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Title: An Exploration of the Experiences of Physical Therapists Who Identify as LGBTQIA+: Navigating Sexual Orientation and Gender Identity in Clinical, Academic, and Professional Roles

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ABSTRACT:

Objective. The purpose of this study was to explore physical therapy through the stories of physical therapists who identify as lesbian, gay, bisexual, transgender, queer, intersex, asexual, and other related identities (LGBTQIA+) to consider how the profession enacts and constructs gender and sexual orientation.

Methods. Physical therapists with clinical, academic, and professional roles who identify as LGBTQIA+ were recruited from Australia, the United Kingdom, Canada, and the United States. In-depth data were collected via narrative interviews. An iterative group discourse analysis was used to examine key discourses underpinning interview narratives and how these relate to the physical therapy profession.

Results. Twenty-two physical therapists were interviewed. Participants had between 1.5 and 40 years of experience across various clinical areas and settings. Participants identified with varying sexual orientations and gender identities. Analysis identified discourses discussed under the following headings: (1) *normativity*, which related to heteronormative assumptions about sexual orientation and to cisnormative assumptions about gender identity and the intersectionality among sexual orientation, gender identity, and other forms of marginalization; (2) *stress and labor*, which explored the stress experienced by physical therapists who are LGBTQIA+ (due to fear of discrimination or actual discrimination) and additional emotional and other types of labor or work done in the workplace to hide aspects of their lives to feel safe, educate colleagues, and be a role model; and (3) *professionalism*, which related to the heterosexual/cisnormative (and other) “norms” that comprised participants’ ideas of presenting as “professional” and positioning physical therapists who are LGBTQIA+ as “unprofessional.”

Conclusions. Findings suggest that cultural norms may need to be reconceptualized in physical therapy to promote inclusion and belonging of individuals who identify as LGBTQIA+. Approaches to upskill new and existing physical therapists may include elements such as individual and institutional reflexivity, learning and implementing appropriate terminology, displaying indicators of inclusivity, and cultural safety training. These elements may provide the first steps to promote inclusive and culturally safe environments for individuals who identify as LGBTQIA+ within the profession.

Impact. This is the first known study to explore the lived experiences of those who identify as LGBTQIA+ in the physical therapy profession. The findings highlight how prevailing normative discourses in Western society are also present in physical therapy and impact those who identify as LGBTQIA+.

Introduction

In 2019, World Physiotherapy, the global organization for the profession, published policy stating that it “recognizes and supports the international declarations and work programs of the United Nations and World Health Organization in support of diversity and inclusion.”¹

These efforts include providing safe workplaces for people who experience marginalization.

Research into diversity and inclusion in physical therapy has focused on individuals seeking care and the micro-politics of interpersonal interactions,²⁻⁴ race/culture,⁵ gender,^{6,7} disability,⁸ health condition stigma^{9,10} and weight stigma.¹¹⁻¹³ These studies raise concerns about cultural norms and practices in physical therapy that negatively impact how people, who are marginalized, experience the profession. Yet, detailed reflexive consideration of how physical therapists experience the ‘culture’ of physical therapy at their places of work is needed and some areas of diversity, such as LGBTQIA+ (lesbian, gay, bisexual, transgender, queer, intersex, asexual and other related identities) communities, require attention.

Currently, there is a dearth of knowledge about how physical therapists who identify as LGBTQIA+ experience the profession. This is important because, despite some positive achievements (e.g. legal status of same sex marriage in some countries), individuals worldwide who are LGBTQIA+ continue to experience multiple inequities related to their experiences of marginalization,,¹⁴⁻¹⁶ including high incidences of death amongst transgender communities,^{17,18} mental health challenges,¹⁹⁻²¹ and fear of violence.²² Further, individuals’ workplace experiences are situated amid, and impacted by, ongoing macro-political issues such as the erosion of rights during the Trump era in the United States of America (USA),²³ the lasting legacy of homophobic law ‘section 28’ in the United Kingdom (UK),²⁴ and ongoing discrimination in Australia on the basis of sexual orientation, gender identity and other axes of social difference.²⁵

To our knowledge, the only research exploring how physical therapy and the LGBTQIA+ community intersect is about the experiences of patients who identify as LGBTQIA+ when attending physical therapy.²⁶ That study highlighted that the LGBTQIA+ community reports experiences of persistent erroneous assumptions of hetero- and cisnormativity when attending physical therapy in Australia, implying physical therapists assume that ‘heterosexual’ is the default sexual orientation and that everybody has a gender identity matching their biological sex (assigned at birth). Repercussions for patients include fearing

or experiencing discrimination resulting in lack of disclosure of relevant information and anxiety, a heightened discomfort about being touched or undressing, and a perception that physical therapists lack specific knowledge about the health needs of people in the LGBTQIA+ community.²⁶ These issues exist despite the ethical obligation of physical therapists and physical therapy organizations to ensure equity, inclusion, belonging and minimize discrimination.¹ It is possible that physical therapists who identify as LGBTQIA+ might have similar or related experiences of the profession.

In other health professions, nurses and physicians who are LGBTQIA+ nurses^{27,28} face disparaging comments and discriminatory behavior, with up to 22% not finding their workplace LGBTQIA+ friendly. Further, 43% of nurses report not feeling comfortable being 'out' to their co-workers,²⁷ while many physicians describe a lack of LGBTQIA+ visibility in policies. The experiences of nurses and physicians may not translate to physical therapy given its own cultural norms and professional practices.^{7,29} To address this issue, the aim of this study was to gain greater insights into the cultural norms and practices regarding gender identity and sexual orientation by examining how physical therapists navigate their LGBTQIA+ identity in their professional roles. Exploring these factors enables consideration of how gender identity and sexual preference might be reconceptualized in the profession to promote inclusion and belonging of individuals who identify as LGBTQIA+.

[H1] Methods

[H2] Methodology and theoretical underpinnings

We employed a qualitative methodology based on discourse analysis using narrative interview methods.³⁰ Discourse analysis is underpinned by a social constructionist theoretical framework. As such, this type of analysis seeks to understand phenomena by deconstructing and interpreting language.³¹ Social constructionism was a theoretical shift from considering language "as a set of unambiguous signs" with which to understand reality, to reconceptualizing language as achieving particular "social objectives".³² Empirically this meant a shift from attending to "individuals and their intentions to language and its productive potential".³² Aligned with social constructionism, we used discourse analysis to interpret data to facilitate attention to different constructions of 'truth' and 'normality' evident in participants' stories in relation to gender identity and sexual orientation, and to which discourses have more/less power (productive potential) in

physical therapy. Through this approach, in-depth insights can be garnered about complex experiences of negotiating gender identity and sexual orientation in a particular context.³³

Discourse analysis enables questions such as:

- What discourses about gender identity and sexual orientation are dominant (and less dominant) in physical therapy?
- What impact do these discourses have on physical therapists who identify as LGBTQIA+ in the context of their work?

Participants and Procedure

Following The University of Queensland Human Research Ethics Committee approval, we invited qualified physical therapists who self-identified as LGBTQIA+ to participate in an interview. Participants were recruited between May and August 2020 through the investigators' (physical therapists and members of LGBTQIA+ communities in Australia, Canada, UK or USA) personal and professional networks and the general physical therapy community through social media advertisements. Snowballing was encouraged. Some of the participants were known to the investigators as we drew on our existing networks to gather the sample. We sought a diverse sample from a range of LGBTQIA+ identities, ages, length of physical therapy experience, countries, and ethnic backgrounds. Interviews were analyzed as data collection progressed and recruitment ceased when there was sufficient repetition and depth of emergent discourses to garner insight into the research topic.³⁴ Participants were emailed study information and provided formal written and verbal consent prior to the interview. Data were collected through audio-recorded semi-structured narrative interviews of 20-90 minutes via teleconferencing software and were professionally transcribed and anonymized. The six interviewers (JS, JH, LC, MM, DB, AW, JB) were working in different areas of physical therapy (clinical, research and teaching) and were trained in Wengraf's^{30 35} narrative interviewing methods. The interviewers identified as men, women, nonbinary and gender-queer; and with sexual orientations included bisexual, lesbian, gay, and queer.

[H2] Materials

Interviews were designed using Wengraf's narrative approaches,^{30 35} which involved two stages:

1: Response to an open question prompting interviewees to tell the story (without interviewer interruption) of their life as a person who identifies as LGBTQIA+ since entering the profession.

2: The interviewer asked questions to garner more information about key events/memories/experiences that the interviewee mentioned in Part 1.

[H2] *Analysis*

A subgroup of the research team (MHR, JS, JH, AW, JLW, JB, DB) conducted initial data analysis using a combination of individual and team techniques. While all investigators had access to all transcripts, we reviewed a selection of transcripts in detail to identify concepts relevant to the research aim. The subgroup then analyzed the emergent data during two video conferencing meetings to refine key conceptual patterns and consider how these might impact individuals in terms of inclusion/marginalization or positioning as appropriate/not appropriate in physical therapy. To facilitate identification of discourses underpinning the participants' narratives, extensive notes were taken during these two meetings and were used when MHR, JS and JH returned to the whole dataset. They then consolidated the analysis and presented amalgamated findings to all investigators for additional input. Any differences in perspectives among investigators were acknowledged and included in the analysis. A preliminary analytic summary was sent to the participants for commentary and the majority replied. All respondents agreed that the analysis reflected their experiences. A number described that it was a positive but emotional experience reading research that reflected their experiences for the first time. One respondent requested minor adjustments to our use of their pronouns (which we corrected).

Study rigor was guided by Tracy³⁶ who outlined eight key markers of qualitative research quality, including worthy topic, rich rigor, sincerity, credibility, resonance, significant contribution, ethics, and meaningful coherence. Reporting rigor followed the Consolidated Criteria for Reporting of Qualitative Research (COREQ).³⁷ All relevant markers and criteria were addressed.

[H1] **Results**

Twenty-two physical therapists with between 1.5 and 40 years of experience from four countries participated (Table 1 and 2). Participants preferred a range of pronouns (e.g., she/her, they/them) and identified with varying sexual orientations (e.g., bisexual, gay, lesbian, queer) and gender identities (e.g., nonbinary, female, cis-male).

Analysis identified a number of discourses related to the research aim discussed under the following headings: 'normativity', 'stress and labor' and 'constrained ideas of professionalism'. The concepts were overlapping and interrelated but are presented separately below for clarity of discussion. Pseudonyms are used for confidentiality.

1: 'Turning my light down' in physical therapy discourses of normativity

Discourses of '*normativity*' were pervasive and underpinned much of what participating physical therapists discussed, highlighting that physical therapy marginalizes difference. These discourses commonly included *heteronormative* assumptions about sexual orientation; *cisnormative* assumptions about gender; and *intersectionality*, which involved interactions between sexual orientation and/or gender and other forms of marginalization such as race, religion and culture.

Heteronormativity (see Appendix for a glossary of terms) narratives underpin almost all participants' interviews about their experiences of being LGBTQIA+ in physical therapy. As a result, sexualities other than heterosexual are frequently positioned as invisible and outside of what is expected by society. For example, participants describe common workplace discussions with colleagues or patients about intimate relationships, families and children: "*The way people talk about their wives, their kids, and ski trips they go on and all these very typical heterosexual based activities and lifestyle...*" (Frankie). Here, Frankie perceives that colleagues who are heterosexual often have conversations easily and without fear of judgement/discrimination and relates this to his own discomfort, as do other participants. Kamala's narrative indicates a different experience of invisibility. She discusses how her colleagues assume that she is heterosexual because she is married to a man. She states that in some ways this shields her from judgement/discrimination: "I am aware of what privilege I have, in a way, and not everybody [who is LGBTQIA+] has that." In recalling these moments, Kamala, Frankie and other participants talk about deciding either to 'come out' or to hide part or all their sexual orientation and the potential negative (and sometimes positive) consequences of both.

Many participants discussed feeling the need to hide their sexual orientation in professional contexts. For example, Charlie said:

It was [difficult]. But it didn't seem to be difficult at the time, you just kept your mouth shut ... and whenever I needed to [make it appear that I was heterosexual], I could always say, "Oh, well my kids." Blah, blah, blah. Or, "My husband." That immediately puts out any fire or flames, or anything that people maybe think might be there, that knocks that on the head, and they go, "Oh, okay, good, you're okay then." ... I was going to cop [take] it. If I didn't cop it for being gay, I was going to cop it for doing it to the kids.

Like many other participants, Charlie's story indicates that being non-heterosexual is positioned in physical therapy as outside of the norm. As a result, Charlie describes taking quite extreme measures to hide her relationships with women. Although participants responded in different ways to this positioning, almost all participants describe commonly feeling the need to conceal their sexual orientation, or aspects of it, amongst colleagues. Some participant stories detail negative feelings associated with heterosexual assumptions of the workplace (eg, feeling excluded, shame, frustration, anger), whereas others describe a 'passing privilege,' which at times offered them safety, albeit fragile. These discourses also relate to how the participants navigate their personal/professional identity and this will be discussed further in the professionalism discourse later.

Heteronormativity also underpinned participant narratives about their relationships with their patients. For example, John describes how he deflected questions to hide his sexual orientation. When patients ask questions such as: "Do you have a girlfriend?" John mentions, at times, he has responded "No, I don't have a girlfriend." Initially, John "wouldn't elaborate" describing the situation as "...quite a vulnerable spot to be in, to not know if you're going to receive some judgement or negative response to finding out your sexuality."

Although participants had quite different stories about this, with some hiding their sexual orientation, and others being open about it, all were shaped by discourses of heteronormativity. This pressure to conform is acutely evident in stories related to its inhibiting effects on developing therapeutic alliances. Participant Rahul uses the metaphor "turn[ing] my light down" to describe the impact of hiding his sexual orientation and other marginalized characteristics to fit into constrained ideas of professional norms in physical

therapy. Participant disclosure of sexual orientation, when it occurred, was enabled by specific contexts (eg, HIV rehabilitation) or after developing trust over a series of interactions. Participants described a variety of ways in which they were open about their sexual orientation: by starting to correct people when they made mistakes, by making time to 'come out' in one-on-one discussions with colleagues they trusted and by bringing up their sexual orientation from the very start of their employment.

Cisnormativity was also pervasive in the narratives, despite participants suggesting that certain deviations from broader societal norms (e.g., 'sporty' appearance for women) are positioned as acceptable/encouraged in physical therapy. Deviations from binary gender norms were often discouraged, ridiculed and/or considered unprofessional. For example, Andrew, who identifies as nonbinary, discusses feeling pressure to fit the category of 'man' at two workplaces - see Figure 1.

Andrew's stories highlight how cisnormativity is overriding. Even at what Andrew describes as a more progressive workplace, Andrew discussed how they are positioned by their manager as transgressing acceptable binary gender expressions. They are 'allowed' to express their gender identity, but their manager resists and/or mocks them (e.g., eye rolling, making jokes). Andrew is not entirely safe in that workplace either, needing to take a cautious 'graded' approach to express their gender.

Participants describe professional situations in which they have been disrespected or misgendered by peers or others who lack knowledge about trans or nonbinary gender. For example, Ellie discusses the change they felt in their colleagues' perception of them when pregnant "people gender me even more femininely than they used to [leading to] dealing with people's gender assumptions about me as a result and the language that they use about pregnant people." However inadvertent, this treatment is discriminatory as it denies the gender that Ellie had explicitly clarified at their workplace.

Many participants clearly describe the physical therapy profession as having cis-normative tropes. Frankie echoes other participants when he shares a story about the musculoskeletal sub-disciplines (including sports and orthopedics) that he perceives as particularly cis-normative:

The people that I saw doing outpatient orthopedics were mostly cisgender heterosexual males, often the frat president or varsity athlete type... and I did not see myself as that person... it felt like you had to be of that world to connect into that world...

Frankie eventually became a leader in orthopedics but expressed frustration that the normative pressures in the profession prevented him from entering the field earlier.

Intersectionality: This study focused on physical therapists' LGBTQIA+ identities, but importantly we observed *intersections* between cis/hetero-normativity and normative assumptions about other factors, notably race, ethnicity, religion, and mental health. The impact of being marginalized for more than one factor affected the experience of being LGBTQIA+ in physical therapy and often compounded experiences of marginalization. For example, in Figure 2, Rahul discusses their experiences as a non-white, non-European person studying physical therapy, describing it as a lonely and scary time.

Similarly, Samira says *"it's not the most common thing to get a Muslim woman who wears a headscarf, who's a lesbian, who's also a physiotherapist. These things don't tend to work well together."* Both Rahul and Samira shape their stories and physical therapy identities within discourses of whiteness alongside cis-/hetero-normativity. These are compounded by what is seen as the professions' lack of diversity across multiple domains.

Counter-discourses: In contrast to the discussion about normativity, some participants discuss the positive difference it makes when they are supported and celebrated for their identities in their work environments. This occurred when the workplace countered normativity discourses. For example, when physical therapists were inclusive in their language or vocal in their support for their colleagues who are LGBTQIA+. Andrew describes how it felt to be supported to express their gender identity at his more progressive workplace (Fig. 3).

2: 'Doing the safety math' in discourses of stress and labor

Narratives were produced around discourses of the *stress* and *labor* of constructing LGBTQIA+ identities in physical therapy.

Stress: Discourses of *stress* were evident in all stories often related to a multi-level lack of safety, including fearing discrimination for expressing sexual orientation or gender identity, ongoing challenges of repeatedly coming out (or not) in cis/hetero-normative environments, and the effects of these stressors on people's health. Many participants discuss stressful experiences of discrimination, or fear of discrimination. For example, Mary shares her early experiences amongst colleagues; "I was completely closeted and terrified that my physio classmates would find out because a number of them were assholes, and made really homophobic comments ..." Sophia describes years of explicit and implicit homophobic bullying, discrimination and emotional manipulation by her workplace supervisor (in a university setting) directly related to her sexual orientation. This discrimination has had enduring effects on her career and mental health and resulted in her leaving the position at considerable cost to her and her family. These incidents were not limited to a distant past, with many participants describing recent experiences of discriminatory off-hand remarks, inappropriate jokes, inquisitive and unnecessary questions and comments. For example, Yasmine states that her (most recent) employer was "...not openly homophobic, but just that really sort of casual jokes that they'd make that made it a bit more uncomfortable to deal with them and say anything in defense." Due to a fear of judgement, Samira describes recent experiences of coming out in her current workplace as "horrible ... this feeling in the pit of my stomach, like a sick sensation. I'd get clammy. I'd feel really hot, like that feeling before you're about to faint or something..."

The pressure to conform to cis-/hetero- normative physical therapy environment often positions participants in dilemmas of 'choice' (often spanning many years, colleagues, workplaces and patients) about disclosing (or not) their gender identity or sexual identity. Participants indicate that neither option is without stress. Being open about LGBTQIA+ identity places people at risk of feeling 'different' or 'odd' and potentially facing discrimination. On the other hand, not 'coming out', positions people as devious/inauthentic and they experience ongoing fear about potential 'discovery'. Having to make this choice results in considerable inner conflict for participants. Participant Ellie calls it "doing the safety math". They describe how these "*social calculations*" affect their

capacity to work as a physical therapist on a daily basis by consuming cognitive and emotional energy. Even if participants are “out” to some or all of the people in their work environment, there are often parts of their LGBTQIA+ lives that are important to them they do not feel are acceptable to discuss at work.

Some participants describe the serious and enduring impact these stressors have on their mental health. For example, Nathan describes feeling:

“...so split... In terms of different me’s... and who I could present them to. This [feeling] still has a residue of that sort of shame that I was carrying around for a long period of time. I think it has still fed into, and it is part of my probably ongoing depression and anxiety that I still have.”

Ellie discusses the work-related pressures of being LGBTQIA+ in the cis-/hetero- normative environment of their physical therapy workplace and their potential to impact physical therapists’ lives and livelihoods: *“...from lack of sleep or from lack of mental space, from lack of emotional energy, all that kind of thing takes a toll. If you have mental health stressors that are triggered by the workplace, then your work becomes significantly harder.”*

Labor: Related to stress were discourses of *labor*: emotional and other work that had to be done by physical therapists who are LGBTQIA+ to make their work environment safe and/or tolerable for themselves. This work included efforts to hide elements of one’s sexual orientation or gender, efforts to educate colleagues or patients, and expectations of being a ‘diversity’ role model or representative. For example, Andrew’s gradual introduction of different hair colors in the workplace (Fig. 1) illustrates how they have to navigate/moderate their own or others’ emotions to reveal aspects of their LGBTQIA+ identity. Similarly, Mary discusses the exhaustion she felt being closeted during her physical therapy career in the USA: “it was too bloody much work and it sucked...I don’t like hiding...[in the end] I just wasn’t prepared to hide anymore because it was a lot of work...”

These stories demonstrate the considerable labor involved in hiding sexual orientation and gender identity, and the risks of disclosure.

A different element of the *labor* that participants discuss is the emotional effort and time it takes to provide education for or support marginalized colleagues and patients. In Figure 4, Ellie describes a lack of workplace awareness about how exhausting it is for her to

continually educate people about gender identity and Margaret discusses her experiences educating patients.

These types of discussion involve risk, emotional labor, complex communication skills and time. The narratives describe the overwhelming burden of stress and labor of being LGBTQIA+ in physical therapy and highlight the cumulative and layered effect and the complexity of navigating professional demands of physical therapy and sexual orientation/gender identity. As Ellie says, this labor contributes to 'burn out' because it is on top of the emotional energy already required to be a physical therapist:

Physiotherapy as a profession takes a significant amount of brain power and emotional energy. And that's why I like the profession, but I can't do it to the extent I want in the environment that I'm in with the identity that I have.

3: 'The physio me, and the rest of me' in discourses of professionalism

Many narratives were constructed around discourses of "professionalism" in the context of physical therapy. The apparent accepted default of professionalism in physical therapy included norms that are cis-/hetero-normative (eg, wearing stereotypically masculine/feminine clothes, being married) and also related to other norms such as white and middle-class norms (eg, constrained mannerisms, constrained patterns of speech). This meant that many aspects of being LGBTQIA+ (and, although largely beyond the scope of this paper, other marginalized characteristics such as "blackness") are seen as deviant/strange/other in contrast to the default professional and led some participants to be positioned as unprofessional. Many participants spoke about how their attempts to be "professional", using this narrow definition, meant that they had to separate their personal life from their professional life in ways in which physical therapists who are non-LGBTQIA+ do not. Mary put it this way: "...the only way to navigate physio school was to just have that separate box, that this was the physio me, and the rest of me lived outside of the box." The extent to which people who are LGBTQIA+ felt they had to 'tone down' or hide parts of themselves was described to be much more than their cis-/hetero-normative colleagues.

To be considered professional in physical therapy, people who are LGBTQIA+ often felt like that had to hide core parts of themselves. This reduction in authenticity resulted in physical therapists who are LGBTQIA+ 'dulling down' (Fig. 2) their presence at work when relating to

both colleagues and patients. More superficial engagement and interactions with others were described as less enjoyable, relevant and interesting. For example, Troy describes the lack of diversity in his workplace making “...things a little less relatable in the lunchrooms... when you can’t really relate to your peers and co-workers on that deep level.” Gina also describes the conflict between disclosing the complex and rich relationships within her non-nuclear LGBTQIA+ family and being professional. For example, she shares that she sometimes thought it might be helpful to make her LGBTQIA+ status known to her patients but was unsure whether this is overstepping professional boundaries. For example, she says “...I wanted to talk about my life so [my patient and her same sex partner] knew that they weren’t really ... in the minority, in that conversation.”

Professionalism plays out differently in sub-disciplines of physical therapy. As mentioned above, Frankie responded to cis-normative discourses in the profession by excluding himself from the musculoskeletal sub-disciplines for many years. Another participant also describes self-exclusion from working in pelvic health due to fearing judgment for being ‘inappropriate’ (unprofessional) for a physical therapist to be same-sex attracted and working in this field. The narrow positioning of what professionalism means in physical therapy created a disconnect between physical therapists who are LGBTQIA+ wanting to be their ‘authentic selves’ but knowing that this might come at the cost of being considered ‘unprofessional’.

Most of the discourses of professionalism were implicit in the interviews, however, in Figure 5, Andrew directly discusses the issue.

Positioning LGBTQIA+ characteristics and lifestyles as ‘unprofessional’ affects participants considerably. These narratives describe situations where the participants’ appearance, behaviors, social media profiles, and conversations about life outside work were judged by colleagues and patients through the lens of ‘professionalism’. Discourses of professionalism were largely conservative or constrained and limited diverse aspects of being LGBTQIA+ in physical therapy.

When participating physical therapists could bring their diverse characteristics into the workplace, they could connect better with patients, and foster supportive and inclusive workplaces for others, including students, patients and colleagues. Emma said “...when I talk to students, I bring that up too. Being your whole self in a space, it always empowers other

people, even if you don't know or expect that." Similarly, John describes how visible acceptance of other 'out' classmates and colleagues made him feel safe and confident to come out in both university and at his workplace.

[H1] Discussion

The key findings of our analysis of interviews with physical therapists who identify as LGBTQIA+ were: persistent cis-/hetero-normativity in the profession; evidence of the stress and labor participating physical therapists experienced related to this normativity; and critique of the current framing of 'professionalism' in the discipline. These findings suggest a pervasive normativity relating to sexual orientation and gender identity in physical therapy, frequently intersecting with other factors such as race and ethnicity. Heteronormativity and experiences of discrimination reflect the research in other health and social care professions,^{27,28} and demonstrates the hegemonic persistence, despite obligations on all public facing professions, for inclusion.

The findings of this study align with a recent study exploring the physical therapy experiences of Australian patients who identify as LGBTQIA,²⁶ suggesting that 'heterosexuality and gender normativity are woven into physical therapy'. In order to welcome a more diverse spectrum of people into the profession and enhance comfort in the profession, both studies suggest a need for physical therapy to reflect on its cultural norms and create opportunities for more inclusive, equitable and just practices. This reflexive focus is aligned with contemporary understandings of cultural safety,³⁸ which argue for a shift of focus from those who are marginalized to those who are in the mainstream.³⁹ This can be enacted by greater institutional inclusion of cultural safety training by trained educators.⁴⁰ Further, individual physical therapists can use inclusive practices such as asking about and using people's preferred pronouns,^{41 42} using gender-neutral language and active/visible participation in and support of LGBTQIA+ related events such as Pride and Mardi Gras.

Linked to normativity, our findings also indicate that physical therapists who identify as LGBTQIA+ experience considerable stress related to the pressure to conform, or to experiences of direct or indirect discrimination. This experience was coupled with additional labor required to manage the stress, and also to educate colleagues and workplaces. Although these are novel findings in physical therapy contexts, understandings of stress and labor for minority groups, including LGBTQIA+ communities are not new elsewhere.

'Minority stress' is known to have a large impact on people's lives⁴³ and health⁴⁴ but can be reduced with signals of safety such as inclusive language, visible diversity recruitment policies and impact, and role models.⁴⁵ These examples provide strategies for physical therapists wishing to be LGBTQIA+ allies to demonstrate and share the burden of responsibility for promoting equitable and inclusive practices.^{46 47}

Examining the experiences of physical therapists who identify as LGBTQIA+ raises issues about what is considered to be professional (and what is not). Our findings suggest that professionalism in physical therapy is based on ideas drawn from white, Western and cis-/hetero-normative patterns of behavior and self-expression. Building on other work discussing the narrow constraints of physical therapy's self-conceptualization in terms of focus^{2 48 49} and identity,^{6 7 50} our analysis highlighted how participants often explicitly or implicitly challenged this idea by suggesting the profession could embrace a broader range of self-expressions and characteristics as 'professional'. This shift could include professional regulatory bodies, physical therapy member organizations, and individuals reviewing policy documentation, working together to start to disrupt the narrow conceptualizations of professionalism, and visibly celebrate diversity. This approach could be the first step to promote equity and social justice as well as enhance the experience of the profession for physical therapists, patients and students alike.⁵¹ Physical therapy educators responsible for pre- and post-qualifying education are encouraged to review the diversity of learners and capitalize on their experience to shape a more inclusive curriculum. This study prompts future research exploring the notion of professionalism in physical therapy and effective models of inclusive education.

[H2] *Methodological Considerations*

The researchers' varied experiences/interpretations as physical therapists with a range of LGBTQIA+ identities and international contexts will have impacted study results, and conclusions. They have been informed by a variety of cultures and LGBTQIA+ and physical therapy perspectives. Further, although study participants demonstrated a range of characteristics including LGBTQIA+ identities, years in the profession and professional specialty, our findings were created in a particular context and will not be relevant to all physical therapists. For example, eight of our 22 participants were non-white, yet all were employed in wealthy Western countries with relatively progressive social practices and laws

relating to being LGBTQIA+. As a result, the study is unable to account for discourses in physical therapy contexts outside of these settings. However, our intersectional approach may allow readers from a variety of international and identity experiences to draw their own parallels. Some participants were known to the researchers in a professional or social context; the possible implications of this were that participants may have felt safer to share some details, and perhaps would omit others. The researchers were aware of the possibility of this influence and sought to minimise it during analytic discussions by highlighting possible assumptions and preconceptions.

[H2] *Conclusion*

Overall, our research suggests that gender identity and sexual orientation need to be reconceptualized in the physical therapy community to promote inclusion and belonging of individuals who identify as LGBTQIA+. How might this cultural shift be undertaken? A multipronged approach is likely to be the most effective and could include factors such as individual and institutional reflexivity, learning and implementing appropriate terminology (eg, gender neutral language, pronoun choices), support from professional organizations and associations (eg, presence in Pride marches, modelling LGBTQIA+ inclusivity), showing indicators of inclusivity (eg, diversity flags) and undertaking cultural safety training.

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Ethics Approval

Ethics approval was granted by the University of Queensland Human Research Ethics Committee. Participants provided formal written and verbal consent prior to the interview.

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TABLE 1: Participant Characteristics

ID	Pseudonym	Age, y	Sexual Orientation ^a	Gender Identity ^a	Preferred Pronouns
1	Beth	42	Gay	Female	She/her
2	Charlie	60	Gay	Female	She/her/ they/them
3	Danielle	54	No label	Female	She/her
4	Samira	28	Lesbian	Female	She/her
5	Harry	45	Gay	Male	He/him
6	Rahul	41	Gay	Male	He/she/it/they
7	Nathan	47	Gay male	Male	He/him
8	Zhang	42	Gay	Male	He/him
9	Andrew	35	Not heterosexual	Nonbinary	They/he
10	Troy	32	Gay	Male	He/him
11	Jodie	53	Lesbian	Female	She/her
12	Gina	30	Pansexual	Female (cis)	She/her
13	Margaret	26	Gay	Female	She/her
14	Sophia	49	Queer	Nonbinary	She/her
15	Emma	37	Queer	Cis gender female	She/her
16	Frankie	59	Gay	Cis male	He/him
17	Kamala	49	Bisexual	Female	She/her
18	Ellie	32	Gay	Nonbinary	They/them
19	Mary	50	Lesbian	Lesbian-Faggot	S/He
20	John	26	Gay	Male	He/him
21	Juliana	31	Bisexual	Female	She/her
22	Yasmine	24	Gay/Lesbian	Cis-female/questioning	She/her

^aSexual orientation and gender identity are reproduced exactly as participant's self-described

TABLE 2: Participant Demographics (n= 22)^a

Years Qualified, Median (Range)	18 (1.5 to 40)
Country	
<i>United Kingdom</i>	8 (36)
<i>Australia</i>	7 (32)
<i>United State of America</i>	4 (18)
<i>Canada</i>	3 (14)
Relationship status	
<i>Married</i>	11 (50)
<i>In a relationship</i>	4 (18)
<i>Single</i>	3 (14)
<i>In a relationship, monogamous</i>	2 (9)
<i>In a relationship, non-monogamous</i>	1 (5)
<i>Engaged</i>	1 (5)
Highest level of education	
<i>Masters</i>	8 (36)
<i>PhD</i>	6 (27)
<i>Undergraduate</i>	5 (23)
<i>Doctor of Physical Therapy</i>	2 (9)
<i>Diploma</i>	1 (5)
Primary location of practice	
<i>Hospital</i>	8 (36)
<i>University</i>	7 (32)
<i>Private Practice</i>	5 (23)
<i>Consulting</i>	1 (5)
<i>Community</i>	1 (5)
Sub-discipline	
<i>Musculoskeletal</i>	4 (18)
<i>Musculoskeletal/sports</i>	4 (18)
<i>Neurological rehabilitation</i>	3 (14)
<i>Education</i>	2 (9)
<i>Cardiorespiratory</i>	2 (9)
<i>Rotational</i>	1 (5)
<i>Acute care</i>	1 (5)
<i>HIV/Infectious diseases</i>	1 (5)
<i>Paediatrics</i>	1 (5)
<i>Vestibular</i>	1 (5)
<i>Geriatrics</i>	1 (5)
<i>Pelvic health</i>	1 (5)

^aData are Presented as n (%) Unless Otherwise Specified.

[At a faith-based hospital] they have a uniform policy... So you couldn't wear earrings. Like men couldn't wear earrings. But then I'm like, 'but I'm not a man'. And then you could only have natural hair colour. But somehow for women natural included everything from blonde to brown dah, dah, dah. But for me, if I had my hair blonde that was considered an unnatural colour, and it's actually literally the same box of blonde that one my colleagues [a cis woman] is using ...[At a more progressive hospital] I had a manager who was a straight, white, cis-gender man who I think found a lot of things about me confronting ... And so I tried like a graded approach with him that we started off with just like a blonde and then we did a grey, like a gunmetal grey...and then it would be a little bit of a mauve tint to it, and then it would be purple ... And he would roll his eyes and say, what colour this time Andrew? It just became a bit of a joke, but the ultimate kind of culmination of this was [me] pushing this and seeing what I could get away with - the hair getting brighter, queerer, the earrings getting longer and danglier.

FIGURE 1: Andrew discusses feeling pressure to fit the category of 'man' at two workplaces.

...I had no one to identify with, talk to. There was no representation. So I was just alone... No one to talk to, no nothing... Just no representation like we see in the world now. No pride parade, no nothing, especially [as a non-white person coming from a country with an historically racist regime]... I have internalised racism. Then I have laid on to that internalised homophobia....Show me an article in [a national physiotherapy news forum] of a non-white gay person in the last decade. Show me someone in power, in any position in [a physiotherapy organisation] who has been talked about who is a person of colour or is LGBTI.

FIGURE 2: Rahul discusses experiences experiencing intersecting marginalization in the profession.



...it had been my dream to rock up to work in drag. And so, for the launch of [an internal program at the hospital], I came with a big purple two-tone blown out wig and tights and high heels. ... I'm just glad that I'm in a position in my career and stuff where I can do something like this and it can be received warmly. And I can actually have the support of management and my colleagues and people are getting kind of behind it ... this is a fun way to, I think, integrate some of stuff that I'm interested in and whatever into a workplace environment that sometimes it gets a bit stuffy. It was incredible. It was great. There are videos of me and my manager because he's like, "I've got to get a photo with you." That was probably the first time maybe that he had got to like, I don't know, see a queer person doing their thing. I'm like, "this is what we do"! I look great in heels.

FIGURE 3: Andrew describes how it feels to be supported in the workplace.

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Educating colleagues (Ellie):

[Colleagues] didn't get the societal stressors and the environmental, social stressors, and how much energy it took to just explain to people and field people's inappropriate and curious questions about things that shouldn't matter to them. There were many times at the beginning where I was doing that education until I learned that it was not my job, and I didn't have to do that, and that takes too much energy.

Educating patients (Margaret):

I can maintain my professionalism but also on a personal level, promote the change in society and promote the openness and the thoughts of the LGBTQ+ community. That's what I try to do in my interactions is stay professional and neutral but also be a member of society that can help change people's thinking and plant those seeds of potential change, and some of them grow and you have multiple conversations with patients and some of them don't.

FIGURE 4: Ellie describes exhaustion continually educating colleagues about gender identity and Margaret describes her experience educating patients.

In a new department or something, that wasn't something that I came out with first, like, "Hey, I'm Andrew and I'm a big queer and I've got like this poly[amorous] relationship." ... it is kind of vulnerable in a way and it's definitely burned me before where people maybe added me on social media and then saw stuff and then people are like 'oh that's not professional' and stuff. And I'm like, 'that's my private life and you don't need to follow me on social media, you can unfollow me that's fine'. But I guess that kind of idea about what's 'professional' ... I think a lot of that stuff is kind of open to interpretation ... And I guess when people have an issue with [my sexual orientation or gender] or find that it somehow has any bearing on my abilities as a physiotherapist, I find that bizarre. [I then think] 'clearly that's something you need to unpack but that's on you, not on me'.

FIGURE 5: Andrew discusses the issue of professionalism in their workplace.

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