Transgender Healthcare Primer for Clinical Audiologists

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- Hello, and thank you for joining today's webinar, Transgender Healthcare Primer for Clinical Audiologists. It is my pleasure to introduce our presenters, Shade Kirjava and Darshana Rawal. Shade's pronouns are they them, theirs. Darshana's pronouns are she, her, hers. Shade is a clinical audiologist in Los Angeles, California working in private practice. They are also a PhD student in public health at the University of California Irvine. Their research focus is hearing healthcare services, research and diversity, equity and inclusion in clinical audiology.

Darshana's a student in the program of public health at the University of California Irvine. Her research interests lie in the social determinants of health, primarily as they relate to sexual and reproductive health within the Asian American community. Specifically, she's interested in understanding how sociocultural perspectives and expectations impact the sexual and reproductive health seeking behaviors of South Asian American gender and sexual minorities. You can read more about Shade and Darshana on our course page of our website. Welcome to Shade and Darshana. We are very happy to have you on today.

- Hi everyone. Thanks so much for joining us here, and thank you again, Katie for the warm welcome. My name is Darshana Rawal, as Katie mentioned, and my pronouns are she, her, hers, and I'm a PhD student in public health at the University of California Irvine. And my co-presenter Shade and I are very happy to be here and thanks so much for joining us. And this slide just focuses on our disclosures. So for our learning outcomes, after this course, participants will be able to define transgender and gender diverse identities, describe the legal and social factors influencing transgender healthcare in audiology, and integrate knowledge of the effects of transgender identity on the auditory and vestibular systems into their clinical practice.

And this slide just goes over our positionality. Katie mentioned some of this already. My co-presenter Shade is non-binary, a vestibular audiologist at a private practice in Los

Angeles, California, and a PhD student in public health at the University of California Irvine. And again, I'm also a PhD student in public health at the University of California Irvine. All right, so let's get started. So what is LGBTQ+? You may have seen this acronym or a version of this acronym such as LGBTQI+ or LGBTQIA+, or even the term queer. This acronym as well as variations of it is used to describe lesbian, gay, bisexual, transgender, queer, as well as other identities. Although the acronym itself is being constantly revised, it serves as an umbrella term of identities commonly associated with gender and sexual identities that are outside of the cisgender heterosexual norm.

A cisgender person is a person whose gender identity corresponds with the sex registered at birth. A heterosexual person is the person who is sexually or romantically attracted to people of the opposite binary gender. So for example, cisgender heterosexual person, maybe someone who is born male, identifies as a man and attracted to women. One thing to note before moving forward is that language changes. Some of the terms that you may see or hear being used today may be different from those used in the past to describe similar identities or experiences. Some people may continue to use terms that are less commonly used now to describe themselves, and some people may use different terms entirely. What's important is recognizing and respecting people as individuals, which we will really be diving into today.

Now let's move into the transgender and gender expansive identities. Transgender is an umbrella term that includes anyone whose gender identity does not align with their sex registered at birth. Some transgender individuals may identify with the opposite binary gender to the one that they were assigned. So for example, trans men identify as men and were assigned female at birth. Likewise, trans women identify as women and were assigned male at birth. However, this may not always be the case, which I will get into in the next slide. Some transgender people identify with a non-binary gender

identity. Non-binary is an umbrella term that includes anyone whose identity is not entirely in the gender binary of male or female.

Non-binary identities can include a gender or not identifying with any gender or gender fluid, which is identifying with multiple genders as well as other terms. Individuals with binary or non-binary transgender identities could be referred to as transgender, but some may prefer a more specific term under the transgender umbrella, which more accurately describes their identity. However, some non-binary people do not identify as also being transgender, hence they do not fall under the transgender umbrella. Thus, it is extremely important that individuals are referred to with the labels that they prefer. If you are not sure what term somebody uses to describe their gender, you should ask them politely. Likewise, it is important for us to treat others, transgender and others with respect, and this includes using correct names and pronouns.

I would like to note that everyone, transgender or not, has a gender identity. Many of us just never think about what their gender identity is because it matches their sex at birth. And in this presentation to include transgender and non-binary gender diverse people, we will be using the terms transgender or transgender and gender expansive, shortened to TGE. So moving into transitioning, transgender and gender expansive individuals typically transition which is defined as the process of changing aspects of one's life associated with their assigned sex at birth. And this process is to bring a transgender person in line with their gender identity. And I must note that transitioning is a very unique process and no one size fits all.

What one trans person does may not be the same as what another trans person may do. And transitioning also involves multiple steps including social transition, legal transition, and medical transition, which I will be describing to you in these next few slides. Social transition is usually the first step of transitioning. Social transition typically evolves choosing a new name that more closely aligns with one's gender identity. One

may also begin using different pronouns than their pronouns used for their assigned sex at birth. Likewise, one may also begin making changes to their physical appearance, such as changing the way they dress or styling or dying their hair. And you may be thinking, how does one know that they're transgender?

Some transgender people are aware of their identity at a very early age. Others may need more time to realize that they are transgender and that is completely okay. Some people may spend years, for example, feeling like they don't fit without truly understanding why they feel such a way or they may avoid thinking or talking about their gender out of fear or shame or confusion. For many transgender people, recognizing who they are and deciding to start their transition process can take a lot of reflection. I will get into this later in this webinar, but transgender people risk social stigma, discrimination, and harassment when they tell other people about who they truly are. Parents, friends, coworkers and classmates may or may not be accepting of one's true identity.

And many transgender people fear that they will not be accepted by their loved ones and others in their life despite those risks. However, being open about one's gender identity and living their life authentically, authentically can be a life-affirming and even a life-saving decision. Moving forward to legal transition. Legal transition as the phrase reflects, involves the updating of legal documents to reflect a new name when and where available. Transgender individuals change the gender marker on their driver's license, state ID, birth certificate, and other documents to show the gender that aligns with their identity. It is very important to note here that when a transgender patient updates their legal documents, healthcare providers should also update their health records to match their patients new legal name and sex.

Likewise, I want to note the not all transgender people need or even want to change their identity documents. However, for many, this is a very critical step in their

transition. For many trans people not having identity documents such as a driver's license or passport that matches their gender means that they may not be able to do things that require an ID, such as getting a job, enrolling in school, opening a bank account, traveling, and so forth. Some trans people who use an ID that doesn't match their gender or their physical presentation may face harassment, humiliation, and even violence. Hence, for many transgender individuals, this is a very important step in their transition process to update their legal documents.

And before moving forward, I do want to take a minute to note that there may be challenges and barriers present when legally changing one's name. Not all transgender people may be able to make the changes they need to their IDs and other official documents. Unfortunately, these legal changes are often expansive, burdensome, complicated, and even inaccessible for many people. Hence, healthcare providers may have patients whose legal names do not match with their preferred name. In these situations, it is important to use a person's preferred name or nickname rather than their legal name if it is requested by that patient. And sometimes providers do not know what pronouns or names to use for their patient. To address this, when the provider is introducing themselves to their patient, they can ask the patient for the name that they would like to be called by as well as their pronouns.

And you may ask here, what is the role of pronouns in acknowledging someone's gender identity? Well, everybody has pronouns. And getting those pronouns right is not exclusively a transgender issue. Pronouns are how you and I identify ourselves apart from our name, it's how somebody refers to you in a conversation. Also, when you are speaking to somebody, using their pronouns is a very simple way to affirm their identity. So for example, I go by she and her pronouns. If somebody referred to me with he or him pronouns, I wouldn't like it too much because I don't identify with those pronouns. And by using he or him pronouns when referring to me, you're invalidating my identity. And I would also like to note that using correct pronouns for a transgender

or gender expansive individual is a way to let them know that you see them, you affirm them and you accept them, especially in a time when transgender individuals are being targeted by so many discriminatory anti-trans state laws and policies, which I will be getting into in a couple of slides.

And moving forward to medical transition, some, but not all transgender people undergo medical treatments to make their bodies more congruent with the gender identity and help them live healthier lives. While transition related care is critical and even life-saving for many trans people. Not everyone needs medical care to transition or live a fulfilling life. Different trans people may need different types of transition related care, and people should make decisions about their care based on their individual needs. However, many transgender people opt to undergo medical transition. Specifically, many trans individuals undergo hormone therapy or gender affirming surgery. Hormone replacement therapy alters secondary sex characteristics such as face, body, and deepness of voice. And there are several types of gender affirming surgery.

The more commonly known gender affirming surgeries are bottom surgery, which aligns one's genital to the typical biology of the gender that they identify as, and top surgery, which refers to chest alteration. And these surgeries are often performed on adults or those who are over 18 years of age. When considering medical transition for minors, transgender minors typically do not receive a gender affirming surgery, but they may take hormone replacement therapy to prevent them from experiencing the wrong puberty. Again, I really want to reiterate that transitioning is a very unique process and individuals may choose to undergo all steps of transitioning. While others may not. Transitioning can help many transgender people lead healthy and fulfilling lives. However, no specific set of steps is necessary to complete a transition.

It's truly a matter of what is right for each person. And all transgender people are entitled to the same dignity and respect, regardless of which legal or medical steps that they have taken. So now moving into the legal and social landscapes of trans identity, many individuals identifying as LGBTQ+ or queer have reported that they believe that their identity is a significant barrier to receiving quality healthcare services. A large number of people are reluctant to disclosing their identity to their healthcare provider out of fear of discrimination, prejudice, or stigma. And these fears are truly justified because multiple studies have found that people who have shared their identity face discrimination and prejudice in the healthcare setting by both the providers as well as the staff at the facility, others have been found to be cautious with telling their provider of their identity due to fears of being stigmatized and treated different or given unequal service to cisgender patients.

Likewise, some research has outlined how LGBTQ+ individuals are afraid that their healthcare provider will reveal their identity or out them to their family, which may isolate or ostracize them or put them in a position of vulnerability. Some queer individuals dread that if healthcare providers disclose their identity to their family, they may be taken to a mental healthcare provider or undergo conversion therapy simply due to their families not being accepting of their true identity. Unfortunately, many families still view queer identity as a mental disorder which can place queer individuals at a great risk and in vulnerable positions. Such dissatisfaction and fear within the healthcare setting can result in queer people being less likely to seek healthcare services compared to their cisgender heterosexual counterparts.

Likewise, this makes them more likely to neglect their primary healthcare needs, which unfortunately increases risk of detrimental health outcomes. In particular, transgender people have been found to have significant barriers to accessing healthcare services. Some healthcare providers have noted to be less comfortable with giving care to transgender people or refusing care for transgender individuals altogether. This is

sometimes due to providers personal beliefs or attitudes or because of the lack of medical training regarding transgender and gender diverse individuals, the lack of robust research on queer people and the lack of culturally competent training for care providers are two of the biggest challenges to quality medical care for queer people. Due to a lack of essential training on the needs of LGBTQ+ populations, many providers end up being ill-equipped to provide these patients with competent care and in safe and affirming environments.

And as a result of this, despite healthcare providers having a clear obligation to provide fair and equitable service to all patients, many may intentionally or unintentionally discriminate against transgender individuals. For example, more than one third of transgender individuals have reported that their healthcare providers have treated them disrespectfully. And again, this results in decreased health seeking behaviors. And for example, studies on transgender individuals have found that transgender people may also be subject to verbal and even physical violence during healthcare examinations, transgender individuals who use hormones or undergo gender affirming surgery have also been found to experience more discrimination than trans individuals who do not pursue these options. Does such trans gender related discrimination from providers may result in trans and gender expansive individuals with being uncomfortable discussing transgender specific healthcare needs with their provider, and of course, as I mentioned before, this can consequently delay healthcare.

Likewise, such experiences can result in an internalization of prejudice, discrimination, and stigma, which can severely impact the mental and physical health of transgender and gender expansive individuals and increased uptake of risky behaviors. The right to equal access to quality healthcare is a fundamental right for all people. Unfortunately, transgender and gender expansive individuals are too often denied their rights due to discriminatory behaviors. Moving forward to the legal side, several states have passed or proposed legislation restricting healthcare services of transgender people. For

example, in January of this year, the state of Utah enacted a law blocking gender affirming healthcare for transgender youth. Similarly, in 2022, Alabama enacted a bill criminalizing provision of some gender affirming care to transgender youth and requiring schools to reveal the gender identity of trans youth to their parents.

This can of course, put trans youth at a great risk if their identity is shared with their parents without their consent. And rather than being comfortable about coming to terms with their identity, this may further push trans youth to internalize stigma and prejudice, which can result in serious and damaging mental health outcomes. I must note that these are just two of many states have that have proposed or passed laws restricting healthcare services for trans individuals. These bills have been introduced on this false claim that of protecting trans youth. But in reality, these types of bills are an assault on trans people's ability to make healthcare choices and receive medically necessary care. Likewise, these bills ignore the evidence documenting the benefits of gender affirming medical interventions and can increase negative mental and physical health outcomes amongst transgender populations.

Denying transgender and non-binary individuals and already very vulnerable group access to medically necessary and scientifically supported medical care is dangerous and even spiteful, doctors, trans youth and their parents come together to discuss possible care and make individualized decisions about what kind of care is most appropriate for them. Politicians who do not have this type of medical training or even a true understanding of the harmful impact these types of bans have on trans people should not have a say in how best practice or age appropriate care is delivered. And such bills are a blatant disrespect of human rights and a considerable barrier for transgender people. And another barrier that I would like to discuss is in terms of insurance.

Transgender people are often denied insurance coverage for some medically necessary care, such as for transitioning as well as just for routine care, simply based on their identity. With the Affordable Care Act, there have been regulations prohibiting insurance companies from discriminating against patients based on gender identity. However, many transgender patients who have not pursued health insurance options via the ACA state that they have been denied insurance coverage. For example, the 2015 US Transgender Survey found that 25% of transgender people were denied health insurance coverage for transitioning or for routine care simply due to their identity. It's ridiculous to think that transgender people's coverage has been denied merely based on them being transgender, even if they're seeking care that isn't related to transition.

But for simple routine health checkups, similar to what you and I may get, the ACA laws also differ among various states, and the insurance framework sometimes considers gender affirming surgery as a cosmetic procedure, and as a result, it is not covered by many public insurance companies. Such loopholes in the current policies further promote inequitable distribution of resources between the cisgender and transgender populations. And such determinants of health are increasing health disparities for trans individuals, which I'll be getting into in the next slide. So moving into the social determinants of health. Broadly defined, social determinants of health are the social structures and economic systems that influence health inequalities and health outcomes. These social determinants of health include economic stability, healthcare access, neighborhood and built environment, education and social and community context.

And these social determinants of health can contribute greatly to health disparities. Health disparities are defined by the CDC as preventable differences in the burden of disease, violence, injury or opportunities to achieve ideal health. These disparities negatively impact groups of people who have been systematically oppressed or

experienced economic or social obstacles to health. We have talked about some of these disparities already, such as queer people facing stigma, discrimination, and even violence because of their sexual and gender minority status. For transgender and gender expansive individuals, health disparities can include limited access to healthcare, limited access to gender affirming health services, discrimination from providers, poverty, unemployment, and homelessness. These types of determinants act as barriers and can result from stigma against transgender people present at the structural and institutional level, and they can result in profound health barriers and un unmet healthcare needs.

Returning to the topic of health insurance coverage under employment and unemployment is more common among transgender people due to transphobic employment discrimination. Many of us receive healthcare coverage through our jobs. So transgender people who are unemployed have decreased access to insurance coverage and even for transgender people who do have insurance, they may experience discrimination at the healthcare setting by providers as discussed earlier. Also, I want to note that by limited access to healthcare, I do not only mean a lack of insurance, geographical location or how a provider may treat a trans person. Limited access can also span to the healthcare setting itself. A healthcare setting that is unwelcoming to a transgender individual may prevent patients from disclosing relevant health related information or may discourage them from seeking care at all.

Patients may consciously or unconsciously assess healthcare settings for signs of safety and inclusiveness. So for example, if a trans patient enters a healthcare setting and meets the front desk staff who use judgemental language or make assumptions about their identity, it may deter the patient from further seeking care, not only at that facility but at other facilities as well. Similarly, signs of inclusiveness at a healthcare setting can also span to non-verbal things such as intake forms, posters, or information materials, as well as gender neutral bathrooms. The lack of these types of inclusive

aspects at healthcare settings may discourage transgender people from comfortably sharing information with their provider, which can put off receiving necessary care. I would also like to note that transgender individuals who are also people of color or POC may face multi-layered minority stressors due to their status as a racial or ethnic minority and discrimination based on their gender identity.

These communities not only experience the devastating impact of anti LGBTQ+ laws and policies, but also face insidious and chronic impacts of racism. So for example, an African-American transgender woman may face multilayered minority stressors due to her identity as a transgender woman and her status as a racial minority. Some research on transgender people of color shows how trans POC face greater threats of bullying, discrimination, violence, isolation, and unsatisfactory healthcare experiences compared to Caucasian transgender people. And this often results in trans people of color having a greater mistrust in the healthcare system. Some trans people of color have been noted to be utilizing other sources of healthcare information in receiving treatments from outside of healthcare settings. So for example, in the Smart et al.

study that I have cited here, the researchers actually found that study participants, which were trans women of color, turned to getting medication for hormone therapy from less reputable sources, including online and through smaller grocers because they were unable to receive a medical prescription. This can of course be extremely dangerous if they receive the wrong medication, however, this is unfortunately the reality of many trans people of color that are unable to access care other than by pursuing these potentially harmful means. Similarly, the participants of the study reported to relying on the internet for health information. And as we all know, the internet is not always a reliable source of information. However, as a result of systematic health barriers, trans people of color may turn to these other types of means to receive healthcare and can possibly end up being more damaging to them.

And this is truly a serious healthcare issue. Hence, it is extremely important for us to understand how social determinants of health build upon one another to lead to health outcomes amongst transgender and gender expansive individuals, especially those who faced minority, multilayered minority stressors. And my co-presenter Shade will continue expanding on the important aspect of social determinants of health.

- Absolutely. Thank you so much for all of that. That was really wonderful. Just as a reminder, my name is Shade. I work as a vestibular audiologist and I'm also getting a PhD in public health. My research focuses on applying public health methods to audiology because there are some powerful tools in public health that I think can really benefit our field. We're looking at one now. I think in audiology we do a really good job of understanding biomedical perspectives. We think about things in the body like we think about the ear. We can divide the ear up into systems like the middle ear, think about individual components, like the tympanic membrane. We can even get down to the level of individual cells, but we're going to do the opposite right now.

We're going to think about social determinants of health outside the body. We're going to use this model, it's called a social ecological model that centers an individual at the smallest level and an individual's experiences are affected by interpersonal interactions, which are affected by institutional norms, which are affected by the wider community. And all of this is affected by healthcare policy and other policy. Just like we know that individual body systems and parts of our body can affect disease, all of these outside the body factors can affect hearing loss and vestibular loss too. And we'll really dive into the specifics of that in the mechanisms in just a minute. When we think about these social determinants of health, they affect the conditions and diseases that our patients have and what patients even come to our clinics.

We see that among the patients in our clinics, people who are transgender and gender diverse tend to have poor mental health, largely due to discrimination and often due to

discrimination from healthcare providers, including audiologists. I know it's not nice to think about, but this is not an abstract. These are things that I have personally experienced and witnessed from people, you know, preceptors not permitting queer graduate students to rotate at their sites, to banning students who weren't sufficiently, you know, fitting with the norms of their assigned gender. Audiology has a big problem with this. I think that we need to acknowledge the challenges that we are facing in audiology, and that's going to be the best first step to having a more equitable, more excellent field.

We also see in a person who is transgender and gender diverse, that general health tends to be poorer because there's less access to healthcare and there's less use of healthcare, partly from things like you know, employment discrimination, less access to insurance that we'll talk about. And also due to other things like direct discrimination from healthcare providers, discrimination against transgender people by healthcare providers is widely normalized. That's a pretty typical experience, and I've even had, you know, doctor's offices cancel appointments and refuse to see me when they found out I was transgender. This discrimination is in many states either explicitly allowed or permitted, and it's not necessarily in line with other things in our field, like our professional code of ethics.

We'll talk about how to navigate that in a little bit. We also find that people who are gender diverse tend to have more social isolation and less social support. If you have a transgender patient in your clinic, you might find that they have fewer people who are able to help them manage their hearing aids, or if they have dexterity issues, they are less likely to have people who are able to help them clean and maintain their devices, get them to appointments, adhere to their other healthcare treatments, and we see that all of these issues can be worsened by interpersonal interactions too. Interpersonal factors that can affect trans people trying to get audiology care include things like,

there's not actually a lot of education for us as clinical audiologists on how to work effectively with queer people, including trans people.

Take a moment and think back to your graduate school education. Did you get any education in how to work effectively with trans people? I actually, I didn't personally, and it's hard to find CEUs for this too. We also see that we have unconscious bias, and this is something that affects many people, myself included. We have these unconscious biases that we internalize from messages in wider society and that gonna affect how we interact with trans people, even if we intend to work, you know, fairly and equitably with them. We also see that institutions affect how trans people get healthcare from audiologists. We see that in institutions like universities and many hospital systems, especially religiously affiliated hospital systems.

There isn't a lot of education that's provided on people and trans people especially. This population just isn't much of a priority. Even though trans people make up, give or take maybe about 1% of the population based on recent estimates, we see that, you know, other populations and other conditions, even if they're rare, get a lot more attention. Things like charge syndrome, vestibular schwannoma, other conditions that are much rarer than being transgender get a lot more attention than trans identity. Even though we're seeing, and we'll continue to talk about the many ways, trans identity has huge impacts on the auditorium vestibular system too. We also see that trans people just aren't really a priority for research. I work in research myself and I'm intimately familiar with how many research studies either don't bother collecting information on things like gender and sex or don't collect information on people who are transgender or don't fit into the normal two sexes.

The typical two sexes, male and female aren't the only options. Many people actually don't fit into those. Intersex people have characteristics of either sex and since there aren't just two sexes like intersex people prove, obviously there aren't just two genders,

but many research studies don't bother collect this information. We see that at a wider community level, things like employment discrimination causing reduced income and reduced access to insurance affect the ability to get healthcare, including audiology care. Many of my patients, you know, I have the conversations sometimes that I'm sure many of you do. I encounter people with hearing loss. They don't have insurance that covers hearing aids, and we have to have this tough conversation about is this even healthcare that they can access?

We as audiologists know it's important and untreated hearing loss is linked to things like poor outcomes with dementia. But because people don't have insurance and because trans people are disproportionately affected by less access to insurance, there's less ability to get hearing testing, there's less ability to get vestibular testing, there's less ability to get the treatment that people need. Even though we know evidence-based practice says that people with, you know, hearing loss do benefit from hearing aids, typically the social factors in the community can keep that from happening for trans people. At the widest level, the policy level that affects everything else. From interpersonal interactions to community factors, there are things like trans people aren't always able to legally change their legal documents.

They can face discrimination by, you know, being legally married. Some people avoid that whole process out of fear of discrimination and that can affect, you know, the decision making in people's healthcare. Over the last couple years, you might have noticed in the news that explicit attacks on LGBTQ+ people, especially trans people, have been increasing. Transgender healthcare for adults has been banned in at least one state. And there are laws that, you know, prohibit providing certain types of medically necessary care that, you know, evidence-based practice shows is the best option from these people, and we know that and worsens their health. The literature is very clear on that. We'll talk more about evidence-based practice in just a minute.

Let's take a moment to kind of shift from a public health, social ecological perspective and talk about something that's probably a little more familiar, more of a biomedical perspective. Let's talk about how trans identity can affect the auditory or vestibular systems through mechanisms like ototoxicity, opportunistic infections, and by affecting disorders like vestibular migraine that we know also affect the auditory or vestibular systems. We do see that a lot of research on trans people isn't really done very well and a lot of research that isn't specifically on trans people often excludes them entirely. So a lot of what we're going to talk about is based on, you know, not a lot of studies and on studies of, you know, cis people who change their hormone levels through things like gender affirming, you know, hormones for cis men, which should be taking testosterone.

We also see that people just aren't a priority in research, and since that data isn't collected, it makes a lot of the research that we do less valid. Think about some of our sex-based norms, like for ABR for instance, what norms should we use for someone who's intersex, male or female norms? Neither? Since no one collected norms on intersex people or on transgender people, then we can't really accurately assess them in clinic. I see we're having, we had a question from the Q&A submitted. We'll take some time to answer questions at the end. If you have questions, this is a great safe space to ask, you know, tough questions that might be uncomfortable in other settings.

Definitely ask any questions you have, feel free to submit them anonymously. And if you do have questions that you'd like to discuss privately, there'll also be an option to, you know, to contact Darshana or myself privately and we would love to discuss this with you more. One of the ways that trans identity can affect the auditorium vestibular systems is through a pretty familiar mechanism for us, ototoxicity. We know a lot of ototoxic medications, cisplatin, IV antibiotics, you know, antimalarials, all of those things can be ototoxic, but I don't think that audiology recognizes some of the less common or less ototoxic medications that can affect our patients too. Antiretroviral

therapy for HIV and AIDS, for example, that's several different drugs, and there's different combinations for either preventing you from getting HIV in the first place or for affecting your viral load and controlling symptoms after infection.

But there's some pretty clear research that antiretroviral therapy can be ototoxic, it can worsen our hearing, definitely, and there's not as much research on, you know, how it affects our vestibular system, but since it is ototoxic for at least the auditory system, it's reasonable, it would affect our vestibular outcomes too. This is highly relevant for LGBTQ+ people because queer people are disproportionately affected by HIV. For many factors like employment discrimination, reducing access to healthcare, reducing the ability to prevent HIV or appropriately treat it once you have it, we see that HIV tends to be more common and more serious in queer people. Transgender women, for example, are about 49 times more likely to have HIV than cisgender counterparts.

That means that trans people, especially trans women, are disproportionately affected by this ototoxic medication and probably face ototoxicity because of this more often than cisgender peers. Another mechanism that trans identity can affect our auditory or vestibular system is through opportunistic infection. We actually find that estrogen in our bodies mediates how our immune system works. The more estrogen someone has, the more active your immune system is. We see that cis women who tend to have higher rates of estrogen and trans women who are taking hormones both have more estrogen, which causes a more active immune system and lower rates of infectious disease. And I haven't seen this explicitly researched, again because transgender people are socially stigmatized and not a priority for many healthcare providers.

But we see that trans people who have more estrogen, probably have fewer infections require taking those ototoxic IV antibiotics in the first place. We might expect that trans women have, you know, fewer ototoxic medications than trans men, for example. We also see that HIV, which we know is disproportionately affecting queer people,

especially trans people, can cause opportunistic infections or make them more likely, including things like, you know, suppurative otitis media, upper respiratory infections leading to eustachian tube dysfunction and otitis media. And we see that the more estrogen you have, the more active your immune system is, and the fewer infections you tend to get, including fewer suppurative otitis media, which we know definitely can cause hearing loss.

Trans women would probably be less affected by this than, for example, trans men. We also see that for transgender people, there are some other factors that can affect the auditory vestibular systems like the hormones that people have and the experiences that people have affect the rates and severity of conditions like Meniere's or migraines, which obviously are closely linked with auditory and vestibular function. For migraines, for example, you know, I work a lot with vestibular migraine in my practice, and there's less research explicitly on vestibular migraines, but we know for migraines generally that the more estrogen you have and the less testosterone you have, the worse your headaches and migraines tend to be. That's why we see that in cis women and in trans women, they tend to have worse migraines and cis men and trans men tend to have, you know, less severe migraines.

We also start to see that, we know that there's several different types of biological sex and one of the types is more important than the others. Biological sex isn't one thing. It's our chromosomes, our primary sex characteristics, our secondary sex characteristics, the hormones that are most active in our body, many things are involved. It's not just a simple, are you male or female. In trans people in audiology, it's not really very relevant to talk about the chromosomes or sex characteristics that people have. Audiology just isn't really affected by them. Hormonal sex, though the hormones that are most prevalent in your body is pretty significant to think about because it's the hormones in our body that are affecting the opportunistic infections, rates of HIV and AIDS, migraine prevalence and severity.

So, we'll circle back to this in just a minute, but for now, just kind of think in the back of your mind that when we're asking about things like sex on case history forms, for example, it's not as useful in audiology to know what's was on someone's original birth certificate or what's on their driver's license now. We just need to know things that will help us refer to patients correctly and also to know, you know, what hormone levels they have in their bodies. We also see that fluctuations in estrogen can also cause, you know, increases in migraine prevalence. For example, you know, many trans people are in unstable conditions. They're vastly disproportionately, you know, represented in homeless populations, for example, and may not have reliable access to medications.

So we might see that, you know, trans people in less stable situations with less stable access to medication, have more fluctuations in their hormone levels and worse outcomes for vestibular migraine. If you think back to any vestibular migraine patients you've had, you might remember that oftentimes stress, like caregiver stress, losing a job, losing a loved one and other sources of stress are common triggers for migraines, including vestibular migraines. Stress tends to be a lot worse in minoritized communities from people of color to LGBTQ+ people, and especially in trans people. Trans folks experience things like minority stress, stigma, discrimination, you know, barriers to healthcare, lower socioeconomic status. All of those things increase our general stress and our allostatic load and all of those things can trigger migraines.

There's a couple other conditions that are also affected by our hormone levels and also affect our hearing and balance. You might remember that autoimmune conditions are heavily implicated in, you know, a cause for sudden sensory neural hearing loss and maybe an acute vestibular syndrome, previously known as vestibular neuritis because autoimmune conditions can either cause, you know, narrowing of blood vessels that vascularize the inner ear and cause the formation of blood clots that can move to the inner ear. And we see that autoimmune conditions are affected by estrogen because

estrogen affects how active our immune system is. The more estrogen we have, the fewer infections we have, but the more autoimmune conditions we have. So we tend to see that, you know, trans women who take estrogen are more likely to have autoimmune conditions than, you know, trans men who would take testosterone.

We also see some research that shows that Meniere's is affected by estrogen as well, which isn't surprising because we know it's tightly linked with vestibular migraine. We see that the less estrogen you have, the worse your Meniere's is likely to be. So trans men and cis men are likely to have worse Meniere's outcomes than people with more estrogen. Okay, I'm a vestibular audiologist. I love talking about balance in the vestibular system, but I know for most of us hearing loss is our bread and butter. We see several ways that hearing loss can get affected by transgender identity. For example, we see that both gender, the ways that we interact socially, and sex, the biological characteristics we have, both affect hearing loss.

Partly that's due to, you know, estrogen being involved in the function of our brains and our cochleas, but we also see effects of gender because, you know, more masculine people and men, including cis and trans men, are usually socially expected to do things like, you know, work in noisier positions or do factory or machining work with more ototoxic exposures like solvents or heavy metals. Most positions are often noisier and you know, men are typically socially expected to do that more than women, which is one of the reasons why men tend to have poorer, you know, presbycusis and noise-induced hearing loss outcomes. We also see though that our hormonal sex, the amount of estrogen we have affects noise-induced hearing loss and age-related hearing loss too.

It actually has a protective effect by protecting against free radicals. We know that the inner ear and the brain are strongly affected by the estrogen, you know, that we have in our bodies. And for trans people taking estrogen like trans women, it's less important

to know, you know, what their sex was assigned at birth. It's more important for us as audiologists to know, you know, the hormone levels that they have now. You might remember, I think back in late 2020, during the COVID-19 pandemic, there was talk of using estrogen as a treatment for COVID, and we can actually do the same thing with hearing loss. Administering estrogen slows down hearing loss progression, so it could actually be a treatment for hearing loss to reduce the effects of age-related hearing loss.

I'm not sure how many of our cisgender male patients would buy into that, but it certainly illustrates how impactful our hormonal sex is on the auditory and vestibular systems. In the same way we see that congenital and adolescent hearing loss is more likely for males, partly due to biological factors, partly due to gender factors. Okay, I love talking about the pathophysiology of different conditions. I think it's so interesting and illustrating, you know, just how complex our body is and how many things affect it. But let's take a few minutes and really get practical for, you know, after this appointment, or I'm sorry, after this webinar, what can you do in clinic to work with trans people more effectively?

What are things that you could put into practice on Monday, for example, to make your clinic a more equitable and fair place for trans folks and to open up your clinic to a new patient population that could provide a new source of income? We know that many trans people don't access healthcare at the same rate that cisgender people do, which means that, you know, there's a big patient population of trans people that get hearing loss, you know, sometimes even more often than cisgender people because of the economic disparities that are in transgender people and worsened hearing outcomes. So if your clinic is more accepting and more explicitly supporting of LGBTQ+ people, including trans people, you might find that you have a new revenue stream, a whole new patient population that maybe other clinics in your area just aren't serving well and that your clinic can serve well.

You can think about how you know how welcoming your clinic is to trans people by thinking about what does your online presence look like? You probably have a website for your clinic, I assume maybe you have staff bios if you have explicit reference to LGBTQ+ people, you know, a pride flag, a rainbow, putting your pronouns after your name. All of those things are strong indicators to queer people and trans people especially, that your clinic is a great place for them to go and spend their money. Some things you can do are just list your pronouns after your, you know, name on your business card, like my business card that I've got displayed here. List your pronouns on your marketing materials you mail out, your email signatures and you know, I think that people initially started listing their pronouns so that other people would know how to refer to transgender people correctly.

But I think nowadays, listing your pronouns after your name, like our wonderful moderator did, it's a great signal that you're a safe person to go to and to work with. It's a great signal to trans people and queer people generally that your clinic is going to be an affirming place for them. But let's also think about when someone first walks into your clinic, what are the impressions that they get? I used to work in the South, I work in LA now, and people don't use honorifics like Mr. and Mrs. nearly as much, but in the South, very common. Think about how your office staff greets people. Do they have an initial snap judgment of what someone's appearance is and what their gender must be and use, you know, an honorific they feel is probably right.

That can be not great for trans people who may not initially be referred to with the honorifics they prefer, like for me, for example, I don't have a gender, so calling me Mr. or Mrs. would both be completely wrong and definitely shouldn't be done. It might even be an option not to use those gendered honorifics when you're greeting people and when your office staff are greeting people, and we should also think about how those things are reflected on our case history or patient intake forms. I think all of us

ask for legal name on these forms, but we also should be asking for preferred name. Like many of my patients, they go by their middle name.

For example, I actually do in clinic myself, I go by Dr. Avery in clinic. When we ask for someone's preferred name, then we're not just benefiting the trans people who may not have legally changed their name yet or may be legally prohibited from changing their name. It's also a great way to refer to our cisgender patients correctly and build rapport with them more effectively too. I think that on most case history forms also ask for sex, and oftentimes it's just a male or female checkbox. That's a bad way to do it. Like for example, my passport, you know, my driver's license, everything says that my gender is X. If I was presented with a form, like an online intake form that requires me to enter my sex, it's not possible for me to complete the form.

I have, you know, not gotten doctor's appointments because of it, and I'll just go somewhere else that bothers to collect the correct information from me. If your case reforms ask about gender or sex, they should at the bare minimum include three options to reflect people's legal documents and should probably ask about correct pronouns too. Oftentimes, people's pronouns don't match their legal sex, so it can be helpful just to, you know, have an open box that says, what are your pronouns or to list pronouns, like he, him, she, her, they, them, or enter your own. Those are all great ways that you can be more affirming on your case history forms. All right, we have about five minutes and we're going to answer questions, so do make sure that if you do have any questions, feel free to submit them with your name or anonymously, we'll get to them in just a couple minutes.

During our appointments, there's some things that you can do, like avoiding assumptions about the relationship between the patient and someone they brought with them. Just two weeks ago I had this, I tell myself I won't do this, but I had a patient, he was an elderly male, he brought someone with them and I said, oh, hello,

are you the patient's wife? And nope, it was his daughter, which is really awkward. Not a good way to build rapport. Kind of insulting because I'm implying that she looks older, so it's good to avoid for our cis and transgender patients, it's probably better to just ask something like, who's this person with you? What is their relationship? Instead of assuming the relationships that we have, based on a more cis heteronormative perspective.

We remember that trans people may have very different and may have fewer conversational partners than other patients. That's why we can use things like structured interviewing or the COSI, C-O-S-I, to find out what situations are really important for our patients. That helps us provide that patient-centered care for cisgender patients and trans patients too. Sometimes you may also have someone mention that they're queer during an appointment and just like any other disclosures, like a disclosure of a history of cancer, you should handle that sensitively. Use active listening, show empathetic body language, you know, don't speak judgmentally. All those things are good for building rapport and after an appointment, when you're working on your reports and chart notes, it's always correct to use someone's correct names and pronouns, even if someone's name isn't their legal name.

If you refer to someone how they tell you not to refer to them, it's narcissistic and cruel, the very least that we can do to respect our patients as required by, for example, ADA, OSHA and AAA codes of ethics is to refer to patients correctly and refer to them the way that they ask us to. There is an exception to that for pediatric patients. There are states that permit them to be taken from their families for being trans. There's also other discriminatory laws, and even in the absence of that, disclosing that someone is transgender to, you know, parents and school officials can open them up to unsafe situations, bullying, harassment, physical violence. If you have a patient who's transgender, definitely ask and have a careful conversation about when it's okay to disclose that fact.

I would ask my patients, is it okay to include their correct name and pronouns in reports or should I stick with their legal name? Something to keep in mind. A brief note about evidence-based practice. Let's remember that in audiology, evidence-based practice is absolutely our goal. All the evidence-based practice that we have for just about everything we do in clinic is based on the same evidence that shows that transgender healthcare, including things like hormones, are absolutely the standard of care and medically necessary. All major reputable medical organizations, including the AMA and others, say that, you know, evidence strongly shows that transgender people should get this healthcare. If we reject that transgender people should be getting the healthcare that you know they need, we're also saying that the evidence-based practice that we use in clinic can't be trusted.

If the evidence that shows trans people definitely need trans healthcare can't be trusted, nothing that we do in clinic can be based on anything trustworthy either. If we admit that we're doing evidence-based practice, then we also have to admit that the same evidence shows trans people need their healthcare too. We have a ton of references at the end of this, so if you'd like to do more reading, you can definitely read through the sources. I've written a few articles myself, feel free to look them up. And I have a few questions for us. I'm gonna go ahead and just start at the top with someone who asked the question. I work as an educational audiologist, and have at least two students who are transgender.

Any tips for an IEP, I have heard an anecdotal experience that people with hearing loss have a greater population of gender diverse people. Have you heard any research on this? Yeah, because of the way that transgender identity affects things like the work that we do and the noise exposure that we do and absolutely affects, you know, the hearing loss that we get, and also affects things like our ability to, you know, take our medications and get medications in the first place, and there are many medications

that are ototoxic, so that would reduce rates of ototoxicity and there are many medications that can worsen hearing if they don't get taken, and that can worsen hearing by not taking those.

If that didn't answer your question, please feel free to drop in another. I have a question that says, it's my first time seeing the phrase correct pronouns? What does Shade mean by using the phrase over only pronouns? There's this thing that some people do, they'll call them preferred pronouns, and that kind of says that if you wanna use someone's pronouns, you can. It's preferred, but it's not mandatory. I used a phrase correct pronouns because that is the only correct way to refer to someone and not using someone's correct pronouns is cruel, narcissistic, and ridiculous. That's why I use a phrase like correct pronouns to make it clear that that is the only correct way to refer to someone.

I hope that answered your question. There's an anonymous question that said, have you addressed what HRT causes? If so, I've missed it, question mark. Yeah, HRT, including estrogen, causes many of the effects on the auditory and vestibular system. If you look at the slides just after that graphic on the social ecological model with the five columns side by side, all of those show the effects of HRT on the auditory and vestibular systems. I know we are at 1:02 by my clock. I know we have patients to get to. If you have any final questions, we'll wait for just a moment. Otherwise, I'll let our moderator start to close us out.

- Thank you so much. I'll just wait another moment to see if there's any questions that pop in last moment. Okay. Thank you so much to Shade Kirjava and Darshana Rawal for your time and expertise, and thanks to everyone who participated in today's course. We look forward to your feedback on the course evaluations and hope to see you in future courses on AudiologyOnline. This concludes today's course. Have a great rest of your day.