Considerations for the Stressors of Sexual Minority Identity and How It Affects Mental Health for Those Who Identify as LBGTQ+

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An area that has not been closely considered in the sporting world is the mental health effects on the competitive athletes who identify as Lesbian, bisexual, gay, transgender, queer/questioning (LBGTQ+) and thus, experience discrimination because of their sexual identity. Considerations include concepts an athletic trainer should keep in mind when caring for patients/athletes who identify as LBGTQ+. This article reviews the mental health impact of sexual minority identity stress on LBGTQ+ individuals, steps to address discrimination for those in athletics who identify as LBGTQ+, legal ramifications in the workplace for the LBGTQ+ individual, and the tragic consequences when LBGTQ+ individuals lack coping skills for stress and pursue suicide as a way to cope. Strategies are provided to improve the outcomes, prevent suicide, and create an environment of inclusivity.

Keywords: sexual identity, gender identity, environment, suicide, cisgender

In the past 20 years, the scientific and public awareness of lesbian, bisexual, gay, transgender, queer, and other sexual identities (LBGTQ+) has emerged. The start of the sociocultural shifts in understanding gender and sexual identities, including gay rights, dates back to the 1980s, starting with studies to identify suicidal behavior among “gay” youth, and a U.S. Federal report on the prevalence of gay youth suicide. In the past two decades, there have been significant shifts in public attitudes toward LBGTQ+ people and what they face in relation to their sexual orientation and identities. As a result of this changing attitude toward LBGTQ+ individuals, there has been an increase in research into the mental health of LBGTQ+ youth and adults who identify as LBGTQ+. Gender and sexual identity labels are personally meaningful for those in the LBGTQ+ community because gender and sexual identities are, by nature, complex.

The tension that underlies the discussion and acceptance of LBGTQ+ individuals is still prevalent, despite evolving societal views. In 1977, only 43% of U.S. adults agreed that gay or lesbian relations between consenting adults should be legal. By 2013, the number of U.S. adults agreeing to gay or lesbian relationships becoming legal rose to two out of three surveyed (66%). In addition, the average age of “coming out” or disclosing one’s sexual orientation and sexual identity in 2000 was around age 14. Clearly, LBGTQ+ individuals are declaring, demonstrating, and discussing their sexual orientations and identities more openly today at an early age. However, there are potential mental health implications, and legal ramifications, for the LBGTQ+ individual facing discrimination because of their sexual orientation and/or sexual identity.

The purpose of this paper is to expose the mental health disparities associated with the LBGTQ+ community and to provide strategies for athletic trainers who provide health care to patients within this community.

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Terminology

The LBGTQ+ as an umbrella term represents sexual orientation (LGB+) and various sexual identity labels (T+), deferring to the personal labels of the individual involved. It is helpful to provide terminology used in the LBGTQ+ community to clarify sexual orientation and identities:

- LBGTQ+: Lesbian, bisexual, gay, transgender, queer/questioning, inclusive of all identities.
- Lesbian: A woman who is attracted romantically, sexually, and/or emotionally to other women.
- Bisexual: A person who is emotionally, physically, and/or sexually attracted to individuals of their own gender or different gender.
- Gay: Individuals who are physically, emotionally, and sexually attracted to members of the same sex and gender. Usually referring to men, but can also be applied to women.
- Gender queer: A person who does not identify with the binary term of man/woman. It also is a term used for identities of gender nonconforming/nonbinary.
- Transgender: A person who lives as a member of a gender other than that assigned at birth based on anatomical sex.
- Queer: Individuals who do not identify as straight; also used to describe people who have a nonnormative gender identity. Used historically as a derogatory term, it is not embraced or used by all members in the LBGTQ+ community.
- Questioning: Description of an individual or a time in an individual’s life when they were unsure about their own sexual orientation or identity.
Mental Health Considerations Relating to LBGTQ+ Individuals

Prior to the 1970s, the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders listed homosexuality as a “sociopathic personality disturbance.” In 1973, the American Psychiatric Association removed homosexuality as a mental disorder, even though not all conditions related to attraction to the same sex were removed until 1987. LBGTQ+ mental disorder, even though not all conditions related to attraction to the same sex were removed until 1987. LBGTQ+ individuals are a minority compared to the numbers of heterosexual and cisgender individuals. As a minority, LBGTQ+ individuals experience unique mental health challenges such as minority stress, a theory outlined by Meyer. The minority stress theory suggests that minority members such as members of the LBGTQ+ community experience distinct and chronic stressors that are related to their stigmatized sexual orientation and gender identities. This stigmatization includes victimization, prejudice, and discrimination. Meyer further posits several stress processes in the minority stress model:

(a) Objective or external stressors of structural or institutionalized discrimination and direct personal interactions of prejudice or victimization.
(b) One’s expectations that rejection or victimization will occur and being vigilant as a result of those expectations.
(c) Internalizing others’ negative social attitudes toward members of the sexual minority.

Studies have demonstrated the discrimination against LBGTQ+ individuals. Continuous experience of discrimination, oppression, rejection, harassment, and, at times, violence may leave the LBGTQ+ individual feeling stigmatized. The stigmatization and resulting prejudice toward members of a sexual minority place the LBGTQ+ individual at risk for developing a mental health disorder, as well as other health disparities.

One in every four to five American adolescents and adults meet the criteria for having a mental health disorder in the past year, as a result of discrimination based on sexual orientation and gender identity. Studies show that LBGTQ+ adults and youth are at greater risk for elevated rates of mood disorders and depression. LBGTQ+ individuals also report a higher rate of posttraumatic stress disorder (PTSD), anxiety disorders, and alcohol use and abuse when compared with heterosexual individuals. A 2010 study that interviewed a sample of LBGTQ+ youth (16–20 years old) indicated that nearly 33% of the participants met the diagnostic criteria for a mental health disorder and/or reported a history of suicide attempts. The study also noted that 18% of the lesbian and gay youth participants in that survey met the criteria for major depression. The overall rate in the general youth population has a depression rate of 8.2%. The survey also reported that 11.3% of LBGTQ+ youth met criteria for PTSD in the previous year. About 3.9% in the general youth population met criteria for PTSD. In that same cohort, 31% of the LBGTQ+ sample reported suicidal behavior at some point in their life. Suicidal ideation is 4.1% of the general population youth. Other studies report mental disorders (depression, PTSD, and suicide ideation) in LBGTQ+ individuals at higher rates of psychiatric comorbidities (experiencing two or more mental health disorders concomitantly), and suicide ideation and attempts. LBGTQ+ youth experience higher rates of emotional distress, mood and anxiety disorders, suicide ideation, and self-harm compared with heterosexual youth.

Studies of LBGTQ+ adults demonstrate that the disproportionate rates of mental health symptomology occurred during adolescence. A prevalent occurrence in adolescence is bullying. Researchers have demonstrated that bullying of LBGTQ+ individuals occurs based upon perceived or actual gender identity or sexual orientation. The result can be higher rates of depression, suicide ideation and attempts, and substance abuse among the LBGTQ+ person that has been bullied. It makes no difference whether bullying of an LBGTQ+ individual is done via the internet or in person. Another study suggests that the effects of experiencing bullying related to sexual orientation or gender identity in adolescence carries over into adulthood.

The LBGTQ+ individuals who experience parental rejection are at increased risk for anxiety, depression, and suicide attempts. This family rejection also includes verbal and physical harassment from family members (similar to bullying), resulting in increased suicide ideation and higher levels of clinical depression. LBGTQ+ youth are also more likely to experience rumination related to discrimination, harassment, and stressors which are related to a greater level of psychological distress.

The LBGTQ+ individual, based on data on discrimination and mental health rates, is at a greater risk of developing mental health disorders and suicide ideation and suicidal attempts compared with the heterosexual population. This data should be factored into any interaction with the LBGTQ+ person in the athletic medicine setting.

Now that the stressors perpetuated upon sexual minorities and the impact it has upon mental health of the LBGTQ+ individual have been explored, we will share strategies to assess suicide. The athletic trainer will be provided useful tips on how to provide a safe and secure environment for their LBGTQ+ patients.

Suicide

In some instances, no matter how supportive and inclusive the athletic trainer is, there can be athletes who can see only one solution to their distress, and that is through suicide. As stated earlier, LBGTQ+ youth are more likely to attempt, and complete suicide caused by emotional distress in their lives. It is imperative that the athletic trainer recognizes the signs and symptoms related to thoughts of suicide, what type of conversation to have with someone who is considering suicide, and how to make appropriate referrals.

Athletes feel more comfortable when they know they can trust and confide in someone. Athletic trainers can easily become someone who is trusted, who truly cares about the well-being of the athlete and who maintains confidentiality of concerns.

Risk Factors

During the preparticipation physical the athletic trainer should determine a history, and consider other risk factors that could increase the risk of suicide. Identifying as LBGTQ+ can be a risk factor. Assessing the answers given by the athlete that are related to sexual orientation, gender identity, any mental health conditions, a history of substance abuse, recent losses, loss of family/friends to suicide, self-injury such as cutting, or an illness or injury that may prevent the athlete from participating is vital. Medications listed, such as anti-anxiety, psychotropic drugs, and antidepressants, can also help the athletic trainer identify an athlete who is more at risk for emotional distress or mental illness. Table 1 provides additional information on risk factors.
Risk Assessment

Because an athletic trainer gets to know an athlete, their moods, personality, and what motivates them, the athletic trainer may be the first to notice changes. The first step in assessing an athlete’s persona is to have a conversation with the athlete about how they are feeling and being keenly aware of answers indicating signs or symptoms of mental health concerns. Athletic trainers need to utilize their active listening skills to ascertain the level of significance.61 See Table 2 for a set of active listening skills.

Screening all athletes during a preparticipation physical can be invaluable in determining a baseline. In one study in emergency departments, they were able to find more patients who were at risk for self-harm by doing an assessment, even though that was not the primary complaint.52 Using a screening tool can provide early detection for the athletic trainer. For adult athletes some reliable screening tools include Patient Health Questionnaire 4,46,53,54 Patient Health Questionnaire 2, or Generalized Anxiety Disorder 2.46,53 For adolescents, there is a Patient Health Questionnaire A. Each of these questionnaires is brief and asks questions about things that may be bothering them. Utilizing a scale, zero through three, the questionnaire asks the individual to think about the previous 2 weeks, for example, whether they have been “feeling nervous, anxious or on edge,” “little interest or pleasure in doing things.”

The scoring of these questions will help the athletic trainer determine the level of need, or provide a baseline for future assessments. The objective is to assess conditions that may cause an athlete to be susceptible to poor mental health status. A copy of the questionnaires can be found at: https://www.hiv.uw.edu/page/mental-health-screening/gad-2.

It may become apparent that a follow-up needs to be pursued because of an athlete’s mental health status assessment or after scoring the questionnaires. It is imperative for the athletic trainer to pursue the possibility of suicidal ideation.

According to the National Institute on Health, asking if someone is suicidal does not move that person toward suicide.55 Asking about suicide may be the one question the athlete has been hoping someone would ask, as they fear telling anyone outright.

The National Institute of Mental Health utilizes the Ask Suicide-Screening Questionnaire, which assists in determining the seriousness of the potential for suicide.56 The Ask Suicide-Screening Questionnaire can be utilized for both adolescents and adults56 and is considered reliable.57 This is a brief questionnaire that can be found at: https://www.nimh.nih.gov/sites/default/files/documents/research/research-conducted-at-nimh/asp-toolkit-materials/asp-tool/screening_tool_asq_nimh_toolkit.pdf.

If the athlete indicates having thoughts about hurting or killing themselves or someone else, an athletic trainer (AT) must ask follow-up questions that are more specific. Examples of good questions using empathy are “it sounds like it is really hard right now and I want to help. Can you tell me a little bit more?” (See Table 3). One must get as many details as possible about their plan and access to the means to hurt themselves or someone else. It is appropriate to ask specifically about access to weapons or other forms of self-harm.58

Once the level of intervention has been determined the athletic trainer must act. Athletic trainers are mandatory reporters, so one must act on the information that has been provided. The AT must protect the athlete and anyone else for whom they have indicated harm. At no point should the athlete be left alone once it has been concluded that the athlete is high risk.56,58

The Referral Process59

Level I—the athlete has a situational concern, such as a relationship break up, anxiety about an upcoming test, losing playing time, or an injury. The athlete does not know how to cope with these feelings, so it may be worth seeking professional help to resolve the distress.

Level II—the athlete has mood changes, may be isolating themselves, has fears, unresolved anxiety, depression, or is abusing substances. These behaviors may be impairing daily living and the functioning of this athlete. This may require care from a mental health professional, but it is not an emergency.

Table 1  Suicide Red Flags

The criteria that should raise red flags for the athletic trainer are summarized into the following five categories:44–46.

| I. Family—history of suicide, child abuse, loss (relationships or social network), and rejection by family members. |
| II. Emotions—hopelessness, depression, feeling alone and the need for a way out, mood swings, anxiety, inability to cope with the feeling of being “different,” or being bullied. |
| III. Behaviors—being impulsive, withdrawal from family/friends, saying goodbye to family/friends, giving away items they care about (necklace, wallet, etc.), and talking about dying. |
| IV. Personal history—previous suicide attempts and history of mental health disorder. |
| V. Physical—substance abuse, access to methods of suicide, physical illness, changes in sleeping pattern, and engaging in risky behavior. |

Table 2  Active Listening Skills

Active listening involves the following:

| • Listening but engaging by challenging assumptions—an example statement: “Everyone hates me.” Listener’s response “What about teammates, parents, partners?” |
| • Building the athlete’s self-esteem—Listener’s response “I’m here for you because I care about you.” |
| • Providing feedback—having a two-way conversation, without interrupting the athlete is trying to show them errors in their logic. Asking open-ended questions that will allow the athlete to conclude that their thoughts may not have a foundation. A sample conversation: “I’ll never get a boyfriend.” Listener’s response “Never seems like a very long time, tell me more.” |
| • Making suggestions about options—suggesting referrals for a depressed athlete is appropriate. |
Level III—the athlete is in imminent danger of hurting themselves or someone else. In this instance, the athlete must go immediately to treatment. Someone must accompany the athlete until released to another medical authority. This situation usually results in evaluation at a psychiatric emergency department.

**Suicide Prevention Programs**

The athletic trainer plays a vital role in educational programming for athletes, coaches, and parents. Examples of suicide prevention strategies are life skills; Question, Persuade, and Refer; and resilience training.

Life skills that assist in the prevention of suicide include stress management, conflict resolution, coping skills, problem solving, and critical thinking. When there are challenges in life, these skills are essential for being able to navigate and manage stressors effectively. There are numerous programs that teach these skills either online or within the LBGTQ+ community.

Question, Persuade, Refer is a training geared toward providers who are in a position to recognize the warning signs of suicide, how to question, persuade, and refer the athlete for additional help. This has been an effective method to provide athletes with the help they need in a suicide crisis.

Resilience is defined as the ability to adapt to situations. Resilience training can teach one to have a positive self-concept, use humor and goal setting, avoid overgeneralizations, cope with the reality of situations, and develop optimistic rational thinking in stressful situations.

**Environment for LBGTQ+ Athletic Trainers, Patients, and Athletes**

Most LBGTQ+ adolescents develop into productive and healthy adults. A key element is family support and friendships from those who understand one’s sexual orientation and gender identity, resulting in higher self-esteem, less depression, and fewer reports of suicide.

However, the environment outside of family and friends may be challenging for the LBGTQ+ individuals. Physicians and allied health care professionals who have interactions with LBGTQ+ patients may or may not have the necessary skills to work effectively and competently. Studies have demonstrated that athletic trainers and athletic training students possess high levels of cultural awareness, but desire more skills in this area, including communication skills and education. Seventy-five percent of physicians surveyed agreed that sexual orientation should be covered more often in medical training. In another survey, medical schools reported that they provide between 0 and 5 hr on sexual orientation throughout their entire clinical program.

Other studies of medicine as it relates to LBGTQ+ patients reveal implicit and explicit biases against lesbian and gay people among medical students. Another study of international health care professionals reveal that 20% of those surveyed felt that they were unprepared to treat gay patients and indicated that their own religious beliefs about sexual minorities affected the care they provided.

**Building Protective Spaces and Connectedness**

Some athletes experience a conducive and supportive environment that reduces the risk of suicide. An athletic trainer can provide such a safe and supportive environment that removes barriers in their clinics, athletic arenas, and offices. Some athletic trainers utilize Safe Space—Safe Zone training to create a welcoming environment. The following are examples of ways to reduce mental health risks in athletes by providing safe spaces:

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**Table 3 Informed Questioning**

<table>
<thead>
<tr>
<th>Category</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>General</td>
<td>What is going on? You do not seem the same.</td>
</tr>
<tr>
<td>General</td>
<td>What has changed for you?</td>
</tr>
<tr>
<td>General</td>
<td>What are some of your stressors?</td>
</tr>
<tr>
<td>General</td>
<td>Is there anything you want to talk about?</td>
</tr>
<tr>
<td>Family</td>
<td>What kind of relationship do you have with your family?</td>
</tr>
<tr>
<td>Emotion</td>
<td>Is anything bothering you lately? Are you being bullied?</td>
</tr>
<tr>
<td>Emotion</td>
<td>What are you doing to take care of yourself?</td>
</tr>
<tr>
<td>Emotion</td>
<td>Have you been able to do the things that make you relax?</td>
</tr>
<tr>
<td>Emotion</td>
<td>Sometimes one feels like there is no light at the end of the tunnel—do you feel that way?</td>
</tr>
<tr>
<td>Emotion</td>
<td>Have you had thoughts of hurting yourself? Killing yourself? Someone else?</td>
</tr>
<tr>
<td>Behavior</td>
<td>When you think about the future, how does that feel or seem to you?</td>
</tr>
<tr>
<td>Behavior</td>
<td>Have you talked to friends and family about dying recently?</td>
</tr>
<tr>
<td>Physical</td>
<td>How are your classes?</td>
</tr>
<tr>
<td>Physical</td>
<td>Are you eating? What are you eating?</td>
</tr>
<tr>
<td>Physical</td>
<td>Anything different with your team or at home?</td>
</tr>
<tr>
<td>Physical</td>
<td>Are you sleeping? Are you using pills?</td>
</tr>
<tr>
<td>Physical</td>
<td>Are you cutting? Are you abusing alcohol or drugs? Are you doing anything I would consider risky behavior? Do you have access to ways to hurt yourself—weapons?</td>
</tr>
</tbody>
</table>

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Proper pronoun usage creates inclusion, and should be utilized by the athletic trainer.

Understanding that words matter, and that what is said can be offensive. A person must educate oneself about LBGTQ+ terminology.

A self-assessment is done to learn one’s own personal biases toward LBGTQ+ persons. The Implicit Association Test is one model that can give quick feedback about bias. The Harvard Implicit Bias test is an excellent example of a quick way to expose one’s biases too.

The AT facility is a joke-free, bullying-free, body shaming-free, and name calling-free zone

Embracing the positive and diverse experiences that people bring to conversations shows everyone that everyone is valued

Creating an environment where feedback can be given freely and honestly

The AT must model proper behavior by intervening when discrimination occurs

The AT must provide and give quality patient-centered health care for all athletes

Coaches, athletes, physicians, nurses, emergency medical technicians, and administrators must be educated about optimal patient-centered care for all

Inclusive policies, forms, and communications are developed with LBGTQ+ in mind

Nondiscrimination policies can be posted where all can read them

Providing gender neutral restrooms and locker/dressing/showing rooms are progressive ways to show inclusion and create safe places for all

Readily available resources for LBGTQ+ community members

Posting a Safe Space/Zone sticker in a prominent location shows the AT(s) have gone through cultural competency and Safe Space Ally Training

Conclusion

The LBGTQ+ community as a sexual minority suffers higher rates of internalized negative social stress. There is also structural and institutionalized discrimination, which results in prejudice toward or victimization of the LBGTQ+ community that may be unintentional. Having to experience continuous discrimination, rejection, harassment, and oppression can lead to feelings of stigmatization. The resulting stigmatization and prejudice places the LBGTQ+ athlete and athletic trainer at risk for developing a mental health disorder and health care disparities.

LBGTQ+ individuals report higher levels of PTSD, anxiety disorders, alcohol use and abuse, and suicide attempts. There are also high rates of depression compared to the general population. Suicide is a major outcome of the negative social stress. This paper aims to give the athletic trainer strategies to recognize needs, to know the signs and symptoms of suicide, to understand how to question the athlete regarding their changes in behavior, and to refer the athlete for immediate care. Specific strategies can help prevent suicide or help in intervening before suicide happens.

References


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