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The Role of the Athletic Trainer in Providing Care to Transgender and Gender-Diverse Patients: Foundational Knowledge and Disparities—Part I

Sean M. Rogers, DAT, LAT, ATC*; Rebecca M. Lopez, PhD, ATC, CSCS†; Ashley K. Crossway, DAT, ATC‡; Dani M. Moffit, PhD, LAT, ATC§; Jennifer Sturtevant, MBA, LAT, ATC||; Anisa Hansen, PharmD*

*Drake University, Des Moines, IA; †School of Physical Therapy & Rehabilitation Sciences; Department of Orthopaedics & Sports Medicine, University of South Florida, Tampa; ‡State University of New York at Cortland; §Physical Therapy & Athletic Training Department, Idaho State University, Pocatello; ||Tufts Medicine at MelroseWakefield Hospital, Melrose, MA

Transgender and gender-diverse (TGD) patients experience discrimination, harassment, marginalization, and minority stress at greater rates than their cisgender counterparts, leading to numerous health and health care disparities that negatively affect well-being and access to quality health care.[1] Despite being in an opportune position to improve health equity for TGD patients under their care, many athletic trainers (ATs) report having little to no formal education on TGD patient care, leading to a reduction in self-reported competence. As such, to fill this knowledge gap, the purposes of the first part of this 2-part narrative literature review are to (1) provide readers with foundational information and terminology, (2) explore relevant health and health care disparities, and (3) identify the role of the AT within an interprofessional care team treating TGD patients.

Key Words: LGBTQIA+, health disparities, health care disparities, minority stress, gender identity, gender expression

Key Points

- The use of correct and appropriate terminology relevant to a patient's gender identity, gender expression, and sexual orientation is important to providing equitable and informed care to transgender and gender-diverse patients.
- The gender affirmation framework is a multidimensional model that includes social, legal, and medical actions and interventions that transgender and gender-diverse patients may or may not choose to undergo to affirm their gender identities.
- According to current literature, transgender and gender-diverse patients suffer from higher rates of mental health conditions, physical violence, and substance use and misuse conditions while simultaneously reporting more instances of denial of care, discrimination, and harassment when seeking care from health care providers.
- Individualized interprofessional care teams are valuable for providing high-quality patient care to transgender and gender-diverse individuals while improving health equity.

According to current literature, individuals who identify as lesbian, gay, bisexual, transgender, queer, intersex, asexual, and other (LGBTQIA+) experience health and health care disparities at a higher rate than their cisgender and heterosexual peers.[2,3] These disparities are often attributed to minority stress, discrimination, harassment, and structural inequities that disproportionately affect transgender and gender-diverse (TGD) individuals.[1] Although notable and widespread disparities exist for all individuals in the LGBTQIA+ population, historical evidence has demonstrated that TGD individuals are confronted with the highest rates of structural discrimination, violence, and harassment due to their gender identities.[3,4] These disparities are even more prevalent for TGD people who also experience discrimination and disadvantages due to the intersectional effect of their social identities, eg, ethnicity, socioeconomic status, (dis)abilities, and sexual orientation.[5]

Data collected through the US Census Bureau's Household Pulse Survey in 2021 estimated that more than 1% of the adult US population identifies as transgender, equating to nearly 2 million individuals.[6] This is a notable increase from a previous estimate of 1.3 million individuals in 2017.[7] The rapid demographic change is often attributed to incremental advances in TGD acceptance and visibility, which has led to increased willingness to self-identify over time.[8]

As the number of individuals who feel safe self-identifying as TGD increases, so does the need for athletic trainers (ATs) to be prepared to provide equitable, evidence-based, and patient-centered care. Unfortunately, current researchers have revealed that ATs, like other health care providers,[9] lack formal educational experiences related to this topic, which has contributed to a lack of competence and confidence in many

foundational areas required to treat this patient population.[10] Illustrating the downstream effect of a lack of formal educational experiences, the authors of a recent study found that, even though ATs felt comfortable and competent providing care to transgender patients, competence was notably lacking in specific aspects of patient care.[10] The areas in which ATs reported a lack of competence included working collaboratively with an endocrinologist (36%), using appropriate terminology (45.6%), and the effects of hormone replacement therapy on sport participation (48.1%).[10] Participants also noted that the majority of their education on TGD patient care came from informal sources such as media outlets (35.2%) and friends, family, and peers (33.7%).[10] More than one-third of respondents (35.2%) indicated having never received any formal education on this topic whatsoever.[10] A lack of competence and confidence inevitably has an effect on patient care, as highlighted by investigators who explored the experiences of transgender athletes seeking care from an AT.[11] The TGD athletes regularly identified that their ATs lacked education on transgender people, which, combined with unsupportive environments, led to discomfort and avoidance of care.[11]

Despite the lack of formal education[10] and subsequent lack of self-reported preparation to care for this patient population,[10,12] ATs commonly expressed concern regarding the health and wellness of their TGD patients and desired further education to address their knowledge and practice gaps.[12] As such, the purposes of the first portion of this 2-part narrative literature review were to (1) provide readers with foundational information and terminology, (2) explore relevant health and health care disparities, and (3) identify the role of the AT within an interprofessional care team treating TGD patients.

COMMUNICATION AND TERMINOLOGY

When working with TGD individuals, it is imperative to practice inclusive communication using appropriate terminology. Many TGD individuals have had negative experiences when engaging with health care providers. These negative experiences are often related to language, including the improper use of chosen names (ie, *deadnaming*), inappropriate use of pronouns or honorifics (ie, *misgendering*), or noninclusive electronic medical record forms.[13] Failing to adhere to inclusive communication practices, whether intentional or not, can lead to *traumatic invalidation* of TGD individuals, in which their identities are disrespected.[14,15] Traumatic invalidation, coupled with frequent microaggressions and blatant discriminatory treatment, has led many TGD individuals to avoid seeking necessary medical care due to past negative experiences with health care providers.[13,16]

Although the adoption of inclusive communication practices in clinical settings is a continuous and ever-evolving process, the foundation of these practices is a basic understanding of terminology. When discussing terminology, it is first important to understand the distinct differences among 4 terms that are often misunderstood and used interchangeably: *sex assigned at birth*, *gender identity*, *gender expression*, and *sexual orientation*.

Sex Assigned at Birth

At birth, infants are assigned a sex by health care providers based on anatomical, chromosomal, and hormonal characteristics: male, female, or intersex.[17] *Intersex individuals* are those who are born with atypical chromosomal arrangements that may lead to differences in reproductive anatomy, hormone production, and secondary sex traits. Athletic trainers must recognize the differences between sex and gender and not use these terms interchangeably, especially on electronic medical records and demographics forms.

Gender Identity

An individual's innermost self-identification as a man, woman, neither, or both is known as *gender identity*. Gender identities may align with peoples' sex assigned at birth (ie, *cisgender*) or differ to varying degrees. Those whose gender identities do not fit into the binary of man or woman may identify as *gender diverse*, a broad term representing the numerous diverse identities outside of the binary (ie, man or woman). Although not an all-inclusive list, additional gender identities outside of the binary include gender fluid, gender nonconforming, nonbinary, and agender (Table). Some individuals who identify as TGD may seek out gender-affirming care to better align their secondary sex characteristics with their gender identities. Patients may choose to undergo gender-affirming care for numerous reasons, one of which is to alleviate feelings of gender dysphoria, also known as *gender incongruence*.[21]

When supplying gender-affirming care or care to a patient who identifies as TGD, health care providers must understand that an identity is uniquely one's own, and as such, must be respected and validated regardless of their familiarity with it. Similarly, health care providers must acknowledge and combat the historical practice of pathologizing gender identities. Previous iterations of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) and *International Classification of Diseases* (ICD) supplied diagnostic criteria and ICD codes for conditions such as "transsexualism" and "atypical gender identity disorder" that pathologized an individual's identity, but this practice has since been revised to eliminate stigma and adopt a more evidence-based approach.[22,23] Some TGD patients may still be diagnosed with gender dysphoria to receive insurance coverage for gender-affirming care, yet the new DSM guidelines and ICD codes emphasize clinically significant feelings of incongruence to determine a diagnosis, instead of the patient's gender identity.[22,23]

Gender Expression

Gender identity is an internal concept of one's own gender, and *gender expression* is the outward display of that identity through clothing, personal grooming, cosmetics, jewelry, and other characteristics. These various characteristics are often considered more masculine, feminine, or androgynous by societal expectations of gender. An individual's gender expression may remain relatively steady or be fluid and dynamic, depending on personal preferences, and no one should assume that individuals will ascribe to specific gender norms associated with their gender identities. Health care providers must understand that automatic assumptions of an individual's gender based on outward characteristics of gender expression can be harmful and should be avoided.[24]

Sexual Orientation

Sexual orientation specifically refers to the type of connection or attraction between members of the same or different gender(s); this attraction can be based on physical, romantic, emotional, spiritual, or intellectual characteristics. Although

Table. Gender Inclusive Terminology[18–20]

Term[a]	Definition
Assigned female at birth (AFAB)	An acronym often used in medical documentation to describe a transgender man or nonbinary individual who was assigned female at birth.
Assigned male at birth (AMAB)	An acronym often used in medical documentation to describe a transgender woman or nonbinary individual who was assigned male at birth.
Cisgender	The alignment of gender identity with sex assigned at birth.
Gender identity	An individual's innermost self-identification as a man, woman, neither, or both, which may or may not align with sex assigned at birth.
Gender diversity	The extent to which an individual's gender identity or expression differs from societal norms.
Gender dysphoria	A clinically significant feeling of distress or discomfort in individuals whose gender identities differ from their sex, gender, or both assigned at birth or related to a strong desire to change primary, secondary, or both sex characteristics (DSM-5).[20]
Gender expression	An individual's presentation (eg, clothing, behavior) that communicates aspects of gender identity.
Gender neutral	Often used to refer to language (such as pronouns) that is neither masculine nor feminine (eg, they or them). Health care providers are encouraged to use gender-neutral language when addressing a group of people or someone whose gender identity is unknown or when someone identifies as nonbinary or agender and uses gender-neutral pronouns.
Transgender (trans, trans+, trans*)	When gender identity does not align with the sex assigned at birth. This can include individuals who identify as transgender men, transgender women, or those who do not identify within the gender binary, eg, nonbinary, gender nonconforming, agender, genderqueer.

Abbreviation: DSM-5, Diagnostic and Statistical Manual of Mental Disorders, fifth edition.
[a] This table is not an all-inclusive list of the numerous terms, descriptors, or both that patients may use to self-identify their gender identity, gender expression, or sexual orientation. We encourage readers with additional questions related to terminology to consult reputable organizations such as the Human Rights Campaign (https://www.hrc.org/resources/glossary-of-terms) or GLAAD (https://www.glaad.org/publications/talkingabout/terminology).

not all-inclusive, some examples of sexual orientations are lesbian, gay, bisexual, and pansexual. Individuals may also identify as *asexual* or *aromantic*, indicating a lack of sexual or romantic attraction to others, respectively. Sex assigned at birth, gender identity, or gender expression has no bearing on one's sexual orientation. Similarly, it can be offensive to assume sexual orientation based on one's sex, gender identity, or gender expression.

GENDER AFFIRMATION FRAMEWORK

The gender affirmation framework is a multifaceted model that describes the processes that individuals experiencing incongruence between sex assigned at birth and gender identity may pursue to affirm their gender identities. This framework specifies multiple domains, including social, legal, and medical, in which gender affirmation can be pursued.[25] Providers should understand that TGD individuals may choose to engage with some, all, or none of the processes described within the gender affirmation framework. Regardless of the degree and extent to which individuals seek gender affirmation, their gender identities are valid.

Social Affirmation

Social affirmation refers to the validation and self-actualization of gender identity through internal and external means, such as the use of a chosen name, pronouns, and gender markers that may differ from those assigned at birth. Social affirmation also includes the process of disclosing all or part of one's identity with social networks, including but not limited to friends, family members, coworkers, and community members.[25,26] The process of voluntarily disclosing information relevant to sexual orientation and gender identity is often referred to as *coming out* and is described as a series of strategic decisions about when, where, and how to disclose personal information that occurs multiple times across the lifespan.

When choosing to disclose their gender identities or sexual orientations (or both), TGD individuals must often navigate negative reactions and threats of violence.[27] When an individual's sexual orientation or gender identity is involuntarily revealed, without consent, this is often referred to as *being outed*. The experience of having personal information made public without consent is notably dangerous for TGD individuals and is often linked to higher rates of violence and discrimination.[26–28]

Legal Affirmation

Legal affirmation refers to the process of engaging with institutions, organizations, and governmental bodies to amend names, pronouns, and gender markers to affirm gender identity. Amendments such as these often occur to identifying documents such as driver's licenses, passports, social security cards, medical documents, insurance paperwork, and employee or student records.[25]

The overall ability of TGD individuals to pursue legal affirmation with ease is directly linked to organizational policies and state or federal laws. In many cases, specific state laws prohibit TGD individuals from amending names, pronouns, and gender markers, making legal affirmation difficult or impossible. The practice of governmental bodies proposing and passing legislation restricting the rights of TGD individuals has become increasingly common, in large part due to the current sociopolitical climate.[29–31] These legislative efforts, whether successful or not, have a detrimental effect on the health and well-being of TGD individuals and increase the prevalence of psychosocial conditions that may result in self-harm.[32]

Medical Affirmation

Medical affirmation refers to the various medical procedures and hormone therapies available to better align physical

body and secondary sex characteristics with gender identity. Gender-affirming hormone therapy (GAHT) and gender-affirming surgical procedures are 2 examples of medical affirmation.[25] Numerous reported benefits are associated with medical affirmation, including decreases in severe psychological distress, suicidal ideation, and suicide attempts and an increase in positive health behaviors.[33] However, despite these benefits, well-documented barriers to accessing gender-affirming care exist, such as a lack of financial stability, adequate insurance, appropriately trained health care providers, and proximity to medical specialists.[34,35] In addition to these barriers, an increase in the prevalence of discriminatory state laws banning gender-affirming care puts both health care providers and parents at risk.[34,35] Medical affirmation will be discussed in greater detail in part 2 of this narrative literature review.

Health and Health Care Disparities

The World Health Organization defined *health* as "a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity."[2] Too often, those who identify as TGD do not meet the criteria for health set forth by the World Health Organization due to negative effects related to their social determinants of health.[2] This experience of marginalization due to gender identity has far-reaching effects on an individual's access to safe housing, quality education, employment opportunities, economic stability, and adequate health care services.[2,14] Factors including a lack of social support, high rates of violence, experiences of discrimination and harassment, and a lack of comprehensive legal protection result in high levels of minority stress for TGD individuals.[2,14]

The leading framework to contextualize the oppression that TGD individuals experience and its effect on health and well-being is known as *minority stress theory*.[36–39] Minority stress theory posits that groups minoritized due to their social status experience a greater incidence of stressors such as stigma, prejudice, discrimination, and victimization as well as an unequal allocation of power and resources.[36–39] These stressors in turn have negative effects on the quality of life, health outcomes, and well-being of minoritized individuals.[40]

Compounding the minority stress and health disparities already experienced by TGD individuals, the health of this population has historically not been prioritized. It was not until the Department of Health and Human Services launched its "Healthy People 2020" initiative in 2010 that lesbian, gay, bisexual, and transgender health became an area for allocation of federal government resources.[2] This initiative identified multiple health disparities facing TGD individuals, including an increased risk for mental health comorbidities, substance abuse, suicide, and being the victim of violence; reduced access to health services; and increased use of tobacco, alcohol, or drugs.[2] Societal stigma, discrimination, and denial of civil and human rights were also identified as prominent factors leading to these disparities.[2] Furthermore, the federal government determined that health-related oppression and discrimination negatively affected TGD individuals' health in large part due to the shortage of clinically and culturally competent health care providers.[2] The lack of state and federal laws protecting children and adolescents from antitransgender bullying combined with a lack of social programs for transgender people across the lifespan also caused and contributed to these disparities.[2]

The Affordable Care Act (ACA) of 2010 is widely regarded as a significant advance in the state of TGD health care and care accessibility.[2,41] Before enactment of the ACA, insurance carriers would routinely deny coverage to TGD individuals, citing "gender identity disorder" or "gender dysphoria" as a preexisting condition. To illustrate the effect of insurance denial of care on gender-affirming care, the authors of 1 of the largest studies conducted on TGD individuals concluded in 2015 that 25% of TGD individuals were denied coverage for hormone therapy, and 55% were denied coverage for gender-affirming surgery.[2] In addition, 33% of TGD individuals had at least 1 negative health care experience due to their gender identities in the preceding 12 months, and 24% interacted with health care providers lacking cultural or clinical competency in transgender health care.[2]

Demonstrating the compounding effect of intersectionality on health outcomes and social determinants of health, Black and Latinx TGD individuals experienced the highest rates of poverty and unemployment among the TGD population.[2] Specifically, 38% of Black and 43% of Latinx TGD people indicated experiencing poverty compared with 29% of the entire TGD population. Similarly, 20% of Black and 21% of Latinx TGD people described experiencing unemployment compared with 15% of the entire TGD population.[2] These statistics for poverty and unemployment for TGD individuals were far higher than the national averages reported by the US Census Bureau and US Department of Labor, respectively, during the same timeframe.[2]

To combat oppressive systematic and social structures, many states have passed specific nondiscriminatory legislation affording protections to TGD people.[42] These laws, in 1 study, were found to lower rates of discrimination and victimization reported by TGD individuals while simultaneously decreasing rates of social stigma.[42] Despite the progressive work of some state governments, others are simultaneously proposing and passing regressive legislation affecting access to gender-affirming care, sport participation, inclusive health education, and other aspects of life.[32,43,44]

At the federal level, comprehensive congressional legislation and consistent executive policy guidance protecting the rights of TGD people are lacking.[45] Due to the lack of congressional legislation, the rights and protections afforded to the TGD population are often supported only through executive orders (EOs).[45] In the absence of longstanding protections codified into law, this practice of using EOs to protect the rights of TGD individuals leads to an overreliance on the current presidential administration to enact inclusive EOs. Furthermore, drastic shifts and reversals in federal guidance from administration to administration are commonplace across election cycles.[45] Such inconsistencies in basic protections have led to 75% of TGD youth in 1 survey characterizing politics as having a primary effect on their mental health.[46]

THE AT'S ROLE

Arguably one of the biggest barriers to receiving gender-affirming care for TGD patients is the lack of clinically and culturally competent health care providers.[2,9] In the profession of athletic training, a prominent contributing factor perpetuating these barriers is the lack of formal education and reported competence in TGD-specific patient care.[11,47,48] Along with

providing high-quality and patient-centered care to all patients, ATs are often the first and regular points of contact for patients entering the health care system and requiring evaluation, diagnosis, and care.[49–51] Given their unique position in the health care system, ATs are well positioned to address many of the barriers and related disparities facing TGD patients. To combat widespread health and health care disparities outside of normal patient care responsibilities, the role of the AT when caring for TGD patients is 3-fold:

1. to serve as a care coordinator developing, interfacing, or both with interprofessional care teams;
2. to create and maintain an inclusive environment for the delivery of care; and
3. to be knowledgeable about the various aspects of gender-affirming care while assisting patients in navigating the health care system and, in some cases, the policy requirements of participation in sport.

For each TGD patient undergoing gender-affirming care and seeking to achieve patient-driven goals, a high-performing interprofessional care team is integral. While offering individualized care, high-performing interprofessional care teams have also improved patient satisfaction, medication adherence, self-management skills, patient education, and patient outcomes.[52,53] Some aspects of gender-affirming care are outside the AT's scope of practice, yet ATs are still uniquely positioned to facilitate the development of interprofessional care teams for their TGD patients. However, before establishing an interprofessional care team, each patient's goals of gender-affirming care should be considered. Once these goals are determined, a team of inclusive and proficient providers and specialists can be formed to assist patients in achieving their goals. Although specific makeup of an interprofessional care team will depend on patient goals, the AT should consider including surgical specialists, pharmacists, mental health professionals, adolescent medicine specialists, and dietitians in addition to the patient's primary care provider on the care team. A national list of providers offering gender-affirming and inclusive care can be found at www.glma.org.

While assembling an interprofessional care team, ATs should focus on creating an environment that emphasizes the inclusive delivery of health care within their facility. Creating this inclusive environment may require systemic changes such as the development or amendment of nondiscriminatory and antiharassment policies that specifically protect sexual orientation, gender identity, and gender expression along with existing protected characteristics.[54,55] An audit of current documentation forms (eg, health history questionnaires, injury report forms, referral forms) and practices (eg, shared electronic medical record systems with partnering health care facilities) may also be required to ensure appropriate documentation of gender-inclusive information (eg, chosen name, legal name, and pronouns), protection of patient privacy, and maintenance of confidentiality.[13,55] An extensive checklist of recommendations and resources for developing inclusive athletic training facilities is available at https://www.nata.org/professional-interests/inclusion.

Furthermore, the AT must be knowledgeable regarding the various aspects of gender-affirming care with a specific emphasis on GAHT and gender-affirming surgery. Prescribing hormone therapy is not within the AT's scope of practice, but an awareness of intended therapeutic effects, potential side effects, medication interactions, and administration routes is valuable to improving patient care and communication with the interprofessional care team. In traditional sport settings, the AT may also have unique insights valuable to the interprofessional care team that influence the prescription of GAHT (eg, advising against using testosterone gels in swimming and diving athletes due to the requirement to avoid swimming for 2 to 5 hours after topical application, potentially limiting the ability to practice or compete), the timing of gender-affirming surgery (eg, surgical interventions and recovery timeframes with respect to patient goals and competitive seasons), and compliance considerations (eg, therapeutic use exemptions and navigating participation policies).

With the rapidly evolving nature of participation policies and laws at the secondary school, collegiate, and professional levels that affect TGD individuals' ability to participate in sport, it is difficult for health care providers, sports administrators, and athletes to keep abreast of the changes. Significant consequences associated with misinterpretation of new and evolving policies (eg, disqualification from sport) mean that TGD athletes have a large burden to bear, with minimal room for error, when compared with their cisgender counterparts. As such, a knowledgeable interprofessional care team with relevant and up-to-date knowledge on applicable policies and laws can not only improve patient outcomes but also provide clarity for those competing in organized sport. Sport participation policies will be discussed further in part 2 of this narrative literature review.

CONCLUSIONS

According to the current literature, TGD individuals disproportionately experience stigma, prejudice, discrimination, and victimization at higher rates than cisgender individuals. Minority stress[38] and a lack of knowledgeable health care providers are prominent contributing factors to the numerous health and health care disparities affecting the health and well-being of TGD individuals. Due to their unique and valuable role within the health care system, ATs are in an opportune position to mitigate these health and health care disparities.

As part 1 of a 2-part series, this narrative literature review provides ATs with the requisite foundational knowledge needed to contextualize future learning and improve their ability to care for TGD patients. Part 2 of this narrative literature review builds on this foundation by providing ATs with evidence-based information on various interventions related to gender-affirming care (eg, gender-affirming surgery, GAHT, tucking, and binding). Because the body of knowledge related to gender-affirming care and the improvement of TGD patient outcomes is developing rapidly, clinicians in a position to provide care to TGD patients must remain knowledgeable on best practices using reliable, up-to-date sources.

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Address correspondence to Sean M. Rogers, DAT, Drake University, 2507 University Ave, Des Moines, IA 50311. Address email to sean.rogers@drake.edu.