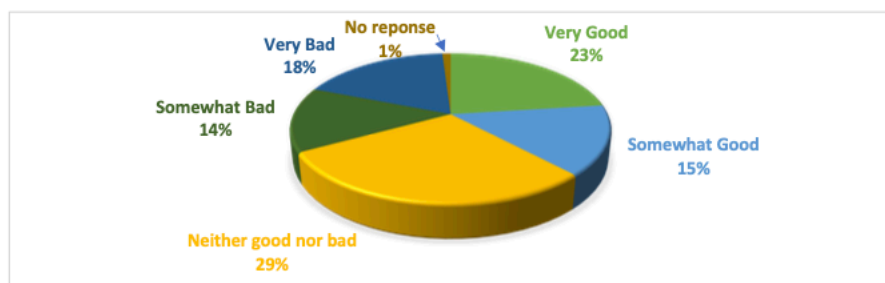


LGBTQ: PREVALENCE AND ACCEPTANCE

According to a recent Gallup poll, 4.5% (nearly 10 million) of USA adults self-identify as LGBTQ, including 5.1% who self-identify as women and 3.8% who self-identify as men (Newport, 2018g). According to the results of a Pew Research Center (2022) survey regarding the USA adult perception of acceptance of trans-

gender people, 23% reported very good, 15% reported somewhat good, 29% reported neither good nor bad, 14% reported somewhat bad, and 18% reported very bad (1% no response). Refer to **Figure 8-1.1. Perceived Acceptance of Transgender People**.

Figure 8-1.1. Approval of Greater Acceptance of Transgender People



HEALTH DISPARITIES BETWEEN HETEROSEXUAL AND LGBTQ+ PEOPLE

Compared to heterosexuals, LGBTQ individuals experience higher rates of disability (Fredriksen-Goldsen et al, 2014), poverty, and homelessness (Rowe et al, 2017). LGBTQ persons are also at higher risk of certain health conditions, such as obesity, breast cancer, and human immunodeficiency virus (HIV) (Yarns et al, 2016). Compared to heterosexuals (12.2%), LGBTQ persons (17.3%) more often experience 'very short sleep' or sleep deprivation, defined as five or fewer hours sleep per night. They are also more likely to have a psychiatric disorder (McLaughlin et al, 2010) — particularly depression (Rowe et al, 2017; Yarns et al, 2016; Yolaç & Meric, 2021) and/or anxiety (Yarns et al, 2016); abuse substances (Herek et al, 2007; Yarns et al, 2016) - including alcohol (Hughes, 2005); have suicidal ideation and commit suicide (Goldbach et al, 2019; Remafedi et al, 1998; Tomicic et al, 2016). Compared to heterosexual men, gay and bisexual men have a higher prevalence of panic attacks, depression, and psychological

stress (Cochran et al, 2003); and compared to heterosexual females, lesbians and bisexual women have a greater prevalence of generalized anxiety disorder (GAD) (Cochran et al, 2003) and overweight and obesity (Fredriksen-Goldsen et al, 2014). Compared to lesbians and gays, bisexual and transgender persons are at even greater risk of poor general health (Fredriksen-Goldsen et al, 2014) and poor mental health, notably depressive and anxiety symptoms (Chan et al, 2020). Older LGBTQ persons are not immune. Firstly, they have "likely experienced mistreatment and discrimination due to living a majority of their lives prior to recent advancements in acceptance and equal treatment" (Yarns et al, 2016, p60). Compared to their heterosexual counterparts, LGBTQ older adults have a higher risk of anxiety, depression substance abuse (Yarns et al, 2016; Zelle et al, 2015), and also suffer more social isolation (Zelle et al, 2015).

majority of the students (~ 83.5%) reported they felt comfortable with providing care to LGBTQ patients and were interested in further education about LGBTQ health issues (84.5%).

Butler and colleagues (2016) have suggested strategies to enhance the provision of healthcare to minorities in general, including to the LGBTQ community, include improving provider behavior at the point of care, altering existing protocols, and empowering patients to interact with the within the healthcare system. For example, a research article titled 'Best practices in LGBT care: a guide for primary care physicians,' recommends physicians regularly screen, and as indicated refer, lesbian and bisexual patients for overweight, obesity, tobacco use, and alcohol and drug use disorders because they are at higher risk for these disorders compared to their heterosexual counterparts (McNamara & Ng, 2016).

In terms of physical therapists' perception LGTB+ patients and providing care to them, a primary reference is Jennifer Stone, PT, DPT, who instructs the continuing education course *Best Practices for Rehab Professionals for Gender Affirming Care*. In her research, Stone (2019) found only 1% physical therapists surveyed fully respect LGBTQ people while 85% reported a tolerance (rather than a respect) of them. Further, 68% of the physical therapists surveyed reported a very low to average knowledge about LGBTQ healthcare – partly due to the complexity of terminology (Stone, 2019). According to Stone, "Physical therapists need to be informed regarding ideal transgender and nonbinary care because there are some potential differences in care to most ideally care for these individuals compared to those who identify as **cisgender** [gender and person identity correspond with their birth sex]; healthcare providers have a responsibility to be aware of and sensitive to the needs of all the patients who may seek their services, and to avoid perpetuating trauma" (2019, p25).

A component of best practice is to communicate in an inclusive manner, such as

with open-ended neutral questions (Landry, 2017; Rowe, 2017). For example, you can ask 'What is your preferred name and correct pronoun?' (Stone, 2019). And, "Do you have a spouse or partner?" is more inclusive than "Do you have a wife/husband?" (Stone, 2019). When documenting a visit with a LGBTQ person for insurance payment, Stone suggests acknowledging the current biologic gender and recognizing the patient's preferred pronoun, for example: "Patient's preferred name is Terry, patient identifies [and] uses they/them pronouns. Current biological sex is male" (2019, p25).

Additional information on the provision of health care to **transgender** patients that might be of use to physical therapists is provided in 'Five Pearls on (Green et al, 2019), a peer-reviewed Audio Podcast which is available in the **Textbook Supplement** at WellnessSociety.org.



Application to Physical Therapy (PT): How well prepared do you feel to provide physical therapy to members of the LGBT+ community? If you are a LGBT+ person, have you shared it with any of your classmates or faculty? If yes, what has been the response? Have any of your peers or faculty shared they are a LGBT+ person and, if so, how do you personally feel about it? When a physical therapist treats a patient who is LGBT, she must not allow any prejudice she might have to interfere. If she is not willing or able to treat objectively, she ought to recuse herself and help the patient secure another therapist.

More atheists are Democrat than Republican (Fahmy, 2018). Atheists are also well educated: 43% have a college degree, compared with 27% in the general public (Fahmy, 2018). And, while 16% of college graduates versus 6% of non-college graduates are atheists (Lipka, 2019). Well-known people who are atheists include **actors** (e.g., Kevin Bacon, George Clooney, Johnny Depp, Zac Efron, Morgan Freeman, Jodie Foster, Julianne Moore, Keira Knightley,

Joaquin Phenix, Brad Pitt, Daniel Radcliffe, Uma Thurman, Bruce Willis) (Diaz, 2020); hundreds of **scientists** (including anthropologists, astronomers, biologists, bio-chemists, chemists, computer scientists, geologists, mathematicians, neurobiologists, physicists) such as physicist Steven Hawking; **physicians** (including geneticists and psychiatrists), and **Nobel Prize Winners** (TBS staff, 2022).

SECLARPHOBIA



Across the spectrum of beliefs, atheists are stigmatized as being immoral and are the most disliked (Zuckerman, 2014). In fact, compared to all other minority religious and ethnic groups, atheists are the least likely to be publicly or even privately accepted (Edgell et al, 2006). The postulated reasons for **secularphobia**, or **atheist stigma**, in the USA are that Americans tend to associate lack of religion - and particularly atheism - with immorality and being unpatriotic; feel their religious faith is being threatened when others do not believe it; and (although there is stigma and backlash to those who are racist, anti-Semitic, homophobic, sexist, etc.) there are no negative consequences to being secularphobic (Zuckerman, 2014). Secularphobia even exists in healthcare. For instance, other factors being equal, atheists are less likely than Christians to receive a kidney if waiting for a kidney transplant (Furnham, 1988). Discrimination against those with a concealable stigmatized identity, such as atheism,

increases their physical health risks and adversely affects their mental health, physical health, and overall **health** and well-being (Abbott & Mollen, 2018). In contrast, "...positive emotions about atheist group identification is associated with higher outness and, in turn, higher psychological and physical well-being" (Abbott & Mollen, 2018). In other words, fostering an open atmosphere in the physical therapy setting might encourage patients to share their non-belief, which may have a positive impact on their health and possibly on their progress in physical therapy. Fostering an open atmosphere for non-believers is just as important as doing so for LBTG+ and other minority groups. Because of the profound and negative impact discrimination can have upon health, atheism should be integrated into the professional education so students can explore their biases and learn to work responsibly and ethically with atheist and other belief minorities (Abbott & Mollen, 2018).

Application to physical therapy (PT):

(1) If a patient asks her physical therapist to engage in a brief prayer for the patient's health / recovery, should the physical therapist oblige? Why or why not? (2) When a physical therapist treats a patient who has religious / spiritual beliefs different from his own, he must not allow any prejudice he might have to interfere in his provision of care. If he is not willing or able to treat objectively, he ought to recuse himself and secure another physical therapist to treat the patient.

CHAPTER 8 – SECTION 3: AFRICAN AMERICANS AND WELLNESS

This section was authored by LaTasha Blanton, DPT

He who does not know one thing, knows another.
African Proverb

HEALTH DISPARITIES AND INEQUITIES BETWEEN WHITES AND BLACKS

In 2018, the U.S. Census Bureau estimated that of the total American population of 327.2 million, 47,841,851 were African American (Black Demographics, 2020). But does this 14.6% statistic hold true in terms of incidence of disease and treatment? The short answer is a resounding no. Compared to white Americans, the incidence rate of hypertension, diabetes mellitus, and stroke, is not only higher in black Americans, but they are also more likely to die from these diseases (CDC, 2017aa). Here are a few statistics: Compared to white Americans, black Americans are twice as likely to have hypertension and are seven times more likely to die from HIV/AIDS (CDC, 2017aa). The disparity is true in women as well. For instance, African American women are 29% more likely to die of heart disease than their white counterparts (NPR, 2006). And the disparity is also true in children. For instance, black children are five times more likely to die from asthma than white children and infant mortality rates are double (CDC, 2017aa). Death from cardiovascular disease, cancer, and diabetes mellitus may be the most visible health problems for African Americans,

but they do not tell the whole story. Mental illness is the second largest cause of morbidity in African Americans, and violence in the form of homicide is the greatest cause of preventable death. And although the death rate for African Americans has declined about 25% over 17 years, primarily for those aged 65 years and older, research indicates African Americans are dying from chronic diseases at a young age (CDC, 2017aa). But why the disparity? Is it genetic? Is it financial? Is it their readiness to seek medical care? Access to health care? Discrimination? It seems there's a wide web of complicated and overlapping causes.



GENETIC DIFFERENCES

There are genetic differences between races, four of which follow. About 8% of American blacks are trait carriers of sickle cell anemia and 1.8 in 1,000 black children will develop the disease (Neel, 1997). While 2.4% of whites have diabetes mellitus type 2 (DM-2), the prevalence in blacks is 3.2% (Neel, 1997). African American

women have three times higher incidents of lupus than white women - developing the disease at a younger age, with more serious complications, and a higher death rate (CDCP, 2017aa). Finally, black Americans produce less vitamin D - a strong weapon to ward off cancer - than their white counterparts (NPR, 2006).

your patient's self-wellness, but also her family wellness, can make the difference in you being able to facilitate her progress to achieve her maximum level of functional mobility and other physical therapy goals. To apply your knowledge of family wellness, consider **Case Scenario 8-4.2. Mrs. Deland and her Family.**

Case Scenario 8-4.2. Mrs. Deland and her Family

You have been providing home health physical therapy to Mrs. Deland, an 85-year-old widow who lives alone. The patient was referred secondary to an accidental fall, right femoral neck fracture, and a total hip arthroscopy (posterolateral approach). Mrs. Deland has several family members who visit often and are involved in her care: her eldest son Tom and his wife Dora (who live out of state and have been staying with the patient since her fall), and her son Benz (who lives and work within an hour's drive of the patient). During each physical therapy session, between one and three of Mrs. Deland's family members are also present. Prior to her accidental fall – which occurred one evening when she was taking trash to the curb for pick-up the next morning, Mrs. Deland did *not* use an assistive ambulation device. During the episode of care you have been educating the patient and, as each is present, one or more of her family members, in two long-term ambulation goals: (1) ambulate at least 300 ft with the least restrictive assistive device (LRAD) with modified independence within the home; and (2) ambulate at least 1000 ft with the LRAD with modified independence outside the home (on the driveway and sidewalk). Physical therapy interventions have also included, among others, safety education including post-surgical precautions, education in pain and edema management, strength training, balance training, instruction in a home exercise program (HEP), medication management, wound management and skin integrity, and caregiver training. You have observed the patient's son Tom is rather 'submissive' to his

wife Dora, who adamantly wants Mrs. Deland to continue to use the walker she has been using since her fall so "she never falls again." The patient's younger son Benz, however, wants her to be able to walk again without an assistive device so she can take out her trash, etc. When questioned, the patient attempts to avoid sharing her opinion, and on occasion has responded "Benz knows best." Your evaluations of your examinations of the patient consistently conclude she will require a cane to safely ambulate outdoors and will require a cane PRN (as needed) to safely ambulate indoors. You have asked each of the family members be present during the next home physical therapy session so you may discuss the patient's ambulation – including PLOF, current status, and goals. Either alone or with peers, describe how this session might play out, both optimally and less successfully.

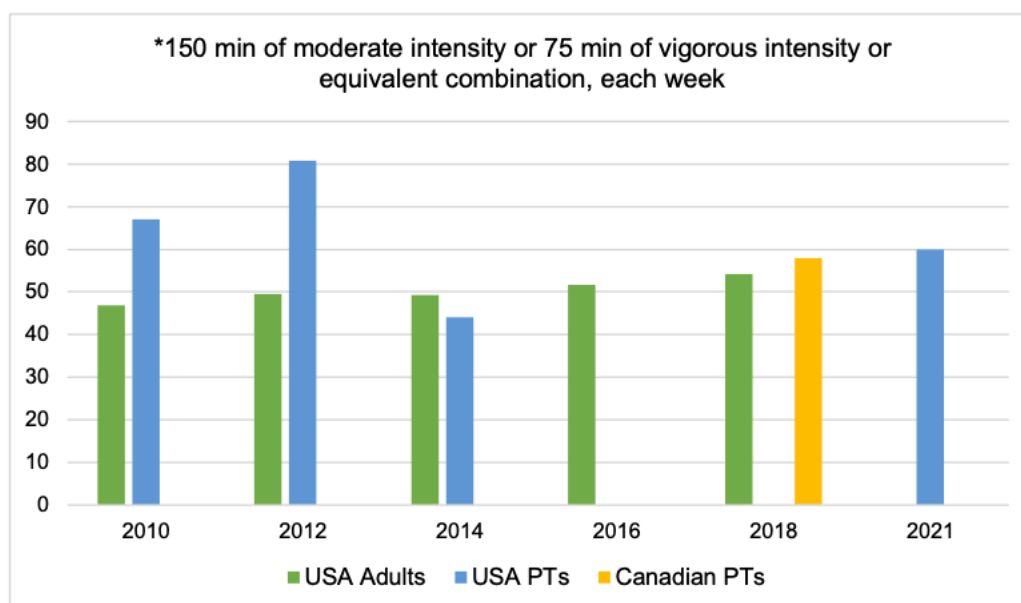


Mrs. Deland

vigorous activity, or a combination thereof, at least five days per week. *Healthy People's* (ODPHP, 2019p) guideline is essentially equivalent: at least 150 min of moderate intensity exercise, or 75 min of vigorous intensity, or an equivalent combination each week. So, how does the aerobic capacity wellness of physical therapists compare to that of USA adults? Per annual self-report, an (essentially) increasing proportion of USA adults have been meeting aerobic capacity exercise guidelines. Selected raw data: 46.9% in 2010, 49.5 in 2012, 49.2% in 2014, 51.7% in 2016, and 54.2% in 2018 (Tableau, 2019). The aerobic capacity wellness of physical therapists is less clear. Data from available research: Chevan and Haskvitz (2010) found 67% for the year 2010, Black (et al, 2012) found 80.8% for the

year 2012, Fink (et al, 2014) found 44% for the year 2014, and Fair (2022) found 60% for the year 2021-2022. Of interest, 58% of Canadian physical therapists met the aerobic capacity guidelines in 2016 (Neil-Sztramko et al, 2017). Refer to **Figure 8-6.1. Proportion of USA Adults versus Proportion of PTs who Meet Aerobic Capacity Guidelines**. Eliminating the physical therapist outliers (80.8% in 2012 and 44% in 2014), it appears that roughly 60% of North American physical therapists possess aerobic capacity wellness, compared to roughly 50% to 54% of USA adults. Analyzing aerobic capacity wellness from a different angle, Fair (2007) found the 'average' physical therapist reported s/he engaged in 30 min or more of moderate intensity aerobic exercise three days per week,

Figure 8-6.1. Proportion of USA Adults versus Proportion of PTs who Meet Aerobic Capacity Guidelines



with females at 3.18 days/week and males at 2.96 days/week. Fink (et al, 2014) also found most physical therapists exercise for cardiovascular benefit three days per week. When the psychomotor and affective domains of aerobic exercise were studied, however, only 24.6% of surveyed physical therapists reported full com-

pliance – that is, they both engaged in the recommended amount of aerobic exercise and they reported they were fully committed to their exercise regime, that is, their commitment level was five on a scale of five (Fair, 2007). The difference between exercising with a sense of commitment to it is an interesting concept to