NATIONAL LGBTQIA+ HEALTH
EDUCATION CENTER
A PROGRAM OF THE FENWAY INSTITUTE

Health at the Intersection of Sexuality, Gender, and Disability

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they|them|theirs
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Our Roots

Fenway Health

- Independent 501(c)(3) FQHC
- Founded 1971
- Mission: To enhance the wellbeing of the LGBTQIA+ community as well as people in our neighborhoods and beyond through access to the highest quality health care, education, research, and advocacy
- Integrated primary care model, including HIV and transgender health services

The Fenway Institute

- Research, Education, Policy

LGBTQIA+ Education and Training

The National LGBTQIA+ Health Education Center offers educational programs, resources, and consultation to health care organizations with the goal of providing affirmative, high quality, cost-effective health care for lesbian, gay, bisexual, transgender, queer, intersex, asexual, and all sexual and gender minority (LGBTQIA+) people.

- Training and Technical Assistance
- Grand Rounds
- Online Learning
  - Webinars, Learning Modules
  - CE, and HEI Credit
- ECHO Programs
- Resources and Publications

www.lgbtqiahealtheducation.org

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- You can contact the webinar host using the chat function in Zoom. Click the “Chat” icon, and type your question.
- Alternatively, e-mail us at education@fenwayhealth.org for less urgent questions

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- Ensure your computer speakers are not muted
- If you cannot hear through your computer speakers: Navigate to the bottom toolbar on your screen, go to the far left, and click the arrow next to the phone icon
- Choose “I will call in.”
- Dial the phone number and access code

After the Webinar

- Close the browser, and an evaluation will automatically open for you to complete

- We very much appreciate receiving feedback from all participants

- Completing the evaluation is required to obtain a CME certificate

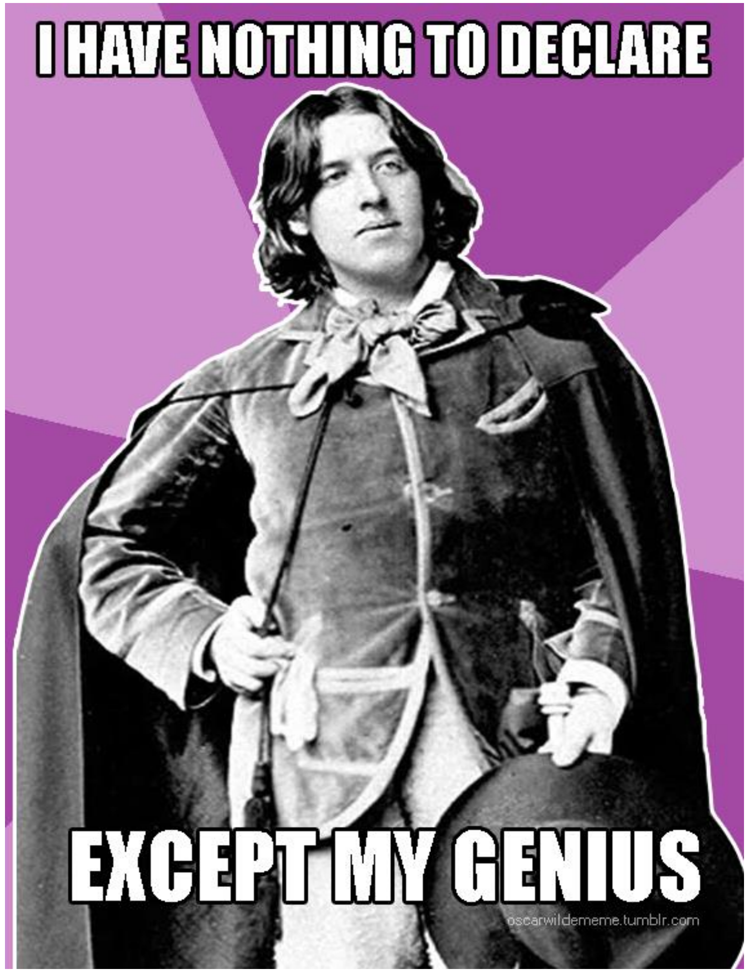
CME/CEU Information

This activity has been reviewed and is acceptable for up to 1.0 Prescribed credits by the American Academy of Family Physicians. Participants should claim only the credit commensurate with the extent of their participation in this activity.

Physicians	AAFP Prescribed credit is accepted by the American Medical Association as equivalent to AMA PRA Category 1 Credit™ toward the AMA Physician'sRecognition Award. When applying for the AMA PRA, Prescribed creditearned must be reported as Prescribed, not as Category 1.
Nurse Practitioners, Physician Assistants, Nurses, Medical Assistants	AAFP Prescribed credit is accepted by the following organizations. Please contact them directly about how participants should report the credit they earned. •American Academy of Physician Assistants (AAPA) •National Commission on Certification of Physician Assistants (NCCPA) •American Nurses Credentialing Center (ANCC) •American Association of Nurse Practitioners (AANP) •American Academy of Nurse Practitioners Certification Program (AANPCP) •American Association of Medical Assistants (AAMA)
Other Health Professionals	Confirm equivalency of credits with relevant licensing body.

Declarations

- I have nothing to declare!



Land Acknowledgement

- "As we live and learn on these territories, we must keep in mind the community struggles for self-determination and colonial legacies of scholarly practices." – Ramona Beltran
- I acknowledge that the University of Michigan resides on the ancestral, traditional, and contemporary lands of the Anishinaabe--The Three Fire Confederacy of the Ojibwe, Odawa and Potawatomi Nations, as well as the Wyandot Nation.
- We must advocate for indigenous struggles against ongoing settler-colonization and strive for a decolonized future.
- Find out whose land YOU are on: https://native-land.ca/

Introduction

- Shanna K. Kattari, PhD, MEd, CSE, ACS
- Master's in Human Sexuality Education (Widener)
- PhD in Social Work (University of Denver)
- Faculty at the University of Michigan
- Intersectional research on disability, sexuality, queer/trans experiences
- Identities: white disabled chronically ill neurodivergent Jewish middle class queer fat nonbinary Femme

Guidelines

SAFER SPACE/

BRAVE SPACE

RESPECT FOR EACH OTHER AND THE TOPIC

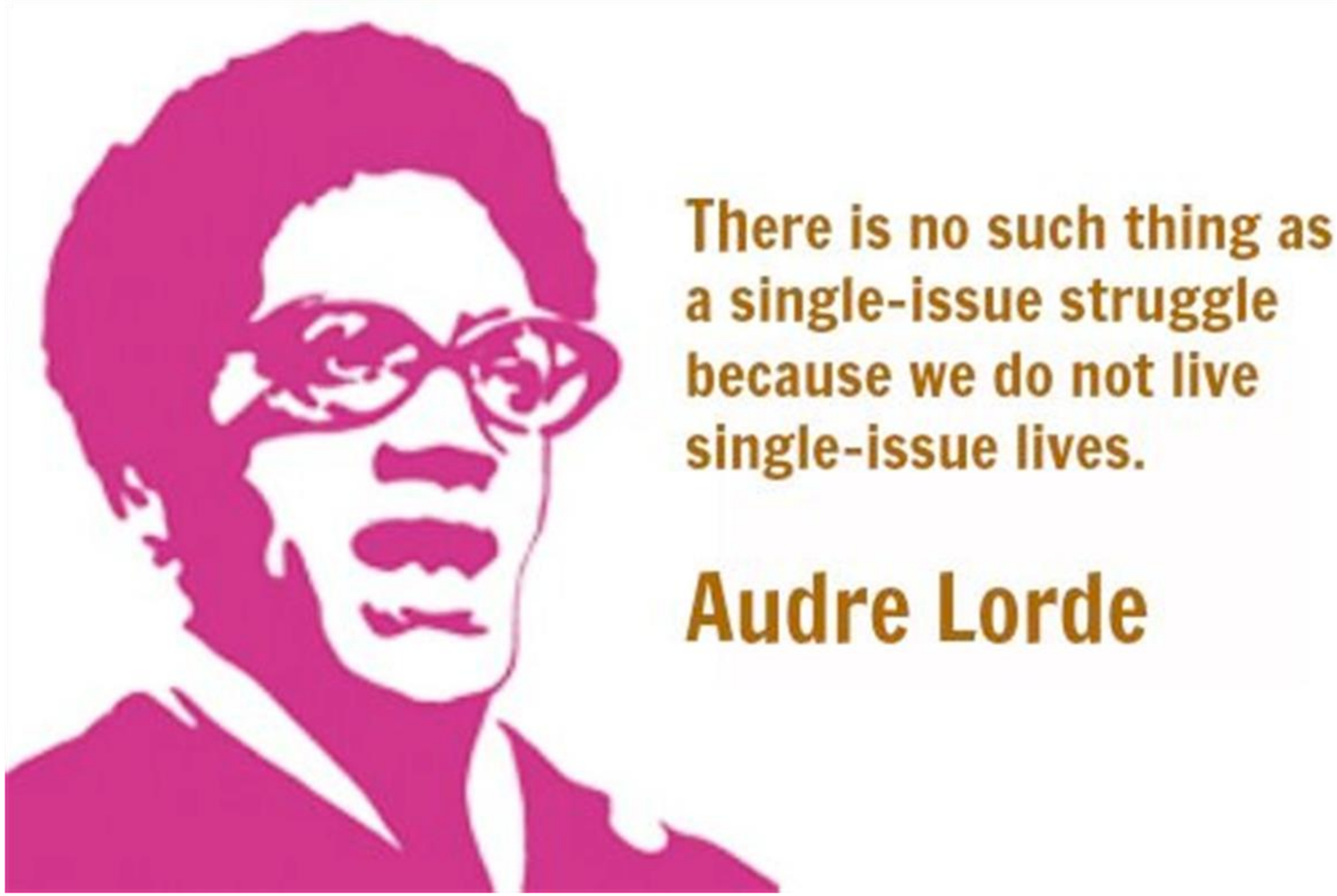
ASK QUESTIONS

ENGAGE

SELF CARE

BE OPEN TO FEEDBACK

Intersectional Lens



> There is no such thing as
> a single-issue struggle
> because we do not live
> single-issue lives.

Audre Lorde

People with Disabilities/Disabled People

- About 26% of adults in the US reported having a disability (Okoro et al., 2018)
- The number of adults with a disability is likely underreported (Okoro et al., 2018)
- Language: person first vs. identity first
  - Will use interchangeably to honor the variety of people's identities
  - Reclaimed language such as crip, mad, etc.

Image Source: hrhero.com

LGBTQIA2S+…

- Lesbian
- Gay
- Bisexual
- Transgender (including of gender diverse, nonbinary, agender, etc.)
- Queer/Questioning
- Intersex
- Asexual (including demisexual, greysexual, etc.)
- Two Spirit (an Indigenous specific identity crossing both gender and sexual orientation)
- + can include omnisexual, pansexual, other identities

Variety of Disabilities

- Acquired vs. congenital
- Visible vs. non-apparent
- Short-term vs. long term
- Concurrent/co-morbid with other types of impairments/differences
- Chronic pain/illness
- Neurodivergence
- How society views the impairment/illness
    - Example: Differential reactions to/understanding of cancer vs. traumatic brain injury (TBI)

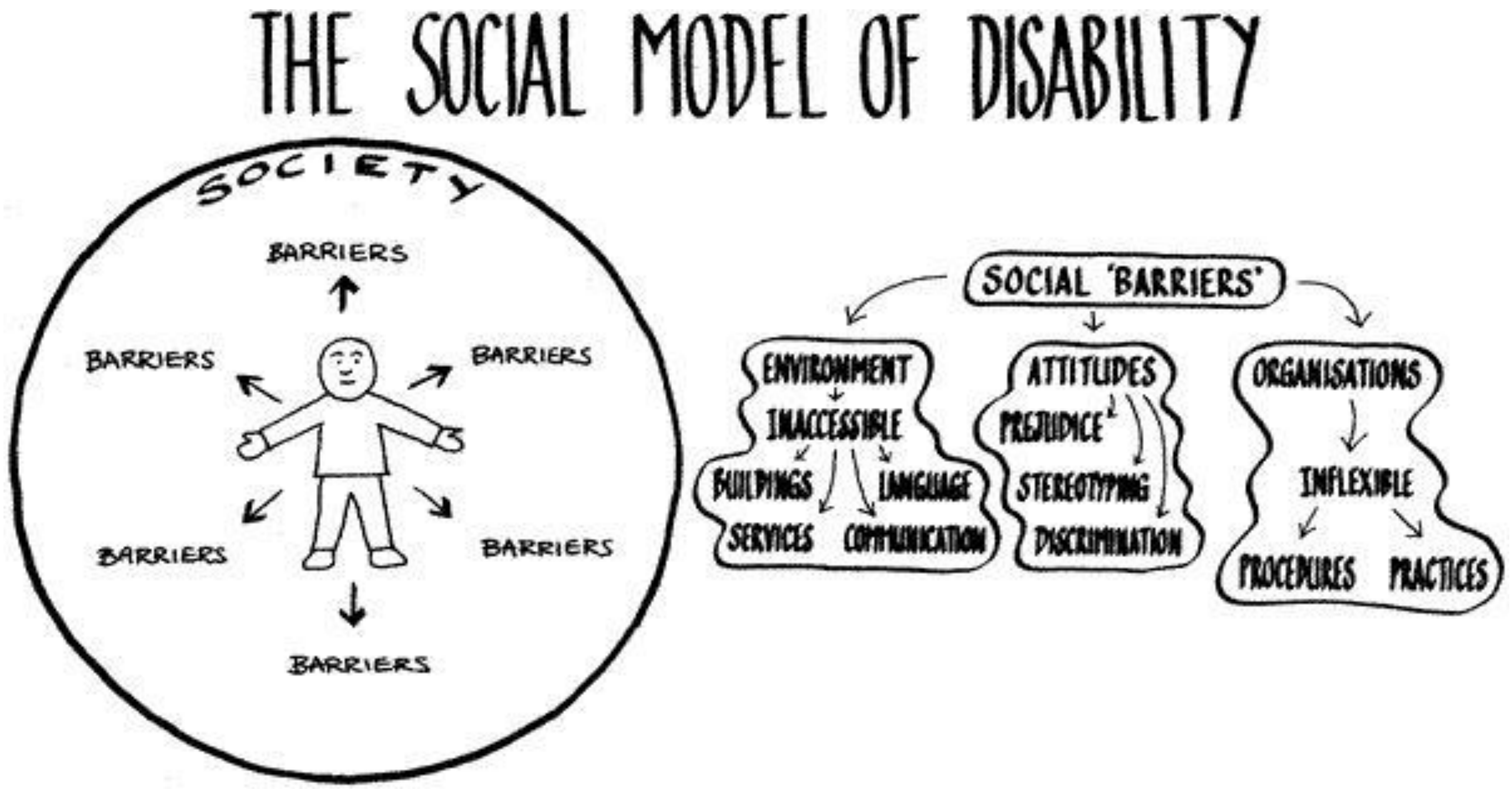


Image source: http://ddsg.org.uk/taxi/social-model.html

Social Model of Disability

- Social vs medical model
- Social model
  - Disability is caused by how society creates/sustains barriers, rather than individual differences
  - Advocate for impairments to be seen as natural human diversity, like race, gender, sexual orientation
  - There should be a shift in focus to “fixing” society rather than “fixing” disabled people
- Work across age groups, strategic education services (SES), access to care, types of impairments
- Healthcare providers should try to support, empower and advocate for disabled people rather than trying to “cure” or “rehabilitate” them
- **Interactional model;** combines medical need for care/support with the social model

Ableism 101

- Ableism is the overarching act of prejudice and/or discrimination against people with disabilities and the devaluation of disability (Hehir, 2002)
- Language emerged out of the disability rights movement in the United States to define the oppression of disabled people (Nario-Redmond, 2019)
- "…deeply rooted beliefs about health, productivity, beauty and the value of human of life, perpetuated by the public and private media, combined to create an environment that is often hostile to those whose physical, mental, cognitive, and sensory abilities fall outside of the scope of what is currently defined as socially acceptable." (Rauscher and McClintock, 1996, p. 198)
- Non-disabled individuals hold unearned social privilege over those who are disabled (Pease, 2021)

Ableist Microaggressions 101

- Microaggressions are **everyday interactions** perpetuating inequalities & stereotypes against those in marginalized communities (Solórzano, Ceja & Yosso, 2000; Sue, 2010).
  - Microaggressions are one way of perpetuating ableism
  - Often unintentional/unrealized
  - Can be verbal or non-verbal
- Ableist microaggressions are correlated with negative mental health outcomes (Kattari, 2020)

Ableist Microaggressions 101

- Microinsults are communications that convey rudeness and insensitivity and demean a person's identity or impairments; subtle snubs; unknown to the perpetrator; hidden insulting message to the disabled recipient (Sue, 2010)
- Microinvalidations are communications that exclude, negate, or nullify the psychological thoughts, feelings, or experiential reality of a person belonging to a particular group (Sue, 2010)
- Microassaults are an explicit identity derogation; verbal/nonverbal; e.g.: name-calling, avoidant behavior, purposeful discriminatory actions (Sue, 2010)

Bias, Bias, Everywhere

- People with disabilities (PWD) often have lower quality of life (QoL) and higher levels of pain than reported than non disabled people
  - Most pain charts are designed for non-disabled people
  - Self-policing (is my pain ‘bad enough?’)
- Women with disabilities and disabled people of color (POC) are less often believed about their pain than their masculine and white counterparts (LeResche, 2011; Mossey, 2011)
  - Can lead to not getting treatment as quickly when they do seek care
  - Which may result in them opting not to seek care, or seek care as quickly as needed in the future

Bias, Bias, Everywhere

- Disabled POC are less likely to be given medication to relieve pain (Mossey, 2011)
- PWD are afraid of being triaged to death in regards to COVID (Kattari, 2020b)
- Treatment for pain has become politicized and even a moral issue (Wailoo, 2014)
  - The “Opioid Epidemic” narrative has resulted in many providers being less able to treat pain in their patients, even when they want to
  - Withholding pain medication/opioids from patients with pain does not have meaningful impact on lessening off label use while it does reduce QoL in patients with pain
- No visitor/support people policies (due to COVID) are have left PWD without their caregivers and Deaf people without interpreters
- The pandemic has reduced access to needed care and PCAs for disabled people generally, resulting in regression in many conditions, including an increase in pain and decrease in ability to do activities of daily living [ADLs] (Schwartz, 2021)

Intersections

- LGBTQIA2S+ disabled people are having to decide between getting appropriate care and getting queer and trans affirming care
  - Do you correct your provider on your pronouns or that your partner is a woman, knowing that might result in you getting lesser care?
- Mental health inpatient facilities (as well as substance use facilities) are often divided by gender
  - Are they trans affirming? Can trans women be placed with women and trans men with men? What about non-binary patients?

Intersections

- Providers who are LGBTQIA2S+ inclusive may not be accessible
    - Example: A post made the round in disability groups last year where a queer therapist posted that one person cannot be inclusive of everyone, and so he was fine having an office up a flight of stairs.
- Specialists in certain areas/illnesses/types of disability may not be LGBTQIA2S+ affirming
    - Example: I had an AMAZING orthopedic surgeon in Denver. However, every time I came into the office, he wanted to ask me questions about my trans masculine partner (many of which were inappropriate generally!). I had to decide whether to keep my mouth shut and play along in order to get the knee surgeries that I needed, or to set a boundary, and potentially lose access to this needed care.

Recent Specific Findings

- Compared to their cisgender counterparts, disabled transgender individuals were (Mulcahy et al, 2022):
  - Over 4 times more more likely to be unable to see their doctor when needed
  - 3 times more likely to be unable to get prescription medicine when needed
  - Almost 3 times more likely to be unable to see a specialist as needed
  - More than twice as likely to be unable to get needed dental services

Structural Ableism Here

- What are some structural (or institutional) types of ableism you've noticed in your practice?
- What are some ways to engage in dialogue and/or action to change them?
- What have been some successes around institutional inclusion of disability/access at your practice?

What LGBTQIA2S+ Disabled People Want You to Know

- “BELIEVE US!”
- “You don’t have to be crying to be 10/10 in pain, we can look fine too. Don’t make me perform my pain for you.”
- “It’s hard for people with severe chronic pain to drive far to an appointment that will only be 5 minutes long.”
- ”Asking for two methods of protective sex to qualify for medications when you are in exclusively same-parts relationships is awkward.”
- “I’d rather spend a few extras days (weeks!) on a medication than rush to taper off of it.”

What LGBTQIA2S+ Disabled People Want You to Know

- “Being disabled is a full time job; between needed down time and tasks taking longer, arranging visits, figuring out referrals, staying on top of insurance, double checking meds with the pharmacists, getting lab tests and following up on results, pre-auths, plus maybe also mental health visits, massage, chiro, arranging accessible transportation, managing refills, etc.”
- “I am the expert in my own experience. Please trust me.”
- “If something won’t work for me, it’s ok, but please be clear. Don’t beat around the bush. It feels like gaslighting.”
- “No matter how educated you are, curiosity is most important in understanding that everyone's needs, wants, communications, learning styles, fetishes, etc., are different!”

What LGBTQIA2S+ Disabled People Want You to Know

- “I need everything written down for me. Seriously.”
- “I imagine the people who are most likely opting into being at this presentation will be providers who want to be affirming and listen and believe their patients. This desire/intent is not enough to make me feel heard or affirmed because I've dealt with so many other providers and people in my life who make me feel unheard/disrespected/ashamed that my brain is hardwired so that even neutral social cues can be perceived as negative/harmful.”
- “I feel like people who really want to do right and be affirming get all upset and rude and dismissive when they get feedback that the impact was different than their intent.”

What LGBTQIA2S+ Disabled People Want You to Know

- “They should be very cautious to make sure they aren’t talking down to us/talking to us like children. They also should err on the side of assuming we know more about our bodies and conditions and act as listeners before they act as teachers.”
- “[expletive] LISTEN!!!!!!!!!!!”
- “Never assume a request for alternative treatment is noncompliance. Sometimes we've tried the primary approach to no positive results.”
- “Carrying all this stuff at once is exhausting. Listen to me. Ask me how I'm doing with all this stuff I'm carrying and get creative with me about how to make stuff a little easier.”

What LGBTQIA2S+ Disabled People Want You to Know

- “Not to make assumptions. Ask and then listen carefully. Trust the patient to know their bodies more (and better) than the health care provider does. Also, review ALL medications one by one for a full picture of current pharmacology.”
- “There’s a relationship between health disparities and identity - and those intersections don’t get enough literature. Fatphobia, white supremacy, ableism, homophobia and transphobia are all leading killers in this country - our science just doesn’t value that information yet. We are not keeping track of those data, and in 100 years, if we are still around, we will look back on these times as barbaric for it.”
- “Learn how to ask about sexual health without assuming I'm straight. Or avoiding all discussion of sexual health when I tell them I'm queer. Or assuming I don't want to talk about reproductive health since I'm partnered with a woman!”

From a Disability Lawyer

- “I hear from providers all the time that they want to help disabled folks get disability benefits, and yet **their records are often the very thing that prevents those cases from going forward.** They need to look beyond the acute issue and **always document any changes to chronic issues or conditions.** I can't tell you how many cases were lost because range of motion, therapeutic levels of medications, etc., weren't tracked by providers because they didn't spend enough time asking. Especially because there is no objective measure for pain, **talk to chronic pain patients about their levels of pain**.”

From a Disability Lawyer

“For mental health providers - only an MD, PhD or such is considered ‘acceptable medical evidence.’ A therapist’s notes don't cut it for disability cases (don't even get me started on why) - they aren't doing their patients any favors by telling them to apply for disability if their notes are missing relevant functional information to support a finding of disability. **Detail symptoms and how they impact functioning**; ‘cannot leave the house with out a support person’ is better than ‘reports social anxiety.’”

Universal Design

- How do we make all spaces as inclusive as possible for everyone?
- PROactive rather than REactive
- General examples:
  - Ramps, elevators, golf carts, people movers
  - Low table tops AND standing space, chairs with and without arms
  - Including accessibility information on every office page
  - Lower and brighter lighting options in patient facing spaces
  - Taking notes from appointments and sending them to patients/clients
  - Active listening

Universal Design

- Other examples:
  - Describing images, using friendly fonts
  - Always offer captions on videos (especially with telehealth visits)
  - Multiple options for ways to communicate (in person, phone, portal messages/email, etc.)
  - Encourage people to record their visits and/or take notes, bring a partner/friend/advocate
  - Body friendly spaces
  - Screen reader accessible forms
- Intersectional opportunities
- Gender inclusive accessible bathrooms are good for everyone!

Ways to Offer a More Inclusive Practice

- Believe your patients/clients
- Think about access!
  - Provide American sign language (ASL) interpreters and captioning (and know how to access them!)
  - Share where accessible spaces & parking can be found
  - Use readable fonts and provide screen reader accessible documents
  - Low/no scent spaces
  - Have different types of chairs (arms, no-arms, benches, higher chairs, sofas)
  - Sensory friendly spaces/lighting/fidget toys/etc.

Ways to Offer a More Inclusive Practice

- Use self determination, person in environment, and empowerment approaches
- Don’t divide by sex or gender if at all possible
- Recognize disability as both a social identity and marginalized community
- Be intentional in creating office spaces, exam rooms, etc.
- Recognize that people should not have to choose which identity is most salient

Things YOU Can Do

- Work on your poker face. Seriously.
- Create accessible spaces, both virtually and in office
- Deconstruct what "health" means to you. Is it really about being non-disabled? Or making direct eye contact? Moving your body? Never being depressed or simply taking care of your mental health?
- Ask more open-ended questions:
  - How do you feel about _____? What are you doing to take care of your body and mind? What else would you like to bring up to me?
  - You said you're struggling with _____ can you tell me more about that?
- Listen to your patients; it is already so hard for them to bring things up to you.
- Validate their realities (pronouns, exhaustion, depression, pain, etc.)

Things YOU Can Do

- Believe your patients
  - The narrative of drug seeking (and even the opioid crisis rhetoric) has harmed SO many people
  - People may not look in pain to be in pain
  - People may not look LBGTQIA2S+
  - People don’t look neurodivergent
- ALWAYS leave space for patients to bring things up to you and be intentional with your reactions
- Keep educating yourself; on language, on activities, on needs of the communities with whom you work
- Create more accessible and inclusive practices
- Have a good network of resources and referrals; use whenever needed!

What Next?

- Take some time to think about the material we have engaged with today.
- What is one thing you can do right away to be more affirming of LGBTQIA2S+ disabled people and in your practice?
- What is one thing you can work towards in the future to be more affirming?
- What is one thing you are going to do to continue to educate yourself on this topic?

Questions?

Contact Me

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