Canadian Audiologist

The Official Publication of the Canadian Academy of Audiology

Toward LGBTQIA+ Cultural Competence

Published July 9th, 2015

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Culturally competent and non-discriminatory care has been identified as a key ethical responsibility of health care service providers by multiple regulatory bodies and professional associations worldwide. In Ontario, the Ontario Human Rights Code prevents discrimination of care provision based on race, ethnic origin, religion, age, disability, sex, or sexual orientation.[1] The College of Audiologists and Speech-Language Pathologists of Ontario affirms that care is to be responsive and receptive to culturally diverse populations, in keeping with their code of ethics[2] which takes respect of clients as persons as a chief ethical principle.[3] Speech-Language & Audiology Canada (SAC) includes caring, respect, and valuing of the well-being and dignity of others (regardless of culture) in their position statement on service delivery in multi-cultural contexts[4] while in the US, the American Speech-Language-Hearing Association (ASHA) strongly urges members to attain cultural competence in their service delivery.[5]

Lavizzo-Mourey and MacKenzie originally described cultural competence as understanding of population-specific health-related beliefs and values in addition to knowledge of populations' disease incidence, health risks, and treatment outcomes.[6] Steckly has since contended that beyond simple cultural *sensitivity* or *awareness*, true cultural *competence* involves active flexibility in practice, allowing operation in different cultural contexts by altering practice to reach marginalized cultural groups.[7] Lesbian, gay, bisexual, transgender, transsexual, two-spirited, queer, questioning, intersex, asexual, and ally populations (abbreviated herein as LGBTQIA+), which are cultural groups by virtue of shared histories, values, language, customs, and thought, have historically been (and continue to be) marginalized in their access to and experience of North American health care.[8] This is due in part to the inadequate cultural education of health care service providers,[9] including communication therapists[10] despite LGBTQIA+ cultural competence having particular relevance to speech-language pathologists and audiologists. For speech-language pathologists, for example,

transgender and transsexual clients may seek voice-transition services (training in how to adopt the speech and communication patterns typical of a gender other than that assigned at birth) to improve their expression of gender identity, improving their quality of life. For audiologists, research has indicated that members of these communities may have a unique experience of hearing handicap, with elderly same-sex couples experiencing handicap more similarly between partners than do different-sex partners, and reporting more emphasis on emotional health and social life restriction compared to different-sex couples.[11] Furthermore, the role of social support (in the form of a committed relationship) on quality of life may be greater for hearing impaired members of the LGBTQIA+ community than for hearing impaired non-members.[12] In addition, it should be noted that members of these communities are typically victims of the stress and associated psychological effects related to both *stigma management* and *social isolation*,[13] both of which are commonly shared in the experience of hearing impairment.[14,15] Though little research exists on communication-related treatment adherence and outcomes for this group, improved primary health care treatment adherence and quality of care experience are reported by LGTBQIA+ patients who find culturally competent practitioners.[16] The practical relevance of these findings might be better appreciated within the context of the increasingly diverse Canadian population. The 2011 Canadian census reported 64,575 same-sex couple families (up 42% from 2006), with nearly 10,000 children living with same-sex parents, and 2.4% of the general population reporting identification as gay, lesbian, or bisexual (without accounting for other LGBTQIA+-encompassed identities).[17] The LGBTQIA+ population in Toronto is estimated at over 10%, according to the Toronto Central Local Health Integration Network.[18] For all of these reasons, audiologists and other communication therapy practitioners should make the development of LGBQTI cultural competence a priority.

As recommended in the LGBTQIA+ cultural competence curriculum goals developed by Hancock and Haskin,[10] this brief overview provides a basic explanation of LGBTQIA+ cultural terminology (see Appendix A) and marginalization experience, a list of common barriers faced by the members in accessing health care, and recommendations from the literature for initial steps toward developing an active cultural competency reflected through provision of a welcoming clinical experience, trust building, and active advocacy and outreach to this historically underserved, overlooked, and neglected community.[19]

LGBTQIA+ Identity

As should be evident from the glossary of terminology included in Appendix A (The glossary is provided to the reader as providing a foundation to LGBTQIA+ cultural competence and also to provide basic orientation to the proceeding discussion.), the “rainbow” of LGBTQIA+ sexual and gender identity is a complex taxonomy relative to the heteronormative “binary” designation of male versus female, (and the associated social expectations), the identity of a given individual being informed by four *mutually independent* aspects of biological sex, gender identity, sexual orientation, and social sex-roles. Acknowledging this diversity, Brotman et al. have prudently cautioned that studies that characterize LGBTQIA+ culture in terms of the experiences of homosexual, gay, and lesbian individuals alone are in danger of further marginalizing individuals with transgender, bisexual,[13] or other experiences, an observation exemplified by reports from HIV-positive bisexual men of resisting treatment in a “Gay”-friendly clinics due to misrepresentation of their own identity.[16] In addition, as in any minority culture, within-group diversity (e.g., according to socio-economic status or ethnicity) will add further variability to a

given individual's experience[20] and it should be realized that no individual's *personal* identity consists exclusively of their *sexual* or *gender* identity.[21] However, the LGBTQIA+ cultures share experience of living in a heteronormative culture where terms like "man," "woman," "husband," and "wife" are commonplace, but in which analogous symbols of LGBTQIA+ relationships are stigmatized as "alternative" or worse, "abhorrent."[22] According to the National School Climate Survey close to 90% of transgender youth in the US report feeling unsafe in school, with 75.4% frequently hearing homophobic remarks without faculty intervention.[23] Meanwhile LGBTQIA+ families continue to lack positive, normalizing representation in media and report feeling ignored or merely tolerated at school-related functions.[20] In addition, due to historical and ongoing abuses such as loss of public and private pension, "corrective" medical intervention (including hormone therapy and electroshock treatment; homosexuality being listed in the DSM until 1986), and personal assault, many elderly, "preliberation-era" members of the gay and lesbian communities report a deeply ingrained mistrust of social and medical institutions and a reticence to disclose their identities to those outside of their culture.[13] Recognition of these experiences of marginalization is of paramount importance in understanding the impact of barriers to these populations' health care access and the importance of establishing trust with our LGBTQIA+ clients.

Common Barriers to Health Care for LGBTQIA+ Cultures

Misunderstanding and Harassment in the Health Care Setting

Though much has changed in the so-called "liberation" era with Canada and much of the US incrementally amending civil rights status for openly LGBTQIA+ citizens, cultural competence curriculum in the education of health care professionals has not kept pace.[8] An international survey conducted by Hancock and Haskin revealed that even though transgender communication training is within the scope of practice for speech-language pathologists, 51% of participating clinicians could not describe the therapy, with 47% claiming it was not included in their education.[10] Average scores on a test of basic LGBTQIA+ cultural terminology and knowledge fell under 50%, with self-efficacy ratings indicating that most respondents were less *knowledgeable* than they were *comfortable* treating LGBTQIA+ clients (only a few participants citing objections to care provision on moral or other grounds). Despite the best intentions, gaps in cultural competence can lead to uncomfortable (even offensive) experiences for LGBTQIA+ clientele. Brotman et al., call attention to the importance to transgender self-concept of "*passing* as a member of one's gender,"[13] with LGBTQIA+ interviewees emphasizing their sensitivity to health care providers' confusions or equivocations between gender, sexual orientation, biological sex, and social sex-roles. A given example was a provider's use of the pronoun "he" according to the biological sex indicated on an intake form, when the client before him was clearly presenting as a woman.[16] Sadly, many LGBTQIA+ members have also experienced intentional harassment and discrimination from health care practitioners. Reported cases reviewed by Masiongale included those in which US practitioners presumed to lecture gay couples on the negative social impact of gay marriage and another in which a doctor provided fertility treatments to lesbian patients, but refused to provide the artificial insemination procedure (recommending patients complete the procedure themselves at home).[8] Canadian HIV-positive LGBTQIA+ members interviewed by Schilder et al., reported physicians making exaggerated gestures of disgust when being asked for hormone treatments by transgender patients, or prejudicially depriving a gay intravenous drug user of local anesthetic in the emergency room, the doctor implying that if the patient was ok with needles for drugs, he

should be able to tolerate this pain, too.[16] Members of this study came to expect prejudicial treatment in health care settings, describing doctors as often judgmental and patriarchal. Canadian LGBTQIA+ seniors interviewed by Brotman et al., reported a range of negative reactions from doctors including hostility, harassment, embarrassment, condescension, avoidance of physical contact, and breach of confidentiality: the effects of these experiences compounding with those of reported past medical abuses under the guise of "corrective" treatments.[13] For some members of this sample, an unfortunate consequence of the impact of these experiences was to learn to avoid accessing services altogether, attempting instead to manage their difficulties on their own. For others, treatment seeking may be primarily guided by a word of mouth referral network where LGBTQIA+-friendly practices are vetted and recommended by other members of the community.

Fear of Disclosure, Invisibility of Identity and Family

A further impact of these discriminatory experiences was documented in a survey of lesbian, gay bisexual, and transgender clients accessing communication therapy services.[24] Nearly half of the respondents commented that they would not disclose their membership in the LGBTQIA+ community when seeking services for fear that they would be treated or perceived negatively by their clinicians or experience a breach of confidentiality. Brotman et al., identified a theme of *profound invisibility* of preliberation gay and lesbian individuals owing in part to learned vigilance in fearfully concealing their identities.[13] This invisibility came at a cost, compromising open communication and trust between client and clinician and concealing key aspects of their participation in social activities, an important area of investigation to most communication care professionals. Importantly, failure to disclose can also conceal social support networks including primary partners and *families of attachment* (i.e., a primary network of friends who best knew, affirmed, and cared for them[16];) chosen following severance of ties with their *families of origin* (i.e., the families in which they were raised). Brotman et al., recorded one consequentially heartbreaking account of a lesbian couple of several decades being separated into different elderly care facilities by family and health care workers who were unaware of their relationship and sexual identities.[13] In contrast, Kelly and Robinson found that many speech and language service seekers considered disclosing their identity as an important opportunity to include their partners and other social supports in their circle of care.[24] Sadly, even those courageous enough to openly identify have historically faced the difficulty of biological families being granted rights and recognitions in treatment decisions, caregiving, and visitation that restrict or supersede those afforded to *chosen* family members.[8]

Heteronormative Intake

Goins and Pye interviewed LGTBQIA+ patients about their experiences completing medical intake forms and discovered several themes related to the ways in which heteronormative assumptions surrounding gender, sexuality, and relationships, can foreclose on the LGBTQIA+ identity and set a negative tone in subsequent relationship building with their provider.[9] Several interviewees reported that they would feel uncomfortable if their providers assumed that they were "straight," but also reported rarely seeing an option to declare sexual orientation on a form. Others described the impossibility of describing their identity using standard checkboxes (e.g., male vs. female), even if an opportunity to declare sexual orientation (e.g., gay vs. straight) was provided. Said one respondent: "Typically I say I'm queer… I've [also] identified as bisexual in the past but being better educated in trans issue made me change."[9] At minimum, it was commonly agreed that an

opportunity to declare both sexual orientation and gender should be provided as separate items, with space provided for further description if necessary. Confusion and discomfort surrounding completion of heteronormative relationship items were also cited, with one lesbian interviewee explaining that checking “single” does not provide her physician with the information that she is in a steady same-sex relationship of over 7 years. A queer female interviewee who had previously been married to a man expressed feeling that answering “divorced” on an intake form often cued her providers to think that she is straight, causing her to relive a painful part of her closeted past. Other interviewees reported finding it difficult to list their partners or *attachment family* members in spaces specifying “next of kin,” or “spouse”. Likewise, Frazier reviews several complexities of LGBTQIA+ parental relationship statuses that do not fit neatly in heteronormative checkboxes.[20] For example, children may be fostered, adopted (with or without visitation rights), or biological, the product of artificial insemination, surrogacy, or a previous heterosexual unions. Unmarried lesbian parents might use the non-biological mother’s last name as the child’s middle, last, or hyphenated last name to strengthen their parental identity. In addition, children will often use different but equivalent names for each parent (e.g., “dad” and “daddy”), which should be known to the clinician to prevent the marginalization of one parent by only using “dad,” (an especially unfortunate error in the case where “daddy” is the non-biological parent).

Recommendations for Audiologists in Developing LGBTQIA+ Cultural Competence

To help address the outstanding need for cultural competence with LGBTQIA+ clients, best practice recommendations have been made in the presently reviewed literature, and disseminated in both the US[25] and Canada.[26] Those recommendations most pertinent to the provision of communication therapy services are explicated in the following.

Practitioner Education

Overall, respondents in the study by Schilder et al., agreed that health providers should be aware of, acknowledge, and affirm their culture, identity, values, and unique experience as an often stigmatized and marginalized community.[16] Hancock and Haskin have recommended that the foundation of this aspect of LGBTQIA+ cultural competence is for care providers to increase their comfort level in dealing with members by learning about basic LGBTQIA+ culture including their diverse identity taxonomy and the marginalization experiences that have, in many cases, led to an understandable apprehension to place trust in health care providers or access health care services.[10] It is hoped that the present review provides an entry point to establishing this foundation in the reader (as it has in the writer). Both Brotman et al.,[13] and Coren et al.,[27] have suggested that care providers should consider enrolling in continuing education courses focusing on human sexuality, gender, and best practices in LGBTQIA+ health care provision.

Creation of a Welcoming, Culture-Affirming Environment

Coren et al., stress that initial contact with the practice environment will determine clients’ comfort level in establishing trust with and disclosing their identity to their health care provider.[27] Their recommendations include the clear posting of a non-discrimination statement indicating that equal care is provided to clients regardless of sexual or gender identity. Staff should be trained in the correct use of identity terms such as “gender” and “sex” and to ask for and use the names and pronouns given by the patient when interacting in the waiting room, without making assumptions about individuals’ sexual orientation or gender identity based on appearance. Ideally, at least one unisex restroom should be available for optional use, with clients allowed to use the gendered

restroom of their identity. Practices may subscribe to and provide LGBTQIA+ magazines or newspapers in the waiting room, and display posters of LGBTQIA+ family configurations (e.g., same sex couples), LGBTQIA+ organizations or LGBTQIA+-friendly symbols such as the rainbow symbol.[28] Where possible, testing materials, especially those used with children, should provide normalizing portrayals of LGBTQIA+ family configurations.[20] Finally, Coren et al., suggest that a culturally competent practice should recognize the value of the word-of-mouth referral network within the LGBTQIA+ community, and be prepared with LGBTQIA+-affirming referral sites and support groups whenever necessary.[27]

Inclusive Intake

Following analysis of LGBTQIA+ interviewees' input, Goins and Pye recommended that the conventional "checkbox" approach was insufficient to adequately represent sexual and gender identity on a clinical intake form. From their perspective, an ideal solution took the form of open questions with blank space provided for sexual, gender, and relationship items.[9] Others suggested including a broad range of sexual and gender identity checkboxes, and space to add clarification or additional information if necessary.[27,28] All authors strongly recommended including gender and sexual orientation questions as separate items, never listing LGBTQIA+ identity options as "alternative," and avoiding heteronormative language in each item (e.g., including "partnered" as a relationship status option). Goins and Pye also recommended providing space to indicate preferred (vs. legal) name and pronouns.[9] Naturally, Lim et al., suggest that the use of gender neutral language be employed in the same way during the intake interview, at which time the practitioner is encouraged to attend carefully to the language used by the client to describe their identity and relationships, and to ask clarifying questions whenever necessary, avoiding assumption.[28] In addition to being a more effective way of gathering more accurate information with which to understand our clients, these strategies also communicate a lack of bias to the client, with the implied acknowledgement that diversity of sexual identity is not adequately understood through a restricted, heteronormative lens. Finally, Goins and Pye recommend that intake forms should make declaration of sexual identity optional, clarify the reason for including these items (i.e., to more effectively serve clients within their social and cultural context), and clearly explain how confidentiality is protected, forwarding any concerns to follow up with the care provider.[9]

Recognizing Families

As the oldest and largest standards setting and accrediting body for health care in the US, the Joint Commission has made several recommendations for the culturally competent recognition of same-sex partners and chosen family members as caregivers in a hospital setting, many which translate

well into communication therapy practice.[25] These include: allowing patients to designate which family members (including same sex partners and chosen family) should be involved in care decisions and planning, preventing parents who disapprove of the patient's sexual orientation to exclude said designated family members, and the involvement of same-sex parents in their child's care, even those who lack legal custody by virtue of being and unmarried, non-biological parent. The recommendations are summarized in the Joint Commission's operational definition of family, being "two or more persons who are related in any way – biologically, legally, or emotionally. Patients and families define their families."[25]

Frazier, reminds us that it is imperative to honour the naming conventions that children use for their same-sex parents and those used for the child (whether legal or preferred) to strengthen the parental identity of a non-biological parent.[20] Just as when determining a patient's chosen family and preferred circle of care, the best way to understand and honour these family dynamics is to ask.

Active Competence: Reflection, Advocacy, and Outreach

The development of cultural competence is a protracted process modeled by some as a multi-stage, iterative progression20 from early stages characterized by emerging awareness and sensitivity to later stages that reflect an ability to modify practices to accommodate culture members and actively reach out to marginalized groups who may not otherwise seek your services.[6] Throughout their iterative development process, the practitioner is encouraged to rely heavily on mindful reflection, evaluating and re-examining how personal morals and beliefs, heteronormative assumptions, and past impressions of the LGBTQIA+ community may be influencing their motivation and practice of cultural competence.[27] As cultural competency matures, practices may consider seeking opportunities to make alliances with the community. This can be done by advertising the LGBTQIA+-affirmative nature of the practice, participating in LGBTQIA+ community events, and providing advocacy for care provision to underrepresented subgroups (such as elderly preliberation members or disenfranchised, HIV-positive gay youth) in the local community and at the level of professional and regulatory associations.[28] In fact, Brotman et al., recommend making connections with these communities early in your development, inviting LGBTQIA+ community leaders to educate you and your staff about LGBTQIA+ culture and issues affecting their community.[13]

Final Remarks

This brief overview was intended as an initiation to the development of cultural competence for the LGBTQIA+ cultures. Though their identities are diverse, they share the experience of marginalization in a heteronormative society, often risking diminished access to quality health care provision. As is true for all of our client-clinician relationships, building trust with this group is paramount in providing them with effective and comprehensive, long-term care. Iteratively implementing the given recommendations will help ensure that members of our local LGBTQIA+ communities are met with communication care providers acting as advocates and allies, who are sensitive to the needs of their unique identities and capable of providing a safe and trustworthy service.

Appendix A

Glossary of LGBTQIA+ Identity Terminology

Prefatory Note: It should be understood that many of the following definitions have been borrowed from a clinical literature that has attempted to support basic awareness of the

LGBTQIA+ identity taxonomy by providing uncomplicated accounts of its application. However, even within the LGBTQIA+ community itself, consensus as to the application of these terms continues to emerge as contextual meaning continues to evolve. As such, these entries may only imperfectly capture their current understanding, and are presented with humility and deference to those to whom the terms have personal significance.

gender expression: "*External* characteristics and behaviours of individuals that are socially defined as either masculine or feminine (e.g., dress, grooming, mannerisms, speech patterns, social interactions); distinct from sexual orientation and gender identity."[25]

gender identity: "Innate, deeply felt psychological identification as [a man, woman, or person of another gender], which may or may not correspond to one's body or assigned sex at birth; distinct from sexual orientation and gender expression."[25]

sexual orientation: "An individual's physical or emotional attraction to [another] gender. Homosexual, bisexual, and heterosexual are examples; distinct from gender identity and expression."[25] *However, note that 'asexuality' should also be understood as a sexual orientation.*

lesbian: "A female person who is primarily attracted physically, sexually and/or emotionally to other females."[26]

gay: "A male person who is primarily attracted physically, sexually and/or emotionally to other males."[26] *However, note that current preferred usage of the term as an adjective has replaced use of the term as a noun.*

Gay: Identifying and participating in gay (or LGBTQIA+) culture.[13]

bisexual: Describes an individual who is primarily attracted physically, sexually and/or emotionally to at least two genders.[26]

transgender: "A term used to describe people whose gender identity or gender expression differs from that usually associated with their biological sex at birth; anyone whose identity, appearance, or behaviour falls outside of conventional gender norms. Can include transvestites, cross dressers, drag queens, transsexuals. Note that not everyone whose appearance or behaviour is gender-atypical will identify as a transgender person."[29] A generic term used for people who transgress social norms around gender.[26]

transsexual: "Transgender people who live or wish to live full time as members of the gender opposite of their biological birth sex; may seek medical interventions, such as hormone therapy or surgery, to make their bodies as congruent as possible with their preferred gender. The transition process from one sex to the other is ***sex reassignment***; independent of sexual orientation."[29]

cisgender and **cissexual:** "Individuals who have a match between the gender they were assigned at birth, their bodies, and their personal identity" as a complement to transgender."[30]

two-spirited: "A positive term for individuals of First Nations or indigenous descent who were traditionally considered to occupy a third-gendered position with the social characteristics of both men and women, often viewed as a sacred gift and treated with reverence."[26]

transvestism or cross-dressing: "The wearing of clothing of the opposite biological sex. Independent of sexual orientation."[6]

queer, genderqueer, androgynous, bi-gender: "Categories of varying definitions that imply a sense of blending or alternating genders."[6] "Describe individuals who do not conform to a binary system of gender."[10]

intersex: "Individuals with indistinct chromosomal or genital sex characteristics."[10]

asexual: "Anyone who does not have sexual attraction… is defined as asexual."[31] *May also be understood as a spectrum which includes those with little sexual attraction, or desire for sexual contact.*

allies: "People who support and actively participate in LGBTQ culture, but do not fall into any of the categories described above. Often, but not always, family members of people who identify as LGBTQ."[10]

pre liberation: A reference to the current cohort of gay and lesbian seniors who grew up prior to the current so-called era of "gay liberation." Often slow to seek health care, typically having suffered negative past experiences and abuses such as forced medical interventions to 'treat' their identity.[13]

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