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FEMALE SEXUAL DYSFUNCTION AND DISORDERS (T LORENZ AND R NAPPI, SECTION EDITORS)

Sexual and Gender Identity Development in Young Adults and Implications for Healthcare

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Abstract

Purpose of Review The purpose of this review is to update what is known about sexual orientation and gender identity development, including factors that facilitate positive development, and healthcare experiences of sexual and gender minority youth (SGMY) in relation to their identity.

Recent Findings Models of identity development have been proposed that draw on the experiences of young people and their families rather than adult models of identity development. Family support can both help and hinder identity development, and healthcare providers are in a unique position to intervene. However, SGMY and their families experience significant barriers to accessing appropriate and affirming healthcare.

Summary Key improvements in provider knowledge, healthcare systems, quality of care, and support for SGMY and their families are needed.

Keywords Sexual and gender minority · Identity development · Healthcare experiences · Gender-affirming treatment

Introduction

Sexual and gender minority youth (SGMY) are at increased risk for substance use disorders, teen pregnancy, being over- or underweight, disordered eating, depression, low self-esteem, poor physical health, and report a worse quality of life [1–8]. The disparities in health conditions and risk behaviors are partially due to the ongoing direct and indirect stress of living in home and community environments that largely assumes people identify with a gender that is in accordance with their sex assigned at birth (cissexism) and that they will be attracted to a person of a different gender (heterosexism) [9]. Stress resulting from these interactions and subsequent health risks may be stratified by other factors such as geographic location, state-level policies, gender identity or expression, and belonging to other marginalized groups (e.g., racial/ethnic minority) [10–19]. In addition, SGM people report unequal access to healthcare and experiences of treatment refusal and discrimination in healthcare settings, which can lead to delaying preventive care and acute care and contribute to the development or worsening of chronic health conditions [20–22]. The purpose of this review is to update what is known about sexual orientation and gender identity development and healthcare experiences of SGMY and to provide suggestions for strategies to create more inclusive therapeutic environments.

This article is part of the Topical Collection on *Female Sexual Dysfunction and Disorders*

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Terminology

Relevant terminology and abbreviations used in the article are presented in Table 1.

Because gender identity and sexual orientation are distinctly different constructs, an individual may identify as both transgender (TG) and as having non-heterosexual orientation [33, 34]. Indeed, non-heterosexual orientations may be common among GMY [35, 36]. Sexual orientation, gender identity, and gender expression are not fixed; people may experience a range of sexual and/or gender identities and express

Table 1 Terminology related to sexual orientation and gender identity[a]

Sex	Refers to a combination of physical traits and genetic material that are used to categorize people as "male" or "female."
Gender identity	Gender identity refers to one's sense of self as a man, woman, or another gender(s) [23]; gender identities are not mutually exclusive [24].
Cisgender	Someone who has a gender identity that matches their sex assigned at birth (e.g., assigned male at birth and identifies as a man).
Transgender	A broad term that can be applied to anyone whose gender identity or expression transcends a binary understanding of gender [25].
Nonbinary	Having a gender that is neither man nor woman and can include not having a gender (agender), having a fluid gender (e.g., genderqueer) [26•, 27].
Gender expression	The ways in which someone communicates their gender identity to others in social interaction through clothing, hairstyle, mannerisms, etc.
Gender nonconforming	Someone who expresses their gender in a way that is different than the cultural expectations for gender based on their assigned sex at birth [28]. Gender nonconforming can be used as both a way to describe someone's gender expression and as an identity; not all people who are gender-nonconforming identify as transgender [29].
Sexual orientation	Refers to a combination of people's sexual identity; sexual, emotional, or romantic attraction; and sexual behavior [30].
Sexual minority	A broad term that includes people who identify as lesbian, gay, bisexual, asexual, pansexual, queer, or some other non-heterosexual identity as well as people who engage in same gender sexual behavior(s) and do not identify as heterosexual [31].
Gender minority	A broad term that includes transgender, agender, nonbinary, gender queer, and other non-cisgender identities [31].
Abbreviations	
GMY	Gender minority youth (transgender or nonbinary)
GQ	Genderqueer
MSM	Men who have sex with men
NB	Nonbinary
PrEP	Pre-exposure prophylaxis
SGM	Sexual and gender minority
SGMY	Sexual and gender minority youth
SMY	Sexual minority youth (e.g., lesbian, gay, bisexual, queer)
SMY-M	Sexual minority young men (e.g., gay, bisexual, queer, other men)
SMY-W	Sexual minority young women (e.g., lesbian, bisexual, queer, other women)
TG	Transgender

[a] Adapted from prior work by the author [32]

their gender(s) differently over the course of their lifetime [37–39]. Sexual fluidity among TG populations is common [40] and may be time and context dependent in relation to other gender identity milestones (e.g., disclosing a TG identity, undergoing social transition) [41, 42].

Evolving Language The language of sexual orientation and gender identity is constantly evolving, especially among young people who may combine words or create new words to communicate how they identify [43–45]. Terms people use to identify their gender can vary based on culture as well [45]. Though a more recent evolution in language in the USA, cultures around the world have recognized gender identities outside of traditional man and woman in both legal and religious contexts [46]. Legal recognition for TG and nonbinary (NB) identities is increasing in the USA; currently, 15 states and Washington, D.C., allow residents to choose a NB (X) option on their driver's license [47].

Population Estimates

It is estimated that approximately eight percent of high school students identify as lesbian, gay, or bisexual [48]. Estimates of the TGY population range from 0.7% [49] to as high as two percent of high school students [50]. In a sample of Canadian TG youth between 14–25 years old, 40% were identified as NB [51]. Nonbinary (NB)-identified people may or may not identify as TG. Approximately 1:10 patients attending a gender treatment program in the United Kingdom (UK) identify their gender as NB [52]. There are reports that the number of

NB-identified people accessing gender treatment services has been increasing [53]. It is worth noting that the prevalence of TG and NB identities may vary based on other sociodemographic characteristics. For example, the proportion of youth who identify as TG may be higher among youth of color than White youth [54, 55] and higher among birth-assigned females than birth-assigned males [2, 51]. NB identities may be higher among older versus younger adolescents [2, 56].

Identity Development

Sexual orientation and gender identity formation are developmental tasks in adolescence that apply to all young people, not just SGMY [57, 58]. Identity is consolidated over time, may not be linear, and may be influenced by interactions with the environment, shifting attractions, relationship orientations (e.g., monogamous vs. polyamorous), and other factors [59, 60]. A number of models have been proposed to outline the development of sexual orientation [60–62], gender identity [33, 63, 64], and parents' and others' process of coming to accept the identity [65–67]. These historical models of identity development were developed through working with adults and have been applied to young people, but newer research in this area improves our understanding of GMY's experiences navigating gender identity development by constructing theoretical models derived from research directly with TG and NB young people and their families in the context of their lives [24, 68–70]. TG or gender-nonconforming young people navigate their identity in transition from youth to adulthood through a process that is conceptualized as moving out of darkness (uncertainty) to knowing and eventually accepting one's self [24]. Identity development is shaped by transactions that occur within and between TG and NB youth and their families and larger society [68]. GQ and NB young adults, whose identities challenge the dominant understanding of a binary identity, may experience specific challenges and may face specific challenges within and outside of the TG community [69].

Facilitating Identity Development Identity development can be shaped by a number of factors, including young people's perceptions of what it means to be (SGMY identity), and may be influenced by puberty, their own or family's religious or cultural beliefs, societal norms, stereotypes and stigma, experiences with discrimination, beliefs of people close to them about the validity of the identity, and access to support/resources [68, 70–75]. Exposure to specific language, formally or informally, and meeting other people with similar identities can be transformative experiences for SGMY [76, 77]. Acceptance and affirmation of identity from parents/family is important to positive identity development among SGMY [78, 79].

Conversely, rejection from parents and family has the potential for negative mental health consequences [71], and even subtler forms of disapproval or behaviors that do not affirm their identity can be painful [79]. Attitudes and behaviors of parents and others can be influenced by religion, sociopolitical beliefs, prior knowledge, or exposure to LGBTQ people [80, 81]. It is important to keep in mind that support may not be either (supportive) or (not supportive); it is possible for loved ones to be both supportive and unsupportive [79, 82–84], and may improve over time [85]. In the absence of parental support, extended family members and other adults can provide necessary emotional support that facilitates the sense of self and emotional well-being among SGMY [83, 86–88]. Healthcare professionals in pediatric primary care, specialty services, and school health centers can create safe spaces and be in a unique position to identify SGMY and to provide direct support and advocacy on SGMYs behalf [89–93].

Friend and LGBTQ Community Support SMY who receive sexuality-specific support report less emotional distress, even in the face of stress related to sexuality [94]. Similarly, SMY who reported both sexuality-specific support and parental support were less likely to be classified as "struggling" with their identity [95, 96]. Positive support from peers and connection to LGBTQ community is beneficial and can increase self-esteem and general well-being [97]. For SGMY (including asexual young people) who live in rural areas or who do not have access to the LGBTQ community for other reasons, the Internet can be an important lifeline to information and support [24, 79, 98].

Negative Influence Social media may also be a source of negative influence due to "infighting," which may be particularly aimed at bisexual, GQ, and NB youth [76, 79]. The online environment can become another place in which SGMY have to navigate identity disclosure or concealment, which may become complicated when they have not disclosed their identity to everyone in their lives [19]. Bisexual youth may experience bullying from within the larger lesbian and gay community as well as their heterosexual peers. Similarly, GQ and NB youth may experience difficulties finding acceptance in the larger TG community due to rigid stereotypical ideals about masculinity and femininity [24, 69]. Negative interpersonal experiences, regardless of where they take place, may influence whether SGMY disclose their identity to others.

Identity Disclosure

Disclosing one's sexual orientation or gender identity to others, or "coming out," is often considered an important developmental milestone [99] and is a process rather than a single event [33]. Studies have demonstrated that SGM people often disclose their identities selectively [100] [101]. Among

SMY who do disclose their identity, feeling in control of when to disclose their identity is associated with better mental health and fewer physical symptoms [101]. In families, young people may disclose their identity to a sibling before disclosing to one or both parents [102], and may be more likely to occur when the young person is in a stable relationship, has more LGB contacts, and has less internalized stigma about the lesbian or gay identity [103].

Identity Disclosure to Healthcare Providers Even when SGMY understand the importance of disclosing their sexual orientation and/or gender identity to get appropriate care, they have to balance that with having enough trust/feeling safe enough in that environment to disclose their identity [104]. Factors identified for not disclosing one's sexual orientation and/or gender identity to a provider include the provider did not ask, not feeling comfortable disclosing, being worried about a negative reaction from the provider, and not seeing their sexual orientation/gender identity as relevant to the reason for their visit [79, 105].

Benefits of Disclosure Young MSM who disclosed their identity to a provider were more likely to report HIV testing as well as having been vaccinated against the human pappiloma virus [106]. Among GMY ages 14–25, having a provider who knew they were TG was associated with better health status [20]. GMY whose gender was not affirmed in their interactions with healthcare providers were more likely to report not using healthcare when they needed it [107].

Barriers to Disclosure Prior negative experiences in the clinical setting (or negative responses of disclosure to the service provider) can lead SMY to anticipate negative reactions and develop a general mistrust of the healthcare system [108]. Among GMY history of discrimination in healthcare setting increases the risk of someone delaying needed care [109] and may also be associated with direct harm. In one analysis, negative healthcare experiences were associated with substance use to cope with the experience of stigma [110].

Identity Management

Navigating one's social networks (in person and online) as a SGMY can be complicated and may require different strategies. Sexually fluid young adults may use different language depending on the person/context in which they were describing their identity (e.g., referring to themselves as "bisexual" with someone they perceive might be offended by the word "queer") [58]. Sometimes, navigating identity for SGMY means concealing it, or at least not focusing on it (termed "role flexing"), and instead emphasize other interests or aspects of the self [111]. Another resilience strategy used by SGMY, quilting support, means to get social support in whatever manner they could from where they could, even though this sometimes means needing to keep their sexual orientation or gender identity hidden in order to obtain the support they sought [111]. Among GMY, specifically, some ways of coping included negotiating gender, avoidance, active engagement, and social support; whether the specific ways of coping were adaptive or maladaptive could depend on the purpose and context (e.g., conforming to gender expectations for the purpose of blending in with the affirmed gender group) [112]. GMY may feel the need to use similar strategies to navigate healthcare settings [113].

Specific Challenges of Identity Development

Gender Dysphoria Gender dysphoria is a medical diagnosis that refers to distress arising from the incongruence between gender identity and biological sex at birth or perceived gender, and *may* be experienced by TG and NB people at different levels in different contexts/at different times in their lives [73, 114, 115]. Puberty may be a time when GMY experience increased distress related to their gender [116]. If criteria are met, and young people have access to a provider (and insurance coverage), puberty blockers can be a useful intervention as they are fully reversible and have the potential to reduce the negative impact that could be associated with body changes not congruent with one's identity [73]. It is worth noting that there is limited evidence on the long-term developmental effects of puberty blockers, which may be a cause for concern among providers and parents alike; however, healthcare professionals generally agree that the benefits of this therapy support its use [89, 114, 117–121] and may be best delivered as part of multi-disciplinary team [122–124]. A prospective longitudinal study of the impact of early treatment for transgender youth is currently underway at five gender clinics serving children and adolescents in the USA [125].

Menstruation Blocking Youth assigned female at birth, particularly those not old enough or not interested in exogenous hormone therapy, may want cessation of menses, which can often be done with the use of hormonal contraceptives (e.g., continuous birth control pills or progesterone depot injection) [126•]. As such, even if not necessary for pregnancy prevention, hormonal contraception may be helpful in alleviating symptoms of gender dysphoria through cessation of menses.

Benefits of Gender-Affirming Treatments

Access to gender transition–related care is identified by GMY with gender dysphoria as a critical need [79]. Administration of gender-affirming treatments such as cross-sex hormones and surgeries (e.g., bilateral mastectomy or "top" surgery) can help alleviate gender dysphoria [127] and also results in

improved mental health [128, 129] including body image–related to primary and secondary characteristics [127].

Barriers to Gender-Affirming Treatment

Access to gender-affirming treatment is limited for many GMY by lack of accessible providers who have appropriate training and specifically serve pediatric patients [79, 130]. Additional barriers to care include service providers' lack of knowledge and experience, poorly coordinated care, insurance barriers, long wait times, and in some cases, moral or ethical opposition to providing gender-affirming care [51, 79, 130–132]. When GMY do get access to treatment, they may experience challenges due to providers' reliance on stereotypes of what it means to be TG and feel as though they have to report a specific experience to get the care that they need [133], a common experience among NB identified people who sought hormone treatment [51]. Finally, insurance denials for the receipt of gender-affirming treatment can be a major barrier for some families [134•].

Sexual and Gender Minority Youths' Experiences Navigating Healthcare Settings

Heteronormative and cisnormative attitudes can come through in health forms and institutional norms, making invisible the experiences of SGM people and creating a barrier to healthcare [104, 135, 136]. Young people may be afraid that the provider will disclose the youth's identity to a family member or worried about their privacy in general, particularly in more rural areas [137]. Youth may also worry about the potential negative impact of disclosing their identity on the care they will receive [135]. Based on youth risk behavioral survey (YRBS) data from Minnesota, GMY reported worse perceived overall health and fewer preventative screenings than their cisgender counterparts [133]. Social support can play a role in health and health-seeking behavior in SGMY. For example, parental connectedness increased the odds that GMY received primary care and dental care, associations that were not significant among cisgender respondents [138]. Similarly, access to community and group affiliations among young, Black MSM was associated with access to health services, care received, and outcomes across the treatment continuum [139].

Negative Experiences in Healthcare Settings In one study, GMY reported more negative experiences in the healthcare setting—being denied treatment and disclosing their gender identity having a negative impact on the care they received—than cisgender respondents [36]. In another sample of GMY, NB identified youth ages 18–25 were almost twice as likely as TG youth to report that they had avoided or delayed healthcare [51]. NB people report unique challenges that could contribute to delaying healthcare including feeling the need to "adopt" binary (trans)gender identities in order to receive the care they need and having providers encourage interventions not in line with their identity [113]. Among SMY, queer and questioning youth reported more frequent negative experiences than lesbian, gay, and bisexual youth [36]. There are differences in access and experience based on gender as well. For example, even though young gay men reported ease of access of services compared with lesbian young women, the young gay men were more likely to report they had postponed care due to discrimination [36]. Negative experiences in healthcare can be cumulative and create more discomfort with and fear of healthcare providers over time [140].

SGMYs Sexual and Reproductive Health Needs

SGM youth have both similar and unique sexual and reproductive health needs compared with their heterosexual, cisgender counterparts, but are less likely to receive health information, screening, or prevention interventions [141–143]. There may be differences in provision of information between SMY based on sex [144].

Following assessment of sexual orientation and gender identity, additional follow-up information should be collected to guide history taking, education, assessment/screening, and intervention.

Sexual Health History Taking It is important to assess not only SGMY sexual orientation and gender identity labels but also their specific behaviors. Specific information about sexual behaviors will allow for the provision of health promotion and disease prevention information and appropriate screening exams and vaccinations. For example, a cisgender young woman may identify as a lesbian and still have intercourse with male partners.

Health Education Healthcare providers are a trusted source of health information and play an important role in the uptake of health-promoting and disease-preventing behaviors [145]. In addition to providing relevant health information, providers should assess SGMY current understanding of important topics as SGMY may not receive adequate information, receive misinformation, or have incorrect beliefs about their risk for sexually transmitted infection or pregnancy [20, 113, 146, 147].

Sexually Transmitted Infections SMY may be at increased risk for sexually transmitted infections, including HIV, and benefit from appropriate education, screening, and preventative interventions. In one study of SMY-W about their use of barriers during sexual activity, the most common reasons for not using barriers was the lack of knowledge that the behavior could lead to a sexually transmitted infection as well as how to use a barrier to protect themselves and their partners [143]. SGM

people–assigned female may be less likely to receive a Pap test and, in some cases, less likely to initiate or complete HPV vaccination [141, 142, 148, 149].

Young black MSM and TG women are disproportionately impacted by HIV but may have less access to preventative care based on experiences with racism, homophobia, and transphobia in the healthcare setting [150]. In one study of young, Black MSM, many of whom reported engaging in high-risk sexual activity, a willingness to take pre-exposure prophylaxis (PrEP), recent provider visit, and a primary provider who was aware of their sexual orientation, only 8% of the sample was currently taking PrEP [150]. Among young TG women, many were not aware of PrEP and surprised that their healthcare provider had never mentioned it, particularly in the context of their other gender-affirming care [151].

Recommendations Provide education about risk reduction for all STI and conduct routine and as-needed screening [152]. Recommend HPV vaccination to all young people under the age of 26 regardless of sex at birth [153] as well as vaccines for hepatitis A and B as indicated [152]. Discuss and provide PrEP to HIV-negative SGMY who engage in behaviors that put them at risk for HIV [150, 151]. PrEP is approved for use in adolescent populations [154]. However, adolescents may require more frequent follow-up to facilitate a level of adherence needed to obtain therapeutic effect [155]; initial studies of text-based interventions demonstrate improved adherence [156].

Pregnancy Risk and Contraception Young people who identify as gay, lesbian, or bisexual or who have partners of same and other genders are more likely to report being involved in or becoming pregnant in their teenage years than young people who are heterosexual identified or only have opposite gender partners [157–159]. Transgender young people may also be at higher risk for unplanned pregnancy compared with their cisgender counterparts [160]. Some of the proposed reasons for higher pregnancy involvement among SGMY include earlier sexual debut, history of sexual assault, less frequent use of multiple forms of birth control (e.g., hormonal and barrier method), more gaps in contraceptive use, and trying to be involved in pregnancy in response to stigma associated with SGM identities [158, 161–163]. Misinformation regarding the effects of hormones is also a potential factor. Though testosterone halts ovulation, making it more difficult to become pregnant, it is not impossible [164]. As such, any young person who is engaging in sexual activity that could lead to pregnancy (and is not actively trying to become pregnant) should be counseled about available options for pregnancy prevention.

Fertility Preservation Even knowledgeable providers may not initiate conversations with TGY about storing sperm or egg cells for future use [165]. The limited data available suggest that utilization of fertility preservation treatments is low among TGY [166–168] even when interest in biological parenting is present [166, 168] and fertility counseling has been provided. TGY may feel societal or parental pressure to express desire to be a biological parent [166, 168, 169] or may have difficulty seeing themselves as biological parents [170•]. Nevertheless, TGY express strong interest in knowing what their family building options may be in the future [166]. As such, TGY (and their families) should be provided with appropriate education about the potential risks of puberty blockers and exogenous hormones, fertility preservation options with referral to specialists as needed [171].

Physical Assessment For some GMY, physical assessment may be extremely uncomfortable; in non-emergent situations, aspects of the physical exam may have to be delayed until a higher level of trust has been established [172]. It is important to make sure patients know why you need to examine certain anatomy, what you will be doing during the exam, and cue before touching [172, 173]. When relevant to the care being provided, skin assessment and health education related to two common practices in GMY—binding and tucking—are also encouraged.

Binding Young people, who were female at birth and did not receive puberty-blocking medication, may use constricting garments or materials to create the appearance of a flat chest, known as binding, which can have health consequences including which most commonly include physical pain (chest, back, shoulder, or abdomen) or skin issues (e.g., scarring, acne, rash, infection) [174]. Health promotion in this area is needed to encourage GMY who bind to have some time without a binder every day, keep the binder clean, and practice good skin hygiene [174]. In providing guidance on binder-related issues, it is also important for healthcare providers to take into consideration the potential positive effects of binding on mental health [174].

Tucking Young people who are assigned male at birth may "tuck," or move the testes back into the inguinal canal and tuck the penis between their legs using a combination of tape, tight underwear, or other materials [175]. Like binding, tucking can lead to skin breakdown and infection, and fertility could be impacted if tucking is used in combination with exogenous hormones [175, 176]. Health-promoting behaviors to discuss include having time not tucked (e.g., while sleeping) and practicing good skin hygiene; in addition, education that acute pain associated with tucking should be evaluated by a healthcare professional [175, 177].

Conclusion and Recommendations

Many changes can take place within the larger healthcare system to support the positive development of SGMY. These include improving provider knowledge, data collection,

healthcare systems, quality of care, and SGMY and their family's access to information and appropriate resources

Improving Provider Knowledge

It is important that service providers across a spectrum of care are well-versed in the unique needs of SGMY. Training should be mandatory as part of professional training and continuing education [20, 130, 178–180], to account for the recognized gap in most current educational programs [181–187]. Educational interventions, particularly those which incorporate (real or standardized) SGM patients, have the potential to increase providers' knowledge of, attitudes toward, skills, and comfort working with SGM populations [181, 188–194]. It is important that providers can do the following:

- Comfortably ask about sexual orientation and gender identity during clinical interactions (including what identity terms mean to the people who use them) without judgment and use the language, the identity language and pronouns, the person has reported [26•, 195].
- Identify, acknowledge, and work to reduce implicit bias [196].
- Validate the identities of all clients, including those who identify as GQ or NB as others in their life may not see their identity as valid [69] and not encouraging medical or surgical interventions that are not in line with the GQ or NB person's own interests [113].
- Avoid making assumptions about what SMGYA needs are based on knowledge of their identity alone as well as the ability to consider the implications for multiple intersecting identities (e.g., sexual and gender minority) [19].
- Ensure privacy and confidentiality for the conversation and assess for levels of support, community connection, etc.
- Routinely assess developmental domains in youth including sexual orientation, gender identity, and expression [197], and make appropriate referrals following screening, assessment, and intervention.
- Appropriately tailor care to the unique needs and desired outcomes of individual patients [120, 198], and manage expectations of adolescent patients and their parent(s) who may be focused on different outcomes [199].
- Discuss questions and concerns related to bodies or sexual health openly and honestly using terminology that is consistent with how the young person experiences their body (e.g., referring to "frontal" instead of "vaginal" sex) [93, 170•, 200].

Improve Healthcare Systems

- Develop/implement inclusive admission forms/interviews with input from stakeholders that allow for the identification of sexual orientation and gender identity and that capture the person's lived experience [26•].
- Implement standardized protocols so SMGY and their families receive the same quality of care and know what to expect throughout that care [130].
- Implement patient navigators to assist families in accessing the care they need and overcoming barriers related to insurance [178].
- Create environments that are welcoming to diverse populations using visual materials signaling inclusivity [93, 137] and by employing diverse staff within the healthcare system.

Increase Quality of Care

Develop and routinely update comprehensive plans of care that are based on assessment of unique risk and protective factors in the SGMYs life, including the following:

- Safety at home and school and prior experiences with violence/victimization as these can contribute to health problems [201].
- Specific sexual behaviors and risk for pregnancy and sexually transmitted infections; provide education for risk reduction using a direct, non-judgmental approach [137, 202, 203] and encourage routine screening of reproductive organs as appropriate based on behaviors [204].

– The Transgender Youth Fertility Attitudes scale [205] may be useful to understand youth and parent attitudes and facilitate a conversation regarding fertility needs and preservation options.

- Internal strengths and external sources of support—within and outside the family—that can be turned to in times of stress [111, 206].

Increase Knowledge for SGMY and Their Families

- Support families by curating a list of specific, relevant evidence-based resources available in the local community and online and creating opportunities for all SGMY to see and have contact with positive, successful role models [26•, 76, 135, 206].
- Ensure that referrals for other services are safe and supportive of gender-affirming treatments [79], which could help increase SGMY's trust with the healthcare system over time.
- Provide a mechanism for SGMY patients and their families to report poor treatment/experiences in the healthcare setting and a process by which to address the reports [207].

Compliance with Ethics Guidelines

Conflict of Interest The author declares that he has no conflicts of interest.

Human and Animal Rights and Informed Consent This article does not contain any studies with human or animal subjects performed by any of the authors.

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