Systematic review

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Transgender and gender diverse youths' experiences of healthcare: A systematic review of qualitative studies

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Abstract

Transgender and gender-diverse (TGD) populations are identified as high-risk for negative healthcare outcomes. Limited data exists on experiences of TGD youths in healthcare. The review aim is to systematically review literature on healthcare experiences of TGD youths. Seven electronic databases were systematically searched for relevant studies. Pre-determined eligibility criteria were used for inclusion with a double-screening approach. Sixteen studies were included. Studies included were quality appraised, data were extracted, and findings were synthesized narratively. Four narratives were identified including experiences of: accessing care, healthcare settings and services, healthcare providers, and healthcare interventions. Long waiting times, lack of competent providers, and fear were reported as challenges to accessing gender-affirming care. Negative experiences occurred in mental health services and primary care, while school counseling and gender clinics were affirming. Puberty blockers and hormone-replacement therapy were identified as protective factors. TGD youths are at risk of negative health outcomes due to an under resourced healthcare system. Further research is needed to assess interventions implemented to improve TGD youth's experiences.

Keywords

Adolescent, delivery of health care, gender identity, systematic review, transgender persons

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Introduction

Health disparities are health differences experienced by populations, commonly reported in the context of a perceived advantaged group, and are linked to economic, social, and environmental disadvantage (Carter-Pokras and Baquet, 2002). Health equity aims to reduce and subsequently eliminate health disparities in society (Braveman, 2014; Gerlach and Varcoe, 2021).

Transgender and gender-diverse (TGD) youths experience significant health related disparities such as limited and delayed access to care (Bauer et al., 2009; Bradford et al., 2013). TGD individuals are those whose sex assigned at birth is incongruent with their experienced gender identity (Lindqvist et al., 2021). Estimations of the TGD youth population range from 1.3% to 2.7% of the gross population which is a marked increase compared to the TGD adult range of 0.1% to 2% (Goodman et al., 2019). TGD population reports higher rates of suicidality, not only in comparison to cisgender counterparts but also Lesbian, Gay, and Bisexual (LGB) peers, with a greater prevalence within younger age groupings (Hunt et al., 2020).

Johns et al. (2019) reported TGD youths are more likely than cisgender peers to report violence victimization, suicide risk, and substance use. Although it is known youth from the general population experience delays in accessing health care (MacDonald et al., 2018) and poor health outcomes (Marie-Mitchell & O'Connor, 2013), recent evidence suggests that TGD youths' experiences are more challenging owing to invalidating environments (Call et al., 2021). TGD identity is linked to intrapersonal, interpersonal, and societal stressors that are seldom experienced by cisgender counterparts (Hunt et al., 2020).

Gender dysphoria, according to American Psychiatric Association (2022), is a clinically marked distress related to an individual's lack of congruence between assigned gender and experienced gender identity. TGD adolescents with gender dysphoria are likely to experience co-morbidities such as anxiety and depression (De Vries et al., 2011). A retrospective cohort study identified a two-to-threefold increase in risk of negative mental health outcomes for transgender youth (Reisner et al., 2015). A significant disparity relating to perceived general health amongst TGD youths was reported, with 62.1% rating their general health as poor, fair, or good (Rider et al., 2018). TGD youth who obtain early and evidence-based intervention for dysphoria are less likely to experience negative health outcomes (De Vries et al., 2014).

Evidently TGD youths require more input from mental health and general healthcare providers. On average, LGBT + education accounts for 2.2–5 h of healthcare provider's education, with TGD-specific education absent from almost all developed curricula (Hana et al., 2021). Rowe et al. (2017) explored primary care providers' knowledge of LGBT + health noting further education is required to increase cultural competency of providers. An understanding of experiences of TGD youth across healthcare, and factors impacting experiences is imperative to enhance and ensure equitable healthcare delivery.

Aim

To identify and synthesize qualitative research on healthcare experiences of TGD youths. Review objectives include: (i) identifying healthcare experiences of TGD youths; (ii) identifying factors impacting healthcare experiences of TGD youths; and (iii) exploring recommendations by TGD youths to improve healthcare experiences.

Methods

Review methods and reporting were based on the Preferred Reporting Items for Systematic Reviews and Meta-Analyses statement (Page et al., 2021). Authors of this review are from various professional backgrounds including higher education, mental health nursing, general nursing, and senior research. Authors also identify across the spectrum of sex, gender, sexuality, and ethnicity. Regular reflexive conversations occurred among all authors which helped minimize potential biases and ensured representation of the TGD youths voice in synthesis and reporting of results.

Eligibility criteria

Eligibility criteria were pre-defined according to review aim and objectives. The Sample, Phenomenon of Interest, Design, Evaluation and Research framework underpinned eligibility criteria (Cooke et al., 2012). Studies focusing on healthcare experiences of TGD youths under 18 years were included to capture experiences of those under the age of consent. Studies focusing on cisgender, or TGD experiences outside of healthcare were excluded. Qualitative research and mixed-methods research with isolated qualitative findings were included; other research designs were excluded. Full eligibility criteria can be found in Supplemental Table S1.

Search

First author conducted a scoping search of Academic Search Complete, Cumulative Index of Nursing and Allied Health Literature plus with Full Text, American Psychological Association PsycInfo, SocINDEX with Full Text, MEDLINE, Social Sciences Full Text (H.W. Wilson), and American Psychological Association PsycArticles to identify relevant keywords used in research on TGD youths. Subject headings were sought from each electronic database and a single search strategy devised, in agreement with all authors. A systematic search of mentioned electronic databases was completed in 2021 and updated in 2022.

Synonyms of key terms "Experience," "Transgender," and "Healthcare" were used. Boolean operators "AND" and "OR" were used. Smart searching tools such as phrase searching, and truncation were employed. Limits included, studies published in English between January 2016 and July 2022. The five-year limit was employed following the introduction of the Yogyakarta Principles Plus 10 (International Commission of Jurists, 2017), which identified 10 additional human rights principles for sexual and gender diverse individuals. A hand search of reference lists of included studies and published systematic reviews (Brown et al., 2016; Chong et al., 2021; Heng et al., 2018; Wilson and Cariola, 2020) was conducted. An overview of the search is available in Supplemental Table S2.

Study selection

Covidence, the primary screening software for Cochrane authors, was used to screen records (Veritas Health Innovation, 2022). Duplicates were removed automatically in Covidence. A review of titles and abstracts, followed by a full-text review of remaining studies was completed. A conventional double screening approach was used. Conflicts were resolved by a third author. Articles identified during hand searching were also screened.

Critical appraisal

The Joanna Briggs Institute critical appraisal tool for qualitative research was used (Lockwood et al., 2015). This tool comprises 10 items to assess congruity between research methodology and philosophical perspective, research questions, data collection methods, representation and analysis of data, and interpretation of results (Lockwood et al., 2015). Further appraisal included locating researchers' positions culturally or theoretically and their influence on the research, ethical approval, whether participants were adequately represented, and if conclusions drawn are consistent with analysis and interpretation of data (Lockwood et al., 2015). A conventional double screening approach was used during quality assessment whereby two authors voted "Yes" (Y), "No" (N), or "Unclear" (U) for each of the 10 items. Conflicts were resolved by a third author.

Data extraction

Data from included studies were extracted using a standardized table (Goodwin et al., 2021). Data extracted included: authors; country and setting; aim; number of participants; participants' age range and identity descriptor; design of studies including data collection methods and data analysis; and key findings. Data were extracted by first author and cross-checked by remaining authors to ensure accuracy. A condensed data extraction table is presented in Table 2 and a comprehensive data extraction table found Supplemental Table S3.

Synthesis methods

A narrative synthesis was conducted in accordance with Popay et al.'s (2006) guidelines. This approach relies on the use of words and text to summarize, present, and explain findings from multiple studies. Data relating to TGD youths' healthcare experiences were extracted into the data extraction table, creating a preliminary synthesis. Relationships within and between studies were explored to identify reoccurring concepts in line with current review aim and objectives. Narratives were constructed by condensing reoccurring concepts. Each narrative comprised illustrative stories from participants.

Identity descriptors were extracted from each included study and categorized into masculine presenting, feminine presenting, and gender diverse identities for ease of comparison. All narratives and gender identity descriptors were constructed by the first author and agreed by all authors.

Results

Study selection

A total of 3503 articles were identified within databases and 1294 duplicates were removed. The remaining 2209 articles titles' and abstracts' were screened for eligibility resulting in exclusion of 1726 studies. A full text review followed for 483 records. Of those, 469 records were excluded, and 14 studies included for review. Hand searching yielded two additional studies. In total, 16 studies were included in this systematic review. Study selection is presented in Figure 1.

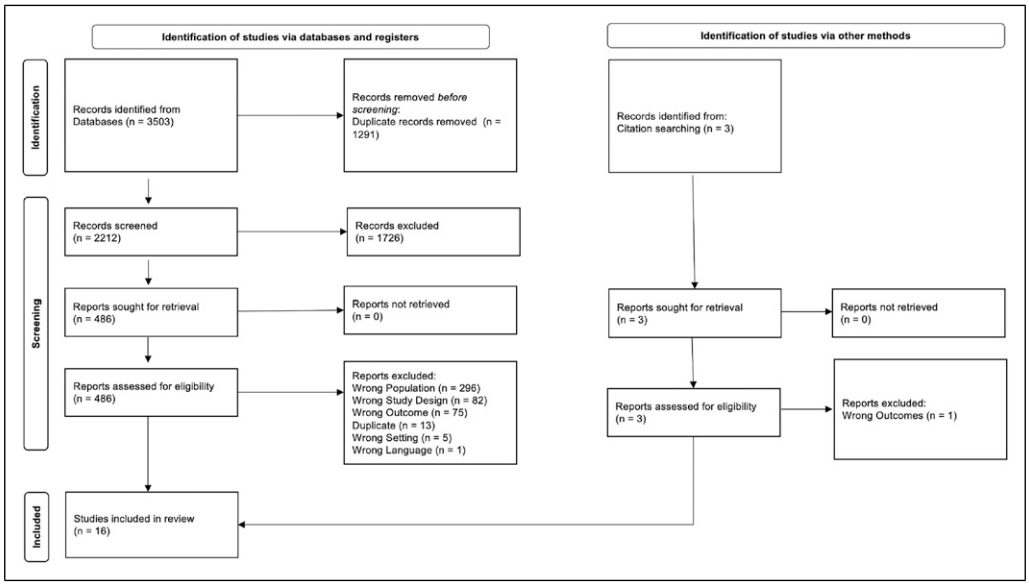

Figure 1. Preferred reporting items for systematic reviews and meta-analysis flow chart identifying results from the search strategy.

Study characteristics

Thirteen studies were qualitative and three were mixed-methods. Seven studies were conducted within the USA, with Australia, Canada, and the United Kingdom (UK) representing three additional studies each.

Participant gender identity descriptors varied, with two studies not providing breakdowns of these descriptors (Carlile, 2020; Zeeman et al., 2017). Hammack et al. (2022) reported results and identifiers for 13 of its 28 participants. A total of 286 TGD youths with varying identity descriptors were represented within this review. Eight studies included parental and care providers' experiences; however, data were only extracted from TGD youth. The average age range of TGD participants across all 16 studies was 11–19 years. Data were only extracted for participants under 18 years as per pre-determined eligibility criteria. Research sites included gender specialist clinics, primary care, mental health services, sexual health services, and school counseling. Table 1 contains summarized study characteristics, with a detailed overview located in Supplemental Table S3.

Critical appraisal

All studies appropriately drew conclusions from analysis of data and established congruity between research methodology and interpretation of results. All but two studies (Mackie et al., 2021; Newhook et al., 2018) had congruity between the research methodology and research question. Newhook et al. (2018) utilized a participatory action research framework, employing a predetermined questionnaire limiting congruity between methodology and data collection. Guss et al. (2019) utilized a qualitative approach but a mixed-methods program for analysis, limiting congruity between methodology and analysis. Three studies aimed to identify experiences of TGD

Table 1. Study characteristics of included studies (n = 16).

Country	United States of America (n = 7, 43.75%) United Kingdom (n = 3, 18.75%) Canada (n = 3, 18.75%) Australia (n = 3, 18.75%)
Setting	Healthcare (n = 6, 37.5%) Gender clinic (n = 5, 31.25%) Mental health services (n = 2, 12.5%) HIV prevention services (n = 1, 6.25%) Wellbeing (n = 1, 6.25%) School counseling (n = 1, 6.25%)
Study design	Qualitative (n = 13, 81.25%) Mixed methods (n = 3, 18.75%)
Sample size[a]	M = 21
Participant age[b]	Mrange = 11–19 years
Primary focus	Experiences of TGD youth and parents in healthcare (n = 5, 31.25%) TGD youth and parents experience of specialist gender clinics (n = 4, 25%) TGD youths' wellbeing (n = 2, 12.5%) Experiences of TGD youth and mental health services (n = 2, 12.5%) Care and support needs of TGD youth (n = 1, 6.25%) TGD youth risk of HIV and experiences of HIV services (n = 1, 6.25%) Experiences of TGD youth in school counseling (n = 1, 6.25%)

Key: TGD = Transgender and Gender Diverse; HIV = Human Immunodeficiency Virus.
[a]Studies including a parent or care provider sample were only eligible if data relating to TGD youths could be extracted independently.
[b]Studies were only included if data for TGD youths under 18 years were distinguishable.

youths and parents; however, appeared to underrepresent TGD youths in results (Bartholomaeus et al., 2021; Inwards-Breland et al., 2019; Newhook et al., 2018). These three studies also missed reporting the influence of researcher on the research and vice versa (Bartholomaeus et al., 2021; Inwards-Breland et al., 2019; Newhook et al., 2018). Quality assessment results are available in Table S4.

Four narratives were identified through data synthesis: (i) experiences of service accessibility, (ii) experiences of healthcare settings and services, (iii) experiences of interactions with healthcare providers, and (iv) experiences of healthcare interventions. An overview of narratives and quotes can be found in Supplemental Table S5.

Experiences of service accessibility

Factors influencing service accessibility were explored in nine studies. These primarily related to care avoidance due to fear of negative reactions from providers or parents (Guss et al., 2019; Mackie et al., 2021; Pullen-Sansfacon et al., 2019), identification of gender-affirming services, (Bartholomaeus et al., 2021; Pullen-Sansfaçon et al., 2018; Paceley et al., 2021; Riggs et al., 2020), disparity of access (Mackie et al., 2021; Newhook et al., 2018; Paceley et al., 2021; Pullen-Sansfacon et al., 2019), and delays accessing services (Carlile et al., 2021; Pullen-Sansfaçon et al., 2019; Riggs et al., 2020).

Table 2. A condensed data extraction table for the included studies (n = 16)

Author(s) and year Country Healthcare setting	Sample	Design	Key findings
Acosta et al. (2019)	Transgender youth n = 9	Qualitative, multi-informant perspective	1. Experiences of service accessibility; 2. Experiences of healthcare settings and services; 3. Experiences of interactions with healthcare providers; 4. Experiences of healthcare interventions
USA			2: Presence of legal name in the care system was a major stressor
Inpatient psychiatric hospital			3: 8 participants reported providers were aware of their identity because they independently spoke up about it. Most commonly during nursing intake when providers use the wrong pronouns
			3: Those that didn't speak up during nursing intake did so eventually sometimes with psychiatrist assessment, or after some time when they were comfortable with providers
			3: Recommend that nursing ask youth directly during the intake
			3: All participants agreed that care providers were generally respectful and supportive and conveyed a sense of acceptance
			3: Participants agreed pronouns were challenging for providers
			3: Participants felt providers tried to use their preferred identifier and they appreciated the effort, however, mistakes were common
			3: Mistakes upset participants, however, providers apologizing afterwards helped ease distress
			3: Mistakes occurred during roll call for groups, med administration, and on wristbands
Bartholomaeus et al. (2021)	Transgender youth n = 10	Qualitative	2: Counseling services did not know about other services available, and more awareness of other services was needed
Australia			3: Professionals who were both affirming and knowledgeable were generally located in paediatric gender clinics
Inside and outside of gender clinics			3: Positive experience with paediatrician and psychiatrist at a gender clinic
			3: Professionals who were affirming but lacked knowledge were generally GP services
Carlile (2020)	TGD youth and parents n = 65	Qualitative research underpinned by a self-developed action research framework	3: 15-year-old was advised that a 6-month period of testosterone would be enough to remove any chance of reproduction using his own biological material but noted there were trans men in the media who had gotten pregnant after being on testosterone for longer than 6 months. Lack of clarity was a source of distress
England	Families n = 27		3: Young trans man advised being misgendered by his GP led to being denied a referral
Healthcare			3: After changing GP he was misgendered again
			3: Participants felt healthcare staff had been under-served by their training providers, particularly on misgendering, deadnaming, non-binary people, and stereotyped ideas about gender presentation and expression
			3: Participants advised the lack of training for healthcare staff led to stereotyped assumptions about their gender, and a lack of adequate treatment
			3: One young trans woman who attended her appointment with GIDS in jeans and trainers was described as not serious enough to warrant support for clinical intervention

(continued)

Table 2. (continued)

Author(s) and year Country Healthcare setting	Sample	Design	Key findings
Carlile et al. (2021) England Clinical care	Trans youth (n = 14)	Qualitative	1: 14-year-old went for private care after a wait of over 2 years for GIDS 1: 15-year-old waited several months before being seen by GIDS. Was further along transition process than providers expected and as such she had to spend time convincing them to provide hormones 2: 17-year-old requested their records to change to non-binary pronouns and name. They found the process very slow and later a referral form was left unsent 3: 14-year-old boy reported GP did not support transgender care and it was their policy not to support it 3: Gender stereotyping common in CAMHS 3: Kieran described ballet company as a place he was happy and affirming, however, the CAMHS therapist used this continued involvement as a reason to query his seriousness about his gender dysphoria and gender transition 3: CAMHS provider did agree that they had gender dysphoria and that a hormone prescription would help with this. However, the provider still delayed referral 4: Don't mention identities outside of the binary to GIDS for fear of treatment being rejected 4: 15-year-old referred and prescribed puberty blockers in 14 months, possibly because of his serious self-harm and suicide attempts 4: 15-year-old said she and her parents prepared for the GIDS appointments to speed things up 4: 15-year-old had to be very insistent to get medication at GIDS 4: 16-year-old reported positive impact of the puberty blockers on his wellbeing 4: 13-year-old tried high dose contraception to suppress menstruation, but this triggered gender dysphoria due to daily pill 4: One youth experienced positive changes in many areas of his life due to gender affirming hormone medication
Fontenot et al. (2021) USA HIV prevention services	TGNC youth n = 30	Qualitative	3: GP had new intake form to include transgender identities. Despite selecting the correct one the incorrect pronouns were still used in the appointment 3: Doctor ceased a sexual health conversation due to the participant having health class in school 4: Advice is generally cisgender and heteronormative
Gridley et al. (2016) USA Clinics serving transgender youth, a support group, and a hospital-sponsored blog	Transgender youth n = 15	Mixed methods	2: Participants who identified outside the gender binary also described dissatisfaction with numerical scales used by mental health providers to quantify how much one's gender identity differs from ones natal sex 4: Age limit to access medical interventions was seen as an obstacle for some

(continued)

Table 2. (continued)

Author(s) and year Country Healthcare setting	Sample	Design	Key findings
Guss et al. (2019) USA Adolescent primary care and gender clinics	Transgender adolescents *n* = 20	Qualitative	1: 14-year-old avoiding care due to previous negative experience 2: 14-year-old recommendation about forms. Suggesting a checkbox on the forms to indicate wanting to speak to doctor in private 2: 15-year-old recommends collecting gender information in private with the doctor 2: 16-year-old recommends having visual symbols such as flags and lanyards to make transgender patients feel more welcome 3: Primary care provider laughed when 14-year-old female/trans disclosed identity, however, after realizing they were serious, they affirmed the disclosure and ensured to use the correct pronouns and names 3: 14-year-old reported office receptionist in GP surgery continuously deadnamed them despite being repeatedly corrected 3: A 15-year-old described the annoyance of deadnaming but stated you become desensitized after some time 3: A 16-year-old identified that they did not feel comfortable correcting the provider deadnaming them and instead internalized it 3: A 16-year-old reported being misgendered and the frustration that occurred because of this
Hammack et al. (2022) USA Mental health services	TGD youth *n* = 28* *Only 13 of the 28 were reported on	Mixed methods	2: Perceived futility of utilizing mental health services in community due to lack of knowledge 3: Lack of cultural competence among mental health providers to address issues related to SGD. Providers were identified as ineffective because they lacked expertise about SGD entirely or had less knowledge than the youth themselves
Inwards-Breland et al. (2019) USA Multidisciplinary team gender clinic. Seattle Children's gender clinic	TGNC individuals *n* = 33	Mixed methods	2: Described the experience with the Seattle Children's gender clinic and appreciated efforts to create a safe space

(continued)

Table 2. (continued)

Author(s) and year Country Healthcare setting	Sample	Design	Key findings
Mackie et al. (2021) Australia School counseling	Transgender youth *n* = 11	Cross sectional qualitative design informed by interpretative phenomenological analysis	1: Experiences were influenced by their prior expectations and conceptions of counseling 1: One participant thought school counseling would be similar to conversion therapy to discourage her from identifying as transgender 1: Another participant prepared themselves for a negative reaction during her first email interaction with her school psychologist due to the nature of her referral 1: Accessibility to counseling was easy for participants as it did not involve a payment, and they could rearrange appointments easily due to the proximity of the space 2: The importance of accessing a safe and non-judgmental school counseling environment was emphasized by participants 2: Participants expressed experiencing a sense of relief due to having a space they viewed as welcoming and safe and easy to access 2: Inclusive materials such as posters and flags were seen as a welcoming sign among participants 3: Found the psychologist to be friendly and welcoming and non-judgmental 3: Participants considered having previous experience of working with transgender clients helpful as they did not feel a burden to educate the provider 3: Lack of this knowledge caused frustration among participants, and it caused awkwardness and discomfort during sessions 3: Psychologists who developed a strong therapeutic relationship with participants were identified as easier to communicate with and more trusting 3: Participants praised psychologists who would support the development of autonomy 3: Acceptance from counselors was desired among participants with a simple acknowledgment of their identity being seen as a portrayal of support 3: Feeling listened to allowed participants to develop a feeling of inclusion and connectedness with the counselor and also their school environment 3: School counselor as an advocate was also highlighted as a positive by participants as they had a trusted figure who could advocate on their behalf 4: Several participants expressed gaining skills of self-management, a sense of self-growth, self-understanding, and hope.
Newhook et al. (2018) Canada Healthcare	TGNC youth *n* = 24	Qualitative feminist participatory action research	1: Multiple challenges to accessing care with parental support a key factor 3: Lack of knowledge of healthcare for trans youth among general practitioners

(continued)

Table 2. (continued)

Author(s) and year Country Healthcare setting	Sample	Design	Key findings
Paceley et al. (2021) USA Healthcare	TGD youth *n* = 4	Multiple case study	1: Participants locating services through word of mouth via peers 1: Travel was another accessibility issue. Had to travel an hour or more to access a physician who competently addressed their healthcare needs 2: Regular changeover of staff in the clinic meant youth had to repeatedly re-establish rapport with their providers 2: Safety was a concern due to clinics being conducted in women's clinics, having to walk through protestors and being yelled at. Safety planning was then required when entering the facility in women's clinics 2: Discomfort accessing services in a women's space due to the gendered nature of the environment 3: Providers were identified as not providing adequate information about services to TGD CYP 4: Costs of medical care caused internal conflict among participants as they were happy for their friends, who could afford to access interventions, but internally distressed that they may not be able to access the same interventions

(continued)

Table 2. (continued)

Author(s) and year Country Healthcare setting	Sample	Design	Key findings
Pullen Sansfaçon et al. (2019)	Trans youth *n* = 35	Qualitative grounded theory	1: Process of accessing care was very long and complicated by many factors, necessary hurdles of coming out to parents
Canada			1: Wait times to get first appointment after referral was from several months to more than a year
Gender affirming speciality clinics			1: Wait time was preceded by a period often extending to years of reflection and waiting as they explored and came to accept their identity 1: Fears to ask parents to access medical interventions affected accessibility to services 1: Barriers to accessing mental health counseling – cost, difficulty getting insurance approval 1: Youth expressed concerns relating to waiting times and possibilities available for medical interventions, and cost of medication 1: Waiting times varied depending on the developmental stage of the youth 1: Delays—Long wait times between first and subsequent appointments, clinic policies particularly around assessment for hormones, lack of consensus between them, providers and parents 2: Clinics described as a place where they could openly discuss some of the difficulties they experienced and get the support they needed 2: Discomfort in the waiting room and being seen there 3: Clinic staff always asked for and used chosen or preferred pronouns and name 3: Legal name in system caused deadnaming and misgendering in other locations such as ED 3: Expressed discomfort discussing certain topics with staff such as suicidality and depression as well as side effects of medical interventions they feared or experienced 4: Medical interventions improved participants wellbeing and outlook on the future 4: Those who had SI or DSH reported decreases in these thoughts or actions since medical interventions 4: Accessing blockers was described as providing a sense of relief and greater optimism and positively impacting mental health 4: Top surgery described as the most significantly positive intervention on wellbeing for 1 participant 4: Puberty blockers linked to hot flashes, and mood swings. Also headaches, knee pain and drinking more water 4: Blockers contributed to one participant developing stress fractures 4: Medical care improved the wellbeing of TGD youth 4: Returning to the clinic repeatedly for evaluations and blood tests before they could start blockers or hormones took away from school and other parts of their life 4: Non-binary participants reported frustration with the limited availability of medical interventions

(continued)

Table 2. (continued)

Author(s) and year Country Healthcare setting	Sample	Design	Key findings
Pullen Sansfaçon et al. (2018)	Trans youth (n = 24)	Qualitative community-based participatory action research and grounded theory	1: Searched services online ahead of attending and found services not adapted to all trans people or welcoming of diversity
Canada			2: Trans youth identified the healthcare system as a primary contributor to their well-being particularly those seeking care for their gender identity
Healthcare			3: 16-year-old described avoiding care due to previous negative experiences with their psychiatrist
			4: 16-year-old advised their wellbeing heavily depended on rapidly finding a doctor who would provide HRT
Riggs et al. (2020)	Trans youth (n = 10)	Qualitative	1: Cancellations allowed for quicker access, however, did inconvenience the family due to the short notice
Australia			1: Parents identified by a participant as a source of advocacy to be able to access services
Medical treatment across healthcare			4: Blockers were reported by some as helpful, and others praised that it stopped puberty but reported it didn't help how they felt about their identity
			4: Sense of disarray for one participant in the process of accessing hormones including wait times
			4: Participants cited a lack of clear information about wait times for accessing hormones so that young people can be prepared
			4: Hormones improved sense of self for participants
			4: Adolescent thoughts continued, that is, self-esteem related despite being on hormones
Zeeman et al. (2016)	Trans youth n = 5	Combined participatory qualitative	2: One participant spoke of their experience of accessing in-patient CAMHS and the need for use of gender inclusive language and spaces being made available
UK			3: Felt misunderstood by both teachers and health professionals, particularly where they accessed health services
Health services			3: Participants thought teachers and health professionals could be better informed about trans issues and their specific emotional needs linked to experiences such as bullying or marginalization
			3: Practitioners were hesitant to discuss issues related to gender and sexuality, resulting in the wrong pronouns being used when addressing them

Key: CAMHS = Child & Adolescent Mental Health Services; HRT = Hormone Replacement Therapy; TGD = Transgender and Gender Diverse; SI = Suicidal Ideation; DSH = Deliberate Self-Harm; ED = Emergency Department; TGNC = Transgender and Gender Non-Conforming; USA = United States of America; SGD = Sexual and Gender Diverse; HIV = Human Immunodeficiency Virus; GIDS = Gender Identity Development Services.

A 14-year-old participant reported avoiding care, despite being unwell, due to fear of healthcare providers' reactions (Guss et al., 2019). Youth's healthcare engagement was impacted by expectations of negative reactions, with some expecting counseling to be a form of conversion therapy (Mackie et al., 2021).

Fear of negative parental reaction prevented youths accessing services early (Pullen-Sansfaçon et al., 2019). Fear delayed youths accessing medical interventions like puberty blockers, and hormone replacement therapy (HRT). Other participants identified parents as advocates who assisted them in accessing treatment in hospitals (Riggs et al., 2020).

Participants used LGBT + peers to identify TGD affirming services (Paceley et al., 2021). Online searches were also used to identify if services were affirming (Pullen-Sansfaçon et al., 2018). Service providers' insular view of care affected their ability to signpost effectively (Bartholomaeus et al., 2021).

Cost of gender-affirming care was noted as a distinct disparity. One participant reported cost impacted their ability to access gender-affirming interventions such as top surgery (removal of breast tissue) (Paceley et al., 2021). Another participant worried about their ability to afford gender-affirming medication, however, identified parents as a source of financial support (Pullen-Sansfaçon et al., 2019). Not all participants had financial or emotional support of parents (Newhook et al., 2018). Access to school counseling was more frequent due to the lack of cost involved (Mackie et al., 2021).

Lack of geographically accessible gender-competent resources was highlighted as an issue. Participants traveled over 2 hours to find physicians that competently met healthcare needs (Paceley et al., 2021). School-based counseling was geographically beneficial to participants (Mackie et al., 2021).

Waiting times to access gender-affirming services was identified as another barrier to service accessibility (Carlile et al., 2021; Pullen-Sansfaçon et al., 2019; Riggs et al., 2020). Delays were common with participants waiting several months to 2 years for first appointment with Gender Identity Development Services (GIDS) (Carlile et al., 2021; Pullen-Sansfaçon et al., 2019). Due to waiting times, a 15-year-old participant advised their transition was advanced which impacted care due to confusion within GIDS (Carlile et al., 2021). Another participant reported accessing private healthcare due to delays in receiving an appointment (Carlile et al., 2021). Instances of swift accessibility were also identified. One participant was able to access care due to a cancellation, however, this caused inconvenience due to short notice (Riggs et al., 2020). A 15-year-old participant was able to access puberty blockers in 14 months, due to ongoing mental health factors (Carlile et al., 2021).

Experiences of healthcare setting and service

Factors influencing TGD youths' experiences of healthcare settings and services related to experiences of gender clinics (Inwards-Breland et al., 2019; Paceley et al., 2021; Pullen-Sansfaçon et al., 2019), mental health services, (Acosta et al., 2019; Carlile et al., 2021; Gridley et al., 2016; Hammack et al., 2022; Mackie et al., 2021) and recommendations to improve healthcare services (Guss et al., 2019; Mackie et al., 2021).

Gender clinics were identified as a safe space where participants could be open and not feel judged (Inwards-Breland et al., 2019; Pullen-Sansfaçon et al., 2019). Participants acknowledged the setting of gender clinics impacted their sense of safety (Paceley et al., 2021). Gender-affirming care

within women's clinics was noted as potentially unsafe and uncomfortable due to the gendered nature of the service (Paceley et al., 2021).

Child and Adolescent Mental Health Services (CAMHS) were described as futile due to a perceived lack of support for the queer community (Hammack et al., 2022). Gender stereotyping was reported as commonplace within CAMHS (Carlile et al., 2021). Individuals' assigned name within the care system caused instances of deadnaming (use of birth name instead of chosen name) and misgendering (use of incorrect pronouns or incorrect assumption of gender identity) in inpatient mental health settings (Acosta et al., 2019). Non-Binary participants also reported frustration with mental health numerical scales to quantify dysphoria (Gridley et al., 2016).

Recommendations by participants included spaces that are safe, inclusive, and gender-affirming. Using LGBT + material such as lanyards as a visual symbol of acceptance within healthcare (Guss et al., 2019). Participants in school counseling praised the availability of LGBT + material (Mackie et al., 2021). Youths in this environment also recommended a need for improved confidentiality (Mackie et al., 2021).

Experiences of service provider interaction

Factors impacting experiences of service provider interactions were discussed across 13 studies predominantly focusing on deadnaming and misgendering (Acosta et al., 2019; Carlile, 2020; Fontenot et al., 2020; Guss et al., 2019; Zeeman et al., 2017), lack of provider knowledge or experience (Bartholomaeus et al., 2021; Carlile, 2020; Hammack et al., 2022; Mackie et al., 2021; Newhook et al., 2018; Zeeman et al., 2017), and service providers being accepting or judgmental (Acosta et al., 2019; Carlile, 2020; Carlile et al., 2021; Mackie et al., 2021; Pullen-Sansfacon et al., 2019; Zeeman et al., 2017).

Identity disclosure to healthcare providers was perceived by participants as difficult and uncomfortable. Disclosure commonly occurred during admission, with nursing staff, however, some participants waited till trust was established (Acosta et al., 2019). During a participant's disclosure to their GP, the provider initially "*chuckled"* but realized the participant was serious and sought to establish correct pronouns and chosen name (Guss et al., 2019: 346).

Deadnaming was commonly reported by participants in primary care settings, even when gender identity was highlighted (Guss et al., 2019). Repeated deadnaming by a primary care office receptionist resulted in one participant feeling unsafe (Guss et al., 2019). A 15-year-old participant internalized their discomfort with deadnaming and accepted it as a part of transitioning (Guss et al., 2019).

Misgendering was reported by participants across services resulting in feeling anxious and frustrated with service providers (Acosta et al., 2019). Participants advised apologizing after a mistake is made can alleviate a lot of discomfort (Acosta et al., 2019). One participant recounted a frustrating incident of misgendering with their doctor whereby they selected their pronouns, and incorrect ones were still used (Fontenot et al., 2020). Misgendering by one participant's GP resulted in denial of a referral and a decline in mental health (Carlile, 2020). Misgendering reoccurred when this participant changed GPs, resulting in feelings of judgement and worthlessness (Carlile, 2020). Participants agreed that providers were reluctant to discuss gender and sexuality, which resulted in instances of misgendering (Zeeman et al., 2017). Participants recommended healthcare providers, specifically nurses, explore aspects of gender identity during admission (Acosta et al., 2019).

Lack of TGD healthcare education was noted across primary care settings (Bartholomaeus et al., 2021; Newhook et al., 2018). One GP was affirming but lacked knowledge of medical interventions

such as Hormone Replacement Therapy (HRT) (Newhook et al., 2018). Discussions around sexual health were discontinued by GPs upon learning TGD youths had sexual health education in school (Fontenot et al., 2020). One participant felt let down by their doctor for not providing adequate education on the transition process (Paceley et al., 2021). Lack of timely information from healthcare providers relating to delays accessing hormones was detrimental, as youths felt they had no time to prepare (Riggs et al., 2020).

Mental health providers were also identified as lacking knowledge about TGD healthcare, additional needs of the population, and cultural competence (Hammack et al., 2022; Zeeman et al., 2017). Knowledgeable professionals were identified in paediatric gender clinics (Bartholomaeus et al., 2021). Lack of knowledge and experience had negative impacts on participants within school counseling (Mackie et al., 2021). School counselors who had previous experience with TGD clients were perceived as knowledgeable and sensitive, and created an effective therapeutic relationship (Mackie et al., 2021). Participants expressed relief about not having to educate counselors about TGD health in this case (Mackie et al., 2021). Participants recommend providers be educated comprehensively about TGD healthcare to ensure a knowledgeable gender-affirming service (Bartholomaeus et al., 2021; Carlile, 2020; Hammack et al., 2022; Mackie et al., 2021; Newhook et al., 2018; Zeeman et al., 2017).

Feeling judged or accepted by healthcare providers was a common experience explored by participants (Acosta et al., 2019; Carlile, 2020; Carlile et al., 2021; Mackie et al., 2021; Pullen-Sansfacon et al., 2019; Zeeman et al., 2017). One participant was denied access to TGD healthcare because it was against policy to support it (Carlile et al., 2021). Another participant had their gender dysphoria and desire to transition queried because of involvement in ballet (Carlile et al., 2021). Participants reported feeling judged by nurses for the bathroom they chose within CAMHS (Zeeman et al., 2017). A trans woman was denied further clinical intervention in GIDS because of their outfit (Carlile, 2020).

Experiences of acceptance were also reported by participants (Acosta et al., 2019; Mackie et al., 2021). Participants agreed care providers were generally respectful and supportive and strived to create a sense of acceptance (Acosta et al., 2019). School counseling was identified as an accepting space (Mackie et al., 2021). The school counselor reacted to participants in a supportive and non-judgmental manner impacting participants' sense of inclusion and connectedness with the service and school (Mackie et al., 2021).

Experiences of healthcare interventions

Experiences of healthcare interventions (e.g., puberty blockers, HRT, and surgery) and factors associated with these experiences were noted across six studies. Provision of interventions was described as frustrating and disorganized (Carlile et al., 2021; Riggs et al., 2020). Convincing providers of the need for interventions was described as frustrating (Carlile et al., 2021).

One TGD youth was advised 6 months of HRT would remove their ability to reproduce; however, they saw other TGD people reproduce, causing confusion (Carlile, 2020). After being diagnosed with gender dysphoria, a participant was left without a referral to gender specialist services despite serious mental health issues related to their dysphoria (Carlile et al., 2021).

Non-binary participants were disappointed with lack of medical interventions available (Pullen-Sansfaçon et al., 2019). Transgender non-binary participants hid their non-binary identity from providers due to fears of interventions being stopped (Carlile et al., 2021).

Participants' mental health was positively affected by interventions. Accessing hormone therapy resulted in positive outcomes to wellbeing (Carlile et al., 2021). Medical interventions reduced the prevalence of suicidal ideation and self-harm (Pullen-Sansfaçon et al., 2019). Interventions instilled a sense of relief, greater optimism for the future, and positively impacted overall wellbeing (Pullen-Sansfaçon et al., 2019).

Negative effects of medical interventions were also explored. Gender dysphoria increased for one participant taking a daily high-dose contraceptive (Carlile et al., 2021) with other youth developing stress fractures which were attributed to puberty blockers (Pullen-Sansfaçon et al., 2019). Puberty blockers caused several physical symptoms such as hot flushes and excessive sweating (Pullen-Sansfaçon et al., 2019). Some participants' gender identity was not affirmed by puberty blockers (Riggs et al., 2020). Attending clinics for blood tests and assessments took away from other aspects of participants' lives (Pullen-Sansfaçon et al., 2019). Despite potential negative effects of interventions, participants expressed they would not consider discontinuing them (Pullen-Sansfaçon et al., 2019).

Discussion

This review aimed to identify and synthesize qualitative research on healthcare experiences of TGD youths in healthcare settings. Care avoidance was reported by several TGD youths citing fear of no parental support, and discriminatory experiences within healthcare services and with providers. While TGD youths are at higher risk of negative physical and mental health outcomes, barriers to help-seeking exist which do not allow engagement with healthcare, including discrimination and lack of sensitivity (Safer et al., 2016). Parental support of TGD youths positively impacted mental health and life satisfaction (Simons et al., 2013). Therefore, to improve help-seeking behaviors among youths, supportive and non-judgmental parents and providers would be beneficial.

Cost and geographical location were frequently reported as challenges to accessing gender-affirming care. TGD youths identified feelings of guilt and worry about the cost treatments placed on their households (Kearns et al., 2021). Cost was directly impacted by disparities within insurance plans, particularly in countries such as the USA where universal healthcare is not available (Kearns et al., 2021). The geographical distribution of clinical care for TGD youths was examined in the USA and was found to affect provision of TGD care negatively (Weixel and Wildman, 2022). In the UK, the need for de-centralized gender identity services was highlighted with recommendations for localized gender services (Cass, 2022).

A need for services that are safe, gender-affirming, and knowledgeable was identified. Experiences of participants varied across healthcare services, with particularly positive experiences noted in gender clinics and school counseling. Experiences in primary care services and mental health services, however, were primarily negative. Similar findings were noted within the TransPULSE study which highlighted poor competency among providers, resulting in one-third of participants having unmet healthcare needs (Giblon and Bauer, 2017). Lack of competent providers is also identified within primary care settings, resulting in TGD youths taking an active role in their care provision (Vermeir et al., 2017). Gender clinics were noted for their gender-affirming approach with positive experiences being linked with level of competence (Wright et al., 2021). A lack of competency exists among healthcare providers and responsibility is being placed on TGD youths to address this issue. A standardized gender-affirming approach delivered by competent providers has the potential to positively impact experiences of TGD youths within healthcare.

A lack of adequate TGD healthcare knowledge among healthcare providers and recommendations for additional training needs is regularly acknowledged. To aid in provision of gender-affirming care, the World Professional Association of Transgender Health (WPATH) released version 8 of the Standards of Care for the Health of Transgender and Gender Diverse People (Coleman et al., 2022). This incorporates a need for providers working with TGD youths to have additional training and expertise on gender identity development theory across childhood and adolescence (Coleman et al., 2022). A systematic review of current education provision amongst medical curricula worldwide found that, at undergraduate level, medical staff received between an hour to half a day of TGD specific education (Van Heesewijk et al., 2022). The Cass Report (Cass, 2022), which assessed current provision of gender specialist care in the UK, noted to provide a safe, viable long-term service, a multi-specialist provider approach including equal access to interventions for TGD youths is required. Further education provision and a review of current service provision are required to meet the standards and recommendations outlined by WPATH (Coleman et al., 2022).

Misgendering and deadnaming were reported frequently. Many linked misgendering and deadnaming to lack of provider knowledge of TGD healthcare. Of note, Stroumsa et al. (2019) posited a lack of correlation between increased knowledge and reduction in transphobia among healthcare providers. Using regression analysis, no reduction in transphobia was identified when TGD healthcare knowledge was increased. Discrimination is experienced frequently within primary care by TGD youths (Vermeir et al., 2017). Despite barriers of current educational programs such as lack of TGD healthcare resources, it is imperative that undercurrents of transphobia are addressed (Van Heesewijk et al., 2022).

Positive physical and mental health benefits of healthcare interventions were explored. Participants reported their desire to remain on treatments despite side-effects. A 60% and 73% reduction in odds of depression and suicidality, respectively, among TGD individuals who utilized healthcare interventions was identified (Tordoff et al., 2022). Lengthy waiting time and assessment period reduced participants' ability to access medical interventions. Additional forms of appointment provision, including telehealth, and online video calls are being utilized in healthcare (Haleem et al., 2021). Telehealth was identified as a tool that would benefit the overall impact of cost and productivity (du Toit et al., 2021; Frye et al., 2022; Snoswell et al., 2022). The First Assessment Single-Session Triage (FASST) system was found to improve levels of depression, anxiety, and quality of life by reaching TGD youths earlier (Dahlgren Allen et al., 2021). A review of current waitlist systems and incorporation of additional methods of communication could reduce wait times of TGD youths resulting in faster access to medical interventions.

Limitations

Results from this review must be considered in the context of some limitations. While included studies met most critical appraisal criteria, almost half did not report on positionality of researchers, therefore reducing trustworthiness. Reviewed studies were conducted in countries which are classified as higher income countries and with majority Caucasian populations. As such, results may not be generalizable to TGD youths in lower income countries or indigenous or minority racial groupings. Gender specialist services, mental health services, and primary care settings were overrepresented. It is therefore difficult to generalize experiences of TGD youths across other healthcare settings.

At the level of the current review, the search was limited to seven electronic databases and did not include records from Grey literature. Limits also included English language and timeframe, leading to omission of non-English studies and studies published prior to 2016, possibly increasing a risk of study selection bias.

Implications

This review has several implications for healthcare services. To ensure gender-affirming care, services need to engage fully with WPATH standards of care (Coleman et al., 2022). Informed by the Cass report (Cass, 2022), national healthcare services should review sustainability of current models of care employed for gender services. Gender-affirming approaches and TGD competent providers should be adopted across healthcare. Resolving existing transphobia within healthcare should be prioritized in parallel with interventions to increase provider knowledge. Although most studies were conducted within Western countries including the USA, Canada, and UK, the cultural environment of healthcare settings ought to be considered when exploring experiences of TGD youths accessing these facilities. Factors like unconscious bias and diversity within the workforce within these settings should be addressed in future research as this might influence experiences of access.

Reviewing healthcare curricula in higher education and including TGD healthcare would benefit future providers. Reviewing TGD healthcare interventions would benefit future intervention creation.

Conclusion

TGD youths are likely to identify negative experiences within primary care, mental health settings and occasionally gender clinics. While some positive experiences were identified, this was within services that were affirming or were willing to self-educate. Parents and providers can impact help-seeking behaviors of TGD youths, as such a gender-affirming approach should be used. Care disparities were identified across healthcare settings. Parity is necessary to ensure TGD youths avail of the same standard of healthcare services as their counterparts. Using alternative technology to access care, such as telehealth could reduce waiting times and allow quicker access to comprehensive care.

Appendix

Abbreviations

TGD	Transgender and gender diverse
HIV	Human Immunodeficiency virus
CAMHS	Child & adolescent mental health services
HRT	Hormone replacement therapy
SI	Suicidal ideation
DSH	Deliberate self-harm
ED	Emergency department
TGNC	Transgender and gender non-conforming

USA	United States of America
SGD	Sexual and gender diverse
GIDS	Gender identity development services
LGBT+	Lesbian, gay, bisexual transgender+
UK	United Kingdom
GP	General practitioner
WPATH	World professional association for transgender health.

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Supplemental Material

Supplemental material for this article is available online.

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