Sex Roles
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ORIGINAL ARTICLE

"Talk about Bodies": Recommendations for Using Transgender-Inclusive Language in Sex Education Curricula

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Abstract

We investigated the impact that trans-exclusionary language in existing sex education resources has on the well-being of transgender and non-binary (TNB) young adults. We conducted qualitative interviews with 11 U.S. TNB young adults receiving healthcare in Seattle, five parents, and five healthcare affiliates. Participants described the negative emotional impact of encountering trans-exclusionary language in prior sex education experiences. Participants recommended four practical strategies for adapting language to be inclusive of TNB bodies, experiences, and identities. These included not gendering anatomy and biological processes, using anatomy-based language, facilitating linguistic self-determination (i.e. autonomy in choosing words used to describe their own bodies), and using narratives that emphasize self-determined TNB identities. Participants suggested that modeling trans-inclusive language has the potential to mitigate the negative impact of trans-exclusionary language TNB young adults are likely to encounter elsewhere and to act as a mechanism for increasing their agency in making decisions about their bodies and sexual health. Our findings suggest that although extant curricula do not meet the needs of TNB young adults, future sex education curricula may have the potential to provide a contextually appropriate setting in which to challenge cisnormative and binary assumptions about gender, particularly regarding language that is used to discuss anatomy and sexual health. Our study highlights that trans-inclusive language practices are an important aspect of working with TNB young adults in a variety of contexts, including conversations with parents, clinicians, educators, and peers as well as in online sources of information.

Keywords Transgender · Non-binary · Sex education · Cisnormativity · Language · Gender affirmation

Transgender and non-binary (TNB) young people and their families face challenges accessing sexual health information that is inclusive of transgender and non-binary bodies, experiences, and identities. Many TNB people may not identify with the binary labels of "man," "woman," "boy," and "girl" (Frohard-Dourlent et al. 2017), and discussions within sexual health education about "girl bodies" and "boy bodies" exclude these young people. Although no known large population-based studies exist to estimate the prevalence of TNB identity among U.S. children and adolescents, studies estimate that 1.3% to 2.7% of high school students identify as transgender (Clark et al. 2014; Eisenberg et al. 2017; Herman et al. 2017; Perez-Brumer et al. 2017), and recent data from the California Health Interview Survey suggests that 27% of California high school age adolescents identify as at least "somewhat androgynous or gender nonconforming" (Wilson et al. 2017).

A majority of TNB adolescents and adults become aware of their transgender identity during pre-pubescence, with one study suggesting that 60% of U.S. TNB individuals felt that

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their gender was "different" before the age of 10 (James et al. 2016; K. R. Olson et al. 2016; Rafferty 2018). Although some transgender children articulate their gender identity to caregivers as young as 3-years-old, the average age adolescents share knowledge of their self-determined gender is 17-years-old (J. Olson et al. 2015; K. R. Olson et al. 2016). Therefore, it is likely that there are pre-pubescent and adolescent youth who will come to identify as transgender later in life, who may be privately experiencing gender dysphoria, or who may not yet have language or social models to express their gender identity.

Sex Education in School

Nearly all adolescents (96%) in the United States receive formal sex education before the age of 18, and there is wide variability in state policies governing the inclusion of lesbian, gay, bisexual, transgender and queer (LGBTQ) content (Hall et al. 2019; Martinez et al. 2010). Twelve states require sex education to be inclusive of sexual orientations, and only seven require the inclusion of diverse gender identities. Furthermore, eight state policies are explicitly discriminatory, describing homosexuality as "lifestyle choice, socially or morally unacceptable, unhealthy, and/or criminal," and five states mandated that sex education be conducted separately for "boys and girls," which implicitly denies the existence of non-binary youth (Hall et al. 2019). Previous studies have explored the impact of exclusionary sex education programs as well as the sexual health needs of lesbian, gay, and bisexual youth (Abbott et al. 2015; Carrotte et al. 2016; Gowen and Winges-Yanez 2014; Mustanski et al. 2015; Newcomb et al. 2018; Proulx et al. 2019). These studies suggest that exclusionary programs fail to provide information that sexual minority youth feel is relevant to their sexual health, that these programs are stigmatizing, and that they are associated with poor mental health outcomes. Few studies have focused specifically on the sex education needs of gender minority youth. A small body of literature suggests sex education programs often do not mention the existence of transgender identities and fail to meet the needs of TNB young people (Bradford et al. 2019; Garofalo et al. 2018; Kuhns et al. 2017; Riggs and Bartholomaeus 2018; Schimmel-Bristow et al. 2018).

Trans-Inclusive Language Practices as Social Support

TNB young people experience higher rates of social discrimination and isolation, including family rejection, bullying, intimate partner violence, and homelessness than their cisgender (non-transgender) peers (Clark et al. 2014; Keuroghlian et al. 2014; Reuter et al. 2016; Robinson and Espelage 2013; Sterzing et al. 2017). Youth who lack social support represent a particularly vulnerable segment of the transgender population and disproportionately experience elevated rates of anxiety, depression, suicidality, and substance use as well as higher risk sexual behaviors, HIV, and sexually transmitted infections (STIs) (Budge et al. 2014; Clark et al. 2014; Eisenberg et al. 2017; Newcomb et al. 2019; Perez-Brumer et al. 2017; Robinson and Espelage 2013; Sharma et al. 2019). For many TNB young people, the ability to socially transition is strongly linked to support in their environment, especially family and school support (Day et al. 2018; Dessel et al. 2017; K. R. Olson et al. 2016; Simons et al. 2013). Social transition refers to an expression of one's gender that is shared with others in the social environment and may involve a change in name, pronouns, presentation, and a request that others recognize a transgender individual's self-determined gender (Ehrensaft et al. 2018).

Affirmation of their self-determined gender is a critical determinant of health for TNB individuals and is associated with improved sense of self-worth, agency, and mental and sexual health outcomes (Johnson et al. 2019; K. R. Olson et al. 2016; Reisner et al. 2016; Sevelius 2013; Sevelius et al. 2016; Simons et al. 2013). Defined as "the process by which individuals are affirmed in their gender identity through social interactions" (Sevelius 2013, p. 2), gender affirmation represents the social processes whereby individuals receive social recognition and support for their gender identity and expression. This encompasses the use of language and practices that are sensitive, responsive, and inclusive of TNB people's identities, bodies, and experiences. In the health literature, discussion of gender-affirming language is often limited to the use of transgender people's correct names, pronouns, and gendered labels (Brown et al. 2019; Gridley et al. 2016; Reisner et al. 2015). However, recent ethnographic linguistics research has emphasized the broader scope of trans-inclusive language practices, which reflects how "the importance of language in the articulation of trans identities reflects the deeply gendered nature of language itself" and, thus, "language is one of the primary fronts on which gender is negotiated" (Zimman 2017b, p. 90). A primary concept emerging from these studies is that gender-affirming language is rooted in linguistic self-determination and centers an individual's preferences for how others refer to them, including their body and anatomy (Zimman 2014, 2017a).

Cisnormativity

The concept of cisnormativity, or cissexism, represents the dominant discourse about gender, grounded in the historical privileging and naturalization of cisgender bodies and experiences (Bauer et al. 2009; Castañeda 2015; Gill-Peterson 2018; Karkazis 2008; Meyerwitz 2002). Coined by Bauer et al.

(2009), cisnormativity is the underlying process driving the erasure of transgender people. TNB people experience erasure through informational systems, characterized as the "lack of knowledge regarding trans people and trans issues and the assumption that such knowledge does not exist even when it may" as well as through institutional systems, whereby institutions "lack policies that accommodate trans identities or trans bodies, including the lack of knowledge that such policies are even necessary" (Bauer et al. 2009, p. 352). Therefore, the fact that many TNB young people face challenges accessing sexual health information that is inclusive of TNB bodies and identities constitutes a form of informational erasure, and non-inclusive sex education curricula are additionally a product of institutional erasure (e.g. through sex education policies and healthcare systems). In both instances, the sex education needs (and comfort) of cisgender students, teachers, and healthcare providers are prioritized over equitable access to information and trans-inclusive curricula. As noted by Zimman (2017b, p. 86), "one of the most important ways cissexism is constructed is through language." Thus, we use the concept of cisnormativity as a framework for understanding the role of language in sexual health and puberty education.

The Present Study

In an effort to develop a trans-inclusive sexual health curricula for TNB adolescents, young adults, and their families, we conducted a qualitative study with the broad goal of identifying gaps in sources of puberty and sexual health information currently available. In a prior analysis of this qualitative dataset, we assessed parent, healthcare affiliate, and young adult recommendations for transgender inclusive curricular content (Haley et al. 2019). In this analysis, we found that participants recommended both trans-specific topics as well as "standard" sex education topics (e.g. HIV and STI prevention, contraception and fertility, relationships and consent) that require reframing in order to be trans-inclusive. As a result, we were interested in better understanding the specific role that language plays in the accessibility of extant puberty and sexual health information for TNB young people. Our exploratory sub-analysis had two aims: (a) to investigate what impact the use of non-inclusive—or trans-exclusionary—language in existing sex education sources might have on TNB young people's well-being and (b) to identify specific recommendations for language that might be used in an effort to make sexual health information more inclusive of TNB young people's specific needs, experiences, and bodies. Understanding TNB young people's specific language preferences is critical in the continuing development of affirming and transgender inclusive sexual health curricula.

Method

Participants and Setting

We conducted a total of 21 interviews in the United States among five clinical and non-clinical staff at Seattle Children's Gender Clinic (SCGC), five parents of TNB youth and young adults, and 11 TNB young adults. Young adult and parent participants were recruited in-person at SCGC by posting flyers and study announcements throughout the clinic as well as through regional listservs of transgender community organizations. Healthcare affiliates associated with SCGC were identified by the authors and contacted directly.

SCGC opened in October 2016 and currently is the only multidisciplinary gender clinic serving TNB adolescents and young adults in Seattle, WA. Seattle and the surrounding regions have strong legal protection for TNB people compared to other regions of the United States. At the state level, Washington has comprehensive transgender non-discrimination legislation protecting employment, housing, public accommodations, and student rights as well as laws that ban transgender exclusions in healthcare service coverage for both private and government insurance policies (Transgender Law Center n.d.). In addition, within the city of Seattle, there are numerous advocacy and community organizations that specifically serve TNB people as well as several organizations that focus on the needs of TNB youth and their families.

Young adult participants included six transgender men, three transgender women, and two non-binary individuals who ranged in age from 18 to 26 years-old. We intentionally recruited TNB young adults to capture perspectives of recent adolescents who currently or recently experienced sex education as well as young adults who are able to reflect with more longitudinal information on the effects of their sex education experiences during adolescence (Ahrens et al. 2016). All parents interviewed were cisgender women, including five parents of transmasculine adolescents and one parent of a non-binary young adult. Parents who participated in our study had TNB children who ranged in age from 14 to 24 years-old. SCGC healthcare affiliates included three physicians (an adolescent medicine specialist, a pediatric endocrinologist, and a pediatric primary care physician), a licensed clinical social worker, and a patient advocate on the community advisory board for SCGC. All interviewed youth and parent participants were White.

Procedure

Methods have been previously described (Haley et al. 2019). To identify the sexual health education needs of TNB young adults, we conducted 30–60-min semi-structured interviews with participants. Interviews were conducted either in person

($n = 6$) or via phone ($n = 15$) based on participants' preferences, and in-person interviews were conducted at the healthcare affiliate's clinical office or at a participant-preferred location (i.e. café, library).

The experiences and positionality of the interviewer are important for understanding how her presence directly influenced the collection of data gathered through interviews. All interviews were conducted by the first author (D.M.T.), a White queer cisgender woman and doctoral student with over 5 years of experience working with LGBTQ young people. Although D.M.T. did not share her position with study participants, her interactions with participants are impacted by White and cisgender privilege, as well as the degree to which her queerness was perceived by study participants based on her presentation as a femme woman.

An interview guide was developed a priori, and additional probes were added during each interview based on what came up for participants. Each interview began by stating that the goal of the interview was to better understand what types of sexual health information would be helpful to transgender young people and their parents as well as the best way to tailor this information. We asked questions about sources of information about puberty and sexual health, transgender inclusiveness, and the importance of having access to sexual health information (see Table 1s of the online supplement for interview script topics and prompts). For sources of information, participants were probed about where they had accessed sexual health information, how the sources they encountered made them feel, and what could be improved. Participants were prompted to define transgender inclusiveness as is relates to written or visual materials, sex education classes, and conversations about sexual health; they were also asked to describe what an inclusive sex education curricula would look like if they were to design it themselves. Participants were asked to discuss the importance of having access to inclusive sexual health information, including for the participants themselves, for their child/patient, and for TNB young people generally. Questions related to desired curricular content areas were also asked and have been previously described (Haley et al. 2019). All parent and young adult participants who completed an in-person or phone interview received a $20 incentive; healthcare affiliates were not compensated for their time. The present research received approval from Seattle Children's Hospital and Research Institute Institutional Review Board under exempt category B prior to recruitment and data collection.

Coding and Analysis

We used theoretical thematic analysis, a stepwise qualitative analysis technique, to analyze the transcribed interviews and to identify patterns and themes within qualitative data (Braun and Clarke 2006). Steps included coders reviewing the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing reports on each theme. Consensus coding was conducted independently by the interviewer (D.M.T.) and two additional researchers (S.G.H.; A.K.) in Atlas.ti version 8. All coders were White and included a doctoral student, pediatrician, and a medical student. Two coders were cisgender women, one coder was non-binary, and all three coders had prior experience working with TNB adolescents and young adults.

For the primary analysis, we initially used a deductive approach, developing the preliminary codebook based on prior research and clinical experience. Each coder independently read the transcribed interviews, applied existing codes to the text, and made comments in the master codebook to create, collapse, or refine theme definitions. The preliminary codes reflected interview guide topics. Additional codes were added to the codebook using an inductive approach to identify new themes based on the data. After transcripts were independently coded, annotated transcripts were combined, and each code application was jointly reviewed by all three coders to ensure consensus.

One theme, encompassing the topic of trans-inclusiveness, was sufficiently large to require a sub-analysis. For this sub-analysis, we developed a second codebook of subthemes and conducted a second round of thematic coding, following the same approach outlined previously. The majority of the themes and quotes presented in the present paper resulted from that sub-analysis. Although a majority of themes for the present paper were developed from the young adult participants' transcripts, parents and healthcare affiliates frequently expressed similar ideas and their perspectives provided additional context for understanding TNB young people's experiences. Thus, we present exemplar quotes from all three participant groups.

The original study aimed to understand gaps in sex education experienced by TNB young adults and to elicit recommended content for a comprehensive and trans-inclusive sex education curricula. Participants were also prompted to talk about examples of and practices relevant to trans-inclusive sex education but they were not explicitly asked questions about language in the setting of puberty and sexual health information or specific language recommendations. What emerged was that gender-affirming language is central to the practice of trans-inclusivity generally and that such language has heightened importance in the context of discussions around embodied gender, sexuality, and reproductive anatomy.

Results

Across all participant groups, an overarching narrative that characterized interviews was the critical importance of using language that is gender-affirming and transgender-inclusive in sources of puberty and sexual health information. We

identified three main themes within this narrative: (a) Participants expressed the negative impact that resulted from encountering trans-exclusionary language; (b) Participants made four specific recommendations—overwhelmingly consistent across participant groups—for the incorporation of trans-inclusive language into puberty and sexual health content; and (c) Participants suggested that modeling trans-inclusive language has the potential to increase the agency and autonomy of young adults in making decisions about their bodies and sexual health. Table 1 provides participant IDs and relevant demographic information. In what follows, we discuss each of the three themes in more detail (see Table 2).

Negative Impact of Non-Inclusive Language

Young adult participants encountered a variety of sources of puberty and sexual health information, including school-based, community-based, or faith-based curricula, online resources (e.g. YouTube, Tumblr), and informal conversations with their peers (Haley et al. 2019). Formal sources of information, which youth encountered most frequently through school-based curricula, typically did not use language that was inclusive of transgender and non-binary bodies, experiences, or identities. Most relied heavily on binary and gendered language and entirely excluded discussions of transgender or non-binary people. This exclusion consistently involved gendering sexual anatomy (e.g. "girl/woman body" versus "boy/man body") and biological processes (e.g. "girl puberty" versus "boy puberty"). One transgender man (ID 7) described the way that his teacher presented material "like only girls could have the female parts … but [my teacher] could have made it okay for men to have those parts, too."

Even though most of the TNB participants—and the TNB children of parent participants—did not yet openly identify as TNB at the time they received sexual health education in school, they nonetheless felt that the sexual health curricula they had received in school was not relevant to them. One participant (ID 8) shared that even though he "didn't have the vocabulary to describe myself at that age," the sex education he received in school didn't feel "relevant" or "applicable" to his life. Beyond not feeling that sex education curricula addressed their information needs, young adult participants felt their transgender identities and bodies were explicitly excluded. One non-binary participant identified that this exclusion was a function of cisnormativity, describing their school's curricula as "very binary, very gender-essentialist." They continued to describe the lasting impact this had on them:

> There wasn't really any discussion of queer people or trans bodies at all. Something that I still struggle with is just finding resources that are relevant to my life, and my experience, and the people that I'm having sex with just because everything is about certain assumptions about there being two types of bodies in the world and there's not a lot of room for intersex bodies or people who are on hormones. […] It's really, really triggering as a non-binary person to be told that I am female. It's really harming me as a person. There are so many barriers to us being able to be healthy and love ourselves and be safe. It [has] a significant effect on my mental and physical health. (ID 3)

In addition, many TNB young adults experienced acute distress after exposure to information that gendered sexual anatomy or only represented cisgender bodies and experiences. Participants described feelings of isolation, anxiety, dysphoria, stress, shame, and anger. For example, one transgender woman shared that:

> It felt rather alienating [...] it was a little difficult to just hear only male, female, and nothing about gender, nothing about sexuality for the most part. So, we [my friends] felt like it was a rare phenomenon that was limited to just us, and it was only us in the world. (ID 11)

Another transgender man (ID 7) described how the cisnormative framing of his school's sex education curricula (whereby transgender people are non-normative) angered him: "They make trans people, they make them seem … they make us seem so not normal. I don't know how to explain it. It really pissed me off."

Several young adults who did not have language to describe gender dysphoria or who did not identify as transgender or non-binary at the time they received sexual health information nonetheless felt that past exposure to trans-exclusionary curricula had a negative impact on their mental and emotional well-being. One transgender man described "dissociating" through his school sex education class:

> I didn't know I was trans back then, but something rubbed me the wrong way about the way that they spoke—drawing the connection between people's genitals and people's gender just rubbed me the wrong way. I never really liked the idea that you could be born into something and just stuck with it. (ID 8)

Another participant (ID 3) felt their cisnormative curricula ("all of the puberty stuff was very cis[gender]") misrepresented transgender people and subsequently impacted their sense of self-worth: "I sort of had the idea of what transgender meant, but a lot of misconceptions. [I have] so much internalized transphobia that I'm still working through."

Recommendations for Trans-Inclusive Language

In general, young adult participants desired accurate and non-gendered information about sex and sexual health.

Table 1 Study participant characteristics

ID	Participant Type	Gender of Participant	Gender of Child	Age of Participant	Age of Child	Recruitment Method
1	young adult	non-binary	–	26	–	Community listserv/flyer
2	young adult	transgender man	–	20	–	Community listserv/flyer
3	young adult	non-binary	–	19	–	Community listserv/flyer
4	young adult	transgender woman	–	20	–	Community listserv/flyer
5	young adult	transgender man	–	18	–	Seattle Children's Gender Clinic
6	young adult	transgender woman	–	18	–	Seattle Children's Gender Clinic
7	young adult	transgender man	–	18	–	Seattle Children's Gender Clinic
8	young adult	transgender man	–	18	–	Seattle Children's Gender Clinic
9	young adult	transgender man	–	18	–	Seattle Children's Gender Clinic
10	young adult	transgender man	–	18	–	Seattle Children's Gender Clinic
11	young adult	transgender woman	–	19	–	Seattle Children's Gender Clinic
12	parent	cisgender woman	non-binary	50	24	Community listserv/flyer
13	parent	cisgender woman	transgender man	47	18	Community listserv/flyer
14	parent	cisgender woman	transgender man	48	17	Seattle Children's Gender Clinic
15	parent	cisgender woman	transgender man	58	14	Seattle Children's Gender Clinic
16	parent	cisgender woman	transgender man	51	14	Seattle Children's Gender Clinic
ID	Participant Type	Role at SCGC				Recruitment Method
17	healthcare affiliate	Adolescent Medicine Physician				Contacted by investigator via email
18	healthcare affiliate	Pediatric Endocrinologist				Contacted by investigator via email
19	healthcare affiliate	Pediatric Primary Care Physician				Contacted by investigator via email
20	healthcare affiliate	Clinical Social Worker				Contacted by investigator via email
21	healthcare affiliate	Patient Advocate				Contacted by investigator via email

Note. All young adult and parent participants were White. Demographic information is not reported for participants who were healthcare affiliates associated with Seattle Children's Gender Clinic (SCGC) to ensure their anonymity

One healthcare affiliate highlighted the importance of querying and directing attention to how we can talk about bodies without implicitly reinforcing normative ideas about sex and gender:

> The language to talk about gender and bodies is something that most people have a real difficult time imagining. How do we talk about bodies without bringing in binary representations of gender? So [we should pay] real strong attention to that because that language is how we move into the future. (ID 21)

In response to the trans-exclusionary language young adult participants often encountered in prior sex education sources, they provided recommendations for how trans-inclusive language can be employed in the delivery of sex education moving forward. Four specific recommendations were identified from interviews and are discussed in detail: (a) not gendering anatomy and biological processes, (b) using anatomy-based language, (c) facilitating linguistic self-determination, and (d) using narratives that emphasize self-determined TNB identities.

Not Gendering Anatomy and Biological Processes

TNB participants recognized the importance of including information already present in most "standard" sex education curricula (e.g. STIs, pregnancy, stages of puberty), as well as adding topics that are unique to TNB young people and that are currently not addressed in most normative curricula (e.g. gender-affirming interventions, gender dysphoria, puberty blockers) (Haley et al. 2019). Notably, they desired information to be presented in a way that does not gender anatomy or biological processes.

Instead, participants recommend use of gender-neutral pronouns (e.g. they, them and theirs) and gender-neutral terminology. For example, participants suggested that sexual health educators use gender-neutral labels by referring to "people" rather than "men and women." This recommendation also includes using gender-neutral labels when talking about anatomy and "not using pronouns like 'she' or 'he' to talk about people who have vulvas and people who have penises." For example, participants recommended saying "their penis" or "the penis" rather than "his penis." Similar preferences were described regarding discussions of biological processes and

Table 2 Themes, subthemes, and exemplar quotes

Theme	Description	Exemplar Quote
Negative Impact of Non-Inclusive Language	Participants expressed curricula were not relevant to them and experienced distress (alienation, anxiety, dysphoria, stress, shame, and anger) when exposed to non-inclusive language.	"Just in general [there's] not really anything about non-binary individuals and how we might be relating to our bodies […] It's really, really triggering as a non-binary person to be told that I am female. It's really harming me as a person. [...] there are so many barriers to us being able to be healthy and love ourselves and be safe. It [has] a significant effect on my mental and physical health." (ID 3)
Recommendations for Trans-Inclusive Language		
Not Gendering Anatomy and Biological Processes	Participants recommended using gender-neutral terms, pronouns and labels when talking about bodies and biological processes.	"When talking about sex, make sure that it's not in gender essential terms. Not using pronouns like she or he to talk about people who have vulvas and people who have penises." (ID 3)
Using Anatomy-Based Language	Participants recommended talking about specific anatomical parts rather than relying on gendered euphemisms, for example, saying "people with penises" or "people with uteruses."	"I'm not female. I'm a man with a vulva who's about to give birth. And no, I'm not going to be a mother. This is my male body because I'm a man and male is the adjective for man." (ID 2)
Facilitating Linguistic Self-Determination	The importance of using individual's preferences for what words are used to describe their body and genitalia.	"There [should] be no connection drawn between genitals and gender because [since] that can cause a lot of dysphoria for people like me specifically. I don't like it when people refer to vulva as female genitalia, and I feel like one way to go about it is asking people first like, 'Does anybody take issue with certain terms? Are there things that will cause you dysphoria that can be avoided, and do you have a term that we can use instead?' And just in the beginning establish what terminology people are comfortable using." (ID 8)
Including Narratives that Emphasize Self-Determined TNB Identities	Participants preferred narratives that emphasized that someone "is a woman, man or non-binary person" over narratives of being born in the "wrong" body/gender or "becoming" another gender.	"Cis[gender] people paint trans folks as people who want to be the other gender than what they are born with, not as that's what they are. That's probably the biggest misconception of trans people that I see." (ID 10)
Increasing Agency through Trans-Inclusive Language	Participants believed that modeling trans-inclusive language can increase youths' ability to advocate for themselves.	"Someone might say, 'You have a boy's body, not a girl's body. So even if you say you're a girl, you're not because this is the way your body is.' I want those youth also to be able to say, 'That's not true. I am a girl. This is my body. This is a girl's body.' And whatever else they might need to say, to be able to stand up for themselves in a confident way." (ID 20)

sexual health products. For example, not talking about menstruation, pregnancy, or birth control as a "female" experience that only girls and women have. One young adult suggested educators and medical providers talk about "menstrual products" rather than "feminine hygiene products." Another participant suggested referring to "internal and external condoms" rather than "female and male condoms."

TNB participants did not provide a fully exhaustive list of these examples, but they did provide a useful framework for linguistic strategies that do not gender anatomy or biological processes, primarily through the use of more specific language. One participant (ID 3) summarized their list of examples by recommending: "Be more specific and talk about what we're actually talking about and stop using these useful but harmful categories of male and female when we're not talking about gender."

Several cisgender healthcare affiliates also advocated for the use of "gender-friendly" terminology that specifically refers to "body parts" instead of gendering bodies. For example, rather than talking about "women's healthcare," "instead talk about how 'people with uteruses have periods, and have reproductive health questions about pregnancy, and eventually get pap smears'" (ID 20).

Using Anatomy-Based Language

Most young adult participants preferred the use of specific anatomy-based language, such as saying "people who menstruate," "people who give birth," or "people with penises." Other youth suggested talking about "female-bodied" and "male-bodied" individuals as a way of distinguishing between anatomical sex and gender identity. It is important to note, however, that

although a few transgender participants who identified with binary genders endorsed the terms "female-bodied" and "male-bodied," a majority of participants strongly disliked this terminology. Participants who disliked this terminology explained that these terms inaccurately ascribed their sex assigned at birth onto their gendered body in a way that did not validate their current gender identity. One non-binary participant explained (ID 3, see Fig. 1s in the online supplement for an artistic rendering of this point): "I am not a female. I am a person with a vagina, I menstruate, I could give birth. That does not make me a female. I am a non-binary person with a non-binary body." Another transgender man (ID 2) echoed this sentiment: "I'm not female. I'm a man with a vulva who's about to give birth. And no, I'm not going to be a mother. This is my male body because I'm a man and male is the adjective for man."

Healthcare affiliates also acknowledged that many of their professional peers may often use gender-essentialist language and demonstrated how to instead use anatomy-based language that is preferred by many TNB young people:

> I think something that we still, even as professionals [working with transgender young people], we can fall into talking about being "born with a girl body," or, "male-bodied people." When people say "male-bodied", what they often mean is "people who have a penis." (ID 20)

Facilitating Linguistic Self-Determination

The two prior linguistic practices are both strategies for removing binary, gender-based terminology from discussions of sexual health. As such, these are strategies people (and curricula) can employ to avoid inadvertently misgendering someone by ascribing a gender or sex label to physiological anatomy or processes (e.g. by equating the pronoun "he" to "men" and "penises"). Participants also emphasized the importance of using individuals' preferences for what words are used to describe their body. In the words of one young adult participant (ID 3): "I want people to respect people's language they use about themselves instead of policing what other people are allowed to use and assigning labels onto them." This practice of prioritizing and respecting the language an individual person uses to describe themselves enacts the principle of linguistic self-determination.

Honoring linguistic self-determination in practice requires that people are explicitly asked about their language preferences, not only about pronouns but also, in sexual health contexts, about their preferred language for talking about bodies and genitalia. One participant (ID 3) emphasized the importance of not making assumptions and instead directly asking people: "'How do you feel about your body? What pronouns do you use? What language do you use?' To turn it into a question instead of assuming and doing it in a way that honors people's self-defined terminology."

In addition to affirming an individual in their gender, participants explained that this strategy enables conversations to be sensitive to TNB young people who may experience dysphoria because it acknowledges that discussions about bodies and sexual anatomy can be distressing for some TNB people. One transgender man explained:

> I know a lot of trans people, if they're FTM [female-to-male] they don't like hearing female words like "vagina" associated with their body, and if they're MTF [male-to-female], they don't like hearing male words like "penis" associated with their body. But me personally, I don't have that much of a problem with it. (ID 10)

Another transgender man provided an example of how an educator (or provider) could solicit language preferences from a group and identify alternative words or phrasing that could be used to make him feel comfortable:

> There [should] be no connection drawn between genitals and gender because that can cause a lot of dysphoria for people like me specifically. I don't like it when people refer to vulva as female genitalia, and I feel like one way to go about it is asking people first like, "Does anybody take issue with certain terms? Are there things that will cause you dysphoria that can be avoided, and do you have a term that we can use instead?" And just in the beginning establish what terminology people are comfortable using. (ID 8)

Several young adult participants argued that young people should be given the option to opt in or out of sex education settings where people may use language about bodies and anatomy that they dislike or find distressing. In describing a favorite trans-identified YouTube blogger who talks about sexual health for transgender men, one participant (ID 7) shared that he liked how this blogger "doesn't want to offend anyone" and when "he uses the proper words for body parts and stuff like that, he apologizes beforehand. He's like, 'If you have really bad dysphoria, click off.'" Ultimately, participants explained that asking and empowering youth to determine what language is used to describe their bodies is an important aspect of respecting and supporting their autonomy: "This is about honoring people's bodily autonomy, and autonomy in naming themselves."

Using Narratives that Emphasize Self-Determined TNB Identities

Lastly, in the discussion of TNB identities, young adult participants emphasized the value of personal narratives as an

important part of affirming TNB bodies, experiences, and identities. Participants preferred narratives that affirmed TNB people's current self-determined gender identity and used the language "sex assigned at birth" over narratives about "being born in a girl/boy body" or "wrong body" or narratives about "becoming" another gender. One participant (ID 10) stated this type of language reveals one of the "biggest misconceptions" cisgender people have about transgender people: "Cis[gender] people paint trans folks as people who want to be the other gender than what they are born with, not as that's what they are."

A few participants shared positive experiences they had during their school-based sex education class when their teacher used definitions of TNB terms that emphasized self-determined gender. One participant shared a story about how his teacher's discussion of TNB people both affirmed his self-determined gender and provided his classmates with language to help them become more comfortable talking about TNB identities:

> I had one teacher who was really great one year in high school. Her [sex education] class went over basic terminology, like trans 101 sort of. [She said,] "a trans person is somebody who does not identify with the gender they were assigned at birth." And I particularly liked they didn't say somebody who is born a blank, and then became a blank. […] She covered non-binary identities, like identifying as genderqueer, or gender fluid, FTM, MTF, trans man, trans woman. She went through and defined those terms, which was great. And she did it in a way which was really validating, which I enjoyed. She was really careful to phrase things like, "a trans guy is a guy." Not like, "a trans guy is someone who is born a girl who decides they're a guy." I liked that. And I think it kind of helped everyone feel a little more comfortable discussing it. (ID 10)

In addition to providing an example of how to define and describe TNB identities using language that emphasizes self-determined gender identities, this quote demonstrates that trans-inclusive language in sex education curricula can have a markedly positive impact on TNB young people. Notably, it highlights how sex education can be a venue for modeling and advocating for affirming, trans-inclusive language.

Increasing Agency through Trans-Inclusive Language

Participants identified agency and bodily autonomy as necessary steps toward TNB young adults believing they deserve respect in a wide range of contexts, including decisions about which family members are permitted to hug them, safer sex negotiations, and decision-making about which medical interventions they do or do not want (if any). Linguistic self-determination plays a central role in these processes. According to one non-binary person's experience (ID 1): "It has been so helpful for me to understand that I do deserve consent and respect and for people to use language that works for me."

Participants also noted that provision of accurate and non-gendered information on sexual health has the potential to mitigate the negative impact of trans-exclusionary language that young people are likely to encounter elsewhere. They pointed out that modeling gender-affirming language can be a mechanism for increasing TNB adolescents' and young adults' autonomy and agency in decision-making about their bodies and sexual health. Parents and healthcare affiliates drew a connection between others modeling trans-inclusive language and young people's ability to advocate for themselves (see Fig. 1s in the online supplement):

> Someone might say, "You have a boy's body, not a girl's body. So even if you say you're a girl, you're not because this is the way your body is." I want those youth also to be able to say, "That's not true. I am a girl. This is my body. This is a girl's body." And whatever else they might need to say, to be able to stand up for themselves in a confident way (ID 21)

Participants acknowledged a connection between self-worth and sexual risk-taking behaviors. One transgender man (ID 8) shared: "I feel like people in the [trans] community are more likely to engage in risky sexual behaviors because they undervalue themselves." Many participants believed that having models of language with which to advocate for themselves translates to an increased ability for TNB young people to set emotional and physical boundaries, including safer sex practices. Several young adult participants shared that they desired better skills for negotiating sex and navigating conversations around dysphoria during sex:

> I wish I had had more examples of [how to talk] about, "Hey, don't touch this because it causes my dysphoria." Or, "Hey, don't do or say this because it causes me to feel incredibly uncomfortable. I don't want you to do that." How to say those things ahead of time and set your boundaries. (ID 10)

Parents and healthcare affiliates, in particular, believed that using trans-inclusive language while delivering accurate and inclusive sexual health information can lower risks of acquiring HIV/STIs and unwanted pregnancy. Participants noted the importance of promoting agency—including, but not limited to, TNB young people—to make decisions about their bodies from an early age.

One healthcare affiliate (ID 20) articulated how promoting agency is fundamentally related to challenging cisnormative

narratives about bodies, that is, narratives in which transgender bodies are seen as non-normative or "wrong": "From a young age, we tell them there's no wrong way to have a body and that only they get to decide what they do with their bodies, and anyone who tells them that boys' bodies are like this and girls' bodies like this isn't correct." This healthcare affiliate further argued that modeling this type of language and self-advocacy could impact TNB young people's future sense of self-worth and comfort setting boundaries: "[Then] when they're of a dating age, and they're more used to being like, 'Wait, there's nothing wrong with my body. You can't shame me into doing whatever thing that you're trying to do.' I feel [it] really carries itself over into dating and sexual health."

Although participants identified agency and autonomy as means to achieving better sexual health outcomes, reductions in certain sexual health behaviors (such as condomless sex or sex under the influence of substances) was not seen as the most important outcome of a trans-inclusive sexual health curricula. Rather, the most powerful and pervasive idea present throughout interviews was the shared belief among participants that increasing TNB young adults' agency and autonomy are inherently central and worthy goals of puberty and sex education. One parent (ID 15) thought that the "general tenor of the whole thing should really be 'You own you. You are the one who makes all the decisions.' Something that puts them in a powerful place." This sentiment was shared by all participants, but was most clearly articulated by healthcare providers and parents:

> The most important thing to me is that [my child knows that] their body is their own, and they decide what they do with it and who touches them in whatever way they're comfortable with. And then, that they understand how to appropriately take care of their sexual health, what resources are available to them … I just want my children to be comfortable in their own bodies and know that they can set boundaries. (ID 14)

Discussion

Transgender and non-binary (TNB) young adults in our study advocated for accurate and non-gendered information about anatomy and sex. However, because most extant sex education curricula reinforce cisnormative assumptions and use trans-exclusionary language, they are not presently designed to meet the needs of TNB young people. We found that exposure to such curricula may in fact negatively impact mental health or cause acute distress among TNB young people, including those who may not identify as transgender at the time they are exposed to a sex education curricula but go on to identify as TNB later in life. Our study participants articulated four practical recommendations for adapting language in sexual health curricula to be inclusive of TNB bodies and identities. These included not gendering anatomy and biological processes, using anatomy-based language, facilitating linguistic self-determination, and using narratives that emphasize self-determined TNB identities. Ultimately, many of our study participants felt that these linguistic strategies could potentially mitigate the negative impact of trans-exclusionary language that young people are likely to encounter elsewhere and could serve as a mechanism for positively impacting their autonomy and agency with regard to making decisions about their bodies and sexual health.

Our findings are consistent with a small body of work linking LGBTQ-inclusive sex education to students' well-being. A qualitative study based in the United Kingdom reported that LGBTQ-exclusive sex education made LGBTQ students feel othered (like "freaks") and pathologized (Gowen and Winges-Yanez 2014). An empirical ecological study found statistically significant reductions in depression and suicidality among lesbian, gay, and bisexual adolescents living in U.S. states with mandated LGBTQ-inclusive sex education curricula (Proulx et al. 2019). Therefore, healthcare providers and educators ought to consider the negative impact that strictly binary discussions of gender and bodies can have on the well-being of transgender young people, particularly those who lack parental support and are unlikely to have access to alternate sources of sexual health information outside of school- and clinic-based sex education (Lefkowitz and Mannell 2017; Olson-Kennedy et al. 2016).

Participants' experiences of how trans-exclusionary language in sexual health education has negatively impacted their physical and emotional well-being can be grounded in two bodies of work on gender affirmation. First, a large body of research has demonstrated how gender affirmation across three arenas (psychological, medical, and social) is a significant predictor of positive mental health outcomes as well as higher self-esteem and self-confidence (Crosby et al. 2016; Glynn et al. 2016; Russell et al. 2018). Parallel to these findings, another study of non-binary youth demonstrated that invalidation of gender identities is associated with poor mental health and increased psychological distress (Johnson et al. 2019). Second, following Sevelius' model of gender affirmation and risk behaviors, empirical studies have shown that gender affirmation is significantly and positively associated with viral suppression and healthcare empowerment among HIV-positive transgender women, whereas lack of gender affirmation has been associated with healthcare avoidance (Goldenberg et al. 2018; Sevelius 2013; Sevelius et al. 2016). Borrowing from Sevelius' framework, we suggest that using trans-inclusive language can promote both psychological affirmation (e.g., through representation in sexual health curricula and using non-gendered labels to talk about people and bodies) and social affirmation (e.g., through linguistic self-determination).

Recommendations for trans-inclusive language made by our study participants strongly aligned with findings from a recent study of transgender youths' narratives of sexual health and intimacy as well as ethnographic research conducted with adult transgender communities in the Western United States (Green 2010; Riggs and Bartholomaeus 2018; Zimman 2017a, 2017b). In this research, Zimman (2017b, p. 100) identified three linguistic tactics employed by transgender people for inclusive and affirming language: challenging gendered labels, avoidance of gendered terminology, and "talking about body parts rather than using identity-based euphemisms." The first tactic includes preferentially using ungendered labels like parent, child, and sibling or using the pronoun "they" instead of "he" or "she." The second tactic includes gender-inclusive language choices, such as saying "another sex" instead of the "opposite sex" or "all people" instead of "men and women." Lastly, Zimman (2017a, p. 236) describes how language employed by transgender people challenges the "hegemonic model of sex" in which bodies must belong to one of two genital-defined categories (e.g. man or male-bodied people have penises and women or female-bodied people have vaginas). This includes modifying statements about sexual health to be more inclusive, demonstrated by Zimman's example of replacing statements like "women need access to cervical cancer screenings" with "people assigned female at birth …" or "everyone with a cervix (typically) needs access to cervical cancer screenings" (Zimman 2017b, p. 99). Lastly, study participants preferred narratives that emphasized self-determined identity over narratives of being born in the wrong body/gender. This preference reflects the concept of gender self-determination in which someone is described as "a woman, man or non-binary person" rather than as someone with a desire to "become a woman, man or non-binary person" (Stanley 2014; Zimman 2017a).

Notably, the themes presented in our sub-analysis relating to language recommendations were identified from interviews in a broader study about sex education for TNB young adults. Participants were asked about transgender inclusive practices and the impact of sexual health curricula on their well-being, but they were not specifically prompted to provide recommendations for gender-affirming language or their specific language preferences. However, participant's recommendations were overwhelmingly specific and cohesive, and they were discussed as central to trans-inclusivity in sex education, which is a topic that participants were prompted to comment on in all interviews. These themes were central to participants' narratives because participants viewed them as critical to the topic of sex education, which reduces the possibility that they were influenced by researcher bias. Our findings highlight that language is foundational to transgender inclusiveness and is relevant in all discussions of bodies and identities, especially regarding puberty and sexual health.

Limitations and Future Directions

Our study had several limitations. First, it is possible that if we had explicitly asked participants about language in sexual health education we would have captured additional themes and recommendations. Our study population was mostly White and had limited representation of non-binary people and transgender women compared to transgender men. Therefore, our findings may not extend to underrepresented racial minority TNB young adults or to the broader spectrum of trans-identified people. Research on intersectionality and resilience among transgender youth of color suggests that intersectional identity development contributes to increased resilience, development of self-advocacy skills, and abilities to navigate both trans-exclusionary experiences and racism (Crosby et al. 2016; Goldenberg et al. 2019; Singh 2013). In spite of this limitation, we believe that the primary themes of distress around trans-exclusionary language and the importance of linguistic self-determination may remain salient for racial minority TNB young people. Nonetheless, researchers should continue to explore sex education content and language preferences in a more racially and ethnically diverse group of TNB adolescents or young adults. Additionally, due to regional political climate and recruitment primarily through Seattle Children's Gender Clinic, our sample likely excludes young people who lack access to basic healthcare and thus may be more vulnerable to intersecting oppressions, including poverty, unsupportive family environments, and lack of other social resources. Finally, the interviewer and two of three coders were White cisgender women; it is possible that additional or different themes would have been identified had the research team included more diverse identities.

To date, the literature on gender-affirming medical care has emphasized the importance of using an individual's pronouns and "preferred name" (Brown et al. 2019; Deutsch 2016; Gridley et al. 2016; Reisner et al. 2016). However, there have been few mentions in the health literature on the broader aspects of gender-affirming language described in our study—that is, the use of gender-neutral and anatomy-based language and language that does not gender anatomy or biological processes. Examples of trans-inclusive language can be found in the context of community-created sexual health resources and resources for medical providers on performing pelvic exams for transgender patients. The latter acknowledges that "patients may prefer to refer to their vagina as their 'front' or 'front-hole'" and that providers should "ask the client how they would prefer to talk about medical issues (through different language, slang)." (Planned Parenthood 2006, page 3; Bellwether 2010; Deutsch 2016; Hill-Meyer and Scarborough 2014, Wesp 2016).

Thus, further research that critically examines the presence of trans-exclusionary language in existing sex education curricula and clinical encounters is needed. Additional areas for

future research include the development of best practices for facilitating self-deterministic trans-inclusive language in educational, clinical, and research settings, as well as the development and evaluation of sexual health interventions for TNB young people.

Practice Implications

The use of gender-affirming language was impactful across a variety of settings, including school sex education; in conversations with parents, clinicians, and peers; and in online sources of information. We have outlined four practical strategies recommended by TNB young adults for how to adapt language to be inclusive of TNB bodies, experiences, and identities. As such, these are strategies individuals can employ to avoid inadvertently misgendering someone (by ascribing a gender or sex label to physiological anatomy or processes) and to solicit individuals' preferences for what words are used to describe their bodies. Our findings suggest that trans-inclusive and self-determined language is critically needed in clinical encounters, in school-based sex education, and in the development of sexual health curricula that aim to be inclusive and effective for diverse TNB populations. Thus, these recommendations may have further implications for how to modify cisnormative language that commonly appears in medical forms, research, and informational materials.

Conclusion

Consideration of transgender-inclusive language is critically important when working with TNB adolescents, young adults, and their caregivers. Puberty and sex education curricula provide a contextually appropriate site in which to query and challenge cisnormative and binary assumptions about gender, particularly regarding language that is used to talk about anatomy, genitalia, and sexual health. Our study demonstrates that trans-inclusive language practices, with an emphasis on using ungendered language and supporting young people's autonomy in naming themselves and their bodies, is a necessary and important aspect of working with TNB young people in a variety of contexts.

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Compliance with Ethical Standards

Conflict of Interest Authors declare that they have no conflicts of interest.

Research Involving Human Subjects This research involved human subjects, and received approval from Seattle Children's Hospital and Research Institute Institutional Review Board under exempt category B.

Informed Consent Study participants were provided with a written statement on research procedures, and were counseled on their rights as participants, potential risk and benefits of participation. All participants provided verbal consent to participate in the study prior to being interviewed.

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