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Transgender Youth's Perspectives on the Relationships Between Pregnancy, Contraceptives, and Dysphoria

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A B S T R A C T

Purpose: To explore how trans youth with pregnancy capacity think through and understand the associations between pregnancy, contraception methods, and dysphoria.
Methods: We conducted 8 asynchronous online focus groups (n = 152) between 2020 and 2021 with trans youth assigned female at birth, and thus presumed capable of pregnancy, aged 14–18, who were living in the United States. Data were analyzed using a qualitative thematic approach informed by interpretive description.
Results: Some youth participants were unequivocal in their belief that both pregnancy and contraception would give rise to gender-related distress, which affected how they framed the acceptability of pregnancy and various methods for its prevention. Others had more dynamic understandings of dysphoria, recognizing that it is not inevitable or uniformly experienced. Still others posited that dysphoria that does occur can be managed considering the individual's priority goal or desire – whether to become a gestational parent or to prevent pregnancy. Participants discussed the importance of accessing sexual and reproductive healthcare, even if doing so requires them to navigate terrains of potential dysphoria, including dysphoria that is provoked by having to access gendered spaces and services and due to the use of gendered language.
Discussion: Youth participants had varied, nuanced understandings of dysphoria and its potential impact on their conception, pregnancy, and contraception experiences. Many did not hold prescriptive views that dysphoria is a defining aspect of their lives as trans people. Findings suggest strategies for the delivery of gender-affirming, youth-friendly sexual and reproductive healthcare that attends to dysphoria-as-distress when it occurs.

IMPLICATIONS AND CONTRIBUTION

Trans youth have dynamic, nuanced understandings of dysphoria and are aware of the potential impact it has on their sexual and reproductive health. Providers should be prepared for the potential that dysphoria will feature in trans youth's health decision-making, while not treating dysphoria as an inevitable, defining personal characteristic.

There are an estimated 300,000 transgender (trans) youth living in the United States [1], whose current gender identity differs from the gender they were assigned at birth, including binary-identified trans girls and boys and nonbinary youth. Approximately 1.4% of adolescents in the United States identify as trans, and 13–17-year-olds are significantly more likely to

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identify as trans than older adults [1]. The number of trans youth is nearly twice as high as previously estimated [1], a rise in recent years due, in part to young people having greater access to language to describe their gender identities, to increasing social acceptance of trans people, and to improved methods for collecting population-level sociodemographic data.

Like other youth, many trans youth are sexually active, and as a result, some trans youth experience pregnancies. Among sexually active trans youth aged 14–18 years, one Canadian study found that roughly 5% had been involved in a pregnancy, suggesting a pregnancy rate at least equivalent to age-matched general populations [2]. Pregnancy rates among trans youth in the United States are unknown, but studies suggest trans people of all ages experience intended and unintended pregnancies [3–5].

Gender dysphoria is a term used in academic, scientific, and clinical literature [6], as well as being taken up by trans people themselves in a variety of ways. The idea of gender dysphoria is multifaceted, and its various uses are often conflated, with some versions considered more salient than others. For example, the American Psychiatric Association changed one of its diagnostic categories from gender identity disorder to gender dysphoria in 2013 and kept this term in the most recent revision of the *Diagnostic and Statistical Manual of Mental Disorders-5-TR*. The 11th revision of the International Classification of Diseases, however, has moved away from using the term gender dysphoria in favour of gender incongruence – a persistent incompatibility between a person's assigned gender and their current gender identity. Although regulatory bodies may be shifting away from the use of the term, gender dysphoria remains a well-established concept in popular, clinical and academic discourse used to describe the experience of significant gender-related psychological distress [6]. Gender dysphoria is also sometimes used to describe personal characteristics within individuals, applied to people who may not meet the diagnostic criteria, nor experience distress, but who are nevertheless described as dysphoric because of their gender identity, modality, or expression [6]. In this use, to be trans is to automatically be gender dysphoric, and gender dysphoria is a particular manifestation unique to trans people. This narrow version of dysphoria is an element of transnormativity, a framework that positions as 'authentic' only those trans people who adhere to binary, *dysphoric*, and medicalized narratives [7]. In this article, we recognize that gender dysphoria has a variety of meanings and uses, and we explore the ways in which trans youth who participated in this study engage and navigate with this varied conceptual landscape.

Gender dysphoria, variably defined, has been found to factor into trans people's reproductive lives. For instance, among some previously pregnant trans adults, pregnancy-related physical changes have been found to heighten, intensify, or complicate the experience of gender dysphoria [4,8,9]. For some, dysphoria has influenced birth planning and preferred modes of delivery, where cesarean sections are preferred over other types of births [4,10]. It can influence preferences for transabdominal over transvaginal ultrasounds during a pregnancy [10]. Trans adults also report concerns over dysphoria affecting their contraception choices [10], and healthcare providers offering contraceptive counseling to trans people have been advised to consider how certain methods may contribute to gender dysphoria [11].

Trans adults and youth alike may access contraceptives to prevent pregnancy and/or to suppress menstruation, as menarche and regular menstruation can be associated with gender dysphoria and distress [12,13]. Chen et al. (2018) conducted an online survey with 156 trans and gender nonconforming youth not explicitly seeking transition-related healthcare [14], and some shared how being asked about fertility was itself triggering of their gender dysphoria, despite seeing the value and necessity of such questions [14]. Over 70% of the participants were interested in adoption, and some commented that pregnancy was less desirable because of the potential for worsening dysphoria [14]. Minority stress and the stigma related to being a trans parent featured in some youth's concerns about becoming parents [14,15]. However, the perceived incompatibility between fertility and medical transition, and concerns about gender dysphoria also featured prominently in their discussions of family formation desires and plans [14,15].

In sum, much of the literature to date has focused on trans adults, including previously pregnant trans adults. Little is known about what contributes to the sexual and reproductive health behaviors of trans adolescents, including how dysphoria may influence their rates of un/intended pregnancy, and how dysphoria is factoring into their decisions about contraceptives. To address this gap, we sought to better understand how trans youth who were assigned female at birth (AFAB) and thus presumed capable of pregnancy think through and describe the associations between pregnancy, contraceptive use, and dysphoria. To do so, we analyzed data from a diverse sample of 152 AFAB trans youth in the United States. We paid particular attention to the varied meanings and uses of the concept of gender dysphoria on which the participants may be drawing.

Methods

This study was part of a larger project to adapt a text messaging-based pregnancy prevention and sexual health program for sexual minority cisgender girls to be more gender-inclusive [16]. Recognizing that trans youth who do not identify as girls may also have unmet sexual health education needs, we conducted focus groups with trans youth to better understand their experiences with and needs for pregnancy prevention programming. As described in more depth elsewhere, the eligibility criteria included anyone whose gender modality was not exclusively cisgender, having been AFAB (and thus presumed capable of pregnancy), aged 14–18 years, living in the United States, able to participate in English, and having their own cell phone (since this substudy was part of a larger project focused on the development of text messaging-based sexual health programming) [16]. The original study was guided by 2 main research questions: (1) Why do trans youth choose to be pregnant or not?; and (2) Why do trans youth choose to use pregnancy prevention strategies or not, when having sex that might result in pregnancy? Emerging from the data collected, our current study explored a further question: How do trans youth consider the relationship between pregnancy, contraceptive use, and gender dysphoria? To address these questions, we conducted 8 asynchronous online focus groups during 2020 and 2021. Asynchronous online focus groups have emerged as an important methodological tool, as they allow for research to be conducted across broad geographic regions, where sensitive topics can be discussed, including with marginalized populations [17,18]. The protocol was reviewed and approved by Pearl Institutional Review Board, Protocol #19-CIPH-102.

Recruitment

Study advertisements were placed on Facebook and Instagram, which connected interested candidates with an online screener, followed by a telephone eligibility assessment. Eligibility was based on self-identification as trans or nonbinary, not on whether they had expressed their gender publicly (youth could be closeted) or whether they had accessed any gender-affirming health care. Of those eligible, 168 AFAB trans youth, aged 14–18 years, were recruited and provided either informed assent (<18 years) or informed consent (18 years); of these, 158 registered in the online focus group, and a final 152 actually participated in the groups (see demographic information in Table 1). A waiver of parental permission was granted to protect youth from the potential harm they could experience if forced to disclose their gender identity to unaccepting caregivers. We enrolled eligible young people with an aim of around 20 participants per focus group with diverse ages, ethnicity, and urban or rural regions. We scheduled each focus group after we had enrolled between 18 and 23 eligible participants for a group by gender and sexual experience to ensure that youth did not wait too long to participate and decide to drop out.

Data collection

Using a purpose-built, proprietary online focus group platform similar to the open-source pHpBB forum software [19], a total of 8 online focus groups were conducted. Youth were grouped according to whether they identified as binary (transgender boys) or nonbinary (genderfluid, genderqueer, pangender, and nonbinary) and whether they had previous sexual experience(s). Those who identified as both binary and nonbinary were asked to choose which group they preferred to join. Participants selected an anonymous screen name and accessed the password-protected focus group platform over the course of 3 days. Due to concerns that some youth may have selected screen names they were already using online, all participants are identified in this paper by a pseudonym derived from but not identical to their self-selected screen name. Focus group moderators posted questions twice a day, centered on experiences and thoughts around pregnancy and pregnancy prevention strategies. Participants were encouraged to visit the focus group 2–3 times a day and respond to posted questions and comment on other participants' responses. To increase response, youth were given a fourth day to respond. Our priority was ensuring that all eligible and enrolled participants were able to contribute to the asynchronous online focus group to which they had been assigned. After 4 focus groups were completed, we reviewed the transcripts to determine whether there appeared to be sufficient richness of data and decided to continue with a second focus group for each gender and sexual experience group.

Table 1
Characteristics of youth participants in online focus groups (n = 149[a])

Youth characteristics	%
Age (Range: 14–18)	16 (Median)
Gender identity	
Cisgender boy	1%
Genderfluid	8%
Genderqueer/pangender/nonbinary	50%
Transgender boy	54%
Unsure	1%
Sexual identity	
Asexual	11%
Bisexual	28%
Gay	26%
Heterosexual	3%
Lesbian	9%
Pansexual	26%
Queer	33%
Questioning	11%
Race	
American Indian/Native American or Alaskan Native	2%
Asian	6%
Black or African American	9%
Mixed race	22%
Native Hawaiian or another Pacific Islander	1%
White or Caucasian	54%
Something else	5%
Do not want to answer	1%
Hispanic ethnicity	23%
Ever had sex	
With a cisgender girl	27%
With a cisgender boy	32%
With a transgender girl	4%
With a transgender boy	13%
With a nonbinary person	27%
Rural setting	34%

[a] Three youths were not included in the table, as we were unable to connect their usernames to the sociodemographic details collected during eligibility screening and intake.

Data analysis

We imported electronic transcripts of the online focus groups into NVivo 12 qualitative software. Transcripts were coded using a combination of inductive line-by-line coding and overall analysis coding. We iteratively returned to the coded data, and to the transcripts, to identify themes, associations, and patterns. Coauthors employed reflexive journaling and analytical memo writing, which along with the coded transcripts, served as springboards for discussions and thematic analysis. We focused our analysis on the entire dataset; the topic of dysphoria was raised in every focus group, usually by many or even most participants, whether in their discussions of pregnancy, contraception, and health care. Although we provide a limited number of exemplar quotes to illustrate our analyses, each of these reflects discussions among multiple participants across the focus groups. We relied on 2 approaches to ensure that the thematic analysis was grounded and emerged directly from the youths' responses. First, we made note of whether youth reported first-hand experiences of pregnancy (defined as having a personal experience of pregnancy, regardless of the outcome) and/or second-hand experiences of pregnancy (defined as knowing someone who had a personal experience of pregnancy). This detail provides insight into whether youth were speaking from personal experiences or offering informed speculations. Second, we conferred with members of the project team who are themselves trans or nonbinary and/or who have extensive research experience focused on the experiences of trans youth to locate salient quotes and develop novel analyses. Our approach to data analysis was informed by Thorne's *Interpretive Description* method, an inductive approach to qualitative analysis, which allows researchers to not only capture themes and patterns in the data but to generate interpretive descriptions that can inform clinical standards, policies, practices, and understandings [20]. As such, we conclude by detailing various implications of the findings for the provision of youth-friendly sexual and reproductive healthcare.

Results

The relationship between pregnancy and dysphoria

Participants discussed dysphoria in the context of pregnancy in 3 distinct ways (Table 2). First, some participants were unequivocal in their belief that pregnancy would give rise to a particular kind of gender-related distress, gender dysphoria, and so pregnancy was undesirable. For example, Mikey (trans boy and sexually experienced) and Ross (nonbinary and not experienced) framed pregnancy as inconceivable in their own lives, given the inevitability of dysphoria associated with getting and being pregnant. Ross had a hard time speculating why other trans youth might intentionally become pregnant, since he expected the experience to be so personally distressing. Conversely, some participants had more dynamic understandings of dysphoria, recognizing that not every trans person experiences dysphoria, and even among those who do, not all experience it in the same way. Prior to participating in this research, CrawlingSpider (trans boy, experienced) had been pregnant once, which ended in abortion. He noted, "*not all trans men will get dysphoria from being pregnant*," and "*dysphoria isn't really a one-size-fits-all experience*." CrawlingSpider described not experiencing dysphoria during his own pregnancy: "*That isn't my case*." Yet he also noted, "*I am the only trans person I personally know of who has ever gotten pregnant*." Along with other participants, CrawlingSpider felt that pregnancy-related gender dysphoria was not inevitable.

Finally, some participants posited that for some trans people for whom pregnancy *would* be a source of distress, the desire for children may outweigh that risk. Participants described how pregnancy might be understood as a worthwhile pursuit despite the potential for dysphoria based on an individual's desire for gestational children. For example, AlasLad (trans boy, experienced) and Enigm@tik8 (trans boy, experienced) framed dysphoria during pregnancy as more or less inevitable: "*If you can handle that dysphoria*" and *"[Pregnancy] would make most trans guys dysphoric*." However, AlasLad, Enigm@tik8, and CrawlingSpider each indicated that dysphoria is something that can be weighed against a person's desires to form a family. Each could conceive of circumstances where pregnancy would be tolerated, although perhaps not experienced positively. Where a desire for gestational children is present, they reasoned pregnancy-related dysphoria could be handled, and experiencing it could be worth it if the result was a wanted child. No youth in our sample referenced surrogacy as an option for having genetically related children without having to be personally pregnant.

The relationship between contraceptives and dysphoria

While some participants described pregnancy as entangled with feelings of dysphoria and distress, many felt contraceptives could also trigger dysphoria (Table 3). For instance, some participants emphasized that birth control is understood and marketed as being for cis girls and women, as being inherently feminine, as a reminder of female sex assignment, and as contrary to their trans modalities and gender identities. When asked "what are some reasons why some nonbinary, trans boys or other gender minority teens are getting pregnant?" some participants shared that being unable to access gender-affirming contraceptive methods was a contributing factor. In some instances, it was clear that participants were speaking personally and reflecting on the role of dysphoria in their own understandings and choice of contraceptives. NotASorcerer (nonbinary, experienced) and Queer.breadbasket (nonbinary, experienced), for example, each shared that birth control caused them distress or dysphoria due to their providing a daily reminder of anatomy and seeing birth control as "*a woman's thing*." Dog3529 (nonbinary, experienced) on the other hand, who had previously experienced both pregnancy scares and miscarriages, did not speak directly about his personal experience. Instead, he spoke generally about what he thought was true for other trans people. As such, it is unclear whether Dog3529 personally experienced birth control as distressing due to it being "*seen as a female thing*," and if so, whether this in any way influenced his own pregnancy prevention strategies.

In addition to oral contraceptives, some participants were aware of other methods, including some which they understood as potentially less dysphoria-inducing. Sorrowconlad (nonbinary and experienced), for example, described intrauterine devices as preferable by some trans youth, because they are "*out of sight, out of mind*." This idea of concealable, long-term methods being potentially less associated with dysphoria suggests that methods that are administered daily may be undesirable and used more inconsistently, even when they are available to trans youth, due to the daily distress they might provoke.

Table 2
The relationship between pregnancy and dysphoria quotes

Theme	Example quotes
Pregnancy as inconceivable due to dysphoria	"*…getting pregnant would be horrible for my dysphoria.*" (Mikey, no first- or second-hand experiences of pregnancy) "*I'm not too sure why they might try to get pregnant because I would personally be really dysphoric over something like that so I can't imagine why someone would do that.*" (Ross, no first- or second-hand experiences of pregnancy)
Dynamic understandings of pregnancy-related dysphoria	*"Different things trigger dysphoria differently in different people. Not all trans men will get dysphoria from being pregnant. That isn't my case, but dysphoria isn't really a one size fits all experience. Some people just want biological kids, and for some trans men (and nonbinary people) that desire for biological kids outweighs the dysphoria for them."* (CrawlingSpider, first and second-hand experiences of pregnancy).
Weighing dysphoria with family formation desires	*"I've met trans men that want to have biological children with their s|o [significant other], which I think is great! If you can handle that dysphoria and you WANT to, then good for you."* (AlasLad, no first- or second-hand experiences of pregnancy) *"[Pregnancy] would make most trans guys very dysphoric, but it's worth it for people that really want biological children."* (Enigm@tik8, no first- or second-hand experiences of pregnancy)

Table 3
The relationship between contraceptive methods and dysphoria quotes

Theme	Example quotes
Dysphoria resulting from the gendering of birth control	*"…a lot of trans and enby people don't like the idea of birth control. It is seen as a female thing and many trans and enby people don't like that."* (Dog3529, first- and second-hand experience of pregnancy).
	"Birth control is marketed and perceived as a very feminine thing. For me (a non-binary teenager), being on a contraceptive does cause some dysphoria because it reminds me daily that I have female primary sex characteristics which is one of my biggest dysphoria triggers." (Queer.breadbasket, no first- or second-hand experience of pregnancy)
	"I can't speak for everyone, but for me personally, I struggled with associating myself with birth control pills as it's a 'woman's thing.'" (NotASorcerer, no first- or second-hand experiences of pregnancy)
Dysphoria as impacting contraceptive selection	*"I think one big reason might be, as others are saying, that birth control very commonly has a 'feminine' connotation, and it can feel emasculating to a transmasc individual, or feel otherwise dysphoria-inducing i.e., every time you take a pill, you're reminded of your birth sex. Other forms of birth control are less dysphoria inducing (for some) as they are more out-of-sight, out-of-mind, like IUDs."* (Sorrowconlad, no first- or second-hand experiences of pregnancy)

The relationship between sexual and reproductive healthcare and dysphoria

Importantly, in addition to the potential dysphoria associated with pregnancy and with some contraceptives for preventing pregnancy, participants also identified sexual and reproductive healthcare spaces as potential sites of distress (Table 4). These spaces, and the healthcare providers who work there, were understood as sources of sexual and reproductive health information, as well as gatekeepers to various methods for preventing pregnancy and engaging in safer sex. For instance, when describing an experience accessing birth control via a gynecologist, NebulaPhantom (trans boy and experienced) used evocative language and described it as a "*nightmare*" and as "*torture*." He characterized it as such due to having to talk about "*something you hate and wish to get rid of*." Although he does not explicitly state to what he is referring, we can deduce based on the context of his statement and his reference to accessing birth control, that the thing(s) he hates and wishes to get rid of, is one or more of the following: his internal anatomy, his fertility, his menstrual and ovulatory cycles, and/or his capacity to become pregnant. NebulaPhantom identified having to discuss his need for birth control as distressing in and of itself. Nevertheless, he understood his need for birth control as something he had to talk about; dysphoria and distress was something he needed to manage in order to have vital conversations with healthcare providers.

Discussion

In this qualitative study of 152 trans youth from across the United States, we explored trans youth's perspectives on the complicated relationships between dysphoria, pregnancy, contraceptive methods, and the sexual and reproductive healthcare spaces they might need to access to be given both information about and methods to prevent pregnancy. First, many participants identified pregnancies themselves as possible triggers for dysphoria as distress. Youth were also aware that dysphoria generally, and pregnancy-related dysphoria specifically, were not inevitable experiences. This is an example of trans youth grappling with, and perhaps ultimately rejecting, the idea of gender dysphoria as personal characteristic. According to trans-normative logics, gender dysphoria is framed as a defining characteristic of trans experience, and pregnancy is framed as necessarily incompatible with identifying as something other than a woman [15,21,22]. Some of the youth in this study, alternatively, were aware that some trans people may not experience dysphoria at all, including during pregnancy. Some also considered how pregnancy-related dysphoric distress might conceivably be managed if the person had strong desires for biological, gestational children. While Chen et al. (2018) found that trans youth rejected pregnancy as a pathway to parenthood in favor of adoption, some youth in this study considered it an alternative, where pregnancy need not be outright rejected [14]. Indeed, there is the possibility of "happiness and fulfillment through the embrace of sex and gender incongruency via biological reproduction" [23], where being pregnant while trans is not distressing but affirming. Trans people describe complex embodied experiences of pregnancy and detail various strategies they use to manage the public and private, visible and invisible aspects of those experiences [24]. For some trans people, pregnancy only becomes conceivable following social and/or medical transition [25,26].

Second, many participants expressed concerns that the use of specific contraceptive methods would exacerbate dysphoria. This is a common concern expressed by trans people of all ages, where wanting to avoid potentially 'feminizing' side effects associated with various forms of contraception has been identified as a factor in birth control decision-making [11,27]. Evidence suggests that among trans youth in particular, knowledge about access to and uptake of contraceptives are challenged by pervasive informational erasure and misinformation, cisnormative policies and practices, and gendered language. This decision-making landscape is then made more complicated for trans

Table 4
The relationship between sexual and reproductive healthcare and dysphoria quotes

Theme	Example quotes
Accessing sexual and reproductive healthcare as distressing	*"…getting birth control can be a nightmare. From personal experience, sitting in the room for the gynecologist is torture, purely from the fact that you have to talk about something you hate and wish to get rid of."* (NebulaPhantom, no first- or second-hand experiences of pregnancy)
	"They may be too embarrassed or dysphoric to ask for help or contraceptives." (Ursocute, no first- or second-hand experiences of pregnancy)

youth who may also be accessing testosterone, where testosterone is frequently misunderstood as an effective contraceptive [28]. All of these are entangled with the potential for dysphoria associated with pregnancy prevention strategies and with the act of discussing pregnancy prevention strategies with healthcare providers [14]. This ultimately represents a kind of Catch-22, where both becoming and being pregnant and the available methods for preventing pregnancy, represent a challenge for trans youth's self-concept and may contribute to feelings of distress. Similarly, as mentioned in our introduction, some trans youth who are not engaging in sexual activity that can lead to pregnancy may also use contraceptive methods to suppress menstruation [13]. This can create a similar challenge, as both menstruation and the methods to suppress might exacerbate dysphoria.

Finally, the participants discussed how accessing sexual and reproductive healthcare spaces and services could also be distressing and worsen dysphoria. Navigating the healthcare landscape of actual and potential distress is more complicated when considering the noted gaps in providers' education about trans people's lives and health. Pulice-Farrow et al. (2021), for instance, found that trans people's dysphoria can be exacerbated by the care itself, rather than being something that necessarily lives in any individual trans person's body [29]. For example, the participants in their study identified how dysphoria could be magnified by gynecologists' (1) lack of trans-specific competencies; (2) their use of one-size-fits-all care and one-size-fits-all understandings about trans people's relationships to their bodies and experiences of dysphoria; (3) their assumptions about trans sexual and reproductive lives; and (4) their use of gendered language (on the name of the clinical space, on forms, and when used during interpersonal communication) [29]. When trans youth such as those in our study are already managing more embodied forms of gender-related distress, navigating spaces that may worsen that distress, as one of our participants put it, can be "torture" and a nightmare.

Taken together, these findings demonstrate how some trans youth are neither simply passively accepting prevailing discourses about dysphoria, especially as it pertains to reproductive life and health, nor are they passive recipients of healthcare. Instead, some are actively navigating knowledge systems that often treat trans modality and identity as sites of necessary, fixed, and uniformly experienced dysphoria, while simultaneously navigating healthcare spaces that are often ill-equipped to meet their specific and varied needs. At a time when many US states are passing laws that restrict healthcare access for trans people, particularly for minors, there is an urgent need for healthcare systems to implement policies that ensure trans-inclusive, gender-affirming care at every level. In practice, this means implementing medical education curricula and in-service professional development, which builds the infrastructure necessary to ensure that trans-competent providers are available for trans youth across the country. Healthcare systems and individual providers must be knowledgeable about trans youth's specific clinical needs with regards to pregnancy and contraceptive choices, including the ways that these might be entangled with dysphoria. They must also empower trans youth to navigate their reproductive lives and health with agency, autonomy, confidence, and in accordance with up-to-date and accurate medical information. This latter call to action is being actively undermined by politically motivated misinformation campaigns, increasingly hostile governments, and ongoing debates across the country about whether even mature minors can give consent for medical care. Future research will need to contend with how state-level bans on gender-affirming care coupled with attacks on aspects of healthcare like abortion, for example, affect trans youth's ability to access reproductive healthcare. We are also left with unanswered questions about how dysphoria is being misinterpreted, misconstrued, manipulated, and weaponized to restrict access to needed medical interventions – where this may have profound negative impacts on trans youth well-being.

Limitations

While we endeavored to prioritize the perspectives of youth with first and/or secondhand experiences of pregnancy, there were relatively few such participants, and they did not always reflect on or speak about their personal experiences in response to questions. However, whether participants were speaking personally or speculatively, we contend their perspectives demonstrate the fears, motivations, logics, and conceptualizations held by trans youth, which are undoubtedly affecting their understandings of and decision-making around pregnancy and pregnancy prevention.

The asynchronous focus group method encouraged participants to write responses of any length to questions posted by the moderator, but most participants' posts were relatively brief, ranging from a few words to a short paragraph at most. It is possible that focus groups conducted synchronously, whether virtually or in-person, would have resulted in lengthier and more robust participant responses. This presents a trade-off: while we secured a substantial dataset for analysis from a large number of diverse trans youth, we could not elicit the depth of insight that might have been obtained from fewer participants in a synchronous approach.

Conclusions

Our findings suggest that trans youth have dynamic, nuanced understandings of dysphoria and are aware of the potential impact of dysphoria on their sexual and reproductive lives. The participants in these focus groups did not hold prescriptive views of dysphoria as gender-related distress and a defining characteristic of life as a trans person. At the same time, they identified ways that the cisnormative gendering of embodied experiences like pregnancy, and by extension, the gendering of contraceptive methods and reproductive health care, may require them to navigate terrains of potential dysphoria. Further, we found that trans youth are aware of the importance of discussing their sexual and reproductive health with healthcare providers, even when these conversations are distressing, embarrassing, or otherwise uncomfortable.

The findings from this study have implications for healthcare service provision. Healthcare providers should be equipped with the language, skills, and information to discuss contraception, fertility, family forming desires, pregnancy, and other related topics with trans youth in ways that acknowledge and attend to dysphoria-as-distress, when it occurs. This includes, for example, communicating support of pregnant people of all genders, supporting youth in making informed decisions about pregnancy and its prevention, providing youth with information and guidance as they determine which contraception methods to access, avoiding the unnecessary gendering of contraception devices and pregnancy, and educating youth about other options

available to become parents, including adoption and surrogacy. Part of youth-friendly, trans culturally competent care is therefore delivering contraception, fertility, and family formation counselling in ways that reflect how hormone therapy may ultimately be a step on the path toward gestational parenthood rather than a decision that forecloses that possibility. It also involves helping youth be aware that even if they anticipate contraceptive or pregnancy-related dysphoria as distress, some young people are able to manage this distress to achieve their goals. Finally, rather than assuming that trans youth will necessarily find pregnancy and pregnancy prevention dysphoria-inducing, our findings suggest that healthcare providers can better meet the needs of trans youth by addressing the sometimes messy space of how gender dysphoria is conceptualized and by attending to the ways that trans youth themselves understand the role that dysphoria might play in their reproductive and sexual decision-making.

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