

Article

Exploring TGE Young Adults' Experiences Seeking Health Information and Healthcare

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Abstract: The number of young adults who identify as transgender or gender expansive is rapidly growing in the U.S. Due to this rapid growth, healthcare providers are not properly informed on how to provide culturally competent healthcare and mental healthcare for this population. The sexual and gender-minority population has already been identified as a health-disparity population by the National Institutes of Health, so this lack of provider knowledge may add to the current health disparities of individuals who identify as lesbian, gay, bisexual, transgender, or queer (LGBTQ+). In this research, we asked how young people who identify as transgender or gender expansive (TGE) seek information related to their health, mental health, and well-being and to understand how they connect to necessary resources to meet their healthcare needs. Participants responded to an online survey which included open-ended questions, and shared how they seek healthcare information and determine if that information is trustworthy. They also shared their own healthcare experiences and recommendations for their peers as they seek health and mental healthcare. Results indicate that many barriers to care still exist and that providers, agencies, and systems still have much work to do to meet the needs of this population.

Keywords: transgender; TGE; healthcare; mental health; young adults; culturally competent care



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1. Introduction

Young people in the United States are identifying as transgender or gender non-binary (meaning they do not fall into the typical male/female binary or do not identify with the gender they were assigned at birth) at a growing rate. Between 2012 and 2017, there was a 40% jump in persons identifying as LGBT (lesbian, gay, bisexual, transgender) [1], and the number of young people seeking care at the Los Angeles Center for Transyouth Health & Development grew from 40 patients in 2008 to 400 patients in 2014 [2]. Further, thirty-five percent of participants in the 2015 National Transgender Survey reported their gender identity as nonbinary [3], and the most recent data from the Williams Institute shows that youth between the ages of 13 and 17 comprise 18% of the transgender population in the U.S., up from previous estimates of 10% [4] (p. 1).

The speed of these changes means that the identities of transgender or gender-expansive (TGE) young people are evolving faster than the knowledge available to providers [5]. As providers see more young adults with these identities, they are becoming aware that some of them are not receiving the care they need. Further, they are realizing that as health and mental health care providers, they are unable to provide the best care to these young people, due both to a lack of training and systemic barriers [5].

Additionally, not much is known about how young people with these identities seek information related to their identities, their health, or their mental health. As such, the authors surveyed young people between the ages of 18–29 who identify as transgender to ask them about their experiences. This project aims to fill some knowledge gaps for providers who work with persons who identify as TGE and to explore how they address

their needs, so that healthcare and mental-healthcare providers are better equipped to meet those needs. The population will be referred to in this paper as TGE or trans, unless cited authors use different designations for the population.

2. Literature Review

2.1. Background Information

In order for providers to provide culturally competent care to young people who identify as TGE, providers need to understand their identities, their language, and their physical- and mental-health needs. As such, we offer some definitions from the literature. Chang and colleagues define transgender as “an adjective and umbrella term that describes a person/people whose sex assigned at birth differs (in varying degrees) from their gender identity” [6] (p. 276). Transgender is frequently used as an umbrella term to describe persons whose gender does not conform to the assumed gender binary which is prevalent in society [7,8]. This binary assumes that there are two and only two genders, male and female, and that all persons who are born have bodies which conform to one of these two categories. Historically, the decisions about the category to which the body belongs have been made by physicians based upon visual inspection at the time of birth. This is what is referred to as “sex assigned at birth.” Some people, however, grow to understand that their gender assigned at birth does not correspond with how they perceive themselves [6].

Beyond transgender, multiple identities are being assumed by young people currently, ranging from non-binary, gender non-conforming, to genderqueer. Vaid-Menon defines gender non-binary as “people who are neither exclusively men nor women” [8] (p. 13) and gender non-conforming as “people who visibly defy society’s understanding of what a man or woman should look like” [8] (pp. 13–14). Genderqueer is defined as “a person who does not identify with binary gender and may consider themselves both, neither, or moving fluidly between categories of male/man or female/woman” [6] (p. 275). The term “gender expansive” has also been used to describe people who are in these categories [6], and we chose to use TGE as an inclusive identity category to describe the population in this paper.

2.2. Healthcare in Trans Populations

The National Institutes of Health (NIH) developed a Sexual & Gender Minority Research Office (SGMRO) in recognition of the health disparities faced by sexual and gender minorities and the resulting impacts on their long-term health outcomes [9,10]. In spite of this acknowledgement, however, providers are not receiving the training and education they need in order to treat the transgender population [11]. This is especially true for the segment of the population that identifies as non-binary, due to a lack of understanding and information related to this population, in particular [12]. The resulting lack of knowledge of transgender health results in many providers being uninformed about the population and their health concerns, and resistant to working with persons with these identities, because of their own discomfort.

Providers of health care and mental health care, however, have entered fields with ethical codes of practice which require them to serve all who come to them for care. The Code of Ethics of the National Association of Social Workers in the U.S. states that “The primary mission of the social work profession is to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty” [13] (para. 1). Further, when discussing the LGBTQIA2S population specifically, the NASW states that, “Social workers have a responsibility to promote policies, laws, and programs that affirm, support, and value LGBTQIA2S+ individuals, families, and communities” [14] (para. 2). Although these examples are taken from the field of social work, such statements are common across different professional disciplines and serve to provide guidelines for how professionals are to engage with clients or patients in their work [15,16]. Further, these professions also have codes of conduct related to cultural competence which encourage

them to take responsibility for learning about populations they treat who may differ from them, such as folks who identify as TGE. However, the fields of both healthcare and mental healthcare are not meeting these requirements yet, as many barriers still exist for TGE people seeking healthcare.

2.3. Barriers to Healthcare Access for This Population

TGE populations have been found to experience both exclusion and discrimination in healthcare settings [17]. Transgender people have reported negative experiences with healthcare providers related to their gender identity, such as verbal harassment, physical or sexual assault, being asked invasive and irrelevant questions, or being denied care [3,18]. Trans persons have also experienced mis-gendering, or being referred to by the wrong pronouns, and frequently needed to educate their healthcare providers on how to care for them [18]. Additionally, trans folks have reported concerns with office staff who are unfriendly, offer unsolicited advice and opinions, and break patient confidentiality [18]. Transgender people of color or with disabilities were even more likely to be treated negatively by their healthcare providers [3,18]. Additionally, non-binary youth have been found to experience greater barriers to gender-affirming care than those who identify as transgender, due to health providers' discomfort with non-binary genders and the framing of much transition-related medical care within a strict gender binary [12]. TGE-identified individuals also have more difficulty in accessing health insurance [3,18].

Some of this research reflects the entrenched nature of the gender binary, in that providers have more ambivalence and less comfort treating young people who identify as non-binary [12]. This also points to some issues within trans medicine in general [11], as healthcare providers receive little training related to patients with trans identities. Medical expertise in this area is challenged by a lack of clinical experience and scientific evidence which does not always provide knowledge about effective treatments for trans people, as longer term outcomes have not been studied [11]. This can result in medical providers who have been steeped in binary gender constructions being faced with non-binary folks who are seeking gender affirmative care, as the providers may struggle to justify treatment decisions outside of the "opposite sex" model of care [12].

In addition to inadequate knowledge, some healthcare providers unintentionally serve as gatekeepers to both healthcare and information [11]. Gatekeeping refers to the power given to medical and mental-health care providers to make decisions regarding whether a person can access gender-affirming care [19]. Yilmazer [19] noted that gatekeeping is often undertaken in attempts by providers to meet standards of care; however, if those providers are not committed to keeping up with shifts in standards and engaging with their trans clients in open conversations about their needs, providers can be gatekeepers in ways that create barriers to care.

These barriers lead to reduced access to health and mental health care, as TGE people do not feel safe to be open with providers. In a 2015 national survey, 23% of respondents reported they did not seek necessary health care due to fear of mistreatment by healthcare providers [3], and other trans adults have reported that they have not seen a primary-care provider in two years due to fears of discrimination, in spite of experiencing depression, suicidal ideation or suicidal attempts within the year prior to the study [17]. Although multiple barriers exist for TGE people trying to access care, research has also identified some facilitators to healthcare access [18].

2.4. Facilitators to Healthcare Access for This Population

Hostetter et al. [18] recently found that several facilitators exist to help TGE folks access healthcare. The first is related to creating environments which are trans-inclusive, where correct names and pronouns are used and facilities include trans-affirming language in their materials and advertising. The second facilitator is the presence of persons to help TGE folks navigate healthcare systems which are historically bound in binary concepts of gender, and the third is having providers who are both trained and experienced in

treating TGE people [18]. Finally, having forms of social support are important, both in terms of having other trans-identified people to help them find and access care and having connections with adults.

Other research has also found that having providers that know the vocabulary of trans people and have an attitude of being respectful and helpful, as well as listening to patients, is very useful [20]. Also, providers who have made an effort to go beyond the minimal training provided to them is important for trans folks, as is provider understanding of the sociocultural context in which trans folks are living, such as what is happening in the media, for example [21]. Additionally, including trans people in decision-making around treatment-based decisions is recommended, as well as having non-mandatory healthcare available [22]. Finally, having community-led and reliable gender-affirming care has been found to protect youth mental health [23].

2.5. Sociocultural Contexts Globally and in the U.S.

Sociocultural contexts impact how TGE persons are seen and treated around the world. Doan refers to “the tyranny of gender” [24], which “intrudes on every aspect of the spaces in which we live and constrains the behaviors that we display” [24] (p. 635) such that trans or gender-variant persons experience their environments as sources of social policing intended to keep them from upsetting the gendered expectations and existing power dynamics that are part of the societies in which they live.

TGE people in Korea, for example, are experiencing increasing trends of prejudice and violence in response to their growing visibility as a population. This has resulted in verbal and sexual harassment in healthcare settings which creates a barrier to care, as well as increased rates of poor mental health for this population [25].

Mexico has been experiencing a dramatic increase in violence against trans people, particularly trans women, in spite of federal legislation aimed to combat discrimination based on sexual and gender diversity. These efforts, however, are impacted by conservative cultures in areas where trans persons can experience transphobic violence in public spaces, through institutional settings such as healthcare, education and public security. This leads to trans people living in fear of violence in public and in social spaces, such that their well-being and mental health are compromised [26].

Similarly, research in Turkey has found that due to the vast majority of the population identifying as Muslim, the LGBT community as a whole is still viewed as immoral and unnatural, and there are no laws in place to prevent discrimination against people with these identities. This results in this population experiencing discrimination, stigma, and violence in the areas of education, employment, housing, and healthcare [27].

Brazil and Sweden, however, have different historical backgrounds than the countries above. Brazil has had policies which are inclusive of trans healthcare needs for many years; however, such care is not being provided due to prejudice against sexual and gender diversity. This has resulted in the avoidance of healthcare by trans populations to the extent that they seek care outside of the institutionalized medicine that is available to them, due to fears of discrimination [28].

Sweden was at the forefront of performing sex-reassignment surgery in the 1960s and is generally perceived as a tolerant country. Sweden has ranked highly in terms of LGBTI human-rights achievements. However, transgender persons still experience barriers to receiving competent treatment from healthcare providers, stating that professionals lack education, rely on sex stereotypes, and use incorrect names and pronouns [29]. Therefore, even in places where policies of inclusion are enacted and overall tolerance of members of sexual and gender minorities is more widespread, TGE people still face barriers.

In the U.S., the lack of knowledge and understanding about TGE persons in healthcare is complicated by a current cultural climate in which TGE identities are highly contested. This is codified into laws at this point in the U.S., such that there is currently a huge push to police the bodies and behaviors of young people who identify on the transgender spectrum. This shows up in proposed legislation which polices bodies involved in sports, polices

medical providers and families for attempting to provide health supports for people who identify as transgender, and policies which topics are allowed to be discussed in schools [30]. Specifically, in 2022, the state of Florida implemented a ban on saying the word “gay” and discussing gender identity in school classrooms [31], and the state of Texas began to conduct investigations of medical providers who treat transgender youth, as well as parents of transgender youth who support their children, as perpetrators of child abuse [32]. In September, California became a sanctuary state for trans youth, blocking “states with anti-trans laws from prosecuting families who seek gender-affirming care in California” [33] (para. 2). These legal issues and their ramifications have impacts upon young people who identify as TGE, their parents, and the providers who treat their health and mental health.

Although we know much about how TGE people experience healthcare in the U.S., we do not know how this population of young people find information about their identities and their health, especially in a cultural context in which their identities are contested. As such, we reached out to young people who identify as TGE to ask them about their experiences seeking such information, and to learn how they go about finding health and mental health care for themselves.

3. Materials and Methods

We approached this research through a lens of feminist standpoint theory [34–36], which holds that those with lived experiences are the experts of their lives and can provide information based upon their standpoints. As such, we went directly to the sources of these lived experiences to find out about their lives. Our research questions were: (1) How do young adults aged 18–29 who identify as transgender or gender expansive (TGE) (this includes gender non-binary and gender non-conforming) seek information related to their health, mental health, and well-being? and, (2) How do they determine if providers are safe and affirming?

3.1. Positionality

The first author is a white cisgender woman who identifies as queer and who is a social-work professor and a parent to a trans young adult. Her work focuses on advocacy and working towards equity and inclusion for the LGBTQ+/SGM community. The second author is a white cisgender woman who identifies as straight and is a nursing professor who is concerned with diversity, equity, and inclusion work in the field of health and human services. The third author is a white cisgender woman whose sexual orientation is fluid and mostly straight. She is an assistant professor of nursing whose research is focused on gender-based violence, and she is a parent to three always-questioning children. The fourth author identifies as a lesbian non-binary person who is white. They recently graduated college with their BSN and are passionate about working with the LGBTQ+ population, particularly with transgender and gender non-conforming people.

3.2. Participant Recruitment

After receiving IRB approval, the authors recruited emerging adults (aged 18–29) [37] who identify as transgender or gender expansive (TGE) (which includes those who identify as gender fluid, gender non-binary, gender non-conforming, and many other identity categories). The researchers created recruitment materials asking for participants who fit these criteria and were willing to share how they find information related to their health and mental-healthcare needs, as well as how they determine what providers are safe. After receiving IRB approval, recruitment materials were shared via social media (Facebook, Instagram) as well as with local and regional advocacy and healthcare organizations that serve LGBTQ+ individuals, such as the Lesbian, Bisexual, Gay, and Transgender Student Services office of WMU, OutFront Kalamazoo, the Grand Rapids LGBTQ+ Healthcare Consortium, and Howard Brown Health Centers. The authors asked these organizations to share recruitment materials in their physical spaces and on their websites, and also encouraged people to share widely with persons they thought may be interested.

3.3. Informed Consent Process

When participants clicked on the link to take the online survey, they were directed to an online informed consent document. After reading the document, they were able to make a choice to continue with the survey (at which point they were redirected to the survey document itself) or to choose not to participate (at which point their browser closed). The informed consent document also notified participants that the data collection was anonymous and could not be linked to them.

3.4. Survey Instrument

A survey was developed using quantitative demographic questions and open-ended qualitative questions. The quantitative portion of the survey focused on demographic information (see Appendix A for demographic survey questions). After completing these questions, participants were given instructions about the remaining questions, which were open-ended questions in which they were asked to share as much as they were comfortable sharing (see below for questions). When participants completed the survey, they were directed to a separate link (to ensure their responses could not be linked to their surveys) where they could enter their email information in order to be entered into a drawing for 20 available USD 50 Amazon gift cards. In an effort to reduce any potential psychological distress which may have occurred while completing the survey, links to local, state, and national mental-health resources and LGBTQ+ organizations were included at the end of the survey.

Data were collected through an anonymous electronic questionnaire using Qualtrics software. The default setting for Qualtrics surveys collects IP addresses, but this feature was disabled to help ensure anonymous data collection. The electronic survey was available for potential participants to complete from February to September in 2021. As responses were received, some adjustments were made (with IRB approval) to question wording (March), and a QR code was added to the survey recruitment materials (April). Due to this, early participants completed a slightly different survey, although the same data was requested in both surveys. For example, responses to a question asking when respondents started to question their gender identities were initially answered with calendar years by some participants (i.e., 2014), while others described this in terms of their age or developmental stage. As a result, the authors changed the wording of the question to: How old were you when you realized that your gender identity differed from that which you were assigned at birth? The open-ended questions asked of participants follow.

3.5. Qualitative Survey Questions (Open-Ended Responses)

The open-ended questions asked of participants followed this text, which was included at the beginning of this section questions: "For all of the following questions, please share as much or as little as you feel comfortable sharing." Each question was then followed by a text box in which the participants could enter their answer, with as little or as much detail as they wished.

- What prompted you to question your gender identity? Please provide as many details as you are comfortable sharing.
- In what part of your gender discovery did you start looking for information related to gender identity?
- How did you determine if the information you found related to gender/gender identity was trustworthy?
- What prompted you to focus on your healthcare and mental healthcare needs?
- Where did you go/look when you were seeking information on healthcare and mental healthcare? Was it easy to find resources to help you?
- How do you determine if the information you are receiving from healthcare providers or mental healthcare providers is trustworthy?
- How do you determine if a healthcare or mental healthcare facility is affirming of your gender identity or safe for you?

- What do you recommend for other young people in your situation in terms of finding appropriate and affirming health and mental healthcare?

The use of an online survey comes with some limitations, as the structure does not allow for additional questioning that may have elucidated further meaning from participants' experiences. However, the online survey format did allow for a wider range of respondents, as participants from varied geographic areas could participate. Additionally, some questions had to be reworded due to some confusion in responses to the quantitative questions; these revisions were made with IRB approval. Another important limitation was the number of valid responses, as many participants stopped after the demographic questions and chose not to answer the open-ended questions which were the focus of the research.

Participants are referred to within the narrative findings by participant number (P#). Since we did not ask participants to select a pseudonym for research purposes and since we are aware of the importance of using proper pronouns for this population, we chose to err on the side of not making any assumptions about our participants out of respect for their identities.

3.6. Sample Description

One hundred and thirty participants took the online survey. Of those, 112 met study criteria (aged 18–29 and identify as TGE); of that number, only 42 participants completed the open-ended questions which were the focus of this research. After further analysis of narrative responses, several were removed due to: (a) partial completion of the study (answering only 1 or 2 questions); (b) apparent duplication, where several responses were identical (same word choice and descriptions in the same questions) and were, therefore, reduced to one entry; or (c) answering all open-ended questions with “I don’t want to say.” Responses that included “I don’t want to say” for some questions were kept. This resulted in 25 valid responses for analysis.

All respondents were from the continental U.S., with participants from California, Washington, Utah, Colorado, Texas, Missouri, Ohio, Wisconsin, Minnesota, and Michigan. Respondents identified where they lived as: rural (8%), urban (64%), suburban (16%) and not sure (12%), and respondent ages ranged from 18–29, with a mode of 23. In terms of race or ethnicity, respondents identified as follows in Table 1.

Table 1. Racial/ethnic identity of participants.

Race or Ethnicity: I Identify as (Please Mark All That Apply):	n	%
Asian or Asian American, Black or African American	1	4%
Asian or Asian American, White or Caucasian	1	4%
Black or African American	4	16%
Black or African American, Native American or American Indian, Native Hawaiian, White or Caucasian	1	4%
Jewish, White or Caucasian	1	4%
White or Caucasian	17	68%

When asked about gender identity, participants shared the following: six identified as transgender; four identified as nonbinary; two identified as men; one identified as a woman, and one identified as genderqueer. The rest of the responses, however, included multiple identifiers in response to the question, as shown in Table 2. Table 3 shows responses regarding the sexual orientation of participants.

In each of these tables, we provide the answers given by participants in order to highlight the frequency with which these young adults use multiple identifiers to describe themselves. This serves as a reminder to be thoughtful when we ask survey questions in order to obtain the best information on how TGE persons identify, versus reducing answer choices to a point where they are less representative of the people who are participating in research.

Table 2. Gender identity of participants.

I Identify as: (Please Mark All That Apply)	n
Agender, Gender nonconforming, Gender queer, Nonbinary, Transgender	1
Gender non-conforming, Genderqueer, Nonbinary	2
Gender non-conforming, Genderqueer, Woman	1
Gender non-conforming, Man, Transgender	1
Gender non-conforming, Nonbinary, Transgender	1
Gender non-conforming, Nonbinary, Transgender, Woman	1
Genderqueer, Man, Transgender	1
Man, Transgender	1
Nonbinary, Transgender	2

Table 3. Sexual orientation of participants.

Sexual Orientation: I Identify as: (Please Mark All That Apply)	n
Asexual	3
Asexual, Bisexual	2
Asexual, Gay	1
Bisexual	8
Bisexual, Gay	1
Bisexual, Gay, Queer	2
Bisexual, Pansexual	1
Gay	3
Gay, Lesbian, Queer, Aromantic	1
Pansexual	2
Blank	1

Ninety-six percent of participants graduated high school, and 72% (18/25) were enrolled in higher education at the time of the survey. Sixty-eight percent of participants reported being currently employed (17/25). Most participants, 92% (23/25), reported having health insurance, with 65% (15/25) having their health insurance through their parents. Thirty-six percent of participants had Medicaid for their insurance (9/25), and 60% had private insurance (15/25), with one participant being unsure about what type of insurance they had. Additionally, 36% (9/25) of participants identified that they had received free lunches when in school. Six participants reported being involved in the foster-care system (24%). Seven participants reported experiencing homelessness (28%), with five of those reporting it was due to their gender identity or sexual orientation.

Twenty-one (84%) participants reported they are living as the gender that most affirms them. When asked, “Have you accessed any medical interventions to affirm your gender?” Eleven (44%) responded “yes,” six (25%) responded “no, and I do not plan to,” five (20%) responded “no, but I plan to,” and three (12.5%) responded, “I haven’t decided yet.” These particular forced-choice answers were constructed acknowledging that affirmation of one’s gender can happen along many different pathways [6], some of which do not involve medical interventions.

3.7. Qualitative Data Analysis

Narrative analysis began after the data had been reduced (as described above), and the authors independently read responses to the open-ended questions and made notes regarding recurring themes, which is a form of open coding [38]. The authors used a constant comparative process, whereby each question response was read repeatedly in order to seek themes [39]. This process was performed independently by the authors, who then met periodically to discuss emerging themes. The authors then moved to selective coding [40], wherein they compared their codes to build larger themes. Analysis continued until the authors discussed their findings and mutually agreed upon themes. AtlasTI and Microsoft Excel were used to conduct the qualitative analysis, depending on author preference.

4. Results

4.1. Developing Awareness of Gender Identity

When asked what prompted them to begin to question their gender identity, participants described how it was connected to developing awareness of themselves. Some participants found this to be connected to developmental changes, others found that pivotal events or moments helped clarify their understanding of their identities and who they were, and some felt like they had always questioned their gender.

Developmentally, participants described questioning their gender identity in elementary school ($n = 3$), middle school ($n = 1$) through high school, and beyond when at college ($n = 5$). Individuals who began to develop awareness recalled the confusion and discomfort they experienced. Participant 19 “didn’t feel like a girl” and asked their parents when they would get a penis. Puberty presented other participants with new bodily discomfort and confusion, even if they did not have the language to describe what was going on for them. “I had never felt comfortable with my body after puberty started, but did not have the words to understand why” (P18).

Some participants described events which triggered both questioning their gender and feeling validated. These events ranged from more mundane occurrences, such as when their mother asked them their pronouns (P22) and they had to take a moment to think on that, to significant events such as attending their first LGBTQ+ conference and feeling validated by the range of identities to which they were exposed (P6). One participant beautifully illustrated how seeing a film suddenly validated feelings they had struggled with for years:

I suppose I had questioned my gender earlier, in the sense that I felt a longing and a strong curiosity toward others who were trans (friends, peers), but always thought “That couldn’t be me, that’s just too uncommon,” or “I don’t want to be doing it for attention.” Only later did I realize that cis people don’t think like that—they don’t feel strange being seen as their assigned gender or long to be trans. For me, a very pivotal point was seeing the film “Colette” (2018) and it clicked for me, seeing the trans characters on the screen, realizing that’s how I wanted to look like and be perceived (P44).

The third category of participants could not identify a time period or event as marking their gender questioning. Participant 23 explained, “I felt like I had always questioned my sexuality and my gender but brushed it off as something everything questions.” Participant 17 echoed this feeling of forever questioning “I always felt like . . . a special kind of gender?”

Regardless of the diverse developmental stages or pivotal events that facilitated gender questioning by participants, all the participants found interactions with others necessary to help them name their feelings and feel a sense of control. The presence of others online, at LGBTQ+ conferences, friends, and family who introduced the language of gender expansiveness allowed participants to feel a sense of “autonomy and control” (P23). Participant 6 felt “felt an instant resonance” with people who identified as non-binary femme when they attended a large LGBTQ+ and realized “you could do whatever you want with gender!”.

4.2. Seeking Information

Many participants started seeking information related to their identities and gender as part of their developmental process when they realized that others felt like them and there were names for the things they were feeling and experiencing. When participants started to seek information about identities, they started with friends, loved ones, and social media (Twitter, Instagram, YouTube) ($n = 5$). Some started this exploration when they got to college ($n = 2$), and others started seeking information when they realized that their identities were not matching with how they felt inside. There was a lot of variance in the answers to this question, as some answers were connected to exposure to ideas and development over time, as explored in the section above regarding gender identity.

For many participants, hearing from friends and hearing the personal experiences of others, whether from social-media sources or from conversations, were their main

sources of information. “I tried to get all of my information from people who had come out themselves, so I took that as honest. Since everyone’s experience is different, I tried to watch and read things from many different people in order to get the most information” (P22).

When asked how they determine if information that they found related to their gender or gender identity was trustworthy, many shared that they were unsure. “I assumed it was all correct” (P13). “I just hoped to hell it was” (P17). One stated, “At the time I didn’t really think about how trustworthy it was. I just assumed it was correct” (P47). At the same time, several discussed “following my instincts” (P6, P10, P39) or using “what felt right when applied to myself” (P45). Others discussed being able to ask friends in queer healthcare spaces, or asking friends in the community in general, and listening to word of mouth. Some found published research related to the topic (P18) or looked at national sites such as Fenway and the University of California at San Francisco (P20). Interestingly, only one participant mentioned getting information from their doctor (P9).

4.3. Pursuing Affirming Care

Decisions to pursue care came from several areas of concern in this group of participants, from mental health to embodiment. Some participants were not ready to pursue this step in their developmental journeys because they were dealing with other life issues which they perceived interfered with seeking care.

Several participants identified having mental-health concerns ($n = 5$), and the experiences they mentioned were serious, such as existing mental-health diagnoses, attempted suicide, and self-harm. In some cases, these participants already had providers that they trusted, but others shared poor experiences with health-care providers.

Participant 21 illustrated the connection between social, mental, and physical health when they explained that they sought therapy “when I realized that I needed to be more mentally stable if I wanted to come out.” Several participants discussed the connection between their experience of gender dysphoria and their mental health. Participant 46 shared a common concern: “I was uncomfortable in the body that I was in and I needed to change it to not have as crippling dysphoria.” Many participants made this connection between issues of embodiment and their decisions to pursue care.

Determining whether a healthcare facility and its staff were safe was an ongoing process for participants. Some participants were unsure about how to determine this ($n = 4$), but other participants shared clues that help them make this determination. Before stepping foot in a healthcare facility, participants did their research ($n = 5$), seeking information from online reviews, asking their own communities, and reaching out to LGBTQ+ advocacy organizations. Some of these tools had been learned from their connections with other TGE people through their information-seeking processes described above. Participants also examined healthcare websites for inclusive mission and vision statements, specific mentions of queer-focused health, and use of pronouns by healthcare professionals. Trans-inclusive marketing in LGBTQIA+ newspapers/websites or trans-specific sites and advertisements and booths at pride events helped participants feel that it was safe to try out a provider.

In spite of this preparation, however, participants experienced several barriers to receiving healthcare when they decided to pursue it. These barriers ranged from logistical concerns, such as lack of time, to concerns about transphobic or uninformed healthcare providers. Once participants entered the office of a provider, they assessed the office paper work and ancillary staff for safety. They looked for consistent use of pronouns of patients by staff and healthcare records that ask about pronouns and gender identity as indicators of safety. The presence of gender-inclusive bathrooms also helped participants to feel safe. The absence of these things, however, conveyed to participants that the settings were probably unsafe. Additionally, participants shared how healthcare staff compromised their safety and confidentiality: “They mis-gender me and talk loudly about me getting HRT in the back where anyone in the lobby can hear them” (P17).

Once participants met their healthcare providers, they were alert for volume of speech, language, and tone, which provided important safety cues for participants. An example

of a positive and safe tone was shared by participant 6: “If they ask questions about my gender, they ask non-intrusively, and with an open or curious manner.” Participants felt safe with providers who were willing to have discussions about gender issues or who felt comfortable in prescribing hormones. Participants also gave examples of intrusive questioning that set a negative tone for them. “The questions he [the doctor] asked me were invasive and ignorant” (P19). Another participant described discriminatory treatment, or “the kinds of questions they ask when they don’t agree with my identity,” stating, “It’s anxiety-inducing” (P17). Another recommended that if people cannot find knowledgeable providers, they should “try and look for those who are willing to admit they don’t know enough, but are willing to do some research to best help you” (P20), acknowledging the challenges of finding informed and respectful providers.

Even if healthcare organizations met all the safety indicators mentioned above, participants emphasized the importance of trusting their gut in healthcare encounters and being willing to advocate for themselves. “Just because you see someone once or twice does not mean you are committed to them. See who is a good fit for you” (P19). Another shared, “Do not settle for less and trust your instincts. If you go somewhere and you feel scared to tell them about your identity, you don’t have to tell them” (P22).

5. Discussion

5.1. Demographic Findings

One of the most important findings from this work is that 92% of participants have health-care insurance, which is different from what much research states about adult trans persons. Sixty-five percent of the participants in this project had insurance through their parents, so there is potential for those percentages to change once these young adults can no longer be included on their parents’ insurance (access for children ends at age 26 in the U.S.). The ages of the participants may also have contributed to their lack of knowledge about how to find information or healthcare providers, since many of them may have had parents who were helping guide them through healthcare access. For those who are not on their parents’ insurance or who have parents who are less accepting of their identities, however, this picture was probably very different. There were seven participants who reported experiencing homelessness, and five of those stated it was due to being kicked out of their homes due to their sexual or gender identity. This would also complicate access to healthcare.

In terms of socioeconomic status, 9/25 (36%) participants indicated they were eligible for free-lunch programs while in school—the same proportion who shared that they received Medicaid, a publicly funded form of health insurance, which many healthcare providers do not accept. This may impact efforts to find affirming care, since the number of providers available may be reduced or the available providers may not be geographically accessible.

Another interesting finding in this work is how these young adults identified themselves in terms of their race/ethnicity, gender identity, and sexual orientation. Our data showed that many use multiple identifiers to describe themselves versus just choosing one identifier under each category. This is important in terms of considering how these different identities are presented to young adults in research and in healthcare settings, as more adjustments may be required in order to continue to collect useful data on these populations. Additionally, the language they are using is important for us to learn if we wish to be effective in our communication with these young adults.

Surprisingly, 84% of our sample reported that they were living as the gender that most affirms them at the time they participated in the survey. This is a hopeful finding, especially given the current sociocultural context in the U.S. This shows that some support was available for these TGE young adults, both in terms of accessing healthcare and being able to practice social transition.

5.2. Qualitative Findings

The narrative findings of this study revealed that some participants felt different than their peers in terms of gender identity from young ages, such as at elementary school. Others became aware as they entered puberty and were uncomfortable with their bodies changing. As self-awareness developed, some participants felt a desire to explore language and identities, and described using the internet to find this information, accessing social-media platforms, or connecting to trans friends/peers. This is echoed in earlier research on LGBTQ+ populations which has found that the internet was important for networking with community members, seeking information on health care, and connecting with social supports [20,41], especially for those living in rural areas [42] where the internet serves to provide information to address gaps in knowledge about their identities and their health. This is not to say that all rural spaces are hostile to TGE folks; however, urban spaces may have more services available and offer more anonymity for people as they transition their gender identities [42].

Access to social-media sites has also been found to enhance LGBTQ+ youth well-being through opportunities to explore their identities, connect with peers, and gain access to resources [43]. The importance of these connections may be explained by the idea of “possible selves” [44]. Possible selves are images of others in our sociocultural contexts who serve as potential role models or as ideas of who we may become [44]; if contexts are constricted from including certain identities, young people may be delayed or hindered in their own identity development processes. Awareness of identity possibilities were important to participants in this project, as several discussed their own development being impacted by meeting people with identities, such as non-binary, with which they were unfamiliar and which helped them make sense of who they were. This served to aid their growth and development, and provided some relief in terms of self-understanding; thus, the ability to engage with TGE communities and information about identity categories is vital.

An area of concern in the participants’ narratives was that many of them were uncertain if the information they were finding was trustworthy or not. They shared several strategies for trying to navigate this, such as seeing if things felt right for them and seeking multiple viewpoints from multiple sources, but it is problematic that access to basic information on healthcare is not something they can expect. This points to a larger problem of access to information in general about their identities.

Barriers to information about LGBTQ+ people in general exist in educational settings in the U.S. through educational policies which practice internet filtering; internet filtering serves to censor what information students can access from school computers [45]. Additionally, public libraries, which are another avenue of access to information for TGE young people [45], exist within sociopolitical contexts of geographic areas in which they are located, and may be faced with attempts to censor the types of resources they make available. This may be compounded for those who are in rural areas, as public libraries have been defunded for providing LGBTQ+ resources for patrons [46] due to the personally held beliefs of residents. These barriers make it especially difficult for TGE young persons to access information related to their growth and development, even though research tells us this information is important for their well-being [43]. Politicizing access to sites which provide access to information and connection to social support means that TGE young people may not be able to find answers to their health questions or to even more basic questions related to their identities.

Some of the participants in this project were uncertain about how to find supportive health care providers. In some cases, they already had relationships with providers that they trusted and were able to obtain information from them. In many cases, however, there was little available information, and participants turned to the internet to find care. They employed strategies such as looking at agency websites for cues that the providers were safe and affirming, paying attention to gender options on forms used by providers and looking to see if providers included their own pronouns in materials. Many of their strategies,

however, needed to be utilized while at the facilities, and sometimes they experienced insensitive care from staff and providers.

One of the final questions asked of participants referred to what they wanted to share with others with their identities. The strongest message to their peers was to be themselves and trust themselves to know what is right for them. Additionally, they encouraged their peers to do their research and reach out to other TGE folks for connection and information. These connections are especially important in terms of health and mental healthcare, as the systems are often discriminatory and repressive, and caring and informed providers are difficult to find [47]. Sharman explains the power of queer and trans communities, as they “crowdsource our health in a community with a long history of caring for one another outside of and often in spite of dominant systems and structures” [47] (p. 11). This happens through sharing information, telling stories, and caring for one another; therefore, these connections can be very useful.

Participants also encouraged their peers to practice self-advocacy when seeking medical care and showed a clear investment in others knowing their rights around care, such as knowing they could change providers and choose not to share information if they did not feel safe. This particular theme also showed up in previous research with older rural trans people, where they encouraged their peers to care for themselves by firing providers if necessary [41].

5.3. Implications

Future research should focus on the lived experiences of young persons with TGE identities and their access to healthcare, mental healthcare, and information about their healthy development. It is also important to continue to collect qualitative information on these populations, since we may still be years from having systems in place to properly track their interactions with healthcare and mental healthcare providers. Although there are national efforts to encourage the collection of this information in the U.S., qualitative work has also been recommended in order to help keep up with the changing identities and language young people are using to describe themselves [48].

As a result of some of these findings, colleges and universities may want to reconsider their role as sites where young people find accessible resources related to LGBTQ+ health and mental-health information, as several participants in this study reported that these sites were important in their own developmental journeys. Although campus health and mental-health centers still have work to do in terms of preparing their staff and providers for treatment of TGE young adults, the efforts to offer proper training and education to on-campus providers may become more important as more young people with these identities join higher education student populations.

6. Conclusions

In this study, it became clear that TGE young adults have benefited in some ways compared to older trans folks, especially in terms of being able to live as the gender that affirms them and in having access to health insurance. However, most of the participants in this research had access to health insurance through their parents. The challenge of finding employment which provides health insurance once they are no longer covered by their parents' insurance may change that level of access and leave these young people experiencing the difficulty in accessing healthcare insurance that many TGE folks currently experience in the U.S. [49], especially since many health insurers do not provide care for TGE-related services [50].

There are also many barriers that TGE young people experience in regard to accessing trustworthy information on their health and their identities and on being able to find safe and affirming healthcare providers. This assumes, however, that they know how to navigate the complexities of the medical system in the U.S., which in itself contains many potential barriers to care [50]. Providers are still under-educated on the proper treatment of TGE populations, care environments are frequently unsafe, and systems of care are not

yet living up to their ethical mandates to provide care to all [50]. Additionally, the current sociopolitical context in the U.S. is becoming increasingly hostile to TGE young people and more (and sometimes more extreme) barriers to care are being introduced which impact their access to information, their access to care, and the abilities of their parents and their providers to offer them the care that research shows improves their well-being [51].

Some recommended policy changes that could help focus on allowing equal access to medical insurance and on creating access to identity documentation which is congruent with TGE young persons' gender identities [52], which could help greatly with issues in healthcare provision. Additionally, social support, including that from families, schools, and the broader communities in which TGE young people live, needs to be addressed so that these populations can experience acceptance, protection from violence and access to healthcare, housing, and employment in order for them to be able to thrive and experience well-being [50]. The case of Brazil has shown that, even if policies are in place, aspects of the sociocultural context can continue to interfere with access to care and basic issues of safety for TGE persons [28].

In an environment which is hostile to the mere existence of TGE young people, ensuring their access to information, access to quality healthcare and mental healthcare, and access to community connections becomes increasingly important. As professionals in health and mental healthcare, we need to start demanding more of our peers, our professional organizations, our workplaces, and our larger social environments to help these young people access the care and the resources they deserve.

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Appendix A List of Online Demographic Survey Questions

1. I identify as (Gender) (please mark all that apply): Agender, Gender non-conforming, Genderqueer, Man, Non-binary, Pangender, Transgender, Woman, I'd prefer not to share this information, Please specify:
2. I identify as (Sexuality/Sexual Orientation) (please mark all that apply): Asexual, Bisexual, Gay, Heterosexual or straight, Lesbian, Man loving man, I prefer not to answer, Please specify:
3. I identify as (Race/Ethnicity) (please mark all that apply): Asian or Asian American, Black or African American, Chicana, Chicano, or Chicanx, Hispanic, Jewish, Latina, Latino, or Latinx, Native Alaskan, Native American or American Indian, Native

Hawaiian, Pacific Islander, White or Caucasian, I'd prefer not to share this information, Please specify:

4. What year were you born? (Please enter year of birth)
5. Where do you currently live? (Please enter name of City and State)
6. Would you classify the area where you live as: Urban, Suburban, Rural, Not sure, I'd prefer not to share
7. Did you graduate from high school or earn your GED? Yes, No, Prefer not to answer (select one)
8. Are you currently employed? Yes, No, Prefer not to answer (select one)
9. Are you currently enrolled in higher education? Yes, No, Prefer not to answer (select one)
10. Have you ever been part of the free lunch program at school? Yes, No, Prefer not to answer (select one)
11. Have you ever been involved in the foster care system? Yes, No, Prefer not to answer (select one)
12. Have you ever been homeless (forced to leave your home and seek shelter elsewhere)? Yes, No, Prefer not to answer (select one)
13. If yes, was this due to being kicked out of your home based on your sexual or gender identity? Yes, No, Prefer not to answer (select one)
14. Do you currently have health insurance? Yes, No, Prefer not to answer (select one)
15. If so, is your health insurance provided through your parents' health insurance? Yes, No, Prefer not to answer (select one)
16. Please identify which type of health insurance you have: Private insurance (through employer or parents' employer), Medicaid/Medicare, I am not sure, I prefer not to answer, Please specify if something else:
17. Have you accessed any medical interventions to affirm your gender? Yes, No, but I plan to, No, and I do not plan to, I haven't decided yet, I prefer not to answer
18. Are you currently living as the gender that most affirms you? Yes, No, Prefer not to answer (select one)

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