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Affirming Care: Lessons from Minority Stress Model to Bolster Mental Health Outcomes for LGBTQ+ Youth in Primary Care

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Individuals in positions of power influence youth wellbeing, self-perception, and overall mental health. According to the minority stress model, individuals who hold marginalized identities, such as LGBTQ+ youth, face unique, chronic, and socially based additive stressors. Research shows that these additive stressors contribute to LGBTQ+ youth experiencing disproportionate rates of mental health concerns. Queer youth are more than four times as likely to attempt suicide than their non-queer identifying peers. Additive stressors that LGBTQ+ youth face include prejudiced events, stigma, decisions of concealment or disclosure, and internalized homophobia and transphobia. This paper will review and integrate research, utilizing the minority stress model as a foundation for understanding primary care physicians' roles in contributing to or dismantling the historical harm that queer youth encounter within the United States healthcare system and beyond. The application of this model allows for an investigation of both individual and systemic factors contributing to the queer youth mental health crisis, advocating for accountability and change for both individual providers and the healthcare system at large. Findings from this integrated review illuminate lessons for primary care physicians to improve mental health outcomes for their queer youth patients. Action steps are recommended, and local, state, and national resources are provided.

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Abstract

Individuals in positions of power influence youth wellbeing, self-perception, and overall mental health. According to the minority stress model, individuals who hold marginalized identities, such as LGBTQ+ youth, face unique, chronic, and socially based additive stressors. Research shows that these additive stressors contribute to LGBTQ+ youth experiencing disproportionate rates of mental health concerns. Queer youth are more than four times as likely to attempt suicide than their non-queer identifying peers. Additive stressors that LGBTQ+ youth face include prejudiced events, stigma, decisions of concealment or disclosure, and internalized homophobia and transphobia. This paper will review and integrate research, utilizing the minority stress model as a foundation for understanding primary care physicians' roles in contributing to *or* dismantling the historical harm that queer youth encounter within the United States healthcare system and beyond. The application of this model allows for an investigation of *both* individual and systemic factors contributing to the queer youth mental health crisis, advocating for accountability and change for both individual providers and the healthcare system at large. Findings from this integrated review illuminate lessons for primary care physicians to improve mental health outcomes for their queer youth patients. Action steps are recommended, and local, state, and national resources are provided.

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Affirming Care: Lessons From Minority Stress Model to Bolster Mental Health Outcomes for LGBTQ+ Youth in Primary Care

This paper utilizes the Minority[1] Stress Model (Meyer, 2003) as a foundation for understanding and integrating existing research on systemic and individual contributors to the queer[2] youth mental health crisis. The aim of this integrative review is to create a guide, grounded in empirical research, for primary care physicians to minimize harm perpetuated on LGBTQ+ youth within the United States medical healthcare system – a system founded in harmful heterosexist, transphobic, and racist beliefs (Safer et al., 2016; Yearby et al., 2022).

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[1] In 2021, APA released Inclusive Language Guidelines aimed at examining and acknowledging language that has been used within the field of psychology to perpetuate harm toward marginalized communities. These guidelines strive to aid the field in moving toward language the creates psychological safety, inclusivity, and respect for all. In these guidelines, APA defines "minority" as "a population subgroup with differential power than those deemed to hold the majority power in the population." That said, APA notes that this is an outdated term, one that contributes to biases of marginalized individuals being *less than*, is not an accurate representation of demographics, contributes to the minimization of cultural influence, and perpetuates violence. Rather, APA suggests the use of specific names of the group being referred to (i.e., people of color vs. racial minorities; queer individuals vs. sexual minorities). Throughout this paper, the phrase "minority stress model" will be utilized to credit Meyer's original work in understanding LGBTQ+ mental health. Beyond direct references to Meyer's model, the terms 'marginalized,' 'LGBTQ+,' 'queer,' and other specific subgroup population names, will be used in accordance with APA's Inclusive Language Guidelines.

[2] Throughout this paper, the terms "queer" and "LGBTQ+" will be utilized as umbrella terms for the queer community, while recognizing a variety of unique identities and experiences within. Some research here-within attempts to examine the unique experiences of lesbian, gay, and bisexual individuals, and thus utilizes the acronym "LGB" as opposed to "LGBTQ+." The Human Rights Campaign (HRC) defines LGBTQ+ as "An acronym for "lesbian, gay, bisexual, transgender and queer" with a "+" sign to recognize the limitless sexual orientations and gender identities used by members of our community." Additionally, HRC defines "Queer" as "A term people often use to express a spectrum of identities and orientations that are counter to the mainstream; often used as a catch-all to include many people, including those who do not identify as exclusively straight and/or folks who are non-binary or gender-expansive." The HRC notes the historical harm of the term "queer" previously used as a slur, while recognizing the recent reclamation of the term by many within the LGBTQ+ community. Throughout this paper, the terms 'LGTBQ+' and 'queer' will be used interchangeably.

Throughout this paper, it is argued that youth mental health and wellbeing *should* be policy and practice priority, as prioritizing mental wellbeing of patients from an early age has the potential to lead to a healthier, more affirming and inclusive society at large. That said, youth mental health is often overlooked, underfunded, under-resourced, and exacerbated by harmful policy. In 2018, suicide was the second leading cause of death amongst young people aged 10 to 24 (Hedegaard et al., 2018). According to the Partners for Children's Mental Health State of Mental Health Report, in 2021, suicide was the number one cause of death among Colorado youth ages 10-19.

LGBTQ+ youth are at an even higher risk of experiencing mental health concerns (i.e., depression, anxiety, etc.) because of how they are mistreated and stigmatized in society (The Trevor Project, 2022). As of April 2023, over 500 anti-trans bills have been proposed at the state level within the United States (Trans Legislation Tracker), with many of these bills aimed at blocking trans people from receiving basic healthcare. Additionally, as of April 2023, an unprecedented 23 anti-trans bills have been introduced at the federal level, with aims of impacting access to healthcare, athletic participation, and education, nation-wide. This oppressive legislation has a direct impact on queer mental health.

It is crucial to emphasize that the disproportionate rate of mental health concerns amongst queer youth is a product of existing in a homophobic and transphobic society, rather than an inherent risk within sexual orientation or gender identity. Based on the minority stress model, LGBTQ+ individuals experience mental health disparities due to LGBTQ+-based victimization, internalization of these experiences, and anti-LGBTQ+ messaging (Meyer, 2003). Additional stressors specific to LGBTQ+ youth include familial rejection, lack of other social support, lack of affirming spaces (such as schools, sports teams, medical providers), transphobic and anti-

LGBTQ+ legislation, and discrimination. Importantly, the impact of the stress from these systems of oppression may be most persistent for individuals who hold multiple intersecting marginalized identities.

Due to the factors mentioned above, LGBTQ+ youth experience disproportionate rates of suicidal ideation – Johns et al. (2020) noted that LGBTQ+ youth are more than four times as likely to attempt suicide than their heterosexual peers. Additionally, transgender and nonbinary youth have an even higher risk, in which they are 2 to 2.5 times as likely to experience depressive symptoms and consider or attempt suicide, compared to their cisgender queer peers (Price-Feeney et al., 2020). It is important to consider the intersectionality of identities within the LGBTQ+ community, as experiences are impacted by interwoven systems of privilege and oppression. For instance, The Trevor Project's 2021 National Survey found that, in 2021, LGBTQ+ youth of color reported higher rates of suicide attempts than their queer, white peers. Specifically, they found that 12% of white youth attempted suicide, compared to 31% of Native/Indigenous youth, 21% of Black youth, 21% of multiracial youth, 18% of Latinx youth, and 12% of Asian/Pacific Islander youth (The Trevor Project, 2021).

Individuals within positions of power, such as caretakers, teachers, coaches, lawmakers, politicians, and doctors, have the ability to impact queer youths' perception of self, sense of community and safety, self-esteem, and overall mental health. This paper aims to educate and empower primary care physicians to examine their role in contributing to *or* dismantling the oppressive practices that exist within the healthcare system and their impact on queer mental health.

Integrated Literature Review

History and Impact of DSM Classifications

In 1973, the American Psychiatric Association (APA) removed the diagnosis of "homosexuality" from the Diagnostic and Statistical Manual (DSM). That said, it is important to understand the beliefs and viewpoints that led to its inclusion in the DSM, its removal from the DSM, and the lingering impacts.

Drescher (2015) identified three broad descriptive categories of homosexuality theories throughout modern history: (a) pathology; (b) immaturity; and (c) normal variation. He elaborated that the theories of pathology regard homosexuality as a disease, deviation from "the norm" of heterosexuality, and a psychopathological disorder which mental health professionals must treat. Drescher (2015) noted that theories of immaturity regard "homosexual feelings" as a "passing phase that one should outgrow." According to these immaturity theories, if one does not outgrow this phase, they may be considered to have "stunted growth." He identified theories of normal variation as those that recognize homosexuality as a naturally occurring phenomenon, in that people are "born gay," and thus homosexuality is not viewed as a psychiatric concern.

The first publication of the DSM (APA, 1952) was largely influenced by psychoanalytic perspectives, which viewed homosexuality as pathological, and heterosexuality as the only biological norm (Drescher, 2015). Thus, the DSM-I classified "homosexuality" as a "psychopathic personality with pathologic sexuality" (APA, 1952, p. 39). While psychiatrists and psychologists were trying to "cure" homosexuality, sex researchers at the time, such as Alfred Kinsey and colleagues, were studying non-patient populations. They found that homosexuality was more common in the general population than was broadly believed, particularly by those psychiatrists who viewed homosexuality as extremely rare (Kinsey et al.,

1948; 1953). Further, psychologist Evelyn Hooker published a study in 1957 that found that gay males had no more signs of psychological disturbances than heterosexual males, refuting the psychiatric beliefs at the time that all gay men had severe psychopathology (Hooker, 1957). The DSM-II (APA, 1968) changed the classification of "homosexuality" from "psychopathic personality with pathologic sexuality" to "sexual deviation."

Factors within APA as well as outside of APA contributed to the reconsideration of homosexuality's place in the DSM-III. The Stonewall Riots in 1969, the inclusion of gay activists providing educational panels at the annual APA meetings in 1971 and 1972, and the 1973 deliberation of homosexuality, were just several factors occurring around this time period, which contributed to the removal of homosexuality from the DSM-III in 1973. Considering all of this, APA's diagnostic reconstruction can potentially be considered "the beginning of the end" of organized medicine's *overt* participation in social stigmatization of LGBTQ+ individuals. The removal of this diagnosis led to a vital shift away from asking "what *causes* homosexuality and how do we *cure* it" to concentrating instead on the health and mental health needs of queer individuals and communities (Drescher, 2015).

Similar to the DSM's history of homophobia, the DSM has a long history of contributing to transphobic narratives and policies. In fact, these histories are related – just as the DSM removed homosexuality as a mental health disorder in 1973, gender identity disorders were introduced (Chang et al., 2018). The diagnosis of transsexualism was introduced in the DSM-III (APA, 1980) and was later shifted to gender identity disorder in the DSM-IV-TR (APA, 2000). These categories classified gender identity as disordered or pathological – a mental illness that required "curing" – similar to the earlier medicalized views of sexual identity. In the 2013 publication of the DSM-5 (APA, 2013), the diagnosis of gender identity disorder was replaced

with gender dysphoria, which remains the current diagnosis utilized for transgender folks to justify medical necessity for gender-affirming medical care (Chang et al., 2018). While this shift demonstrates some progress in focusing on distress rather than identity, it does not allow for the recognition of healthy, disorder-free, experiences of a transgender individuals (Winters, 2013). Additionally, the gender dysphoria criteria assume a homogenous experience of trans identity, which can contribute to medical gatekeeping and denial of gender-affirming care for trans individuals who do not meet full criteria for gender dysphoria (Chang et al., 2018). Further, this model of trans health care relies on pathology to justify treatment, minimizing and invalidating the desire to move toward authenticity and affirming oneself (Chang et al., 2018). Ultimately, as long as transgender identities are viewed through a pathological disease framework, transgender people will continue to experience invalidation, abuse, oppression, and discrimination, from within and beyond the medical field.

An example of a recent movement away from treating queerness as a disease that requires "curing" is the slow progression toward banning conversion "therapy" in the United States. Conversion "therapy" is a harmful practice in which a "helping professional" attempts to "change" one's sexual orientation or gender identity, through violent and unethical tactics such as shaming, hypnosis, inducing vomiting, or electric shocks (Movement Advancement Project, 2017). This terrorizing practice can result in increased shame and stigma of queer youth, as well as contribute to relational divisions amongst children and "trusted adults." California was the first state to ban conversion "therapy" in 2012, and as of January 2023, twenty states within the United States have followed, including Colorado in 2019 (Movement Advancement Project, 2023). While this progress offers some hope, we as a country are far from recognizing the life-threatening impacts of the combination of lack of protective and affirming legislation, with

ongoing legislation that perpetuates beliefs about queerness as a disease, as thirty states continue to uphold partial or non-existent conversion "therapy" bans.

Overall, this painful history is helpful in illuminating the power that health providers have in either contributing to and upholding *or* intentionally and persistently dismantling the stigmatization of marginalized identities within our society. Bailey (1999) argued that this history has contributed to the longstanding stigmatization of LGB individuals. He noted that the higher prevalence of mental health concerns amongst LGB individuals has been historically attributed to stigmatized, antigay beliefs, rather than recognizing the disproportionate rates as a product of systems of oppression that queer individuals endure within our society. The minority stress model (Meyer, 2003) helps us to understand the impact of systemic oppression on queer mental health and will guide the recommendations within this paper.

Minority Stress Model

All individuals within society endure stress, both on an individual and environmental level, requiring adaptation and coping. That said, the minority stress model highlights and distinguishes the *excess* stress that individuals who hold marginalized and stigmatized identities must endure, as a result of their oppressed social position. Thus, the minority stress model indicates a range of external events and conditions, as well as the internalization of these messages and experiences as impacting mental health conditions amongst marginalized individuals, such as LGBTQ+ youth (Meyer, 2003). Meyer's (2003) conceptualization, rooted in meta-analyses, helps us to understand the higher prevalence of mental health disorders amongst queer individuals as a product of the stress that they must endure as they exist in and survive in a heterosexist and transphobic culture, rather than a product of intrinsic aspects of queerness.

Before elaborating on Meyer's minority stress model, let us first acknowledge the fact that the title of this model is stated from a position of privilege. As mentioned above, the term "minority" is outdated, as it contributes to narratives of marginalized individuals and communities being *less than*, is an inaccurate representation of true demographics, contributes to the minimization of cultural influence, and perpetuates violence. Morris (2019) argues that the term "minority" implies the designation is rooted in data and census results, but in actuality, it is a socially constructed designation, rooted in racism and white supremacy, with the function of maintaining white privilege and power. Ibram X. Kendi (2016) notes that the term "minority" only makes sense from the viewpoints of white individuals, who commonly related to Black individuals as numerical minority, thus reinforcing systems of power and oppression which allowed white people to maintain privilege and institutional power. While Meyer uses the term "minority" to refer to the queer community, he neglects to address the inherent perpetuation of systems of power and oppression within the title of his model, as well as the differential cost of stress experienced amongst intersectional identities *within* the queer community. This paper aims to address these gaps, while using the model's recognition of queer individuals being forced to navigate additional barriers and stressors through systems of homophobia and transphobia, to guide primary care physicians in providing affirming care to queer youth.

Meyer (2003) highlighted three underlying and defining features of minority stress: it is (a) unique, in that it is additive to general stress experienced by all people, therefore requiring increased adaptation exertion; (b) chronic, in that it is a product of relatively stable and long-standing social and cultural systems of power; and (c) socially based, in that it stems from institutions and structures beyond the individual.

Additionally, Meyer (1993; 2003) articulated four stress processes relevant to LGBTQ+ individuals, including the (a) experience of prejudice events; (b) vigilance in interactions and expectations of rejection; (c) hiding and concealing identity for fear of harm; (d) internalized stigma/homophobia. These four stress processes foster an understanding of the higher prevalence of mental health concerns within the LGBTQ+ population. These four stress processes are detailed below.

Stress Process 1: Prejudiced Events

Antigay violence and discrimination are foundational stressors that have been shown to impact queer mental health (Garnets et al., 1990; Herek et al., 1999). Institutionalized forms of prejudice and violence have persisted throughout our history. In 2001, Amnesty International reported that LGBTQ+ people are subjected to vast human rights abuses, ill treatment, and violence. They noted that many of these abuses are permitted and exacerbated by governments and society through mechanisms such as laws and prejudiced traditions (i.e., influence of religious traditions on policy and practice) (Amnesty International, 2001). Research has demonstrated that queer individuals are disproportionately impacted by prejudice events, including discrimination (i.e., being fired from a job) and violence (i.e., sexual assault, physical assault, robbery, property crime) related to their sexual orientation (Herek et al., 1999; Mays & Cochran, 2001). Schmitt et al. (2014) examined effect sizes of perceived discrimination on psychological well-being (i.e., self-esteem, depression, anxiety, psychological distress, and life satisfaction). Through the examination of 328 studies (N = 144,246), they found varying impacts of perceived discrimination across intergroup contexts (i.e., experiences of racism, heterosexism, discrimination based on mental or physical illness, weight-bias, etc.). Of note for this paper, they found that experiences of heterosexism have a strong negative impact on well-being (an overall

effect size of r = -0.28 ($p<.05$)). These results support the idea that pervasive discrimination has harmful effects on psychological well-being.

Research suggests that queer youth have an even higher prevalence and psychological impact of antigay prejudice events than their adult counterparts. Schmitt et al. (2014) found higher negative effect sizes of discrimination on well-being for children than adults, indicating that children are likely at more risk of negative psychological outcomes after experiencing prejudice than their adult counterparts. This data was supported by Lee and Ahn (2013) whose meta-analysis of Black American's experiences of discrimination distress found that the relationship between racial discrimination and psychological distress was higher for youth (defined as younger than 16 years old) than adults. Both groups of researchers (Lee & Ahn, 2013; Schmitt et al., 2014) hypothesized that as children mature and are socialized, they acquire resources and develop strategies to more effectively cope with discrimination, thus decreasing the effect on their psychological well-being as they age. The 2019 GLSEN School Climate Survey, completed by 16,713 youth from across the US, found that LGBTQ+ students who experienced higher levels of victimization and discrimination based on their sexual orientation and gender expression had lower self-esteem and feelings of belonging, and higher levels of depression. Further, Goldbach et al. (2014) found that experiences of victimization, threats, and violence were strongly correlated ($\bar{r}$ = .60) with substance use by LGB adolescents. Meyers et al. (2020) highlighted the particular salience of family rejection and peer victimization on LGBTQ+ youth mental health, given the developmental importance during adolescence.

Stress Process 2: Stigma

Through the process of learning to survive within heteronormative and transphobic systems, queer youth may come to hold expectations of rejection and discrimination and may

protect themselves through vigilance in interactions. Since the early 1950s, vigilance has been understood as a protective and adaptive coping mechanism to perceived prejudice (Allport et al., 1954). Over time, queer individuals learn to anticipate negative perception from dominant culture, and thus exert energy to maintain vigilance. Based on the stigma-based rejection sensitivity model (Mendoza-Denton et al., 2002), individuals who have experienced the harm of stigmatized beliefs, may anxiously anticipate, and regularly notice judgement and harm, as a means of protecting themselves from ongoing oppression. Studies have shown that expectations of stigma can diminish social and academic functioning and performance in stigmatized individuals (Crocker et al., 1998). Everyday microaggressions and slights contribute to the stigma associated with being queer, particularly for queer youth in schools. For instance, in 2019, almost all LGBTQ+ students surveyed by GLSEN (98.8%) heard "gay" used with a negative connotation (e.g., "that's so gay") at school and 91.8% of these youth reported feeling distressed and unsafe because of this language use (GLSEN, 2019).

Stress Process 3: Concealment vs. Disclosure

Miller and Major (2000) noted the paradoxical effect of concealment: while it is often used as a way of coping with stigmatization and oppression, it can, in and of itself, contribute to increased stress levels. Schmitt et al. (2014) found that concealable stigmatized identities had a higher negative effect size (r = -0.30) on well-being than non-concealable identities (r = -0.21). Schmitt et al. (2014) speculated that this may be due to the additional stress, diminished support, required suppression, and constant internal dilemma of when, where, and with whom to disclose their 'concealed' identity (such as sexual orientation or gender identity). Other researchers point to the increased cognitive exertion and burden of conscious and unconscious hiding (Smart & Wegner, 2000) and the pattern of suppression leading to intrusive thoughts and thus

psychological distress (Major & Gramzow, 1999). Petrie et al., (1995) noted that repression and inhibition, while potentially protective, also affect immune and health outcomes. They noted that expression of emotions and experiences improved immune functioning. Specifically, within the queer community, Cole et al., (1996) found that HIV infection accelerated more quickly amongst gay men who concealed their sexual orientation than those who did not conceal. Additionally, concealment may increase barriers to identifying and affiliating with other queer individuals, which may be beneficial for social support and mental health outcomes. While "coming out" has been linked to mental health benefits (Ragins, 2004), the process can be intensely stressful and create a loss of well-being (D'Augelli, 2006), especially upon negative disclosure reactions, which have been correlated with substance use among LGB youth (Goldbach et al., 2014). Overall, negotiating "outness" requires an immense and taxing cognitive, physical, spiritual, and emotional burden (Chaudoir & Fisher, 2010; Halkitis et al., 2009).

Stress Process 4: Internalized Homophobia and Transphobia

Queer individuals may experience harm and self-devaluation through the process of internalizing and directing negative societal values and views toward themselves. Early social psychological models argued that self-concept develops through social interactions, suggesting that others' views of oneself are frequently internalized (Goffman, 1963). Thus, perceived discrimination may diminish psychological well-being by threatening the basic needs for acceptance and inclusion (Schmitt et al., 2014). The strength of early socialization experiences within a hetero-and-cis-normative society, as well as chronic experiences and continued exposure to homophobic and transphobic stigmatization, contribute to varying degrees of internalized homophobia and transphobia, which inevitably impact queer mental health (DiPlacido, 1998; Meyer & Dean, 1998; Williamson, 2000; Bockting, 2015).

Intersectionality and Cumulative Harm

While some research silos identities to attempt to clarify correlational variables, this process is minimizing and incongruent to the entire human experience. Kimberlé Crenshaw first introduced the theory of intersectionality in 1989, acknowledging the complex, cumulative way in which multiple forms of discrimination (such as racism, sexism, and classism) combine, overlap, and intersect, particularly in the lives and experiences of marginalized individuals or groups. This intersectional marginalization acts to produce and sustain complex inequalities within our society, and the systems within (Crenshaw, 1989).

It is vital to consider the impact of LGBTQ+ youth holding multiple intersecting, marginalized identities. For instance, research has shown that people of color must confront racism within the queer community *and* homophobia within their racial and ethnic communities (Chan, 1995). Likewise, queer women must confront the sexism inherent in our patriarchal society, and transgender individuals must navigate a transphobic social climate. Future research could benefit from the examination of the minority stress model for individuals who hold multiple intersectional, marginalized identities. The 2019 GLSEN National School Climate Survey found that many LGBTQ+ students of color experienced victimization based on both their race/ethnicity and their LGBTQ+ identities, and Native and Indigenous LGBTQ+ students were generally more likely than other racial/ethnic groups to experience anti-LGBTQ+ victimization and discrimination. Research often fails to explore within-group differences among LGBTQ+ youth, however, the research that does exists highlights increased suicide risk among nonmonosexual youth (i.e., bisexual, pansexual, etc.), transgender and nonbinary youth, and LGBTQ+ youth of color (Bernard et al., 2021; Callis, 2013; Testa et al., 2017).

Additionally, it is valuable to examine the *cumulative* risk associated with stress rooted in oppression, in that multiple negative experiences compound to produce even greater risk for worse mental health outcomes than any single risk factor. Research on adverse childhood experiences (ACEs) highlights the importance of this cumulative perspective (Thompson et al., 2019). A recent study (Clements-Nolle et al., 2018) of the association between ACEs and suicide risk among LGBQ youth found that LGBQ youth with *no* ACEs had nearly four times greater odds of reporting a suicide attempt compared to heterosexual peers with *no* ACEs, while those with three or more ACEs had more than 13 times greater odds of a suicide attempt compared to heterosexual peers with three or more ACEs. Thus, the multiple forms of victimization experienced within the LGBTQ+ community via multiple marginalized identities and cumulative minority stress risk, results in worse mental health outcomes. Therefore, when working with LGBTQ+ youth, primary care physicians must be mindful of the patient's intersecting marginalized identities and experiences of cumulative harm in order to reduce negative impacts of their own power and privilege within the dyad. It is imperative that primary care physicians are working to build awareness of the impact of their own privileged and marginalized identities in order to be able to best show up for queer youth.

Additional Impacts of Minority Stress Among Queer Individuals

Physical Health

Stress endured through experiences of oppression does not just impact mental health, it has also been shown to impact physical health. Frost et al. (2015)'s study of 396 LGB individuals demonstrated that prejudice-related stressful life events have a *unique* harmful impact on individual's physical health (such as cancer, flu, asthma, and hypertension) that persists beyond the effect of non-prejudicial stressful life events. Experiences of discrimination

have also been linked to high blood pressure and cardiovascular disease, (Williams & Mohammed, 2009). Djuric et al. (2010) noted that cumulative burden through daily experiences and adaptation to excessive stress is a risk factor for obesity, diabetes, and inflammatory and autoimmune disorders.

Substance Use

Goldbach et al. (2014) highlighted impacts of oppression-based stress on LGB substance use. They noted that LGB adolescents report higher rates of substance use, particularly the use of cigarettes, alcohol, marijuana, cocaine, and ecstasy, than their heterosexual peers (Corliss et al., 2010; Marshal et al., 2008; Russell et al., 2002). Through a meta-analysis of 12 unique studies of LGB youth, Goldbach et al. (2014) concluded that the strongest risk factors for LGB substance use were victimization, lack of supportive environments, psychological stress, internalizing and externalizing problem behaviors, negative disclosure reactions, and housing status.

Houselessness

For LGB youth, homelessness is often related to their sexual orientation, in that they may run away following negative disclosure, internalized homophobia influenced by homophobic familial messages, or be evicted by their parents. For some LGBTQ+ youth, familial rejection can lead to being unhoused, which is associated with higher rates of substance use and suicide attempts (Rhoades et al., 2018).

Stress-Ameliorating Factors / Minority Strengths Model

Perrin et al., (2020) highlight the deficit-based approach of the minority stress model, and, in response, created a minority strengths model. This strengths-based model outlines both personal and collective strengths within marginalized populations that create resilience and positive mental and physical health. Some of these strengths-based factors include social support,

community connectedness, identity pride, self-esteem, resilience, positive mental health, and health-promoting behaviors.

Other researchers have identified multiple ways that marginalized individuals cope and build resilience against the impacts of oppression-based stress. Some of these stress-ameliorating factors include: marginalized group affiliations, including belonging to community in which they do not experience stigma (i.e., feeling a sense of belonging within the LGBTQ+ community); belonging to community which provides support for negative perceptions by the privileged social group; self-evaluation in comparison to others like them as opposed to members of the privileged culture; and validation and re-appraisal of stressful conditions (Jones et al., 1984; Thoits, 1985). Hershberger and D'Augelli (1995)'s early research demonstrated the ameliorating impact of family support and self-acceptance on the effect of antigay abuse on LGB adolescent mental health. All this said, it's important to note that coping in itself can add stress, such as coping with the stigma by concealing one's identity, which adds a psychological cost (Smart & Wegner, 2000). Additionally, individuals experiencing oppression are often expected to carry the burden of coping, rather than the accountability falling on the oppressive systems causing the distress. Thus, people in positions of authority (i.e., medical providers) have the greatest responsibility in intentionally and actively shifting these oppressive systems.

LGBTQ+ youth are disproportionately impacted by stress rooted in experiences of oppression and marginalization and therefore experience higher rates of mental health concerns – there are a number of protective factors that may serve as buffers for the risks discussed. One key protective factor for LGBTQ+ youth is having at least one accepting adult in their life – The Trevor Project found that this factor alone can reduce the risk of suicide attempt among LGBTQ+ youth by 40% (The Trevor Project, 2019). Additionally, Goldbach et al. (2014) found

that parental support and support from other adults (particularly at school) had significant correlations with substance use among LGB youth, thus that LGB youth who perceived more adult support of their identity, reported lower levels of substance use than their LGB peers with less perceived support. Another protective factor is having affirming spaces and activities, such as extracurricular clubs, the presence of Gender and Sexualities Alliances (GSAs) within schools (Toomey et al., 2011), or supportive spiritual or religious groups. Additionally, policies and practices, such as use of affirming pronouns, affirming legal documentation, and access to gender affirming medical care, are associated with positive mental health outcomes (Green et al., 2021; The Trevor Project, 2021).

Utility of Minority Stress Model

The minority stress model is beneficial, in that it identifies *both* the subjective (individual appraisal) and objective (societal, system-level) influences of stress on an individual's mental health. This view allows for interventions on the individual level, in aiding individuals to cope, find community and support, and build resilience to the stressors they face. Importantly, this view *also* allows for a recognition of the stress-inducing and oppressive environment as a major contributor to the burden that marginalized individuals disproportionately face. Thus, interventions can be targeted on a public policy and advocacy level – recognizing the impact of society on the individual, rather than simply placing the burden to cope on the individual – re-focusing our attention on the systemic contributors, rather than blaming the individuals in marginalized positions. Therefore, we can utilize this minority stress model to aid our understanding of how key contributors to LGBTQ+ health and wellbeing, such as primary care doctors, can utilize their power to decrease the impact of oppression on queer youth mental health.

Role of Primary Care Providers

Differential Access to Quality Medical and Mental Health Care for LGBTQ+ Individuals

Braveman et al. (2017) define health equity as the guarantee that everyone has fair and just opportunity to be healthy as possible. They note that this requires removing obstacles to health such as poverty, discrimination, and lack of access to fair paying jobs, education, safe housing, and health care. Throughout history, LGBTQ+ individuals have experienced barriers to receiving quality medical and mental health care. In 2011, The Joint Commission held a one-day LGBTQ+ stakeholder meeting aimed at identifying and discussing ways to advance culturally competent and patient-and-family-centered care for the LGBTQ+ community. The group of experts included individuals with a variety of backgrounds aimed at advancing LGBTQ+ equity and wellbeing. The commission identified several barriers that LGBTQ+ individuals face in their access to equitable care, including but not limited to refusal of care, substandard care, insensitivity to unique needs, mistreatment, perpetuation of stigma, inequitable policies and practices, and non-affirming visitation policies (The Joint Commission, 2011). Knight & Jarrett (2017) identified additional barriers including: lack of welcoming environment, lack of health insurance coverage, lack of communication, lack of high-quality research and evidence-based guidelines. Many of these barriers remain, in various forms, today. Boyer et al. (2022) surveyed 156 transgender adolescents and found that non-affirming healthcare experiences were associated with healthcare avoidance, exacerbating health disparities.

Impact of Medical Doctors on LGBTQ+ Youth Mental Health

The 2001 Amnesty International report, “Crimes of Hate, Conspiracy of Silence” highlighted the ill-treatment of LGBT people, as well as implicated health-care professionals as complacent and active perpetrators of this violence. It is vital to examine health professionals

and institutions' passive and active contributions to the oppression of the LGBTQ+ community, and subsequent decline in mental health, experienced by queer youth.

Meyer's review of the Amnesty International report highlights the importance of health-care professionals recognizing that social environments that condone prejudice against LGBT people – thus promoting isolation, invisibility, and shame – are detrimental to physical and mental health (Meyer, 2002). Additionally, Meyer (2002) emphasized the power and positionality that the field of medicine, broadly speaking, and the individuals implementing medicinal practices, have on upholding and regulating the boundaries of 'social normality.' He argues that this institutionalized homophobia and transphobia within the medical field have direct mental health implications for the queer community. It is vital for primary care physicians to be mindful of their inherent power and potential to contribute to harm with their LGBTQ+ youth patients.

In addition to the inherent positional power within the primary care physician role, family doctors must also consider their *own* intersecting identities, including those that are both historically marginalized and historically privileged. Moreover, beyond reflecting on their own intersecting identities, primary care physicians must also be able to examine the intersection of their identities with their patients' identities, with a mindfulness around the potential impacts of their own positions of privilege. McPherson & McGibbon (2010) argue that an understanding of the social determinants of health, identity, and geography, is pivotal in guiding policymakers and primary care physicians as they address youth mental health inequities. Approaching and understanding of self and others from an intersectional lens allows for physicians to explicitly attend to complex interactions among root causes for LGBTQ+ youth mental health inequities. Thus, physicians and other treatment team members must be willing and able to recognize and

attend to differential experiences amongst queer youth. For example, they must acknowledge and attend to differential impacts and barriers to care for queer youth of color from their white peers. Similarly, they must be able to acknowledge the additive burden on transgender and gender expansive youth as they navigate historically oppressive healthcare systems and sociopolitical climates, as compared to their cisgender queer counterparts. Within these, they must approach this work with humility, recognizing that intentions may differ from impacts, and when microaggressions or mistakes inevitably occur, they must be willing to acknowledge, apologize, and commit to ongoing learning.

Results

Lessons Learned from Minority Stress Model

While there is a need for increased queer affirming psychotherapy services, therapy alone will not be sufficient to end the crisis of queer mental health. Minority stress model points to the importance of holistic, preventative models to reduce the ongoing perpetuation of harm on our queer youth. Therefore, minority stress must be addressed through policies and ongoing training that explicitly prohibits identity-based discrimination *and* affirms and protects the identities of queer youth (Green et al., 2021) within families, schools, and community providers, such as primary care physicians.

A synthesis of the data described throughout this paper illuminates several key takeaways for primary care providers to minimize the harm they cause and improve mental and physical health outcomes through their interactions with LGBTQ+ youth patients. Let us examine each key process of the minority stress model to highlight an understanding of primary care providers' role in minimizing harm and promoting growth with their LGBTQ+ youth patients. As detailed throughout this paper, the key processes of the minority stress model include (a) prejudiced

events; (b) stigma, vigilance, and expectations of rejection; (c) decisions of concealment vs. disclosure; (d) internalized homophobia**.**

Lessons for Primary Care Providers, Informed by Minority Stress Model: Dismantling Prejudice

In order to work toward dismantling prejudice experienced by LGBTQ+ youth within the primary care setting, physicians and healthcare systems should:

- Utilize positional power to advocate on the local and national level against transphobic legislation. The most prominent medical associations (such as, The World Health Organization, American Medical Association, American Academy of Pediatrics, American Psychiatric Association, The Endocrine Society, and The American Academy of Child and Adolescent Psychiatry) have released statements of support for gender-affirming medical care, acknowledging this care as both safe *and* lifesaving (Simon, 2021). Disseminate these statements and the scientific evidence within, to combat the spread of violent transphobic misinformation.
- Post the clinic's nondiscrimination and grievance policies, as well as the patient bill of rights, in accessible and viewable space (viewable to both employees and patients) (Joint Commission, 2011) and establish a culture of accountability for harm inevitably done.
- Incorporate the presence of accessible gender-inclusive restrooms with clear signage.
    - McGuire & Anderson (2022) emphasized the harmful impacts of gender segregated bathrooms on the safety, health, and equality of transgender and gender-nonconforming youth.
    - Gender-*inclusive* restrooms differ from gender-*neutral* restrooms by implementing Universal Design principles (Steinfeld & Maisel, 2012) of minimizing risks to safety, health, and social isolation.
        - **i.** A gender-neutral bathroom is a separate, single stall, bathroom that exists in addition to traditional gender-segregated spaces that already exist, which may be safer than the presence of only gender-segregated spaces but can contribute to increased social isolation and unsolicited assumptions of gender, without autonomy (McGuire & Anderson, 2022).
        - **ii.** A gender-inclusive bathroom is a gender neutral, multiple-user bathroom which replaces gender segregated bathrooms entirely, which may serve to decrease gender policing and safety concerns faced by transgender individuals in gender-segregated spaces (McGuire & Anderson, 2022; Porta et al., 2017).
- Develop and promote inclusive and affirming visitation policies within hospitals and clinics (Joint Commission, 2011). Specifically, it is important to define 'patients' families' as broadly as possible, to include partners, children, friends, or chosen family,

for equitable visitation access. Attention should also be paid to rooming policies and joint decision-making processes.

- Commit to increasing knowledge, awareness, and appreciation of gender equity and sexual rights, and awareness of discrimination and oppression based on gender and sexual orientation (Goldfarb & Lieberman, 2021). Utilize this knowledge to dismantle harmful societal norms, improve trust, and increase support, through the implementation of informed affirming practices.
    - According to the 2019 GLSEN National School Climate Survey, LGBTQ+ youth with supportive staff (in the school environment) reported feeling safer and more sense of belonging than peers with no or few supportive staff.
    - Education and trainings should be developed in collaboration with LGBTQ+ adolescents and their caregivers in order to build trust and center the specific needs and voices of these youth (Noonan et al., 2018).
    - Providers must continuously examine their own intersecting identities, both historically marginalized and historically privileged, to better understand how this influences their positional power while working with queer youth. Within this, they should also work toward continuous deconstruction of harmful implicit biases.
        - **i.** Providers should engage in CEUs, workshops, training, self-reflection, etc.
        - **ii.** For example, in November 2020, University of Southern California released "Diversity Toolkit: A Guide to Discussing Identity, Power, and Privilege" which provides structure for discourse and reflection upon the role of intersecting identities in relationships, both on an individual and systemic level. The toolkit can be modified to fit clinic's specific goals. This toolkit can be found at: https://msw.usc.edu/mswusc-blog/diversity-workshop-guide-to-discussing-identity-power-and-privilege/
- When working with queer youth living within unsupportive families, primary care physicians can utilize their positional power to provide psychoeducation to increase family support and acceptance of youth. As detailed above, parental support is a protective factor and thus should be reinforced by other influential adults.
- Ensure and demonstrate equitable treatment, recruitment, and inclusion of LGBTQ+ providers (Joint Commission, 2011).
    - Protect staff from discrimination based on intersecting marginalized identities and maintain accountability when harm is done.
    - Equalize healthcare coverage and other benefits for queer providers.
    - Incorporate feedback (both anonymous and focus groups) from LGBTQ+ providers on their unique needs for sustainability in the workplace.
    - Develop explicit, transparent, and sustainable policies to protect whistleblowers from retaliation.

Lessons for Primary Care Providers, Informed by Minority Stress Model: Dismantling Stigma

In order to work toward dismantling stigma experienced by LGBTQ+ youth within the primary care setting, physicians and healthcare systems should:

- Incorporate the presence of accessible gender-inclusive restrooms with clear signage.
- Ensure that waiting rooms, patient rooms, and communal areas reflect diverse and intersectional LGBTQ+ experiences (through wall art, magazines, brochures, music, etc.) and be developmentally appropriate (teen-friendly, kid-friendly) (Joint Commission, 2011).
- Develop and promote inclusive and affirming visitation policies, including patients' right to identify a support person of their choice and recognition of a broad definition of 'family' (Joint Commission, 2011).
- Provide resources specific to LGBTQ+ services in local region (see Appendix B for Colorado specific resources for LGBTQ+ youth).
- Utilize inclusive, gender/sexual orientation non-assumptive (remove assumptions of heteronormativity and cisnormativity) and neutral language on forms and in conversation (Lawlis et al., 2019) – recognize that physician behavior must match speech in order to build sustainable trust (i.e., affirming language throughout medical documentation and in conversation with patient) (see Appendix C for inclusive language chart).
    a. Assumptions and judgements based on queer stereotypes lead to more negative health care experiences for LGBTQ+ individuals (Brotman et al., 2002). The queer community is far from homogeneous – recognize the individuality and diversity of LGBTQ+ folks by asking open-ended and non-assumptive questions.
    b. Do not assume pronouns based on appearance or sex assigned at birth. Rather, introduce yourself with your pronouns and ask for the patient's pronouns – respectfully use their correct pronouns in conversation and medical documentation (Lawlis et al., 2019). Inquire if the patient would like other providers to be alerted to their pronouns, and if they feel safe with this, make sure to clearly document the patient's pronouns within their chart, so others can utilize these when providing treatment.
    c. Include "chosen name" within intake forms and medical documentation and use this name while working with and documenting about the patient. Be transparent about when legal name may be required (i.e., insurance purposes). Gender-inclusive language (written and verbal) can increase freedom of expression, as well as feelings of trust and safety (Lee et al., 2017).
- To decrease vigilance, increase transparency – have a transparent conversation with youth about confidentiality, including documentation requirements (what is included and why) and parental access. This transparency can also serve to empower youth, strengthen autonomy and choice, and model informed consent. Note that the content of these conversations may vary depending on relevant state laws.

- Given the impact of family rejection on LGBTQ+ mental health, interventions should be aimed at building acceptance within family systems, as well as recognizing chosen family systems as legitimate forms of support (Green at al., 2021).
- Given the historical harms many LGBTQ+ individuals have experienced within the medical system, work to develop rapport and trust through attunement and openness.
    a. Actively involve queer youth in their health care decisions to increase empowerment, form a positive relationship, and decrease reinforcement of traditional hierarchies of power (Lee et al., 2017).

Lessons for Primary Care Providers, Informed by Minority Stress Model: Recognizing Burden of Decisions of Concealment vs. Disclosure

In order to work toward recognizing the burden of decisions of concealment vs. disclosure experienced by LGBTQ+ youth within the primary care setting, physicians and healthcare systems should:

- Incorporate accessible gender-inclusive restrooms to enhance autonomy and choice over disclosure (McGuire & Anderson, 2022).
- Provide LGBTQ+ affirming and developmentally appropriate sexual health education for *all* youth, regardless of disclosure of sexual orientation or gender identity – LGBTQ+ inclusive and affirming sex education has been shown to have positive implications for *all* youth, regardless of sexual orientation or gender identity (Proulx et al., 2019).
    - According to the 2019 GLSEN National School Climate Survey, youth that have access to LGBTQ-inclusive education were less likely to report feeling unsafe because of their sexual orientation (44.4% vs. 62.7%) and gender expression (33.5% vs. 44.7%) and felt a greater sense of belonging.
    - According to the National Sex Education Standards (2020), effective comprehensive sex education addresses the patient's values, attitudes, beliefs, and group norms that support health enhancing behaviors for all – contributing to the dismantling of heteronormativity and transphobia.
    - While comprehensive, affirming, and inclusive sex education for all is vital, be mindful and affirming of asexual individuals. Asexuality is often treated as a mental health or medical condition which needs to be treated (similar to other historically oppressed gender and sexual identities discussed above), rather than the valid identity and orientation that it is (Foster & Scherrer, 2014).
    - Substance Abuse and Mental Health Services Administration (SAMHSA) has created a list of professional training curricula to aid providers in increasing knowledge, awareness, and skills necessary to improve well-being of LGBTQ+ patients. See link to training curricula here: https://www.samhsa.gov/behavioral-health-equity/lgbt/curricula

    - National LGBTQIA+ Health Education Center provides educational programs, resources, and consultation to health care organizations with the goal of optimizing quality, accessible health care for LGBTQIA+ folks. See link to extensive training library here: https://www.lgbtqiahealtheducation.org/
- Create and sustain a non-judgmental, welcoming environment that supports culturally competent healthcare (Knight & Jarrett, 2017) and maintain a culture of accountability in order to foster trust and communication. Allow youth to develop trust at their own pace through earned and felt trust and safety.
- Research has shown that the overall quality of LGBTQ+ individuals' experience with healthcare is heavily determined by the professional's reactions to disclosure of identity (Brotman et al., 2002).
- Improve hiring and retention strategies to retain LGBTQ+ providers and administrative staff – representation matters.
    - According to the 2019 GLSEN National School Climate Survey, only 19.4% of LGBTQ+ youth were taught positive representations of LGBTQ+ people, history, events, and 17% were taught negative content. Positive representation of identities can aid youth in developing a secure sense of self.
- The American Academy of Pediatrics (2013) noted that physicians should never inform parents/guardians of youth sexual or gender identity or sexual behavior, as it could lead to more harm. Rather, physicians should allow youth space to communicate identities at their own pace and attune to the potential risks of "coming out."
- Have a transparent conversation with youth about confidentiality, including documentation requirements, parental access, policy on sharing information with insurance companies (and why), and instances when maintaining confidentiality is not possible.
    - Be transparent and use age-appropriate language to explain mandatory reporting obligations, including instances of disclosed imminent harm to self. Have age and identity-based resources available to provide the patient with support, as needed. See Appendix B for local resources.
    - Practice transparency in disclosing diagnoses added to youths' medical records, including reasons to include (specifically if related to gender or sexuality, i.e., if gender dysphoria diagnoses is required to receive insurance reimbursement on gender-affirming medical care) and create space to process potential impact of diagnosis (see section above on historical harm of DSM diagnoses) in order to increase trust within medical system.
- If caregivers are already aware of their child's sexual or gender identity, but display non-affirming beliefs, providers can offer parental support (American Academy of Pediatrics, 2013), such as directing them to PFLAG ("Parents, Families, and Friends of Lesbians and Gays"). As detailed above, parental support is a protective factor and thus should be reinforced by other influential adults.

Lessons for Primary Care Providers, Informed by Minority Stress Model: Minimizing Contributions to Internalized Homophobia and Transphobia

In order to work toward minimizing contributions to internalized homophobia and transphobia experienced by LGBTQ+ youth within the primary care setting, physicians and healthcare systems should:

- Provide LGBTQ+ affirming and developmentally appropriate sexual health education for *all* youth, regardless of disclosure of sexual orientation or gender identity.
    - According to the National Sex Education Standards (2020), effective comprehensive sex education addresses individual values, attitudes, beliefs, and group norms that support health enhancing behaviors for all – contributing to the dismantling of heteronormativity and transphobia.
- Pediatricians should be available (and educated) to answer questions specific to LGBTQ+ health and mental health, and they should be able to correct misinformation and provide resources, including referrals for psychotherapy or support groups, for additional support (see Appendix B). Pediatricians should NOT support nor recommend conversion "therapy" to any patients.
    - Incorporate suicide prevention resources throughout the office and attune to the impact of oppression on increased rates of suicidal planning and actions, as discussed throughout this paper.
- Improve hiring and retention strategies to retain LGBTQ+ providers and administrative staff.

Discussion

Primary care physicians have the opportunity and responsibility to provide vital healthcare to youth. Within this position of power, they can choose whether to use their power for good – through accountability and affirming practices that dismantle the systems of historical oppression that queer youth face within healthcare – or for bad – through complacency and perpetuation of harm. The lessons learned from Meyer's minority stress model, which contributed to this accessible, concise, and empirically supported tool, should serve as a starting point of action steps that primary care physicians and their healthcare teams can take to ensure they are moving in the direction of using their power to aid mental wellbeing of queer youth, a

marginalized population with a disproportionately high risk of mental health concerns, including suicidality. While primary care physicians are only one influential figure within a young persons' life, they must utilize their contact with youth to affirm, empower, and educate. Not only could this aid queer youth in navigating homophobic and transphobic societies through affirming support, but also contribute to the deconstruction of these very homophobic and transphobic environments and systems. This may be a particularly challenging endeavor for providers working within states that restrict affirming care through anti-LGTBQ+ laws. Providers working within these states would likely benefit from consultation with attorneys and lawmakers. Overall, this paper is a call to action to primary care physicians to be on the right side of history for LGBTQ+ youth.

Limitations and Future Directions

Current U.S. Political Environment

As of April 2023, over 500 anti-trans bills have been proposed at the state level within the United States (Trans Legislation Tracker), with many of these bills aimed at blocking trans people from receiving basic healthcare. Additionally, as of April 2023, an unprecedented 23 anti-trans bills have been introduced at the federal level, with aims of impacting access to healthcare, athletic participation, and education, nation-wide. This political environment poses a threat to the implementation of the suggestions within this paper, as primary care physicians are being put into positions to challenge or even break the law in order to serve their LGBTQ+ patients. Future research would benefit from studying the impact of transphobic and homophobic legislation and political discourse on the queer youth experience of the medical system. It may be beneficial for researchers to collaborate with attorneys and policymakers to better understand the implications of laws on queer youth health equity. Additionally, this research should be utilized in advocacy

efforts in order to educate the public and politicians on the mental health implications of oppressive practices within and beyond healthcare systems. This research could be generalized to school environments, sports teams, youth clubs, and family systems.

Homogeneity

Throughout this paper and much of the research that this paper is founded on, the LGBTQ+ community is regarded as homogenous, when it is far from it. Future research could benefit from an increased focus on intersectionality within the queer community. Some examples may include examining impacts of the intersection of queer identity and (a) race; (b) ethnicity; (c) religion/spirituality; (d) ability status; (e) socioeconomic status; (f) age, on experiences within the healthcare system. Future research would also benefit from studying experiences of transgender and gender nonconforming youth more specifically. Finally, this paper was limited in time and resources, and thus was rooted in previously conducted research. Future research could benefit from surveying queer youth directly, through qualitative methods, to center a deeper understanding of their experiences and needs within primary care. Qualitative examination of individual feelings and needs, through methods such as focus groups, could assist in highlighting the nuances and differing experiences amongst the queer community. A focus on highlighting and elevating the lived experiences and voices of queer youth should be a top priority within this research.

Primary Care Physicians' Resources and Culture

A limitation of this paper is that it does not directly consider the reality and accessibility of resources within healthcare, including time, financing, education/training, and primary care cultural norms. Additionally, it does not discuss the differential impact of attempting to implement these suggestions within more conservative states that have a higher prevalence of

anti-LGBTQ+ legislation and legal restrictions, in which this knowledge and implementation may be less accessible. Rather, it takes an optimistic perspective of abundant resources and legislative support to implement the suggestions. Future research would benefit from surveying doctors directly regarding their needs and identifying support to be able to increase feasibility of these suggestions. Additionally, it would be beneficial to survey healthcare administrators to better understand barriers to change, which would allow for a more targeted approach, in the hopes of increasing chance of implementation. In addition to surveying administrators, it may be beneficial to survey providers regarding current climate barriers within primary care – specifically, examining the cultural norms that exist within primary care that interfere with the suggested changes. It is also important to recognize that resources and needs vary immensely by geography and specific setting of the healthcare provider. Finally, it would be beneficial to better understand the barriers faced by queer youth who are not connected to care. A better understanding of their experiences would allow for a bridging between patients and providers.

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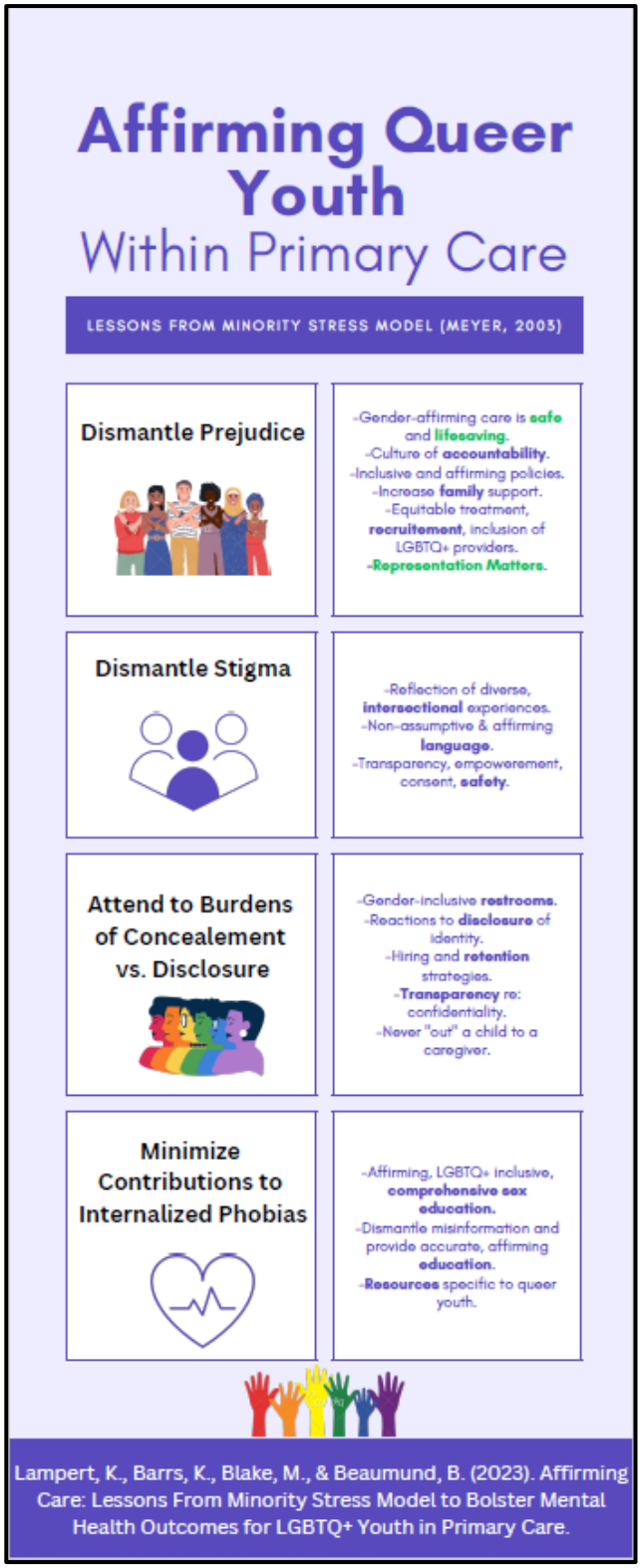
Appendix A

Infographic of Lessons Learned



Appendix B

Resource List for CO Providers (BY REGION)

DENVER METRO

- **AIDS Project**: free, confidential HIV testing and medical resources for those living with or affected by AIDS. Locations in Boulder and Denver.
- **Boulder Valley Women's Health Center Teen Clinic:** offers comprehensive women's health care, including contraception, abortion, HIV/STD testing, pregnancy care, and transgender health services (primary care, mental health care, hormone therapy, surgery referrals). All services are free or low-cost and confidential. Locations in Boulder and Longmont.
- **The Center:** an LGBTQ+ community center, which includes Rainbow Alley, and affirming environment for LGBTQ+ youth ages 11-21. Services include events, activities, counseling and support groups, health services and life skills.
- **Denver Health LGBTQ+ Health Services:** services include primary care, gender affirming care (including Hormone Replacement Therapy (HRT); Voice therapy; surgery options), sexual health services (including HIV services), and Behavioral Health. Patient navigators available to aid in navigating care options. Accepts Medicaid and most major insurance plans.
- **Transgender Center of The Rockies NXT Program:** services specific to queer and trans teens and young adults, ages 12-22. Services include behavioral healthcare, drop-in hours, library, peer support, access to technology, substance-free social groups/outings, and educational programming (including sex education).
- **Urban Peak Denver**: assists homeless and at-risk youth (ages 15-24) through a crisis shelter, drop-in center, housing, and provision of education and outreach.

NORTHERN COLORADO

- **Northern Colorado AIDS Project (NCAP):** free, confidential HIV testing and medical resources for those living with or affected by AIDS. Locations in Fort Collins and Greeley.

SOUTHERN COLORADO

- **Southern Colorado AIDS Project (S-CAP)**: free, confidential HIV testing and medical resources for those living with or affected by AIDS. Located in Colorado Springs.
- **Inside Out Youth Services**: community organization, whose goal is to educate and provide resources to LGBTQ+ youth (ages 13-24) in Southern CO through resources, drop-in center, food pantry, counseling, and sexual health education.
- **Urban Peak Colorado Springs**: assists homeless and at-risk youth (ages 15-24) through a crisis shelter, drop-in center, housing, and provision of education and outreach.

WESTERN COLORADO

- **Western Colorado AIDS Project (WCAP)** free, confidential HIV testing and medical resources for those living with or affected by AIDS. Located in Grand Junction.

STATE-WIDE

- **Children's Hospital Colorado – Adolescent Medicine:** comprehensive primary care and mental health support for adolescents throughout the state of Colorado.
    - Includes the TRUE Center for Gender Diversity, which offers specialized services for gender-expensive youth in Colorado.
    - Includes sex health and education services, including free birth control, STD testing, and pregnancy testing: https://bc4u.org/
- **Colorado Crisis Services**: hotline / first-line resource for youth (and adults) in crisis. Call 1-844-493-8255 or text TALK to 38255.

NATIONAL

- **988 Suicide & Crisis Lifeline:** 24/7, free, and confidential lifeline. Call 988.
- **LGBT National Youth Talk Line**: free and confidential hotline. Call 1-800-246-7743.
- **The Trevor Project**: 24/7 hotline for LGBTQ+ youth. Call 1-866-488-7386 or text START to 678678.
- **Trans Lifeline**: provides trans peer support, run by and for trans people. Call 877-565-8860.

Appendix C

Examples of Inclusive Language for Medical Providers / Intake Paperwork

Language that reinforces heteronormativity and transphobia	Inclusive and affirming language
"Do you have a boyfriend / girlfriend?"	**"Are you dating?" / "Do you have a romantic partner(s) or significant other(s)?"**
Mom / Dad	**Caregivers / Parents** (define 'family' as broadly as possible, to include chosen family or adoptive families)
Sex / Gender	Example for intake form: **"My current gender identity**[1] **is _____"** (open-ended allows for self-definition and fluidity) **"My sex assigned at birth is _____"** (only if needed) **"My pronouns are _____"** **"My sexual orientation is _____"**
Name	**Legal name** (only if needed) + **Name they use** + **Pronunciation**
Assuming pronouns, based on appearance or sex assigned at birth	**Introduce yourself with your own pronouns and then ask for patient's pronouns** (ensure correct pronoun use in chart); **Always listen to and reflect the patient's choice of language when describing themselves** (identity or relationship); **Inquire if patient feels safe and/or wants other providers to be alerted to their pronouns via their medical chart** (ensuring choice over outness).
"Transgendered"	**"Transgender"** (The term "transgendered" connotates that being transgender is something done to a person and perpetuates misconceptions that being trans requires medical treatment)
"Birth sex" "Born a girl" "Born a boy"	**"Sex assigned at birth"** **"Assigned female at birth"** (AFAB) **"Assigned male at birth"** (AMAB)
Generic gendered-exclusive expressions ("boys and girls," "you guys")	**Generic gendered-inclusive expressions** ("folks," "everyone," "people")

[1] Some examples of gender identity terms include, but are not limited to: agender, androgyne, bigender, cisgender man, cisgender woman, demigender, gender-expansive, gender-fluid, gender non-conforming, gender questioning, gender questioning, graygender, intergender, neutrois, nonbinary (or "enby"), novigender, omnigender, pangender, polygender, transgender/trans, trans man, trans woman, trans person, transfeminine, transmasculine, and two-spirit.