Facilitating the Transition to Affirming, Structurally Competent Adult Primary Care for Transgender and Gender Non-Conforming Adolescents

By

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Abstract

The healthcare transition from pediatric to adult care for transgender and gender non-conforming (TGNC) adolescents can exacerbate existing health disparities associated with healthcare inaccessibility and stigma. The current adolescent healthcare transition literature is insufficient and existing care transition models have limited application within TGNC adolescent populations. There are currently no scientific papers outlining specific evidence-based healthcare transition strategies for TGNC adolescents. The current paper recommends policy and practice changes to existing pediatric-adult healthcare transition models informed by frameworks that connect gender minority stress and stigma to disparities in health and healthcare. These recommendations center the unique experiences of TGNC adolescents and intersecting identities of gender, sexuality, race, culture, class, ability, etc. that impact the ways in which they experience and participate in the formalized healthcare system. Specific recommendations focus on the barriers to healthcare transition, and they organize healthcare transition strategies within micro-, meso-, and macro- levels of intervention. These strategies include building TGNC adolescents' resilience and agency in healthcare interactions, promoting caregiver involvement, integrating organizational support, and advocating for TGNC adolescents in the many spaces they occupy. The goal of this paper is to inform evidence-based interventions to address care discontinuity and lack of access to affirming, structurally competent healthcare throughout TGNC adolescents' pediatric-adult primary care transition.

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Facilitating the Transition to Affirming, Structurally Competent Adult Primary Care for Transgender and Gender Non-Conforming Adolescents

Adolescence represents a pivotal time in people's lives—one of identity formation, physical changes, emotional growth, and familial tension (Curtis, 2015). In healthcare, adolescence often marks the transition from pediatric to adult care, during which time an individual gains autonomy over their/her/his own health decisions while simultaneously having to adapt to the complex adult system, often with fewer holistic supports (White & Cooley, 2018). Research on adolescent healthcare transition documents the association between unstructured transition policy and adverse health outcomes, non-adherence to treatment, higher costs, and higher use of emergency departments (Crowley et al., 2011; Tuomainen et al., 2020; White & Cooley, 2018). For individuals who identify as transgender or gender non-conforming (TGNC), there are additional factors such as gender identity transition, gender minority stress, and intersecting oppressions of gender, race, sexual orientation, ethnicity, immigration status, ability, socioeconomic status, and more that affect healthcare access and continuity (Abramowitz, 2018; Ehrensaft et al., 2019). Almost entirely absent from the adolescent healthcare transition literature and TGNC healthcare literature are specific ways in which healthcare transition can be improved for TGNC adolescents (Abramowitz, 2018; Ehrensaft et al., 2019).

This is an important topic to study because TGNC individuals experience well-documented health disparities linked to gender minority stress and intersecting forms of oppression (James et al., 2016; Wesp et al., 2019). The 2015 U.S. Transgender Survey found that in the month preceding the survey, 39% of respondents experienced serious psychological distress—a figure that rests at 5% in population estimates (James et al., 2016). Likewise, 22% of respondents rated their health as fair or poor, compared to 18% of the U.S. population (James et

al., 2016). These disparities are exacerbated by the lack of accessible, gender-affirming healthcare (James et al., 2016; Wesp et al., 2019). Gender-affirming healthcare describes a model of care that supports an individual living in the gender they are most comfortable, providing social, medical, and emotional interventions according to their individual treatment goals rather than clinician assumptions (Chen et al., 2016; Coyne et al., 2020; Ehrensaft et al., 2019; Hidalgo et al., 2013). Gender identity transition is a component of gender-affirming care, but many TGNC individuals do not seek medical interventions related to gender identity transition. This model encompasses a greater framework of respect, validation, education, and advocacy.

However, the current U.S. medical, insurance, legal, and associated social systems stigmatize and discriminate against TGNC individuals, making gender-affirming care largely inaccessible. According to the 2015 U.S. Transgender Survey, one in four respondents were denied insurance coverage for gender transition-related or routine care (James et al., 2016). The lack of healthcare provider (HCP) education, understanding, and acceptance of TGNC identities likewise leads to TGNC individuals' experiences of non-affirmation, discrimination, victimization, and rejection in healthcare settings (Testa et al., 2015; Xavier et al., 2007). One-third of survey respondents reported at least one negative experience in healthcare related to gender identity, with higher rates of healthcare discrimination reported by TGNC BIPOC (Black, Indigenous, and people of color) and TGNC people with disabilities (James et al., 2016). Many TGNC individuals report feeling dehumanized in healthcare settings, having their experiences essentialized and explained away (Glick et al., 2018). They are misgendered, face verbal harassment, physical or sexual assault, care refusal, and receive overall poor-quality medical care (James et al., 2016; Seelman et al., 2017). In addition, TGNC individuals are often expected to teach HCPs basic information about TGNC identities and experiences and are subject to

assumptions about gender identity and sexual behaviors (Ehrensaft et al., 2019; Glick et al., 2018; James et al., 2016).

Due to the high prevalence of discrimination in healthcare for TGNC individuals, care is often delayed or forgone (Clark et al., 2017; Seelman et al., 2017). Gaps in healthcare can be incredibly harmful to TGNC adolescents, who are at an increased risk of experiencing depression, anxiety, suicidal ideation and behaviors, engaging in sexual risk behaviors, substance use, and smoking compared to their cisgender peers, stemming from experiences of gender minority stress and structural stigma (James et al., 2016; Puckett et al., 2020). Primary healthcare represents an important site of intervention for TGNC adolescents seeking gender-affirming care and experiencing these gender-related stressors, making the transition from pediatric to adult care even more pivotal. The current paper will contextualize TGNC adolescent healthcare experiences within gender minority stress and intersectionality frameworks, adapting interventions from the adolescent chronic illness and mental healthcare continuity literature to facilitate the transition to affirming, structurally competent adult primary care.

The choice to include healthcare transition literature focused on adolescent chronic illness is in no way implicating TGNC identities as forms of illness—rather, it is an acknowledgement that individuals with TGNC identities have different healthcare experiences than their cisgender counterparts and as such, they require affirming, person-centered care which, unfortunately, is often inaccessible. The intersecting identities of mental or physical health disability, like gender variance, are highly stigmatized, and require targeted interventions that center education and advocacy alongside best practices within medical care. Adolescents with chronic health conditions participate in regular health monitoring, especially when taking medications. TGNC adolescents—like all people—would benefit from routine visits to an

affirming care practice to check-in, improve medication dosage, engage in preventive medicine, and address any other conditions or concerns (Ehrensaft et al., 2019; Fallin-Bennett et al., 2016). In addition, many TGNC adolescents have participated in some form of mental healthcare throughout their lives and may receive diagnoses or take medications that require regular sessions with a licensed mental health practitioner (Becerra-Culqui et al., 2018; James et al., 2016). Although the chronic illness and mental healthcare transition literature will inevitably differ in scope and purpose from the focus of this paper, they represent an important starting point from which to facilitate TGNC adolescents' primary healthcare transition.

The unifying frameworks throughout this paper are adapted from the gender minority stress and resilience (GMSR) model, describing the relationship between gender-based discrimination and health of TGNC individuals (Hatzenbuehler, 2014; Puckett et al., 2020; Testa et al., 2015), and the concept of intersectionality, which names and analyzes identities in the context of overlapping systems of domination (Crenshaw, 1989). The GMSR model theorizes that due to the ongoing marginalization of TGNC people, they are likely to experience discrimination and negative reactions stemming from bias and stigma—on individual and structural levels (Hatzenbuehler, 2014; Puckett et al., 2020). Not only does this oppression result in hypervigilance and poor mental health outcomes, it perpetuates chronic stress that, if left untreated, puts TGNC individuals at risk for chronic disease (Hatzenbuehler, 2014; Puckett et al., 2020; Testa et al., 2015). The attention to intersectionality can likewise be conceptualized as "structural competency," or an understanding of the ways in which institutionalized forms of oppression function and interact within TGNC adolescent healthcare experiences (Metzl & Hansen, 2014; Wesp et al., 2019). Understandings based in both GMSR and intersectionality

frameworks are necessary for identifying barriers to TGNC adolescents' healthcare transition and proposing tailored solutions to overcome them.

The current paper addresses challenges experienced by TGNC adolescents as they transition to adult primary care by (1) describing the healthcare needs of TGNC individuals, (2) identifying the barriers to accessing healthcare for adolescents and young adults, and (3) recommending an adapted, intersectional healthcare transition model that considers best practices in gender-affirming care and adolescent healthcare transition research.

Defining Key Terms

Gender identity, or *affirmed gender*, has come to be defined as an individual's subjective sense of self in relation to masculinity, femininity, or no gender at all (Simons et al., 2014). This concept is fluid and may change throughout one's life (Ehrensaft et al., 2019; Hidalgo et al., 2013). However, that is not to say that gender identity is a choice—it is a complex phenomenon facilitated by biological, developmental, and social factors—and part of a natural human diversity of experiences (Coyne et al., 2020; Hidalgo et al., 2013; MacKinnon, 2018). Another term, *gender expression*, refers to the ways in which an individual communicates their/her/his gender within their culture, such as through dress, hairstyle, or mannerisms (Simons et al., 2014). *Gender variance* is a broad term that describes the identity or expression of individuals that differ from culturally prescribed norms for their *assigned gender*, or gender associated with their natal or biological sex (Simons et al., 2014). *Intersex individuals*, or individuals with variations in sexual characteristics, may also identify as gender variant. Individuals who identify as transgender or trans are those whose affirmed gender identity differs from their natal sex, whereas cisgender individuals' gender identities and natal sexes are congruent. The term transgender includes those who complete a female-to-male or male-to-female transition, in

addition to individuals who do not identify within binary definitions of “man” or “woman” but rather as gender non-conforming, non-binary, agender, genderqueer, and more.

The term *gender dysphoria* (GD) describes the emotional distress associated with the incongruency between one’s gender identity and natal sex, as outlined in the DSM-5 (American Psychiatric Association, 2013). Not all transgender or gender diverse individuals experience GD. It is important to note that GD is not a *disorder*, but rather a description of something with which an individual may struggle (Coleman et al., 2012). In this way, it is important for mental healthcare professionals to address what this diagnosis may mean for someone and maintain a person-centered approach that situates pathology within the social context of distress rather than within the individual (Budge, 2015; Hidalgo et al., 2013). This is necessary because medical gender transition services (hormones, surgery) and insurance coverage almost always necessitate a formal diagnosis of GD (Budge, 2015; Wesp et al., 2019). Many professionals and activists within TGNC communities are advocating for the removal of GD from the DSM and a shift from psychiatric diagnosis to informed decision-making in the gender identity transition process (Schwend, 2020; Wesp et al., 2019).

Language is a very important marker of identity and so it is a crucial element to understanding the ways in which gender identity and expression are conceptualized and may impact TGNC adolescent healthcare experiences. That being said, not all individuals who have transitioned genders identify as transgender or use this language to describe their experiences. Similarly, some gender non-conforming individuals identify as transgender and others do not. This language is important for theoretical examinations and research, but when it comes to working with individuals, it is best to ask them in a receptive and non-judgmental way how they choose to identify. Just as language can be affirming, validating, and healing, language

describing TGNC identities and experiences is also rooted in a socio-historical context of past and present discrimination, ignorance, and harm. To fully understand the ways in which TGNC adolescents access and utilize healthcare (or are restricted in doing so), it is necessary to analyze the roots of transgender health disparities and the ongoing "othering" of TGNC bodies within the U.S. healthcare system.

Socio-Historical Context of TGNC Identities and Experiences in Healthcare

When analyzing health disparities and the unique experiences of TGNC individuals, it is necessary to adopt a cultural-historical lens in which behaviors are understood in the context of intersecting oppressions, trauma, adaptation, and resilience (Gutiérrez & Rogoff, 2003). In this way, academics and researchers avoid assumptions that liken the experiences of TGNC individuals to those of cis individuals, while also avoiding "othering" TGNC communities through the evaluation of intrinsic differences (Gutiérrez & Rogoff, 2003). The health disparities, risk factors, and coping mechanisms that have been measured among TGNC populations, when viewed through a gender minority stress framework (Testa et al., 2015), represent responses to external discrimination and negative internal evaluations of self (Puckett et al., 2020; Testa et al., 2015). Tied to these negative messages is gender-related stigma and the history of medicalization, racialization, and pathologization of TGNC bodies and experiences (Gill-Peterson, 2018; MacKinnon, 2018).

Medicalization of Gender Diversity

As Julian Gill-Peterson (2018) notes in *Histories of the Transgender Child*, the popularized notion of transgender children as "new" is far from the truth. There is an extensive history of exploitation, experimentation, and trauma experienced by gender diverse children at the hands of the U.S. medical institution throughout the 20th century (Gill-Peterson, 2018).

Included in this history is the racialization of TGNC children as white, with young transgender BIPOC being denied access to medical interventions, systematically dehumanized, and even institutionalized in psychiatric facilities when seeking gender-related treatment (Gill-Peterson, 2018). The “treatments” that were available reflected “corrective” or “conversion” approaches to TGNC healthcare, born in an attempt to “cure” TGNC individuals of their deviant identities and associated discomfort—distress that is now understood to stem from non-affirmation of gender identity, rejection, discrimination, victimization, and transphobic cultural attitudes (MacKinnon, 2018; Schwend, 2020; Testa et al., 2015). This conversion approach has since been discredited due to abundant evidence that it causes significant harm, yet the modern requirement to receive a psychiatric diagnosis of GD before accessing medical transition healthcare remains problematic (Coleman et al., 2012; MacKinnon, 2018; Schwend, 2020).

Psychiatric diagnoses like Gender Identity Disorder (GID) in the DSM-IV and GD in the DSM-V, or research that centers biological causes of gender diversity, have the potential to contribute to systemic and internalized stigma and represent an area of intense controversy (Budge, 2015; MacKinnon, 2018; Schwend, 2020). The impact of this language is substantial—it positions TGNC individuals as intrinsically sick before medical intervention, whereas cisgender individuals are categorized as healthy and normal (MacKinnon, 2018). In many ways, DSM criteria for GD and GID essentialize trans experiences and promote binary, trans-normative narratives, usually in the form of “born this way,” “trapped in the wrong body,” or having been aware of one’s trans identity from a young age (MacKinnon, 2018). They leave no gray area for individuals who do not experience clinical GD but would like to access gender identity transition-related healthcare. They likewise exclude gender non-conforming individuals who do

not fit in on either end of the gender binary and often report later awareness of gender identity (James et al., 2016; MacKinnon, 2018).

The proliferation of these narratives may be one factor contributing to the cultural invisibility of gender non-conforming individuals and stigmatization within personal, work, school, legal, and social spheres (Lefevor et al., 2019). Gender non-conforming individuals report being victimized more than any other gender identity group, and they experience more discrimination than their cisgender or binary transgender counterparts, including increased medical care refusal (James et al., 2016; Lefevor et al., 2019; Puckett et al., 2020). Many transgender individuals may deeply connect to these trans-normative sentiments, as they are validating and true to their individual experiences while being simultaneously intelligible to cisgender individuals. However, the processes of gatekeeping, stigmatization, and diagnosis control TGNC bodies and experiences, limiting and defining what it means to possess a TGNC identity (Budge, 2015; MacKinnon, 2018). This is important to remember when analyzing TGNC adolescents' experiences in healthcare because even when gender-affirming care is accessible and is utilized, it is still within a greater social context of complex power dynamics (Schwend, 2020). Included within these dynamics is the intersection between age and healthcare use, including consent to treatment, agency (or lack thereof), and sources of available support.

Understanding the Context of Adolescence

The complex physical and social transition into adulthood, known collectively as adolescence, represents a time of limited autonomy—one in which a young person is often dependent on parents or caregivers legally, financially, and emotionally. This is clear within healthcare decision-making for TGNC adolescents in which semi- or irreversible treatments (hormones, surgery) require parental consent. For TGNC young people who live in rural areas,

whose parents are non-affirming, or who experience overlapping forms of systemic oppression (e.g. racism), gender-affirming healthcare is often inaccessible. HCPs involved in adolescent-targeted healthcare transition programs must be mindful that many TGNC individuals may be accessing gender transition-related care for the first time and sources of family support may be limited. On the other hand, TGNC adolescents who regularly utilize affirming pediatric services may be accustomed to high parental involvement in healthcare decision-making and advocacy, which must be negotiated throughout the healthcare transition process as the adolescent can consent to treatments and manage their/her/his own health more independently.

Parental acceptance is not only important for accessing gender-affirming care—it is critical to the health and wellbeing of TGNC youth and adolescents (Curtis, 2015; Ryan et al., 2010). Adolescence is often characterized by a marked increase in paternal conflict and its emotional intensity (Curtis, 2015). For TGNC adolescents, this can be exacerbated by the "coming out" process and negative reactions or lack of parental and peer support. When comparing family support, friend support, and community connectedness as moderators of gender minority stress for TGNC individuals, family support proved to have the strongest association with depression and anxiety and was the only support significantly associated with resilience (Puckett et al., 2019). In other words, family support has a huge influence on the mental health of TGNC adolescents, with the potential to buffer the effects of gender-based stigma and build resilience with levels of high support, or, conversely, exacerbate negative outcomes in non-affirming family environments.

Another key aspect of adolescence is puberty, during which the development of secondary sex characteristics occurs alongside psychological and social changes (Blakemore & Robbins, 2012; Curtis, 2015). This is often accompanied by a greater awareness of one's gender

and increased experiences of body dysphoria for both cisgender and TGNC youth. Puberty may potentially increase experiences of GD among TGNC youth as well (Curtis, 2015; Ehrensaft et al., 2019). Mental health disorders such as depression and anxiety may be exacerbated by internal experiences of GD, body dysphoria, low self-esteem, and low parental acceptance, in addition to school, home, or other environmental stressors experienced by TGNC adolescents. The unique context of TGNC adolescents—within decision-making, parental acceptance and support, and psychological distress—must be understood to begin to develop targeted healthcare transition interventions.

Healthcare Needs of TGNC Adolescents

Moreover, adolescence in the context of healthcare is generally understood to include low general healthcare use, high emergency department use, and high risk-taking behaviors (White & Cooley, 2018). Many aspects of adolescent development, including growing autonomy, mistrust of authority, navigation of family relationships, and peer or social influences, often lead to poor adherence to treatment and disengagement with healthcare (Paul et al., 2013). All of this is happening in the context of pediatric-adult healthcare transition, during which TGNC adolescents shift care providers to someone unfamiliar, risking discrimination, care refusal, victimization, and non-affirmation of one's gender identity in the process (Glick et al., 2018; Testa et al., 2015). These barriers make the development of best practices within TGNC adolescent healthcare transition critical, speaking to the intense need for accessible, affirming care and continued support. Due to existing stress-linked health disparities, affirming primary care for TGNC adolescents must incorporate standard screenings for substance abuse, STIs, and mental health concerns while maintaining an awareness of intersecting forms of systemic oppression and their consequences. Health status is far from the only manifestation of gender

minority stress in TGNC adolescents' everyday lives—the stigmatization and oppression experienced by TGNC individuals exists in many spaces and not all TGNC young people have access to key resources to help manage it.

In this way, the healthcare needs of adolescents include not only access to gender-affirming healthcare, but also resources for housing, education, employment, mental health, managing discrimination, and more. Adult primary care clinics traditionally offer less wrap-around support for healthcare users, as compared with pediatric spaces in which social workers, legal counsel, housing supports, and behavioral medicine clinicians are often available (White & Cooley, 2018). These entities represent important resources for adolescents and young adults, especially TGNC individuals, who face systemic stigma and discrimination in many of these areas, negatively impacting their health and wellbeing. Integrating these holistic supports is an example of structural competency, applying the intersectionality framework to understand and meet the needs of TGNC adolescents (Metzl & Hansen, 2014; Wesp et al., 2020). Primary healthcare represents a space in which these resources may be readily integrated and, as such, primary care is an important site of intervention within TGNC adolescent healthcare continuity.

Theoretical Frameworks

Intersectionality

TGNC individuals experience systemic oppression, which includes but is not limited to discrimination in healthcare, employment, services, housing, school, insurance, and legal policy on the basis of their gender identity (James et al., 2016; Wesp et al., 2019). However, gender is one of many identities for which structural stigma, or oppressive laws, societal conditions, and social norms, exist (Hatzenbuehler, 2014; Metzl & Hansen, 2014). Other identities include race, immigration status, ability, sexual orientation, age, ethnicity, education level, socioeconomic

status, and more (Hatzenbuehler, 2014; Puckett et al., 2020; Wesp et al., 2019; Williams et al., 1994). This way of naming and examining systemic power relations originated within Black feminist scholarship dating back to the 1800s, with the term "intersectionality" later coined by Kimberlé Crenshaw in 1989 (Crenshaw, 1989). Altogether, intersectionality is a framework used to name and understand systemic oppression born of overlapping identities within a matrix of power, holding vast implications for addressing structural stigma, reducing health disparities, and care inaccessibility among TGNC adolescents during healthcare transition (Wesp et al., 2019).

For example, TGNC individuals who identify as Black, Indigenous, Latinx, Asian American or Desi American will experience cisgenderism and racism in distinct and intersecting ways. The 2015 Transgender Survey revealed that even though transgender individuals overall were twice as likely to be living in poverty, trans BIPOC were over three times as likely to be living in poverty compared to the U.S. population overall (James et al., 2016). In addition, trans BIPOC experience greater health disparities, an unemployment rate four times the national average, and among Black transgender women, an HIV rate of 19% (compared to 1.4% among transgender respondents and 0.3% among the U.S. population) (James et al., 2016). Similarly, undocumented transgender respondents experience physical violence, intimate partner violence, poverty, and homelessness at much higher rates, and those with disabilities are unemployed, experience poverty, psychological distress, attempt suicide, and are mistreated by HCPs disproportionately (James et al., 2016). Because TGNC individuals experience discrimination and stigma in overlapping and unique ways, any interventions to facilitate TGNC adolescent healthcare continuity must also address racism, cisgenderism, heterosexism, classism, ableism, colonialism, nativism, and other systems of oppression.

Gender Minority Stress and Resilience Model

The gender minority stress and resilience (GMSR) model (Testa et al., 2015), adapted originally from the racial minority stress model (Williams et al., 1994) and later from the sexual minority stress model (Hatzenbuehler, 2014), conceptualizes the ways in which distal and proximal stressors may lead to poor mental and physical health outcomes for TGNC individuals (Testa et al., 2015). Distal, or external, stress factors include gender-related discrimination, rejection, victimization, and non-affirmation of gender identity, as perpetrated by other individuals or larger systems of oppression (e.g. cisgenderism) (Testa et al., 2015). Proximal, or internal, stress factors defined in this model are internalized transphobia, negative expectations, and concealment of one's gender identity, which are influenced by distal stressors but ultimately manifest within oneself (Testa et al., 2015). Distal and proximal stressors interact with one another to perpetuate anticipated stigma, or an expectation that distal stress factors (enacted stigma) will occur.

Some documented health disparities or outcomes within this model include experiences of depression, anxiety, PTSD, suicidal ideation, and health conditions linked to chronic stress (Breslow et al., 2015; Puckett et al., 2020; Seelman et al., 2017; Testa et al., 2015; Whitehead et al., 2016). There may also be an increase in substance abuse, sexual risk behavior, incarceration, homelessness, lower healthcare utilization, and decreased preventative care engagement among TGNC individuals, which can exacerbate physical and mental health comorbidities (Hidalgo et al., 2013; Seelman et al., 2017; Whitehead et al., 2016). Coyne et al. (2020) propose adolescent-specific adaptations to the Testa et al. (2015) GMSR model, including the addition of body dysphoria and identity confusion within proximal stressors and family support as a resilience factor. Developing a model of gender minority stress specific to TGNC adolescents' healthcare

experiences may prove crucial to understanding and developing strategies to facilitate and improve primary healthcare transition for this population.

There are many ways in which stressors are theoretically linked to health outcomes. Puckett et al. (2020) conceptualize the pathways between stressors and mental health outcomes as measures of coping, including engaging in education and advocacy, detachment, substance use, resistance, and internalization. For example, if a TGNC individual experiences refusal of care in a healthcare setting, they may cope by detachment (i.e. avoiding healthcare spaces to protect their/her/himself from experiencing this form of discrimination). This could likewise trigger psychological distress associated with avoidance and other health disparities related to inaccessible and forgone care (Clark et al., 2017; Puckett et al., 2020). TGNC individuals live and participate in a world that, in many ways, is not safe for them. Some coping mechanisms are generally considered healthful and positive responses, whereas others have the potential to cause harm. It is important to remember that the above coping mechanisms represent survival adaptations in cisnormative and transphobic contexts and may be less effective in non-threatening situations (Lefevor et al., 2019). Understanding the effects of gender minority stress, specifically within healthcare utilization, is crucial to developing models of affirming primary healthcare transition for TGNC adolescents (Ehrensaft et al., 2019; Glick et al., 2018; Goldenberg et al., 2019; James et al., 2016; Whitehead et al., 2016).

Moreover, the GMSR model also seeks to identify resilience factors or protective mechanisms that moderate the association between stigma and physical and mental health outcomes. These have been operationalized as scales of community connectedness and pride (Testa et al., 2015), family acceptance (Ryan et al., 2010), resilience and collective action (Breslow et al., 2015), and emotional regulation (Pachankis, 2015), to name a few. As mentioned

before, social support (especially family support) serves as a buffer between stigma and mental health, protecting against depression, substance abuse, and suicidal ideation/behaviors (Puckett et al., 2019; Ryan et al., 2010). Because transgender individuals report less support overall than their cisgender counterparts, and gender non-conforming individuals experience less support than both binary transgender and cisgender individuals (Lefevor et al., 2019), this represents a critical area of intervention within models of healthcare transition.

In addition to forms of social support, resilience is often used to characterize the ways in which individuals can adapt to and respond to stressors. Defining resilience for TGNC individuals will inevitably look different from resilience measures developed for other groups. A valid measure of TGNC resilience may include self-affirmation of one's gender identity (Puckett et al., 2020), self-esteem (Breslow et al., 2015), and resistance to gender-identity related stigma (Breslow et al., 2015; Puckett et al., 2020), all of which may serve to buffer the internalization of transphobia or associated psychological distress (Breslow et al., 2015). Likewise, resilience can be conceptualized on a community level as collective action, describing activities conducted by community members and allies for the purpose of decreasing stigma and reclaiming agency (Breslow et al., 2015). Collective action may serve as both a buffer and risk factor for gender minority stress as it connects individuals with support systems while also engaging with transphobia, shared trauma, and sometimes violence (Breslow et al., 2015). Overall, however, family support, resilience, and community support-based interventions may be successful in facilitating healthcare transition among TGNC adolescents, and a better understanding of coping in the context of intersecting stigma will inform structurally competent policies and procedures.

Model of Gender-affirming Care

Gender minority stress research has informed a gender-affirming healthcare model, in which TGNC individuals are provided social, medical, and emotional support to live as the gender in which they feel most comfortable (Chen et al., 2016; Coyne et al., 2020; Ehrensaft et al., 2019; Hidalgo et al., 2013). Hidalgo et al. map out five guiding principles of gender-affirming care: gender diversity is not a disorder; presentations of gender are diverse and culturally-dependent; biology, socialization, culture, and context all contribute to gender identity; gender is not binary and may be fluid; and pathology stems from cultural reactions to gender diversity rather than from the individual. The gender-affirming care model includes person-centered care relating to social and/or medical gender identity transition, using the correct names and pronouns of patients, pursuing continuous relevant education, training all clinical staff appropriately, and advocating for TGNC patients within their healthcare systems, place of employment, or school when facing systemic stigma (Ehrensaft et al., 2019). This may also include building the support systems of TGNC adolescents by connecting them with other TGNC individuals their age, LGBTQ+ community organizations, and working with the parents of TGNC young individuals to educate them on how they can best support their children (Ehrensaft et al., 2019).

An important aspect of gender-affirming care is gender identity transition. Gender identity transitions are generally characterized as either social or medical, with a complete social transition often a requirement for accessing medical transition care (Ehrensaft et al., 2019). A social transition may involve adapting one's gender expression to match that of their affirmed gender, for example, changing their name and pronouns. Medical interventions generally become available to TGNC youth once puberty has begun, with the option to receive fully reversible

puberty blocking medication, and semi-reversible gender-affirming hormone therapy with parental consent and diagnosis (Chen et al., 2016; Coleman et al., 2012). TGNC individuals undergoing medical transition may choose to undergo fertility preservation treatments (collection of eggs or sperm to store for future use) or surgical interventions (mastectomy, breast augmentation, penectomy, oophorectomy, vaginoplasty, or phalloplasty, etc.) (Coleman et al., 2012). Also available to TGNC individuals is voice and communication therapy, which can help change the tone of one's voice to match that of their affirmed gender (Chen et al., 2016). The interventions outlined above, as facilitated by an interdisciplinary care team of psychotherapists, surgeons, endocrinologists, primary care physicians, nurses, and social workers, represent the current best practices in gender identity transition-related affirmative care for TGNC adolescents (Chen et al., 2016; Coleman et al., 2012; Hidalgo et al., 2013). These may occur at any time in one's life and are not a requirement for claiming or maintaining a TGNC identity (Schwend, 2020).

In addition, it is important to note that these services are not widely available or accessible to TGNC individuals. Gender clinics that specialize in gender identity transition-related services are largely limited to urban areas and are white-dominated, as BIPOC have been historically excluded from TGNC healthcare spaces (Gill-Peterson, 2018; Whitehead et al., 2016). Moreover, healthcare providers (HCPs) who are familiar with transgender and gender non-conforming affirmative care models and practices are hard to find—pre, during, or post-gender identity transition (Whitehead et al., 2016). Lastly, gender identity transition-related medical care is not always covered by insurance providers (James et al., 2016). More than half of all 2015 Transgender Survey respondents were denied coverage for gender-affirming surgeries in the previous year, and one in four were denied coverage for gender-affirming hormone

treatments (James et al., 2016). Therefore, gender-affirming care models, as related to gender identity transition, primary care, or any other care specialty, remain effective, but not efficient. There are substantial systemic barriers for HCPs to be aware of throughout TGNC adolescent healthcare transition and, ultimately, work to change.

Barriers to Healthcare Transition

There are many barriers to accessing affirmative, adult primary care for TGNC individuals, including the lack of HCPs who offer it, anticipated and enacted stigma, insurance, financial, and legal restrictions, geographic or transportation issues, non-disclosure of TGNC identity, unstable living conditions, low parental involvement, and more (Abramowitz, 2018; Clark et al., 2017; Ehrensaft et al., 2019; Glick et al., 2018; James et al., 2016; Seelman et al., 2017; White & Cooley, 2018; Whitehead et al., 2016). For TGNC adolescent healthcare users who age out of their pediatric care unit or are no longer covered under a parent's insurance plan, continuing care can be extremely difficult (Abramowitz, 2018; Ehrensaft et al., 2019). For many, it will be hard to leave a pediatric primary care provider (PCP) with whom they have developed a strong relationship, others may never have had parental support or access to gender-affirming care before reaching the age of consent and will be tasked with finding an affirmative care provider on their own. Without extensive, structurally competent healthcare transition policies in place, TGNC adolescents may lack the knowledge and confidence to manage their own healthcare effectively into adulthood. These barriers—lack of insurance coverage, unstructured transition policy, building an entirely new patient-provider relationship, limited resources, disempowerment—are similar to those outlined in the chronic illness and mental healthcare continuity literature, from which interventions will be adapted in the next section.

Another set of barriers to healthcare transition for this population are present among PCPs themselves. Generally speaking, PCPs lack education and training pertaining to gender-identity, TGNC health, and affirming care practices (Whitehead et al., 2016). In addition, adult PCPs may lack expertise on how to treat adolescent and young adult populations, whose needs and contexts differ substantially from adults'. Changing care providers amidst this challenging developmental stage is a substantial barrier in and of itself, and the associated anxiety will undoubtedly hinder disclosure of adolescents' TGNC identities, health histories, substance use, sexual behaviors, and other risk factors (Ehrensaft et al., 2018; White & Cooley, 2018). On an organizational scale, there is a lack of communication between pediatric and adult PCPs throughout healthcare transition, including consultations, information sharing, transition coordination, and follow-up after patient transfer (White & Cooley, 2018).

The last set of barriers, conceptualized on the national or cultural level, detail limitations of the existing adolescent healthcare transition infrastructure (White & Cooley, 2018). For TGNC adolescents who face discrimination, systemic stigma, and other elements of gender minority stress, primary care transition may be markedly more difficult. Although best practice models in affirming care and medical interventions for TGNC adolescents exist (Coleman et al., 2012), there are currently no national policies or procedures detailing best practices in primary healthcare transition for this population, no methods of collecting regular feedback from TGNC healthcare users, and limited funding supporting research and development in this area (Ehrensaft et al., 2018). Many national policies, such as insurance age cut-offs or absent gender identity transition coverage, further marginalize TGNC communities. The resulting gaps in healthcare access are often filled by community healthcare workers who are not compensated or recognized within formalized systems of care (Glick et al., 2018; Torres et al., 2017).

Integrating Theory into Practice: Suggestions for Facilitating Primary Care Transition

Given the lack of evidence-based studies outlining best practices within primary care transition for TGNC adolescents, models of healthcare transition in chronic illness and mental health specializations can be adapted for this population (Crowley et al., 2011; Hepburn et al., 2015; Paul et al., 2013; Tuomainen et al., 2020; White & Cooley, 2018). Some key aspects within the existing healthcare transition literature include developing interpersonal relationships between healthcare users and clinical staff (Crowley et al., 2011; Paul et al., 2013), detailed transition policy with clear roles for each actor—patient, clinician, caregiver, staff, social services (Hepburn et al., 2016; Paul et al., 2013), and structured readiness assessments, progress tracking, and feedback collection (Crowley et al., 2011; White & Cooley, 2018). In addition, they advocate for the development of comprehensive programs of multi-tiered support (National Institute for Health and Care Excellence, 2016) and national policy and funding to bolster health system capabilities (Hepburn et al., 2015).

Table 1 outlines connections between the GMSR model (Testa et al., 2015), barriers to care continuity among TGNC adolescents, and interventions which address them. It does not represent an exhaustive list, nor does it explicitly identify resilience measures as they relate to community connectedness, pride, social support, self-esteem, resilience, collective action, and more (Breslow et al., 2015; Ryan et al., 2010; Testa et al., 2015). These elements are implicit within the intervention strategies and future research has the potential to define these roles more clearly in the context of healthcare transition. The aim of developing Table 1 was to visually connect gender minority stress concepts to TGNC adolescent healthcare transition in a simplified, linear way. A more detailed analysis of suggestions is provided below, with important elements of these frameworks reconceptualized within micro-, meso-, and macro- levels of

Table 1

Analyzing Gender Minority Stress Factors in the Context of Healthcare Transition

GM stress factors	Barriers to care continuity	Healthcare transition strategies
Distal stressors		***Micro- Meso- Macro-***
Discrimination Rejection Victimization Non-affirmation	Discriminatory or transphobic laws, policies, and attitudes[1] Lack of access to gender-affirming healthcare[2] Anticipated and enacted stigma[3]	Education of HCPs, adolescents, and caregivers about TGNC issues Advocacy for TGNC adolescents in healthcare, school, political, employment, and legal spheres Development of national guidelines and protocols; government funding and research; HCP awareness of intersecting experiences of systemic stigma
Proximal stressors		
Internalized transphobia	Limited awareness about diversity in TGNC healthcare options Low self-esteem[4]	Education and connection to LGBTQ+ community resources; motivational interviewing; empowerment within healthcare decision-making Effective community outreach tools and increased clinic visibility
Negative expectations	Previous negative experiences in healthcare[5]	Trusted contact with whom adolescent can follow-up post-transition Joint appointments with pediatric and adult PCPs pre-transition
Non-disclosure	Non-inclusive healthcare spaces[6] HCP ignorance of TGNC adolescent identities and experiences; lack of structural competency and reflexivity[7]	Ask for name and pronouns; use of PCP or transition coordinator specializing in TGNC adolescent health All-gender restrooms; TGNC representation in staff and published materials; specialized TGNC adolescent clinics/joint protocols; practitioner pairing HCP education in gender-affirming care, adolescent needs, and structural competency; certification courses; HCP and researcher reflexivity
Body dysphoria	Lack of access to gender-affirming healthcare[8]	Use of digital technologies to improve healthcare accessibility Insurance policies and legal protections related to gender-affirming care
Identity confusion	Lack of support, acceptance[9]	Caregiver involvement Wrap-around support in social, legal, employment, school, and housing

[1] James et al., 2016
[2] Coleman et al., 2018
[3] Testa et al., 2015
[4] Breslow et al., 2015
[5] James et al., 2016
[6] Eckstrand et al., 2017
[7] Metzl & Hansen, 2014
[8] Coleman et al., 2018
[9] Ryan et al., 2010

intervention—incorporating principles of affirming care, gender minority stress, and intersectionality.

Micro- Level

Healthcare User Interventions

As can be expected, there are many suggestions for facilitating healthcare transition that center the voices and involvement of the adolescents themselves. TGNC individuals utilizing pediatric care services may receive education on community resources and how to find and build relationships with affirmative adult PCPs. They should also be granted the opportunity to speak to their pediatric PCPs alone during medical visits, which has been shown to prepare adolescents to manage their own healthcare, adhere to treatments, engage in care, and be more likely to disclose health risks with their clinicians (White & Cooley, 2018). Empowering adolescents to be involved in and make decisions at every step of the planning process will likewise improve confidence and adherence to care (White & Cooley, 2018). This process of motivational interviewing is reflected in the resilience element of the GMSR model, in which adverse health outcomes may be moderated by self-esteem and self-affirmation (Breslow et al., 2015; Coyne et al., 2020). It likewise follows gender-affirming care principles of validation, depathologization, and acceptance.

Furthermore, because family acceptance predicts greater self-esteem, social support, and better overall health status (Ryan et al., 2010), engaging with and educating families and promoting caregiver involvement is a key intervention strategy to reduce health disparities and facilitate healthcare transition among TGNC adolescents. Transition to adult primary care represents a shift to lower family involvement and increased patient autonomy, which must be

negotiated between the patient, caregiver(s), and clinicians involved. Healthcare interventions to strengthen the adolescent-caregiver relationship and give caregivers the tools they need to understand and accept their child's gender identity will improve adolescent wellbeing alongside strengthening care continuity. This is especially important for TGNC adolescents who lack a strong family support system. These healthcare user interventions centering education, empowerment, and support should be implemented on individualized timelines, starting very early (age 11 or 12), throughout healthcare transition process, and continued after transition is complete (White & Cooley, 2018).

Clinical Staff Interventions

Next, there are various ways in which HCPs and clinical staff can support TGNC adolescents' primary care transition through relationship building, holistic support, and readiness assessments. The use of a transition coordinator proved to be a common element of successful programs in healthcare transition among adolescent populations (Abramowitz, 2018). A transition coordinator, much like a social worker, may work with TGNC adolescents to secure medical insurance, mediate costs, and identify resources in school, housing, employment, and more (Crowley et al., 2011; National Institute for Health and Care Excellence, 2016; Tuomainen et al., 2020). Healthcare settings should be intentional in their hiring practices, seeking transition coordinators who identify as TGNC and share similar experiences, while also having training and expertise in navigating healthcare spaces. This follows principles of gender-affirming care as it advocates for holistic support, simultaneously mediating gender minority stress through social support, education, and advocacy mechanisms. In addition, a transition coordinator may work with each adolescent to generate a personalized profile and health history, outline emergency care plans, caregiver involvement, and future goals for treatment throughout the healthcare

transition planning process (National Institute for Health and Care Excellence, 2016). Providing TGNC adolescents with the tools to write their own health histories, plans, and treatment goals decenters the power imbalance within patient-provider interactions and gives agency to adolescents operating within the past and present context of TGNC healthcare discrimination.

Similarly, pediatric PCPs or transition coordinators can work with adolescents to instill motivation, confidence, and build self-care tools that will improve transition readiness, following research on resilience and gender-affirming care practice (White & Cooley, 2018). Pediatric PCPs or transition coordinators should track transition readiness with regular assessments throughout the transition process, checking in with adolescents and determining which topics or aspects of healthcare transition to focus on (White & Cooley, 2018). These experiences not only prepare adolescents for successful primary care transition, they also build trust and facilitate a contact with whom the adolescent can follow-up post-transition, which is incredibly important (National Institute for Health and Care Excellence, 2016). These staff-level interventions reflect the person-centered approach to care and acknowledgement that each adolescent has unique needs, promoting agency of TGNC adolescent healthcare users throughout each step of the care transition process.

Meso- Level

Organizational Interventions

Moreover, service delivery could be adapted to meet TGNC adolescents' needs by creating clinics that exclusively serve young adults (Crowley et al., 2011) or developing shared transition protocols between pediatric and adult healthcare spaces (National Institute for Health and Care Excellence, 2016; White & Cooley, 2018). Clinics that serve adolescents exclusively circumvent many issues which stem from PCP unfamiliarity with the needs and context of

adolescent healthcare users. They also present greater flexibility with which to address TGNC health disparities in terms of intersectional systems of oppression and gender minority stress. However, adding an adolescent-only clinic within the healthcare transition process may represent an additional, anxiety-inducing healthcare transition for TGNC adolescents and limit the patient-provider relationship to the short span between adolescence and young adulthood. There are also many resources needed to establish an adolescent-specific clinic and accessibility issues given the feasible quantity and location of such clinics.

The second suggestion, detailing joint protocols between pediatric and adult healthcare spaces, may prove to be more realistic. Joint protocols often include early transition planning, information sharing between pediatric and adult HCPs, and joint appointments during which TGNC adolescents can build relationships with adult PCPs prior to transition (National Institute for Health and Care Excellence, 2016). There is also the potential for practitioner pairing between child and adult services, providing a direct avenue of transition for adolescents and facilitating joint protocols (National Institute for Health and Care Excellence, 2016). Clinicians who are familiar with one another are more likely to communicate and follow-up after adolescent transfer. Encouraging pediatric-adult PCP collaboration before, during, and after healthcare transition will improve the quality of care an adolescent receives (National Institute for Health and Care Excellence, 2016).

Relevant to organization-level interventions is hiring practices and TGNC representation among clinical staff and in published materials, such as pamphlets in waiting rooms or content on websites. Creating a TGNC-inclusive environment by establishing all-gender restrooms, routinely asking all patients for their name and pronouns, and maintaining representative staff and materials is central to gender-affirming healthcare (Eckstrand et al., 2017). These practices

can lessen negative expectations of healthcare as outlined in models of gender minority stress and help cultivate an affirming environment (Testa et al., 2015). Likewise, resources available in pediatric units, such as social workers, legal counsel, housing, employment, and school advocates, must be integrated within the adult care system, especially when serving adolescents, who may benefit from added organizational and community support (White & Cooley, 2018). These institutionalized systems of support reflect gender-affirming care principles and the integration of GMSR and intersectionality lenses within TGNC adolescent healthcare transition and delivery.

Applications of Technology

Another promising way to improve accessibility and communication throughout healthcare transition is through the development of digital technologies. Young people are at the forefront of adopting new technologies, and the current coronavirus pandemic has accelerated the integration of digital technology into healthcare delivery (Sanci, 2020). The use of phone or computer apps for encrypted messaging, video conferencing, accessing or sharing medical information, receiving personalized care recommendations, making or changing appointments, and managing insurance and finances may improve healthcare accessibility and continuity for TGNC adolescents (Sanci, 2020; White & Cooley, 2018). In addition, digital technologies may also accommodate healthcare users with disabilities, providing visual, audio, and other flexible formatting (National Institute for Health and Care Excellence, 2016). However, any technological advancement comes with ethical implications, including disproportionate access to reliable internet and electronic devices, privacy concerns, and limitations of online platforms to facilitate relationship building and trust (Sanci, 2020). Therefore, these represent an adaptation to extenuating circumstances, rather than a replacement for in-person primary care.

Macro- level

State and National Policy-Making

In facilitating healthcare transitions for TGNC adolescents, governmental bodies must address the inaccessibility of affirming PCPs through policy and education. Government programs can utilize curricula developed by the World Professional Association for Transgender Health (WPATH) and similar organizations to educate PCPs about gender-affirming care, as well as adolescent-specific care considerations, starting in medical school. This will increase the number and availability of structurally competent, affirming PCPs qualified to support TGNC adolescents throughout healthcare transition. The government can also promote specialized certification courses that PCPs can take to register as gender-affirming clinicians in government databases, becoming more visible to TGNC adolescents seeking care. Other U.S. policies to generate joint transition protocols, define roles for cross-sectoral groups (education, social services) involved in the transition process, develop long-term follow-up guidelines, and secure ample government funding for continued research and implementation support are critical (Hepburn et al., 2015). Specific legal measures, such as extending health insurance coverage for young adults on their parents' plans and making age cut-offs for pediatric care flexible, will help accommodate individualized healthcare transition timelines. Altogether, these macro--level changes, in addition to a deeper understanding of the ways in which intersectionality and structural stigma impact the lives of TGNC adolescent healthcare users, will be crucial to facilitating primary healthcare transition.

Moreover, understanding the ways in which structural stigma impacts TGNC adolescents also requires intentional reflection on how intersecting systems of power affect oneself. As a theoretical framework, intersectionality not only describes those impacted negatively by systems

of oppression and exclusion—it is also a means of naming identities that possess privilege and disrupting the "human normal" of white, cisgender individuals (Crenshaw, 1989; Wesp et al., 2019). Incorporating intersectionality can be done in part by encouraging self-reflection on the part of HCPs, researchers, clinic staff, families, and everyone else involved in the healthcare transition process. This active reflection speaks to the concept of reflexivity, or the ongoing interaction between a researcher's context of overlapping identities and the context of their/her/his work (Shimmin et al., 2017; Wesp et al., 2019). I am writing this paper as a white, cis woman—identities that possess certain privileges that shape the way I experience the world and how I am able to understand and conceptualize TGNC adolescents' healthcare experiences. As I do not share the embodied knowledge of TGNC individuals, I rely on stories and scholarship by TGNC individuals and allies. Through lenses of intersectionality and reflexivity, I am able to continuously reflect on my position within these systems and this academic space of knowledge production and dissemination. A similar acknowledgement and process of understanding should be encouraged and facilitated among PCPs involved in TGNC adolescent healthcare transitions.

Supporting Research

Lastly, supporting research to measure the efficacy of these interventions among TGNC young adults and long-term outcomes such as number of visits, subjective strength of patient-provider relationship, pre- and post-health status characterization, and overall satisfaction will aid in reducing these disparities. Incorporating healthcare transition questions into national health surveys for young adults will provide additional data with which to evaluate interventions (White & Cooley, 2018). As mentioned earlier, national policy and accredited curricula will prove instrumental in implementing these changes on a large scale. These may also include counseling

guides for clinical staff to use with non-affirming caregivers and HCP reflexivity or systemic competency trainings. In addition, research should prioritize the development of a TGNC-specific resilience measure and TGNC adolescent-specific gender minority stress model. These will aid tremendously in strengthening research quality and directing interventions accordingly. Moreover, incorporating TGNC voices and scholarship within the development, implementation, and evaluation of research and interventions will further strengthen the data and reduce assumptions on the part of cisgender researchers who do not share these experiences (Schwend, 2020). Because healthcare transition among TGNC adolescents represents a diverse and growing field, and one in which extensive research has yet to be published, these suggestions represent only a few of many that can studied among this population (Abramowitz, 2018; Ehrensaft et al., 2019).

Conclusion

The lack of healthcare transition infrastructure has documented negative outcomes among adolescent healthcare users, including poorer assessments of health and wellbeing, non-adherence to treatment, care discontinuity, higher costs, and patient dissatisfaction (White & Cooley, 2018). Moreover, TGNC individuals face additional barriers to healthcare transition linked to care inaccessibility, discrimination, and systemic stigma, all of which contribute to health disparities among TGNC populations (Coyne et al., 2020; Goldenberg et al., 2019; Puckett et al., 2020; Seelman et al., 2017; Xavier et al., 2007). TGNC adolescents are particularly vulnerable to experiencing many of these health disparities due to developmental characteristics and age-specific life stressors, making affirmative, structurally competent primary healthcare crucial (Ehrensaft et al., 2019). Given this information, the absence of evidence-based research centering pediatric-adult healthcare transition for this population is unacceptable.

The suggestions outlined in this paper and in Table 1 present potential interventions to facilitate primary care transition among TGNC adolescents using principles from the gender-affirming care model and frameworks of gender minority stress and intersectionality. These interventions, organized as micro- (e.g., developing interpersonal relationships, educating, and empowering TGNC adolescent healthcare users), meso- (e.g., connecting to community resources and developing joint protocols), and macro- (e.g., large-scale healthcare transition policy, political and social change), are only the beginning. Future research in this field will not only be critical to the wellbeing of TGNC adolescents—it will be lifesaving. Cisgender health professionals, researchers, academics, teachers, mentors, friends, and family members all have a role to play in pursuing education about TGNC health and health disparities, reflecting on the power systems that generate cisgender privilege and their role within them, and advocating for change. This paper provides initial suggestions on how to better serve TGNC adolescents within these systems and promote accountability on the part of institutions and those operating within them, serving as both a call to action and tool for change.

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