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4-2023

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ScholarWorks Citation
Omilian, Stella, "Cultural Competency in Practicing Audiologists Serving LGBTQIA+ Clients" (2023). *Honors Projects*. 928.
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Cultural Competency in Practicing Audiologists Serving LGBTQIA+ Clients

LGBTQIA+ Disparities in Healthcare:

The visibility of LGBTQIA+ (transgender, lesbian, gay, bisexual, queer/questioning, intersex, asexual +) people across the nation and the world has increased steadily within the past decade, and along with that, the vocalization of needs has increased as well (Bristow et al.2022). These needs concern public safety, legal protections, and equal rights, and are being fought for daily. A particular area in which a need for improvement is a necessity and where needs can often be overlooked or misrepresented is within medical care. Healthcare discrimination results in improper client care (Hafeez et al., 2017). The need for change is not new, but with the accessibility of the internet and forums to discuss needs and challenges, the discussion on rampant healthcare disparities faced by this marginalized community has grown to reach a national and global level of attention (Howe, 2022). Merriam-Webster defines disparity as "a noticeable and usually significant difference or dissimilarity" and, in medical scenarios, often refers to inequality of care or misrepresentation of client needs (Merriam-Webster, 2022). It manifests in unequal practices with LGBTQIA+ clients, assumptions of gender identity and sexual preference, or lack of accommodation for non-binary or gender non-conforming clients. The lack of resources or the missing base of knowledge to work with LGBTQIA+ clients can lead to avoiding healthcare consultations with their providers due to fear of mistreatment (Howe, 2022). The disparity in healthcare is built on unfamiliarity, unavailability, and assumption and is compounded by a lack of provider/staff training for facilitating that change (Weeden, 2020).

In a study by Rowe et al., (2017), the results stated that LGBTQIA+ people face unique challenges unfamiliar to practicing physicians. These include providing care for a transgender client and using appropriate pronouns, not making assumptions based on gender expression, providing a medical examination to a non-binary client, hearing testing protocols following gender binary data for normative comparison of scoring, and lack of an intake form which accommodates multiple options to collect the sexual orientation and gender identity (SOGI) data which causes a mismatch of identity and record. These issues are also often compounded by prejudice, stereotype, and an unwillingness to accept LGBTQIA+ clients. In regions where LGBTQIA+ people are a minority and face oppression, the perspective on receiving reliable and best care can feel quite bleak and often involves years of struggle to receive it (Sharma et al., 2019). It is one of the reasons why training programs in LGBTQIA+ sensitivity and familiarity are essential to bringing cultural humility into the practice. Still, assessing the progression's path at each stage is crucial to understand the barriers and challenges ahead. Training the healthcare organizations would bring a systemic change or change in infrastructure to meet the healthcare needs of the LGBTQIA+ community. The reality is that norms around LGBTQIA+ people are changing rapidly, and the progression of equal rights for these clients, in general, is an ever-present issue (Weeden, 2020).

Disparities in Audiology and Ear Care for LGBTQIA+ Clients

The main hindrances facing audiologists when working with LGBTQIA+ clients are a lack of research, experience, and familiarity with the culture and people. As a field, there are no standard sensitive practices for working with this community yet, and cultural training could go a long way in this area (Alpert et al., 2017). Hard of hearing (HoH) or Deaf intersectionality, along with being LGBTQIA+, can lead to a deepened sense of isolation and hindrance to getting needed support. It means one might have special needs related to their gender or sexual identity

and communication barriers that can hinder treatment, explanation, and communication with others about them (The Trevor Project, 2022). It can even be attributed to a higher rate of suicidal thoughts or tendencies due to a significant gap in communication and understanding of this intersectionality. It can feel incredibly isolating when one needs support, care, and understanding from others to help process a healthy change and growth. Once again, cultural competency programs would lay the foundation and give those with hearing differences the ability to effectively communicate their treatment needs with family, friends, and medical providers. In audiological settings, it could mean the use of appropriate pronouns or an appropriate name, accommodation on testing to meet these identities, and an understanding of the struggles that they may carry. It could raise the standard of medical care and support an intersectionality of people who need representation within the medical field.

<u>Healthcare Disparities: Deaf and Gender Spectrum:</u>

The intersectionality here is complex and relates closely to how personal this experience often is (Howe, 2022). A common issue facing the Deaf community is the need for an interpreter within a medical setting to communicate and explain the issues or reasoning for treatment. ASL can use non-gendered terms, but sometimes, an interpreter may not know this practice in relation to working with an LGBTQIA+ client. Additionally, interpreting self-identity or belief by an interpreter who is only familiar with binary norms may be unclear or uncomfortable (The Trevor Project, 2022). Expressing a non-binary or gender non-conforming identity is often difficult or stressful for hearing clients. To do so in the presence of an interpreter using ASL is much more challenging (Howe, 2022). The issues of unfamiliarity within the field still stand as they do within plenty of others, but accessibility for Deaf and HoH clients to communicate their needs is ever-present and frustrating. The effect of rural or community bias on the availability and reliability of healthcare must also be considered (Sharma et al., 2019). There may be scenarios where there is adequate accessibility for gender identity but not for hearing differences or the other way around, which can be tiresome to LGBTQIA + individuals who want to live authentically. This is one of the baseline goals for this community and yet these barriers would instead slow down the progress in accessibility. If a provider presents with a bias toward Deaf and HoH clients who also have an LGBTQIA+ identity, it can negatively impact the individual's overall care and well-being (Sharma et al., 2019). There is a need to conduct more research on Deaf/HoH and LGBTQIA+ intersectionality to improve their healthcare needs. Offering cultural competency training programs to their healthcare providers would significantly improve the quality of care and access.

<u>Purpose of the study:</u>

The primary objective of this project is to cultivate a better understanding of clinicians' cultural attitudes and behaviors within the field of audiology concerning LGBTQIA+ clients. The current study describes the attitudes and behaviors of clinical audiologists serving individuals in the LGBTQIA+ community. It also explores a few barriers to healthcare needs for these clients, including hearing habilitation and rehabilitation. An anonymous survey will be used to collect data from the clinicians in the West Michigan area on their current knowledge of LGBTQIA+ related terminology and language, affirmative attitudes and behaviors, and cultural sensitivity to these clients receiving audiological services. The researchers will submit an IRB proposal and await approval before distributing the survey to professional platforms such as American Speech-Language and Hearing Association's "sig" groups.

Results:

Distribution of the survey was conducted through multiple sources including the American Speech-Language-Hearing Association, the Michigan Auditory Coalition, the American Academy of Audiology, and the Michigan Speech-Language-Hearing Association. Overall, it resulted in a total of 26 responses. The states of Florida and New York have 20% of the responses each, which also correlated with the highest results for states of primary work. About 92% were considered white or Caucasian with 65.4% of respondents being in the age range of 31-50. Among the respondents, 84.6% of them had a professional AuD degree with 19.2% also having a Ph.D. Eighty-one percent (81%) were cisgender women and 84.6% identified as heterosexual. The variance of chosen responses for sexual orientation was also limited to asexual (3.9%), bisexual (3.9%), gay (3.9%), and pansexual (3.9%).

The first section of the survey included ten knowledge-based items to be answered using multiple choices for each question. About 88.5% of the individuals answered 8/10 items correctly. Two items were incorrectly answered by 46.2% of the respondents. This could be due to a confusion in fluidity in gender and sexuality. The separation of gender and sex is not a historically new concept but the reality is that within recent years there has been a growing effort to teach the difference between the two. The other question was to define what ‘Q’ stands for in LGBTQIA+ terminologies where almost half of the respondents thought both genderqueer and questioning are the same and the terms are interchangeable. The efforts are showing progress but it also results in confusion amongst those who generally do not identify themselves with the LGBTQIA+ community or struggle with changes in terminology. This split within answers is somewhat to be expected but it also speaks to the necessity of cultural competency programs in relation to LGBTQIA+ topics.

The second section of the survey included eight items identifying LGBTQIA+ affirming attitudes using a Likert scale of 5, where ‘1’ meant strongly disagree and ‘5’ meant strongly agreed. Five out of eight items have a negative effect. Examples of some items are ‘Using gender-neutral terms for a client would be possible for me, but it would feel unnatural and strange’ and ‘I don't feel that I have much of a need to learn more about LGBTQIA+ clients or their identities’. The ideal responses should be equal or below 2 which means the respondents were expected to disagree with these statements to consider expressing LGBTQIA+ affirming attitudes. The average mean for these five items was 2.04, indicating ‘disagree’. Three out of eight items have a positive effect. Examples of some items are ‘If a client asked me to use a different name for them I would know how to change it within a records system’ and ‘I feel that I am able to be sensitive to the special needs of LGBTQIA+ clients, even if I cannot entirely identify with the reasoning’. The ideal responses should be equal to or above 4 which means the respondents were expected to agree with these statements to consider expressing LGBTQIA+ affirming attitudes. The average mean for these three items was 4.11, indicating ‘agree’. The ideal expression of the responses being strongly agreed or disagreed was not seen. This may be due to a perception of how clinicians may feel that they might not always be directly involved in confronting situations which reflects an implicit bias. The most substantial deviation point for answers was on question 3 which related to the use of gender-neutral terms for a client feeling unnatural. It is entirely possible to attribute this variance to the claim that using gender-neutral terms is a more recent request, but this argument neglects to interact with the reality that nonbinary or trans clients using gender-neutral terms are still deserving of correct pronoun usage within medical settings.

The third section of the survey included eight items identifying LGBTQIA+ affirming behaviors using a Likert scale of 5, where '1' meant strongly disagree and '5' meant strongly agreed. Seven out of eight items have a negative effect. Examples of some items are 'Working with a client of another sexual orientation would be troubling or difficult for me' and 'I feel comfortable making assumptions about my client's sexual orientation based on their gender identity'. The ideal responses should be equal or below 2 which means the respondents were expected to disagree with these statements to consider expressing LGBTQIA+ affirming behaviors. The average mean for these seven items was 1.61, indicating 'disagree'. One out of eight items has a positive effect, i.e., 'I feel I know enough about the issues and struggles facing LGBTQIA+ clients to advocate for them'. The ideal responses should be equal to or above 4 which means the respondents were expected to agree with the statement to consider expressing LGBTQIA+ affirming behaviors. The average mean of the item was 2.5, indicating 'disagree' to 'neutral'. This could either mean that the clinicians are not knowledgeable enough to learn about the common issues faced by this community or need some guidance to find resources to educate themselves to provide appropriate care. The other hypothesis could be with the result of answering 7 out of 8 negative statements above and can be considered as a question on overconfidence in terms of professional competency skills.

The last section of the survey included seven items identifying culturally competent provider skills using a Likert scale of 5, where '1' meant strongly disagree and '5' meant strongly agreed. Four out of seven items have a negative effect. Examples of some items are 'I feel that the evaluation of hearing to gendered expectations is more important than working to include gender identity of a client in treatment' and 'I would feel uncomfortable prepping and coaching an interpreter before a session to ensure correct name and gender of a client are used'. The ideal responses should be equal or below 2 which means the respondents were expected to disagree with these statements to consider expressing LGBTQIA+ affirming behaviors. The average mean for these seven items was 2.17, indicating 'disagree'. Three out of seven items have a positive effect. Examples of some items are 'I am comfortable collaborating with the SLP of a transgender client undergoing gender-affirming voice training' and 'I understand that disclosing sensitive personal information may be difficult for a client with an interpreter and would be willing to foster a safe space for them'. The ideal responses should be equal to or above 4 which means the respondents were expected to agree with these statements to consider expressing LGBTQIA+ affirming attitudes. The average mean for these three items was 3.95, indicating 'slightly neutral to strongly agree'. One of the items with a positive effect was answered to be neutral which was in reference to having appropriate resources for referrals with regard to the gender affirmation process. For a survey of professional audiologists, the focus is going to be on provisioning an accurate hearing assessment first, but once again it does speak to a need for more cultural competency training for working with LGBTQIA+ clients.

Conclusions and Future Directions:

By examining the data collected within this study it is apparent that there is a need for more cultural competency sessions or training sessions regarding LGBTQIA+ clients. The data is often close enough to where it needs to be for the ideal responses but it is possible to attribute that to testing patterns or how the items were written and organized. The survey is not conclusive and it is not intended as a guideline for enacting this change but rather to point out patterns in the data collected. Ideally, a survey of this nature would include a large sample size in multiple regions of the country to have an equitable representation of practitioners belonging to diverse

communities. Audiology as a field is meant to serve all people's hearing needs, therefore those needs must also accommodate those who wish to update their names or pronouns within a consultation and seek professional advocacy in the process of gender affirmation and health equity.

The structure of the Likert scale items often lends itself to showing its skew blatantly, which may have influenced the answers of respondents. In other cases, the items may have been worded in a way where the ideal answer was not too obvious upon reading. Adding another item to the third Likert questionnaire would have kept things uniform at eight items per section. Varying the distribution of positive and negative statements could have had an effect on the mean overall. The scope of collected responses was viable for a project of this scale but it doesn't change the fact that distributing surveys is tricky by nature. In the process of distributing this survey, the researchers identified that the surveys are typically distributed by mailing addresses as opposed to by bulletin boards and community postings. Given the nature and timing of the project, the online distribution method worked effectively. The researchers encountered issues with survey distribution within the state of Michigan especially because of the short timeline. Lastly, statistical methods should be used to evaluate the reliability of items in future studies.

Timeline 2022-23:
Mid-December to Mid-January: IRB Process and Approval
Mid-January to February: Survey Distribution
February to Mid-March: Data Analysis
Mid-March to Mid-April: Write-Up and Project Submission

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