

Transgender Athletes' Experiences With Health Care in the Athletic Training Setting

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Context: The term *transgender* refers to individuals whose gender identity does not match their sex assigned at birth. Transgender people often report negative health care experiences, leading many to avoid seeking care. The experiences of transgender athletes with athletic trainers (ATs) are currently unknown.

Objective: To describe common experiences they have had with ATs and to identify barriers transgender athletes may encounter when seeking care.

Design: Qualitative phenomenologic study.

Setting: Individual phone interviews.

Patients or Other Participants: Nine transgender participants from high school ($n = 2$), collegiate ($n = 4$), club ($n = 2$), and semiprofessional ($n = 1$) athletics (age = 23.56 ± 5.32 years). Participants were either current athletes or had been athletes within the past 5 years. They consisted of transgender men ($n = 3$), transgender women ($n = 3$), and nonbinary or genderqueer people ($n = 4$), with 1 participant identifying as both a transgender man and nonbinary.

Data Collection and Analysis: Participants completed semistructured phone interviews that addressed positive and negative experiences, avoidance, and perceived AT knowledge

of transgender concerns. The interviews were analyzed for themes and evaluated with a peer reviewer. Member checking was conducted to validate the findings.

Results: Three main themes emerged. *Education* described ATs' knowledge of transgender concerns and receptiveness to learning. *Primacy of the patient* addressed ATs' behaviors when interacting with transgender athletes. *Environment* involved how social environments affected transgender athletes' comfort with ATs. Participants commonly perceived a lack of clinician education on transgender needs, which combined with a lack of support or hostile environment to lead to discomfort and avoidance. Respecting privacy, demonstrating support, and being open to education led to positive experiences.

Conclusions: Athletic trainers can improve their care of transgender athletes in several areas. Information about transgender people should be included in athletic training curriculums. Athletic trainers can also use inclusive language, signal that facilities are safe for all, and be familiar with resources for transgender athletes.

Key Words: gender minority, lesbian, gay, bisexual, transgender individuals; inclusion

Key Points

- The experiences of transgender athletes in the athletic training setting can be categorized as involving education, primacy of the patient, and the environment.
- Transgender athletes described barriers to care as including a perceived lack of clinician education, uncertainty about whether they will be safe and supported, and an unsupportive team or local environment.
- To improve their care of transgender patients, athletic trainers should pursue education on relevant topics; promote receptiveness, open mindedness, and a safe environment for all; use inclusive language; and be aware of helpful resources.

The term *transgender* refers to individuals whose gender identity does not match their sex assigned at birth (see Table 1 for additional definitions).^{1,2} In 2011, the US transgender population was estimated to total only about 700 000 people, or 0.3% of the general population.³ However, in 2014, the estimate grew to as high as 1.4 million people, or 0.6% of US adults.^{4,5} Thus, the number of people in the United States who openly identify as transgender seems to be growing, especially within younger generations.⁶

Transgender people face discrimination in many areas of life, including health care.^{1,6} In 2015, 33% of respondents to the US Transgender Survey reported having had a negative health care experience within the past year due to being transgender.¹ Negative experiences commonly reported by transgender patients include (but are not limited to) being

denied care, having health care professionals refuse to discuss transgender-specific health concerns, and being subjected to hurtful or insulting language.^{1,7–10} Health care settings not commonly associated with transgender-specific health care, such as emergency departments, can be especially difficult for transgender people to navigate.^{8,10,11} For example, a 2014 survey of transgender people living in Ontario, Canada, showed 52% of transgender participants reported negative experiences when visiting an emergency department.⁸ Transgender patients also commonly described having to educate their health care providers about their needs because many health care professionals did not receive education on these topics.^{7–10,12,13} These negative experiences and barriers resulted in transgender people often avoiding medical care altogether.^{1,7–9,11,14} Although barriers to care appear to exist across a wide variety of medical

Table 1. Gender Terminology

Term	Definition
<i>Gender identity</i>	A person's internal sense of gender (such as man, woman, etc) ²
<i>Sex assigned at birth</i>	The sex that is assigned on the basis of physical characteristics at birth, typically either male or female ²
<i>Transgender (or trans)</i>	Identifying as a gender that does not match the sex one was assigned at birth ²
<i>Transgender man (trans man)</i>	A person who identifies as male but was assigned female at birth ²
<i>Transgender woman (trans woman)</i>	A person who identifies as female but was assigned male at birth ²
<i>Nonbinary</i>	Having a gender identity that is not solely male or female. Some people may prefer or also use the term <i>genderqueer</i> , which has a similar definition. ²
<i>Cisnormativity</i>	The assumption and expectation that all people are cisgender (having a gender that matches the sex assigned at birth) ²
<i>Gender pronouns</i>	Pronouns are a part of speech that can be used as a substitute for nouns, such as <i>he</i> , <i>she</i> , or <i>they</i> ; in discussions of gender, the pronouns used for someone are an important part of respecting the person's gender identity. ^{2,23}
<i>Misgender, misgendering</i>	To refer to an individual in a way that does not align with the person's gender identification. This includes calling someone a gender the person is not (eg, calling a transgender man a woman), calling someone by pronouns the person does not use, refusing to call someone by the name the person chose, etc. This can be intentional or unintentional, but regardless, can be distressing for a transgender person. ²³
<i>Intersectionality</i>	A term describing the effect of having multiple social identities. For example, this term was originally coined to describe experiences in which race and gender intersect. ³⁰

professions, little is known about whether the same barriers exist for transgender people in an athletic training setting.

Transgender people face significant barriers in athletics, including both structural and social barriers.^{15–17} *Structural barriers* include policies that may prevent transgender individuals from playing on the sports teams matching their gender identity, as well as “spatial barriers” such as gendered locker rooms and bathrooms.^{15–16} The social climate of sports can also be difficult for transgender people to navigate because they may face ignorance from staff, teammates, and the public.^{15–17} Both structural and social barriers may make it difficult for transgender people to participate in sports.^{15–17} Exclusion from sport on the basis of gender identity contributes to an overall isolation from society in terms of missing out on networking opportunities, building teamwork skills, being physically fit, and fostering a sense of identity.¹⁵ On the other hand, transgender athletes who are able to participate in sports and physical activity can gain a greater sense of body-subject awareness and a meaningful coping strategy.¹⁶ Athletic departments themselves play a role in determining the sports environment for transgender athletes and can act as agents of social change

by demonstrating the value of inclusion and modeling alternate approaches to institutional structures.¹⁸ However, the role athletic trainers (ATs) may play in creating a trans-inclusive sports environment has not been examined. Given ATs' unique roles in both athletics and health care, ATs could be instrumental in creating an inclusive environment in which everyone has the opportunity to participate in sports and seek related health care.

At this point, the growing body of literature in athletic training related to lesbian, gay, bisexual, and transgender (LGBT)² patients has mostly considered the LGBT community as a whole and primarily examined ATs' perceptions of those patients.¹⁹ No known literature exists regarding transgender patients' experiences with ATs. Athletic trainers treat patients from a variety of backgrounds in all settings, including athletics. With the increasing percentage of the population who openly identifies as transgender,^{4–6} it is reasonable to expect that ATs may encounter transgender patients during their careers. As Nye et al¹⁹ found, many ATs already recognize the need to prepare for the possibility of treating transgender patients.

Given the unique barriers faced by transgender athletes and by the general transgender population, we chose to focus this study on the athletic patient population. The purpose of our study was to understand the experiences of transgender athletes within an athletic training environment and examine the barriers transgender athletes may face in accessing athletic training health care.

Theoretical Frameworks: Effects of Stigma and Erasure in Health Care

We used 2 theoretical frameworks to guide this study. The first theoretical framework, developed by Hatzenbuehler et al,²⁰ explains how stigma functions as a cause of health care inequality among populations. Stigma both influences physical and mental health outcomes (increasing health care needs) and limits a population's access to resources (decreasing the ability to mitigate increased health care needs).²⁰ These 2 effects of stigma create a cycle that traps populations in a self-perpetuating loop of health care inequality.²⁰

The second theoretical framework, developed by Bauer et al,⁷ describes how erasure of transgender people affects health care interaction. Using this framework, the researchers⁷ demonstrated how cisnormativity² (defined in Table 1) produces informational and institutional erasure. *Informational erasure* describes the lack of research, clinician education, and information on standards of care for transgender patients. *Institutional erasure* results from discriminatory or exclusionary policies, incorrect forms and documentation, and infrastructural inequality. Together, informational and institutional erasure place the burden of education on transgender patients rather than on their health care providers.⁷ Both stigma and erasure guided the methods and interview questions used in this study.

METHODS

Design

We chose a phenomenological qualitative design consisting of semistructured interviews that explored the

Table 2. Participant Demographics

Participant Pseudonym	Gender Identity	Pronouns	Sex Assigned at Birth	Age, y	Country	Setting of Athletics (Most Recent)
Blair	Woman; “feel like not a woman sometimes” (genderqueer ^a)	She/her	Female	21	US	High school
Cassandra	Girl or woman (transgender woman)	She/her	Male	35	US	College/university
Dean	Transgender man	He/him	Female	22	US	College/university
Ellis	Nonbinary or genderqueer	They/them	Female	22	US	College/university
Felix	Transgender man or nonbinary	He/him, they/them	Female	18	Canada	Club/league
Jenny	Girl or woman (transgender woman)	She/her	Male	28	US	Semiprofessional
Liam	Transgender man	He/him	Female	18	US	Club/league
Riley	Genderqueer	She/her, he/him, they/them	Female	25	US	College/university
Skyla	Transgender woman	She/her	Male	23	US	High school

^a Participants who identified partially with their sex assigned at birth and partially with another gender option on the initial survey were contacted before interviews to confirm whether they fit the study’s definition of *transgender*. Blair was able to clarify this before the interview.

participants’ experiences with ATs and athletic training facilities. The phenomenological approach is primarily concerned with examining how an individual experiences a phenomenon.²¹ In this instance, the phenomenon being examined was the experience of being a transgender athlete in an athletic training setting or facility. We chose this approach because it allowed for in-depth exploration of participant experiences through interviews and thus was useful for gathering descriptive and detailed data.

Participants

We obtained approval from the Ohio University Institutional Review Board before data collection. We sampled participants from a preliminary quantitative survey of LGBT athletes’ experiences with ATs. The initial survey was distributed online via social media, via LGBT organizations, and by contacting all National Collegiate Athletic Association (NCAA) institutions (via emailing the head AT or director of sports medicine) and asking them to distribute it to their athletes. During the survey, participants were asked if they were willing to complete follow-up interviews about their experiences. We contacted those who answered *yes* and indicated in the survey that they were transgender (ie, listing their gender identity differently from their sex assigned at birth) for interviews. Participants were also recruited for the interviews by word of mouth: a person who learned of the study (typically through another current participant) and met the inclusion criteria but had not taken the survey before it closed could still be included in the interview process. In total, 6 of the 9 participants were recruited through the quantitative survey and 3 were introduced by word of mouth.

The inclusion criteria were that participants identify as transgender, be between the ages of 18 and 50 years, be current athletes or have been athletes within the past 5 years, and have had access to an AT or athletic training facilities at some point in their athletic careers. Demographic information was gathered during the quantitative survey or, if the participant had not taken the survey, at the beginning of the interview. We obtained informed consent from the participants at the beginning of the online survey and then again orally from all participants before the interview. Participants had the opportunity to ask questions before being enrolled in the study or starting the interview.

We informed them that they were free to discontinue their involvement in the study at any time, and they would remain anonymous. All participants are referred to herein using pseudonyms.

We interviewed 9 participants: transgender men^{1,2} ($n = 3$), transgender women^{1,2} ($n = 3$), and those who identified as nonbinary or genderqueer^{1,2} ($n = 4$; 1 participant identified as both a transgender man and nonbinary). Definitions for these categories can be found in Table 1. Ages ranged between 18 and 35 years (mean age = 23.56 ± 5.32 years). Participants described experiences in a variety of athletic settings: high school ($n = 2$), collegiate ($n = 4$), semiprofessional ($n = 1$), and club or league ($n = 2$) sports. The participants’ demographics information is shown in Table 2.

Table 3. Interview Questions^a

1. Have you ever seen an athletic trainer (AT) for an injury or any other health care need? (if no: Have you had a health care need that you wanted to see an AT for but chose not to seek the AT’s care?)
2. If applicable, describe a time you may have avoided seeking care from an AT.
3. Describe any positive or negative experiences you have had with ATs or in an athletic training facility.
4. When interacting with an AT did you or would you feel comfortable coming out to them? If you have come out or discussed issues related to gender identity with them, describe that experience. If you have not or would not, describe why not.
5. How did people in the athletic training facility, such as other patients or athletes, talk about transgender people or react to your gender identity (if they did at all)? How did the AT react to such situations?
6. How educated about gender identity and transgender issues did the AT seem? Describe any experiences in which you felt the need to educate your AT about your gender identity or your own needs as a transgender person. Also, describe any experiences in which an AT seemed particularly knowledgeable or educated already about these topics.
7. Describe the characteristics or behaviors you appreciate in health care professionals.
8. How do you think ATs could better serve transgender patients and athletes?
9. Is there anything else that you would like to tell me about?

^a Items are presented in their original format.

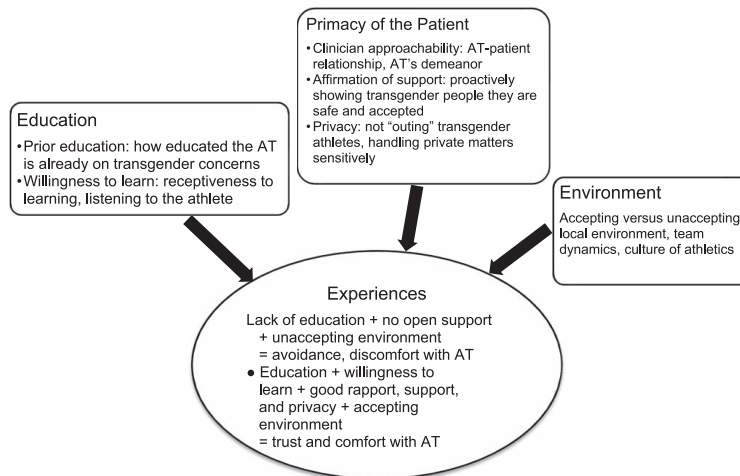


Figure. Relationship of themes. Abbreviation: AT, athletic trainer.

Procedures

Interviews. All interviews began with obtaining informed consent. We allowed the participants to ask any questions they had and gathered demographic data if they had not taken the initial quantitative survey. The interviewer then asked a set of open-ended questions (Table 3), which allowed for follow-up questions or further discussion of the participant's responses. Previous research^{1,7–14,20} into transgender health care experiences revealed a number of common themes, including health care avoidance, lack of clinician education that resulted in patients having to educate clinicians, and experiences of “coming out” to providers. Thus, in addition to asking general questions about participants' experiences with ATs and the athletic training environment (eg, “Describe any positive or negative experiences you have had with ATs or in an athletic training facility.”), we developed interview questions that would specifically address health care avoidance, perceived level of clinician education, and experiences of coming out in the context of athletic training (eg, “When interacting with an athletic trainer, did you or would you feel comfortable coming out to them? If you have come out or discussed issues related to gender identity with them, describe that experience. If you have not or would not, describe why not.”). We finished each interview by asking the participants about what they appreciated in health care professionals, what they thought ATs could do to better serve transgender patients, and if there was anything else they would like to share.

We conducted all interviews via telephone because many participants were in distant locations. The interviews were recorded and transcribed before data analysis, and then the audio recordings were destroyed.

Qualitative Analysis and Credibility. We conducted interviews until data saturation was reached. Once all interviews had been conducted and transcribed, the initial coding process took place. This involved the primary researcher (E.E.M.) reading all the interview transcripts and then beginning to identify common themes. We addressed credibility using 2 methods: peer review and member checking. The initial themes were checked and debriefed with a peer reviewer and then were further consolidated and refined as necessary until agreement was reached. The

process of synthesized member checking as validated by Birt et al²² was conducted. *Synthesized member checking* involves sending each participant the interview transcript, as well as short descriptions of the identified themes. We asked the participants to address the accuracy of the transcript and themes and comment any questions or concerns they had. Of the 9 participants, 7 responded to member-check emails, and all agreed with both the accuracy of the transcript and validity of the themes.

RESULTS

We found 3 overarching themes: *Education* describes how an AT's level of education on transgender topics and receptiveness to education influenced interactions with transgender patients. *Primacy of the patient* describes the effects of an AT's professional behavior on a transgender patient's comfort with seeking care. *Environment* examines the roles that local culture, team dynamics, and the environment of the athletic training facility played in a transgender patient's comfort with approaching an AT. *Education* and *primacy of the patient* also encompass several subthemes, which are described in each section. Elements of all 3 themes together form the experiences (positive and negative) that participants described having with their ATs (Figure).

Education

Education encompasses 2 subthemes: prior education and willingness to learn. *Prior education* refers to the amount of knowledge an AT had on transgender topics before encountering a transgender patient. *Willingness to learn* refers to the AT's receptiveness to receiving education, often directly from the transgender patient.

Prior Education. Five of the 9 participants described their ATs as lacking knowledge of the needs of transgender athletes. Dean remarked, “My athletic trainers were definitely not knowledgeable in any way. Like, scale of 1 to 10, it would be, like, zero. It was pretty bad.” Dean cited a lack of education as a reason he avoided seeking care for a groin injury. He shared, “He's a super nice guy, but just wasn't educated, and . . . I didn't really want to deal with it

with him, or I guess with any other athletic trainer.” Ellis expressed a similar sentiment:

The athletic trainers I have interacted with have all seemed ignorant. They didn’t all seem unaccepting in any way, but just ignorant, is an accurate term for that; had no idea how to interact with me as a trans athlete.

Participants believed that ATs should be educated on a variety of topics regarding transgender patients. Dean felt that ATs should learn about the importance of inclusive language. Dean wanted ATs to understand the emotional effect that misgendering²³ (defined in Table 1) can have on a transgender person. He explained, “Like, these things affect me and affect my team, because if you call me a girl before I go out on the field, and then I go out on the field and that’s what I’m focusing on, I’m not focusing on the game, and then my head’s not in it.” Others, such as Ellis, suggested it would be helpful for ATs to be educated on the mental and emotional health risks transgender people might face, as well as the affirming resources to which a transgender patient could be referred.

Participants also thought education needed to take place on the risks and side effects of certain transition-related medications. For example, spironolactone is a drug commonly prescribed to transgender women for its antiandrogen effects, but it is also a diuretic.²⁴ Jenny and Cassandra, who are transgender women, both reported having difficulty staying hydrated during athletic competition and felt spironolactone played a role. Cassandra shared:

So I found many times I would get heat exhaustion and I would get sick . . . You can’t really talk about the fact it’s this medication that I have to take. And I don’t think a lot of [athletic] trainers know that. Or maybe they do and they’re just not thinking about it.

Overall, a clinician’s prior education was an important factor in a participant’s comfort. Skyla, summarized this by saying, “I think having any population of people that have to deal with trans people, it’s good for them to almost have this preexisting knowledge and set of information they can draw from, because it’s already hard enough to go through a lot of medical processes.”

Willingness to Learn. In the absence of prior clinician education, participants often took on the responsibility of educating ATs about their needs. For Felix, this interaction went very positively. He described the need for some education on inclusive language, “but the athletic trainers always have done well, they were always pretty receptive to it, and it’s not something that comes up too much.”

Other participants were instead met with resistance when trying to educate or correct their ATs. Dean discussed the importance of being referred to using the correct name and pronouns²³ (defined in Table 1) with his AT multiple times but was met with what he perceived as ambivalence:

It’d be a lot of [pauses] He would misgender me constantly. I would have to, like, remind him, “Hey, remember, it’s ‘he.’” And he would be like “Oh, yeah, yeah” and then not really say anything about it; he would just kind of blow it off.

As a result, Dean felt the AT was not truly listening: “He didn’t really care because it wasn’t on his radar, as much as it probably should have been. It’s just the kind of person that he is; he just didn’t really give a crap at all.”

Ellis, a nonbinary collegiate athlete, also described unsuccessful attempts to share education with ATs:

Several times over during my 4 years at [university], I wrote several articles that talked about my experience being nonbinary in [sport], . . . and I shared this with my coaches, my teammates, anyone on staff at the time, and, you know, part of these were explanations of “this is why it’s really important that my correct pronouns are used; this is why it’s really important [to use] my name . . . And so there were those kinds of education opportunities that I distributed widely, and I never really received any acknowledgment from the athletic trainers.”

Ellis also perceived direct resistance to educational efforts. One such experience was during a visit to an emergency department:

I had to go to the emergency room . . . with the athletic trainer on duty at that point, and in that entire interaction throughout the morning, it was she/her pronouns, it was telling everyone at the ER that I was on the women’s [sport] team and emphasizing [pauses] . . . At least to me, it seemed to be emphasizing all the gender things, and that is, of course, a biased perspective, but it was just over and over and over again. “She/her, women’s [sport] team, female athlete,” like all these different things.

Ellis experienced similar difficulties with ATs even when supportive teammates were present:

So there would be situations where we would be having a conversation where [teammates] would be referring to me with the correct pronouns, with they/them/theirs, and the ATs who would be part of the conversation would just interject comments with the wrong pronouns. And for me that was very, very jarring, and even when correct pronouns were being used, the ATs were not part of that.

As a result, Ellis began to avoid seeking care from the ATs at all “because I felt more affirmed and safe with a general practitioner than I did with athletic trainers or the athletic medicine department who refused to use my pronouns, refused to use my name until it was legally changed, and were generally entirely ignorant of any trans-related health care needs.”

When asked about what they appreciated in health care providers and ATs, many participants cited the value of receptiveness. Felix commented:

I appreciate when health care professionals are receptive to the information that I’m giving them. They don’t try to fight or argue like “No, that’s made up” or “That’s just how kids these days are.” Or whatever. Like, they actually want to take the time to understand what being transgender is and how to better serve transgender patients.

Primacy of the Patient

In the fifth edition of the “Athletic Training Education Competencies,” under the “Foundational Behaviors of Professional Practice,” *primacy of the patient* is defined as the practice of advocating for patient needs, recognizing conflicts of interest, providing the best care possible for patients, and respecting confidentiality.²⁵ Thus, primacy of the patient encompassed 3 subthemes that deal with the application of these professional behaviors to interactions with transgender patients: *Clinician approachability* referred to building a rapport between an AT and a transgender patient. *Affirmation of support* described making a proactive effort to ensure that transgender patients were safe and included. *Privacy* involved respecting a transgender patient’s confidentiality about their transgender identity, as well as using proper sensitivity when discussing personal concerns.

Clinician Approachability. For participants who were anxious about approaching ATs due to their gender identity, already having a good rapport with an AT was important. Riley demonstrated this when discussing a relationship with an AT that started out tense but became more comfortable over time. Riley perceived the AT as being initially “kind of sarcastic and snarky and you couldn’t really tell how he felt about you.” Riley further explained, “When I first started out, I thought he was super mean, and then I could never really talk about stuff like [gender identity] with him.”

However, as a closer relationship developed between Riley and the AT while working together throughout various injuries, Riley began to feel accepted and understood:

I guess the key point is my relationship that improved, and that trust that I found in my athletic trainer was really important, and I wish that he would have given that or offered that support and that trust earlier on, um, which could have expedited my ability to be more out and be more comfortable.

The influence of a preexisting clinician-patient relationship on the comfort of those who were beginning to realize their gender was also reflected in the experience of Blair, who depicted a tense relationship with an AT due to a misdiagnosed knee injury. Blair (who identified as gender-queer but continued to use the pronouns *she* and *her*) had felt during evaluations that the AT had not taken her injury or pain seriously, in part because she was perceived as a “female” athlete. This already negative relationship influenced Blair to assume the AT would not accept her true genderqueer identity: “I guess because I felt so strongly judged by my, like, perceived gender as a woman, that I couldn’t even fathom, like, the idea that the [athletic] trainer could have understood a queer gender identity.”

Overall, participants felt more comfortable approaching clinicians who exhibited traits such as open mindedness and calm in all situations. Jenny described this as “probably someone who listens, pays attention, has basically, like, a calm demeanor, like in a situation that calm demeanor kind of helps balance you out a bit.”

Affirmation of Support. Some participants felt that there was an aspect of “having to wonder” whether they would

be supported and accepted when approaching an AT. Riley explained, “There’s always this unsaid, unspoken tension with myself and any health care professional I feel, like, because I don’t know if they are accepting.” Riley ascribed this uncertainty in part to the lack of visible assurances of acceptance or known nondiscrimination policies around the athletic training facilities: “So if something did happen or something was said, it would . . . I actually don’t know what would happen.”

For some participants, this lack of assurance led to avoidance, as Cassandra identified with regard to yearly preparticipation examinations:

Every single year, I found my own doctor, because the athletic training facilities would have people come in to do physicals . . . So that was something that the team was able to do at no charge to them, whereas I had to go pay my own doctor and incur those charges because I just wasn’t comfortable, or I wasn’t really given any assurances by anyone how things would go.

However, during other situations during Cassandra’s athletic career, she had been given assurances. For example, when she was required to come out to the athletic department and ATs at her NCAA institution for compliance purposes, she was directly told that she “would be supported or else the people who were not supportive would have a problem with the school.” This direct affirmation of support made her feel much more comfortable approaching the ATs.

Felix’s ATs also made proactive efforts to be reassuring and supportive. Felix appreciated the way in which the ATs handled situations such as filling out medical forms:

They always sort of briefed me for that; they were like, “Hey, we’re going to have to use this name because that’s your legal name, we’re going to have to use this information, even though we know that may not be true to who you are.”

Participants proposed a variety of ways in which ATs could show their support. Riley suggested using visual signaling methods:

I think the best way to do that is just in a passive way, having a sign up or something like that . . . Or if that’s too public, having in your documents if the athlete has to sign a consent form or something to be treated . . . a statement saying, “If you have any of these identity differences, you’re safe and you’re supported.”

Other participants emphasized the use of inclusive language, both on paper and orally, as a way of signaling safety to transgender patients. Ellis remarked:

I really like medical forms that either don’t necessitate you identify[ing] a gender or have a blank space so you can fill it in, or have a whole bunch of different options to choose from and so don’t require a binary classification. I really like health care professionals that not only have a space for pronouns but also really respect pronouns.

Felix also emphasized inclusive language, stating, “I think a lot of change needs to come in the language that is used. I know many sports are separated by gender, and so with trans participants, just opening up the language that is expected of ATs really makes trans athletes feel safer.”

Privacy. Participants felt it was important that conversations with ATs relating to their transgender identity take place in a location where they would not be “outed” to those who could overhear. For example, Dean described conflicting feelings about being approached by his AT in a hallway after a coach had revealed his transgender identity: “I was really caught off guard because, like, in the hallway, it’s a really random thing in front of a bunch of other people. So that kind of sucked. But it was nice to have the topic out there.”

Dean was not necessarily upset about the AT knowing that he is transgender or answering questions about it. However, discussing this topic in a hallway full of people, rather than in a more private setting, made him uncomfortable.

Whereas some participants were vocal about their transgender identity, others emphasized the need for information to be kept private and only available to those who needed to know. Cassandra attributed much of the comfort she had at her NCAA institution to her privacy being respected:

And when I had disclosed that I was trans to the athletic director, I made clear that I wanted it to be known on only a need-to-know basis. Because I didn’t want to be, I still didn’t want to be out. But in order to be compliant with NCAA rules, I informed the people who needed to know, which was the athletic director, and from there informed the athletic trainer, so the athletic trainer knew, and also our head coach, so those were the only people who were informed.

Some participants were even hesitant about sharing private information with ATs. Liam indicated that unless it was relevant to an evaluation, coming out as transgender to an AT would put him in a “vulnerable position.” His perception was that “for that 1 session, they’ll be focused more on that than why I’m actually there.” Jenny felt similarly, but she and her ATs found creative ways to work around her discomfort while discussing pertinent medical history:

When I’ve given some of my medical history, I have used the phrase like “in a former life.” [laughs] I use that when I’m talking about before transition. And they never questioned it, so they didn’t really get personal about it.

The ATs were most likely aware that Jenny was transgender from her medical history, yet allowing Jenny to describe that in her own words made her feel much more comfortable approaching them.

Whereas participants varied in their personal experiences of privacy, most emphasized that transgender patients should be able to choose whether their transgender identity and personal information is shared with anyone beyond the athletic training staff.

Environment

Environmental factors affected the participants’ comfort level with ATs and athletic training facilities. One such factor was the environment of the athletic training room itself. Riley noted that because many other athletes are often in an athletic training facility, it could be a place where transgender patients may compare their bodies to others or feel that others are judging them:

I guess one of the hardest things is like my perception of what people are thinking without them speaking or anything. A general discomfort with how I present myself and I think that pressure is always there with athletes in general . . . And then to add the layer of gender to it can make it more complex, I think, just because I’m comparing myself to, like, a lot of the male athletes, and I have this general discomfort with female athletes, you know, so I think it creates this layer of perception of what other people are thinking of me and how I fit in with other athletes.

Jenny and Cassandra both mentioned that ice baths were an aspect of the athletic training environment that caused them discomfort. Ice baths are often expected to be taken in tight-fitting clothing and thus can “out” a transgender person. Cassandra explained:

The only time I avoided the athletic trainers during my time playing NCAA sports was, I was probably the only person on the team who wouldn’t take an ice bath, which was in the athletic training room, because I hadn’t had my surgery at the time and I was just very self-conscious about it.

Beyond the athletic training facility, the team and athletic department environment also influenced participants’ comfort with seeking care from ATs. Cassandra experienced the effects of both positive and negative environments. Before transferring to participate at an NCAA institution, Cassandra participated in her sport on the women’s team at a junior college. The junior college was not a very safe or accepting environment for transgender people. For example, Cassandra recalled, “But at the junior college, I did hear teammates kind of poking a little fun at trans people, you know saying like ‘trannies’ and things like that. And you know, that was part of the reason why I didn’t want to come out then.” Cassandra was afraid of people at the junior college finding out that she was transgender because she feared “what the reactions would be and even if I was allowed to play.” This led her to avoid seeking care from the athletic training staff: “At the junior college, I wasn’t out, nobody knew I was trans, so I would pretty much avoid going to an athletic trainer whenever possible.”

When Cassandra transferred to an NCAA school to continue her athletic career, she became far more comfortable approaching ATs. When asked what about the NCAA institution made her feel more comfortable, she reflected:

Well, it was more comfortable for me, for one because I knew I was eligible to play, and I wasn’t scared of losing

eligibility based on them knowing I was trans. And then, uh, the second part of that was, when I chose [a school to transfer to] . . . making sure where I was going to go was going to be a place where I could kind of just be an athlete and didn't have to worry about discrimination or anything like that, and I chose to go to [university] because [of] the environment that I would be going into."

The broader local culture of an area also had a significant influence on participants' comfort with ATs. For Skyla, growing up in an unaccepting community influenced her perception of her high school's AT:

Well, so my high school was in [rural area], so I suppose you can imagine demographically, very [pauses] not a strong trans or even LGBT community in general . . . So I would have a hard time imagining any—in fact, I know that the athletic trainer, one of them personally I know would have no idea about how to even approach dealing with issues that trans people might have. Nor do I think he would really be open to learning, so very much just a not trans-accessible community. I can't see any situation in which an athletic trainer would be accommodating."

She explained that seeing the hostility faced by the few other transgender people in her community led her to believe "anything medically related would be about the same, would be treated very similarly. And so the people involved would not be interested in learning, for instance, learning any trans-specific medical care, unless they were absolutely forced to."

Overall, participants felt it was important for ATs to understand the stress that environmental factors could place on transgender patients. Skyla summarized this by saying,

So let's say that there's an athletic trainer dealing with a trans student-athlete. I think it would be best if they would know (1) basic information about medical information pertinent to the trans student-athlete but also (2) understand how, you can't just deal with an athlete who's in a school setting and neglect how their trans identity interacts both with other students and then the environment as a whole. So I guess it can't be limited to just medical knowledge. I think that would do a lot to help young trans people.

DISCUSSION

The first objective of our study was to describe the experiences of transgender athletes with ATs. Most of the participants' experiences could be described using a combination of all 3 themes, which together formed overall positive or negative experiences regarding ATs. For example, when a lack of clinician education was combined with other factors, such as a lack of privacy (as in Dean's case), participants described their experiences with ATs more negatively and often reported having avoided seeking care. However, when participants' experiences involved several positive factors, such as a supportive team or athletic department environment and a respect for privacy (as Cassandra found at her NCAA institution), they

characterized the interactions as more positive (see the Figure).

The second objective of our study was to identify barriers that transgender athletes may face when seeking care from ATs. Participants mentioned a variety of potential barriers and suggestions for mitigating these barriers. One commonly mentioned barrier to seeking care was a lack of prior clinician education on transgender people and topics. When asked about the education level of their ATs, 5 participants said they perceived a lack of education among their clinicians. The other 4 participants were unsure about the education level of their ATs and did not feel comfortable speculating about how much education their ATs may have received.

Avoidance of ATs due to gender identity was also a frequent experience among participants. When asked about avoidance, 6 participants described having avoided ATs for reasons directly related to their gender identity (an additional 2 reported avoidance for reasons that were complex and not entirely due to gender identity). The prevalence of both the perceived lack of education and avoidance of ATs mirrored transgender health care experiences in other health care professions.^{1,7-9,11,14,26}

Erasure and Health Care Inequality

The findings of this study, particularly the prevalence of both the perceived lack of clinician education and avoidance, align with the theoretical framework developed by Bauer et al⁷ concerning institutional and informational erasure. The lack of education that some participants perceived in their ATs is in the category of informational erasure, whereas experiences such as a lack of open support or inclusive-language use during interprofessional interactions reflect institutional erasure.⁷ Participants who experienced institutional or informational erasure with their ATs often took on the role of educating their ATs about their needs or even avoided seeking care altogether, which follows the cycle previously described.⁷ However, not all participant experiences were negative. For participants such as Felix, whose ATs demonstrated behaviors such as willingness to learn, the cycle of erasure was broken. This demonstrates how, through relatively small changes, ATs can combat institutional and informational erasure for transgender patients seeking care.

One point brought up by participants was that ATs may need to be aware of the health problems that transgender people commonly encounter. Transgender people face a wider variety of health disparities than the general population, most notably mental and emotional health concerns.¹ Authors of the 2015 US Transgender Survey¹ found that 39% of participants reported psychological distress within 1 month of the survey, compared with 5% of the general US population. In addition, 40% of participants reported having attempted suicide in their lifetime, versus 4.6% of the general US population.¹ Health care discrimination could play a role in these increased rates. In 2017, Seelman et al²⁶ found that transgender patients who described their health care providers as less trans inclusive reported lower general health scores and were more likely to display symptoms of depression. This reflects the Hatzenbuehler et al²⁰ framework of health care stigma leading to a self-perpetuating cycle of health care inequality

for marginalized populations. As more emphasis is put on ATs' role in the management of psychosocial concerns, it is important to consider how the psychosocial health of transgender people may interact with these systems of stigma and what role ATs may play as their health care providers.

Suggestions for Addressing Barriers

A common suggestion from participants was to increase the level of education ATs receive about transgender topics. Nye et al¹⁹ observed that collegiate ATs desired more education and information on caring for transgender patients. In health care professions other than athletic training, researchers proposed that including LGBT education as part of professional curricula may have positive results. For example, Sawning et al²⁷ evaluated the effectiveness of an LGBT health certificate program in increasing knowledge and accepting attitudes of medical students. By the end of the program, knowledge of and positive attitudes toward LGBT patients increased.²⁷ A similar design could be worthwhile for athletic training education programs. Currently practicing ATs who have not received education on transgender needs can also seek such education on their own. Many universities and colleges have LGBT centers that offer educational programming and resources. As research on transgender experiences and needs increases, educational opportunities via professional conferences and continuing education programs are likely to increase as well. The willingness-to-learn aspect of education should also not be forgotten. As Rogers et al²⁸ pointed out in their article, "Creating a [sic] LGBTQ+ Inclusive Culture in the Athletic Training Facility," changing one's practice to become more inclusive requires the ability to self-analyze both intentional and unintentional reactions to people of diverse backgrounds. By recognizing their own biases and developing an interest in improving care for transgender patients, ATs who exhibit a willingness to learn can continue to educate themselves after they complete their degree.

Athletic trainers can address the primacy of the patient using several methods. One option for affirming support is to identify ways of signaling that athletic training facilities are safe spaces for transgender patients. This may include participating in "Safe Zone" trainings and, subsequently, using Safe Zone posters, pins, and signs around the athletic training facility. Riley's suggestion to put notices of antidiscrimination policies and practices in the consent information that patients are required to sign would be a more subtle (but equally viable) approach. Another method is using gender-inclusive language. To promote the use of gender-inclusive language, ATs can use the pronoun(s) and name a person prefers. The appropriate pronoun can be determined by either asking the individual directly in a private setting or by having a space for pronoun(s) and preferred name on medical history and consent documents. Athletic trainers can also provide expansive gender options on paperwork and forms whenever possible. These recommendations align with those of both Rogers et al²⁸ and the National Athletic Trainers' Association's "Checklist for Creating an Inclusive and Welcoming AT Facility."²⁹ Both resources offer additional suggestions for affirming support.

Ultimately, it is important to remember the importance of privacy. When considering ways to make athletic training facilities safer for transgender patients, ATs must ensure confidentiality. Conversations pertaining to a patient's gender identity should occur in a private environment. Athletic trainers should be aware that transgender patients may feel uncomfortable revealing their personal information or history related to their transgender identity and should manage these situations with patience and sensitivity.

As Cassandra's NCAA experiences showed, it could be helpful to have policies and procedures in place for how information about a transgender athlete should be shared. In a collegiate setting, compliance directors and athletic directors may need to know about an athlete's transgender identity to ensure the individual's ability to play on a sport team. This information should be disseminated discreetly, and the athlete should be an active part of the process if possible. Although none of our participants described experiences in which an AT had revealed a minor's transgender identity, we acknowledge that this can be a difficult situation. Based on our knowledge of this topic, we believe that unless it is relevant to co-occurring self-harm, abuse, or threat to oneself or others or is necessary information for receiving proper medical care, a minor's gender identity does not inherently need to be disclosed to others (including parents). Transgender minors may not be out to their families or other adults for a variety of reasons, including adults who may have been vocally transphobic in the past; coming out to them may have negative consequences. However, that is strictly our opinion: ATs should be aware of local laws or workplace policies concerning reporting minor gender identity, follow best practices, and consider collaborating with available school counselors or other professionals.

Environment is the factor that may be most often outside of an AT's direct control. Regardless, it is important for ATs to know how local culture and team dynamics can affect transgender patients. For ATs who are in environments that are hostile to transgender people, it is especially crucial to find ways of signaling that their athletic training facilities are safe. Athletic trainers should also be aware of the local resources (eg, health care providers, advocacy groups, LGBT centers) available in their communities so they can refer transgender patients if necessary. When possible, ATs should work with those around them (eg, fellow ATs, supervising physicians, administration, coaches) to create facility-wide nondiscrimination policies that include gender identity.²⁹

Limitations and Future Research

Our study had several limitations. First, all participants who volunteered for this study reported their race and ethnicity as white. This is important because in much of the literature regarding transgender health experiences, transgender people of color and African American transgender women in particular reported the highest rates of discrimination and lack of access.¹ Future researchers should thus consider the role of intersectionality—the experience of living at the intersection of more than 1 marginalized identity³⁰ (further defined in Table 1)—in the experiences of transgender people of color. Another limitation is that,

because all of the interviews were conducted by phone, participants may not have felt as comfortable talking about their experiences as they would have in an in-person interview. Finally, given that the data in this study were based on the participants' subjective perceptions of interactions, it is possible that a lack of rapport with all patients or generally poor communication skills on the part of an AT could have influenced participants to perceive their AT as holding more of a bias against transgender people than the AT actually had.

Further investigation is needed to examine how prevalent the experiences and barriers found in this study may be among transgender athletes. Future authors could also examine the experiences of transgender patients of ATs in emerging settings. In addition, developing transgender-competency educational programs for ATs is necessary. Finally, the unique health care needs of transgender athletes should be explored.

CONCLUSIONS

The experiences of transgender athletes in the athletic training setting can be described using 3 main themes: education, primacy of the patient, and the environment. These themes interact to create positive or negative experiences between transgender patients and ATs. These themes also describe areas in which transgender patients may experience barriers to seeking care, such as a lack of clinician education, lack of knowledge about whether they will be safe and supported, and an unsupportive team or local environment. Athletic trainers can improve their care of transgender patients by (1) including education about transgender people in professional athletic training curriculums, (2) seeking continuing education on transgender topics, (3) promoting the values of receptiveness and open mindedness, (4) using gender-inclusive language, (5) visually signaling that athletic training facilities are safe for all people, (6) understanding the importance of a transgender patient's privacy, and (7) being aware of local resources for transgender patients and athletes.

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