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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

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Abstract:

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 healthcare disparities that negatively impact wellbeing and access to quality healthcare.[1] While 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 purpose of the first part of this two-part narrative literature review is to 1) provide readers with foundational information and terminology, 2) explore relevant health and healthcare disparities, and 3) identify the role of the AT within an interprofessional care team treating TGD patients.

Key Words: TGD, LGBTQIA+, health disparities, healthcare 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 TGD patients.
- The gender affirmation framework is a multi-dimensional model that includes social, legal, and medical actions and interventions that TGD patients may or may not choose to undergo to affirm their gender identity.

- Current literature demonstrates that TGD patients suffer from higher rates of mental health conditions, physical violence, and substance use and misuse conditions while simultaneously reporting higher instances of denial of care, discrimination, and harassment when seeking care from healthcare providers.
- Individualized interprofessional care teams are valuable for providing high-quality patient care to TGD individuals while improving health equity.

Introduction

Current literature demonstrates that individuals who identify as lesbian, gay, bisexual, transgender, queer, intersex, and asexual (LGBTQIA+) experience health and healthcare 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 impact transgender and gender diverse (TGD) individuals.[1] While notable and widespread disparities exist for all individuals within the LGBTQIA+ population, historical evidence demonstrates that TGD individuals are confronted with the highest rates of structural discrimination, violence, and harassment due to their gender identity.[3,4] These disparities are even more prevalent for TGD people who also experience discriminations and disadvantages due the intersectional effect of their social identities (e.g., ethnicity, socioeconomic status, (dis)abilities, sexual orientation, etc).[5]

Data collected through the United States Census Bureau's Household Pulse Survey in 2021 estimates that more than 1% of the adult population of the United States identify 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] This 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 research has 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, a recent study found that while ATs felt comfortable and competent providing care to transgender patients, there was a notable lack of competence in specific aspects of patient care.[10] These 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] In the same study participants also reported 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] A number of participants (35.2%) reported having never received any formal education on this topic whatsoever.[10] A lack of competence and confidence inevitably has an impact on patient care, as highlighted in a recent study exploring the experiences of transgender athletes seeking care from an AT.[11] It was found that TGD athletes regularly identified a lack of education on transgender needs in their ATs, which combined with unsupportive environments, lead 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] current research shows that ATs do commonly express concern regarding the health and wellness of their TGD patients and desire further education to address their knowledge and practice gaps.[12] As such, the purpose of the first portion of this two-part narrative literature review was to 1) provide readers with foundational information and terminology, 2) explore relevant health and healthcare 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 through the use of appropriate terminology. Current literature has demonstrated

that 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 name (i.e., deadnaming), inappropriate use of pronouns or honorifics (i.e, misgendering), or non-inclusive electronic medical record forms.[13] A lack of adherence to inclusive communication practices, whether intentional or not, can lead to traumatic invalidation of TGD individuals in which their identity is 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]

While the adoption of inclusive communication practices in clinical settings is a continuous and ever evolving process, the foundation of said practices come from a basic understanding of terminology. When discussing terminology, it is first important to understand the distinct difference between four terms that are often misunderstood and used interchangeably: sex assigned at birth, gender identity, gender expression, and sexual orientation.

Sex Assigned at Birth

At the time of birth, infants are assigned a sex by health care providers based on anatomical, chromosomal, and hormonal characteristics.[17] Infants are assigned either male, female, or intersex based on the aforementioned characteristics. 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. It is important to recognize the differences between sex and gender, and not to 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*. An individual's gender identity may align with their sex assigned at birth (i.e., cisgender) or it may differ to varying degrees. Individuals whose gender identity does 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 (i.e., man or women). While not an all-inclusive list, additional gender identities outside of the binary include, gender fluid, gender non-conforming, non-binary, and agender (Table 1). Some individuals who identify as TGD may choose to seek out gender-affirming care to better align their secondary sex characteristics with their gender identity. 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.[18]

When providing gender-affirming care, or care to a patient who identifies as TGD, health care providers must understand that a patient's identity is uniquely their own, and as such must respect and validate that identity regardless of their familiarity with it. Similarly, healthcare providers must also acknowledge and combat the historical practice of pathologizing gender identities. While previous iterations of the Diagnostic and Statistical Manual (DSM) and International Statistical Classification of Diseases and Related Health Problems (ICD) provided diagnostic criteria and ICD codes for conditions such as 'transsexualism' and 'atypical gender identity disorder' that pathologized an individual's identity, this practice has since been revised to eliminate stigma and adopt a more evidence-based approach.[19,20] While TGD patients may still be diagnosed with gender dysphoria in order to receive insurance coverage for gender-affirming care, the new DSM guidelines and ICD-11 codes place an emphasis on the presence of clinically

120 significant feelings of incongruence to determine a diagnosis, instead of the patient's gender

121 identity.[19,20]

122 **Table 1: Gender Inclusive Terminology [21-23]**

Term*	Definition
Assigned Female at Birth (AFAB)	An acronym often utilized in medical documentation to describe a transgender man or non-binary individual who was assigned female at birth.
Assigned Male at Birth (AMAB)	An acronym often utilized in medical documentation to describe a transgender woman or non-binary individual who was assigned male at birth.
Cisgender	The alignment of an individual's gender identity aligns with their 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 identity differs from their sex and/or gender assigned at birth, or related to a strong desire to change primary and/or secondary sex characteristics. (DSM-5)
Gender Expression	An individual's presentation (e.g., clothing, behavior) that communicates aspects of their gender identity.
Gender Neutral	Often used to refer to language (such as pronouns) that is neither masculine nor feminine (e.g., they/them). Health care providers are encouraged to use gender neutral language when addressing a group of people, someone whose gender identity is unknown to you, or when someone identifies as non-binary or agender and uses gender neutral pronouns.
Transgender (Trans, Trans+, Trans*)	When an individual's gender identity does not align with their sex assigned at birth. This can include individuals that identify as a transgender man, transgender woman or those who do not identify within the gender binary e.g., nonbinary, gender nonconforming, agender, genderqueer.
*This table is not all-inclusive of the numerous terms and/or descriptors that a patient may utilize to self-identify their gender identity, gender expression, or sexual orientation. The authors 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)	

Gender Expression

While gender identity is an internal concept of one's own gender, *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 androgenous by societal expectations of gender. An individual's gender expression may remain relatively steady, or be fluid and dynamic, depending on personal preferences and assumptions should not be made that an individual will ascribe to specific gender norms associated with their gender identity. Health care providers must understand that assumptions of an individual's gender based on outward characteristics of gender expression can be harmful, underscoring the importance of avoiding automatic assumptions.[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. While not all-inclusive, some examples of sexual orientations include lesbian, gay, bisexual, and pansexual. Individuals may also identify as asexual or aromantic, indicating a lack of sexual or romantic attraction to others respectively. An individual's sex assigned at birth, gender identity, or gender expression has no bearing on their sexual orientation. Similarly, it can be offensive to assume one's sexual orientation based on their sex, gender identity, or gender expression.

Gender Affirmation Framework

The gender affirmation framework is multifaceted model that describes the processes that an individual experiencing incongruence between their sex assigned at birth and gender identity may pursue to affirm their gender identity. This framework identifies multiple domains including

social affirmation, legal affirmation, and medical affirmation in which gender affirmation can be pursued.[25] It is important for providers to recognize 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 an individual seeks gender affirmation, their gender identity is 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 than 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.

Literature shows that TGD individuals must often navigate negative reactions and threats of violence when choosing to disclose their gender identity and/or sexual orientation.[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/student records.[25]

The overall ease and ability of TGD individual to pursue legal affirmation is directly linked to organizational policies and state or federal laws. In many cases there are specific state laws that 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 socio-political climate.[29-31] These legislative efforts, whether successful or not, have a detrimental impact on the health and well-being of TGD individuals and have been found to increase in 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 an individual's physical body and secondary sex characteristics with their gender identity. Gender-affirming hormone therapy (GAHT) and gender-affirming surgical procedures are two examples of medical affirmation.[25] There are numerous reported benefits associated with medical affirmation including a decrease in severe psychological distress, reduction in suicidal ideation and suicide attempts, and an increase in positive health behaviors.[33] However despite these benefits, there are well documented barriers to accessing gender-affirming care including a lack of financial stability, adequate insurance, appropriately trained health care providers, and proximity to medical specialists.[34,35] In addition to these barriers, there is also an increase in prevalence of discriminatory state laws banning gender-affirming care

putting both health care providers and parents at risk.[34,35] Medical affirmation will be discussed in greater detail in part two of this narrative literature review.

Health and Healthcare Disparities

The World Health Organization (WHO) defines 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 WHO due to negative impacts to their social determinants of health (SDoH).[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 healthcare services.[2,14] Factors such as a lack of social support, high rates of violence, experiences of discrimination and harassment, and lack of comprehensive legal protection, lead TGD individuals to experience high levels of minority stress.[2,14]

The leading framework to contextualize the oppression that TGD individuals experience, and its impact on health and wellbeing, is known as Minority Stress Theory.[36-39] Minority Stress Theory posits that groups who are 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 a negative impact 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 that the federal government allocated resources to.[2] This initiative identified multiple health disparities facing

TGD individuals, including an increased risk for mental health co-morbidities, substance abuse, suicide, being the victim of violence, reduced access to health services, as well as 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 the development of the aforementioned disparities.[2] Furthermore, the federal government identified that the health-related oppression and discrimination negatively impacted TGD individuals' health in large part due to the shortage of clinically- and culturally-competent healthcare providers.[2] The lack of state and federal laws protecting children and adolescents from anti-transgender bullying, combined with a lack of social programs for transgender people across the lifespan, also were found to cause and contribute to these disparities.[2]

The Affordable Care Act (ACA) of 2010 is widely regarded as a significant event advancing the state of TGD healthcare and care accessibility.[2,41] Prior to the 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 that insurance denial of care has on gender-affirming care, one of the largest studies conducted on TGD individuals in 2015 concluded that 25% of TGD individuals were denied coverage for hormone therapy and 55% were denied coverage for gender-affirming surgery.[2] The same survey also concluded that 33% of TGD individuals had at least one negative healthcare experience due to their gender identity in the preceding twelve months, and 24% interacted with healthcare providers lacking cultural- or clinical-competency in transgender healthcare.[2]

Demonstrating the compounding effect of intersectionality on health outcomes and SDoH, Black and Latinx TGD individuals experienced the highest rates of poverty and unemployment within the TGD population.[2] Specifically, 38% of Black and 43% of Latinx TGD

people reported experiencing poverty compared to 29% of the entire TGD population. Similarly, 20% of Black and 21% of Latinx TGD people reported experiencing unemployment compared to 15% of the entire TGD population.[2] All the aforementioned statistics for poverty and unemployment for TGD individuals were far higher than national averages reported by the US Census Bureau and US Department of Labor respectively during the same time frame.[2]

To combat many of the oppressive systematic and social structures, many states have proposed and passed specific non-discriminatory legislation affording protections to TGD people.[42] These laws, in one 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, there are many state governments simultaneously proposing and passing regressive legislation impacting access to gender-affirming care, sport participation, inclusive health education, and other aspects of life.[32,43,44]

At the federal level, there is a lack of comprehensive congressional legislation and consistent executive policy guidance protecting the rights of TGD people.[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] Lacking longstanding protections codified into law, this current practice of solely utilizing 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 between election cycles.[45] Such inconsistencies in basic protections have led to 75% of TGD youth in one survey to report politics as having a primary impact on their mental health.[46]

The Athletic Trainer's Role

Arguably one of the biggest barriers to receiving gender-affirming care for TGD patients is the lack of clinically- and culturally- competent healthcare providers.[2,9] Within the profession of AT, one prominent contributing factor perpetuating these barriers is the lack of formal education and reported competence in TGD specific patient care.[11,47,48] In addition to providing high-quality and patient-centered care to all patients, ATs are often the first and regular point of contact for patients entering the healthcare system and requiring evaluation, diagnosis, and care.[49-51] Due to their unique position within the healthcare system, ATs are well positioned to combat many of the barriers and related disparities facing TGD patients. To combat widespread health and healthcare disparities outside of normal patient care responsibilities, the role of the AT when caring for TGD patients is threefold:

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

High performing interprofessional care teams are an integral component required to achieve the patient-driven goals for each TGD patient undergoing gender-affirming care. In addition to offering individualized care, high performing interprofessional care teams have also been reported to improve patient satisfaction, medication adherence, self-management skills, patient education, and patient outcomes.[52,53] While some aspects of gender-affirming care are outside of the ATs scope of practice, ATs are still uniquely positioned to facilitate development of

interprofessional care teams for their TGD patients. However, prior to establishing an interprofessional care team, consideration should be taken to determine the patient's individual goals of gender-affirming care. Once patient goals are determined, a team of inclusive and proficient providers and specialists can be formed to assist the patient in achieving their goals. While the specific makeup of an interprofessional care team will be dependent on patient goals, the AT should consider inclusion of surgical specialists, pharmacists, mental health professionals, adolescent medicine specialists, and dieticians 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.

In addition to creating an interprofessional care team, the AT should focus on creating an environment that emphasizes the inclusive delivery of healthcare within their facility. It is probable that creating this inclusive environment may require making systemic changes including the development or amendment of non-discriminatory and anti-harassment policies that specifically protect sexual orientation, gender identity, and gender expression in addition to existing protected characteristics.[54,55] An audit of existing documentation forms (e.g., health history questionnaires, injury report forms, referral forms) and practices (e.g., shared electronic medical record systems with partnering health care facilities) may also be required to ensure the ability to appropriately document gender-inclusive information such as chosen name, legal name, and pronouns while protecting patient privacy and maintaining confidentiality.[13,55] An extensive checklist of recommendations and resources for developing inclusive athletic training facilities can be found at https://www.nata.org/professional-interests/inclusion.

Furthermore, the AT must be knowledgeable regarding the various aspects of gender-affirming care with specific emphasis on GAHT and gender-affirming surgery. While

prescribing hormone therapy is not within the scope of an AT, an awareness of intended therapeutic effects, potential side effects, medication interactions, and administration routes is valuable to improving patient care and bilateral communication with the interprofessional care team. In traditional sport settings, the AT may also have unique insights valuable to the interprofessional care team that influences the prescription of GAHT (e.g., advising against using testosterone gels in swim & dive athletes due to the requirement of avoiding swimming for 2-5 hours after topical application, potentially limiting the ability to practice or compete), the timing of gender-affirming surgery (e.g., surgical interventions and recovery timeframes in respect to patient goals and competitive seasons), and compliance considerations (e.g., 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 impact TGD individuals' ability to participate in sport, it is difficult for healthcare providers, sports administrators, and athletes to keep abreast of the changes. With significant consequences associated with misinterpretation of new and evolving policies (e.g., disqualification from sport), TGD athletes have a large burden to bear, with minimal room for error, when compared to 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. These topics involving sport participation policies will be discussed further in part two of this narrative literature review.

Conclusion

Current literature demonstrates that 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 healthcare disparities impacting the health and well-being of TGD individuals. Due to their unique and valuable role within the healthcare system, ATs are in an opportune position to mitigate these health and healthcare disparities.

As part one of a two-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 two of this narrative literature review builds on the foundational information discussed in this manuscript by providing ATs with evidence-based information on various interventions related to gender-affirming care (e.g., gender-affirming surgery, GAHT, tucking, and binding). Due to the rapidly developing body of knowledge related to gender affirming care and the improvement of TGD patient outcomes, it is recommended that clinicians who are in a position to provide care to TGD patients remain knowledgeable on best practices through reliable up to date sources.

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