Affirmative Sexual Health Care for Transgender & Nonbinary Youth: Toward a Sex-Positive Approach

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Print

Clinical Vignettes

Jasper

Jasper (they/them/theirs) is a 17-year-old, Mexican American, pansexual, transmasculine person. As a health service psychologist, Jasper was referred to you for depressive symptoms. You have been conducting weekly therapy sessions with them for the past six weeks. In their most recent session, Jasper tells you a story about a visit to the doctor's office. They report having visited a doctor at a "women's clinic" for their annual pap smear and to test for sexually transmitted infections (STIs). They were dreading the visit to the gynecologist, as similar experiences have caused them mental distress and gender dysphoria (distress related to feeling that one's body or appearance is not congruent with one's gender). After checking in at the front desk, Jasper anxiously waited for their name to be called, bouncing their legs with restless energy. When the nurse called out Jasper's dead name (their name given at birth), Jasper did not know how to respond, and froze in their seat. When the nurse called the name again, Jasper found themself getting up and proceeding behind the double doors to the exam rooms, hanging their head.

As the nurse inquired about their sexual history, Jasper shared that they currently have two sexual partners. The nurse gave them a look of concern and asked whether their partners are male or female. As their partners include another transmasculine individual and a transgender woman, Jasper simply stated "both," unsure of how to respond. The nurse exhaled loudly and left the examination room. As Jasper undressed and seated themselves on the examination table, they began to feel disconnected from their body. When the doctor entered with the nurse to complete their examination, Jasper heard them repeatedly using she/her pronouns to describe them. Jasper felt unable to speak up for themself. They followed the doctor's instructions until the examination was over, listening when the doctor told them having sex with multiple partners can be dangerous. Jasper simply nodded, feeling detached from their environment and unable to take in information. They finished the examination and left the clinic crestfallen. As Jasper shares this incident, you notice their blank stare and a monotone voice. They state they have been struggling with excess dysphoria in the week since the examination.

Shaina

Shaina (she/her/hers) is a 13-year-old White bisexual young woman. Shaina is visiting your therapy office for an intake appointment after her mother Lisa (she/her/hers) recently discovered she is sexually active. Shaina reports her mother immediately called her pediatrician to make an appointment for STI testing and a full physical exam after overhearing Shaina discussing her sexual experiences with a friend. Shaina tells you that, when she and her mom arrived at the medical clinic, the front desk assistant was confused, stating Shaina's health records indicate she is male. Shaina's mother took a deep breath as she explained that Shaina is a trans girl who is on "puberty blockers," or medications that keep her from developing masculine secondary sex characteristics such as facial hair and a deeper voice. The front desk assistant proceeded to ask misinformed and intrusive questions about Shaina's genitals and sexual behaviors, such as asking if she has "actually had sex change surgery." Shaina teared up while describing her misery in this moment to you, stating she wished she could escape as she endured the shame of such questions. Shaina reports that this episode with the front desk assistant added to other traumatic medical experiences she has had in the past.

Shaina tells you she and her mother finally took a seat in the waiting room full of other patients. Shaina reported feeling like everyone in the room was looking at her as time slowed to a crawl. Feelings of nervousness and exhaustion arose within her as she realized she would need to self-advocate and even educate her own doctors, an experience that would likely increase her gender dysphoria. When she was called by the nurse, she was taken to an exam room where she had to re-explain her transition history and current anatomy. While reviewing her sexual health history, the nurse asked Shaina several dysphoria-inducing questions, including "of course you don't have a period, right?" and "Did you know you can't get pregnant, but still need to be using condoms?" Shaina found herself explaining transgender health care to her doctor as well, who accidentally referred to Shaina as "he" three times. Shaina became exhausted and nauseous, feeling set back in the progress she had made regarding her identity. She tells you that as soon as her exam was over, she vowed not to return to the clinic due to this experience.

Key Background on Topic

Sexual health is defined as “a state of physical, emotional, mental and social well-being in relation to sexuality” and “it is not merely the absence of disease, dysfunction or infirmity” (World Health Organization, 2015). In this paper, transgender and nonbinary (TNB) will be used as an umbrella term referring to individuals who identify with a gender different than the corresponding sex they were assigned at birth (e.g., people with binary transgender, genderfluid, nonbinary, and other diverse gender identities). For TNB individuals, their gender, or internal sense of being a man, woman, some combination of these, or an alternative gender differs from their biological sex assigned at birth, which can be male, female, or intersex (American Psychological Association [APA], 2015). Sexual health care considerations extend beyond medical interventions surrounding prevention and treatment of problems such as sexually transmitted infections (STIs), disorders of sexual functioning, and reproductive care. They also include the provision of anatomically correct and unbiased information to empower individuals to make their own sexual health choices. In this paper, we discuss how health service psychologists and related providers can use a sex-positive approach in their work with TNB youth, particularly when offering support to TNB youth seeking sexual health care.

Discrimination and Barriers to Care

Experiences of TNB youth should be understood within the social and systemic context of minority stress. Stressors related to marginalization such as discrimination and stigmatization are collectively referred to as minority stress (Meyer, 2003). Minority stress is inversely related to mental and physical health such that, as TNB people experience more minority stress, their health quality decreases (Hendricks & Testa, 2012). TNB youth experience stressors such as homelessness, bullying at school, and rejection from family members (Tankersley et al., 2021). It is important to note that negative medical experiences interact with, magnify, and reinforce broader forms of stigmatization and discrimination experienced by TNB youth as demonstrated in the vignettes above. Additionally, coping with minority stressors depletes TNB people’s energy to engage with potentially cissexist social structures (those that promote transphobic and cisnormative assumptions), such as initiating and attending medical appointments. This is especially true when they encounter stigma and prejudice at their health care facility.

TNB people experience increased barriers to and negative experiences with sexual health care access. This is especially the case for people of color, nonbinary people, and youth (Pulice-Farrow et al., 2021; Rider et al., 2018). Much like Jasper and Shaina, TNB youth report being treated as oddities, including being subject to invasive questioning, physical examinations, and breaches of confidentiality (Chong et al., 2021). TNB youth also experience incorrect pronoun usage, dismissal and/or mockery of their identities, and being mistreated by providers who are morally opposed and/or uncomfortable working with them (Chong et al., 2021; Rider et al., 2018). Each of these experiences, ranging from microaggressions to explicit rejection, has the potential to negatively impact TNB youth and lead to delay or avoidance of future care (Rider et al., 2018).

Lack of Culturally Competent Care

Health care providers are rarely trained to manage the unique needs of TNB patients and therefore lack skills, an inclusive vocabulary, and often enact microaggressions (Pulice-Farrow et al., 2021). In non-affirming, cissexist health care settings, TNB youth like Shaina face the burden of educating clinicians about their own health care needs (Chong et al., 2021). For sexual health care in particular, providers report a vague understanding of how risks for STIs, cancers, and pregnancy apply to gender diverse individuals, resulting in perpetuation of misinformation that can lead to dangerous health consequences (Bauer & Hammond, 2015; Chong et al., 2021). Sexual health care has the potential to trigger gender dysphoria among TNB youth due to the nature of discussing and examining body parts that often have gendered associations. Thus, educating health care professionals on TNB-affirmative practices is vital to improving the health and well-being of TNB youth.

As demonstrated in both Jasper and Shaina’s cases, medical facilities often rely on rigid expectations of gender as aligned with biological sex, providing little wiggle room for individuals who exist outside of these norms. TNB youth often lack the option or space to specify their affirmed (or chosen) name and pronouns, with medical staff making cissexist assumptions that their assigned sex, name assigned at birth, and current gender are all in alignment. In the experiences of Jasper and Shaina, incorrect pronoun usage, invasive questioning, and limited ability to self-advocate resulted in invalidating experiences with health care providers. Even wording on routine documents, such as the question of sexual partners being “males, females or both?” in Jasper’s case, limits the ability for Jasper to explain their sexual relationships, resulting in an experience that not only leaves them misunderstood but also inhibits medical staff from providing appropriate sexual health care based on Jasper’s needs.

Recognizing Resilience

Although access issues increase avoidance and degrade health, health service providers may use affirmative interventions to cultivate resilience in TNB populations, which counteract negative health outcomes, reduce cissexist practices, and buffer the destructive impacts of minority stress (APA, 2015). Scholars continue to call for a shift in focus from distress and pathology in TNB populations to investigations of resilience strategies and adaptive development because most research and scholarship has focused on difficulties facing TNB people and not on what can be done to address them (Matsuno & Israel, 2018). The challenges facing TNB people are considerable, and even more extensive among TNB youth, but researchers continue to find evidence of incredible flexibility, strength, and vitality in TNB populations (Matsuno & Israel, 2018).

An affirming approach cultivating resilience goes beyond avoiding discriminatory experiences to help connect TNB patients to resources that can mitigate the negative impacts of minority stressors. For example, resilience-focused providers help patients connect with supportive social networks such as TNB communities to help patients cope with the negative impacts of minority stressors. In addition to fostering resilience, affirming providers validate patient experiences, push back against toxic social norms,

and focus on their own areas of growth through being open to learn and engage in self-exploration (Singh & Burnes, 2010). With a shared goal of providing empowering, affirmative care, affirming interventions leveraging resilience can be paired with a sex-positive model of care to provide sexual and reproductive health services to TNB youth, which further counteract cissexist practices.

A Sex-Positive Framework

Sex-positive care, an approach historically neglected in health service disciplines like psychology, can be defined as a holistic, open, and pathology-free acceptance of sexual and pleasure-informed practices beyond heteronormative and behavioral conceptualizations (Burnes et al., 2017). Consistent with the guiding principles of affirming care, a sex-positive framework embraces the diversity of sexuality in an intersectional manner, acknowledging the various forms of oppression facing some groups over others (Burnes et al, 2017). Societal ideas of what constitutes sex are rooted in cisnormative and heteronormative standards recognizing intercourse between a cisgender man and cisgender women as the only possible form of sexual behavior. This, in turn, causes health professionals to hold limited understandings of sex, which often leave the many alternatives to penile-vaginal sex out of the picture (Burnes et al., 2017).

In contrast, sex-positive care recognizes the diversity in sexual activity that can exist for individuals of various bodies, abilities, genders, races, sexual orientations, kink preferences, affectional orientations, and understandings of eroticism (Mosher, 2017). This, in turn, presents a health care model that empowers individuals to make use of their own understandings of their bodies, sexualities, and erotic pursuits (see Mosher, 2017). For TNB youth, and youth in general, sexuality is often treated as a taboo topic, with abstinence espoused as the best (and sometimes only) option for adolescent sexual health (Harden, 2014).

Rather than emphasizing the risks of engaging in sexual behavior, a sex-positive framework invites the possibility that sexual exploration is a normal part of adolescence and can even contribute to well-being and overall health (Harden, 2014). It is important to note that sex positivity does not condemn abstinence, but situates this as one of several informed choices adolescents can make in pursuing sexual well-being (Harden, 2014). Empowering TNB youth to understand their own bodies and make informed choices regarding sexual health can promote resilience and improve corresponding health outcomes.

A sex-positive framework can look like comprehensive sex education inclusive of all sexualities and gender identities, use of gender-affirming language when referencing TNB patients' body parts (Tordoff et al., 2020), and confidential, accessible, and TNB-knowledgeable health care providers. Affirmative, sex-positive language uses patient-defined terminology (the patient's own words) for TNB youth's sexual behaviors and body parts. Research suggests this practice increases positive self-advocacy for TNB youth, including healthy expression of boundaries and feelings of bodily autonomy (Tordoff et al., 2020). These indicators of well-being exemplify how health service psychologists' use of a sex-positive framework can improve mental and physical health for TNB youth, helping patients to build resilience in the face of minority stress through competent, affirming care.

Clinical and Ethical Challenges

Many of the clinical and ethical challenges surrounding sex-positive affirmative care for TNB patients stem from a lack of health service professionals who are able (e.g., trained, experienced, qualified) to provide this care. In addition to providers lacking the necessary training in sex-positive affirmative care, some TNB youth cannot access care due to lack of parental support, or even legal restrictions on gender-affirming health care access. It is the job of every health service professional to advocate for changes in training, public opinion, and policy to make it easier for TNB patients to access the care they need. In time, many of the clinical and ethical challenges listed in this paper may be resolved as providers continue to lobby and push for TNB-affirming changes to public health systems.

Do No Harm

Health service psychologists are governed by the American Psychological Association (APA) Ethical Principles of Psychologists and Code of Conduct (2017), a code that directs psychologists to work toward not only avoiding harming their patients but also toward increasing benefits for patients. The work of health service providers is also governed by standards such as the American Medical Association (AMA) Code of Medical Ethics (see Riddick, 2003), a document that calls on providers to offer competent care that respects the human dignity of patients. As indicated in the vignettes above, failing to adopt affirming approaches to sexual health, such as sex-positive care, with TNB patients runs counter to ethical principles that call on health service professionals to competently treat patients while avoiding harm. In fact, when professionals fail to practice sex-positive care, they run the risk of pathologizing patients' identities and behaviors, thereby increasing patient distress, decreasing likelihood that patients will return for services, and further widening health disparities that negatively impact TNB patients (Pulice-Farrow et al., 2021; Rider et al., 2018).

In short, we assert that the use of sex-positive care is an ethical imperative. However, the training and oversight necessary to support such practices have yet to catch up to the need for this type of care. Health service training programs do not provide unbiased, sex-positive training, nor do they require clinical experience with TNB patients. Therefore, many providers graduate from their academic internship, residency, and post-doctoral programs without ever reflecting on the need to de-pathologize sexual health care among youth or extend sexual health care to TNB communities. Furthermore, a majority of providers already in practice, especially those who have been practicing for 10 or more years, are unlikely to have had the option to even pursue elective, supervised TNB practice. As illustrated in the vignettes, the disconnect between providers' knowledge and the needs of their TNB patients results in regular harm to patients seeking sexual health care who leave appointments feeling dejected, fearful, and unaided.

This disconnect between need and competence is further complicated by the fact that providers are cautioned against offering care that falls outside their area of competence and/or specialization (Riddick, 2003; APA, 2017). Some providers, such as health service psychologists focused on women's health, as well as endocrinologists and gynecologists, may consider work with TNB adolescents to fall outside their scope of practice and may deny services to TNB patients, considering it unethical to provide care outside of their expertise. However, providers are also directed by ethical codes to seek appropriate consultation and continuing education (Riddick, 2003; APA, 2017). Therefore, we posit that many education-based or competence-related ethical dilemmas facing providers who work with TNB adolescents can be resolved through continuing education and consultation.

Parental Objections

Even when providers are trained and prepared to provide sex-positive care, they may confront parent/guardian disapproval and refusal to consent to treatment for TNB youth. For example, a provider may be aware that a TNB youth uses he/him pronouns, but the youth's guardian may use she/her pronouns. In this case, the provider may feel torn between the needs of the patient and the expectations of the parent. Regarding TNB treatment options, some parents may be fearful of compromising their youth's fertility through the introduction of puberty-blockers (medications that delay the onset of puberty) or other transition-related care with a direct impact on sexual and reproductive health.

Acknowledging the diversity of gender identities and empowering a patient to make their own decisions regarding their body, a sex-positive health care psychologist would explore the best options for care. For instance, a provider might endorse puberty blockers for a TNB youth to delay the onset of a dysphoria-inducing puberty, resulting in better mental health outcomes (Tankersley et al., 2021), while also discussing options to preserve fertility options for the future. Although puberty blockers could be potentially lifesaving for a TNB youth, parents can deny their child this treatment, thereby inhibiting a health psychologist or other provider's ability to broach certain sex-positive health care options. This can occur even when research indicates the treatment is the best course of action and solutions are available to address parents' concerns.

Laws and Policy

Even when providers are prepared to offer sex-positive care and guardians consent for treatment, options may be limited by state and local laws. Many U.S. states are moving to pass laws that restrict affirmative care access for TNB youth. For example, in February 2022, the governor of Texas directed Family Services, the agency overseeing the safety of minors in the state, to investigate parents of transgender kids for possible child abuse charges. He asserted that health service professionals and families of minors who are receiving transition care (e.g., recognition/affirmation of their genders, puberty-blockers) may be acting in ways that equate with child abuse. Other states are moving to ban discussions of gender diversity and sexuality in schools, both of which are key tenants of sex-positive care. It is likely that the restrictions and implications of these laws will continue to threaten access to services for TNB youth. These actions instill fear in health service providers who may risk litigation if, consistent with sex-positive care, they facilitate resilience, progress, and adaptive behaviors in TNB youth.

It is clear that current anti-TNB laws run in opposition to health science and research. Major associations like AMA and APA continue to issue amicus briefs and policy documents that support affirming care for TNB youth and adults. Major health organizations also eschew attempts to deny care to TNB people and/or change the gender identities of TNB people to align with social gender norms that are associated with their sex assigned at birth (APA, 2015). Consistent with ethical codes (e.g., Riddick, 2003; APA, 2017), providers are directed to advocate for changes in misguided laws that require them to act in ways inconsistent with appropriate patient care, such as laws banning abortion or framing transition care as child abuse. The passage of current and future laws may require providers to act creatively as they seek to provide affirmative options such as sex-positive care within the confines of law and policy.

Evidence-Based Assessment/Practice Considerations

Although a lack of randomized controlled trials with TNB populations have led to criticism of evidence-based practices (EBPs) with such individuals (Holt et al., 2021), researchers and practitioners continue to produce evidence of the benefits of sex-positive and other affirmative approaches that promise to strengthen and expand the evidence basis for sex-positive assessment and practice with TNB youth. Research on evidence-based practices for working with TNB populations indicate a heavy reliance on clinical judgement with a dearth of supporting EBP factors of objective research and patient characteristics (Holt et al., 2021). More specifically, evidence-based interventions with TNB people appear to lack intersectionality in their approaches, with a call for an increased awareness of cultural dimensions beyond gender (Holt et al., 2021).

Sex-positive care answers this call by emphasizing cultural competence in practice and assessment with TNB youth (Mosher, 2017). A sex-positive framework includes an awareness of two key aspects of health service systems: (a) the oppressive history of health service settings and (b) patient rights. Counter to current cissexist approaches to medicine that make health service providers the sole experts when it comes to care, sex-positive approaches acknowledge patient diversity and their ability to engage in informed consent. Sex-positive providers accept that patients' care needs are not rooted in pathology, instead recognizing the diversity in sexual health care needs and addressing such challenges in culturally competent ways (Burnes et al., 2017). Such providers also understand that patients are experts regarding their own bodies and medical decision-making. In short, sex-positive care is patient-centered.

Counteracting Oppressive Health Service History

The prevailing risk-based approach to sexual health for youth views any expression of adolescent sexuality as inherently dangerous, lacking a sex-positive understanding of sexual health as a normal and natural part of human development (Harden, 2014). The unique combination of traditional risk-based approaches to adolescent sexuality combined with cissexist structures allowing little divergence from traditional gender norms produce a uniquely taxing environment for TNB youth seeking sexual health care. For patients with additional marginalized identities, we must also recognize that the history of structures such as sexual health care is not only cissexist, but also heterosexist, racist, ableist, and overall oppressive (Mosher, 2017). To overlook such aspects is to ignore the growing body of literature concerning systemic oppression and intersectionality, which highlights how continued interactions with cissexist structures, in combination with other forms of oppression, leave TNB youth with limited access to care that is truly sex-positive (Mosher, 2017).

In response, we propose a more comprehensive model for promoting sexual wellness among TNB youth in assessment and practice, centering culturally competent sexual health care as a human right. Use of a sex-positive framework to appropriately assess TNB sexual health needs includes an understanding of how sexual and gender stigma, alongside other identity-related factors, impacts patient functioning, willingness to seek care, and treatment effectiveness. Sex-positive health psychologists treat individual patients, but retain an intersectional mindset in acknowledging the impacts of systemic oppression on diagnosis, treatment, and access to care.

Culturally Competent Assessment

Consistent with a more comprehensive intersectional model, sexual health assessments can be modified to be more sex-positive by conducting a culturally informed intake upon first meeting with a patient. Sex positivity focuses on the significance of multiculturalism in patients' abilities to express sexual behaviors and desires (Mosher, 2017). To gain an accurate assessment of how patients view themselves within the context of their various identities, methods of assessment that do not pathologize patients' beliefs, behaviors, or bodies is essential to their engagement in health care practices. Conducting a thorough cultural assessment allows health care providers insight into how patients' worldviews might impact their knowledge of and approach to sexual health (Burnes et al., 2017). While few if any resources currently exist regarding sex-positive cultural assessments, recommended assessments explore patients' race, ability status, ethnicity, class, values, and histories in addition to gender and sexuality in an open, honest format allowing for diverse responses.

One key aspect of fostering more sex-positive and TNB-affirmative health care settings includes a clear differentiation of gender and sexuality in assessing patients' sexual histories (Joyner & Bahng, 2019). For providers who may lack general knowledge concerning gender and sexual orientation, cissexist and heteronormative conceptualizations of sex may result in inadequate sexual health care. Sex-positive sexual health history-taking might involve directly asking patients preferred terminology for their sexual organs, asking which of their organs come into contact with which sexual partners' organs, and generally asking "how do you like to have sex?" (Joyner & Bahng, 2019, p. 2). These patient-centered, unassuming methods allow for expansive definitions of sexual behavior to be discussed in treatment, fostering a more comprehensive and open format of sexual health assessment.

Additional assessment considerations include modifying questionnaires to make them more applicable to gender and sexually diverse patients. For instance, many sexual health assessments inquire as to whether a patient's sexual partner is "male or female" and whether individuals use condoms "never, sometimes, or always." These questions are wrought with assumptions that only allow for a limited scope of sexual behaviors and can bar patients from providing accurate and honest responses. TNB youth report communication initiated from providers, especially about their pronouns and gender, helps create an environment where their differences are normalized and they feel safe and respected (Eisenberg et al., 2020). Implementing assessment measures that prioritize patients' pronouns, preferred name, gender identity, and diverse modes of sexual expression is key to establishing sex-positive health care.

Medical Terminology and Precision

In keeping with culturally competent, patient-guided approaches, sex-positive care is guided by foundational evidence-based guidelines. Research tells us that health care visits can be less dysphoria-inducing for transgender youth when providers embrace patient diversity and sex positivity from the start (Eisenberg et al., 2020). Research on use of sex-positive interventions indicates anatomical language, patient autonomy in determining how body parts are referred to, and trans-knowledgeable medical care in general are associated with better sexual and mental health outcomes for youth (Tordoff et al., 2020). Therefore, amplifying the use of such practices can improve the livelihoods of TNB youth seeking affirmative medical services.

A sex-positive approach to terminology includes not using gendered terms to apply to anatomical or biological processes (e.g., opting for the term "menstruation" versus "a woman's cycle"), modeling language inclusive of trans identities (e.g., "people who can give birth" versus "women"), and creating space for patients to use their own terminology to refer to their own bodily parts and functions (this is also called linguistic self-determination; Tordoff et al., 2020). Linguistic self-determination is one method of recognizing the patient as the expert on their own body, allowing medical professionals to follow patients' guidance in using these terms; research indicates this method also improves self-worth and lowers sexual risk-taking behaviors by encouraging bodily autonomy and empowerment (Tordoff et al., 2020). TNB youth report that providers who create a space for communication regarding gender identity, pronouns, and sexual behaviors make an important positive impact, no matter how uncomfortable those

providers may seem when approaching the topic (Eisenberg et al., 2020). Additionally, asking patients about which sexual health care practices may be more dysphoria-inducing for them, and making them aware of resources and options available as early as possible, is key in establishing a TNB-affirmative climate.

Patient Rights and Informed Consent

One major way that providers can leave the oppressive, risk-based frameworks in favor of a more affirming, sex-positive approach is by believing that patients know who they are and what they need to achieve optimal health. Gender researchers and scholars have identified two primary approaches to sex-positive care practiced by health service professionals centered on patient rights: the gatekeeping model and the informed consent-based model. Here we extend the concept of gatekeeping beyond hormone/surgical care to include access to any sex-positive interventions or resources (e.g., fertility preservation, contraceptives, and abortion care). Gatekeeping professionals take the responsibility of determining a patient's fitness for care, working to minimize liability by thoroughly determining if a patient should have access to resources such as puberty blockers or some forms of contraception. Conversely, informed consent providers take the responsibility of thoroughly and accurately providing patients and their guardians with all information, resources, referrals, and support they need to make well-informed decisions for themselves. This may include helping patients to find and/or referring patients to providers in other states if some forms of sexual health care are banned in their state.

Informed consent providers trust that patients will make the best decisions for themselves if they are given the information, tools, and assistance they need. Sex-positive providers take this a step further working to counteract stigma, demystify medical processes, and teach patients about their bodies and choices. For example, a sex-positive health service psychologist providing services for Shaina would listen to her concerns, empower her to push back against inaccurate assumptions made by her provider, coach her on ways to speak to providers about her needs, and offer a referral list with more TNB-affirmative providers in her area or even in other states. If Shaina sees a sex-positive medical provider in the future, she may expect to interact with medical staff who ask open questions, provide culturally competent information about sexual health, use her pronouns, and involve Shaina in the decision-making process as they plan for her care.

Respecting Adolescents' Autonomy

Research also tells us that being culturally informed is key to understanding patients from a multidimensional perspective. Rather than projecting their values, stereotypes, and expectations onto a patient, sex-positive providers recognize they cannot understand a patient without first asking questions. Research informs us that adolescents do, in fact, have the capacity to conceptualize their own sexual well-being, including sexual pleasure, rights to freedom from sexual pain or harm, ability to assert sexual preferences and boundaries with partners, and perceptions of their own worth as a sexual being (Harden, 2014). Therefore, rather than utilizing scare tactics to prevent adolescent sexual engagement, which can actually result in higher rates of sexual risk-taking and other negative health outcomes, sex-positive treatments are affirmative of TNB youth in emphasizing consensual and developmentally normative sexual exploration; this approach can result in improved mental and physical health outcomes for these adolescents (Harden, 2014).

Conclusion/Lessons Learned

TNB youth must navigate multiple barriers in accessing both mental and physical health care due to provider bias and lack of cultural competence, parental disapproval, cissexist health care systems, and more. TNB youth may face even greater difficulty accessing affirmative sexual health care and are often faced with uninformed providers who enact outdated, harmful practices (as in the case with Jasper and Shaina). Topics of sexual health may be particularly challenging for TNB youth due to widespread gendered and cisnormative assumptions, which may trigger gender dysphoria. As indicated by research, negative experiences with sexual health care, such as the experiences Jasper and Shaina describe, increase avoidance of future healthcare; this is associated with TNB youth anticipating minority stressors. Thus, TNB youth may miss critical health care opportunities, resulting in significant health disparities (Rider et al., 2018).

For these reasons, there is a critical need for health service psychologists to provide sex-positive care that advocates for the sexual well-being of TNB youth. The case vignettes of Jasper and Shaina highlight all-too-common negative experiences TNB youth face when accessing sexual health care. In both cases, Jasper and Shaina were misgendered from the start either through use of the incorrect name, pronouns, or being referred to as the wrong gender (e.g., "but your chart says male"). This made Jasper and Shaina feel unwelcome and anxious about proceeding with their appointments. These examples demonstrate the need for affirming medical settings wherein staff and providers are trained in TNB inclusivity, as providing a safe and welcoming environment for TNB youth is key to improving health care outcomes across the lifespan.

Shaina was not only misgendered but asked invasive questions about her body that were likely not asked of cisgender patients. She was also forced to educate to her health care provider, leaving her feeling drained and upset. Given medical providers may need to ask questions about patients' bodies and sexual activities, an awareness of how to do so in an affirming way is vital to avoid triggering patients' gender dysphoria or making them feel alienated and misunderstood. This includes employing sex positivity from the start, beginning with asking TNB youth directly about their gender identity, name, and pronouns; editing intake and assessment forms to have inclusive options; avoiding gendered terminology; and employing linguistic self-determination (using patients' terminology in reference to their own body parts). Additionally, while remaining sex-positive allows the patient to be the expert on

their own body, the importance of cultural competence training for providers cannot be overstated. When providers are untrained to work with TNB youth, already vulnerable situations are further exacerbated, resulting in patients like Shaina being exhausted, misunderstood, and unproperly cared for.

When Jasper reported having two sexual partners, they were met with judgement and essentially scolded for their behavior. Rather than preventing or decreasing sexual health risks, this approach would most likely result in Jasper avoiding treatment or prevent them from being forthcoming about their sexual behaviors in future appointments. If Jasper does not feel safe enough to be honest about their sexual behaviors, this may prevent them from obtaining important information or care. Jasper's experience underscores the need for a sex-positive approach to sexual health care and therapy. A sex-positive approach would exercise Jasper's bodily autonomy, empowering them to make healthy, informed decisions while providing comprehensive resources for promoting and maintaining their sexual health.

Overall, application of a sex-positive approach to sexual health with TNB youth involves engaging with the core tenants of cultural competence, patient autonomy, and advocacy, beginning with recognizing the wealth of diversity and resilience this population holds. Despite navigating countless obstacles, research clearly indicates "when [TNB] youth are permitted to be themselves and find acceptance (both in life, and in treatment), they have the ability to thrive" (Tankersley et al., 2021, p. 203).

Key Clinical Considerations

- Increase cultural competence for work with TNB youth by engaging in ongoing training.
- Create an affirming environment by conducting culturally competent assessments and using inclusive language.
- Employ trans-affirmative resilience-based clinical interventions when working with TNB youth.
- Use a sex-positive approach and respect patient autonomy.
- Advocate for systems and policies that promote the health and well-being of TNB youth.

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