents about transgender healthcare and gender more generally. Central to this study was the notion that youth are capable of generating invaluable knowledge about their lives and experiences and that this knowledge is integral to the transformation of issues and institutions that impact their health and well-being.

All youth participants were given the option to interview in the presence of a youth advocate whose role was to ensure that participants understood their rights as research participants, or in the presence of a trusted family member or friend. One of our primary objectives was to attempt to neutralize power dynamics between the interviewer and youth participants and to give participants the opportunity to discuss with an adult who was not the primary researcher and interviewer how and if they wanted to answer specific interview questions. The youth advocate (D.M.T) was a doctoral student in the Department of Epidemiology at the University of Washington’s School of Public Health with 7 years of experience supporting and advocating for youth under severe distress from housing insecurity, medical emergencies, substance use, discrimination, mental health crises, and suicidal ideation. The primary researcher and interviewer (A.S.) was a pediatric emergency medicine nurse and doctoral student in the School of Nursing at the University of Washington with over 15 years of experience working with children and youth in medical emergencies and mental health crises. Prior to interviews, he disclosed his transgender status to all participants and invited them to ask any questions they had about his experience or identity. The youth advocate, when present, also shared her identity as a queer cisgender woman and discussed her relationship with transgender communities.

Of the 11 participants who participated in one-on-one interviews for this study, seven chose to participate without their parents present. Three of these youth requested the presence of the youth advocate during consenting, and two of these youth further requested her presence during the interview

itself. One interview participant requested the presence of a trusted friend during the consent and interview process. Some shared that they spoke with their parents about the study. Others shared that it would not be safe for them to talk with their parents about participation in a study related to their transgender status. When relevant, participants were provided referrals to appropriate social and community services, and all participants were given information about how to contact the primary researcher or youth advocate with concerns or questions. Youth participants received a US\$25 retail gift card to thank them for their time.

Participant Characteristics

A total of 11 youth participated in one-on-one interviews and ranged in age from 13 to 17 years. Of the 11 youth participants, eight were assigned female at birth, and three were assigned male at birth. Six parents of trans youth also participated and discussed their experiences interacting with the health care system on behalf of their child. See Table 1 for study participant demographics. Participants lived in a variety of locations in the Seattle-Tacoma area, including in both urban (N=8) and rural (N=2) settings.

Data Collection

Six of the 11 interviews took place in participants' homes, most often this was in cases where youth elected to interview in the presence of their parents. Of the six interviews conducted in participants' homes, 2 participants were living independently of their parents/guardians. In cases where youth chose to interview without their parents/guardians present, the remaining interviews took place at LGBTQ service organizations, public libraries, or university campuses. Interview space was chosen based on accessibility to youth, as well as comfort, and interview space was secured by the primary researcher and interviewer.

Before interviews began, the interviewer noted the potentially sensitive nature of interview questions and topics, such as experiences of discrimination and exclusion when seeking healthcare services. Prior to the start of each interview, participants were invited to ask any questions they had about the research process and reminded that they were not required to share information about their

experiences that they did not wish to share, that they could stop or exit the interview at any time, or request that the audio-recorder be turned off. Participants were also invited to share feedback and reactions to specific interview questions and the experience of interviewing in real-time. Written consent was obtained from participants prior to the start of interviews and after all questions had been addressed.

A semi-structured interview guide consisting of open-ended questions was employed in flexible ways to ensure that participants could speak about their experiences on their own terms. Interview design was informed by the Identity, Research, and Health Dialogic Interview⁴³, which addresses how identity informs healthcare encounters. This style of interviewing requires heightened attention to what type of knowledges are generated about the relationship of demographic data to health outcomes⁴³. While all interviews are naturally discursive, a discursive interviewer pays particular attention to power differentials between the researcher and participants. Additionally, discursive interviewing techniques 1) allow for diversity of responses (rather than emphasize similarity), 2) are more informal conversational exchanges than other interviewing techniques (e.g., they do not follow an interview “script”), and 3) involve interviewers as active participants rather than positioning them as neutral “speaking questionnaires”^{44(p156)}. Discursive interviewing techniques explore the boundaries of discourses (including practices of exclusion regarding that which is permissible to say and that which remains unsaid or obscured), as well as how discourses exert power and constrain and enable action. Table 2 provides some of the questions asked during interviews. However, these questions were not necessarily asked in this order and additional probing questions were asked when needed.

The primary researcher and interviewer initially framed the interview by sharing that the purpose of the interview was to 1) learn more about trans young people’s interactions with healthcare providers, 2) how they felt aspects of their identity impact their health, and 3) what they think about how healthcare providers talk about their identities, experiences, and health needs. Participants were asked about particularly memorable or pivotal healthcare encounters during which they felt that their gender was a factor in the quality of their interaction, or central to how meaning was assigned to their particular health concern(s). They were then invited to share their thoughts and feelings about how their transgender status

impacted the quality of their encounter or their purpose in seeking healthcare. Participants spoke about their experiences with a range of healthcare services, including primary care, psychotherapy, outpatient and inpatient surgical procedures, outpatient surgical consults, urgent care, emergency medicine, laboratory, pharmacy, and gender specialists and clinics. Interviews lasted between 60 to 120 minutes and were audio-recorded and then transcribed by a professional transcriptionist. Once initial interviews were transcribed, participants were given a copy of the transcript and invited to make edits or additions to the original interview material. Participants were also invited to contact the primary researcher or youth advocate if they felt additional aspects of their experience were important to share.

Data Analysis

All youth participants were invited to participate as members of the data analysis team and in the dissemination of results. This is consistent with a community-based participatory approach to research, which recognizes the importance of involving members of a study population as active and equal participants in all phases of a research project⁴⁵. Of the 11 participants who participated in one-on-one interviews, two chose to participate as data analysts. Both youth data analysts, as well as a third participant-researcher, chose to participate in the dissemination of results and manuscript development. The analysis team was comprised of the primary researcher and interviewer (A.S), the youth advocate (D.M.T), two trans youth participant-researchers (W.S.P.N. and A.T.C.), and one faculty mentor with experience conducting discourse analysis (I.K.G.). Three members of the analysis team identified as transgender and two as cisgender. All of the data analysts were White.

We utilized Willig's framework for CDA using a Foucauldian perspective to guide the analytic process³⁸. After reading through the transcripts to develop familiarity, the focus of our analysis was the examination of the transcripts for discourse, i.e. "practices that systematically form the objects of which they speak"^{36(p15)}. We first analyzed the various ways in which discursive objects (what Willig calls "objects of study") were constructed relating to the aims of our study. Given that we were ultimately interested in understanding the role that discourse plays in shaping transgender young people's encounters

within a variety of healthcare contexts, we examined the transcripts for constructions of ‘transgender’ in participants’ narratives. As such, we understood ‘transgender’ not as a predetermined category into which identities or bodies are slotted, but as a shifting discursive category produced through medical, legal, and cultural practices over time⁴⁶.

Next, we examined the transcripts for differences between and across constructions of the discursive object. For example, in what ways did participants strategically frame (or ‘construct’) themselves in terms of the dominant discourse regarding transgender youth identity, experience, and health in order to access particular health services? This stage of the analysis sought to identify the various discursive constructions of transgender youth health within broader, system-level discourses; for example, cisgender discourse.

We then focused on a closer analysis of the discursive contexts in which the different constructions of trans youth and their health needs took place. Willig asks, “What is gained from constructing the object in this particular way at this particular point within the text?”^{38(p174)}. For example, youth frequently recounted framing their experiences in a particular way when they were evaluated by mental health providers in the pursuit of acquiring a transgender-related diagnosis (e.g., gender dysphoria). Next, we identified various subject positions and how discourses constructed particular subject positions. Subject positions are about the creation of subjectivities, which speakers can take up as well as place others within. In the case of transgender youth, if ‘transgender’ is the object of study, what types of transgender youth subjectivity are constructed as legitimate, believable, etc.? Here we also considered what types of parent and provider subjectivities are created through discourses identified in the text, and the interconnectedness of various youth, parent, and provider subjectivities.

Next, we examined the relationship between discourse and healthcare practice by systematically exploring the ways in which discursive constructions and the subject positions contained within them facilitate or foreclose opportunities for action within the healthcare context. This entailed exploring how discourse plays a normalizing and regulatory role and reflecting on how discourses encourage certain ways of relating and discouraging others. Our final stage of analysis focused on exploring the

relationship between discourse and subjectivity, considering the sociopolitical implications of discourse in the lives of trans youth seeking a variety of healthcare services. How does discourse shape how trans youth healthcare access has come to be understood, what health resources are deployed on their behalf and under what conditions, and what barriers to adequate and equitable healthcare continue to persist?

Results

We identified three sets of discourses across interview transcripts – *discourses of normativity*, *discourses of temporality*, and *discourses of access*. Discourses of normativity frequently centered on youths’ experiences seeking a transgender-related diagnosis (i.e., gender dysphoria) and were also prevalent in talk about goals of care. Discourses of temporality encompassed the role that waiting played in participants’ narratives of health care access, as well as how risks and benefits were framed in terms of less or more permanent interventions. Discourses of access centered on how youth and families were able to find pathways around or pathways through the barriers they encountered in pursuit of particular health services and interventions. Each of these discourses were present across multiple layers of healthcare practice. We have highlighted sections of participant quotes for emphasis.

Discourses of Normativity

“While to be ‘normal’ is to fall within a statistical range known as the mean or average, through medicalization these normalcies become biological ‘truths’ of what a person should be.

Normativity depends on a hierarchy of privilege and shame where those who fall within the category of ‘normal’ are privileged, and those who fail at normativity are often disadvantaged and shamed by society.”^{47(p23)}

Whether or not youth participants sought biomedical intervention, they overwhelmingly encountered discourses of normativity in their pursuit of healthcare services, both at the level of the individual and at the institutional or systemic level. Discourses of normativity constituted a set of social ideals about gender that are unquestioned and presumed to be essential and unchangeable.

Cisgenderism discourse

Cisgenderism is “the cultural and systemic ideology that denies, denigrates, or pathologizes self-identified gender identities that do not align with assigned gender at birth as well as resulting behavior, expression, and community”⁴⁸. This discourse represents the dominant discourse against which all other discourses about gender are situated. It is grounded in the historical privileging and naturalization of cisgender bodies and psychic experiences, which has changed throughout history as ideas about sex and gender have changed^{8,9}. Historically, sex has been framed as the natural, corporeal state of being either male or female and is often referred to as ‘natal sex’ in contemporary literature regarding transgender youth health. In contrast to sex, gender has traditionally been regarded as a social construct. However, poststructuralist feminists have argued that ‘biological’ sex is no less constructed than gender⁴⁹. Related to cisgenderism is Connell’s argument that “gender structures are macro-level patterns found across institutions worldwide that are socially embodied, dynamic, and highly influenced by colonial processes over the past 500 years.”⁵⁰ Although cisgenderism discourse impacts transgender individuals most deeply, it also disciplines cisgender individuals who do not conform to hegemonic standards of ‘masculinity’/‘manhood’ and ‘femininity’/‘womanhood.’

In this study, cisgenderism discourse encompassed the assumptions about normative gender that youth faced, particularly when seeking a transgender-related diagnosis to aid them in accessing pubertal blockers, hormones, or surgeries. It was present in participants’ narratives most often as the constant need to explain one’s gender. One participant recounted her experience seeking referral to a gender specialist for the initiation of medications to facilitate medical gender transition. Here she talks about her interaction with a primary care provider she had been seeing most of her childhood.

“I think the big question, the question I’ve come back to over and over again...he asked me, ‘What does being a girl mean to you? What does that mean when you say you’re a girl?’ I didn’t have an answer, and he was very skeptical of my lack of an answer for that. He was like, ‘Well, I feel like you should be able to talk about this. I think you might be moving too fast if you can’t

talk about this'. And I was like, 'Well, no. I think it's just a stupid question.' But I didn't say that because I was 14 and small and nervous. **Cis[gender] people don't have to answer this question – 'How do you know you're a woman?' I don't know how I can be expected to.'**

(pt3)

Across interviews, participants talked about the need to prove their genders and they frequently recounted being questioned about being '*trans enough*' or being '*really trans*.' Youth were acutely aware that their receipt of a diagnosis (and thus access to desired healthcare) was contingent upon convincing providers of their authenticity as a trans person, and that this was, in turn, dependent on their reproduction of certain narratives of gender identity development and 'pain.'

"I had heard about – especially when it came to like therapists and getting a gender dysphoria diagnosis – about them wanting like a very specific way of talking or...sequence of events in your life to like prove that you had known for long enough. And you had like done enough...or that you were in enough pain. I remember I went to a cis[gender] therapist before I ended up seeing a trans therapist and she kept asking me to explain how I felt about my body and how like the dysphoria felt for me. She was taking all these notes and I was really nervous that I wasn't going to like convince her."

(pt4)

"On some level **it felt like I had conformed to what [my parents] thought I was**, and what they thought, like, me being trans was." (pt2)

Cisgenderism often required youth seeking biomedical intervention to construct narratives or 'gender histories' that demonstrated a certain level of pain or distress about their gender assigned at birth, since cisgenderism functions to pathologize trans identities and embodied experiences. Participants talked of 'playing up' their experiences in order to ensure they were taken seriously, to construct narratives that demonstrated they were 'in enough pain.'

“I felt like I sort of played up...I don’t think exaggerated is the right word, but sort of...I don’t know...made things seem more serious than they might have been **in hopes that my therapist would sort of take it more seriously himself.**” (pt2)

Youth also talked about the need to differentiate themselves from young people who might be categorized as ‘masculine girls’ or ‘feminine boys’, who might not be diagnosed as gender dysphoric and thus not appropriate candidates for pubertal suppression and gender-affirming hormones and surgeries. Participants were intimately familiar with the dominant biomedical discourse on transgender identity in childhood and adolescence, which suggests that differentiating gender expression from gender identity can be used as a sorting tool aimed at making accurate diagnoses, and ultimately, interventions⁵¹. Within a cisnormative paradigm, ‘non-normative’ gender expressions and identities thus become intelligibly diagnosable and treatable. In their interactions with healthcare providers, youth felt pressured to perform gender identities in ways that adequately matched existing criteria for ‘gender dysphoria.’ Most often, this was talked about in the context of youth seeking prescriptions for ‘cross-sex’ hormones.

“At the time [I saw the pediatrician for a referral], I was still very much like...presenting masculine, I guess. I had shown up for the appointment in an oversized T-shirt and basketball shorts, which was how I dressed at the time. It was all I was comfortable in. And I had short hair, because my parents made me cut my hair...not that long hair is essential to femininity in any way. But... I was definitely presenting as someone who would use ‘he’ pronouns...to the extent that it makes sense to say that. **I was not what he wanted out of a trans person and so...he wanted me to prove to him that I was trans somehow.**” (pt3)

“I remember I was really nervous because I didn’t want to do or say anything wrong that would make [the doctor prescribing hormones] say, ‘Well no I think we can wait a little bit longer.’ ...And the feeling going into it – I was like, ‘I have to say everything right. I have to dress correctly, like my hair has to look good. I need to talk as well as I possibly can. I didn’t want to act or portray as though I was at all feminine. I’ve grown out of that a little bit, but at that time I

was like, ‘I can’t at all be feminine’. **[The doctor] needs to know that I’m uncomfortable in this body.** So, I wanted to portray that as much as I could.” (pt11)

Youth frequently encountered cisgenderism discourse in healthcare providers’ talk about surgical outcomes and goals of care. Successful surgical outcomes, for example, were framed as those in which transgender bodies were made to be the most ‘cis-passing’. In these cases, cisgenderism discourse functioned to create an optimal transgender subject, one who strived to be as cisgender as possible, and whose ultimate goal is to bring their body into alignment with the ideal cisgender body⁵².

“One thing I haven’t loved is that almost every time I’ve done surgery stuff, I’ve had surgeons’ main focus [be on] scarring...**I feel like surgeons often come from a place of trying to make you look cis[gender].**” (pt4)

“[Medical providers] do assume that your goal is to achieve some level of cis[gender] passing-ness at least. For a lot of people, it may be. But I definitely...especially around bottom surgery, I’ve spoken to guys that that’s not their goal. Their goal is for some comfort within themselves, which is my goal too.” (pt4)

Cisgenderism discourse also operated to silence participants from speaking about the complexity of emotions they felt over time related to medical intervention and embodied change. For example, the need for proof required that youth privilege certainty about their genders over other feelings such as fear, grief, and loss related to their social positioning as ‘other.’

“It’s very difficult to talk about the hard things that come with transitioning... Like I said before [I often feel that you] have to prove how you’re feeling and sort of for a second, you’re like, ‘oh I’m scared’, or ‘oh, this is hard’. I often feel apprehensive about saying stuff like that. The grief that I would say that I feel is just kind of that I’ve had to do some of the things that I’ve had to do... I remember a moment like a little bit into my transition, where I kind of realized that there were things that weren’t ever gonna go away. **Even if you have multiple surgeries and are on hormones for many years, like it’s never going to be a cisgender body.** That’s hard to deal

with and it's something I've had to become okay with because I can't really do anything about it." (pt4)

Hegemonic transnormativity

Hegemonic transnormativity, like cisgenderism discourse, is a normative ideology that pressures trans people to perform a normative identity and fixes a hierarchical order of legitimacy in trans identities. As defined by Johnson, the concept of transnormativity refers to "the specific ideological accountability structure to which transgender people's presentations and experiences of gender are held accountable"⁵³. This discourse operates by means of two main assumptions: 1) transgender identity is an early psychological condition characterized by the refusal of one's own body, and 2) hormone therapy (more recently referred to as 'gender-affirming hormones') and sex reassignment surgery (more recently referred to as 'gender-affirming surgery') are the central goals – if not *need* – of every trans person⁵⁴. Transnormativity privileges a medical model of transgender identity and marginalizes and delegitimizes transgender and gender non-normative people who cannot or do not wish to medically transition.

Specifically related to trans youth, transnormativity constructs an ideal timeline during which youth should undertake particular biomedical interventions in order to lead 'normal, happy lives' and to avoid the possible negative health outcomes overwhelmingly associated with adult transgender individuals. Participants spoke about how transnormativity had both material and psychic implications for them and about how transnormativity constrained their access to care.

"For a long time when I was first coming out [as trans], I was moving inside a lot of trans circles that had this kind of path where you realize you're trans, you come out to your parents, they put you on hormones, they buy you a new wardrobe and then you're you. And you forget that you ever weren't [you] and everything is dandy. And I'm like, **'Well I failed step one. Can't come out to parents. What now? Guess I'm not making any progress.'**" (pt1)

For this participant, disclosure of his gender identity to his parents would have put him at risk of losing access to medical insurance he received through his parents and potentially result in being kicked

out of their home. He spoke about the need to prioritize access to medical insurance for necessary care related to an autoimmune disease, and about how a lack of parental support impacted his ability to access hormones or surgeries. He went on to recount the ways in which he reconstructed the notion of transition against transnormative discourse.

“I was trying to interrogate within myself this idea of making progress towards trans-ness, and the idea specifically of transitioning...what counts as transitioning? So, I was like, okay, **I’m going to decide when I come out to my friends and I chose a name for myself and I put this name on some of my homework. That’s transitioning. That’s me changing how I’m presenting myself to the world and to this institution.** Just because my body isn’t physically changing doesn’t mean it’s not transitioning. In that sense, I’m still by a lot of classic definitions, like ‘pre-transition.’ I haven’t started hormones yet therefore I’m not transitioning yet. But I think I would rather read it as, like, these are acts of transitioning.” (pt1)

Later in the interview, this participant recounted a visit to urgent care during which transnormative discourse inhibited the degree to which he was read as a recognizable or intelligible trans youth. When asked by the receptionist what his ‘preferred name and pronouns’ were, he felt it wasn’t safe to disclose because of fear that his parents might gain access to his medical records, given his status as a minor.

“For where I’m at that totally sets up a binary – either you have a preferred name that you can share with us and that we can put down in our records and give to the institution and give to all your doctors, or you don’t and you’re just cis[gender]. And that felt weird. **I felt kind of alienated. It felt like I was a subset within a subset.** And I think that’s something that I also see in a lot of discourse around trans-ness...like okay, well if we accommodate people who are [cis]-passing or we accommodate people who are out that’s enough, because we can’t accommodate people who are a subset within a subset.” (pt1)

When participants’ experiences didn’t follow a dominant construction of transgender childhood, transnormative discourse limited the scripts available for talking about their embodied experiences of

gender. This often involved a lack of vocabulary in describing how they knew what they knew about themselves, particularly in ways that garnered legitimacy within a medical model of transgender identity.

“Growing up I knew constantly...if I had a choice, like I would definitely be a girl, but it sucks for me...I don't have a choice. I knew at the time that I wanted to be a girl. But I didn't say that – ‘I want to be a girl’. There's definitely the narrative of trans people who like know from the beginning, right? And like the small child insisting like, ‘No, like I am my preferred gender. I am. I am not a boy...I am not a girl’ or whatever. I didn't have that. I was shy and I just didn't really – I was still having a hard time believing that I was trans. **I knew I wanted hormones before I knew I was transgender.**” (pt3)

Transnormative discourse also functions to uphold existing hierarchies and systems of power as they relate to the intersection of one's social identities such as race, ethnicity, class, culture, age, and ability status⁵⁵. In establishing a hierarchical order of legitimacy in trans identities, transnormative discourse occludes the possible diversity of trans childhoods and perpetuates a biomedical logic that renders some bodies more valuable as potential successful outcome stories. Success results from aligning one's body with that which has been naturalized throughout history – the white cisgender body. Framing successful outcomes in this regard results in limited possibilities for a trans future. One participant shared how lack of representation of adult trans people of color makes it difficult to see a future for himself: “As a young trans person of color, **I don't see myself reflected in adults and that makes it hard for me to like envision a future for myself** to put that very bluntly and sadly.” (pt5)

Discourses of normativity were not limited to individual acts but were also considered as embedded in broader structural and systemic processes and practices. Youth and parents held a variety of perspectives about who or what is ultimately responsible for the proliferation of normative discourses within healthcare contexts, and they frequently expressed conflicted feelings about providers with whom they interacted.

“[The surgeon's office] dealt with all this insurance stuff. That's way more than they would [usually] have to do... So, I did feel like, ‘Wow, here's this doctor who is really doing the right

thing, but I felt angry also. Like why should I have to feel grateful for that. **But it wasn't her fault that I had to feel grateful. It's like the system, insurance and education for providers.**" (parent of pt4)

"I didn't dislike [the surgeon]. I think part of me was like, 'Oh, I'm thankful that she was willing to do my surgery. And then **another part of me was angry that I felt thankful.**" (pt4)

Youth talked of experiencing mixed emotions about whether they would classify their healthcare experiences as entirely 'supportive' or 'affirmative' or entirely 'bad' and 'discriminatory,' often sharing that their experiences 'could have been worse.'

"It felt like ultimately [the pediatrician] could have been worse. He could have said 'no, I think you need to sit with this, why don't we meet again later?' Thankfully he was happy to send us on. Like he could have taken it into his own hands. **So he had a sense [that] like as a medical professional that he should be accepting** in something like this... but also his personal instinct was like, 'no, maybe not.' So, he did both. He was just super noncommittal – like he wasn't going to commit to saying 'don't do this,' but he wasn't going to not send us on." (pt3)

Participants spoke to multiple encounters with medical system issues, particularly with registration and medical records, and they talked about practices of normativity both within and outside specialized gender clinics. Of note, electronic medical records and the collection of demographic information often functioned to reinforce discourses of normativity by either requiring 'proof' or through processes of erasure in which transgender young people were made not to fit.

"There were other things about the gender clinic. Like at one point they wouldn't give [my child] a [medical ID] bracelet with [his] legal name until I showed them the [legal] name change order, which was really disturbing to me." (parent of pt8)

Discourses of Temporality

Waiting

Across interviews, participants' experiences navigating and accessing healthcare services were characterized by discourses of waiting. Talk of waiting often referenced the pace of embodied change that young people either experienced or anticipated 'from' one gender 'to' another gender and were characterized by a kind of liminality. Youth spoke about the powerlessness they felt regarding how slowly or quickly their bodies changed or didn't changed, which was directly related to their abilities to access particular types of healthcare services – most often, puberty blockers, hormones, or surgeries.

“I just wanted the waiting period to be over...waiting to see if Dr. [redacted] responded to our request for the consultation, waiting for the consultation, waiting for the sperm banking and the blood test, and then waiting for the prescription. **It just felt like a bunch of waiting. It felt like I didn't need to do that waiting.** I could [have been] doing it faster but I [wasn't]. And I just wanted to start [estrogen] as soon as possible and get the changes going.” (pt2)

Discourses of waiting took place within broader narratives of progress and development and were often contingent on the initiation of hormone therapy.

“**It's better waiting now [that I've started estrogen] because I'm seeing the progress** and the results and then I feel like I'm getting somewhere and I feel like I'm getting there as fast as I can instead of waiting before...where I had nothing to show for the waiting.” (pt2)

Often their perceived ability or inability to safely disclose their transgender status to parents impacted how long and in what ways participants waited. Waiting was talked about as a way of protecting themselves from the possible reactions of others, frequently parents and other family members. Youth were acutely aware of the societal marginalization confronting transgender individuals, and all participants talked of anticipating how transphobia would likely impact their futures.

“When I first realized I was trans my instinct was like, ‘I'll wait and then I'll just run away from everyone and do this on my own’. Because I don't really want to deal other people. I was really

resistant to like, being trans...like I don't want to be trans. **I wanted to disappear and transition and just like not deal with being 'the trans person'** in the family, or whatever. I didn't want that for myself. Because who does? I mean you're told that being trans is not something people generally...[cis]gender people generally don't love trans people, I think." (pt3)

Fantasies of disappearing involved avoiding a particular kind of gender liminality, that which is framed as abject, a kind of 'in-between' gender state, where disappearing functioned as a possible avenue for protecting oneself from harm. On the other hand, participants also talked of waiting as a 'waste of time', an impediment to progress.

"Initially I was like, 'Oh I'll wait until I'm 18 and then I'll transition, and I won't have to like, deal with coming out to my parents. **I had this total fantasy about how I was going to like, disappear and go be trans.** Then I kind of realized... I don't really want to wait that long. Like every minute I don't work towards this is wasted." (pt4)

Waiting to access care was frequently related to participant's status as minors or to medical guidelines that regulate when and at what age youth are able to access particular services or interventions. For example, particular surgeries were only accessible once participants had reached specific pubertal stages.

Waiting often also involved a kind of pain, where the longer one was made to wait, the longer one endured pain. For some participants, biomedical intervention was considered a pathway to alleviating this pain.

"I remember it very distinctly. It was all pretty new and we didn't know...like how much did it cost? Would we be able to afford it financially? So, I just said to my son, 'I think you're going to have to wait until you're 16'. **And I just remember this really well – his eyes filled with tears and he said, 'I don't know if I can wait that long.'**" (parent of pt4)

The process of waiting was intimately tied up with insurance access, approvals, denials, and exclusion. For example, one participant talked about the role that insurance delays played in his experience waiting for a hormone blocker to be implanted and how this impacted his anticipation of

unwanted pubertal changes. He talked about how insurance delays constrained the degree to which he felt he had agency over how puberty would impact his body and, ultimately, his mental health.

“The whole [insurance] hiccup phase was when I could have gotten the blocker earlier. And so, I thought shark week (i.e. onset of menses) was gonna happen. So, I was concerned. I mean it kind of sucks that [getting the blocker] was delayed for 3 months. Because like [shark week] could have happened and that wouldn’t have been good for my emotional state... **I knew we didn’t have all the control over what we could do and how fast we could move.**” (pt7)

Another participant spoke directly to how issues related to intersectionality and broader structural inequities within the healthcare context can ‘set you back’.

“**If you’re a person of color that’s trans or if you’re low income and trans...or if you’re low income and a person of color that’s trans...even not being a straight trans person can set you back.** I feel like that happens a lot with a lot of lower income trans youth. It’s like their entire experience is impacted by their parents’ income, which I don’t think is fair. I have a friend who has... quote unquote ‘worse’ insurance than me... for like people that are lower income than I am. And he waited like an entire year to get on [testosterone]. **I feel it’s kind of a not fair system because it’s based on what your income is.** I think it kind of sucks they just like have to wait longer because they weren’t as privileged to be born into like a rich family... **It just sucks that it’s an unfair system.**” (pt10)

Permanence

Discourses of permanence were frequently called upon in youths’ narratives of both provider and parent perspectives about biomedical intervention, which were framed as more or less permanent and thus, more or less risky. This showed up as talk about change or no change (i.e., intervention vs. no intervention), where the possible permanence of intervention was used to both justify and caution against pubertal blockers, hormones, and surgeries.

“When I talked initially about top surgery, I remember [my parents] being like, ‘Wait! You want to do what? Like **that could be really dangerous.**” (pt5)

Talk of permanence often became talk of risk and was used to support particular timelines about when and how youth could access particular types of interventions (and if they should have access to them at all). Discourses of the risks and benefits of medical intervention often took a paternalistic tone of protecting children from harm.

“You have to talk to five different people to make sure that you know what’s going on. I felt like [my son] was there. But all kids aren’t fortunate that they either feel that way [e.g. sure, certain, etc.] or that they have the support, so that makes it more difficult. So, I think that these [age guidelines] are in place for a reason and I think they feel like it’s **protecting the kids**. But I think it does end up hurting in some cases, so that’s frustrating.” (parent of pt7)

Discourses of permanence were intimately tied up with discourses of waiting, and participants and parents were often cautioned against moving too quickly *because of* the permanence associated with particular interventions – namely, the initiation of hormones or when seeking surgeries. This notion of permanence and medical intervention being specific to trans youth was challenged and reframed by a number of participants. One participant, for example, talked of how a medical provider framed his recommendation that she wait to start estrogen because of the permanence associated with hormonal intervention. She interrogated how cisgender puberty is not framed in the same terms of permanence.

“[The pediatrician] was like... ‘I will give you a recommendation [to a gender specialist] if it’s what you really want but I’m really’ – **He wanted to caution us against moving too quickly because he’s against permanent changes in children at a young age.** He said he doesn’t think it’s a good idea. He hasn’t seen it work out well in the past. He just doesn’t think there’s enough science behind it to back it up or... **At the time I was like just starting like ‘assigned male at birth puberty’ kind of stuff. And he didn’t conceive of that as a permanent change at all in any way.** He was like, I think you guys might want to wait, like, be careful.” (pt3)

Lastly, discourses of permanence were constructed in terms of ‘need’ versus ‘choice’ regarding intervention and often centered on talk about youths’ reproductive possibility, as well as the likelihood that youth might later regret their decisions. Youth, however, did not frame their decision-making processes in terms of permanence as a possible risk of intervention. One participant talked about his experience with hysterectomy.

“After I had surgery it was like, ‘That’s it. I’ve made my decision and there’s no changing my mind.’ I didn’t feel like regret or anything, but I definitely had a moment of sadness. I wouldn’t say [it] was because I could no longer have children. I think of myself as if I just don’t have that ability. There are people that just don’t have the ability to do that. That’s just a fact of my life, I think. **I don’t really consider my hysterectomy of my choosing that.** I think I just never would have [given birth to a child]. I think even if I had decided to somehow have a ...child in that way...I think that would make me uncomfortable. I think I didn’t feel like it was an option for me not to [have a hysterectomy].” (pt4)

Discourses of Access

Across interviews, discourses of access characterized participants talk of their experiences navigating a variety of healthcare services. This showed up in the text as either *backdoor channels* or *healthcare workers as gate-openers*. Discourses of access were related to how participants and their parents encountered the discursive and material practices and processes through which trans bodies are systemically rendered invisible or made not to fit; for example, in electronic medical record systems where participants were frequently made to fit in a male-female binary or be categorized as ‘other’.

Discourses of access were about *ways around* or *ways through* the typical or standard path.

“There’s a big machine that we are playing...trying to game out the machine first...you know, figure it out. What is our system? What is our pathway? And then we go about being successful at that game”. (parent of pt7)

Backdoor channels

In their experiences of seeking access, youth and families often talked about ‘backdoor channels,’ or ways in which they were able to access particular services or particular providers through channels that are not formalized or that originate from community and peer connections. Community and peer connections operated both in-person and online to facilitate new possibilities and unknown or infrequently traveled pathways forward or through the system of care. Unlike access to other specialty services where navigation is often required to facilitate timely and appropriate access, this experience is unique to trans individuals because of the role that cisgenderism discourse plays in excluding and erasing trans people from medical knowledge, practice, and systems. Participants frequently mentioned having to ‘go back,’ ‘resubmit,’ and ‘appeal’ insurance exclusions and about how rapidly evolving diagnostic categories influenced how they moved through the system.

“[The insurance company] is still coming up to date with their transgender health...terminology. So, for example, the appointment with Dr. [redacted] – the one we [saw] for the diagnosis – **they denied it because the code came back as like ‘transvestitism.’ It was archaic.** It was really weird. It was miscoded... So I had to appeal that and go back and be like, ‘listen!’.” (parent of pt7)

Depending on the channels or pathways through which youth were able to access services, a variety of different policies, institutional guidelines, and personal biases guided the time one was made to wait or the services that were or were not available. Discourses of access showed up as both talk about entry points, as well as talk about the quality of services one received. Youth and parents spoke to the porous nature of the medical system and the usefulness of being guided by people within and outside the healthcare system, often other trans youth or parents of trans youth.

Exposure to other trans youth and parents of trans youth provided alternate pathways with multiple points of entry. These alternatives provided encouragement and were constructed in terms of the possibility for many participants.

“And so **I just saw people figure it out and that makes it look possible**, right? So, then you’re like, I can figure this out too, I guess. **That’s meaningful to me.**” (parent of pt4)

“I feel like a lot of what we’ve been able to do and a lot of the educated decisions that I’ve been able to make have just come from like access and specific moments. Like I was thinking about bottom surgery and I was thinking about going to one bottom surgeon and then someone told me that I shouldn’t go to that bottom surgeon because of...issues. Because the only reason that I found the names of the people that I’m going to [now] were because I happened to see a transgender man who is a therapist... **If we didn’t know like the steps to the insurance process like we might have just given up.**” (pt4)

Participants talked of turning to community and peer resources when looking for answers to trans health-related questions or when seeking assistance navigating the health care system. Participants also frequently talked of community organizations, individuals, and online networks as critical to identifying access points and alternatives. Youth, in particular, noted that when they encountered a lack of medical knowledge or were looking for trans-affirming providers or clinics (“*not all medical professionals are created equally and some of them are just terrible*”), they turned to the internet as a primary source of information, or as a starting point in determining a path forward or a path through.

Youth also talked about the benefit of building relationships with other trans people, particularly trans adults, and how relationships with trans adults helped to provide context for their experiences and support for their identities: “[It’s] been really cool seeing other trans people talking about their experiences and relating to them. So, I feel that’s helped me a lot.” (pt5)

For many youth, their parents’ participation in community support groups often led to parents ‘changing their minds’ or ‘coming to terms’ with assisting youth in seeking hormones and surgeries. Community organizations were frequently named as central to how participants made decisions about where to seek care and what pathways became possible. One parent shared that “...it probably would have been very hard for us to find this doctor on our own.” A number of participants talked about seeking

access to a particular provider's private practice, who was 'no longer taking new patients', but through backdoor referral channels, youth were permitted entry.

"I think because he's not open to new patients except for...trans and non-binary youth...you have to like e-mail him or call him, explain your situation, and he may or may not, like schedule a consultation." (pt2)

When families did obtain access to a particularly well-known and recommended doctors, this was often characterized as serendipitous.

"I was super lucky. I don't think – he hasn't been accepting new patients for a while but I was super lucky and got in right before he stopped accepting new patients or something." (pt3)

However, backdoor channels were not available to all youth and sometimes resulted in youth accepting undesirable clinical experiences. When backdoor channels were not available, youth often had to seek care far from their homes, traveling great distances to get to providers or clinics who could offer appropriate services. One participant spoke of his experience transitioning from his primary care provider to a provider able to make a gender dysphoria diagnosis.

"It's just kind of isolating because I can't go to the same place I've always gone to since I was a kid. And now I have to go kind of far away, or I could go to Portland. And even this clinic that I go to in [redacted town name]...it's kind of like run down. I don't feel like as safe or as comfortable there just because it's not what I'm used to. It's a different town. [The provider] is the only one licensed in our area to treat trans people and ...like assign us onto hormones. So **she's the only one who can look at you and say, 'okay, your gender is not for you'.**" (pt11)

Healthcare Workers as 'Gate-Openers'

Participants often talked about pivotal experiences with providers who either 1) weren't considered 'gender specialists' but who were willing to work with youth and families to get them what they needed in order to move forward in their process, or 2) who spent a considerable amount of time with families in order to help them understand insurance reimbursement processes and who 'went out of

their way'. These providers were often framed as 'doing the right thing' or invested in changing the system.

“One of the things that I liked about [the surgeon] is [that] he spent a fair amount of time talking about fighting with the insurance system to get them to reimburse us. But not just to help reimburse us but with trying to correct the system so that the system is more cooperative...you know [he said], 'expect to have to appeal three times. And then you'll go to a state mediation board. And by the time you get to the state medication board then you'll...'. And I remember he asked, 'Who is your insurer?' and I said, 'Regence'. And he said, 'Oh, they're the worst'. He spent a fair amount of time talking about that and **he made it very clear that he was on the right side.**” (parent of pt4)

This notion of 'the right side' produces a moral opportunity regarding the treatment of trans children, where healthcare providers may attempt to alter, attenuate, and interrupt dominant ideas regarding the treatment of transgender children that are upheld in protocols, practice guidelines, and insurance exclusions. This also works to construct some providers as 'good' providers or 'trans-friendly' providers as well as reinforce the idea of the medical provider as savior. On the other hand, providers who were seen as gate-openers often disrupted the notion of physicians and psychotherapists as experts or saviors and acknowledged their lack of knowledge but were willing to use the tools available to them to help move a youth or families forward in their process.

“[The psychologist] was very upfront. He was like, 'Okay, I don't have experience with this but just tell me what's going on'. And so [my child] was sitting outside and I talked to him first and just explained everything that was going on. And then he called [my child] in and asked him a bunch of questions and we just had a conversation. Then he pulled out the book [the DSM] and he pointed to gender dysphoria and he's like 'yep, yep.' So, basically at the end of that he said, 'It seems to me like you meet most of these criteria and that's what we need in order to do a diagnosis'. So, after just one meeting he wrote like a page and a half basically saying, 'Yes, this is what is going on'. (parent of pt7)

Participants frequently spoke of one provider in particular, who was framed as providing the highest standard of care for trans youth. Even when youth weren't able to gain access to his practice because of insurance issues or lack of parental support, many participants knew of him and named him as an ideal medical provider. Youth who were able to see him for services framed their encounters as radically different than those they had had at specialized gender clinics. He was constructed in these conversations as a kind of beacon for those trans youth and families able to access care through his private practice.

“I feel like **he was very understanding and didn't really ask me a lot to like prove [I'm really trans]**. I've even had doctors who ...wanted me to explain to them how I feel [in terms of gender]. And he didn't even really ask that, I don't think. I was kind of just like, 'I want this', and he was like, 'Okay'. I think that's why it stands out to me... like I've heard people talk about informed consent and I think **he knew that I knew what I was getting myself into**. He was like, 'Okay, if [you] know what you want, then I'm just willing to do it for [you].” (pt4)

Other participants noted this provider's willingness to share divergent possibilities and directions in seeking healthcare services, which garnered trust and supported the notion that he was providing them with 'all the information.'

Discussion

In this study, we utilized discourse analysis and principles of community-based participatory research to better understand the healthcare-seeking experiences of transgender youth under age 18 and how youths' transgender identity and legal status as minors impacted their ability to access care or influenced the quality of care they received. We identified discourses that both enabled and constrained youths' ability to access health care services. Discourses of normativity, which included *cisgenderism* and *hegemonic transnormativity*, centered on youths' experiences seeking a transgender-related diagnosis (e.g., gender dysphoria) and were also prevalent in talk about goals of care. Discourses of temporality, which included *waiting* and *permanence* encompassed the role that waiting played in participants'

narratives of health care access, as well as how risks and benefits were framed within their health care encounters in terms of less or more permanent intervention, or less or more permanent change. Discourses of access, which included *backdoor channels* and *healthcare workers as gate-openers*, centered on how youth and families were able to find pathways around or pathways through the barriers they encountered in pursuit of particular health services and interventions. Discourses of access centered on the notion of possibility, where what was and was not possible depended on a number of factors including age, parental support, insurance status, race, geography, and the representation of other trans individuals in participants' lives. These discourses were present across multiple layers of the healthcare system, within and outside specialized gender clinics, and at both the interpersonal and institutional levels.

Findings from this study highlight the processes by which contemporary trans youth are made intelligible or recognizable in healthcare contexts, as well as processes by which they are erased or excluded from institutional and medical knowledge and practice. This concept of erasure^{5,56} has been reflected in other studies that have explored how transgender individuals navigate and engage in healthcare services and represents “a defining condition of how transsexual/transgender is managed in culture and institutions, a condition that ultimately inscribes transgender as impossible”^{56(pp4-5)}. This showed up in our study across multiple levels of discourse. For example, youth were subjected to answering questions by providers – and sometimes by parents – about their gender that their cisgender peers generally are not (for example, “*How do you know you’re a woman?*”). Explaining one’s gender represented a kind of making oneself possible within an impossible system. The narratives youth were called upon to craft regarding their embodied experiences both did and did not reflect their lived experiences and were configured strategically. Youth and families talked about constructing narratives that made their passage through the system possible, which often involved accepting subpar clinical experiences, investing significant time and personal labor to navigate insurance exclusions, and having conflicting feelings about the care they received. At the institutional level, participants frequently encountered issues with medical record systems and insurance coding when their sex assigned at birth

“did not match” their gender and this often rendered their particular gender configurations invisible, impossible, or undesirable.

Together discourses of normativity, temporality, and access influenced when and in what ways study participants were or were not able to access healthcare services, and their abilities to access adequate and trans-affirming care were often facilitated or impeded by parents. Discourses of normativity inscribed what was and was not permissible to share about one’s gender and what types of narratives and experiences were believable as ‘real trans childhoods.’ This need to prove their transgender identity limited how much and in what ways youth disclosed information to adults about their embodied experiences of gender and often produced feelings of fear, anxiety, and distress. Participants’ gender presentations and expressions were held accountable in ways that cisgender youths’ presentations and expressions are not. When youth were able to construct narratives or ‘gender histories’ that were consistent with existing diagnostic criteria (i.e., gender dysphoria), when they were able to garner support for their identities from parents, and when they had private insurance, their experiences navigating health care were more flexible or porous. Alternately, when participants’ experiences did not fit within dominant narratives of trans childhood, or when they lacked the kind of parental support that enables youth to consent for health care services and navigate insurance exclusions, they were often met with resistance or disbelief about their need or eligibility for such services. Of note, discourses of access that focused on ways around or ways through the existing system of care centered on relationships and connections with other trans people. This suggests that the representation of other trans individuals – both peers and adults – is critical in the lives of trans youth and directly impacts their health and well-being.

Our findings are consistent with other studies that have argued that erasure is why trans individuals need to navigate health care in ways that are different from cisgender individuals^{57,58}. For example, a 2015 grounded theory study that sought to depict the process by which transgender individuals engage in health care. This study found that transgender adults responded to health care barriers by engaging in a process that involved navigating the healthcare system by 1) moving forward in deciding to

seek trans-competent care, 2) doing due diligence to find this care, 3) finding loopholes to utilize the care, and 4) continually trying to make their health care work for them⁵⁷. Additional researchers have argued that trans individuals experience uncertainty and ambivalence when engaging with health care providers and systems not adequately prepared to meet their health needs⁵⁸. This was echoed by participants in our study, as well. Our research adds to understandings about how trans individuals are excluded from health care practices and illuminates some of the specific issues facing trans youth under the age of 18, both with and without parental support. These data highlight power dynamics present in clinical interactions – particularly when parents are present or when youth lack parental support entirely – that impact how trans young people present themselves and self-censor their experiences in order to ensure their safety and access to care.

In recent years, there have been significant efforts to improve access to care for trans youth. Nonetheless, there is a need for more research that provides answers to questions about how power dynamics related to age and gender impact the abilities of trans youth under 18 to access adequate health services, as well as how making oneself fit within existing models of care and diagnostic categories may itself be a distressing factor in trans youths' lives. Existing data suggest that a significant portion of trans individuals experience explicit rejection from family members as a result of their gender identity^{59–62}. In the case of trans youth under 18, family rejection or ambivalence limits their access to care and is likely to exacerbate health disparities within this vulnerable population. We suggest that a shift in research paradigms and medical practice is needed for sufficiently addressing the health disparities facing trans youth, especially those most likely to experience inequitable access to care. Future research, especially studies addressing barriers to healthcare access, should make significant efforts to recruit trans youth participants from non-clinical settings. Waivers of parental permission that permit the participation of youth under the age of 18, both with and without parental support, should be considered a necessary and fundamental strategy for centering embodied knowledge and recognizing youths' autonomy in research about their lives and health needs.

There are limitations to this study. Participants were predominantly White, and thus these results may not represent the discourses that underrepresented racial minority youth encounter in pursuit of health care services, particularly as they relate to the intersections of racism and cisgenderism discourses. Participants represent a cross-section of the varied experiences of trans young people. There is a selection bias in favor of participants who were interested in and willing to talk about their experiences seeking and navigating health care, which may not include many trans youth who have reasons to believe they cannot or should not share their stories. At the center of our analyses was a concern with the role of language in the construction of social reality. This was both a strength and limitation of this research; for example, not all youth whose embodied experiences of gender transcend binary categories of boy/man or girl/woman use the word 'transgender' to identify or describe themselves and these youth may be less likely to respond to study recruitment materials seeking 'transgender' participants. In light of these limitations, we believe that the methodological innovations we undertook during the conduct of this research support a new and as yet untold perspective of trans youths' experiences with health care access.

Discourse analyses, particularly critical discourse analyses like the one we have presented, can help to illuminate the power relations at play in the provision and regulation of health care services for trans youth, as well as the provision and regulation of health care services for transgender individuals more generally.

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Table 2.1. Study Participant Characteristics

ID	Participant Type	Gender of Participant	Gender of Child	Age of Participant	Age of Child	Race/Ethnicity	Healthcare Encounters Addressed	Parental Presence	Recruitment Source
1	Youth	transgender male	–	17	–	White	urgent care, primary care	No	LGBTQ+ student listserv/flyer
2	Youth	transgender female	–	16	–	White	psychotherapy, gender specialist/clinic, primary care	No	LGBTQ+ student listserv/flyer
3	Youth	transgender female	–	17	–	White	psychotherapy, gender specialist/clinic, primary care	No	LGBTQ+ student listserv/flyer
4	Youth	transgender male	–	17	–	White	psychotherapy, surgery & surgical consults, OBGYN, gender specialist/clinic	Yes	LGBTQ+ student listserv/flyer
5	Youth	queer/gender-nonconforming	–	15	–	Asian	nutrition, emergency medicine, primary care, gender specialist/clinic		LGBTQ+ youth center/flyer
6	Youth	transgender female	–	15	–	White	school-based health center, primary care	Yes	word of mouth
7	Youth	transgender male	–	13	–	White	psychotherapy, gender specialist/clinic	Yes	transgender community listserv/flyer
8	Youth	transgender male	–	15	–	White	gender specialist/clinic, OBGYN, surgery & surgical consults	Yes	transgender community listserv/flyer
9	Youth	transgender male	–	15	–	White	primary care, gender specialist/clinic	No	psychotherapist referral
10	Youth	transmasculine/FTM	–	13	–	White	psychotherapy, gender specialist/clinic	No	online social media
11	Youth	transgender male	–	17	–	White	laboratory, pharmacy, primary care, gender specialist/clinic	No	LGBTQ+ youth advocacy workshop
12	Parent	cisgender male	transgender male	–	17	White	–		–
13	Parent	cisgender female	transgender male	–	17	White	–		–
14	Parent	cisgender male	transgender male	–	13	White	–		–
15	Parent	cisgender female	transgender male	–	13	White	–		–
16	Parent	cisgender female	transgender male	–	15	White	–		–
17	Parent	cisgender female	transgender female	–	15	White	–		–

Age is not reported for parents. In addition to the healthcare encounters addressed by each youth participant, all parents who assisted their children in interviews addressed health insurance reimbursement.

Table 2.2. Sample Interview Questions

- * What influenced your decision to seek healthcare at this particular time/for this particular issue?
 - * What – if anything – did you know about this provider before you met them?
 - * How did you get this information?
 - * How important was it to you to know something about the provider before you met with them for the first time?
 - * What role – if any – did insurance play in your decision about where to seek healthcare?
 - * What role – if any – has online information, or online friendships & connections, played in how you think of your gender and how/where you seek healthcare?
 - * How were your parents involved or not involved? In what ways did their presence or absence help or hinder your experience accessing services?

In what ways did you “prepare” for the visit i.e. think about how you would describe your experience of your body and your gender in very specific terms, rehearse what you would or would not say about yourself, imagine questions the provider might ask you and pre-plan answers, etc.
 - * What barriers - if any - did you encounter throughout your experience?
 - * What role has legal documentation played in how you have been access healthcare?
 - * What – if anything – about your appearance – your body, your clothes, etc. – do you think impacted your interaction with the provider?
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Chapter Four

Age, Autonomy, and Authority of Knowledge: The Role of Consent in Regulating Access to Care for Transgender Youth Under 18

Abstract

This study was aimed at better understanding the power dynamics present in trans youths' relationships with both parents and providers – particularly related to age and trans youths' legal status as minors. We were interested in how notions of age, consent, and autonomy influenced youths' ability to access care and their inclusion in informed consent processes. This analysis was undertaken as part of a broader qualitative study, the purpose of which was to better understand the healthcare-seeking experiences of transgender youth under age 18 and how youths' transgender identity and legal status as minors impacted their ability to access care or influenced the quality of care they received. As such, the present analysis also aimed to better understand how notions of age, consent, and autonomy intersected the discourses previously identified in our primary analysis (i.e. discourses of normativity, discourses of temporality, and discourses of access). We conducted 1 focus group with high school age trans youth (n=8) and a total of 11 one-on-one interviews with 11 trans youth between the ages of 13 to 17 years in the Seattle-Tacoma area of Washington state regarding their experiences seeking and accessing a variety of healthcare services. Six parents of trans youth who participated in one-on-one interviews were also included and discussed their experiences interacting with the health care system on behalf of their child. Using critical discursive analytic methods, we identified two sets of discourses across interview and focus group transcripts – *discourses of autonomy* and *discourses of support* that characterized how youths' ability to make decisions about their bodies and health were regarded by both parents and providers. Discourses of autonomy included confidentiality, self-determination, and authority of knowledge and encompassed the ability to which youth were granted the authority to self-govern or self-determine their genders, as well as how their health needs were prioritized and facilitated or denied, dismissed, and occluded. Discourses of support included role ambiguity, trust/mistrust, and good/bad parent subjectivities and encompassed the various roles and positions that youth, parents, and providers took up or were placed within in terms of authoritative decisional capacity. Findings from this study highlight

multiple issues present at the intersection of health care and the law for trans youth under 18, as well as complexities in adult-child relationships that are often present for transgender youth. We found that there were significant intersections between the discourses identified in our previous analysis (discourses of normativity, discourses of temporality, and discourses of access) as well as between the discourses of autonomy and support that we identified in the present analysis.

Introduction

Informed Consent

Informed consent is considered a fundamental part of the communication exchange between healthcare practitioners and patients, ensures that patients understand treatment options, and is critical to patients' decision-making processes¹. Defined as “the treatment authorization given by a patient to a physician”^{1(p344)}, informed consent must be intentional, voluntary, and based on knowledge of the treatment, intervention, or procedure under consideration as well as potential risks and benefits. Informed consent models were ushered in by the bioethics movement of the 1960s and represented a shift from a beneficence approach (which was characterized by maximum physician discretion) to an autonomy approach (which underscored the need for increased patient involvement) regarding decision making in medicine². Informed consent models were developed to address concerns that medical providers disproportionately held power in scientific research and clinical encounters and are intended to facilitate patients' authoritative decisional capacity in making decisions about their bodies and health³. The critical need for informed consent is based on the bioethics principle of autonomy, or self-determination, and “emphasizes respect for individuals' rights to control their lives and actions by their own choices”³. While adults receive substantial encouragement to participate in medical decisions about their bodies and health, the issue of informed consent is complicated for adolescents whose status is that of a legal minor and who, excepting few circumstances, are generally not granted the same authoritative decisional power as adults or access to confidential medical treatment.

Adolescents and Informed Consent

In practice, adolescents' ability to consent for medical services is essentially triadic in that youth under age 18, providers, and parents/guardians are each involved in medical decision-making processes related to adolescents' bodies and health needs. Parents' permission, or consent, for medical treatment is generally required because of adolescents' status as legal minors⁴⁻⁶. The degree of power-sharing among youth and adults in this context is variable and likely to be influenced by parental attitudes about their

children's ability to make autonomous decisions regarding their bodies and health, provider attitudes regarding the value of youths' perspectives when making medical decisions (as well as their communicative abilities to facilitate such conversations), and the degree to which youth feel safe and empowered to advocate for themselves in health care contexts. Excepting in contexts of abuse or neglect, parents or legal guardians are granted the authority to make decisions on behalf of legal minors and to provide consent for medical services because of their legal responsibility as parents/guardians and the assumption that they will act 'in the best interests of the child'¹.

This notion of 'the best interest of the child' is inherently subjective and conceptually vague and presents unique issues for adolescents who seek healthcare for concerns which are frequently stigmatized and often not permissible for some youth to disclose to their parents/guardians; for example, sexual and reproductive health services, substance use treatment and counseling, and psychiatric issues. In these cases, some minors may choose to go without care or treatment rather than seek parental permission. In most states, adolescents aged 13 to 18 are granted the authoritative decisional power to consent for medical care related to these specific health concerns⁷. Granting legal minors the ability to give consent autonomously in these circumstances is based on the notion that allowing legal minors the ability to consent ensures unconditional access to care for those adolescents who might otherwise be impeded or dissuaded from seeking medical attention⁸. However, laws vary from state to state and there are a lack of guidelines that address the confidentiality of clinical encounters, such as in medical records and explanations of benefits. Given that the vast majority of minors rely on parents – through public or private insurance – as the primary source of payment or eligibility for medical care, such lack of clarity regarding confidentiality in medical records and explanations of benefits poses significant challenges to maintaining confidentiality for legal minors⁹.

Transgender Youth, Informed Consent, and Access to Care

Additionally, no such provisions exist to protect legal minors who seek healthcare for issues related to gender identity (e.g. transgender and non-binary youth seeking health services or interventions

aimed at facilitating medical gender transition – namely, puberty blockers, hormones, and surgeries). Existing data suggest that a significant percentage of transgender individuals experience explicit rejection from family members as a result of their gender identity or expression¹⁰⁻¹⁴. Parents/guardians of transgender youth are likely to have a range of reactions when they first learn of their child’s transgender identity, some more harmful than others¹⁵. These include feeling a sense of loss, viewing their child’s gender-nonconformity as a phase, viewing the youth’s gender identity as a symptom of a resolvable psychological issue, and psychologically or physically abusing the youth^{16,17}. Parental reactions to their children’s transgender identity is likely to impact the vast majority of transgender youth’s ability to access trans-affirming health services and interventions, specifically because of youths’ status as legal minors. Many parents/guardians require significant support in coping with the stigma surrounding their child’s transgender identity and in their efforts to advocate on behalf of the children’s health and health needs. A 2011 parent survey identified six areas for support, including identification of their child’s transgender status, family’s response/reaction, emotional support, dealing with negative responses from others and concerns about safety, seeking and accessing medical services, and seeking and accessing political, government, and legislative support¹⁸. While many parents/guardians may not explicitly reject their children, researchers have suggested that many parents’/guardians’ attempts to enforce dominant societal norms of gender presentation on their transgender children are motivated by a desire to protect their children from judgment, hostile questioning, bullying, and harm¹⁹. When one or both parents are unwilling to consent for treatment (i.e., when parents disagree), or when youth are not currently living with their legal guardians (potentially because their parents/guardians are not supportive of their trans identity) informed consent for treatment of transgender adolescents may pose significant ethical and legal challenges and prevent such youth from accessing critical health services and interventions²⁰. In cases where youth are not living with their parents, contact with legal guardians for consent to access medical services might compromise youths’ physical, emotional, or psychological wellbeing.

Adding to this complexity, researchers have highlighted issues in performing informed consent in transgender healthcare more generally. For example, in settings where protocols and consensus are

lacking, medical providers have been found to “double down” on upholding medical authority and claims to expertise^{21,22}. Consensus statements across professional medical associations regarding transgender medicine are lacking, and there remains a great deal of uncertainty about the long-term risk of hormone interventions²³. As researchers have previously demonstrated, such inconsistencies in the provision of transgender medicine have been found to increase stigma in clinical encounters²⁴ and interfere with the degree to which collaborative decision-making is carried out in practice²⁵. A 2019 study analyzing how medical providers understand and perform informed consent in clinical encounters with adults seeking trans-affirming medical interventions such as hormone therapy found that providers of trans medicine bring bias into clinical encounters with their patients and uphold healthcare inequities through performing informed consent²⁶. For example, when patients did not conform to binary configurations of gender or seek treatment to transition *from* ‘one’ gender *to* ‘the other,’ providers were found to assert their authority through gatekeeping practices that regulate who is and is not eligible and deserving of trans-affirming health services and interventions. These issues are likely to be exacerbated in the case of transgender adolescents because of their status as legal minors and the challenges they may face in garnering parental support for their identities. Issues related to consent and transgender minors have not been adequately addressed in existing literature on transgender youth health, largely because of limited inclusion of transgender youth under age 18 in research about their healthcare-seeking experiences, both with and without parental support.

Present Study

This analysis was undertaken as part of a broader qualitative study, the purpose of which was to better understand the healthcare-seeking experiences of transgender youth under age 18 and how youths’ transgender identity and legal status as minors impacted their ability to access care or influenced the quality of care they received. We utilized discourse analytic theory and methods to examine 11 one-on-one interview transcripts of youth and parent narratives seeking healthcare and identified three sets of discourses – discourses of normativity, discourses of temporality, and discourses of access. Discourses of

normativity were prevalent in youths' experiences seeking a transgender-related diagnosis (e.g., gender dysphoria) and were often identified in talk about goals of care. Discourses of temporality encompassed the role that waiting played in participants' narratives of health care access, as well as how risks and benefits were framed in terms of less or more permanent intervention. Discourses of access centered on possibility and described how youth and families were able to locate alternate pathways when they encountered barriers in pursuit of health services and interventions. Together, these discourses influenced when and in what ways trans youth were or were not able to access healthcare services, and their abilities to access the health care services they desired were often facilitated or impeded by parents. In the current analysis, we focus on better understanding the power dynamics present in trans youths' relationships with both parents and providers – particularly related to age and trans youths' legal status as minors. We were interested in how notions of age, consent, and autonomy influenced youths' ability to access care, their inclusion in informed consent processes, as well as how notions of age, consent, and autonomy intersected the discourses previously identified in our primary analysis (i.e., discourses of normativity, discourses of temporality, and discourses of access).

Methodology

In this study, we utilized discourse analytic theory and methods to guide our analysis. A discursive approach to research explores language as a “form of action”²⁷ and seeks to understand how individuals and institutions use language to create and enact identities and activities²⁸. We adopted a Foucauldian definition of discourse in which the word discourse refers to “practices that systematically form the objects of which they speak”^{29(p15)}. A Foucauldian approach to discourse analysis examines the institutional and societal discourses that enable and constrain individual action at a particular moment in time³⁰. We took up a *critical* discourse perspective in that our analysis was particularly focused on the power relations within which transgender individuals have been constructed as “other” in relation to the taken for granted cisgender norm, and we considered the relationship between language and power in transgender young people's encounters within the healthcare context. Critical discourse analysis

examines not only what is said, but also how it is said, and in what contexts³¹; for example, in the context of trans youths' conversations with parents or in the context of both parent and youths' interactions with varying levels of the health care system (e.g., patient and family interactions with medical providers, parents' interactions on behalf of their children with insurance systems, etc.). Theory and methodology are discussed in more detail in *Chapter 3/Paper 2*.

Methods

Participants and Setting

We conducted one focus group with high school age trans youth (n=8) and a total of 11 one-on-one interviews with 11 trans youth between the ages of 13 to 17 years in the Seattle-Tacoma area of Washington state. Six parents of trans youth who participated in one-on-one interviews were also included and discussed their experiences interacting with the health care system on behalf of their child. However, not all individual interviews with youth participants included parent participants. Flyers with information about this study and how to contact the researchers were posted electronically via online social media and social support groups. Printed materials were distributed at local organizations that serve youth (both LGBTQ+ specific and not) as well as at LGBTQ+ youth advocacy and community organizing events. Of the one-on-one interview participants, five heard about the study through LGBTQ+ student listservs/flyers, two from transgender community listservs/flyers, one from an LGBTQ+ youth advocacy workshop, one via online social media, 1 through a psychotherapist referral, and 1 participant reported hearing about the study via word of mouth.

Focus group participants were invited to participate in this study via an existing gender discussion group at a local high school that welcomes and supports transgender and non-binary youth. The group moderator was notified of this study by a parent who participated in a one-on-one interview with their child. A flyer with information about what study participation entailed and a focus group research information sheet, which included information about how to contact the researcher with questions, was shared with potential focus group participants two weeks in advance of the scheduled focus group. All

existing group participants were given the option not to join the focus group at no penalty to them or their future participation in regularly organized group discussions.

Inclusion criteria for one-on-one interviews were self-identification as transgender or non-binary, age 13 to 17 at the time of the interview, English-speaking, and having sought care in the Seattle-Tacoma area. There was no specific eligibility screening of individuals that participated in the focus group as participation in the existing gender discussion group met the eligibility criteria for age, language, and transgender status.

Ethical Considerations & Waiver of Parental Permission

Ethical approval was obtained from the University of Washington Institutional Review Board. A waiver of parental permission was obtained that permitted the enrollment of transgender youth under age 18 with and without parental involvement or consent. Ethical considerations specific to trans youth and the advantages of obtaining a waiver of parental permission have been discussed in more detail in *Paper 2*. However, it is notable to reiterate our perspective that youth are capable of generating invaluable knowledge about their lives and experiences and that requiring parental consent for participation in research among trans youth may be contributing to a narrow view and agenda about which health services and interventions are necessary and important in this population³².

All youth interview participants were given the option to participate in one-on-one interviews in the presence of a youth advocate whose role was to ensure that youth understood their rights as research participants, or in the presence of a trusted family member or friend. One of our primary objectives was to attempt to neutralize power dynamics between the interviewer and youth participants and to give participants the opportunity to discuss with an adult who was not the primary researcher and interviewer how and if they wanted to answer specific interview questions. The youth advocate was also present during the focus group. In an effort to ensure focus group participants' comfort participating in the discussion, the existing discussion group moderator – with whom focus group participants' had existing

positive relationships in which they are supported in their identities – was also present for the focus group discussion.

The youth advocate (D.M.T) was a doctoral student in the Department of Epidemiology at the University of Washington’s School of Public Health with seven years of experience supporting and advocating for youth under severe distress from housing insecurity, medical emergencies, substance use, discrimination, mental health crises, and suicidal ideation. The primary researcher and interviewer (A.S.) was a pediatric emergency medicine nurse and doctoral student in the School of Nursing at the University of Washington with over 15 years of experience working with children and youth in medical emergencies and mental health crises, as well as seven years of experience facilitating support groups for trans youth and parents of trans youth. He disclosed his transgender status to all focus group and one-on-one interview participants and invited them to ask any questions they had about his experience or identity. The youth advocate also shared her identity as a queer cisgender woman and discussed her relationship with transgender communities.

A total of 11 youth participated in one-on-one interviews and ranged in age from 13 to 17 years. See Table 1 for one-on-one interview participant demographics. Interview participants lived in a variety of locations in the Seattle-Tacoma area, including in both urban (N=8) and rural (N=2) settings. A total of 8 youth participated in the focus group. We did not collect any individual information or identifiers for focus group participants, including demographic information. Of the 11 participants who participated in one-on-one interviews for this study, seven chose to participate without their parents present. Three of these youth requested the presence of the youth advocate during consenting, and two of these youth further requested her presence during the interview itself. One interview participant requested the presence of a trusted friend during the consent and interview process. Some participants shared that they spoke with their parents about the study. Others shared that it would not be safe for them to talk with their parents about participation in a study related to their transgender status. When relevant, participants were provided referrals to appropriate social and community services, and all participants were given information about how to contact the primary researcher or youth advocate with concerns or questions.

Youth participants received a US\$25 retail gift card for participating in one-on-one interviews and a US\$20 retail gift card for participating in the focus group. Written consent was obtained from participants prior to the start of the focus group and each of the one-on-one interviews and after all questions had been addressed. Audio recordings were transcribed by a professional transcriptionist, and any identifiers were redacted from transcripts. Audio-recordings and transcripts were stored on a secure file server, which was only accessible to the research team.

Data Collection: One-on-one Interviews

Six of the 11 one-on-one interviews took place in participants' homes, most often when youth elected to interview in the presence of their parents. Of the six interviews conducted in participants' homes, two participants were living independently of their parents/guardians. In cases where youth chose to interview without their parents/guardians present, the remaining interviews took place at LGBTQ service organizations, public libraries, or university campuses. Interview space was chosen based on accessibility to youth, as well as comfort, and interview space was secured by the primary researcher and interviewer.

Before interviews began, the interviewer noted the potentially sensitive nature of interview questions and topics, such as experiences of discrimination and exclusion when seeking healthcare services. Prior to the start of each interview, participants were invited to ask any questions they had about the research process and reminded that they were not required to share information about their experiences that they did not wish to share, that they could stop or exit the interview at any time, or request that the audio-recorder be turned off. Participants were also invited to share feedback and reactions to specific interview questions and the experience of interviewing in real-time.

A semi-structured interview guide consisting of open-ended questions was employed in flexible ways to ensure that participants could speak about their experiences on their own terms. Interview design was informed by the Identity, Research, and Health Dialogic Interview³³, which addresses how identity informs healthcare encounters. This style of interviewing requires heightened attention to what type of

knowledge is generated about the relationship of demographic data to health outcomes³³. While all interviews are naturally discursive, a discursive interviewer pays particular attention to power differentials between the researcher and participants. Additionally, discursive interviewing techniques 1) allow for diversity of responses (rather than emphasize similarity), 2) are more informal conversational exchanges than other interviewing techniques (e.g., they do not follow an interview “script”), and 3) involve interviewers as active participants rather than positioning them as neutral “speaking questionnaires”^{34(p156)}. Discursive interviewing techniques explore the boundaries of discourses (including practices of exclusion regarding that which is permissible to say and that which remains unsaid or obscured), as well as how discourses exert power and constrain and enable action. Table 2 provides some of the questions asked during interviews. However, these questions were not necessarily asked in this order and additional probing questions were asked when needed.

The primary researcher and interviewer initially framed the interview by sharing that the purpose of the interview was to 1) learn more about trans young people’s interactions with healthcare providers, 2) how they felt aspects of their identity impact their health, and 3) what they think about how healthcare providers talk about their identities, experiences, and health needs. Participants were asked about particularly memorable or pivotal healthcare encounters during which they felt that their gender was a factor in the quality of their interaction, or central to how meaning was assigned to their particular health concern(s). They were then invited to share their thoughts and feelings about how their transgender status impacted the quality of their encounter or their purpose in seeking healthcare. Interview participants spoke about their experiences with a range of healthcare services, including primary care, psychotherapy, outpatient and inpatient surgical procedures, outpatient surgical consults, urgent care, emergency medicine, laboratory, pharmacy, and gender specialists and clinics. Interviews lasted between 60 to 120 minutes and were audio-recorded and then transcribed by a professional transcriptionist. Once initial interviews were transcribed, participants were given a copy of the transcript and invited to make edits or additions to the original interview material. Participants were also invited to contact the primary researcher or youth advocate if they felt additional aspects of their experience were important to share.

Data Collection: Focus Groups

The focus group was conducted in a private space at the hosting organization to ensure confidentiality and participant comfort. Before the focus group began, the researcher reminded participants that the purpose of the focus group discussion was to explore their thoughts and experiences accessing healthcare. Participants were reminded of the potentially sensitive nature of focus group topics (e.g., experiences or ideas about discrimination and/or exclusion when seeking healthcare services), that they were not required to share any information about their experiences, and that they could leave the focus group at any time or remain silent. Additionally, participants were asked to preserve confidentiality and not tell anyone outside of the group what any particular person said. We asked that participants in the group use only first names during the discussion and reminded participants that we could not guarantee that each participant would keep the discussion private. Group consensus was established to audio-record the discussion.

Prior to the start of the discussion, the researcher addressed ground rules for group participation, which are addressed in more detail in Table 3. Initially, participants were invited to write down their thoughts in response to an introductory prompt designed to generate ideas. The prompt encouraged participants to reflect on their experiences with healthcare providers, how their gender identities may have impacted the quality of care they received, where and how they've experienced barriers to accessible healthcare, as well as any thoughts they had about how health service provision might change in order to better meet their health needs as trans youth under age 18. After participants had time to write down or think about their initial thoughts, the researcher facilitated interchange among participants with the goal of creating a permissive environment for the expression of personal, shared, and potentially conflicting viewpoints on healthcare access. Participants were given the option to choose whether their written notes were included as research data and reminded that they were not required to share written comments that they did not wish to share.

The primary researcher (A.S) was responsible for facilitating the communicative dynamics that took place in the course of the focus group which included asking participants to raise their hands when

they had something to share with the group, asking clarifying questions, and ensuring that all members of the group had the opportunity to share their perspectives if they wished to. Of note, one focus group participant communicated with the assistance of text to voice technology. The youth advocate (D.M.T) was responsible for taking notes during the focus group discussion and assisted the primary researcher in facilitating communicative dynamics. Prior to the start of the discussion, she shared the purpose of note-taking and invited participants to view her notes during or after focus group discussion. The youth advocate noted the gender pronouns that each participant preferred throughout discussion as well as in the future drafting of manuscripts. The existing group moderator also assisted in facilitating communicative dynamics, which included helping to generate ideas that focus group participants had frequently brought up during regularly scheduled discussion groups and one-on-one mentorship activities. Focus group participants spoke about a diversity of topics which included, for example, privacy and confidentiality in the healthcare context when youth lacked parental support, neurodiversity and the role of ableism in health service provision for trans youth, age restrictions on youths' ability to access transgender health-related services and interventions, the use of trans-inclusive language in healthcare contexts, and the impact of gender dysphoria on health issues for trans youth. The focus group lasted approximately 90 minutes, and the audio-recording was transcribed by a professional transcriptionist. Focus group participants were invited to contact the primary researcher or youth advocate if they felt they had additional perspectives they wished to share related to the specific aims of this research or their experience participating in focus group discussion.

Data Analysis

All youth participants were invited to participate as members of the data analysis team and in the dissemination of results. This is consistent with a community-based participatory approach to research – specifically, youth-led participatory action research – which engages young people in identifying problems relevant to their lives, in the conduct of research to understand these problems, and in advocating for changes based on research evidence³⁵⁻³⁷. Of the 19 youth participants who participated in

the focus group or one-on-one interviews, two chose to participate as data analysts. Both youth data analysts, as well as a third participant-researcher, chose to participate in the dissemination of results and manuscript development. The analysis team was comprised of the primary researcher and interviewer (A.S), the youth advocate (D.M.T), two trans youth participant-researchers (W.S.P.N. and A.T.C.), and one faculty mentor with experience conducting discourse analysis (I.K.G.). Three members of the analysis team identified as transgender and two as cisgender. All of the data analysts were White.

We utilized Willig's framework for CDA using a Foucauldian perspective to guide the analytic process³⁰. Foucault's work was directed at entire systems of thought or "knowledge systems"³⁸ (e.g., medicine, psychology, law) and was concerned with the dynamics through which individuals become – or are forced to become – institutionally recognizable types of subjects, e.g. 'real transgender youth.' Therefore, we understood 'transgender' not as a predetermined category into which identities or bodies are inherently formed or 'ready-made,' but as a shifting discursive category produced through medical, legal, and cultural practices over time^{39,40}. According to Willig, "Foucauldian discourse analysts focus on the availability of discursive resources within a culture [or particular time period] – something like a discursive economy – and the implications of this for those who live within it"^{30(p130)}. In the present analysis, we were interested in how consent – what it stands for and who gets to execute it at which age – might problematize access to health services for trans youth as well as notions of confidentiality, decision-making capacity, and traditionally understood or constructed parent-child and patient-provider dynamics.

After reading through the transcripts to develop familiarity, the focus of our analysis was the examination of the transcripts for discourse, what Foucault defined as "practices that systematically form the objects of which they speak"^{29(p15)}. We first analyzed the various ways in which discursive objects (what Willig calls "objects of study") were constructed relating to the aims of our study. Our primary analysis focused on understanding the role that discourse plays in shaping transgender young people's encounters within a variety of healthcare contexts, and thus, we examined the transcripts for constructions of 'transgender' in participants' narratives. In the present analysis, we focused more specifically (i.e.,

‘zoomed in’) on how notions of age, autonomy, and authority of knowledge presented unique issues for transgender minors.

Next, we examined the transcripts for differences between and across constructions of the discursive object. For example, in what ways did participants strategically frame (or ‘construct’) themselves in terms of the dominant discourse regarding transgender youth identity, experience, and health in order to access particular health services? How did one’s ability – or lack of ability – to legally consent to health services and interventions intersect with ideas about trans young people under age 18 knowing ‘who they really are’? This stage of the analysis sought to identify the various discursive constructions of transgender youth health and decisional power within broader, system-level discourses; for example, discourses of consent.

We then focused on a closer analysis of the discursive contexts in which the different constructions of trans youth, their health needs, and their authoritative decisional power took place. Willig asks, “What is gained from constructing the object in this particular way at this particular point within the text?”^{30(p174)}. Next, we identified various subject positions and how discourses constructed particular subject positions, e.g., ‘good’ and ‘bad’ parents. Subject positions are about the creation of subjectivities, which speakers can take up as well as place others within. In the case of transgender youth, if ‘transgender’ is the object of study, what types of transgender youth subjectivity are constructed as legitimate, believable, etc. and how does this complicate constructions of the decision-making capacity of legal minors, particularly in the healthcare context? We also paid particular attention to what types of parent and provider subjectivities were created through discourses identified in the text – how parents or providers were constructed as supporting or hindering youths’ ability to consent to particular health services or to enact particular identities – and the interconnectedness of various youth, parent, and provider subjectivities. How were ‘good’ parents constructed? What did they say about their children in terms of gender and in what contexts? What did they do and not do that worked to position them as ‘supportive’?

Next, we examined the relationship between discourse and healthcare practice by systematically exploring the ways in which discursive constructions and the subject positions contained within them facilitated or foreclosed opportunities for action within the healthcare context. In the present analysis, we gave particular attention to how consent was constructed in both parent-child and patient-provider interactions. Our final stage of analysis focused on exploring the relationship between discourse and subjectivity. For example, how were youth, parents, and providers constructed as knowledgeable and/or granted decision-making capacity, and what implications did this have for trans youth seeking particular health services and interventions for which they generally cannot legally consent?

Results

We identified two sets of discourses across interview and focus group transcripts – *discourses of autonomy* and *discourses of support* that characterized how youths' ability to make decisions about their bodies and health was regarded by both parents and providers. Discourses of autonomy included confidentiality, self-determination, and authority of knowledge and encompassed the ability to which youth were granted the authority to self-govern or self-determine their genders, as well as how their health needs were prioritized and facilitated or denied, dismissed, and occluded. Discourses of support included role ambiguity, trust/mistrust, and good/bad parent subjectivities and encompassed the various roles and positions that youth, parents, and providers took up or were placed within in terms of authoritative decisional capacity.

Discourses of Autonomy

Confidentiality

When participants lacked parental support for their trans identities, they were often put in precarious situations with regard to the role that medical records might play in inadvertently “outing” them as transgender to parents. In some cases, youth had previously shared their transgender status with parents and were met with negative responses or attempts by parents to ‘block’ them from expressing ‘non-normative’ gender identities. In other cases, youth had not previously shared their transgender status

with parents. In both cases, youth feared that parents might gain access to medical records or medical visit summaries in which aspects of their trans identities were discussed and recorded by providers. The precarity with which youth were able to access medical or mental health services without their parents present also was defined by a kind of hypervigilance about health information, in which youth were called upon to monitor how providers took notes in electronic medical record systems regarding the details of their visits. This was particularly true when youth interacted with providers in primary care or urgent care clinics, where their health concerns both were and were not related to ‘transgender health issues’ e.g. chest binding, initiation of medications to facilitate medical gender transition, or in clinical interactions with mental health providers during which youth disclosed or explored their transgender status. In these situations, it was often unclear to both providers and youth what information parents may be able to access or request from youths’ medical records.

One participant, for example, sought medical evaluation at a primary care clinic for chest pain that he thought might be related to chest binding. In order to ensure that his trans status wouldn’t be inadvertently disclosed to his parents, he felt it was necessary to provide an alternative ‘chief complaint’ that protected his confidentiality. This included reporting to the receptionist at the clinic that he wanted to speak with the physician about birth control (which was also what he reported to his parents) rather than having the freedom to share his actual reason for seeking care at this appointment.

“I had given this line [about birth control] to the receptionist. I didn’t exactly tell the receptionist, ‘oh, just a second, I’m lying to my parents and then I’m going to go into the doctor for a different thing.’” (pt1)

He went on to recall the need he felt to monitor how the provider recorded his reason for seeking care.

“I was in the room with this doctor, and I thought I saw her put something about binding into the computer. I’m not necessarily in the habit of reading over doctor’s shoulders and policing what they’re putting down, but I was like ‘hey, did you just put down that I was binding? Because as I mentioned, I’m a closeted trans man whose parents cannot know that I was binding. So could you

put down something else?’ The doctor was like, ‘okay, what else do you want me to put down?’ I was like, ‘wow that was a close call.’ My main concerns were specifically around my parents finding out that I was using this name at the university and that I was binding or like enacting trans-ness.” (pt1)

Participants spoke about their concerns related to parents ‘finding out’ about their trans status via institutions – for example, school records where ‘preferred names’ and ‘preferred pronouns’ might be recorded or medical records where chief complaints might inadvertently ‘out’ youth. They worried that institutional support for their identities would likely have a different meaning for parents versus if parents found out about their children’s trans status through adolescent peers. Many youth were aware that parents might view the authority of institutions as more legitimate than that of their peers, and that this was more likely to provoke harassment from parents or parental actions aimed at preventing youth from expressing ‘non-normative’ genders.

“Especially in an institutional context, I felt and continue to feel that if [my parents] hear [that I’m trans] from a friend, I can play it off as a different thing but specifically in the context of the university, of healthcare, of these institutional steps... I know that it would freak them out a lot that I was doing anything that looked like taking these steps without their participation and consent.” (pt1)

The need for confidentiality – or partial confidentiality – also limited what youth felt they could share with medical and mental health providers when parents were present in clinical encounters. For example, one participant talked about how she self-censored during a visit with a medical provider during which her parents were also present in the room.

“It was kind of awkward. I felt like I couldn’t be as truthful as I could if it was just – somehow, I wish it was just me and [the doctor]. Because there were some things that I wasn’t sure about saying around my parents.” (pt2)

For some youth, the issue of confidentiality was further complicated when parents shared custody of participants, when participants lived in more than one home, and when youth had support from one parent but not from another. Concerns about one unsupportive parent ‘finding out’ posed significant safety risks to youth and other members of their families, such as another parent or siblings. One participant spoke about his family’s experience previously living with an abusive father, and he feared that if his father were to learn of his trans status through medical records that this would put him, his mother, and his sibling in an unsafe situation.

“At first when I lived with both of [my parents] like back and forth it sucked because [my mom] couldn’t change [my name and gender marker] in the [medical record] system because if [my dad] took me to the doctor he would find out and I wouldn’t be in a safe position.” (pt13)

Additionally, the need to withhold their trans status from parents involved a great deal of deliberation about what settings were safe for youth to ‘be themselves’ in versus those that presented potential safety issues. These experiences required a great deal of labor and were characterized by evolving levels of precarity and questionable safety.

“It was hugely convoluted. In terms of binding, I was sometimes changing on campus, which was an event. I was asking people to use my name who were friends in certain spaces and not in certain other spaces and around certain people and not around certain other people. I was trying to be...as out in an institution which doesn’t necessarily allow for partial outness as I could be without actually having the chance of coming to [my mother’s] attention. I was almost moved out [of my parents’ home]. I was out in half of my classes or using the name. I had a folder of papers that had one name on it and a folder of papers that had another name on it. I was trying to do my best to make sure that [my mom] didn’t encounter this folder. It was something that I was putting a ton of thought and energy into. Constantly I was like, ‘okay, how can I do this? How can I do this? Can I afford to use this name in this space? When do I come out to the scholarship?

When do I like start moving in this direction knowing that I'm going to be living with my parents over the summer?" (pt1)

Self-Determination

Broadly defined, self-determination is understood as the process by which a person controls their own life⁴¹. Specific to transgender individuals is the concept of gender self-determination. Zimman argues that the self-determination of gender is made possible by a particular cultural framing of body and self, where "knowledge of the self is cast as something that can be accessed only by the individual in question"^{42(p229)}. This notion of gender self-determination diverges with other frameworks of knowledge of the mind, such as psychoanalysis, and challenges the historical framing of transsexuality, or transgenderism, as a diagnosis⁴².

Trans youth are confronted with unique issues with regard to gender self-determination because of their position as children and their legal status as minors. Youth participants frequently recounted experiences in which they were not afforded the agency to self-determine when and how they disclosed their transgender status. They spoke of situations in which their parents required them to 'out' themselves as trans before parents were willing to support them in accessing health interventions aimed at facilitating medical gender transition or legal services aimed at changing youths' names and gender markers. Participants spoke about feeling as if they had no choice but to 'go along' with parent requests because they needed parental consent to access health services and interventions such as pubertal suppression, hormones, or surgeries. This often involved a kind of parental bartering, in which parents were not always aware of the safety concerns that youth had about when and how they wanted to disclose their trans status to others, if they wanted to disclose at all.

"[My mom's] first response was, 'fine, but you have to start coming out to people if you're doing this.' What I wanted to do was I wanted to pursue hormones, I wanted to start hormones and not tell anyone and transition later. I wanted to literally do hormones before I transitioned. I wanted to get a few months in and just see where I was at and then go from there. And [my mom] was

like, 'no, you don't have to present for six months or whatever but like you have to like put your money where your mouth is if you want to do this'. I was like, 'well, no'. But she didn't care, she dragged me to my aunt's house who lives in the same neighborhood, and she was like, 'we're coming out to auntie right now.' And she did it for me, and I just went. And then she was like, 'cool, that's a first step now I will call and see if we can get an appointment [with the doctor].'

(pt4)

Youth also talked about feeling pressured by mental health providers to present themselves as their 'preferred genders' before they would be eligible to access health interventions to facilitate medical gender transition. This involved 'making a case' that one was really trans, which intersected with discourses of normativity (e.g., cisgenderism discourse) that we identified in our previous analysis. For example, participants talked about the need to prove their genders and frequently recounted being questioned about being '*trans enough*' or being '*really trans*.' The need to prove one's transgender status inhibited the degree to which youth had agency over the trajectories their transitions took, what health services they were able to access, and under what conditions. Historically this notion of "transition" has stood for a standardized trajectory of "sex reassignment," in which individuals pass from psychiatrist to endocrinologist, to surgeon, to judge and where there is an assumption of a normalized "endpoint"^{43,44}. Since the 1990s, "transition" has been more frequently "deployed to refer to the ways in which people move across socially defined boundaries from an unchosen gender category"^{43(p235)}. In our previous analysis, we found that youth participants often reframed the meaning of transition to include their experiences of waiting, particularly when they lacked parental support for their identities and/or when parents were unwilling to consent for medical intervention. Here a participant talks about a therapist's request that she 'start presenting' before the initiation of hormone therapy and how this constrained the degree to which she was able to self-determine her transition trajectory as well as the fear she had about her safety.

“And then [the therapist] was like, ‘you have to start presenting at some point if you want to do this. It’s better to do it sooner rather than later. It makes your case stronger, and the sooner you do it then the sooner – then by the time you’re 16 we can start [hormones] immediately. Which I was super resistant to. I was very hung up and continued to be – which [is] kind of just internalized transphobia – on the idea of passing and like feeling like I have to be cis passing. And I didn’t want to transition unless I could be cis passing. And I didn’t want to present unless I could be cis passing. I was like, I don’t want to, like it’s scary. Like, I’m not gonna pass. I don’t see why I have to like wear dresses for six months before you can give me hormones. Like is it gonna be safe? She was like, ‘well, if you have to [transition], this is how it goes. Like I wish I had something else to tell you.’” (pt2)

Additionally, youth recounted experiences in which they were met with resistance when they requested they be referred to by their correct names and pronouns in health visits and that this information be recorded in medical record systems. Often they were met with resistance specifically because of their age and required the assistance of parents – some of whom were not supportive of youths’ transgender status – to advocate on their behalf. For youth, the ability to change one’s name and be referred to with the correct name and pronouns was an issue related to safety and confidentiality, and youth felt that they should have the right to be primary decision-makers regarding when they do or do not disclose their transgender status.

“I asked to change my name in the system – not even like change it legally. They just change your preferred name so that when I’m in the hallway, I don’t get outed [and then] I [don’t] have to come up to them when they call my [dead name, or old] name and be like, look. So I tried to do that and [the doctor] was kind of like, you can’t do that. I’m like, actually I can. So I talked with my mom, and she called the doctor’s office, but it was like kind of disrespectful that they thought because I was not 18, like I don’t know what I’m talking about.” (pt13)

Authority of Knowledge

Participants recounted a variety of experiences in which their authority of knowledge was questioned or discounted, specifically because of their age. On the one hand, trans youth were required to be sure of themselves in terms of gender, which called on them to perform a strong authority of knowledge. On the other hand, their abilities to make decisions about their bodies and identities were often hindered by dominant perceptions of adolescents as being ‘too young’ to make decisions about gender, as well as about their bodies and identities more generally. Their fears about being regarded by adults (e.g., providers and parents) as ‘too young’ to make decisions informed how and in what ways they were willing and able to disclose their trans identities.

“I had overheard [my parents] talking about how I was too, it was too early, and I was too young to be making these decisions with regards to whether or not I was gay at the time. And so that sort of stuck in my mind, and I was worried that they might not be too accepting [of me being trans].” (pt2)

Similar to discourses of self-determination, discourses of youths’ authority of knowledge intersected with discourses of normativity – namely cisgenderism discourse – that required youth to prove that they were ‘*trans enough*’ or ‘*really trans*.’ Participants talked about how adults’ concerns about their abilities to make decisions ‘at such a young age’ put them on edge with medical and mental health providers and put them on the defensive in clinical encounters.

“I had heard generally negative things about trans people’s interactions with doctors. And so I remember just like at the beginning when I first started seeing therapists or when I first went to a gender doctor or when I first saw my primary care provider again after coming out, I was like very much like on the defensive. You’re ready to defend yourself. Especially if you’re younger, I feel like you need to be ready to like prove that you like know enough.” (pt5)

In some cases, parents were willing to support – or accept – their children’s trans identities socially but were not willing to offer their consent for the initiation of medications aimed at facilitating

medical gender transition. In these cases, discourses of youths' authority of knowledge intersected with discourses of waiting (identified in *Paper 2*). In part, discourses of waiting encompassed a kind of powerlessness that youth felt regarding their abilities to access particular types of healthcare services – most often, puberty blockers, hormones, or surgeries – that were contingent on parental consent.

“I didn’t even think I would be on hormones until after I was 18 because of how [my parents] were talking when I came out to them. They were like, ‘no medically transitioning!’” (pt8)

When parents expressed concern about their children’s abilities to ‘know for sure,’ parents often responded by seeking medical or psychiatric evaluation of their children. In many cases, youth were ultimately able to garner parental support for their identities through the authority of knowledge regarding trans identities that was performed by medical and mental health providers.

“When I came out to my parents the first thing my mom said was, ‘well we should go – we’ll set up an appointment with the pediatrician and see what he says, what he thinks’. Which the idea was to get a recommendation for a therapist. They wanted a therapist to confirm if I was insane or something. [The therapist] could pretty confidently say that I’m probably trans, which totally my dad was like, oh, shit! So he did not – it was not the response they wanted I think. They wanted someone to back them up that we should wait, which I’m so lucky that that didn’t happen. Because if someone had said like we should wait like my parents that would have given my parents the backbone they needed to be like, yeah, we’re waiting, like this is what the therapist and the doctor said. Like, you’re 14, you don’t know. That’s why the therapist was good because like someone talking to [my dad] like from a position of authority was good for him, although he had a hard time with it just being spoken to [by] a woman in a position of authority ” (pt4)

Discourses of Support

Role Ambiguity

Participants' narratives often challenged dominant constructions of parent-child and patient-provider relationships in which parents and providers 'know what's best for kids' and in which providers are constructed as benevolent and all-knowing. Many participants talked about knowing more than the providers they interacted with, which was reinforced by other trans people in their lives who had similar experiences with providers.

“I think that most trans people – I mean I’ve heard this from trans people over and over again. I know just as much if not more about what I want than the doctors around me do. You know, like they don’t know what I want my life to look like. I do. I know every single time I’ve gone to a doctor, for something gender-related I’ve known everything they were going to say to me. Because I’ve been reading about it since I was 13.” (pt5)

For many participants, this was an issue of the way that consent was constructed. Youth felt that their authority of knowledge about their bodies and identities should be unconditionally trusted and that the desire for intervention should not include additional regulations such as the need to present as one's 'preferred gender' for a set amount of time before being able to access hormones, or the need for expert psychological evaluation before being granted access to particular surgeries. Participants recounted experiences in which they were frequently called upon to explain things to providers that non-trans youth might generally not be required to explain, and they envisioned ideal patient-provider relationships in which this was not the case.

“[I want providers who] understand and at least have been around the trans community for a long enough time that they have watched people experience what I’m experiencing before, so they’re not trying to figure it out as fast as I am because that’s always awkward when they’re the ones that are supposed to be prescribing me things.” (focus group participant)

For many youth, this created a kind of role ambiguity, in which they were at once required to be experts, but not granted the authority of knowledge or decisional power that experts are generally granted. In many cases, youth encountered this as a need to explain transgender-related terminology to providers.

“Well like, I had doctors who are like, well, like, they’re like, what is non-binary? Like, they’re not actually like educated. Like they don’t actually know what it even is let alone - But like having the ability, because at least for me like I don’t like to ask, to have people ask me strange questions. And that’s happened a lot when I came out, they’re like what does [non-binary] mean? I’m like, shouldn’t you know that? Like, you’re the doctor.” (focus group participant)

Role ambiguity was often intersected by discourses of autonomy – namely, authority of knowledge – which frequently hinged upon notions of trans youth as ‘too young to know’ or ‘too young to make these decisions.’ For example, one participant recounted an experience in which he was called upon to explain to a primary care provider how chest binding was utilized as a self-intervention that supported his mental health. While the doctor was clear that she ‘wasn’t familiar with trans issues’ she also felt entitled to enforce her opinion that the participant was ‘awfully young’ and interrogated the participant about whether or not he ‘should be [chest binding] at all.’ As with many clinical encounters participants recalled in interviews, this dynamic put the participant in a situation where he was called upon to explain ‘trans issues’ or teach the provider. As a result, many participants felt that they could trust other trans people – and collective transgender community knowledge – more than they could trust medical and mental health providers.

“[The doctor’s] advice was kind of, ‘well, I can’t really tell. Are you sure you should be binding anyway? Because you’re awfully young.’ I was 16 at the time. They were like, ‘I’m not really informed on trans issues, but I think you know you’re not fully grown yet and so are you sure that this is something you should be doing at all?’ And I was like, ‘Well this is kind of something that’s super important to my mental health. It tends to be that way for trans many trans people, many trans men, and it’s something that’s about comfort and being in my body and I’m willing to

take a break, but I certainly think that I wouldn't say that I shouldn't have been doing this at all.' And she kind of hemmed and hawed and she was like, 'well, but like physical safety is more important, don't you think? And maybe just save it for when you're older'. I came away with the impression that like doctors are not – there are probably a whole bunch of 13-year old trans people who had given me equally useful advice.” (pt1)

Participants talked about how such provider lack of knowledge and role ambiguity made them fear future clinical encounters and often exacerbated the distress for which they sought health services and interventions in the first place. In order to mitigate the distress they anticipated, participants often prepared for subpar clinical experiences by educating providers about their gender identities in advance of appointments. Even when youth and parents made significant attempts to ensure safe clinical environments, they were met with ignorance about their identities and health needs.

“I had like a panic attack before I went to the doctor and my parents called [the doctor's office] and told them I was trans because I was like freaking out about like my primary healthcare provider dead naming me and stuff. And they didn't but she was really, really, really uneducated about trans things. Like she kept misgendering me and I swear she used like all three different pronouns for me like within a span of 5 minutes. And like when she was talking to my mom, it was good she was talking to my mom because my mom wasn't on board with all the hormone things but when she was talking to my mom she was like, uh, yeah it's better to start early before anything happens obviously referring to like my body and how like I don't have a chest. Because I'm wearing a binder and she would have known that if she knew anything about trans people.” (pt8)

Participants' narratives of parental involvement and support – or lack thereof – were also characterized by a similar kind of role ambiguity. For many youth, this involved explaining their health needs and experiences to parents, wherein parents' understandings of their children's health needs and experiences were limited, or in which parents discounted the severity of distress that participants experienced. Parents often view interventions aimed at facilitating medical gender transition (e.g.,

hormones and surgeries) as ‘fixing the problem.’ However, youth recounted experiences in which they continued to experience distress despite these interventions, and they struggled to help their parents understand the complexities of their need for support over time, whether or not they were interested in and able to access puberty blockers, hormones, and surgeries. In these cases, participants talked about wanting access to medical and mental health providers who might help their parents understand the impact of gender dysphoria, for example, within the broader landscape of trans youths’ lives. In this sense, role ambiguity also intersected with discourses of normativity, particularly transnormativity, which operates by centering medical intervention as the primary health need of every trans person.

“And like also like I tried to explain to my mom yesterday that like I was feeling dysphoric and she was like, well you like have all of this. It’s never like, oh, let’s work on that, it’s like, oh, it’s just this, this and this. It’s not like pointing out like, I’m like, hey I’m feeling dysphoric and my mom’s like, you’re just like feeling down. I’m like, no! I’m feeling dysphoric and I want like as a part of that therapy to be able to explain to my parents what dysphoria actually is and what it means and the different forms it comes in. It’s not just like black and white, just like being trans or like you know so like, top surgery and you’re done.” (focus group participant)

For many participants, parents did not outright reject their transgender children but did not necessarily offer ongoing support to their children in their pursuit of health services, interventions, and information. This required youth to exercise a great deal of maturity and responsibility and to strategically navigate pathways for garnering their parents’ consent for medical services related to their trans identities. This put some participants in situations where they felt ambivalence about being afforded some level of agency to advocate for themselves and also wishing their parents might take up more labor in support of their efforts to navigate the health care system.

“I feel like whenever I like, if I want to like seek some like transition thing I like will bring it up with my dad first and like make sure he’s on board, so I feel like, like I feel like I can maybe potentially like do stuff on like the down low without him like knowing, but I would feel like nervous about it. So I like try and make sure like he’s on board first, and then usually I end up

like making the appointments and stuff for things. I feel like I like being able to have some independence and freedom to like take care of things myself, but also I feel like sometimes I like ask my dad to like do things and then he like doesn't and then so, I'm kind of forced to do it myself, which can be kind of frustrating.” (pt12)

In the same way that youth were called upon to explain their health needs to providers, this was also often true of their relationships with parents. Participants frequently felt that they were called upon to assuage their parents' fears about 'the unknowns' of treatment, and youth did not necessarily share the same fears. This is consistent with other studies that have demonstrated that while youth and parents share similar concerns with regards to medical treatment, their perspectives about risk and benefits of treatment were not always congruent⁴⁵. Youth often felt pressure to educate their parents about risks and benefits of treatment, for fear that the potential risks – which youth did not always see as risks – might impede their parents' decisions to consent for particular health services and interventions related to medical gender transition.

“I feel like my mom... whenever I try to explain concepts to her or correct her if she uses the wrong terminology... she'll always say she's doing the best she can and I can't get mad at her, but then she'll be like, 'I'm just ignorant to these concepts'. And I'm like, 'man I'm just trying to inform you so you won't be ignorant right now if you would just listen to me'. There is a lot of unknowns. At least for them. For me I don't see that but [my parents] haven't done an extensive amount of research. I have. And it's all like the disclaimers they give you when you're at the doctors, they're like, 'oh yeah you're going to have increased rate of heart disease and my parents are like, 'oh my God.' And I'm like, 'just chill out, it's the same risk as with [cisgender] dudes.’” (pt8)

For some participants, this involved rectifying parents' misperceptions and fears about trans identity and experience with youths' own need to be recognized. Some youth participants were explicitly harassed by their parents about their trans status or subjected to parents' arguments about not being 'real' – i.e., 'real men' or 'real women.' In these cases, discourses of support intersected with discourses of

normativity – namely, cisgenderism discourse. Youth experienced ambiguity regarding parent-child roles in the sense that parents privileged what they wanted for their children (i.e., normative gender identities) over their children’s truths and lived experiences.

“[My dad] tried to tell me that like I would never – what he said was, you’ll never – you can’t really be a woman, you’ll just be trans and I don’t want that for you. And then he got more specific too, he was like, you can take hormones and dress however you want but you’ll never – the quote that he said that for some reason it sticks in my mind and it’s such a weird place for him to go I don’t know why he went here of all the places. But what he told me, he was like really quiet he was like, you know you’ll never be able to have a clitoris. I was like, okay, (a) you’re wrong and (b) I don’t understand what you’re talking about. Like, why are you going here? He doesn’t know anything about this at all and he totally was spit balling here and like it was really weird. I didn’t even know how to respond to that or why he thought that that was a relevant thing to say.” (pt4)

Many parent participants who were supportive of their children’s trans identities spoke more generally about learning from their children. This was both related to risks and benefits of medical intervention as well as developing more complex understandings of gender more generally. For example, one parent talked about the paradigm shift she experienced related to binary constructions of gender through learning from her son.

“I struggle with that sometimes with the traditional what we feel are the traditional gender things and clothing and you know. And my kids always tell me, clothing doesn’t have gender. Colors doesn’t have gender. I’m like, ugh! It’s so engrained.” (parent of pt10)

Trust/Mistrust

The role ambiguity that youth participants encountered often led them to feel that they couldn’t trust providers’ and/or parents’ abilities to provide them with the support and care they needed. Many participants talked about *wanting* to put their trust in adults but feeling that their abilities to trust providers

and parents were constrained by the need they felt to protect their emotional and physical safety. Participants frequently recounted reflecting on what aspects of their experience they felt they could surrender to adults for support. This often included deliberation over how to share their experiences with adults in terms that would be most acceptable to parents and providers, as well as contributed to feelings of discomfort and adult-child dynamics in which youth participants felt ‘out of place.’ A number of participants commented on how this role destabilization resulted in feeling ‘on edge’ during clinical encounters and how over time, this produced a particular anxiety about whether or not they would know and understand all of their available health options in the future. Participants felt caught up in a dynamic in which they necessarily relied on providers and/or parents because of their age but were often required to guide providers and parents through conversations about their health and health needs. One youth, in particular, spoke about how his social position as a transgender person of color complicated his willingness to put trust in medical and mental health providers.

“I think definitely yeah as a trans person and like a person of color it’s like the feeling that like doctors are going to like screw you over. And then they don’t know what’s right because people put so much trust in them like you have to. But as someone who has been like had experiences with like being misgendered or dead named or being made vastly uncomfortable by doctors I think that’s definitely a big reason why I don’t trust them. there’s these people where I, and especially doctors and like your parents where you want to put all your trust and faith and be like, yes, I agree. You all know what you’re doing. I’m gonna agree with you. But then it’s like me knowing everything and my doctor and my mother knowing nothing. And it’s such a weird position to be in and it makes me uncomfortable. And I feel out of place. And I felt really uncomfortable with [the doctor] and I think definitely right from the start someone dead naming me and misgendering me makes me even more uncomfortable with them.” (pt8)

Another participant spoke about how a previous negative experience in which he felt he had not been provided with ‘all the information’ to make an informed decision about possible interventions for

menstrual suppression led to feelings of hypervigilance about ‘having all the information’ when making decisions about his body and health in the future.

“I am often very nervous that they’ll ask something, and I won’t know the other alternatives.

And I’ll go, yeah sure, without realizing that is in fact, bad, and I should not. And because I don’t have things like the internet at my disposal at that time [to vet my options].” (pt11)

This fear about knowing all of one’s options, as well as doubt about the degree to which youth and parents could trust any given provider or practice was echoed by a number of parents as well. When parents felt they weren’t able to protect their children or ensure safe clinical encounters, some parents felt they had failed their children. Finding a ‘good provider’ was framed as both an issue of healthcare consumption as well as an issue of healthcare navigation, which required significant personal labor and was not possible for all families.

“I thought I was doing the right thing by identifying this provider that was called ‘the gender clinic’. And it was known supposedly for following the WPATH guidelines. And it supposedly had this board and was very progressive, etcetera. And I could get on a waitlist to do it. And so, you know I thought I was doing the right thing. And going in there I guess I was – even though you know, I have a doctoral degree and I’m not saying this to brag. I’m saying this to say – there are a lot of privilege issues here. If I were this bamboozled, I can only imagine how youth without, you know, a parent to help navigate this ...oh my gosh, you know, where are they? How does a healthcare consumer figure out who to trust? Especially youth who don’t have supportive parents? I mean, because I don’t think adults are very good. I mean, I wasn’t able to find [my son] a good provider, and I analyze things for a living.” (parent of pt11)

‘Good’ & ‘Bad’ Parents

Across interview transcripts, we identified multiple parent subjectivities. Frequently, parents neither completely supported or rejected their children because of their trans status, but the support they were able and willing to offer – which included consent for transgender-related health services and

interventions – was dynamic and, in many cases, changed over time across a good-bad parent continuum. Parents who supported their children were seen as exemplary and unique, which promoted a binary construction of ‘good’ versus ‘bad’ parents. For example, one youth participant spoke about the problems with this type of construction of parent subjectivity related to parenting a trans child but also acknowledged the privilege he experienced having two parents who not only supported his identity but made significant efforts to assist him in navigating healthcare services.

“Like I’d say, like, oh, I love my parents, they’re really great and supportive. And people are like, oh, well they’re just doing what they should do. I’m like, that might be true but like there are [trans] people that don’t have that, you know.” (pt5)

All participants were aware that many transgender individuals experience explicit family rejection over the course of their lifetimes – including participants in this study – and youth often contextualized their parents’ degree of support – or lack thereof – within broader discourses of family rejection among transgender individuals. A number of youth spoke about their experiences with parents who actively made efforts to ‘block’ their children from expressing their gender identities, particularly with regards to embodied change.

“Over the summer my mom found my binder. I don’t know if she even figured out what it was. But she definitely got rid of it and didn’t mention it to me. So I guess the response would be pretty much like confiscating that article of clothing. I had to go figure it out myself. Yeah that was something. It was very something. I felt like the reaction she would have had is, hand over your binder, I’m getting rid of it. This isn’t you. You’re not allowed to do this.” (pt1)

Other participants talked about parents using other health issues as ‘weapons’, creating barriers to health care access to trans-specific health interventions, e.g., puberty blockers, hormones, and surgeries. In these cases, parents were not constructed as permanently blocking their children from accessing certain health interventions, but rather, bartered with them or presented youth with ultimatums.

“Some other things that I’ve seen used by adults as weapons or barriers for access – So we can’t talk about trans stuff, we can’t talk about transition until you put on weight, until you stop taking a lot of drugs or until you go see a doctor. Until your mental health is in a good place.” (focus group participant)

Youth also talked about their experiences of parental support over the broader course of their childhoods, during which they felt it was necessary to self-censor their identities in ways that their cisgender siblings were not required to. In these cases, discourses of support intersected discourses of normativity – particularly cisgenderism discourse – in which parents constrained, obstructed, or forbid youths’ ability to self-determine their genders and gender expressions. In the quote below, a participant relates how her parents’ responses to ‘non-normative’ gender behaviors at a young age led her to self-censor over time.

“In terms of like gender stuff too when I was small, when I was young we moved into a house when I was 5, which I grew up in for the rest of the growing up time. I wanted to paint my room bright pink and my parents wouldn’t let me. They let my sister paint her room bright pink. She was younger than me, but they didn’t let me paint my room bright pink. Not to assert that I was a girl because I wanted to paint my room pink or whatever but that was what I wanted. And they were like, ‘no, it’s okay for your sister but it’s weird if you do it. You’re gonna regret it later’. And so I was like, ‘oh, okay’. Which I took it – I didn’t question it. There was definitely an implicit message of like ‘femininity is not something for you. I know that you want this but like it’s not cool’. So I didn’t say anything. And I always – I self-censored too. I made sure that I was very conscious about not reading books that had female main characters and not listening to music where

the singer was a woman. Because I was worried that [if I had] any kind of interest in anything [feminine] ever, I would give myself away.” (pt4)

Other parents did not actively prohibit or forbid their children from attempting to access transgender-related health care services and interventions but were not particularly supportive either. In these cases, discourses of support were characterized by a high degree of role ambiguity, in which youth were left to navigate and advocate for their health and health needs in the absence of direct parental involvement. As the participant below suggests, parents’ stances were often ‘unclear,’ and in some cases, youth moderated their narratives of parental support in ways that seemed to protect their parents from being constructed as entirely ‘bad’ parents.

“My dad isn’t very open about like his feelings or like his thought processes so it’s kind of unclear for me. But I do think he was hesitant about it. I just think in the general way that like this is like a weird new thing, like a medical thing that he like doesn’t know very much about that he was just like, I don’t know. You know how some parents are like, or like what if you’ll change your mind or something? He didn’t specifically say that, or like specifically what his issue was, but he was just, you know, kind of hesitant about it, but he’s not very open about like the specific things he’s like thinking.” (pt12)

‘Good’ parents, on the other hand, were overwhelmingly constructed as those parents who ‘let their kids choose’ or ‘let their kids decide’ and their narratives were characterized by a kind of power-sharing.

‘Good’ parents supported their children’s right to gender self-determination and frequently advocated on their behalf in medical and mental health contexts.

“Like my parents weren’t going to be like, oh, we aren’t going to help you do this if you don’t do it how we want to do it. Like, I’ve heard that from other trans people that I know. Like, they need to like appease their parents, like it’s a barter or something and it’s not that, you know. But I know in the end that it would be up to me and I know in the end that it’s like my decision, which I

think a lot of trans young people don't get to know, you know and I think it has been like that for most of the time that I've been out. So I think that's a big part of like why I feel like I can talk to them about things." (pt5)

Youth participants talked about feeling supported by their parents when they were not 'forced to choose' and when they were afforded flexibility in their identities. When participants were supported in this way, some youth were not aware of their 'gender non-normative' behavior until it was regulated by adults in other contexts; school, for example.

"Like my parents never forced me to wear feminine things or masculine things. I got to choose. I was like, I'm going to wear this scarf despite a man's shirt and sweatpants I'm going to do it. Like that was kind of the thing that was never really forced on me as a child. I didn't really start realizing anything until [gender] was really strictly enforced by the teacher." (pt10)

Similarly, parent participants – who were also most frequently those parents who overwhelmingly supported their children's gender identity and advocated on their behalf – constructed their roles as 'good' parents in terms of allowing their children to make decisions about their bodies and health and facilitating access to care that required parental consent.

"You know I never felt that it was my place to dictate what they did with their bodies. And so I think that's just been our approach. Like about sexuality or other things – once they get to be a certain age when they're a teen it's not really my business unless they want to share it with me or they want to know what I think." (parent1 of pt5)

Even when they feared the cost of intervention, 'good parents' recognized their children's right to make choices about their bodies and supported their children in weighing the pros and cons and risks and benefits of various medical interventions.

"I was pretty horrified in part because, you know, he didn't want – he felt very disassociated with his vagina. Understandable. And he gets to make his choices. I knew that he didn't like invasive procedures anyway like vaccines, even the flu vaccine. We talked out the pros and cons. He gets

to make the choice, but he wanted so desperately to cease his menstruation he was willing to go through with [the placement of an intrauterine device].” (parent of pt11)

For some parents, the imperative to support their children in seeking transgender-related health services and interventions was not immediately clear, but when confronted with data regarding negative health outcomes among transgender populations, parents’ perspectives often shifted. One parent, for example, recounted a challenging time in his child’s life in which he feared for his child’s safety and wellbeing. Ultimately, this experience represented, for him, ‘a huge shift in mindset.’

“It suddenly became not about me. It was about what C wanted. For me that was a huge shift in my mindset. I’m not going to barter with him about some surgery. I was at a parent meeting and we were talking about top surgery, and a parent said to me, ‘well how do you feel about it?’ And I said, ‘I haven’t even really thought about how I feel about it. If C needs this surgery it’s not about [what I think].” (parent2 of pt5)

Similarly, youth talked about how “statistics” and “data” related to negative health outcomes among trans populations were “for cis people, and they’re for parents of trans youth to see” (pt5). As one participant said, “I think I already knew what it was gonna be like for me to not transition, and so I just think my parents needed to know that” (pt5).

Discussion

In this study, we utilized discursive analytic methods to better understand how notions of age, consent, and autonomy – particularly as they related to trans youths’ status as legal minors – influenced the degree to which youth were granted the authority to make decisions about their bodies and health. Discourses of autonomy included confidentiality, self-determination, and authority of knowledge and regarded the extent to which youth under age 18 were granted the ability to make decisions about their bodies and genders, as well as how their health needs were prioritized and facilitated or dismissed and denied by adults (e.g., parents and providers). Discourses of support included role ambiguity, trust/mistrust, and the construction of ‘good’ and ‘bad’ parent subjectivities. Discourses of support

characterized the various roles and positions that youth, parents, and providers took up or were placed within in the context of medical decision-making most frequently related to trans-specific health interventions aimed at facilitating medical gender transition (e.g., puberty blockers, hormones, and surgeries). Findings from this study highlight multiple issues present at the intersection of health care and the law for trans youth under 18, as well as complexities in adult-child relationships that are often present for transgender youth.

Presently, the gender affirmative model of healthcare defines “gender health” as “a child’s opportunity to live in the gender that feels most real or most comfortable to that child”⁴⁶. While this may be attainable for some trans children, findings from this study problematize the notion of individual choice and suggest that not all youth are afforded the same level of freedom to live in the gender that feels most real or most comfortable to them, especially because trans individuals under the age of 18 are presented with unique issues related to their status as legal minors. The ability of many participants in our study to express their genders “with freedom from restriction, aspersion, or rejection”⁴⁶ was constrained in multiple healthcare contexts. In these contexts, youth often were not able to access services because they did not have access to a consenting parent or legal guardian. Additionally, in many instances, youths’ self-knowledge or capacity to make decisions about their bodies and health was not regarded with the same level of certainty with which parents’ perspectives are generally regarded in medical decision-making about children’s lives. As Levine et al. have argued, “no other authority – medical, legal, or other professional – has the same privileged status as the parent in our society”⁹. One’s right to gender self-determination is influenced by a number of complex social, political, and historical factors and in the case of trans youth is largely contingent on the degree to which they are able to demonstrate ‘decision-making capacity’. While all children and youth under 18 are confronted with issues related to their age and ‘decision-making capacity’ in healthcare contexts, trans youth are confronted with unique issues that are specific to the construction of gender non-normativity, particularly among children and adolescents. In this sense, trans youth are in a unique position – one characterized by a kind of institutional and societal ambivalence in which they are at once invited, if not required, to be

certain of themselves in terms of gender, but not granted the legal authority to make decisions about their bodies without the confirmation or authority of adults (e.g., parents and providers).

With the exception of a few cases, rarely were parents of trans youth constructed as ‘all good’ or ‘all bad.’ Parents had a variety of reactions at different time points to being taught and learning from their children as well as different perspectives on power-sharing and autonomy related to parent-child dynamics. These findings are consistent with existing studies that have investigated the transactional process of identity development between trans youth and their caregivers. Katz-Wise et al., for example, have demonstrated that “caregivers’ efforts to make their children adhere to societal norms of gender presentation [are] rarely grounded in an intention to suppress gender identity but rather [are] motivated by a constant struggle to ensure their [children are] protected from judgment, hostile questioning, bullying, and harm”^{19(p259)}. The construction of ‘good’ and ‘bad’ parents may ultimately alienate parents of trans youth from marginalized backgrounds who would most benefit from support and resources. Not all parents have the privilege of time, money, and health care access that frequently characterizes the narratives of parents of trans youth who are constructed as ‘supportive.’ Additionally, Klein et al. have argued that “in contrast to individuals from many other stigmatized groups (e.g., those who experience discrimination based on race/ethnicity, socioeconomic status, or religion), transgender individuals and their family members do not typically possess a shared stigmatized identity”⁴⁷. As a result, transgender individuals lack what has been termed “primary group member” support, which is the kind of support that a family member or significant other is able to provide when they have experienced and overcome similar stigma and discrimination⁴⁸. This may contribute to the role ambiguity we identified among participants’ narratives of support as well as their feelings that parents often ‘lagged behind’ them in their understanding of trans-related health issues.

Notably, we found that there were significant intersections between the discourses identified in our previous analysis (discourses of normativity, discourses of temporality, and discourses of access; see *Paper 1* for more detail) as well as between the discourses of autonomy and support we identified in the present analysis. For example, self-determination frequently intersected with discourses of normativity –

particularly cisgenderism discourse, which encompassed the assumptions about normative gender that youth faced in their experiences seeking health care. This suggests that transgender minors' ability to self-determine when and how they disclose their transgender status may be complicated by assumptions about normative gender that are specific to the construction of childhood and adolescence (i.e. children and adults are required to perform gender normativity – as well as gender non-normativity – differently). Discourses of youths' authority of knowledge frequently intersected with discourses of waiting and were limited and defined by the time it took parents to 'get on board' with their children's transgender identity. Discourses of role ambiguity intersected with discourses of normativity – particularly transnormativity – in that parents often expected their children's experience to follow a dominant pattern that situates transgender identity as an early psychological condition. When youths' experiences diverged from this dominant construction of transgender identity, participants were often met with parental disbelief that they were 'really trans.' And lastly, discourses of support intersected with discourses of normativity – particularly cisgenderism discourse – and presented as ongoing and dynamic parent-child and provider-patient role destabilization. This suggests that trans youth are not allowed to 'grow up' in the same way as their cisgender peers. In order to ensure their safety, trans youth are often required to perform a strong authority of knowledge and self that is generally not required of cisgender minors.

There are limitations to this study. Participants were predominantly White, and thus the results may not represent the diversity of experiences of trans youth and parents whose experiences with consent are likely to intersect with discourses of racism within the healthcare context. Participants represent a cross-section of the varied experiences of trans youth under age 18, and there is a selection bias in favor of participants who were interested in and willing to talk about their experiences seeking and navigating health care. This may not be inclusive of many trans youth who have reasons to believe they cannot or should not share their stories – particularly those youth who may be most likely to lack parental support and may fear for their safety if participation in a research study might risk unintended disclosure of their transgender status to unsupportive parents. At the center of our analysis was a concern with the role of language in the construction of social reality. This was both a strength and limitation of this research; for

example, not all youth whose embodied experiences of gender transcend binary categories of boy/man or girl/woman use the word ‘transgender’ to identify or describe themselves, and these youth may be less likely to respond to study recruitment materials seeking ‘transgender’ participants. Additionally, the construction of parent subjectivities identified via our analysis was limited to the reports of supportive parents and accounts from youth who interviewed without their parents present (often because they did not feel safe disclosing their transgender status to parents or because they felt they could not speak freely about their experiences if their parents were present). Future research is needed that includes the perspectives of ‘unsupportive’ parents as well as siblings of trans youth in order to understand the complex family dynamics that many trans youth navigate and that impact their ability to safely access health care services and interventions. Additionally, future research is needed that explores the perspectives of healthcare providers navigating consent conversations with trans youth and their families in order to better understand how health care providers encounter disagreements about treatment among youth and parents and how they navigate consent and conversations about goals of care in these contexts.

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Table 3.1. Study Participant Characteristics

ID	Participant Type	Gender of Participant	Gender of Child	Age of Participant	Age of Child	Race/Ethnicity	Healthcare Encounters Addressed	Parental Presence	Recruitment Source
1	Youth	transgender male	–	17	–	White	urgent care, primary care	No	LGBTQ+ student listserv/flyer
2	Youth	transgender female	–	16	–	White	psychotherapy, gender specialist/clinic, primary care	No	LGBTQ+ student listserv/flyer
3	Youth	transgender female	–	17	–	White	psychotherapy, gender specialist/clinic, primary care	No	LGBTQ+ student listserv/flyer
4	Youth	transgender male	–	17	–	White	psychotherapy, surgery & surgical consults, OBGYN, gender specialist/clinic	Yes	LGBTQ+ student listserv/flyer
5	Youth	queer/gender-nonconforming	–	15	–	Asian	nutrition, emergency medicine, primary care, gender specialist/clinic		LGBTQ+ youth center/flyer
6	Youth	transgender female	–	15	–	White	school-based health center, primary care	Yes	word of mouth
7	Youth	transgender male	–	13	–	White	psychotherapy, gender specialist/clinic	Yes	transgender community listserv/flyer
8	Youth	transgender male	–	15	–	White	gender specialist/clinic, OBGYN, surgery & surgical consults	Yes	transgender community listserv/flyer
9	Youth	transgender male	–	15	–	White	primary care, gender specialist/clinic	No	psychotherapist referral
10	Youth	transmasculine/FTM	–	13	–	White	psychotherapy, gender specialist/clinic	No	online social media
11	Youth	transgender male	–	17	–	White	laboratory, pharmacy, primary care, gender specialist/clinic	No	LGBTQ+ youth advocacy workshop
12	Parent	cisgender male	transgender male	–	17	White	–		–
13	Parent	cisgender female	transgender male	–	17	White	–		–
14	Parent	cisgender male	transgender male	–	13	White	–		–
15	Parent	cisgender female	transgender male	–	13	White	–		–
16	Parent	cisgender female	transgender male	–	15	White	–		–
17	Parent	cisgender female	transgender female	–	15	White	–		–

Age is not reported for parents. In addition to the healthcare encounters addressed by each youth participant, all parents who assisted their children in interviews addressed health insurance reimbursement.

Table 3.2. Sample Interview Questions

- * What influenced your decision to seek healthcare at this particular time/for this particular issue?
 - * What – if anything – did you know about this provider before you met them?
 - * How did you get this information?
 - * How important was it to you to know something about the provider before you met with them for the first time?
 - * What role – if any – did insurance play in your decision about where to seek healthcare?
 - * What role – if any – has online information, or online friendships & connections, played in how you think of your gender and how/where you seek healthcare?
 - * How were your parents involved or not involved? In what ways did their presence or absence help or hinder your experience accessing services?
 - * In what ways did you “prepare” for the visit i.e. think about how you would describe your experience of your body and your gender in very specific terms, rehearse what you would or would not say about yourself, imagine questions the provider might ask you and pre-plan answers, etc.
 - * What barriers - if any - did you encounter throughout your experience?
 - * What role has legal documentation played in how you have been access healthcare?
 - * What – if anything – about your appearance – your body, your clothes, etc. – do you think impacted your interaction with the provider?
-

Table 3.3. Focus Group Script

Introduction	<p>Thank participant(s) for participating</p> <p>Focus group facilitator introduces themselves and their pronouns. Group facilitator clarifies their role as someone who helps to facilitate interchange among participants and generate ideas, as well as ensures that anyone who wishes to share with the group has the opportunity to do so.</p> <p>· “First, I have a few logistical things to mention...”</p> <ul style="list-style-type: none">o Ensure that participant(s) have no remaining questions about their rights as research participant(s) and/or about what study participation entailso Our session will last about an hour to an hour and a halfo Remind participants of the potentially sensitive nature of focus group topics (e.g. experiences or ideas about discrimination and/or exclusion when seeking healthcare services), that they are not required to share any information about their experiences that they do not wish to share, and that they can leave the focus group at any time or remain silent.
Ground Rules	<ul style="list-style-type: none">o There are no right or wrong answers to questions. The aim of our discussion today is not to reach a consensus about your experiences with healthcare but to bring forth different perspectives on accessing healthcare.o Group members need not all agree on issues, but all perspectives will be heard and respected.o I will do my best to protect your confidentiality, as we have previously discussed during the consent process. However, there are limitations on my ability to protect the confidentiality of information you present to the group. For example, if you share during the group that you are thinking about hurting yourself or someone else. I am required by law to share that you or someone else is in danger, and I will work with you to make sure that you get the support that you need.o Please raise your hand to indicate that you have something you would like to share with the group.o Remind participants not to tell anyone outside the group what any particular person said. Invite participants to use only first names during the focus group and that researchers cannot guarantee that each participant will keep the discussions privateo Determine if all members of the group are okay with the discussion being audio-recorded. Note, if any member of the group prefers not to have the focus group discussion audio-recorded, it will <i>not</i> be recorded.
Introductory Prompt	<p><i>“Please spend a few minutes thinking about your thoughts and experiences accessing healthcare. One of the goals of this research study is to better understand where and how you experience barriers to accessible healthcare and get your thoughts about what might change. My goal is to learn more about what you think about your experiences with healthcare providers and how your gender identity might impact your experiences with health and healthcare. Take a few minutes to think about or write down what comes to your mind. After a few minutes thinking alone we’ll spend time talking together about what came up for you.”</i></p>

Chapter Five

Conclusion

Summarization of findings

The overarching goal of this dissertation was aimed at better understanding the experiences of trans youth when seeking and navigating healthcare (both with and without parental support), highlighting how youths' perspectives might challenge existing ideas within health research – and health care practice more generally – about what constitutes equitable access to care in this population.

In Paper 1, we identified discourses of gender non-normativity, risk, and gender affirmation in the extant healthcare literature (e.g., medicine, psychology, nursing, and social work) by applying discursive analytic methods to a small purposively assembled sample of 10 exemplary texts. These texts represented the dominant discourse presently inscribing and enabling the notion of contemporary 'transgender youth health' and informing the provision of health services aimed at addressing health disparities facing trans youth in the United States today. Together discourses of gender non-normativity, risk, and gender affirmation combined to produce a dominant, overarching discourse of gender abnormality or pathology that situates 'transgender' within biomedical discourse as always already fractured and establishes 'transgender youth health care' as a medical subspecialty – one that many trans youth under 18 are unlikely to be able to access.

In Paper 2, we utilized discourse analytic methods and principles of community-based participatory research to better understand the healthcare-seeking experiences of trans youth under age 18 (both with and without parental support) and how youths' transgender identity and legal status as minors impacted their ability to access care or influenced the quality of care they received. We identified three sets of discourses that both enabled and constrained youths' ability to access health care services. Discourses of normativity, which included *cisgenderism discourse* and *hegemonic transnormativity*, centered on youths' experiences seeking a transgender-related diagnosis (e.g., gender dysphoria) and were also prevalent in talk about goals of care. Discourses of temporality, which included *waiting* and

permanence encompassed the role that waiting played in participants' narratives of healthcare access, as well as how risks and benefits were framed within their healthcare encounters in terms of less or more permanent intervention, or less or more permanent change. Discourses of access, which included *backdoor channels* and *healthcare workers as gate-openers*, centered on how youth and families were able to find pathways around or pathways through the barriers they encountered in pursuit of particular health services and interventions. Discourses of access centered on the notion of possibility, where what was and was not possible depended on a number of factors including age, parental support, insurance status, race, geography, and the representation of other trans individuals in participants' lives. These discourses were present across multiple layers of the healthcare system, within and outside specialized gender clinics, and at both the interpersonal and institutional levels.

In Paper 3, we utilized discourse analytic methods and principles of community-based participatory research to understand better the power dynamics present in trans youths' relationships with both parents and providers – particularly related to age and trans youths' legal status as minors. Our analysis focused on notions of age, consent, and autonomy and how they influenced youths' ability to access care, their inclusion in informed consent processes, as well as how notions of age, consent, and autonomy intersected the discourses previously identified in our primary analysis (e.g., discourses of normativity, discourses of temporality, and discourses of access). We identified two sets of discourses – 1) discourses of autonomy, which included *confidentiality*, *self-determination*, and *authority of knowledge*, and regarded the extent to which youth under age 18 were granted the ability to make decisions about their bodies and genders, as well as how their health needs were prioritized and facilitated or dismissed and denied by adults (e.g., parents and providers); and 2) discourses of support, which included *role ambiguity*, *trust/mistrust*, and *'good' and 'bad' parents*. Discourses of support characterized the various roles and positions that youth, parents, and providers took up or were placed within in the context of medical decision-making most frequently related to trans-specific health interventions aimed at facilitating medical gender transitions (e.g., puberty blockers, hormones, and surgeries). We also found significant intersections between the discourses identified in our previous

analysis (e.g., discourses of normativity, temporality, and access) as well as between discourses of autonomy and support. For example, self-determination frequently intersected with discourses of normativity, particularly cisgenderism discourse, which encompassed the assumptions about normative gender that youth faced in their experiences seeking health care. We argue that transgender minor's abilities to self-determine when and how they disclose their transgender status (if they wish to disclose at all) are complicated by assumptions about normative gender that are specific to the construction of childhood and adolescence.

Implications for future research

Findings from this study suggest that a shift in research paradigms is needed for sufficiently addressing the health disparities facing trans youth, especially those most likely to experience inequitable access to care, particularly poor trans youth, trans youth who lack parental support, and trans youth of color¹. We suggest that future studies consider the following four practical strategies for including trans youth under 18 in research about their bodies and health:

- 1) **Recruitment Outside of Clinical Settings:** Future research, especially studies addressing barriers to healthcare access, should recruit participants from non-clinical settings. Towards the goal of including trans youth who 1) may not have not disclosed to their guardians, healthcare providers, or schools, 2) don't have supportive caregivers, or who 3) face other structural and economic barriers to accessing care at specialized "gender clinics", investigators should prioritize recruitment through a wide range of mediums and organizations, including schools, organizations that serve youth (both LGBTQ+ specific and not), and social media. In addition, research and interventions conducted solely among clinical samples of trans youth should be critically assessed for sampling bias.
- 2) **Waivers of Parental Permission:** Waivers of parental permission that permit the participation of youth under the age of 18 with and without parental support should be considered a necessary and fundamental strategy for centering embodied knowledge and recognizing youths' autonomy in

research about their lives and health needs. Many trans youth may not have disclosed their trans status to their parents or guardians *because* disclosure of their trans status might put them at risk for parental harassment, abuse, or expulsion from the home². Additionally, not all trans youth currently live with their legal guardians precisely because their legal guardians or parents are not supportive of their trans status. In such situations, contact with legal guardians for consent to participate in research can compromise youths' physical or emotional wellbeing. This is a very vulnerable segment of the larger population of trans youth who are most susceptible to health inequities and inadequate and/or inaccessible healthcare services and who are capable of providing valuable data on how lack of support from parents/caregivers affects their health and health needs. Excluding this segment of the population from participating in research because of the inability to obtain parental consent prevents research teams from understanding and meeting their unique needs. Furthermore, given the stigmatization that often surrounds one's trans status, trans young people may be better informed than their parents about transgender healthcare and gender more generally. Excluding trans youth without parental consent violates ethical research principles, does not recognize youths' autonomy, and limits the collection of data related to their health and health needs.

- 3) **The Use of Youth Advocates:** To mitigate for lack of parental permission, trans youth research participants who are minors should be given access to a youth advocate whose role is to ensure that participants understand the consent process and their rights as research participants. The primary functions of youth advocates are to attempt to neutralize power dynamics between researchers and youth participants, ensure that youth realistically weigh the costs and benefits of research participation, and to protect against researchers presenting any undue pressure on potential participants³. There remains a critical need for trans and queer representation among research teams, and whenever possible, youth advocates should reflect the diversity of LGBTQ+ populations.

4) Including Youth as Participant-Researchers in Analysis and Manuscript Writing:

Consistent with the Intersectionality Research for Transgender Health Justice Framework⁴, participatory approaches for involving youth participants in data analysis and the dissemination of results is critical. Collaborative relationships that center the embodied knowledge and analytic perspectives of trans young people are essential to the analysis of how health disparities are produced and sustained among transgender populations. Power should be addressed in the analytic process, and discussion of research findings and results should center on strategies for improving the conditions within which transgender minors experience societal marginalization, exclusion, and health inequity.

Ethical participatory practices for research with trans youth under the age of 18 are necessary for accurate representation, as well as for creating institutional and systems-level change that positively impacts the health and wellbeing of these youth. Findings from this study highlight power dynamics present in clinical interactions, particularly when parents are present, that impact how young people present themselves and self-censor their experiences to ensure their safety and access to care. Failure to mitigate the structural and interpersonal power relations at play in research and clinical settings related to both age and the regulation of trans bodies ultimately impacts the representativeness of studies and may bias their conclusions. Thus, participatory practices in future research with youth under the age of 18 are critical to ensuring the equitable, accurate, and ethical production of knowledge on the care and wellbeing of trans youth. The four practical strategies outlined above reflect our belief that certain considerations should be paid to methodology and rigor that are specific to working with trans youth who are legal minors and are consistent with the recently published Intersectionality Research for Transgender Health Justice (IRTHJ) Framework⁴. Ultimately, we recommend a shift in research away from the medicalization of transgender children and youth – and the drive to discreetly identify them at earlier and earlier stages of life – towards knowledges and practices that center the lived experiences of trans individuals and that privilege counter-discursive, trans-situated language and knowledge⁵.

Relevance to the field of nursing

This study is consistent with an emancipatory philosophy of nursing research, a critical aspect of which involves accounting for structural causes of health inequity such as globalization of neoliberal economic and social policies, the ongoing racialization of wealth and health, and the persistence of gendered inequities that stem from systems of patriarchy⁶. As critical trans scholar Harper Benjamin Keenan has argued about educational practices, we suggest that the present structure of the United States healthcare system makes little room for children and young people to engage in thoughtful dialogue with healthcare providers about the meaning of their bodies in the world and instead, functions to categorize young people's bodies by routinely sorting out who is 'normal' from who is 'different'⁷. The overwhelming focus in previous health research on trans youth from insured families who seek medical intervention in the form of puberty blockers, hormones, and surgeries – in combination with a lack of attention paid to the social and institutional forces that produce distress in the lives of trans young people – conceals how the fact of diagnosis functions as a kind of normative cruelty^{8,9} that renders trans youth as fractured and in need of repair. Simply expanding an affirmative politics of gender through the multiplication of pediatric gender clinics is unlikely to address the root causes of health and societal marginalization experienced by trans youth.

We suggest that nurses work toward the de-medicalization of trans childhood while simultaneously advocating for increased access to healthcare for all children via two strategies – 1) expanding the provision of transgender health services and interventions within pediatric primary care, and 2) advocating for legislative change that might clarify consent laws for minors seeking gender-related health care services. Expanding the provision of transgender health services and interventions within pediatric primary care begins with the inclusion of transgender individuals, as well as transgender-specific health issues, in nursing curricula at all levels of nursing education. One-hour or one-day long training sessions that focus on defining transgender individuals only in terms of their difference and teaching providers the 'right' words to say when working with trans patients will not solve the problem of health

inequity for trans people. Rather, we must begin to include trans bodies and health issues across multiple aspects of nursing education (e.g., primary care, pediatrics, reproductive health, adolescent health, etc.) and work toward destabilizing discourses that situate transgender healthcare as a form of specialty medicine. This includes addressing the construction of binary gender in health education and across multiple sectors of healthcare practice (e.g., ‘women’s health’). Secondly, nurses are well-positioned to advocate for legislative changes that clarify consent laws regulating the provision of healthcare for trans minors and that, in some cases, contribute to hesitancy by providers to treat and work with trans youth under 18. Unlike reproductive and mental health services, trans minors are unable to access services such as puberty blockers, hormones, and surgeries except through the mature minor doctrine¹⁰, which may delay access to services and complicate family and power dynamics in the lives of trans youth under 18. To achieve health justice for trans minors, nurses might advocate for the inclusion of gender-related health services and interventions among the health services that can be provided to minors without parental consent.

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Vita

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