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Lesbian, Gay, Bisexual, Transgender, and Queer Patients: Collegiate Athletic Trainers' Perceptions

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Context: Research suggests that patients who identify as lesbian, gay, bisexual, transgender, or queer (LGBTQ) are at risk for certain conditions and denied equal access to health care in physician offices compared with their heterosexual counterparts. However, little evidence exists regarding the treatment of LGBTQ student-athlete patients in the athletic training clinic and the role the athletic trainer (AT) plays in these health care experiences.

Objective: To explore the perceptions of ATs treating LGBTQ student-athlete patients.

Design: Cross-sectional study.

Setting: Web-based survey.

Patients or Other Participants: A total of 1077 collegiate and university ATs completed the survey (5685 e-mails distributed, 1214 surveys started, access rate = 21.4%, completion rate = 88.7%).

Main Outcome Measure(s): Demographic information and level of agreement in 3 areas (approach, quality of care, and comfort) were obtained on a 5-point Likert scale. We asked ATs their likeliness of providing guidance to student-athletes about navigating their sexuality generally and as it related to athletic participation, if they thought they provided equal health care to a student-athlete who identified as LGBTQ, how comfortable they were treating LGBTQ student-athlete patients, and how comfortable they thought student-athlete patients would be seeking care from them or from providers in their clinic.

Results: Overall, we found differences among groups for sexual orientation, gender, religion, and the existence of interpersonal contact with LGBTQ friends or family for approach, quality of care, and comfort. We also identified 2 main themes indicating ATs' desire for more training and education, specifically in caring for transgender student-athletes and providing patient-centered care with professionalism, regardless of gender identity or sexual orientation.

Conclusions: Although differences existed among demographic groups, ATs had a generally positive view of treating LGBTQ student-athlete patients and wanted more training and education on the specific needs of this population.

Key Words: diversity, health care, gender, sexuality, inclusion

Key Points

- We identified influences of sexual orientation, gender, religion, and interpersonal relationships with lesbian, gay, bisexual, transgender, and queer friends and family on the approach, quality of care, and comfort provided by athletic trainers to lesbian, gay, bisexual, transgender, and queer student-athletes.
- Athletic trainers want more training and education to meet the needs of their transgender patients.
- Collegiate and university athletic trainers were aware of their need to provide patient-centered care, regardless of gender identity or sexual orientation.

A recent report[1] from the Institute of Medicine (National Academies of Medicine–Health and Medicine Division) Leading Health Indicators for Healthy People 2020 focused on lesbian, gay, bisexual, and transgender (LGBT) health concerns and health care disparities. In a 2012 literature review[2] of nurses' attitudes toward LGBT patients, 17 studies demonstrated negative attitudes, and a corresponding study[3] showed that nursing students had a 10% passing level of knowledge about the needs of LGBT people. Addressing this lack of knowledge has emerged as a priority for nursing educators, likely because marginalized populations are at elevated risk of poor health, disability, and premature death.[4] Compared with heterosexuals, lesbian, gay, and bisexual (LGB) populations have higher rates of disability, more physical limitations, and poorer general health.[4] Elevated risks of acquiring human immunodeficiency virus are present among gay men, and obesity is prevalent among lesbians.[4]

Refusal of care, harassment and violence, and lack of provider knowledge with respect to the LGBT community, particularly for individuals who identified as transgender, have been demonstrated.[5] In 2008, the National Center for Transgender Equality and the National Gay and Lesbian Task Force[5] conducted the first comprehensive national transgender discrimination survey. Participants in this study

were denied equal health care treatment in physicians' offices and hospitals (24%), emergency rooms (13%), and mental health clinics (11%) and by emergency medical technicians (5%) and drug treatment programs (3%).[5] Correspondingly, 28% of participants reported verbal harassment in a physician's office when seeking medical care.[5] This discrimination is a major deterrent to accessing health care services,[6] negatively affecting the health of these individuals.

Health care disparities have been well documented in the health care literature; however, little research exists on the unique needs of lesbian, gay, bisexual, transgender, and queer (LGBTQ) patients participating in collegiate athletics. Lesbian, gay, bisexual, and transgender athletes face a multifaceted and heteronormative culture in athletics, which may have negative effects, both physically and mentally.[7] Previous researchers[8] evaluated the effect of a coach's role on athletes' perception of inclusiveness. Using the Coach Athlete Relationship Questionnaire, they found evidence to suggest that athletes who identified as LGBTQ had weaker relationships with their coaches than other athletes.[8] Similarly, LGBTQ athletes' experiences with their teammates have also been explored, with an overwhelming agreement regarding the need to increase both the awareness of these teammates and support of student-athletes who identify as LGBTQ.[9] Despite these strides to better understand the experiences and perceptions of LGBTQ athletes in athletics departments, little research has been conducted to investigate the relationship between the athletic trainer (AT) and patient.

The most recent study[10] in this area, published in 2011, explored heterosexual ATs' attitudes toward LGB student-athletes at National Collegiate Athletic Association (NCAA) institutions. The authors found that ATs held mostly positive views of student-athletes who identified as LGB; however, this differed statistically among sexes, age groups, and religious affiliations,[10] and 15% of the ATs held negative views toward LGB student-athletes.[10] Since 2011, resources, social norms, and legislation targeted at improving inclusivity have emerged, warranting further exploration of this topic. One of the most notable resources is the NCAA Inclusion Initiative Framework (http://www.ncaa.org/about/resources/inclusion/lgbtq-resources), which provides information about participation for transgender student-athletes, diversity training workshops, and best-practice recommendations, as well as articles of interest for those wishing to be more inclusive. Although these resources offer valuable information to student-athletes, coaches, and athletic administrators, ATs have not been involved in developing best-practice recommendations for athletic training clinics.

Racial and ethnic disparities in health care access exist based on social and economic inequality, prejudice, and internal bias.[11] An important factor when considering the AT's role in these disparities is their level of cultural competence. A culturally competent person understands and integrates differences, incorporates them into daily care, and works effectively in cross-cultural situations.[12] Athletic trainers may not be aware that the cultural differences between them as health care professionals and the patients they treat could create a hostile environment for diverse individuals. Although ATs reported a high level of cultural competence when treating diverse individuals, previous investigators[13] argued that ATs were less culturally competent in delivering health care services. To close the gap between ATs' perceptions of and actual cultural competence in the delivery of athletic training services, we must first understand how ATs perceive treating such a population. The information gained by evaluating ATs' perceptions related to LGBTQ patient care will provide insight into potential biases, which can then be addressed through training and education.

Athletic trainers must comply with the Board of Certification "Standards of Professional Practice," Code 1: Patient Care Responsibilities,[14] which states that ATs must "render quality patient care regardless of ... any ... characteristic protected by law." Therefore, the purpose of our study was to evaluate ATs' perceptions of student-athlete patients who identified as LGBTQ. We examined ATs' level of approach, quality of care, and comfort when treating student-athlete patients who identified as LGBTQ. Our research questions were

1. Does the comfort of ATs with a family or friend who identifies as LGBTQ differ in treating a student-athlete patient who identifies as LGBTQ?
2. Are ATs with different religious affiliations less comfortable treating a student-athlete who identifies as LGBTQ?
3. Are ATs, in general, less comfortable treating a specific member of the LGBTQ community?
4. Why do ATs feel the way they do regarding their approach, quality of care, and perceived comfort?

METHODS

We used a cross-sectional survey research design.

Participants

Collegiate and university ATs (N = 1077; men = 420, women = 653, female to male = 2; 2 individuals did not provide data) with various years of experience, religious affiliations, and levels of education participated in this study (Table 1). Each participant was asked to complete the questionnaire regarding his or her perceptions of providing care to patients who identified as LGBTQ. We did not collect any identifying participant or institutional information. The Indiana State University Institutional Review Board approved this study. A random sample of participants was recruited through the e-mail addresses provided by the National Athletic Trainers' Association (NATA). We sent e-mails to individuals who were identified as working in the collegiate setting. Athletic trainers working in any other practice setting or not working clinically were excluded from the study. In total, 5685 e-mails were sent to ATs using Qualtrics software (Qualtrics LLC, Provo, UT); 1214 individuals began the survey and 1077 completed it (access rate = 21.4%, completion rate = 88.7%).

Instrumentation

Using Qualtrics software, we constructed a 19-item questionnaire to assess the approach, quality of care, and perceived comfort of ATs with student-athletes who identified as LGBTQ. The questionnaire aimed to address

Table 1. Participant Demographics (N = 1077)[a]

Characteristic	Frequency (%)
Sex (n = 1075)	
Male	420 (39.1)
Female	653 (60.7)
Female to male	2 (0.2)
Years of experience (n = 1066)	
0–1	79 (7.4)
2–5	305 (28.6)
6–10	227 (21.3)
11–20	272 (25.5)
>20	183 (17.2)
Religious affiliation (n = 1065)	
Christian	659 (61.9)
Non-Christian	17 (1.6)
Nonreligious	285 (26.8)
Not practicing	104 (9.8)
Highest degree earned (n = 1074)	
Bachelor's	146 (13.6)
Master's	790 (73.6)
Clinical doctorate	15 (1.4)
Academic doctorate	123 (11.5)

[a] Not all participants answered all questions.

gaps in the current literature[10] and answer the research questions. We identified a panel of 4 experts (2 survey experts and 2 experts in the area of LGBTQ student-athlete–AT relationships) to conduct a content analysis. The panel made suggestions for revisions (predominantly grammatical) and after making those changes, we conducted a pilot study with ATs at a Midwest NCAA Division I institution to establish internal consistency and determine the feasibility of the study. Eighteen ATs completed the pilot study. This allowed us to identify any navigation problems within the tool. The pilot study also revealed that the average time to completion was reasonable (5–10 minutes). Overall, the tool demonstrated excellent overall internal consistency (Cronbach $\alpha = 0.918$) and reasonable internal consistency for each of the populations assessed (lesbian [women] = 0.577, gay [men] = 0.659, bisexual = 0.672, transgender = 0.734, and queer = 0.727).

We asked 7 demographic questions to characterize our participants. Additionally, we asked 3 questions specific to previous LGBTQ experiences. These consisted of 1 question regarding the AT's exposure to student-athletes who identified as LGBTQ, 1 question regarding the AT's exposure to a friend or family member who identified as LGBTQ, and 1 question regarding previous education or training on caring for LGBTQ athletes. We created 7 matrices to address our variables of interest, with 5 populations represented in each matrix: (1) lesbian (women), (2) gay (men), (3) bisexual, (4) transgender, and (5) queer. Participants were asked to answer the question for each of the 5 population items using a 5-point Likert scale.

The variables of interest were level of approach, quality of care, and comfort. Approach and quality of care were assessed with 1 question each regarding the differences from or similarities to providing health care for a student-athlete who identified as LGBTQ versus heterosexual. Level of comfort was assessed with 5 questions regarding the ATs' likeliness of providing health care to a student-athlete who identified as LGBTQ; how comfortable that student would be seeking care from him or her as a health care professional, as well as from the clinic; and how comfortable the AT would be providing guidance to student-athletes about navigating their sexuality, both personally and as it related to athletic participation. These questions were intended to gather information on ATs' level of comfort discussing specific needs of the LGBTQ population. We had 2 open-ended items for each construct to allow the ATs to provide any explanation or rationale for their perceptions. We asked participants to "please explain why you feel the way you do" after the Likert-scale questions on approach, quality of care, and comfort.

Procedures

We e-mailed potential participants a description of the study and directions on how to complete the questionnaire and provided a link to the questionnaire via an encrypted survey system (Qualtrics). We sent reminder e-mails every week for 4 weeks and closed the survey after 5 weeks. If participants clicked on the link, they landed on a page requesting informed consent. They indicated consent by clicking "I agree to participate." They then completed the questionnaire, answering only the questions they wanted to, and could close the browser at any time.

Statistical Analysis

We conducted analyses to calculate the characteristics of central tendencies to evaluate the approach, quality of care, and level of comfort from ATs' perceptions of student-athletes who identified as LGBTQ. We performed comparative analyses among sexual orientation, gender, years of experience, interpersonal contact, and religion using Mann-Whitney U or Kruskal-Wallis tests on the items that addressed our variables of interest (approach, quality of care, and level of comfort). We performed nonparametric statistics (Mann-Whitney U and Kruskal-Wallis tests) because the groups were of unequal sizes. Partial data were used in the analysis, and the number of participants was indicated throughout the results for each analysis. Participants often began a questionnaire but responded only to specific items or discontinued responding at their discretion. This is their right as research participants and aligns with the principle of voluntariness in the Belmont Report.[15] As such, the number of respondents may vary with each question. This missing data were not random, which made it difficult to eliminate bias using missing data-management techniques. Partial data-analysis techniques are consistently used throughout the literature. Significance was set a priori at $P < .05$.

We performed a process of inductive coding to develop themes from the qualitative feedback. We systematically evaluated the data using codes to group common themes in the open-ended responses.[16] Two reviewers read each participant comment and met to discuss their findings and develop a codebook. They then coded responses using the consensus codebook until data saturation occurred. When consensus was not achieved, a third reviewer was consulted. The findings were audited by an experienced qualitative researcher to establish credibility. For the question regarding comfort working with an LGBTQ patient or how comfortable a patient might be seeking care

Table 2. Participants' Perceptions of Approach, Quality of Care, and Comfort (Mean ± SD)

Question	Lesbian	Gay	Bisexual	Transgender	Queer
Approach					
Does your approach to providing health care change when providing health care to a student-athlete who identifies as _____ as compared to a heterosexual student-athlete?	1.37 ± 0.81	1.34 ± 0.81	1.38 ± 0.81	1.60 ± 0.98	1.44 ± 0.86
Quality of Care					
Does the quality of health care you provide differ between a student-athlete who identifies as _____ as compared to a heterosexual student-athlete?	1.12 ± 0.54	1.12 ± 0.54	1.12 ± 0.54	1.17 ± 0.59	1.15 ± 0.56
Comfort					
How comfortable would you feel providing health care to a student-athlete who identifies as the following?	4.88 ± 0.51	4.86 ± 0.54	4.87 ± 0.50	4.64 ± 0.78	4.78 ± 0.64
How comfortable would a student-athlete who identifies as _____ feel seeking care from you as a health care professional as compared to a heterosexual student-athlete?	4.78 ± 0.61	4.76 ± 0.62	4.77 ± 0.62	4.68 ± 0.72	4.71 ± 0.68
How comfortable would a student-athlete who identifies as _____ feel seeking care from your clinic as compared to a heterosexual student-athlete?	4.65 ± 0.73	4.62 ± 0.75	4.61 ± 0.74	4.52 ± 0.85	4.57 ± 0.81
How comfortable would you feel if a student-athlete who identifies as _____ seeks your guidance for navigating his or her sexuality?	3.42 ± 1.45	3.34 ± 1.14	3.39 ± 1.14	3.23 ± 1.17	3.29 ± 1.12
How comfortable would you feel if a student-athlete who identifies as _____ seeks your guidance for navigating his or her sexuality specifically regarding athletic participation?	3.80 ± 1.10	3.78 ± 1.10	3.78 ± 1.07	3.56 ± 1.13	3.69 ± 1.10

from an AT's clinic, we received 883 responses. For the question specifically regarding how comfortable an AT would feel providing guidance on navigating sexuality, we received 839 responses.

RESULTS

A large majority (n = 844, 78.9%) of participants indicated that they had a close friend or family member who identified as LGBTQ, and 771 (71.6%) indicated they had worked with another AT who identified as LGBTQ. Overwhelmingly, participants (n = 1021, 94.8%) reported they had worked with a patient or AT who identified as LGBTQ. The majority of ATs identified as heterosexual (n = 913, 84.8%), whereas a smaller demographic identified as lesbian, gay, bisexual, transgender, queer, intersex, or androgynous (LGBTQIA; n = 167, 15.5%). In terms of approach, ATs strongly disagreed that their approach or quality of care would differ when treating a patient who identified as LGBTQ (Table 2). Most ATs agreed that they would feel comfortable providing care to a student-athlete who identified as LGBTQ (Table 2). Athletic trainers also commented that they believed a student-athlete would feel comfortable seeking care both from them, as health care professionals, and from their clinic (Table 2). A large portion of of our participants reported that they had received no formal training on the needs of lesbian (n = 444, 41.2%), gay (n = 444, 41.2%), bisexual (n = 455, 42.2%), transgender (n = 482, 44.8%), or queer (n = 477, 44.3%) individuals. Very few participants reported that they had received formal training on the needs of lesbian (n = 115, 10.7%), gay (n = 109, 10.1%), bisexual (n = 107, 9.9%), transgender (n = 103, 9.6%), or queer (n = 96, 8.9%) individuals.

Sexual Orientation

The LGBTQIA and heterosexual ATs differed in regard to their perceived comfort in treating lesbian ($P = .002$), gay ($P = .001$), bisexual ($P = .001$), transgender ($P = .031$), and queer ($P = .002$) individuals. Additionally, the LGBTQIA and heterosexual ATs differed in regard to their perception of how comfortable a student-athlete would feel seeking care from them as a health care professional for lesbian ($P = .001$), gay ($P < .001$), bisexual ($P = .001$), transgender ($P = .004$), and queer ($P < .001$) individuals but not in comfort seeking care from their clinic. Athletic trainers who identified as LGBTQIA felt more comfortable than heterosexual ATs providing guidance on navigating the student-athletes' sexuality in general and as it related to athletic participation for student-athletes who identified as lesbian ($P < .001$), gay ($P < .001$), bisexual ($P < .001$), transgender ($P < .001$), and queer ($P < .001$).

Gender

Athletic trainers in general did not perceive that their approaches to LGB and queer individuals were different, but female ATs noted differences in their approach to transgender individuals ($P = .028$; Table 3). Male ATs indicated that the quality of their care changed significantly with all LGBTQ individuals (Table 3). Female ATs described being more comfortable providing guidance for navigating sexuality generally and as it related to sport participation among lesbian ($P < .001$), gay ($P = .003$), bisexual ($P < .001$), transgender ($P = .005$), and queer ($P = .001$) individuals (Table 3). Compared with their male counterparts, female ATs described feeling more comfortable providing care for lesbian ($P = .014$), gay ($P < .001$), and bisexual ($P = .002$) individuals. Female ATs also believed that LGBTQ individuals would feel more

Table 3. Comparison by Gender for Approach, Quality of Care, and Comfort[a]

Statement	Population	Mode	Mean ± SD (Range) Female (n = 597)	Male (n = 373)	*P* Value
Does your **approach** to providing health care change when providing health care to a student-athlete who identifies as ___?[c]	Lesbian	1	1.37 ± 0.80 (1–5)	1.34 ± 0.78 (1–5)	.788
	Gay	1	1.38 ± 0.81 (1–5)	1.36 ± 0.79 (1–5)	.795
	Bisexual	1	1.10 ± 0.49 (1–5)	1.14 ± 0.54 (1–5)	.898
	Transgender	1	1.15 ± 0.56 (1–5)	1.18 ± 0.58 (1–5)	.028
	Queer	1	1.13 ± 0.51 (1–5)	1.16 ± 0.55 (1–5)	.550
Does the **quality** of health care you provide differ between student-athletes who identifies as ___?[c]	Lesbian	1	1.10 ± 0.49 (1–5)	1.14 ± 0.54 (1–5)	.014
	Gay	1	1.10 ± 0.49 (1–5)	1.14 ± 0.54 (1–5)	.017
	Bisexual	1	1.11 ± 0.51 (1–5)	1.14 ± 0.52 (1–5)	.014
	Transgender	1	1.16 ± 0.57 (1–5)	1.17 ± 0.56 (1–5)	.033
	Queer	1	1.13 ± 0.53 (1–5)	1.15 ± 0.53 (1–5)	.039
How **comfortable** would you feel **providing health care** to a student-athlete who identifies as the following?[b]	Lesbian	5	4.92 ± 0.39 (1–5)	4.85 ± 0.56 (1–5)	.014
	Gay	5	4.93 ± 0.36 (1–5)	4.79 ± 0.64 (1–5)	<.001
	Bisexual	5	4.92 ± 0.39 (1–5)	4.82 ± 0.59 (1–5)	.002
	Transgender	5	4.68 ± 0.71 (1–5)	4.60 ± 0.85 (1–5)	.544
	Queer	5	4.82 ± 0.56 (1–5)	4.74 ± 0.70 (1–5)	.089
How **comfortable** would a student-athlete who identifies as ___ feel seeking care from **you**?[b]	Lesbian	5	4.84 ± 0.51 (1–5)	4.67 ± 0.74 (1–5)	<.001
	Gay	5	4.84 ± 0.52 (1–5)	4.64 ± 0.75 (1–5)	<.001
	Bisexual	5	4.84 ± 0.51 (1–5)	4.65 ± 0.75 (1–5)	<.001
	Transgender	5	4.75 ± 0.62 (1–5)	4.55 ± 0.84 (1–5)	<.001
	Queer	5	4.79 ± 0.59 (1–5)	4.60 ± 0.79 (1–5)	<.001
How **comfortable** would a student-athlete who identifies as ___ feel seeking care from your **clinic**?[b]	Lesbian	5	4.68 ± 0.68 (1–5)	4.59 ± 0.80 (1–5)	.190
	Gay	5	4.66 ± 0.71 (1–5)	4.57 ± 0.81 (1–5)	.113
	Bisexual	5	4.67 ± 0.69 (1–5)	4.58 ± 0.81 (1–5)	.216
	Transgender	5	4.54 ± 0.83 (1–5)	4.49 ± 0.87 (1–5)	.441
	Queer	5	4.60 ± 0.78 (1–5)	4.53 ± 0.84 (1–5)	.234
How **comfortable** would you feel if a student-athlete who identifies as ___ seeks your **guidance for navigating his or her sexuality**?[b]	Lesbian	4	3.56 ± 1.14 (1–5)	3.21 ± 1.14 (1–5)	.788
	Gay	4	3.49 ± 1.13 (1–5)	3.22 ± 1.15 (1–5)	.795
	Bisexual	4	3.53 ± 1.14 (1–5)	3.21 ± 1.14 (1–5)	.898
	Transgender	3	3.35 ± 1.17 (1–5)	3.03 ± 1.17 (1–5)	.028
	Queer	4	3.42 ± 1.17 (1–5)	3.10 ± 1.16 (1–5)	.550
How **comfortable** would you feel if a student-athlete who identifies as ___ seeks your guidance for navigating his or her sexuality specifically **regarding athletic participation**?[b]	Lesbian	4	3.89 ± 1.05 (1–5)	3.65 ± 1.08 (1–5)	<.001
	Gay	4	3.86 ± 1.05 (1–5)	3.65 ± 1.10 (1–5)	.003
	Bisexual	4	3.87 ± 1.05 (1–5)	3.64 ± 1.08 (1–5)	<.001
	Transgender	4	3.66 ± 1.12 (1–5)	3.45 ± 1.15 (1–5)	<.001
	Queer	4	3.78 ± 1.09 (1–5)	3.55 ± 1.12 (1–5)	.001

[a] Instrument is reproduced in its original format.
[b] Scale: 1 = *extremely uncomfortable*, 2 = *somewhat uncomfortable*, 3 = *neither comfortable nor uncomfortable*, 4 = *somewhat comfortable*, 5 = *extremely comfortable*.
[c] Scale: 1 = *definitely not*, 2 = *probably not*, 3 = *might or might not*, 4 = *probably yes*, 5 = *definitely yes*.

comfortable seeking care from them and their clinic than did their male counterparts (Table 3).

Religion

Athletic trainers indicated that their approach to providing health care was not influenced by religion when treating lesbian ($P = .603$), gay ($P = .676$), bisexual ($P = .309$), transgender ($P = .276$), or queer ($P = .364$) patients. Similarly, religious differences did not influence ATs' perceived quality of health care for lesbian ($P = .356$), gay ($P = .324$), bisexual ($P = .356$), transgender ($P = .141$), or queer ($P = .104$) patients.

Religion influenced ATs' comfort in treating gay patients ($\chi^2_3 = 8.596$, $P = .035$), whereas those with no religious affiliation were more comfortable treating gay patients than were Christians ($P = .009$). Similarly, religion influenced comfort in treating queer patients ($\chi^2_3 = 8.792$, $P = .032$), as ATs with no religious affiliation were statistically more comfortable than Christians ($P = .009$) and those whose religion was not listed ($P = .009$; Table 4).

Christian and nonreligious ATs' comfort levels differed when providing guidance to lesbian ($\chi^2_3 = 17.854$, $P = .000$), gay ($\chi^2_3 = 14.327$, $P = .002$), bisexual ($\chi^2_3 = 18.734$, $P = .000$), transgender ($\chi^2_3 = 11.814$, $P = .008$), and queer ($\chi^2_3 = 14.165$, $P = .003$) patients about navigating their sexuality. Nonreligious ATs felt more comfortable than did Christian ATs in treating queer patients ($P = .009$; Table 4). Religion also influenced the comfort providing guidance about navigating sexuality with respect to athletic participation, as Christian ATs were less comfortable than nonreligious ATs with lesbian ($P = .001$), gay ($P = .001$), bisexual ($P < .001$), transgender ($P = .007$), and queer ($P = .001$) patients (Table 4). Nonpracticing or nonreligious ATs were more comfortable providing such guidance in regard to athletic participation than non-Christian ATs to lesbian ($P = .047$) and queer ($P = .039$) patients. The ATs' perceptions about whether their lesbian ($P = .242$), gay ($P = .188$), bisexual ($P = .248$), transgender ($P = .094$), and queer ($P = .091$) patients were comfortable with them as clinicians did not differ. Similarly, the perceived comfort of patients with the AT's clinic for lesbian ($P = .242$), gay (P

Table 4. Comparison Among Religious Groups for Approach, Quality of Care, and Comfort[a]

Statement	Population	Mode	Mean ± SD (Range)			
			Christian (n = 594)	Non-Christian (n = 14)	Not Practicing or Not Religious (n = 261)	Not Reported (n = 96)
Does your **approach** to providing health care change when providing health care to a student-athlete who identifies as ___?[d]	Lesbian	1	1.36 ± 0.80 (1–5)	1.64 ± 1.15 (1–4)	1.33 ± 0.72 (1–4)	1.36 ± 0.80 (1–5)
	Gay	1	1.37 ± 0.80 (1–5)	1.64 ± 1.15 (1–4)	1.34 ± 0.76 (1–4)	1.38 ± 0.79 (1–5)
	Bisexual	1	1.37 ± 0.80 (1–5)	1.79 ± 1.19 (1–4)	1.33 ± 0.71 (1–4)	1.38 ± 0.80 (1–5)
	Transgender	1	1.59 ± 0.96 (1–5)	2.07 ± 1.44 (1–5)	1.57 ± 0.94 (1–5)	1.59 ± 0.96 (1–5)
	Queer	1	1.44 ± 0.86 (1–5)	1.86 ± 1.29 (1–4)	1.39 ± 0.77 (1–4)	1.45 ± 0.81 (1–4)
Does the **quality** of health care you provide differ between student-athletes who identifies as ___?[d]	Lesbian	1	1.14 ± 0.57 (1–5)	1.00 ± 0.00 (1)	1.07 ± 0.35 (1–5)	1.10 ± 0.47 (1–5)
	Gay	1	1.14 ± 0.58 (1–5)	1.00 ± 0.00 (1)	1.07 ± 0.35 (1–5)	1.10 ± 0.47 (1–5)
	Bisexual	1	1.14 ± 0.57 (1–5)	1.00 ± 0.00 (1)	1.07 ± 0.35 (1–5)	1.10 ± 0.47 (1–5)
	Transgender	1	1.18 ± 0.62 (1–5)	1.00 ± 0.00 (1)	1.11 ± 0.44 (1–5)	1.20 ± 0.61 (1–5)
	Queer	1	1.17 ± 0.60 (1–5)	1.00 ± 0.00 (1)	1.08 ± 0.36 (1–5)	1.13 ± 0.42 (1–3)
How **comfortable** would you feel **providing health care** to a student-athlete who identifies as the following?[b]	Lesbian	5	4.86 ± 0.55 (1–5)	4.93 ± 0.27 (4–5)	4.93 ± 0.31 (3–5)	4.90 ± 0.37 (3–5)
	Gay	5	4.84 ± 0.57 (1–5)	5.00 ± 0.00 (5)	4.94 ± 0.30[c] (3–5)	4.88 ± 0.47 (2–5)
	Bisexual	5	4.86 ± 0.55 (1–5)	4.86 ± 0.54 (3–5)	4.77 ± 0.56 (3–5)	4.90 ± 0.37 (3–5)
	Transgender	5	4.60 ± 0.84 (1–5)	4.64 ± 0.84 (2–5)	4.50 ± 0.94[b] (2–5)	4.63 ± 0.74 (2–5)
	Queer	5	4.74 ± 0.71 (1–5)	4.86 ± 0.36 (4–5)	4.89 ± 0.39 (3–5)	4.77 ± 0.53 (3–5)
How **comfortable** would a student-athlete who identifies as ___ feel seeking care from **you**?[b]	Lesbian	5	4.75 ± 0.66 (1–5)	4.71 ± 0.73 (3–5)	4.84 ± 0.49 (3–5)	4.75 ± 0.58 (3–5)
	Gay	5	4.74 ± 0.67 (1–5)	4.71 ± 0.73 (3–5)	4.83 ± 0.49 (3–5)	4.74 ± 0.59 (3–5)
	Bisexual	5	4.74 ± 0.68 (1–5)	4.71 ± 0.73 (3–5)	4.83 ± 0.49 (3–5)	4.75 ± 0.58 (3–5)
	Transgender	5	4.64 ± 0.79 (1–5)	4.64 ± 0.75 (3–5)	4.78 ± 0.55 (3–5)	4.66 ± 0.65 (3–5)
	Queer	5	4.68 ± 0.74 (1–5)	4.71 ± 0.73 (3–5)	4.81 ± 0.52 (3–5)	4.70 ± 0.62 (3–5)
How **comfortable** would a student-athlete who identifies as ___ feel seeking care from your **clinic**?[b]	Lesbian	5	4.63 ± 0.78 (1–5)	4.64 ± 0.75 (3–5)	4.67 ± 0.71 (1–5)	4.67 ± 0.66 (2–5)
	Gay	5	4.65 ± 0.71 (1–5)	4.64 ± 0.75 (3–5)	4.67 ± 0.70 (1–5)	4.55 ± 0.66 (2–5)
	Bisexual	5	4.65 ± 0.70 (1–5)	4.64 ± 0.75 (3–5)	4.66 ± 0.71 (1–5)	4.66 ± 0.66 (2–5)
	Transgender	5	4.54 ± 0.82 (1–5)	4.57 ± 0.76 (3–5)	4.56 ± 0.81 (1–5)	4.56 ± 0.72 (2–5)
	Queer	5	4.60 ± 0.77 (1–5)	4.64 ± 0.75 (3–5)	4.64 ± 0.73 (1–5)	4.57 ± 0.74 (2–5)
How **comfortable** would you feel if a student-athlete who identifies as ___ seeks your **guidance for navigating his or her sexuality**?[b]	Lesbian	4	3.34 ± 1.15 (1–5)	4.00 ± 0.96[e] (2–5)	3.64 ± 1.13[c] (1–5)	3.23 ± 1.17[f] (1–5)
	Gay	4	3.31 ± 1.15 (1–5)	3.86 ± 0.86[e] (2–5)	3.57 ± 1.11[c] (1–5)	3.20 ± 1.18[f] (1–5)
	Bisexual	4	3.32 ± 1.15 (1–5)	3.93 ± 0.92[e] (2–5)	3.63 ± 1.11[c] (1–5)	3.19 ± 1.18[f] (1–5)
	Transgender	3	3.15 ± 1.19 (1–5)	3.71 ± 1.07[e] (1–5)	3.41 ± 1.14[c] (1–5)	3.05 ± 1.14[f] (1–5)
	Queer	4	3.23 ± 1.18 (1–5)	3.75 ± 0.93[e,g] (2–5)	3.47 ± 1.12[c] (1–5)	3.08 ± 1.18[f] (1–5)
How **comfortable** would you feel if a student-athlete who identifies as ___ seeks your guidance for navigating his or her sexuality specifically **regarding athletic participation**?[b,d]	Lesbian	4	3.73 ± 1.06 (1–5)	4.50 ± 0.63[g] (3–5)	3.97 ± 1.02[c,h] (1–5)	3.65 ± 1.18[e,f] (1–5)
	Gay	4	3.71 ± 1.08 (1–5)	4.38 ± 0.72[g] (3–5)	3.95 ± 1.01[c] (1–5)	3.64 ± 1.17[e,f] (1–5)
	Bisexual	4	3.71 ± 1.06 (1–5)	4.44 ± 0.63[g] (3–5)	3.07 ± 1.02[c] (1–5)	3.63 ± 1.18[e,f] (1–5)
	Transgender	4	3.53 ± 1.14 (1–5)	4.19 ± 0.91[g] (2–5)	3.74 ± 1.07[c] (1–5)	3.44 ± 1.21[e,f] (1–5)
	Queer	4	3.61 ± 1.12 (1–5)	4.44 ± 0.63[g] (3–5)	3.87 ± 1.04[c] (1–5)	3.56 ± 1.17[e,f] (1–5)

[a] Instrument is reproduced in its original format.
[b] Scale: 1 = *extremely uncomfortable*, 2 = *somewhat uncomfortable*, 3 = *neither comfortable nor uncomfortable*, 4 = *somewhat comfortable*, 5 = *extremely comfortable*.
[c] *Christian* was different from *not practicing* or *not religious*.
[d] Scale: 1 = *definitely not*, 2 = *probably not*, 3 = *might or might not*, 4 = *probably yes*, 5 = *definitely yes*.
[e] *Not reported* was different from *non-Christian*.
[f] *Not practicing* or *not religious* was different from *not reported*.
[g] *Christian* was different from *non-Christian*.
[h] *Not practicing* or *not religious* was different from *non-Christian*.

= .188), bisexual ($P = .248$), transgender ($P = .094$), and queer ($P = .091$) patients did not differ.

Interpersonal Contact

Those with a close friend or family member who identified as LGBTQ were more comfortable providing care to lesbian ($\chi^2_2 = 13.353$, $P = .001$), gay ($\chi^2_2 = 18.338$, $P < .001$), bisexual ($\chi^2_2 = 17.823$, $P < .001$), transgender ($\chi^2_2 = 9.782$, $P = .008$), and queer ($\chi^2_2 = 21.401$, $P < .001$) individuals (Table 5). Athletic trainers with a close friend or family member who identified as LGBTQ were more comfortable providing care to bisexual ($P = .013$) and queer ($P = .025$) patients than ATs who were unsure of whether they had interpersonal contact with an LGBTQ individual. Those who had interpersonal contact with an LGBTQ individual also perceived that a patient who identified as lesbian ($\chi^2_2 = 20.724$, $P < .001$), gay ($\chi^2_2 = 21.401$, $P < .0001$), bisexual ($\chi^2_2 = 20.820$, $P < .001$), transgender ($\chi^2_2 = 21.734$, $P < .001$), or queer ($\chi^2_2 = 21.626$, $P < .001$) would feel comfortable seeking care from them as a health care professional (Table 5). The approach to and quality of care did not differ between ATs with a close friend or family member who identified as LGBTQ and those without.

In terms of comfort with guidance in navigating sexuality, those with a close friend or family member who identified as LGBTQ felt more comfortable with lesbian ($\chi^2_2 = 52.2057$, $P < .001$), gay ($\chi^2_2 = 48.860$, $P = .002$), bisexual ($\chi^2_2 = 48.852$, $P < .001$), transgender ($\chi^2_2 = 44.226$, $P < .001$), and queer ($\chi^2_2 = 46.719$, $P < .001$)

Table 5. Comparison of Those With and Those Without a Previous Relationship With a Lesbian, Gay, Bisexual, Transgender, or Queer Person for Approach, Quality of Care, and Comfort[a]

Statement	Population	Mode	Mean ± SD (Range)		
			Yes (n = 765)	No (n = 182)	Unsure (n = 28)
Does your **approach** to providing health care change when providing health care to a student-athlete who identifies as ___?[f]	Lesbian	1	1.37 ± 0.80 (1–5)	1.32 ± 0.78 (1–5)	1.32 ± 0.77 (1–4)
	Gay	1	1.38 ± 0.81 (1–5)	1.34 ± 0.76 (1–5)	1.32 ± 0.77 (1–4)
	Bisexual	1	1.37 ± 0.80 (1–5)	1.35 ± 0.79 (1–5)	1.32 ± 0.77 (1–4)
	Transgender	1	1.60 ± 0.97 (1–5)	1.53 ± 0.83 (1–5)	1.75 ± 1.18 (1–4)
	Queer	1	1.44 ± 0.85 (1–5)	1.42 ± 0.84 (1–5)	1.43 ± 0.92 (1–4)
Does the **quality** of health care you provide differ between student-athletes who identifies as ___?[f]	Lesbian	1	1.11 ± 0.51 (1–5)	1.14 ± 0.52 (1–5)	1.04 ± 0.19 (1–2)
	Gay	1	1.11 ± 0.51 (1–5)	1.14 ± 0.52 (1–5)	1.07 ± 0.26 (1–2)
	Bisexual	1	1.11 ± 0.51 (1–5)	1.14 ± 0.52 (1–5)	1.04 ± 0.19 (1–2)
	Transgender	1	1.16 ± 0.57 (1–5)	1.17 ± 0.56 (1–5)	1.14 ± 0.45 (1–3)
	Queer	1	1.13 ± 0.53 (1–5)	1.15 ± 0.53 (1–5)	1.14 ± 0.45 (1–3)
How **comfortable** would you feel **providing health care** to a student-athlete who identifies as the following?[b]	Lesbian	5	4.92 ± 0.42 (1–5)	4.81 ± 0.61[c] (1–5)	4.75 ± 0.70 (2–5)
	Gay	5	4.90 ± 0.44 (1–5)	4.79 ± 0.623 (1–5)	4.75 ± 0.59 (2–5)
	Bisexual	5	4.91 ± 0.43 (1–5)	4.86 ± 0.54[c] (1–5)	4.93 ± 0.31[d] (3–5)
	Transgender	5	4.70 ± 0.70 (1–5)	4.50 ± 0.94[c] (1–5)	4.39 ± 1.10 (2–5)
	Queer	5	4.82 ± 0.58 (1–5)	4.69 ± 0.73[c] (1–5)	4.57 ± 0.84[d] (2–5)
How **comfortable** would a student-athlete who identifies as ___ feel seeking care from **you**?[b]	Lesbian	5	4.67 ± 0.69 (1–5)	4.59 ± 0.85[c] (1–5)	4.43 ± 0.88[d] (3–5)
	Gay	5	4.80 ± 0.57 (1–5)	4.66 ± 0.74[c] (1–5)	4.39 ± 0.88[d] (3–5)
	Bisexual	5	4.80 ± 0.57 (1–5)	4.68 ± 0.74[c] (1–5)	4.39 ± 0.88[d] (3–5)
	Transgender	5	4.72 ± 0.68 (1–5)	4.59 ± 0.79[c] (1–5)	4.18 ± 0.98[d,e] (2–5)
	Queer	5	4.78 ± 0.63 (1–5)	4.63 ± 0.78[c] (1–5)	4.21 ± 1.00[d,e] (2–5)
How **comfortable** would a student-athlete who identifies as ___ feel seeking care from your **clinic**?[b]	Lesbian	5	4.63 ± 0.78 (1–5)	4.64 ± 0.75 (1–5)	4.67 ± 0.71 (3–5)
	Gay	5	4.65 ± 0.71 (1–5)	4.55 ± 0.88 (1–5)	4.46 ± 0.88 (3–5)
	Bisexual	5	4.65 ± 0.70 (1–5)	4.58 ± 0.85 (1–5)	4.43 ± 0.88 (3–5)
	Transgender	5	4.54 ± 0.82 (1–5)	4.47 ± 0.93 (1–5)	4.25 ± 0.93 (3–5)
	Queer	5	4.60 ± 0.77 (1–5)	4.52 ± 0.92 (1–5)	4.29 ± 0.94 (3–5)
How **comfortable** would you feel if a student-athlete who identifies as ___ seeks your **guidance for navigating his or her sexuality**?[b]	Lesbian	4	3.56 ± 1.11 (1–5)	2.95 ± 1.15[c] (1–5)	2.82 ± 1.12[d] (1–5)
	Gay	4	3.52 ± 1.11 (1–5)	2.91 ± 1.12[c] (1–5)	2.86 ± 1.18[d] (1–5)
	Bisexual	4	3.53 ± 1.11 (1–5)	2.96 ± 1.15[c] (1–5)	2.79 ± 1.17[d] (1–5)
	Transgender	3	3.35 ± 1.15 (1–5)	2.78 ± 1.17[c] (1–5)	2.68 ± 1.09[d] (1–5)
	Queer	4	3.42 ± 1.14 (1–5)	2.82 ± 1.16 (1–5)	2.79 ± 1.66 (1–5)
How **comfortable** would you feel if a student-athlete who identifies as ___ seeks your guidance for navigating his or her sexuality specifically **regarding athletic participation**?[b]	Lesbian	4	3.91 ± 1.02 (1–5)	3.39 ± 1.15[c] (1–5)	3.46 ± 1.04[d] (1–5)
	Gay	4	3.88 ± 1.03 (1–5)	3.38 ± 1.15[c] (1–5)	3.46 ± 1.04[d] (1–5)
	Bisexual	4	3.89 ± 1.02 (1–5)	3.37 ± 1.15[c] (1–5)	3.43 ± 1.00[d] (1–5)
	Transgender	4	3.69 ± 1.09 (1–5)	3.19 ± 1.22[c] (1–5)	3.14 ± 1.11[d] (1–5)
	Queer	4	3.79 ± 1.07 (1–5)	3.30 ± 1.17[c] (1–5)	3.29 ± 1.08[d] (1–5)

[a] Instrument is reproduced in its original format.
[b] Scale: 1 = *extremely uncomfortable*, 2 = *somewhat uncomfortable*, 3 = *neither comfortable nor uncomfortable*, 4 = *somewhat comfortable*, 5 = *extremely comfortable*.
[c] *Yes* was different from *no*.
[d] *Yes* was different from *unsure*.
[e] *No* was different from *unsure*.
[f] Scale: 1 = *definitely not*, 2 = *probably not*, 3 = *might or might not*, 4 = *probably yes*, 5 = *definitely yes*.

patients (Table 5). A similar trend was evident for comfort providing guidance as it related to athletic participation: those with a close friend or family member who identified as LGBTQ felt more comfortable with lesbian ($\chi^2_2 = 36.629$, $P < .001$), gay ($\chi^2_2 = 33.873$, $P < .001$), bisexual ($\chi^2_2 = 38.005$, $P < .001$), transgender ($\chi^2_2 = 30.441$, $P < .001$), and queer ($\chi^2_2 = 34.001$, $P < .001$) patients (Table 5).

OPEN-ENDED RESPONSES

The purpose of our study was to evaluate ATs' perceptions of student-athlete patients who identified as LGBTQ. Throughout the qualitative portion of our study, we gained valuable insight into these perceptions, particularly about why ATs responded the way they did in their ratings of approach, quality of care, and comfort. Athletic trainers addressed their comfort in working with an LGBTQ patient and how they perceived the patient might feel seeking care from their particular clinics. We also asked participants to expand on their comfort regarding advising LGBTQ patients about navigating their sexuality. Two main themes emerged: resources and referral (36.4% of responses) and patient-centered care (46.2% of responses). Within the main theme of resources and referral, 2 subthemes arose: concerns regarding transgender patients (18.6% of responses within the theme) and lack of training and education (29.2% of responses within the theme). Within the main theme of patient-centered care, 2 subthemes emerged: holistic care (24.0% of responses within the theme) and professionalism (26.4% of responses within the theme).

Resources and Referral

Many ATs reported that although they lacked the proper education and training regarding the needs of LGBTQ student-athletes, they would seek out educational resources for both themselves and their patients. Some of the

resources ATs would seek out were the NCAA Web site, the campus counseling center, and campus policies regarding inclusion and diversity. For example, 1 AT stated,

> I am not trained sufficiently in how to handle those issues, but I know enough to listen and direct them to the appropriate resources. In cases when that has happened, I stress that I am happy to listen but lack the skill to really help with those questions and refer to the appropriate resource.

Training and Education. A subtheme in the ATs' feedback was a concern about their lack of training and education when addressing the needs of the LGBTQ population. Participants reported that they would be comfortable speaking with a student-athlete about the student-athlete's gender identity if they had more training and access to educational resources. The majority of ATs indicated that they were willing to provide advice for LGBTQ student-athletes navigating their sexuality; however, they admitted they did not have the proper training to do so. One person noted, "I'm not sure I have proper training to advise [patients] on navigating issues regarding sexual preference or orientation. I would find resources/others with specific training to help them." Another respondent indicated, "I do feel that this would make a great lecture or Webinar, and I would certainly like to learn so that I can increase my cultural competency and awareness."

Transgender Student-Athletes. Several ATs indicated that transgender athletes gave them more concern than lesbian, gay, bisexual, or queer athletes because of a lack of training. These responses provide insight regarding our third research question, "Will ATs, in general, be less comfortable treating a specific member of the LGBTQ community?" Although participants generally felt comfortable with LGB student-athlete patients, they had specific concerns regarding their comfort levels with transgender student-athlete patients. Many observed that, if given the proper information (eg, which pronouns to use, regulations affecting participation, effects of hormone therapy), they would feel much more comfortable in providing advice regarding identity navigation as it related to athletic participation. One AT remarked,

> Transgender is something that I am less experienced with and do not have as much formal training [in]. I have peers who have helped athletes through their transition. If an athlete asked me about care regarding their transition, it is not something that I would have a lot of knowledge in but would do my best to help them through the process and continue to participate in sports if that is what they wanted.

Patient-Centered Care

The second major theme that developed from the open-ended feedback was the importance of patient-centered care. A majority of ATs indicated that a student-athlete's sexual orientation or gender identity did not affect their comfort level and specifically did not affect their ability to perform their job. Several participants stated that, if a student-athlete felt uncomfortable seeking health care in their clinic, the ATs were not performing their job correctly. One AT commented, "They look to us for support in all areas physically, mentally, and emotionally. . .no reason to refuse that because of their sexual preferences or orientation."

Holistic Care. One umbrella term that arose from several comments was *whole-body care*. Many ATs noted that their job goes beyond treating physical illness, and ATs also find themselves serving as a resource for emotional and mental well-being. One participant said, "I treat the person, not the orientation," demonstrating an awareness of whole-body health care. Conversely, several ATs felt that treating anything but the physical component of the student-athlete's conditions was outside their responsibility. One AT noted, "I do not believe this is in my job description. . .I would only be comfortable treating their injury."

Professionalism. The other subcategory within patient-centered care was the theme of professionalism. Most participants noted that all clinicians should uphold a professional level of medical care for all patients. As one AT explained,

> My staff and coworkers hold ourselves to the highest degree of professionalism. . .we do not treat any of our student-athletes differently and will continue to respect all differences in our patients.

However, some clinicians believed that it would be unprofessional to speak with a student-athlete who identified as LGBTQ about any concern beyond an injury, even if it was in regard to that student-athlete's athletic participation. Several ATs preferred to direct this student-athlete to the compliance office or athletic director.

DISCUSSION

The purpose of our study was to evaluate ATs' perceptions of student-athlete patients who identified as LGBTQ. We examined ATs' level of approach, quality of care, and comfort when treating student-athlete patients who identified as LGBTQ. Based on our results, the majority of ATs held positive views toward LGBTQ patients, yet we did see systematic differences with regard to gender, religion, and previous relationships, suggesting that ATs followed social norms as much as the general population. Our results are consistent with previous literature[10] regarding the perception of ATs providing care to student-athletes who identified as LGB, which suggested that gender, religion, and having a close friend or family member who identified as LGB played a role in their comfort. Our study is unique in that participants were asked to report their approach, quality of care, and comfort when treating not only LGB student-athletes but transgender and queer patients as well. Even with an overall positive opinion of LGBTQ student-athletes, some ATs still demonstrated prejudice and discrimination, particularly in relation to transgender people. The participants asked for more training and education to resolve their lack of awareness in treating transgender patients. We also saw, consistent with a previous investigation,[10] that gender, religion, and previous interpersonal relationships played

systematic roles in influencing participants' comfort with the LGBTQ population.

Prejudice and Discrimination

The concept that sexual prejudice and heteronormativity are commonplace in many intercollegiate athletic settings has been explored.[7] Experts[17] agreed that fear of discrimination caused athletes at various institutions to remain quiet about their sexuality. In response, the NCAA has been active in adopting nondiscriminatory practices and has worked diligently to promote conversation about the needs and experiences of LGBTQ student-athletes. However, ATs have been largely left out of the conversation as to how they can help in these areas. Among the NCAA policies is the LGBTQ Subcommittee statement[18] supporting student-athletes, a document opposing all forms of discrimination against all individuals, as well as a call to action for straight allies to join the NCAA in speaking out about prejudice against LGBTQ athletes. Additionally, in 2012, the NCAA released a comprehensive LGBTQ resource, including best practices, LGBTQ terminology, and organizational resources for inclusivity.[19] Among these best practices were procedures for creating inclusive athletic departments and teams focused on athletic administrators, coaches, and student-athletes.[19] However, these documents specifically addressed prejudice in the locker room and on the court; no overarching policies exist regarding discrimination in the athletic training clinic. As such, the NCAA and NATA should work to develop nondiscriminatory policies for athletic training facilities and best practices for ATs and health care professionals involved in the health care of LGBTQ student-athletes. The athletic training clinic should abide by these nondiscriminatory polices and best practices commonly adopted by hospitals and other health care facilities. The Healthcare Equality Index has published a call to action for health care facilities to have a patients' nondiscrimination policy or a patients' bill of rights that includes the words *sexual orientation* and *gender identity*,[20] which may be adopted for the athletic training clinic as well. Our findings suggest that overall, ATs held positive views, but prejudice and discrimination existed, even when inclusive policies were in place. Our results also indicate that more education and policies that extend into the realm of health care for LGBTQ student-athletes are still necessary.

Transgender Student-Athletes

Our study provides insight into the importance of addressing the specific needs of student-athletes who identify as transgender. A previous author[21] indicated that transgender individuals may be hesitant to seek treatment because other transgender individuals have reported past discriminatory treatment by health care service providers. Additionally, physicians in general demonstrated negative opinions toward transgender women, and individuals who did not conform to traditional conceptions of sex and gender were more likely to be at risk for discrimination in the health care setting.[21] The ATs we surveyed reported that their approach to treating a transgender patient would change, which may be explained by a lack of training and education on the specific needs of transgender patients. The participants indicated that they would feel more comfortable providing health care to and speaking about athletic participation with a student-athlete who identified as transgender if they had more training to do so, and most respondents stated that they had no formal training on LGBTQ concerns. This theme is consistent with earlier research[22] showing that health care professionals were not necessarily familiar with the terminology or distinctions within different communities. This lack of experience often led to unhelpful, uncomfortable, or hostile treatment experiences for the patient.[22]

Training and Education

Our participants reflected a general lack of training or education regarding any of the LGBTQ populations. To combat the lack of education, particularly for the treatment of transgender patients, several areas of training for health care professionals have been outlined, including awareness, appropriate language, and incorporation of diversity into the curriculum.[22] Evidence suggests that nondiscriminatory policies and diversity training help to create an affirming, open environment for LGBTQ people by raising awareness of the concerns that affect them.[23] Various LGBTQ interest groups have provided best practices for cultural competence when treating diverse populations.[24] In light of current literature and political events, several health care organizations have implemented mandatory training in LGBTQ cultural competence for all employees in an effort to provide more equitable care for all.[24] Many patient-centered communication standards and field guides have been pioneered by the Joint Commision and developed for hospitals and health care providers.[24] These best practices and guides to providing patient-centered care for diverse populations are available to all health care disciplines and should be adopted by ATs as well.

Gender and Religion

In general, male ATs were more likely to hold negative views of LGBTQ student-athletes than their female counterparts, providing more evidence of this discriminatory trend.[25,26] We also found a trend that ATs who practiced Christianity held more negative views regarding comfort and approach to care, which may be problematic, as researchers[27] noted a relationship between being exposed to homophobic messages such as shame and guilt and internalized homonegativity from religious sources. In previous studies,[10,28] the groups with the most positive views toward LGB athletes were Catholics, those with no religious affiliation, and Jews. Our results indicated that ATs who were nonpracticing or nonreligious held the most positive views. Investigators[29] have proposed a possible explanation for these positive viewpoints in that those individuals who were Jewish fostered a more liberal view toward the rights of minority groups. Similarly, among those with a religious preference, frequency of worship was related to antigay prejudice among those belonging to antigay denominations.[28]

Interpersonal Contact

Interpersonal contact with a person who identified as LGBTQ predicted attitudes better than any other demographic or social psychological variable.[30] We, too, found

that those who had a close friend or family member who identified as LGBTQ were more likely to hold positive views. This may be explained by the fact that those who knew someone who identified as LGBTQ perceived that they had more knowledge about LGBTQ individuals and their rights.[31] Those who had interpersonal contact with an LGBTQ friend or family member were exposed to diversity and perhaps would be more exposed to inclusivity. Also, positive attitudes correlated with increased familiarity.[31] In recent years, the popular media have provided increased coverage of LGB people; increased familiarity has been proposed to generate a form of social contact, which correlates with empathy and attitude change.[31] Another factor describing this relationship is the correlation between contact with a person who is "out" and those with an "alliance"; that is, those with a close friend or family member who identified as LGBTQ were inspired to become activists in order to protect those who were close to them.[32] These relationships also serve to normalize homosexuality and challenge myths and stereotypes about LGBTQ people.[32]

Health and use of health care services among LGBTQ individuals appeared to be adversely affected by marginalization, and 30% of LGBTQ adults either did not seek health care services or lacked a health care provider.[33] These statistics, however, may not be accurate in a student-athlete population because of the unique role sports medicine professionals play in the collegiate athletic setting. Yet fear of approaching the health care provider may persist, especially in heteronormative clinic environments. This gap offers ATs a unique opportunity to serve as the health care providers for these individuals. To supply patient-centered care, ATs should be trained in the unique needs and experiences of LGBTQ student-athletes. Resources should be developed and provided to ATs and student-athletes with regard to inclusivity in the athletic training facility as well as strategies for overcoming discrimination in the health care setting.

Several limitations were present in our study. Although we asked participants to select their religious affiliation, we did not ask about self-perceived religiosity or how strongly they identified with or how closely they practiced their individual religions. Another limitation was the potential for participant bias. Generally, the results of this survey were positive, and it is difficult to determine if the trend of positive perceptions occurred because those who completed our survey had an interest in or bias toward this topic.

CONCLUSIONS

Our participants' responses about their overall approach, quality of care, and comfort in treating patients who identified as LGBTQ were promising. However, prejudice still exists in athletic training, especially regarding their approach to and comfort in treating transgender student-athletes. The majority of ATs indicated that they would feel more comfortable providing treatment and guidance to transgender student-athletes if they had more training and education. Most reported that they would likely refer student-athletes to the athletic administration or counseling center for the specific needs of this population. As the profession moves into a more patient-centered approach, if we are to treat LGBTQ student-athlete patients appropriately and successfully, we must develop more culturally competent clinicians and move the profession as a whole forward. The NATA should provide cultural competence training, and individual institutions and health care facilities should pursue diversity training and resources.

Many ATs acknowledged that their job was to treat the patient and not the patient's sexual orientation or gender identity. Similarly, the majority of participants reported a sense of professionalism or a responsibility to behave professionally. Yet the results on professionalism were mixed: some ATs noted they would be professional and treat any student-athlete patient, whereas others commented it would be unprofessional to help a student-athlete patient navigate sexuality as it related to athletic participation. Overall, our results were positive, and many ATs were practicing holistically and inclusively. However, several participants indicated a level of bias and prejudice against the LGBTQ population. Athletic trainers should work to make themselves aware of their own potential biases and their athletic training clinics more inclusive by adopting nondiscriminatory policies and best practices for treating LGBTQ student-athlete patients.

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