LGBTQ+ Considerations Related to Physical Therapy:

A Qualitative Study in Washington State

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Abstract

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There is little known of lesbian, gay, bisexual, transgender, queer or questioning and other sexual and gender minorities' (LGBTQ+) experiences and recommendations related to physical therapy services. The LGBTQ+ community is a collective of people with diverse identities related to gender identity and sexuality. As a broadly defined group, this community has faced marginalization and health disparities, though has also demonstrated resiliency. This study aimed to use community-based engagement and a strengths-based approach to answer the following research questions: 1) How do people who identify as LGBTQ+ describe experiences related to the utilization of physical therapy services?; and 2) In what ways can the physical therapy profession support equitable health and provide equitable health care for people who identify as LGBTQ+? The study used a grounded theory approach was informed by the Standards for Reporting Qualitative Research (SRQR). Data were collected via recorded semi-structured interviews. Eligibility criteria included adults who identified as LGBTQ+, had either had physical therapy or tried to access physical therapy, spoke English, and resided in Washington

State. Analysis used coded transcriptions to develop a theoretical model. Nineteen participants completed interviews. The first question resulted in a theoretical model describing interrelated overall themes of ‘quality of care,’ ‘intersectionality,’ and ‘patient safety.’ This emphasized patient treatment and access for high quality health, diverse experiences as whole human beings, and safety related to emotional, psychological, and physical well-being in the physical therapy environment. The second question resulted in recommendations for implementing an ‘inclusive organizational environment,’ ‘establishing trust,’ and being involved in ‘the bigger picture’ as it relates to health and physical therapy. Recommendations included trauma-informed practices, having options that respond to peoples’ preferences for disclosure and environmental safety considerations, authentically carrying out practices, gender and sexuality training for providers and personnel, actively engaging in continuing education and engagement with the LGBTQ+ community, and working collaboratively for financial, holistic, and preventive care that promotes equitable LGBTQ+ health. By targeting those in the LGBTQ+ community as experts, this research acknowledges the importance of stakeholder engagement related to physical therapy utilization and can inform future clinical practice, research, policy, and professional education.

This research was conducted with the approval of the Human Subjects Division

of the

University of Washington.

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Plain Language Summary

Often lesbian, gay, bisexual, transgender, queer, questioning, and other gender and sexual minorities (LGBTQ+) have worse health and experiences with health care than people who are not in this group. There are people who work on ways for improving health and health care in this group, but little is known about LGBTQ+ experiences and ways to improve in physical therapy. To learn more, nineteen adults who self-identified as LBGTQ+ were interviewed; all had used physical therapy. They shared their experiences and their ideas on what could be done to better physical therapy and health care.

We learned from the people interviewed that good health matters to them. They use physical therapy to improve their lives, movement, and their ability to do more in the community. They care about quality health care, safety in physical therapy spaces, and being understood as people with complex identities that relate to histories and the influences of society. Some talked about people in the LGBTQ+ community who do not get care because they fear being treated poorly or they had bad experiences in the past with health care.

The people also talked about how to make things better. They shared that it would be helpful for organizations and people in health care to be aware that many people have a history of trauma. People who seek care also want to be affirmed and have options. They said it was important for everyone in physical therapy and health care settings to do things in ways that are genuine, meaning that they do what they claim to do. The physical therapists and other people working at physical therapy sites should learn about LGBTQ+ language and needs. People also talked about the need for better care in all of health care, having ways to pay for it, having access

to health care before getting sick or injured, and being seen as whole humans. These ideas can make inclusion better for people who identify as LGBTQ+ and promote safety in health care.

What we learned could help physical therapists, schools, health care leaders, and researchers learn more about LGBTQ+ health. It can guide how to continue doing things that work well and find ways to be better when there are problems. It can also guide people toward ways to do more to advocate for LGBTQ+ health in the future.

Acknowledgement

Funding for this research came from the Walter C. and Anita C. Stolov Fund. Thank you to the study participants who shared their time and insights, without whom this work would not be possible. Thank you to the Dissertation Supervisory Committee at the University of Washington for ongoing time and support: Dr. Kartin – Chair, Dr. McCoy, Dr. York, Dr. Fuentes, Dr. Harniss, and Dr. Berridge, Graduate School Representative. Thank you to M. Mork, SPT, for extensive time and dedication to this study. Thank you as well to those who helped with study recruitment and development and review of study materials.

Dedication

This study is dedicated all in the LGBTQ+ community, out or otherwise.

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Chapter 1 – INTRODUCTION

Background

Many adults who identify as lesbian, gay, bisexual, transgender, queer or questioning, or other gender or sexual minorities (LGBTQ+) access or attempt to access physical therapy services as part of their health care. US estimates of this diverse collective of people range between 1.4% and 6.8% of the population (up to ~22 million people) who identify as homosexual, gay, lesbian, or bisexual, with 0.6% of adults (nearly 2 million people) who identify as transgender (Flores, Herman, Gates, & Brown, 2016; Graham et al., 2011). Gender and sexual minorities, including many who identify with language other than those noted above, are referred to in this study by the stated acronym and use of a plus sign to demonstrate inclusivity. Gender and sexuality are combined for consistency with previous literature, though should be recognized as distinct constructs, linked through commonalities in how they have been historically perceived and treated related to divergence from heterosexuality and gender norms (Graham et al., 2011). All aspects of the study focus on health considerations of this diverse group as they relate to physical therapy.

Demonstrating equitable practices requires taking intentional approaches to better understand the lived experiences of the community. Engaging with people regarding their experiences is a form of cultural humility, which acknowledges that people are the experts in their own lives (Tervalon & Murray-García, 1998). This is particularly important for groups that have been historically marginalized and oppressed, including those in the LGBTQ+ community (Graham et al., 2011; Makadon et al., 2015; World Health Organization, 2020). The Institute of Medicine's (IOM) first report on the health of those in the LGBTQ+ community, along with other literature, describe ways in which the group has experienced discrimination, health

disparities, and decreased quality of care in many health care environments (Cannon, Shukla, & Vanderbilt, 2017; Dispenza, Harper, & Harrigan, 2016; Graham et al., 2011; Maragh-Bass, Torain, Adler, Schneider, et al., 2017; Nguyen & Lau, 2018; Noonan et al., 2018). Discriminatory practices can happen at individual, organizational, and systemic levels (Braveman, 2006; World Health Organization, 2020). On the individual level, people who identify as gender and sexual minorities have been shown to be on the receiving end of explicit and, at times, traumatic experiences while interacting with health providers (Gonzales & Henning-Smith, 2017; Maragh-Bass, Torain, Adler, Schneider, et al., 2017; Ross & Setchell, 2019). Even when not intended, literature focusing on implicit bias shows that many in health care have unconscious biases that potentially impact the provision of care within the LGBTQ+ community (Sabin, Riskind, & Nosek, 2015). Health care organizations may also have underlying discriminatory policies in place that do not support optimal health for gender and sexual minorities, including, in many organizations, lack of inclusive language or protective legal documentation that even acknowledges peoples' identities outside heteronormative and binary contexts (Graham et al., 2011; Hadland et al., 2016). On a systemic level, LGTBQ+ communities often face discriminatory laws and legislative initiatives, many of which actively attempt to strip any existing protections within health care in favor of prejudicial language that permits openly denying those who seek care (Braveman, 2006; Gahagan & Colpitts, 2017; Pomeranz, 2018). Discrimination within health care, in conjunction with many factors related to social determinants of health, has resulted in decreased quality of care and disproportionately poor mental and physical health outcomes as they pertain to gender and sexual minorities collectively (Gonzales & Henning-Smith, 2017; Makadon et al., 2015; Parent, DeBlaere, & Moradi, 2013). These disparities are often compounded when considering other marginalized

identities in addition to gender and sexuality, including people of color, those with lower income, and people with disabilities (Glick, Leamy, Molsberry, & Kerfeld, 2020; Makadon et al., 2015; Parent et al., 2013).

While there is extensive literature documenting negative health experiences, outcomes, and marginalization of the LGBTQ+ community, there is also evidence of resiliency and community networking for improved overall health and wellness (Graham et al., 2011). Furthermore, some studies directly advocate for more health research that focuses on identifying strengths-based strategies for resiliency and successful interventions for equitable care (Colpitts & Gahagan, 2016; Gahagan & Colpitts, 2017).

Statement of the Problem

With respect to physical therapy, little is known about the context of health considerations for people who identify as LGBTQ+, the extent to which people experience discrimination or bias in physical therapy settings, and intervention strategies to help mitigate health disparities and promote health. Ross & Setchell, in their Australian-based study consisting of an online survey with 108 eligible participants who accessed physiotherapy, found that participant experiences varied with respect to the themes of ‘assumptions’ related to their sexuality or gender identity, discomfort related to proximity and body exposure during care, experiences of discrimination or fear of discrimination, and a ‘lack of knowledge about transgender-specific health issues,’ with some noted positive responses within these overall themes (Ross & Setchell, 2019).

For its part in the provision of equitable care, the physical therapy profession has a responsibility to uphold professional standards set forth by the governing bodies associated with the profession. The American Physical Therapy Association (APTA), in its vision for

"transforming society by optimizing movement to improve the human experience," appeals to physical therapists to consider the work as influential to society at large (APTA, 2019). By including societal influence, it is implied that therapists and physical therapy organizations have to consider how people live within the context of the broader society. Under the APTA Code of Ethics, physical therapists have an obligation to "respect the inherent dignity and rights of all individuals," and "be trustworthy and compassionate in addressing the rights and needs of patients/clients". This includes providing equitable care for specific populations who have unique health care needs (Swisher & Hiller, 2010). The APTA Health Policy and Administration Section includes a catalyst group, PT Proud, to provide a central resource for physical therapists, physical therapist assistants, and students interested in "affecting change in the profession of physical therapy through advocacy, policy, and promotion of competency education" (APTA, 2020). Other studies have focused on improving equitable care as it relates to gender and sexuality via provider training within physical therapist education programs (Braun et al., 2017; Copti, Shahriari, Wanek, & Fitzsimmons, 2016; Glick et al., 2020). This work will add to the growing body of research related to LGBTQ+ health in physical therapy as the first known community-based study in the United States to use semi-structured interviewing to develop a theoretical model to describe LGBTQ+ patient experiences.

Conceptual Framework for the Study

Given the challenge of having only limited collectable demographic data available for research, many studies on gender diverse health have utilized qualitative methods such as semi-structured interviews, focus groups, and cognitive interviewing to identify patient needs and experiences in health care settings (Graham et al., 2011; Klein et al., 2018; Makadon et al., 2015; Pechak et al., 2018; Reisner et al., 2015; Starks & Brown Trinidad, 2007). Community-

based input can be used as a valuable tool for research within the LGBTQ+ population and will be used for this study (Colpitts & Gahagan, 2016; Noonan et al., 2018).

Purpose of the Study

This research will seek to document peoples' experiences in physical therapy, as well as identify existing equitable strategies and ideas. Given the dearth of literature related to LGBTQ+ physical therapy considerations in the US, it is essential that the research methods and process involve people in the LGBTQ+ community as the primary source of information. In order to be consistent with practices of cultural humility in research and health care, this community-based approach will directly engage with people who are most affected by potential disparate outcomes, who have the most at stake when implementing changes related to their health and health care, and who can help identify existing successful strategies for equitable care.

Research Questions

1. How do people who identify as LGBTQ+ describe experiences related to the utilization of physical therapy services?
2. In what ways can the physical therapy profession support equitable health and provide equitable health care for people who identify as LGBTQ+?

Definition of Terms

Equity "the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically" (World Health Organization, 2020)

Gender “Gender refers to the roles, behaviours, activities, attributes and opportunities that any society considers appropriate for girls and boys, and women and men. Gender interacts with, but is different from, the binary categories of biological sex” (World Health Organization, 2020)

Health Equity “all people having fair opportunities to obtain their healthiest potentials and avoid negative health outcomes” (World Health Organization, 2020)

Health “the state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity” (World Health Organization, 2020)

LGBTQ+ Inclusive term to describe lesbian, gay, bisexual, transgender, queer or questioning, or any other gender or sexual minority

Methods

This study was developed using a grounded theory approach and semi-structured interviews for conceptualization (Starks & Brown Trinidad, 2007). It has been informed by the Standards for Reporting Qualitative Research (SRQR), which is a 21-item checklist to ensure rigor, transparency, and accountability in qualitative research (O'Brien, Harris, Beckman, Reed, & Cook, 2014). The standards were systematically developed by a team of five experts in qualitative health care research who synthesized previous literature related to guidelines, reporting standards, and critical appraisal for qualitative methods (O'Brien et al., 2014).

Inclusion Criteria

Eligibility criteria for participation included people who were age 18 years or older, identified as LGBTQ+ (however someone describes it in their own terms), had either had

physical therapy or tried to access physical therapy, spoke English language, and resided in Washington State.

Data Collection

Data were collected between February 2020 and June 2020. Snowball sampling was used for recruitment efforts and material distribution (Dillman, 2014). Recruitment sites were located by internet identification of organizations that serve the LGBTQ+ population throughout Washington State, as well as networking through people known to the research team in the LGBTQ+ and physical therapy communities. Recruitment efforts were completed with consideration for seeking diversity of perspectives regarding multiple cultural factors: diversity of sexuality, gender, age, rural/urban geography, disability status, and race or ethnicity.

Semi-structured interviews were conducted with 19 participants using an interview guide developed from a five-phase framework that was established as a result of a systematic methodological review (Kallio, Pietila, Johnson, & Kangasniemi, 2016). This approach entails: 1) identifying the prerequisites for using semi-structured interviews, 2) retrieving and using previous knowledge, 3) formulating the preliminary semi-structured interview guide, 4) pilot testing the guide, and 5) presenting the complete semi-structured interview guide (Kallio et al., 2016). Consistent with semi-structured interviews and qualitative research, follow-up questions were guided by the participant response, and findings and interview experiences informed subsequent interview questions (Kallio et al., 2016). The researcher disclosed personal demographics and status as a physical therapist to participants prior to each interview.

For three participants, interviews were conducted in-person at a mutually agreed upon location between the interviewer and participant. Telephone interviews were conducted for one participant due to geographic limitations for reasonable access, as well as for the remaining 15

participants due to government and research policies related to COVID-19. Interviews were audio recorded, with interviews ranging between 17 and 58 minutes in duration, and mean time 31 minutes. Field notes were kept as part of data collection. Four participants were known to the interviewer prior to the research study, none in a therapeutic context. Data collection ceased when saturation was reached. Saturation was defined in this study as no new concepts relevant to research questions and recognized through the process of concurrent coding.

Analysis of Data

Participants were assigned a research ID number, with randomization of ID order completed prior to data collection. Digital audio recordings were transcribed verbatim using online transcription services. The transcriptions were reviewed for accuracy by a member of the research team and all identifying information was removed. Seventeen distinct content codes were developed using data from five transcripts. A cloning method was used for coding all transcripts, with one member of the research team creating excerpts and duplicating the excerpts for separate coding. Two members of the research team then separately assigned codes to each transcript using Dedoose software (Dedoose, 2020). Partial or full agreement of coding application was attained for 354 excerpts (80.6%). The two coders reconciled each of the remaining 85 excerpts (19.4%), coming to agreement for all 439 excerpts. The coded excerpts were then used in a thematic analysis approach by extracting data content for each code and using that content to develop themes and subthemes, consistent with recommendations for this approach (Nowell, Norris, White, & Moules, 2017).

Participant Checking

The trustworthiness of the study data and credibility of the data analysis were enhanced by including an option for participants to engage in member checking. Six participants indicated

that they would like to be re-contacted for member checking via the consent form. All six were contacted and three confirmed they would like to review results. One indicated a preference for viewing-only without providing additional feedback and the other two verified themes.

Significance of the Study

This research supports the profession's broad research agenda to garner more knowledge about disparities in relation to access and provision of physical therapy (Goldstein et al., 2011). It is a necessary step forward to learn about the extent to which we can address specific health needs of people in diverse LGBTQ+ communities and work toward intervention strategies that improve the health outcomes of our patients. It also presents information taking a strengths-based approach involving community input for building upon existing foundations for health advocacy in the LGBTQ+ community and identifying areas where there is needed growth and opportunities to practice resiliency.

Limitations of the Study

Limitations of this study include that experiences in physical therapy were largely in outpatient settings and with limited geographical diversity across Washington State, despite directed efforts for broad perspectives within the LGBTQ+ community. Other limitations include self-selection for participation, perhaps skewing this representation toward people who had overall positive experiences in therapy and missing opportunities for growth in the overall profession. Without access to large databases in this population, this study relied on snowball sampling methods, which may also make it difficult to access people who are not out and/or less connected within LGBTQ+ networks where study information was shared. Data were also collected between February 2020 and June 2020, requiring telephone interviews for a majority of participants due to restrictions in place in response to COVID-19. Furthermore, government and

organizational policies related to COVID-19 likely limited the number of gatherings and events held by LGBTQ+ community-based organizations in Washington State during study recruitment, which likely reduced the sharing of the invitation to participate in the study.

Organization of the Study

This study and chapters are organized using a linked papers format. This, Chapter 1, serves as an introduction to the entirety of the dissertation. Chapter 2 will be a complete paper that answers the first research question regarding the experiences of those in the LGBTQ+ community who have accessed or attempted to access physical therapy. Chapter 2 will also present a theoretical model to describe these experiences. Chapter 3 will consist of another complete paper answering the second research question. Chapter 4 will be a concluding summary of the entire dissertation, with further discussion of how this dissertation can be used as a catalyst for future clinical, research, and academic studies and interventions.

Chapter 2 - USING A THEORETICAL MODEL TO DESCRIBE LGBTQ+ PATIENT EXPERIENCES RELATED TO PHYSICAL THERAPY

Abstract

Background: There is little known of lesbian, gay, bisexual, transgender, queer or questioning and other sexual and gender minorities (LGBTQ+) experiences related to physical therapy services. The LGBTQ+ community is a collective of diverse identities related to gender identity and sexuality that has, as a broadly defined group, faced marginalization and health disparities, though has also demonstrated resiliency. This work, as part of a larger study, "LGBTQ+ Considerations in Physical Therapy: A Qualitative Study in Washington State," used a community-based engagement and strengths-based approach to introduce a theoretical model in response to the following research question: How do people who identify as LGBTQ+ describe experiences related to the utilization of physical therapy services?

Methods: The study was designed with a grounded theory approach and informed by the Standards for Reporting Qualitative Research (SRQR). Data collection was completed via recorded semi-structured interviews. Eligibility criteria included adults who identified as LGBTQ+, had either had physical therapy or tried to access physical therapy, spoke English, and resided in Washington State. Analysis was completed using coded transcriptions to develop a theoretical model based on participant data.

Results: Nineteen participants completed interviews. A theoretical model describes interrelated LGBTQ+ priorities in physical therapy as they relate to overall themes of 'quality of care,' 'intersectionality,' and 'patient safety.' Treatment, access, and recreation fall under the broad theme for 'quality of care.' The 'intersectionality' theme includes information as it relates to

identity(ies), historical context, and sociopolitical influences. The theme of ‘patient safety’ includes information related to peoples’ experiences as they pertain to their overall well-being, disclosure, the body, and the physical therapy environment.

Conclusion: The theoretical model describing LGBTQ+ patient experiences related to physical therapy can be used as a tool to guide providers, administrators, researchers, and educators by providing context for the diverse needs and experiences of the collective LGBTQ+ community. It can be used to further look at specific and intersectional needs within subgroups of the LGBTQ+ community. The model also provides guidance for therapists and other personnel inquiring about the individual priorities and preferences of those seeking care.

Background

Demonstrating equitable practices for lesbian, gay, bisexual, transgender, queer or questioning, and other sexual and gender minorities (LGBTQ+) in physical therapy requires taking intentional approaches to better understand the lived experiences of the community. Engaging with people regarding their experiences is a form of cultural humility, which acknowledges that people are the experts in their own lives (Tervalon & Murray-García, 1998). This is particularly important for groups that have been historically marginalized and oppressed, including those in the LGBTQ+ community (Graham et al., 2011; Makadon et al., 2015; World Health Organization, 2020). The LGBTQ+ acronym is an umbrella term which comprises incredibly diverse sub-identities and communities across gender and sexuality, two constructs that are often linked in social, research, and political contexts despite their distinct meanings (Gahagan & Colpitts, 2017; Hadland, Yehia, & Makadon, 2016; Makadon et al., 2015).

In 2011, the Institute of Medicine (IOM) published its first report on the health of lesbian, gay, bisexual, and transgender people. The report, along with many other studies in health literature show people in the LGBTQ+ community experience discrimination, health disparities, and decreased quality of care in many health care environments (Cannon, Shukla, & Vanderbilt, 2017; Dispenza, Harper, & Harrigan, 2016; Graham et al., 2011; Maragh-Bass, Torain, Adler, Schneider, et al., 2017; Nguyen & Lau, 2018; Noonan et al., 2018). Discriminatory practices can happen at individual, organizational, and systemic levels (Braveman, 2006; World Health Organization, 2020). On the individual level, people who identify as gender and sexual minorities have been shown to be on the receiving end of biases and, at times, traumatic experiences while interacting with health providers (Gonzales & Henning-Smith, 2017; Maragh-Bass, Torain, Adler, Schneider, et al., 2017; Ross & Setchell, 2019). Some biases are known to

the person or persons with the biases, however even when not intended, literature focusing on implicit bias shows that many in health care have unconscious biases that potentially impact the provision of care within the LGBTQ+ community (Sabin, Riskind, & Nosek, 2015). Health care organizations may also have underlying discriminatory policies in place that do not support optimal health for gender and sexual minorities, including, in many organizations, lack of inclusive language or protective legal documentation that even acknowledges peoples' identities outside heteronormative and binary contexts (Graham et al., 2011; Hadland et al., 2016). On a systemic level, LGTBQ+ communities often face discriminatory laws and legislative initiatives, many of which actively attempt to strip any existing protections within health care in favor of prejudicial language that permits openly denying those who seek care (Braveman, 2006; Gahagan & Colpitts, 2017; Pomeranz, 2018). Discrimination within health care, in conjunction with many factors related to social determinants of health, has resulted in decreased quality of care and disproportionately poor mental and physical health outcomes as they pertain to gender and sexual minorities collectively (Gonzales & Henning-Smith, 2017; Makadon et al., 2015; Parent, DeBlaere, & Moradi, 2013). These disparities are often compounded when considering other marginalized identities in addition to gender and sexuality, including people of color, those with lower income, and people with disabilities (Glick, Leamy, Molsberry, & Kerfeld, 2020; Makadon et al., 2015; Parent et al., 2013).

While there is extensive literature documenting negative health experiences, outcomes, and marginalization of the LGBTQ+ community, there is also evidence of studies that seek to identify protective factors and take a strengths-based approach to developing resiliency and successful interventions for equitable care (Colpitts & Gahagan, 2016; Gahagan & Colpitts, 2017). The IOM report states, "(t)he HIV/AIDS epidemic resulted in the deaths of thousands of

gay and bisexual men; at the same time, it created a resilient and more unified LGBT community" (Graham et al., 2011). Moving away from deficit-based research, community-based research that engages people by inquiring about strengths and resiliency provides a more holistic perspective that can guide interventions (Colpitts & Gahagan, 2016; Noonan et al., 2018). In the absence of large databases for the LGBTQ+ population, many studies have utilized qualitative methods such as semi-structured interviews, focus groups, and cognitive interviewing to identify patient needs and experiences in health care settings (Graham et al., 2011; Grasso et al., 2019; Klein, Paradise, & Goodwin, 2018; Makadon et al., 2015; Pechak et al., 2018; Reisner et al., 2015; Starks & Brown Trinidad, 2007).

In physical therapy, little is known about the health needs and experiences specific to LGBTQ+ persons while accessing services. Ross & Setchell (2019), in their Australian-based study consisting of an online survey with 108 eligible participants who accessed physiotherapy, found that participant experiences varied with respect to the themes of 'assumptions' related to their sexuality or gender identity, discomfort related to proximity and body exposure during care, experiences of discrimination or fear of discrimination, and a 'lack of knowledge about transgender-specific health issues,' with some noted positive responses within these overall themes. Other studies have focused on improving equitable care as it relates to gender and sexuality via provider training within physical therapist education programs (Braun et al., 2017; Copti, Shahriari, Wanek, & Fitzsimmons, 2016; Glick et al., 2020). This work will add to the growing body of research related to LGBTQ+ health in physical therapy as the first known community-based study in the US to use semi-structured interviewing to develop a theoretical model to describe LGBTQ+ patient experiences.

Methods

Study Design

This study was developed using a grounded theory approach, utilizing semi-structured interviews for conceptualization (Starks & Brown Trinidad, 2007). It has been informed by the Standards for Reporting Qualitative Research (SRQR), which is a 21-item checklist to ensure rigor, transparency, and accountability in qualitative research (O'Brien, Harris, Beckman, Reed, & Cook, 2014). The standards were systematically developed by a team of five experts in qualitative health care research who synthesized previous literature related to guidelines, reporting standards, and critical appraisal for qualitative methods (O'Brien et al., 2014). The study was reviewed and approved by the University of Washington Human Subjects Division.

Inclusion Criteria

Eligibility criteria for participation included people who were age 18 years or older, identified as LGBTQ+ (however a person describes it in their own terms), had either had physical therapy or tried to access physical therapy, spoke English language, and resided in Washington State.

Data Collection

Data were collected between February 2020 and June 2020. Snowball sampling was used for recruitment efforts and material distribution (Dillman, 2014). Recruitment sites were located by internet identification of organizations that serve the LGBTQ+ population throughout Washington State, as well as networking through people known to the research team in the LGBTQ+ and physical therapy communities. Recruitment efforts were completed with consideration for seeking diversity of perspectives with respect to cultural factors related to diversity of sexuality, gender, age, rural/urban geography, disability status, and race or ethnicity.

Semi-structured interviews were conducted with 19 participants using an interview guide developed by using a five-phase framework that was established as a result of a systematic methodological review (Kallio, Pietila, Johnson, & Kangasniemi, 2016). This approach entails: 1) identifying the prerequisites for using semi-structured interviews, 2) retrieving and using previous knowledge, 3) formulating the preliminary semi-structured interview guide, 4) pilot testing the guide, and 5) presenting the complete semi-structured interview guide (Kallio et al., 2016). Consistent with semi-structured interviews and qualitative research, follow-up questions were guided by the participant response, and findings and interview experiences informed subsequent interview questions (Kallio et al., 2016). The researcher disclosed personal demographics and status as a physical therapist to participants prior to each interview.

For three participants, interviews were conducted in-person at a mutually agreed upon location between the interviewer and participant. Telephone interviews were conducted for one participant due to geographic limitations for reasonable access, as well as for the remaining 15 participants due to government and research policies related to COVID-19. Interviews were audio recorded, with interviews ranging between 17 and 58 minutes in duration, and mean time 31 minutes. Field notes were kept as part of data collection. Four participants were known to the interviewer prior to the research study, none in a therapeutic context. Data collection ceased when saturation was reached. Saturation was defined in this study as no new concepts introduced relevant to research questions and recognized through the process of concurrent coding.

Analysis of Data

Participants were assigned a research ID number, with randomization of ID order completed prior to data collection. Digital audio recordings were transcribed verbatim using online transcription services. The transcriptions were reviewed for accuracy by a member of the

research team and all identifying information was removed. Seventeen distinct content codes were developed using data from five transcripts. A cloning method was used for coding all transcripts, with one member of the research team creating excerpts and duplicating the excerpts for separate coding. Two members of the research team then separately assigned codes to each transcript using Dedoose software (Dedoose, 2020). Partial or full agreement of coding application was attained for 354 excerpts (80.6%). The two coders reconciled each of the remaining 85 excerpts (19.4%), coming to agreement for all 439 excerpts. The coded excerpts were then used in a thematic analysis approach by extracting data content for each code and using that content to develop themes and subthemes, consistent with recommendations for this approach (Nowell, Norris, White, & Moules, 2017).

Participant Checking

The trustworthiness of the study data and credibility of the data analysis were enhanced by including an option for participants to engage in member checking. Six participants indicated that they would like to be re-contacted for member checking via the consent form. All six were contacted and three confirmed they would like to review results. One indicated a preference for viewing-only without providing additional feedback and the other two verified themes.

Results

Participants

Nineteen participants meeting eligibility criteria completed interviews. Participant age at the time of the interview ranged from 29 to 73 years old. Participant diversity included six different identifications of race/ethnicity, varied ability status, eight different gender identifications, varied transgender or history of transition status, and eleven different sexualities at the time of interviews. Additional participant demographic data is detailed in Table 2.1.

Table 2.1. *Participant Demographics*

ID	Age (yrs)	Race/Ethnicity	Identify as Having Disability	Gender Identity	Transgender or History of Transition	Sexuality
1	30	White	No	Man	No	Gay
2	32	White	No	Gender-fluid, Man, Non-binary	Unsure, Questioning	Gay, Lesbian, Pansexual, Queer
3	61	White	Yes	Man	No	Gay
4	53	Black/African	No	Man, Other (Person)	No	Gay, Pansexual, Other (in person chemistry)
5	39	Black/African	Yes	Woman	No	Queer
6	43	White	No	Woman	No	Queer, Gay, Lesbian
7	59	Middle Eastern/White	No	Man	No	Gay
8	29	Hispanic/Latinx	No	Woman	No	Gay, Queer
9	29	White	No	Woman	No	Lesbian, Pansexual, Queer
10	44	American Indian/Alaskan Native Black/African Hispanic/Latinx White	Yes	Gender-fluid	Yes	Fluid, Pansexual, Panromantic (including at times self-sexual and aromantic)
11	51	White	No	Man	No	Gay
12	32	White	No	Woman	No	Gay; Lesbian; Queer
13	40	White	Yes	Gender-fluid, Non-binary, Woman, Other (Autgender)	No	Bisexual, Gay, Pansexual, Queer
14	63	White		Woman	No	Lesbian, Other (Previously bisexual)
15	34	White	Other	Woman, Other (Gender-queer, gender non-conforming)	No	Gay, Queer
16	31	White	Yes	Gender-fluid, Nonbinary	Yes	Asexual, Bisexual, Pansexual, Queer, Other (Aromantic)
17	73	White Other (Jewish, secular)	Yes	Woman	No	Lesbian, Queer
18	69	White	Other (Temporary)	Man	No	Gay
19	40	White	No	Woman	No	Gay, Lesbian, Queer

Note: At the time interviewed, all participants reported to reside in the same county in Western Washington, with the exception of participant #14, who reported to reside in a county in Eastern Washington. Some participants noted during the interview process that they have previously lived in other counties in Washington State.

Theoretical Model

A theoretical model was developed to describe peoples' experiences as they relate to utilization of physical therapy and accessing physical therapy. The human in the center is intended to represent that each person utilizing therapy services has a different, unique makeup of the surrounding areas and a different set of priorities and preferences. The arrows indicate that there is a dynamic relationship wherein peoples' experiences in each lead topic – 'quality of care,' 'intersectionality,' and 'patient safety' - are interrelated with aspects of one another. Considerations within 'quality of care' highlight the priority that people have for high quality of care in physical therapy settings and the meaningfulness of related access and activity. 'Intersectionality' emphasizes that individuals accessing or attempting to access care have their

own unique combination of experiences, stories, thoughts, and identities that can dynamically shift depending on context. The topic of 'patient safety' highlights the safety considerations that participants in this study discussed related to their overall health and well-being in physical therapy and health care settings.

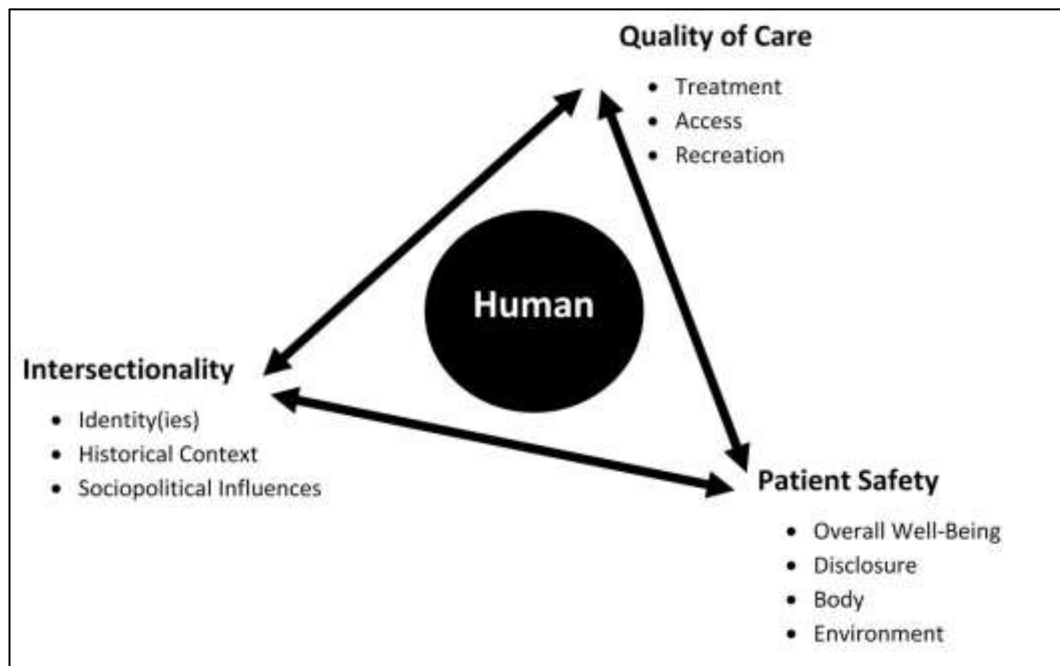

Figure 2.1. Theoretical model describing LGBTQ+ patient experiences related to physical therapy utilization

Quality of Care

Treatment

People care about addressing their health condition in physical therapy so that they may return to activities. Many participants shared positive experiences in physical therapy and often attributed this to quality providers that actively engaged with patients about their injuries and the interventions in ways that are meaningful to their lives. When therapists did not address what is meaningful for patients, it was a less positive experience.

> "Well, I like going to physical therapy because it's been effective for me, number one. It's worked." ~*Participant #18*

> "The practitioner listens to me, what I say about what I want to do, what my goal is for physical therapy. And they listen to when I say 'I can't do that one. It hurts too much.' And they don't say, 'okay, well we're only going to do one of those then' or whatever. That's the most important thing, I think." ~*Participant #14*

> "I was hit by car when I was riding my bicycle and I was a cyclist. I was a daily commuter cyclist, and the thing is a lot of people are, but being a cyclist meant a lot more to me because I'm Autistic. It was like part of why I worked to live in the city was I could ride my bike and not have to do vehicles. Public transportation is often inaccessible to me sensory wise, and so having that disrupted, it was very hard to communicate how big of a deal that was, and there definitely were health care providers who were like, 'Well, now you just get to switch - now you can start running,' or whatever, which also really does ignore my other health conditions. So now I've taken up indoor rowing… it was hard to find an activity as a way for me to increase my heart rate that is compatible for me holistically, and it certainly wasn't easy to find anybody who really understood that or could let alone help me with that." ~*Participant #13*

Access

Choices for providers and clinics are largely driven by financial status, insurance, location for convenience, and availability within the region. Some people do take additional and/or intentional actions to locate physical therapy practices that promote inclusive care for patients in the LGBTQ+ community. At times, when physical therapy is not accessible, people will utilize others within their networks and communities as an alternative or stop gap.

> "[Participant notes location and insurance] would be my top priorities, or you're limited at first to your insurance. Then from there you get to be less and less picky, but that's where you start. I haven't had to find a provider for a while, but I actually will have to find a provider soon and I'll probably use a database to hopefully find a provider network that's LGBT friendly." ~*Participant #9*

> "I specifically was looking for somebody who had pelvic floor expertise who practiced close to my home. I feel genuinely lucky that I actually found a wonderful PT who does practice who was 10 minutes from my house. It felt kind of amazing, but I just didn't bother to do any research about whether or not she, as an individual therapist, had any experience working with queer people." ~*Participant #19*

> "So I just know a lot of people who don't access physical therapy and whenever I talk to folks about accessing health care a lot of times I end up being just like, 'Well I learned

> these movements from my physical therapist. So maybe it's something you could try,' as a stop gap between them not taking care of anything and never seeing a health care provider but passing along informal information about something that worked for my body in the past but might not work for theirs… I feel like that's a pattern and if people have actual real health care access, the access piece, right? So being able to afford it, it being part of their insurance or even have insurance in the first place and then feeling comfortable going to a physical therapist; I feel like a lot of people who need it and can benefit from it, but there are just a lot of barriers there, so I'm glad that you're addressing one of the barriers which is just folks being good physical therapists." ~*Participant #16*

Recreation and Community

People noted that they often seek physical activity through preferred exercise, whether through individual, group, or organized team activities. This can be another way to access resources related to physical therapy. For some, recreational and physical activity can be a way of building community and relationships.

> "It's a magical thing that happens in sports that are really open to queerness, and rugby is one of those that's like a haven for queerness and for all sorts of people to join and be a part of. And from it, it's kind of built upon itself. First you have this team, and then one alumni joined, at least that happened, invited me to a gym with them. And so I went to the gym and that gym is connected with physical therapist office, and that physical therapist office has a rugby trainer or a rugby person, and so like makes full circle like that. And this physical therapy is one example of the magic of rugby." ~*Participant #8*

> "I really just wanted to share an activity with other people all doing their own thing. With children with Autism, you parallel play. I want to parallel work out with people. It doesn't mean we're trying to interact directly. Just like, I feel company- I'm feeling company with other people doing that." ~*Participant #10*

> "I do think I prefer it when there's other LGBT people in the activities. I do. So right now when I'm not in isolation [referring to government orders related to COVID-19], I play ultimate frisbee - my team that I play with regularly. There's a lot of other queer people and that sense of community has been really nice." ~*Participant #12*

Intersectionality

Identity(ies)

Gender and sexuality have varying degrees of importance to individuals in physical therapy. Though gender or sexuality may be a large or small part of someone's identity in the context of physical therapy, there are many other aspects of peoples' lives and identities that make up whole human beings and these aspects also fall along a spectrum of what may or may not be important to people in care. This spans demographic, interpersonal, professional, and recreational identities and roles in peoples' lives that can shift across time and context.

> "I'm kind of genderfluid, a male who likes to present feminine sometimes, but not all the time. Some people just don't understand. That's fine. But sometimes in the PT setting, you have skin exposed or you're in a compromising position. And sometimes I get more anxious than normal. If I'm dressed pretty feminine and someone's massaging me, for some reason that's just a little more intimidating to be public about or whatever." *~Participant #2*

> "But most of the PTs that I've worked with and I like to stay with are ones that they've either had experience dancing themselves, so they just know my mentality as a dancer or they're just willing to listen and get to know what it means." *~Participant #7*

> "I think sometimes racial identity factors in health care. I mean, I identify as African American or Black. Black. I haven't had any negative experiences with that, but that's something that I do think about when I'm going to see a new provider or looking for a provider." *~Participant #5*

> "I don't think about it a ton, but I am White and I think that makes things easier for me in terms of accessing health care being taken seriously. So the fact that I don't really think about race in my health care is probably informed by the fact that I'm White." *~Participant #12*

> "One, I'm (tall). Two, I am African-American. Three, then there's the gay thing. Four, I'm not the type of person that is going to sit back and allow myself to be led down a path without thinking through what those choices mean… So, those four things I think definitely can challenge a provider when I walk in for the first time and they're meeting me, because I'm not just a pushover, and the height and the being a person of color, and

> if they're not experienced with all of those things in their environment ever, then they might feel intimidated by that experience." ~*Participant #4*

Historical Context

Participants described their experiences as they relate to time and generational contexts, many of which include strong ties to gender and sexuality. Individuals have a unique combination of stories and perceptions related to their personal histories, systemic histories, and experiences in health care. There is added complexity when personal histories are embedded within the larger society, with contextual change over time and space.

> [Participant speaking of Buddhist community group] "So it's mainly mixed race and queer. But I feel, I learned so much about my own privileges. And then I also learned a lot about what they call the target community, where you're considered the victims of society. And then the other is the privilege side. I think in general, I'm much more privileged than many people, but I also feel that the parts of me, I have experienced a bunch of antisemitism when I was growing up, and so I have that experience plus my lesbian life too… I just find it's a rich experience to understand both the joys and the sufferings of marginalized people… I'm still coming out in a way. I came out in the early '90s but I still feel like I'm just… the younger generation is showing me a new concept, a new way of looking at all of us and the fluidity of it all. And so from that I'm just really learning a lot." ~*Participant #17*

> "The first time that was back in the '90s and my husband and I had been in a motor vehicle accident. And to be honest, way back then, it was a little bit uncomfortable because we both went to the same clinic and there was - When I referred to him as my husband, the therapist did a double take-ish, reacted like she hadn't heard me correctly. So it was a little uncomfortable. And then that subject was just dropped altogether."
> ~*Participant #11*

> "I think I had to be taught that I could speak up, that I was just, because generally I wouldn't feel empowered to say anything, but I had to learn how to speak up. I had to learn that it was okay for me to have a voice and not just take or be stuck in an uncomfortable position." [When the interviewer prompted how the participant would recommend that other people learn from that strength and be able to do that as well, the participant continued,] "The only way they can do that is to have self-love, self-confidence, and have had experiences that allow them to sort of build a sense of identity that allows them to have a voice." ~*Participant #3*

Sociopolitical Influences

Participants discussed ways in which perceptions of social contexts and political-relational dynamics related to the LGBTQ+ community may or may not influence care and behaviors of those both seeking and providing physical therapy. This could be related to direct interaction, or can be broadly applicable to the organizations, systems, and climates of power and privilege that relate to perceptions of gender and sexuality in the local community or nation.

> "I think it's probably good that they (physical therapists) exerted effort to make everyone feel comfortable that they could talk or express as they felt discomfort, and I don't necessarily need to be able to read that they're supportive of my sexuality or anything like that politically or personally or whatever but the fact that... I'm not sure I'll be able to qualify specifically what they've done, but the ones that I've come in contact with, they always do seem like none of that stuff is the matter." *~Participant #1*

> "I like going to the YMCA because they've totally rebranded and they're very queer friendly now. They're pioneers in LGBTQ advocacy and health and fitness right now." *~Participant #9*

> "So we've always been pretty aware of like, since we were out early, we were always out when we were in the '70s looking for apartments, we would always make choices to live in a more welcoming area. And we were lucky. We're White privileged men. We have middle-class careers. So we had that choice that we didn't have to, we could choose to live in safer, more middle-class places, which sort of go hand in hand. And so we were not limited by, an economic thing that to live in a place that was, less welcoming or less affirming." *~Participant #3*

Patient Safety

Overall Well-being

Safety was incorporated into many conversations with participants. Some participants explicitly acknowledged and expressed a sense of overall safety that included thoughts and discussions about general wellness, responsiveness, and adaptations for optimal emotional, physical, and psychological well-being in physical therapy.

> "In my experience with physical therapy, it's very up close and personal and it's a longer visit time with your provider. At least my appointments have been between 30 minutes and an hour. For most of that time, the physical therapist is touching you and you're talking and it's close quarters. It's a pretty intimate setting and you definitely want to feel safe, physically and emotionally. Finding a provider that wouldn't have reservations about your sexuality or gender identity I think is important." ~*Participant #9*

> "Well, if you're someplace and you're worried about saying the wrong thing. If you're worried that the person or the therapist or the doctor who's in a position of power that can actually harm you if they want to, if you think they disapprove of you, you're going to be spending all your energy and attention on dealing with them, rather than doing the actual exercises and paying attention to your body. Yeah, your mind has to be completely calm, and then you can focus on your therapy." ~*Participant #18*

Disclosure

Preferences for disclosure of sexual and/or gender identity to providers and organization via the intake process vary widely. There are often ways in which people seeking care gauge a sense of safety and may choose to disclose based on a combination of external and internal indicators that vary in importance from person to person. This could include visual cues within the environment, time and trust built with a provider, or geographical considerations, among others. One of the more common ways to disclose safely includes reference to other people, such as partners or spouses, which some participants noted can add a layer in the decision-making process for those who are single or have multiple others and wish to disclose.

> "I think maybe a lot of us are conditioned to sort of be careful and look for signs. I think we've all had interactions in professional lives and personal lives where you can see when the light bulb goes on, where they figure out that you're not what they presume that you are, and then you can see the behavior change or you can see discomfort arise or something like that. I think when it comes to professional interactions or medical interactions, and especially when things get touchy and personal, I think maybe it gets exacerbated. I think in knowing that they were, or at least perceiving that they were friendly, progressive or just at least the nonjudgmental or something. I think it did alleviate a lot of the pressure that I went in having." ~*Participant #1*

> "I think because of AIDS and STDs, I think I chose a gay doctor, my husband and I chose a gay doctor to see. It's interesting, I didn't think about it until now, but yeah, we wanted - I mean, definitely, all those things would come up more immediately. With a PT, it didn't have to (come up), but inevitably would. But that was usually just me bringing it up as an aside. Yeah, like, 'Oh, my husband da, da, da,' or 'my husband would love this exercise. My husband needs to do this exercise.' But yeah, with an MD, it was more like husband or no husband, I need to bring it up." *~Participant #7*

> "My most recent physical therapist is very heterosexual and I didn't ever think I needed to say anything to her... I don't need to be out to anybody." *~Participant #14*

Body

Physical therapy addresses the body and for many people who identity as LGTBQ+, this can add to the vulnerability of talking about the body and being touched. Participants noted that the vulnerability can vary depending on the reason for seeking physical therapy. Some participants added appreciation for validating, body-positive approaches to care.

> "What I'm looking for when I say queer responsive is a person who asks a question if they don't quite understand something, somebody who doesn't assume they know everything and somebody who also recognizes, at the end of the day, that a body is a body - and who doesn't want to make my body or my gender into a problem. I think way too often for queer and trans folks interacting with health care we become pathologized and medicalized in these ways that take us out of our bodies. I think in space like physical therapy that involves a lot of touch, in my experience anyway, it's really important to have a clinician who understands my relationship to my body."
> *~Participant #15*

> "We talked very comfortably about our families and our kids, and she never seemed fazed by the fact that I was queer, but it didn't feel like she probably knew a lot of queer people in her life. So then when we did pelvic floor PT, I think I was aware of my own discomfort, and then I was worried that she would be uncomfortable because I was queer and because she had her fingers in my vagina and all this. So oh, that kind of leveled it up a little bit." *~Participant #19*

> "I know a lot of people who are LGBTQ - a lot of folks are in physical jobs or in you know hourly manual labor type things who do get injuries frequently and I know a lot of folks who don't do a great job of taking care of their bodies because they feel - I mean there's, especially for trans folks, feelings around someone else touching their body. It can be really rough based on just dysphoria or just not trusting the strangers in general.

And also a history of sexual abuse if they have a lot of baggage there for accessing any kind of health care where someone would be potentially touching you. So there's a lot of trauma that can spring up for different reasons." *~Participant #16*

Environment

Participants in this study were skewed heavily toward outpatient settings. Many brought up safety considerations related to the general culture of the organization, the intake process that includes personnel other than just the physical therapist, as well as the physical treatment space. For some, it is important to have private space for treatment, while others feel more safety in an open gym space with others around. These preferences are often dependent on context in terms of what is being treated, trust in the physical therapist, and whether or not conversations could be heard by others in an open space.

> "This same clinic that I had the most recent experience in that it has a lot of Latino people, and it's comforting to just have that cultural background of speaking Spanish, but also the way clinics are run, it's more comfortable like this." *~Participant #8*

> "It's an outpatient practice, but it was situated in a gym, which I think was the thing that was complicated for me as a queer and gender non-conforming person because it meant that the bathrooms available to me were inside the gym locker room." *~Participant #15*

> "When we started, they had me working out in the main room and that didn't work for me, feng shui or privacy, vulnerability wise, but they were able to accommodate me with a private room. In fact, they even were able to adjust the lighting. I don't know what's up with other people that they are happy to lie on a table with very bright lights shining in their eyes, but I'm accustomed to asking for an accommodation for something like that, and they were accommodating, and so that was definitely something that played into it working there. …And I don't recall that they had a safe space sticker, and this is what my point is, is that they demonstrated that they cared and that they would be accommodating, and to me that is much more meaningful than someone thinking that they already are being accommodating or assuming that by displaying a safe space sticker." *~Participant #13*

> "I think the other funny dichotomy that I think can happen is that you develop a lot of rapport and intimacy with someone when you are in that enclosed space. At one PT practice that I went to, the physical therapists themselves would do your consult in the

> private room and maybe do some body work, and then they would want you to go practice your exercises, and they would pass you off to someone else who was more junior, they always seemed like interns to me. They were often young or assistants or something like that. Then we would practice the exercises out in that open space. I think, again, you now feel like you have more of an audience. You can hear other people having their sessions. You can hear what they're talking about. So any rapport that you might have established can feel more tenuous when you're out in an open space, again, I think." *~Participant #19*

Discussion

A theoretical model may be a useful tool in providing equitable health care as it pertains to the lived experiences of LGBTQ+ patients accessing physical therapy services. The model presented describes pertinent considerations that are conceptually common to LGBTQ+ people who utilize physical therapy services, while inherently emphasizing that each human has their own constellation of priorities related to quality of care, intersectionality, and patient safety. It is a complex undertaking to determine the factors related to health for anyone (Maldonado, Fried, DuBose, Nelson, & Breida, 2014). Physical therapists are familiar with this multipurpose approach, commonly using models of disability as tools to frame collective experiences of those with similar-seeming presentations, while maintaining that patient-centered care requires considering the unique aspects of peoples' lives and environments that vary in the degree to which the similarities are actually consistent with the expected descriptions of the group at large (Vargus-Adams & Majnemer, 2014; World Health Organization, 2002). Particularly with the LGBTQ+ community, there is incredible diversity under the umbrellas of gender and sexuality (Graham et al., 2011). By acknowledging that people are the experts in their own lives, the physical therapy profession can promote interventions that demonstrate cultural humility at individual, organizational, and systemic levels. This model can be utilized as a tool to shift away from the notion that it is possible to be 'competent' in others' cultures, and shift toward ways to empower others by drawing out, validating, and building upon the strengths that people have

within their own selves and within their communities to optimize health (Colpitts & Gahagan, 2016; Gahagan & Colpitts, 2017).

Participants in this study shared variations in the extent to which gender and/or sexuality plays a role in physical therapy services, including the overall quality of care. Unsurprisingly, from a treatment perspective, the overall sentiment was that high quality of care matters and that the provision of care was enhanced when providers attended to the meaningful aspects of peoples' lives. This is consistent with the expectations and standards put forth by the profession (Swisher & Hiller, 2010). Of course, to receive high quality of care in physical therapy services, people must first have access to those services. This came across in the study with respect to financial status, insurance options, convenience, and regional availability. Studies indicate that access to services is more limited for people who are poor, lack insurance or insurance options, and do not have reasonable options within local or regional contexts, including those in rural communities (Cannon et al., 2017; Downing & Przedworski, 2018; O'Bryan et al., 2018). While this study's eligibility criteria included those who have attempted to access physical therapy, all participants have previously accessed physical therapy. Future research should consider additional efforts to identify those who may have needs that are not currently being addressed so that as many people as possible can benefit from high quality skilled physical therapy services and not rely on alternatives via well-intended, though untrained, friends or family members. This study did demonstrate, however, that friends, family, and others in the LGBTQ+ community often seek recreational outlets that can positively support LGBTQ+ health and wellness, many times resulting in networking for physical therapy resources (Colpitts & Gahagan, 2016; Gay, 2009; Noonan et al., 2018).

Intersectionality, conceptually born of out of Black feminist movements from the Combahee River Collective and coined in legal doctrines by Kimberle Crenshaw, speaks to the complexity and relational aspects of identity in relation to privilege, power, and oppression (Colpitts & Gahagan, 2016; Crenshaw, 1989; Taylor, 2017). Shifting dynamics across time and context affect how LGBTQ+ people exist within themselves, through personal and collective histories, and within the larger sociopolitical environment. The way that this comes up in physical therapy varies widely depending on personal identities that include gender and sexuality, though also include many other aspects of what makes people whole across a diverse array of demographics and roles. Intersectionality takes into account that individuals with similar gender and sexual identity could experience differences in their considerations for health care depending on other factors such as disability, racial identity or age (Colpitts & Gahagan, 2016; Glick et al., 2020; Moreno, Laoch, & Zasler, 2017). Each person presents with varied priorities and, for some, identifying as LGBTQ+ plays an enormous role in how they present in and seek health care, while others report that is of little to no significance in the context of physical therapy. For many, historical context related to personal, generational, and cultural influences plays a big role in their experiences in physical therapy, with some emphasizing that often empowerment and learning opportunities are born out of a need to demonstrate resiliency (Gahagan & Colpitts, 2017). In the sociopolitical realm, this is evident in the programming and community-based opportunities to engage in health advocacy for LGBTQ+ populations (Braun et al., 2017; Reisner et al., 2015). As a profession, this takeaway message from participant input highlights the continued need for physical therapy to grow in aspects of cultural humility and acknowledge that often the people who can offer solution-oriented practices are the ones who have experienced it (Noonan et al., 2018).

Participants shared many insights regarding safety as it pertains to overall well-being, decisions about disclosing gender and/or sexuality, their own bodies, and the physical therapy environment. On an individual level, patients may take stock of language and behavioral responses during interactions with providers and other personnel. This can be useful information for the profession to consider related to increased efforts for trainings in support of LGBTQ+ community health and wellness (Graham et al., 2011; Maragh-Bass, Torain, Adler, Ranjit, et al., 2017; Moreno et al., 2017). A strengths-based approach to care through an individually-oriented perspective includes self-reflection and acknowledgement of positionality in relation to others. Individual rapport may also factor into how, when, and if patients choose to disclose their gender identity and/or sexuality. Some people will choose to disclose or not disclose based on a variety of other factors as well, including, but not limited to, organizational influences, geographical considerations, general personal preferences for privacy or being out, and whether the disclosure affects a person's health and care (Maragh-Bass, Torain, Adler, Ranjit, et al., 2017; Maragh-Bass, Torain, Adler, Schneider, et al., 2017; Thompson, 2016). Consistent with Ross & Setchell, 2019, participants shared the varying ways in which gender identity and/or sexuality factor into physical therapy experience as it relates to the body, many noting the nature of treatment that includes close proximity and touch, which can bring up added vulnerability in an already intimate interaction (Ross & Setchell, 2019). On an organizational level, the space, intake process, and culture all play a role in the comfort of patients seeking physical therapy services.

Limitations of this study include that experiences in physical therapy were largely in outpatient settings and within limited geographical diversity across Washington State, despite directed efforts for broad perspectives within the LGBTQ+ community. Other limitations include self-selection for participation, perhaps skewing this representation toward people who had

overall positive experiences in therapy and missing opportunities for growth in the overall profession. Without access to large databases in this population, this study relied on snowball sampling methods, which may also make it difficult to access people who are not out and/or less connected within LGBTQ+ networks where information shared. Data were also collected between February 2020 and June 2020, requiring telephone interviews for a majority of participants due to restrictions in place in response to COVID-19. Furthermore, government and organizational policies related to COVID-19 likely limited the number of gatherings and events held by LGBTQ+ community-based organizations, which likely reduced recruitment efforts in Washington State.

Future directions should include expanding this work in scope. This could include utilizing the theoretical model to develop study designs that lend themselves to larger samples, such as web-based survey research to broaden geographical reach and incorporate more varied perspectives. Continued qualitative studies within sub-communities may also provide valuable information to help develop and implement practices that meet unique needs specific to populations within the broader LGBTQ+ group, such as those in the elderly community, inpatient settings, disability community, rural areas, youth, or racial and ethnic cultures. For example, collective experiences of gender and sexuality may differ in Black, Indigenous, Hispanic, Asian or many other cultures. Interdisciplinary engagement in this research with those in and outside of health care can also support ways to optimize strengths-based approaches to health and wellness in the LGBTQ+ community and build upon the advocacy structures already in place to enhance practices in physical therapy services.

Conclusion

The development of a theoretical model to describe LGBTQ+ patient experiences in physical therapy can provide clinicians, administrators, researchers, and educators with a tool that can be used in various environments to support health and wellness. Priorities and preferences vary depending on quality of care, intersectionality, and patient safety. The model itself acknowledges diversity of experiences and needs under the broad umbrella of gender identity and sexuality, incorporating dynamic factors that shift depending on environmental and situational context. This model was developed with a community-based approach to seek informed perspectives from those within the LGBTQ+ community. It can be used to help demonstrate cultural humility in future practice and research by guiding inquiry that empowers and validates people as experts in their own lives.

Conflicts of Interest

There are no conflicts of interest to declare.

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Chapter 3 – LGBTQ+ COMMUNITY-BASED RECOMMENDATIONS FOR EQUITABLE PHYSICAL THERAPY PRACTICES: "IT MAKES HEALTH CARE MORE, IS HOLISTIC THE RIGHT WORD? WHOLE."

Abstract

Background: There is little known of lesbian, gay, bisexual, transgender, queer or questioning and other sexual and gender minorities (LGBTQ+) recommendations for physical therapy services. The LGBTQ+ community has a history of demonstrating resiliency and health advocacy born out of a necessity to combat inequitable health practices on individual, organizational, and systemic levels. This work, as part of a larger study, "LGBTQ+ Considerations in Physical Therapy: A Qualitative Study in Washington State," aims to introduce themes developed in response to the following research question: 'In what ways can the physical therapy profession support equitable health and provide equitable health care for people who identify as LGBTQ+?' Taking a community-based approach to identifying solutions, there is a recognized need to better understand successful strategies and areas for growth.

Methods: The study was designed with a grounded theory approach and informed by the Standards for Reporting Qualitative Research (SRQR). Data collection was completed via recorded semi-structured interviews. Eligibility criteria included adults who identify as LGBTQ+, had either had physical therapy or tried to access physical therapy, spoke English, and resided in Washington State. Analysis was completed using coded transcriptions to develop a theoretical model based on participant data.

Results: Nineteen participants completed interviews. Broad recommendations include implementing 'inclusive organizational environment,' 'establishing trust,' and being involved in

‘the bigger picture’ as it relates to health and physical therapy services. Having ‘inclusive organizational environment includes implementation of trauma-informed care practices, demonstrating organizational authenticity, and having options that are inclusive of privacy needs through the intake process, in the physical space of the organization, and with choice of providers. Provider training and provider authenticity were identified as valuable way of establishing trust in the interactive relationships. Participants also advocated for involvement in larger scope needs for improved financial advocacy, community engagement, and having approach of patients occur with a preventive mindset as part of holistic care.

Conclusion: Using strengths-based approaches, the physical therapy profession can build upon existing networks for health advocacy, engage with those with lived experiences, and continue to work toward optimal health for those in the LGBTQ+ community.

Background

The United States population includes estimates of between 1.4% and 6.8% of the population (up to ~22 million people) who identify as homosexual, gay, lesbian, or bisexual, with 0.6% of adults (nearly 2 million people) who identify as transgender (Flores, Herman, Gates, & Brown, 2016; Graham et al., 2011). Many of these individuals have or will access physical therapy services as part of their health care, each deserving of a fair opportunity to reach their highest health potential while avoiding poor health outcomes, the defining features of health equity according to the World Health Organization (World Health Organization, 2020).

These population estimates may not be capturing additional sexual or gender minorities, depending on the extent of inclusive language used in the data collection. Many sexual minorities use language such as queer, pansexual, asexual, or other terminology (Moreno, Laoch, & Zasler, 2017). With respect to gender, many people identify as non-binary, gender-fluid, agender, and other terms that may or may not coincide with binary options at a given time (Graham et al., 2011). These individuals may or may not be transgender or have a history of transition (Lombardi & Banik, 2016; Tebbe & Budge, 2016). Gender and sexual minorities are referred to in this study by the acronym associated with the terms for lesbian, gay, bisexual, transgender, and queer or questioning, with a plus sign indicating inclusivity for those with related gender or sexual identities (LGBTQ+). While used collectively to describe people in terms of gender and sexuality, two distinct constructs with many diverse sub-communities within each construct, the use of this term is to keep consistency to the extent possible with previous literature.

Dynamic shifts in language and conceptual understanding of gender and sexuality are evidence of some of the challenges related to data collection in this population and why,

subsequently, research in this population often relies on small sample sizes and convenience sampling in the absence of large data sets (Flores et al., 2016; A. R. Flores, Brown, & Herman, 2016). Existing literature shows that while many people within the LGBTQ+ community have health needs that require utilization of health care services, they often face challenges with access to care, poorer health outcomes, systemic discrimination, and historic marginalization of the population. Much of these relate to decreased financial, social, educational housing, and employment resources, all collectively considered as part of the social determinants of health (Colpitts & Gahagan, 2016; Gahagan & Colpitts, 2017; Makadon, Mayer, Potter, Goldhammer, & American College of Physicians (2003-), 2015; Quigley, Baxter, Keeler, & MacKay-Lyons, 2019; Reisner et al., 2015). Despite assertions that collecting data could violate privacy concerns for people in LGBTQ+ communities, most research related to gender and sexuality in health care indicates preferences by people within the community that health care providers have more accurate information available (Lombardi & Banik, 2016; Maragh-Bass, Torain, Adler, Ranjit, et al., 2017; Maragh-Bass, Torain, Adler, Schneider, et al., 2017). Specific to gender identity, research indicates that having options for inclusive gender demographics reduces opportunities for patients to be misgendered or vulnerable to re-traumatization (Maragh-Bass, Torain, Adler, Schneider, et al., 2017). Proponents of strengths-based approaches to research in the LGBTQ+ community support continued investigation to enhance and identify these types of protective factors and progress toward increased resiliency.

For its part in the provision of equitable care, the physical therapy profession has a responsibility to uphold professional standards set forth by the governing bodies associated with the profession. The American Physical Therapy Association (APTA), in its vision for "transforming society by optimizing movement to improve the human experience," appeals to

physical therapists to consider the work as influential to society at large (APTA, 2019). By including societal influence, it is implied that therapists and physical therapy organizations have to consider how people live within the context of the broader society. Under the APTA Code of Ethics, physical therapists have an obligation to "respect the inherent dignity and rights of all individuals," and "be trustworthy and compassionate in addressing the rights and needs of patients/clients;" this includes providing equitable care for specific populations who have unique health care needs (Swisher & Hiller, 2010).

The APTA Health Policy and Administration Section includes a catalyst group, PT Proud, to provide a central resource for physical therapists, physical therapist assistants, and students interested in "affecting change in the profession of physical therapy through advocacy, policy, and promotion of competency education" (APTA, 2020). Additionally, some are engaging in efforts to highlight a need for more attention to the needs of the LGBTQ+ community through physical therapist education and training (Braun et al., 2017; Copti, Shahriari, Wanek, & Fitzsimmons, 2016; Glick, Leamy, Molsberry, & Kerfeld, 2020). While this indicates advocacy for equity within the profession, this is the first known study using community-based qualitative methods to describe recommendations from participants in the LGBTQ+ community with lived experiences who have accessed physical therapy services.

This research is part of a larger study, "LGBTQ+ Considerations in Physical Therapy: A Qualitative Study in Washington State." The purpose of this work is to introduce themes developed in response to the research question: In what ways can the physical therapy profession support equitable health and provide equitable health care for people who identify as LGBTQ+?

Methods

Study Design

This study was developed using a grounded theory approach, utilizing semi-structured interviews for conceptualization (Starks & Brown Trinidad, 2007). It has been informed by the Standards for Reporting Qualitative Research (SRQR), which is a 21-item checklist to ensure rigor, transparency, and accountability in qualitative research (O'Brien, Harris, Beckman, Reed, & Cook, 2014). The standards were systematically developed by a team of five experts in qualitative health care research who synthesized previous literature related to guidelines, reporting standards, and critical appraisal for qualitative methods (O'Brien et al., 2014). The study was reviewed and approved by the University of Washington Human Subjects Division.

Inclusion Criteria

Eligibility criteria for participation included people who were age 18 years or older, identified as LGBTQ+ (however a person describes it in their own terms), had either had physical therapy or tried to access physical therapy, spoke English language, and resided in Washington State.

Data Collection

Data were collected between February 2020 and June 2020. Snowball sampling was used for recruitment efforts and material distribution (Dillman, 2014). Recruitment sites were located by internet identification of organizations that serve the LGBTQ+ population throughout Washington State, as well as networking through people known to the research team in the LGBTQ+ and physical therapy communities. Recruitment efforts were completed with consideration for seeking diversity of perspectives with respect to cultural factors related to diversity of sexuality, gender, age, rural/urban geography, disability status, and race or ethnicity.

Semi-structured interviews were conducted with 19 participants using an interview guide developed by using a five-phase framework that was established as a result of a systematic methodological review (Kallio, Pietila, Johnson, & Kangasniemi, 2016). This approach entails: 1) identifying the prerequisites for using semi-structured interviews, 2) retrieving and using previous knowledge, 3) formulating the preliminary semi-structured interview guide, 4) pilot testing the guide, and 5) presenting the complete semi-structured interview guide (Kallio et al., 2016). Consistent with semi-structured interviews and qualitative research, follow-up questions were guided by the participant response, and findings and interview experiences informed subsequent interview questions (Kallio et al., 2016). The researcher disclosed personal demographics and status as a physical therapist to participants prior to each interview.

For three participants, interviews were conducted in-person at a mutually agreed upon location between the interviewer and participant. Telephone interviews were conducted for one participant due to geographic limitations for reasonable access, as well as for the remaining 15 participants due to government and research policies related to COVID-19. Interviews were audio recorded, with interviews ranging between 17 and 58 minutes in duration, and mean time 31 minutes. Field notes were kept as part of data collection. Four participants were known to the interviewer prior to the research study, none in a therapeutic context. Data collection ceased when saturation was reached. Saturation was defined in this study as no new concepts relevant to research questions and recognized through the process of concurrent coding.

Analysis of Data

Participants were assigned a research ID number, with randomization of ID order completed prior to data collection. Digital audio recordings were transcribed verbatim using online transcription services. The transcriptions were reviewed for accuracy by a member of the

research team and all identifying information was removed. Seventeen distinct content codes were developed using data from five transcripts. A cloning method was used for coding all transcripts, with one member of the research team creating excerpts and duplicating the excerpts for separate coding. Two members of the research team then separately assigned codes to each transcript using Dedoose software (Dedoose, 2020). Partial or full agreement of coding application was attained for 354 excerpts (80.6%). The two coders reconciled each of the remaining 85 excerpts (19.4%), coming to agreement for all 439 excerpts. The coded excerpts were then used in a thematic analysis approach by extracting data content for each code and using that content to develop themes and subthemes, consistent with recommendations for this approach (Nowell, Norris, White, & Moules, 2017).

Participant Checking

The trustworthiness of the study data and credibility of the data analysis were enhanced by including an option for participants to engage in member checking. Six participants indicated that they would like to be re-contacted for member checking via the consent form. All six were contacted and three confirmed they would like to review results. One indicated a preference for viewing-only without providing additional feedback and the other two verified themes.

Results

Participants

Nineteen participants meeting eligibility criteria completed interviews. Participant age at the time of the interview ranged from 29 to 73 years old. Participant diversity included six different identifications of race/ethnicity, varied ability status, eight different gender identifications, varied transgender or history of transition status, and eleven different sexualities at the time of interviews. Additional participant demographic data regarding individual self-

identified race/ethnicity, ability status, gender identity, transgender or history of transition status, and sexuality is detailed in Table 3.1.

Table 3.1. *Participant Demographics*

ID	Age (yrs)	Race/Ethnicity	Identify as Having Disability	Gender Identity	Transgender or History of Transition	Sexuality
1	30	White	No	Man	No	Gay
2	32	White	No	Gender-fluid, Man, Non-binary	Unsure, Questioning	Gay, Lesbian, Pansexual, Queer
3	61	White	Yes	Man	No	Gay
4	53	Black/African	No	Man, Other (Person)	No	Gay, Pansexual, Other (in person chemistry)
5	39	Black/African	Yes	Woman	No	Queer
6	43	White	No	Woman	No	Queer, Gay, Lesbian
7	59	Middle Eastern/White	No	Man	No	Gay
8	29	Hispanic/Latinx	No	Woman	No	Gay, Queer
9	29	White	No	Woman	No	Lesbian, Pansexual, Queer
10	44	American Indian/Alaskan Native Black/African Hispanic/Latinx White	Yes	Gender-fluid	Yes	Fluid, Pansexual, Panromantic (including at times self-sexual and aromantic)
11	51	White	No	Man	No	Gay
12	32	White	No	Woman	No	Gay; Lesbian; Queer
13	40	White	Yes	Gender-fluid, Non-binary, Woman, Other (Autgender)	No	Bisexual, Gay, Pansexual, Queer
14	63	White		Woman	No	Lesbian, Other (Previously bisexual)
15	34	White	Other	Woman, Other (Gender-queer, gender non-conforming)	No	Gay, Queer
16	31	White	Yes	Gender-fluid, Nonbinary	Yes	Asexual, Bisexual, Pansexual, Queer, Other (Aromantic)
17	73	White Other (Jewish, secular)	Yes	Woman	No	Lesbian, Queer
18	69	White	Other (Temporary)	Man	No	Gay
19	40	White	No	Woman	No	Gay, Lesbian, Queer

Note: At the time interviewed, all participants reported to reside in the same county in Western Washington, with the exception of participant #14, who reported to reside in a county in Eastern Washington. Some participants noted during the interview process that they have previously lived in other counties in Washington State.

Overall Recommendations

LGBTQ+ participants in this study identified recommendations for equitable physical therapy practices based on what they have encountered in previous experiences in physical therapy and in health care. Many of these recommendations include successful strategies that they have encountered and can be replicated on a more expansive basis. Other recommendations are offered as potential solutions in response to unsuccessful encounters while accessing or

attempting to access physical therapy services or other health care. Recommendations fall within the broad themes of 'inclusive organizational environment,' 'establishing trust,' and 'the bigger picture.' The theme of 'inclusive organizational environment' emphasizes the development and maintenance of organizations that have inclusive structures built into the policies and practices to account for varied personal needs and preferences. The theme of 'establishing trust' stems from participants who frequently noted the extended periods of time spent with providers within sessions and across days, weeks, months, or even years; these participants emphasized the importance of establishing trust through the patient-provider relationship when seeking care. In many conversations, participants shared ideas about physical therapy within the larger scope of health and well-being. They offered perspectives on 'the bigger picture' by highlighting the need for financial advocacy, community engagement, and preventive and holistic approaches to health and health care. See Figure 3.1 for a visual representation of recommendations.

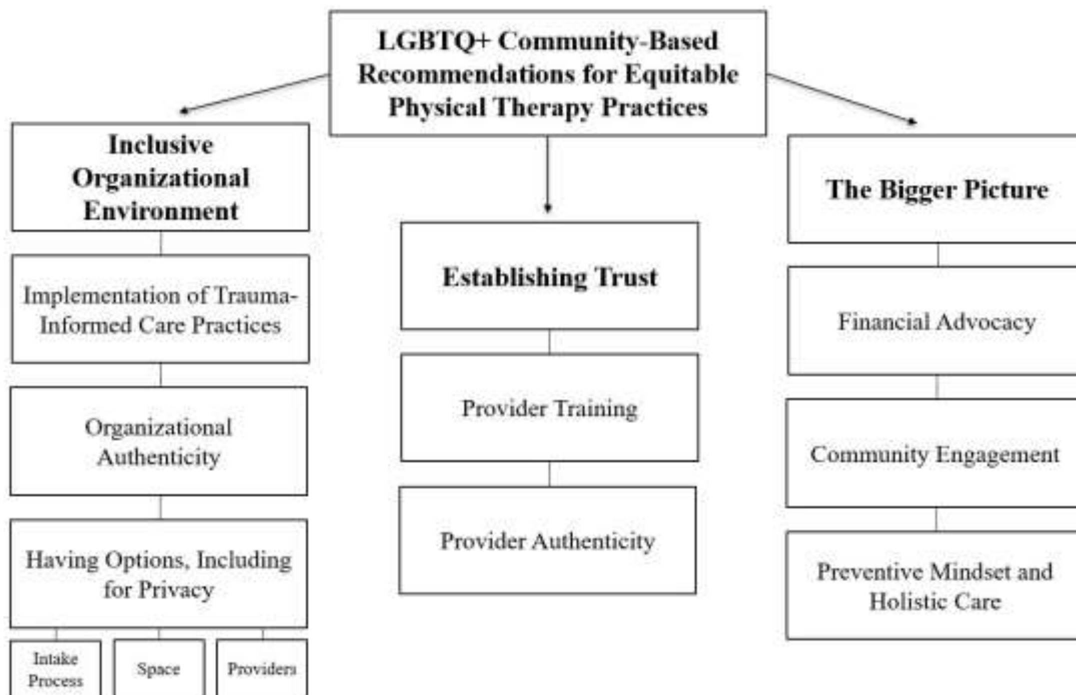

Figure 3.1. LGBTQ+ community-based recommendations for equitable physical therapy practices

Inclusive Organizational Environment

Implementation of Trauma-Informed Care Practices

Some participants actively advocated for organizational structure consistent with trauma-informed care policies and practices. An example of a trauma-informed care practice is for organizations to implement practices to ask each patient if there are certain types of treatment that they do not want included in their plan of care, such as manual bodywork. Others noted that opportunities to practice trauma-informed care may come out of necessity to respond to real-time engagement with patients who have a history of trauma. Some noted that implementing trauma-informed care practices by addressing patient concerns and acknowledging responsibility for prior harm, unintended or not, can help prevent further re-traumatization health care.

> "I think it would've been great if somewhere on that form there had been a thing that was sort of like if you have a history of physical trauma and would like to discuss that with your physical therapist, please check here and then we will have a private discussion about that. Or an area that said something like, 'are there any areas where you do not like to be touched?' You could imagine that that might be ... I think that because queer and trans folks have higher rates of experiences of violence it's a perfectly reasonable thing. The thing that's so great about asking a question like this is it's not just for queer and trans folks, right? When you center on the margins everybody does better. If you write a really inclusive intake form you'll find that a ton of cis, straight clients and patients actually also have trauma histories and if you had just been asking you would've learned those things." ~*Participant #15*

> "I will say that with that one really bad experience I had at [medical system], that when I made a complaint, my complaint completely fell on deaf ears." ~*Participant #11*

Organizational Authenticity

Participants largely shared the sentiment that whether organizations do or do not utilize external features of safety for LGBTQ+ populations, it is more important that safety for this community be authentically demonstrated in the entirety of the physical therapy experience. They noted that a statement of inclusion or sticker in the window is only helpful if the practices

of all the personnel and providers within the organization substantiate it with authenticity and prioritize the health of the people receiving their services with high quality education in all areas related to their practice.

> "No physical therapy practice should put gender-inclusive items on a form if their person at the front desk is then going to be super awkward with a trans woman who walks in the door. So you can't do it just because somebody told you to do it or because it's what the HRC health care quality index recommends or whatever. So I think that's the other thing about forms that I think is really important, is that they need to be part of an inclusive or more comprehensive program at a health care organization that is actually ensuring that people are going to have at worst neutral and at best positive experiences, but not bad experiences related to their sexual orientation or gender identity." *~Participant #19*

> "[It means that] any claims that they make in their literature - like their mission, their website, handouts that they give people, like, 'We are accepting of, and here's the list, regardless of sexual orientation, gender, blah, blah, blah,' - for providers to look at what their institution is claiming they offer and to just totally dwell into that and not take any of that superficially. If it's having meetings among one another and going line by line and being like, 'Okay, what does this mean when it says this? What's the difference between acceptance and tolerance? Yeah, it's okay for you to be here.'… It's constant active work." *~Participant #10, describing the meaning of 'trans-competent'*

Having Options, Including Option to Maintain Privacy

There are things that can be put into place on an organizational level that will most appropriately allow people to maintain privacy or disclose as it relates to their own preferences and within the context of the situation. This includes processes related to the intake process, space considerations, and provider options.

Intake Process

The intake process is most often the first entry-point into physical therapy services. Participants indicated that advanced thought should be put into how people are asked for information, whether that information is relevant to care, and how that information will be

carried throughout a person's duration of care and across the organization. One participant suggested that having options for language preferences can be useful in health care settings, as some people prefer plain language while others prefer medical/anatomical terminology. The individual noted that this strategy could be inclusive of the those in the LGBTQ+ community as it could provide an opportunity to indicate specific language preferences such as the use of the word 'chest' versus 'breasts.' Other participants also proposed training options for personnel including those who manage the intake process.

> "I think pronouns is definitely a good one to ask. And maybe, level of comfort with medical providers because some people rarely go to the doctor unless they have to - just because they haven't had good experiences. So, I think knowing that someone might not have had positive experiences before might be helpful." ~*Participant #5*

> "I don't ever feel seen by answering check boxes on an intake form. And I'm open to thinking somebody does by being able, but I personally prefer not to be asked about my gender because I don't like lying, or I don't like marking something that doesn't feel really, really true to me, but I also really don't want to deal with that with almost anybody. So me personally, I would rather read a one sentence acknowledgement that the provider is along with society and the rest of the world is trying to work through gender and sexuality…Or if there's something that seems really important - I have had trans partners who I think sometimes really do love an opportunity to say, 'I want to be seen and viewed and related to as X pronoun or gender,' and so making space for that to happen for people where that's validating, empowering, and useful, great, but that we just don't all fit there. I think reading the questions sometimes I've seen on intake forms, "Is there anything you think is important for us to know?" is not a bad one." ~*Participant #13, who continued on to note that while open-ended questions are not challenging to complete personally, they may be difficult for some people with Autism and that should be considered when developing inclusive intake materials.*

Space

Participants shared the recommendation that having space options for private care or care in a more open layout in an outpatient setting can be very useful. Peoples' preferences vary and can also vary within individuals from visit to visit, depending on differences in context.

> "Even though my latest physical therapist is a guy and we're friends, I definitely - because we're in a space to ourselves - sometimes I just have to get myself to relax. I'm always - I'm definitely more on edge. Not that he's ever done anything that has ever made me wonder if there would be a problem, but I just think that it's being alone in a room with the opposite sex is just a little unnerving sometimes." *~Participant #6*

> "[Physical therapy] has been in an open space, and I like that better for a couple of reasons. One is like, well when I was going through like my knee surgery, I could see people in multiple stages of recovery from my same injury, and that was really - you could see somebody on the table next to you that was just coming out of surgery, and then somebody else that was a couple months along, And it's like a breath of fresh air... I was thinking, 'oh I can be like that.'" *~Participant #8*

Providers

Participants in this study recommended having choice when seeking a provider for consistent care. Some added that they would like to take the demographics and experiences of the provider into account, while others do not have demographic preference related to providers.

> "I think people should have a choice. I don't know that they do because I have stuck with the same therapy group for a long time and I pretty much got a woman to start with and then when she retired, I moved on to another woman." *~Participant #14*

> "If I was working with a gay man who was a physical therapist, when I think about it now, I might be more, as much as they might be more accepting, there might be more judgment because I'm a fat gay man and they're a fit gay man… Fat phobias are out there - especially in an industry that, or at a profession that is supposed to be providing care." *~Participant #3*

Establishing Trust

Provider Training on Concepts of Gender and Sexuality

Having education about concepts in gender and sexuality are essential for providers to provide optimal care for all patients. It can fall to patients to educate providers on gender and sexuality but this could be an ineffective and inappropriate use of time in clinical care for the patient. That said, providers must acknowledge biases and maintain humility in recognizing that

people are the experts in their own selves. If patients want to share important information, it must be taken as their true experience. Through education, physical therapist practices will be better suited to identify when there are important elements that affect care, for example noting important differences between aspects of trans or other gender minority health and cisgender health.

> “Just have more education of themselves. I feel like most doctors I interacted with, their understanding is gay, lesbian, and other, they don't know the depths of an other, and there's a lot. I feel like I constantly have to be an educator to people who have a medical degree and that's not really what I want to do with my time. I go by he/him pronouns, so that hasn't been an issue, but I know my friends have certainly had all kinds of f------g problems being referred how they like to be referred to.” *~Participant #2*

> “I guess one thing that comes to mind is it would be cool if there were trans specific information that relates to physical therapy. Because a couple of things I'm thinking about. I'm trans in a way that I wore a binder for a while and I got top surgery to remove tissue and wearing a binder can be really damaging to your body, so physical therapists having an understanding of something like that and also post-surgery type physical therapy… if people want to be really good at their jobs, that would be something that they look into or learn and especially think about because, actually yeah, with the binder thing I feel like it was something I didn't ever want to bring up with my physical therapist. But it did impact what was going on with my physical body and how I operated.” *~Participant #16*

> “But they shouldn't be informed [referring to disclosure of sexuality] until they've been trained. That's the tricky part, because a lot of them will mistreat you. We've been dealing with that a little bit in terms of the elder community, elder queer community, because the studies show that often when people get older they go back in the closet, if they're by themselves particularly they'll go back in the closet. Because they have to go into retirement homes or have places where people aren't trained and are very prejudice against people who are queer. And so they can actually, if you get really old and you can't speak for yourself anymore, they can abuse you. So that's been an issue.” *~Participant #17*

Provider Authenticity

Similar to organizational authenticity, participants in this study recommend that when physical therapists implement practices that aim to support LGBTQ+ patients and clients, the providers must back it up with consistently meaningful actions for the practices to be genuinely inclusive and equitable. Additionally, they suggest therapists present themselves with their own

authentic selves in a way that does not detract from the care for individuals in the LGBTQ+ community.

> "I don't want you to be welcoming, I want you to be affirming. I don't want you to be tolerating me or recognizing me 'as a gay person that you're allowed in this space.' I want to be welcomed into your space. I want to be affirmed. And it's a subtle distinction, but one thing feels from the heart and one thing feels from a law book. And I guess I want people to provide a space." *~Participant #3*

> "I mean, it's kind of corny, and just not limited to this arena, but do the work to know yourself and be comfortable with yourself so you get to be yourself and model that for who you're with. I mean, we have evidence that not being ourselves or having to shut down parts of who we are literally takes years off of our life expectancy. It's harmful." *~Participant #13*

The Bigger Picture

Financial Advocacy

Some participants talked about financial and insurance issues that can be limiting with respect to access to health care and opportunities for participation in wellness programming. They reported a need for improved funding mechanisms and ways of navigating complicated insurance systems.

> "There's no way I could afford a membership to any of the places that are talking about having a queer community in their facility or whatever." *~Participant #10*

> "I feel like insurance coverage, that's like - so I haven't had to access physical therapy lately, but friends have. And supporting someone when they're trying to navigate, first you just need to find out who takes my insurance because you could find the perfect provider for you, but if you can't pay for it, you're not going to go. So, and I always feel like front desk staff are usually pretty helpful at that, but it just sucks to have to call around to a bajillion places and - yeah, it's just not an easy thing to figure out if you have insurance coverage." *~Participant #16*

Community Engagement

There will always be dynamic shifts in the needs of and within this diverse collective of individuals in the LGBTQ+ community and some participants reflected on the intention and continued education that are necessary to make positive changes across time and context. Additionally, this study was limited in geographic scope and provided information largely about experiences in outpatient physical therapy settings, as one participant highlighted the need for continued efforts to better understand the diverse needs and valuable recommendations from people with many different lived experiences.

> "One of the things that I learned in business school, which applied to any profession, is that if you make something, if you make a tool or a product or whatever, and then of course like with any product, 'Oh, we're going to update and we're going to update and we're going to update,' well those updates are forcing society to have to retrain. So, why wouldn't the same thing apply for individuals when you are learning to adjust to what society is willing to accept now that changes from what you previously 20 years ago learned was unacceptable in the environment? So, does that mean you need to still go through additional training to understand where we are today as opposed to where you were 20 years ago? Yeah. Are there new techniques that are coming along that help you do certain types of brain surgery that doesn't require the same kind of intense removal of various parts now? Yeah. I mean, yes, so that is necessary I think for any profession, to constantly update your skillset to know how to deal with those people, these people, any people, of what their needs may be." *~Participant #4*

> "What you guys do is touch. That's an essential part of what you do is you have physical contact with people. And I can imagine, especially around issues of language and self-identification in gender expression and multiple uses of pronouns and alternative pronouns, it can become more complicated, but it can become, more specific. One of the things that I was talking to somebody and they were complaining about pronouns and being forced to do this. And I said, 'well, we're making the language richer and we're finding ways to make more space for people by having these options.' And it's just, I think the people are saying the world is more complicated and I'm like, the world is more accurate in this full expression." *~Participant #3*

> "I think basically that this go beyond [city in WA], like I said, it goes to the small towns. And I don't know how much you can do that with your study, but I think it's something that these interviews should be happening all around the state. And even helping people

who are, well I guess you can't really reach people who are totally closeted, but people who are less out to express their experiences. Because there's probably a lot of discrimination that we don't even know about." *~Participant #17*

Preventative Mindset and Holistic Care

Speaking to ways in which the physical therapy profession can meet the needs of people in meaningful ways, participants offered innovative and intersectional insights for proactive, holistic, and strengths-based care. Participants spoke to the need for increased provider representation, interdisciplinary approaches, preventive care, community-based wellness initiatives, and overhauls in health care systems and the way that health is conceptualized.

> "Having providers of multiple racial, cultural, language backgrounds, age groups." *~Participant #8, on recommendations for successful approaches to health*

> "I'm very proactive these days because I'm in my thirties, I can't just hope it gets better and do nothing about it. That's definitely a barrier I've encountered. I don't know how it's related to LGBTQ particular. But I feel that way in a lot of other ways too. I'm seeking a mental health therapist. I'm like, 'Well I'm dealing, but I want to be better.' What's the code for that? One of you better write it. So you're like, 'I'm working on myself-itis.' I guess that's kind of a barrier. A lot of queer people I know don't want to call themselves diseased or have a syndrome or whatever, but often you need that just to be treated with respect in having a problem in the medical setting. Having a lower bar to seeking out care would be great. I'm not sure how much of that is the PT office thing versus the industry insurance thing. It's definitely a constant issue for me, for everyone who wants to fix something before it's broken." *~Participant #2*

> "When I was living in [city on East Coast], I got primary care at an LGBT Center of Health Excellence, which is an experience I really miss because [city in WA] does not have one of those. My primary care doctor was a queer woman of color, a Black queer woman and the clinic itself was a - it's a federally qualified health center, but specializes in care of the LGBTQ community." *~Participant #15*

> "[City in WA] has a pretty vibrant, at least not even just looking at rec teams, but community-type organizations where you have pick-up games or events and things. I would say that it's pretty fulfilling to have those. I've definitely met a lot of people through those organizations, and I would say that my sports participation has probably increased because of their existence. I probably wouldn't have gotten into soccer as much if there hadn't been a close gay community around soccer." *~Participant #1*

> “Well, number one, as soon as the doctor comes into my office, and this even includes the dentists; they always ask, "How is [your husband]?" Because everyone likes [him]. [He] is very, very - a sweet, sweet, sweet man. They always ask, "How's [your husband]?" That immediately makes me feel comfortable, that not only are they going to take care of my aches and pains or whatever, but I know they're aware of my psychic situation, of my emotional situation… My doctor knew all about me having to give [husband] up to go to [assisted living center]. They were very careful to ask me questions. I know they were trying to find if I was depressed - so that just - It makes health care more, is holistic the right word? Whole.” ~*Participant #18*

Discussion

This study highlights valuable input from participants in the LGBTQ+ community who offered recommendations for the physical therapy profession with respect to equitable health practices at individual, organizational, and systemic levels. On the organizational level, suggestions for implementing practices were consistent with ideas of trauma-informed care as defined by the Substance Abuse and Mental Health Services Administration (SAMHSA, 2014). This tool utilizes four key elements to acknowledge and recognize the breadth and effects of trauma while utilizing practices to respond to and prevent further negative effects of trauma through six strength-based principles, including safety and empowerment (SAMHSA, 2014). This is relevant for culturally appropriate responses within the LGBTQ+ population, particularly given the existing health disparities and historic marginalization of this community.

In addition to trauma-informed care practices, physical therapy organizations can present with authentic engagement with LGBTQ+ patients and clients. This includes avoidance of marketing services to the community without adequate structures in place to actually provide support for the health and safety of those in the community (Braun et al., 2017; Gay, 2009; Noonan et al., 2018). Inclusive organizational policies may include formalizing ways to consistently offer options to those utilizing services, working with people to develop language within intake processes, ensuring there are private and open physical spaces available within

treatment, and advocating for more feasible ways to incorporate choice of providers for continuity of care. Organizations can continuously respond to peoples' needs at the onset of care by having options available for everyone to indicate provider preference criteria. This may relieve people of the additional burden of having to decide whether to state their preference without prompt, endure discomfort, seek care elsewhere, or not seek care at all, particularly if there are already limited options due to location or insurance considerations (Makadon et al., 2015; Noonan et al., 2018). Intentional efforts to these types organizational structures will ultimately support overall best practices for all patients, reiterating what a participant stated, "when you center on the margins everybody does better."

On the individual level, establishing trust through the patient-provider relationship can enhance the quality of care. Participant recommendations for training initiatives is supported by research focusing on provider training in health care, generally, as well as in physical therapy, more specifically (Braun et al., 2017; Copti et al., 2016; Glick et al., 2020; Noonan et al., 2018). Research indicates that training can concurrently enhance the overall well-being of people in the LGBTQ+ community by validating their strengths while reducing risk for further harm (Braun et al., 2017; Copti et al., 2016; Glick et al., 2020; Noonan et al., 2018). This sentiment was expressed by one participant speaking on the vulnerability of those in elder community. It also highlights an additional intersectional component of education that someone may be very highly trained in one area of health, such as working with a transgender population, while still requiring continuing education for equitable care for others. As with organizational authenticity, participants in this study also advocated for provider authenticity in physical therapy services, including engaging in self-reflective practices that allow for more genuine interactions throughout experiences in treatment (Gay, 2009; Hayward & Li, 2014).

Systemically, the financial limitations within the health care system are extraordinary and have lasting implications on peoples' health and well-being in many areas of their lives. This is amplified for many in the LGBTQ+ community who experience economic disparities, and further compounded for those that identify with other historically oppressed groups such as people in the disability community or in Black, Indigenous, or Hispanic communities (Braveman, 2006; Cannon, Shukla, & Vanderbilt, 2017; Mollon, 2012; Noonan et al., 2018). Addressing ways to change organizations and systems with policy shifts and restructuring in innovative ways to make services accessible, affordable, and sustainable can have lasting positive effects for those seeking services, including people within the LGBTQ+ community (Colpitts & Gahagan, 2016; Gahagan & Colpitts, 2017; Makadon et al., 2015; Quigley et al., 2019; Tebbe & Budge, 2016).

Physical therapists and health care organizations can continue to engage directly with people with lived experiences as they relate to LGBTQ+ health. There can be more efforts toward a form of systemic humility, recognizing the continuous need for education and research from people who are experts in their own lives (Noonan et al., 2018; Tervalon & Murray-García, 1998). Learning from people with lived experiences can lead to higher quality of care for others, working with existing networks for health advocacy and improving systems and practices on a large scale (Gahagan & Colpitts, 2017; Tervalon & Murray-García, 1998). By taking a community-based approach to understanding recommendations for improved physical therapy practices from people who identify as gender and sexual minorities, we can continue to build upon existing success and expand strategies in areas where needed for equitable and liberating health care (Cannon et al., 2017; Colpitts & Gahagan, 2016; Wallerstein & Duran, 2010). The World Health Organization states, "a characteristic common to groups that experience health

inequities—such as poor or marginalized persons, racial and ethnic minorities, and women—is lack of political, social or economic power. Thus, to be effective and sustainable, interventions that aim to address inequities must typically go beyond remedying a particular health inequality and also help empower the group in question through systemic changes, such as law reform or changes in economic or social relationships" (World Health Organization, 2020). Participants in this study advocated for the physical therapy profession to take part in this through changes at every level that focus on preventive and holistic approaches to health.

Limitations of this study include primarily perspectives related to outpatient physical therapy settings and with limited geographical diversity across Washington State, despite recruitment efforts intended to garner diverse perspectives within the larger LGBTQ+ community. Other limitations include self-selection for participation, with participant representation likely skewed toward those who had overall positive experiences in therapy leading to potentially missing opportunities for growth in the overall profession. The study relied on snowball sampling methods due to lack of existence of large databases for this population, which increased the difficulty of accessing people who are not out and/or less connected within LGBTQ+ networks where information was shared. Data were also collected between February 2020 and June 2020, requiring telephone interviews for most participants due to restrictions in place in response to COVID-19. Furthermore, government and organizational policies related to COVID-19 likely limited the number of gatherings and events held by LGBTQ+ community-based organizations in Washington State during study recruitment, which potentially resulted in reduced sharing of the invitation to participate in the study..

Future directions should include the development and implementation of interventions at individual, organizational, and systemic levels that incorporate the recommendations proposed

by those with LGBTQ+ lived experiences. This involves time and resource investment to identify appropriate interventions based on needs within any given setting. Interventions should be based in cultural humility, with appropriate training at each level, accompanied by assessment methods that incorporate accountability into the action plan. Research should include more geographic diversity to solicit recommendations related to gender identity and sexuality as it pertains to physical therapy and physiotherapy in national and international contexts, respectively. Future studies can include populations within the broader LGBTQ+ community who may have recommendations specific to intersectional needs, such as those in the elderly community, disability community, rural areas, youth, or those who identify within racial or ethnic cultures such as Black, Indigenous, Hispanic, or Asian communities. Interdisciplinary engagement in this research can also support health and wellness in the LGBTQ+ community by networking and learning with and from existing health advocates.

Conclusion

LGBTQ+ study participants shared successful strategies for equitable physical therapy practices based on their experiences seeking care. Interventions using individual, organizational, and systemic strategies can help mitigate social, economic, and environmental disadvantages that lead to health disparities, and ultimately benefit all who seek services. Using strengths-based approaches, the physical therapy profession can build upon existing networks for health advocacy, engage with those with lived experiences, and continue to progress toward improved health for those in the LGBTQ+ community. Through interdisciplinary collaboration, this work can be adapted and expanded for optimal wellness.

Conflicts of Interest

There are no conflicts of interest to declare.

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Chapter 4 – CONCLUSION

This research study documents peoples' experiences in physical therapy, as well as identify existing equitable strategies and ideas. By targeting those in the LGBTQ+ community as expert sources, this research study acknowledges the importance of stakeholder engagement related to physical therapy utilization that can inform future clinical practice, research, policy, and professional education.

To answer the first research question, regarding how people who identify as LGBTQ+ describe experiences related to the utilization of physical therapy services, a theoretical model was developed. The human in the center is intended to represent that each person utilizing therapy services has a different, unique makeup of the surrounding areas and a different set of priorities and preferences. The arrows reflect the dynamic relationship wherein peoples' experiences in each lead topic – 'quality of care,' 'intersectionality,' and 'patient safety' - are interrelated with aspects of one another. Considerations within 'quality of care' highlight the priority that people have for high quality of care in physical therapy settings and the meaningfulness of related access and activity. 'Intersectionality' emphasizes that individuals accessing or attempting to access care have their own unique combination of experiences, stories, thoughts, and identities that can dynamically shift depending on context. The topic of 'patient safety' highlights the safety considerations that participants in this study discussed related to their overall health and well-being in physical therapy and health care settings.

In response to the second research question, LGBTQ+ participants in this study identified recommendations for equitable physical therapy practices based on what they have encountered in previous experiences in physical therapy and in health care more broadly. Many of these recommendations include successful strategies that they have encountered and can be replicated

on a more expansive basis. Other recommendations are offered as potential solutions in response to unsuccessful encounters while accessing or attempting to access physical therapy services or other health care. Recommendations fall within the broad themes of ‘inclusive organizational environment,’ ‘establishing trust,’ and ‘the bigger picture.’ The theme of ‘inclusive organizational environment’ emphasizes the development and maintenance of organizations that have inclusive structures built into the policies and practices to account for varied personal needs and preferences. The theme of ‘establishing trust’ stems from participants who frequently noted the extended periods of time spent with providers within sessions and across days, weeks, months, or even years. These participants emphasized the importance of establishing trust through the patient-provider relationship when seeking care. In many conversations, participants shared ideas about physical therapy within the larger scope of health and well-being. They offered perspectives on ‘the bigger picture’ by highlighting the need for financial advocacy, community engagement, and preventive and holistic approaches to health and health care.

Both the model and the recommendations offered by the participants in this study can serve as tools that can be used in various environments to support LGBTQ+ health and wellness. Clinicians can use this information as a way to gain insight into common experiences of those with similar-seeming presentations, while providing patient-centered care that recognizes the uniqueness of each individual through the lenses of empowerment and validation. Administrators can utilize the theoretical model and recommendation to craft policies, procedures, and initiatives that set the organization up to successfully meet the needs of the LGBTQ+ community, with carryover that benefits all who engage in physical therapy services within the inclusive organizational structures.

Researchers can develop study designs that lend themselves to larger samples, such as web-based survey research to broaden geographical reach and incorporate more varied perspectives. Continued qualitative studies within sub-communities may also provide valuable information to help develop and implement practices that consider the intersectional needs specific to populations within the broader LGBTQ+ group, such as those in the elderly community, inpatient settings, disability community, rural areas, youth, or racial and ethnic cultures – such as Black, Indigenous, Hispanic, or Asian.

Educators can design curriculum and conduct trainings that support continued growth and attention to LGBTQ+ health. Focus on individual, organizational, and systemic strategies can help mitigate social, economic, and environmental disadvantages that lead to health disparities. Interdisciplinary engagement in clinical, research, and educational contexts with those in and outside of health care can also support ways to optimize strengths-based approaches to health and wellness in the LGBTQ+ community. This can be an effective and efficient way to build upon the advocacy structures already in place and enhance practices in physical therapy services.

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