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“The doctor said I didn’t look gay”: Young adults’ experiences of disclosure and non-disclosure of LGBTQ identity to healthcare providers

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Abstract

Shifting cultural attitudes and legislation have increased focus on the healthcare needs of lesbian, gay, bisexual, transgender, and queer (LGBTQ) patients. However, patient non-disclosure of LGBTQ identity creates a barrier to accessing care. This study examined a diverse sample of LGBTQ young adults and their experiences of disclosure and non-disclosure to medical providers. Participants (N = 206, age range 18–27) completed questionnaires assessing healthcare access and use as part of a larger study. Participants’ responses to open-ended items asking about experiences of LGBTQ identity disclosure to medical providers and reasons for non-disclosure were analyzed thematically. Results revealed intra- and interpersonal factors related to patient disclosure. Reasons for participant non-disclosure included providers not asking about identity, internalized stigma, and belief that health and LGBTQ identity are not related. When participants did disclose, they experienced reactions ranging from discrimination and disbelief to affirmation and respect. Findings confirm and extend previous research on young adults’ identity disclosure and provide avenues continuing education for health professionals working with LGBTQ patients.

Keywords

LGBTQ; Disclosure; Health Communication; Delivery of Health Care; Healthcare Disparities; Social Discrimination

The transition from pediatric to adult healthcare in the United States is associated with poorer health outcomes for young adults (Stroud, Walker, Davis, & Irwin, 2015). As compared to adolescents and older adults, young adults have less access to care, participate in more risk-taking behaviors (Irwin, 2010; Neinstein & Irwin, 2013), experience higher rates of substance use/abuse, and are at increased risk for serious mental health issues and sexually transmitted infections (STIs) (Stroud, et al., 2015). Similar negative health outcomes are seen in lesbian, gay, bisexual, transgender and queer (LGBTQ¹) populations, with LGB individuals being at even higher risk for certain STIs like HIV/AIDS (Wolitsky,

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Stall, & Valdiserri, 2008) and behavioral risk factors such as smoking, alcohol, and substance use (Ward et al., 2014) than their heterosexual counterparts. Moreover, LGBTQ individuals report higher rates of depression, anxiety disorders, suicidality, and suicide attempts (Eliason & Schope, 2001; Mayer et al., 2008; Lehavot & Simoni, 2011; Reisner, White, Bradford, & Mimiaga, 2014) relative to heterosexual and cisgender people. For LGBTQ young adults, their developmental stage and sexual and/or gender identities converge to create a nexus of risk factors and negative health outcomes that augment the health disparities seen in this population (Strutz, Herring, & Halpern, 2015).

Increasing knowledge and improving provider-patient interactions is essential to decreasing LGBTQ young adults' health disparities and allowing for creation of targeted interventions that address their unique health needs. Yet, despite the health risks and challenges impacting LGBTQ young adults, little is known about their healthcare experiences for several reasons. First, the terms adult and youth are not clearly defined in the literature and young adults are often subsumed within either youth or adult samples, thus rendering their experiences invisible. In addition, healthcare services sensitive to the needs of LGBTQ young adults requires patients' willingness to disclose their sexual and/or gender identities. To increase the knowledge base on young adult LGBTQ individuals and begin to address the myriad of health disparities they face, the present study examined reasons for LGBTQ young adults' nondisclosure of identity to medical providers, as well as experiences with providers following identity disclosure.

Nondisclosure of LGBTQ identity in healthcare

Nondisclosure of LGBTQ identity to medical providers is not uncommon, with over a third of LGB adults avoiding disclosure (Eliason & Schope, 2001; Bernstein et al., 2008; Durso & Meyer, 2013). However, the literature on disclosure has focused on gay and lesbian adults, obscuring the experiences of other identities and age groups. This omission is problematic given that rates of nondisclosure are higher among younger LGBTQ individuals and those who identify as bisexual, queer, or transgender (Grant et al., 2011; Meckler et al., 2006) – groups who are at elevated risk for adverse health outcomes relative to gay and lesbian adults. For example, one study on LGBTQ adolescents found that only 35% of the respondents had disclosed their identity to their health care provider, with bisexual youth disclosing at lower rates (Meckler, et al., 2006). Few studies have sought to understand the disclosure experiences of young adults specifically. A better understanding of young adults' reasons for nondisclosure is needed to create a more holistic picture of LGBTQ patients' experiences within healthcare systems.

Healthcare and Patient Factors Influencing Disclosure

Studies of healthcare experiences among LGBTQ adults can provide context to understand some of the barriers to disclosure for younger adults. LGBTQ patients report alarming rates of identity-based discrimination in healthcare settings, with 10% of LGB and 21% of

¹LGBTQ will be used to collectively refer to all gender and sexual minority populations. Other acronyms (e.g., LGB) are used to reflect the specific subpopulations in a given study or set of studies.

transgender patients experiencing harsh or abusive language (Lambda Legal, 2010) and 8% of LGB patients and 27% of transgender patients having been refused care (Lambda Legal, 2010). Such concerns are a reason patients choose to not disclose their identities to their healthcare providers (Boehmer & Case, 2004; Stein & Bonuck, 2001). Even if patients do not experience overt discrimination, they may experience non-affirming care. For example, healthcare professionals may assume patients are heterosexual (Beehler, 2001; Utamsingh, Richman, Martin, Lattanner, & Chaikind, 2016) or address health from a heteronormative perspective (Johnson & Nemeth, 2014; Eliason & Schope, 2001). These experiences can create an unwelcoming environment for LGBTQ patients (Beehler, 2001) and result in a decreased likelihood of seeking care in the future (Johnson & Nemeth, 2014).

In addition, intrapersonal factors have been shown to influence disclosure, such as patients' feelings that sexual orientation is a private matter, belief that identity is not related to health concerns, and patients' negative internalized feelings about identities (Boehmer & Case, 2004; St. Pierre, 2012; Stein & Bonuck, 2001). Intrapersonal factors impacting disclosure may be especially pertinent among young adults, who may still be navigating and defining their identities, and may be more selective about whom to disclose. Additionally, sociodemographic characteristics of the patient, such as race and income, have been associated with non-disclosure among men who have sex with men, with African American and/or low-income individuals being less likely to disclose their sexual orientation to providers (Petroll & Mosack, 2011). These findings suggest that rates of disclosure may be vary, not only between different identity groups within the LGBTQ spectrum, but also based on racial/ethnic identity and socio-economic status.

Qualitative inquiry into LGBTQ identity disclosure has found that it is a complex process for patients in which they weigh the benefits of disclosure with the possible negative consequences (Beehler, 2001; Hitchcock and Wilson, 1992; St. Pierre, 2012). For youth, the process of disclosing to healthcare providers can be as challenging as disclosing to friends and family (Law, Mathai, Veinot, Webster, & Mylopoulos, 2015). While multiple qualitative studies have examined experiences of disclosure for LGBTQ populations (Beehler, 2001; Hitchcock & Wilson; 1992; Law et al., 2015; Rounds, Burns, Mcgrath, & Walsh, 2013), few have focused specifically on the disclosure experiences of young adults.

Current study

LGBTQ young adults are vulnerable to a variety of negative health outcomes, and understanding their experiences with identity disclosure and nondisclosure with medical providers is a much-needed step toward improving their health and well-being. One of the goals of the present study was to utilize qualitative analysis to understand patient reasons for non-disclosure to healthcare providers. Additionally, while the literature on disclosure contains multiple qualitative studies focused on lesbian and bisexual women and gay men, there exist notable gaps in understanding how other individuals within the LGBTQ population experience the disclosure process. As such, this study also sought to validate and expand on past findings about young adult identity disclosure to medical providers (i.e., Johnson & Nemeth, 2014) among a racially diverse community sample of LGBTQ young adults.

Method

Participants

The sample for this study was drawn from a larger longitudinal study (Mustanski, Garofalo, & Emerson, 2010) examining the health and development of a community sample of LGBTQ youth and young adults in a large, urban setting. Inclusion criteria included being between the ages of 13 and 24 years old at baseline and either identifying as LGBT or questioning one's sexual identity. Most of the sample (74%; $n=153$) lived in the city of Chicago.

Participants were recruited through incentivized snowball sampling and community outreach. All study procedures were approved by the university's Institutional Review Board. The analytic sample consisted of 206 participants who participated in the 48-month follow-up assessment conducted from June 2012 to March 2013. The study was conducted in-person at a large LGBTQ community center where participants completed computer-based assessments and semistructured interviews; participants were compensated \$30 for each study visit.

At the 48-month follow-up, participants were between 18–27 years old ($M = 23.0$, $SD = 1.6$ years) and over half (60%; $n=123$) had completed one year of college or more. A majority of participants identified as racial or ethnic minorities (83%) and 61% identified as gay/lesbian (Table 1). When provided the opportunity to write in additional sexual identity label(s) with which they identified, participants listed a variety of terms, such as asexual, fierce, homoflexible, pansexual, same gender loving, open, and trysexual. In terms of gender identity, 54% ($n=112$) identified as female and 39% ($n=80$) identified as male. Four percent of the sample ($n=9$) identified as transwomen (MtF) and 1% ($n=2$) identified as transmen (FtM). Three participants chose not to provide a response. When asked if there were better terms to describe their gender identity, 20 participants provided responses including androgynous, femme, genderqueer, goddess, "I can be a girl and I can be a boy, I can do both," queer, stud, and transgender.

Measures

As part of a larger measure of healthcare access and experiences (Macapagal, Bhatia, & Greene, 2016), participants were asked whether or not they had disclosed their LGBTQ identity to their healthcare providers. If participants did not disclose, they were asked the following open-ended question: "Please describe why you have not told a doctor or other medical professional about your sexual orientation or gender expression." If participants had disclosed, they were asked the following open-ended question, "Please describe the reactions of the doctor(s) or other medical professional(s) you have told about your sexual orientation or gender expression." These questions allowed participants to reflect and provide their perspectives on their experiences on disclosing and not disclosing their identities when seeking healthcare.

Analysis

All participants' responses to the open-ended items were thematically analyzed (Miles & Huberman, 1994) using an essentialist epistemological stance (Braun & Clark, 2006). During the initial phase of coding, the first author (a White, queer, non-binary psychologist) read all responses and each unique idea was condensed into a short statement (i.e., code). Following this process, different analytical approaches to the data on disclosure and non-disclosure were employed.

Given the lack of current theoretical frameworks related to non-disclosure of LGBTQ identity to healthcare providers, data from participants who did not disclose their identity was inductively coded to identify themes and subthemes about reasons for non-disclosure. The inductive coding process allows for a "bottom up" creation of themes based on what is presented in the data, as opposed to applying theoretical content to the data (Braun & Clark, 2006). For the non-disclosure data, codes were examined and, through a process of constant comparison, were placed into higher order categories. Following this, thematic coding was conducted, in which higher order categories were examined for similarity and grouped to create unifying themes that described the patient experiences of non-disclosure. Three themes and seven subthemes were discovered that reflected reasons participants did not disclose their LGBTQ identity to healthcare providers (Table 3).

Data from participants who did disclose their LGBTQ identity to healthcare providers was deductively coded using Johnson & Nemeth's (2014) conceptual model on young lesbian and bisexual women's experiences of identity disclosure in the healthcare setting. Deductive coding based on Johnson and Nemeth's model allowed for evaluation of the model with a more diverse population and provided additional methodological rigor for the analysis. Johnson and Nemeth conceptualized healthcare interactions for young adults in three separate phases; Pre-Interaction, which included patients' seeking healthcare and their expectations of providers; Healthcare Interaction, which included patient disclosure of identity and provider reactions to disclosure; and Outcome, which included health outcomes and proximal outcomes. For the purposes of the analyses, only the part of the model involving providers' responses following identity disclosure (i.e., Healthcare Interaction) was used. Within the Healthcare Interaction phase, healthcare providers' reactions to disclosure were reflected in three main themes: *Knowledge* (i.e., providers' understanding/lack of understanding of patients' sexual health concerns), *Communication* (i.e., providers' ability to communicate their level of comfort with identity disclosure) and *Attitude* (i.e., providers acting respectful, understanding, accepting, or disrespectful).

Following the creation of codes for disclosure data, Johnson & Nemeth's model was used as a framework for the coding of higher order categories and themes. When codes did not fit within the model, new higher order categories and themes were created. Following the deductive coding process, eleven new subthemes and one new theme were created for data that did not fit into the existing model (Table 4). Such an expansion of the model was expected, given the broader sample of LGBTQ identities present in the current sample.

At each step of the analytic process, the data was subject to an audit by the third author. The auditor evaluated the codes for clarity and consistency and provided feedback to the first author. The auditor's feedback was incorporated into each subsequent step of the analysis.

Results

Regarding health status, healthcare access, and healthcare utilization, 68% of participants reported having had a medical checkup in the last year; 8% of the sample indicated that they were HIV positive. Forty-three percent of participants did not have health insurance and 26% did not have a specific location where they sought care. Of the 206 participants, 63% (n= 130) of participants indicated that they had disclosed their LGBTQ identity to healthcare providers while 37% (n=67) did not disclose. Ninety-eight percent of the total participants provided written responses about their disclosure or non-disclosure to healthcare providers.

Reasons for Non-Disclosure of LGBTQ Identity

For the participants who did not disclose, three primary themes emerged: Provider Factors in Non-Disclosure, Patient Resistant to Disclosure, and Patient Understanding of Identity and Healthcare.

Provider Factors in Non-Disclosure—In the *Provider Factors in Non-Disclosure* theme, participants noted aspects of their experience with providers that contributed to non-disclosure of their identities. Two subthemes emerged: Lack of Inquiry and Provider/Patient Relationship. The most commonly provided reason for not disclosing one's LGBTQ identity overall was that providers did not ask about it. Responses in this Lack of Inquiry subtheme were described in a variety of ways with statements such as “No one asked” and “The topic [was] never brought up.” Another reason for non-disclosure identified by participants related to problems in the Provider/Patient Relationship. In this subtheme, issues such as dislike of providers, or providers making assumptions about sexuality, created a barrier to patient disclosure. One participant noted, “It feels awkward to tell the doctor you've had since you were born your sexual orientation. While I'm comfortable with being gay to my friends and family (at least most of my family), I haven't felt a need to tell my doctor at this point...” (24 year old, other race/ethnicity, cisgender man). Here, the long-standing relationship the participant has with the provider creates a challenge to identity disclosure. Such situations can be particularly challenging for young adults who are still utilizing their pediatric healthcare providers.

Resistant to Disclosure—Participants also provided several intrapersonal reasons for being *Resistant to Disclose* to their providers. Within this theme, four subthemes were identified. The most commonly reported subthemes were Discretion and Stigma. In the Discretion subtheme, participants highlighted their desire to maintain privacy about their identity as their reason for not disclosing. As one participant stated, “I feel like my sexuality is my business in what I do and who I do it with” (25 year old, Black, lesbian, cisgender woman). In the subtheme of Stigma, participants listed a number of concerns around disclosure, including not wanting to be treated differently, fear of what providers might say, and generally not wanting to talk about their sexual orientation or gender identity. One

participant stated, “I didn't want to be labeled as homosexual” (24 year old, Black, bisexual, cisgender man).

The remaining subthemes were less frequently described. In the Conditional Disclosure subtheme, participants indicated that they would consider disclosing their LGBTQ identity in some circumstances. For example, one participant stated, “I wouldn't mind telling them, especially if it would help me in some way” (23 year old, Black, bisexual, cisgender woman). Finally, in the Ambivalence subtheme, participants indicated either internal conflict over the disclosure process or simply stated that they did not have a specific reason for not disclosing. One participant said, “Part of me feels that my sexual orientation is my business. However another part of me knows from a medical standpoint, my sexual orientation is relevant to my overall health” (22 year old, black, lesbian, stud). This quote illustrates the conflict between discretion and disclosure highlighted by many of the participants in the *Resistant to Disclose* theme.

Identity Not Relevant to Healthcare—In this theme, participants indicated that they did not disclose their identities to providers because it was perceived to have no bearing in healthcare settings. As one participant stated, their identity was “irrelevant to medical aspects of my life.” Some participants simply felt that there was no need to disclose in that particular healthcare setting, while others felt more strongly that identity and health had no relationship. This is best exemplified by the participant who stated, “Disease effects (sic) both straight and LGBT equally without discrimination” (22 year old, Black, gay cisgender man). Such statements reflect a lack of knowledge among some LGBTQ young adults about the health disparities impacting their community.

Confirmation and Expansion of Johnson and Nemeth's Model

Open-ended responses describing participants' impressions of provider reactions to LGBTQ identity disclosure were categorized into four different themes: *Provider Knowledge*, *Communication to Patient*, *Attitude of Provider*, and *Patient Expectations of Provider*. The first three themes were consistent with past findings about lesbian and bisexual women's disclosure to providers (Johnson & Nemeth, 2014), and one additional theme emerged that expanded the existing model.

Provider Knowledge—This theme captured the kinds of information that providers relay to patients in response to their identity disclosure. Two subthemes reflected varied levels of understanding of LGBTQ health: LGBTQ Affirmative Knowledge and Lack of LGBTQ Knowledge. Under the LGBTQ Affirmative Knowledge subtheme, participants described providers asking about safer sex, inquiring about STI/HIV testing, or adjusting questions based on their sexual identity. As one participant stated, “All the doctors told me that they provided dental dams, and were open to questions regarding safe lesbian sex” (22 year old, black, pansexual, cisgender woman). It is essential to note that in almost all of the examples about providers demonstrating LGBTQ Affirmative Knowledge, the information provided centered solely on sexual health among sexual minority individuals. There were no examples of competent information being provided based on participants' gender identity/expression.

In the Lack of Knowledge subtheme, participants described instances where providers demonstrated a lack of understanding about LGBTQ issues and patients. One participant stated, “A few nurses had confusion about my sexual orientation or seemed unprepared for knowing what that meant/lack of understanding” (23 year old, White, gay, genderqueer individual). In a similar vein, another participant noted that providers “...don't know how to effectively or properly handle a trans client/patient.” (24 year old, White, queer, transguy). While sexual health of sexual minority patients may be an area where providers are more capable, knowledge in other areas of LGBTQ health such as transgender health may need improvement.

Communication—This theme captured the variety of ways providers communicated to participants following disclosure, including overt, covert, verbal, and non-verbal communication. Seven subthemes were identified. Consistent with Johnson and Nemeth’s model (2014), the subthemes of Comfortable and Uncomfortable were found. In Comfortable, participants highlighted ways that providers were able to verbally communicate openness to the patients’ disclosure. One participant reported that a provider said, “Everybody is treated equal [sic] in this facility.” In contrast, participants also noted how their providers communicated being Uncomfortable through being “surprised,” “uncomfortable,” “unhappy,” or by expressing “disbelief” when participants disclosed their identities.

Analyses also revealed a variety of additional emotional reactions that served as communication between patients and providers following disclosure. The most commonly reported reaction of providers was an Absence of a Reaction. Participants most often wrote “no reaction,” but some elaborated with statements like “didn’t see any change in emotions.” Additionally, participants noted that providers “didn’t care” or that disclosure of identity “didn’t really matter” to the providers. In Positive Reactions, participants described reactions that indicated recognition of the patient following disclosure. Such responses were distinct from the Comfort subtheme in that the providers were explicitly affirming of the patient’s identity.

In addition to emotional reactions, providers presented participants with more overt communication following disclosure. Several participants noted that their Providers also Identified as LGBTQ. While it is not possible to know in this analysis whether providers’ identity disclosure was the result of participant disclosure or whether it was known beforehand, it is clear that knowledge of provider identity did impact patients’ own disclosure process. This point is illustrated by a participant who noted, “The doctor I [saw] felt comfortable with [disclosure] because she is a lesbian as well” (21 year old, Black, lesbian, cisgender woman).

Finally, participants also recounted experiences of verbal and non-verbal Microaggressions made by their providers following disclosure. One participant reported that their provider stated, “Oh my god do you know you should get a HIV TEST [sic] its very good for you people.” (19 year old, Black, gay/open-minded, FTM). Others reported that providers assumed the participants were straight and then were surprised or did not believe the participant following disclosure of LGBTQ identity. In terms of non-verbal communication,

one participant reported getting “bad looks of disapproval” while another reported receiving a “look of disgust” following identity disclosure.

Provider Attitude—In contrast to the Communication theme, the theme of Provider Attitude captured providers’ behaviors in response to participants’ identity disclosure. Consistent with Johnson and Nemeth (2014), the subtheme of Acceptance was found, in which participants reported that providers acted “welcoming” and “understanding,” and showed that they “accepted me as I was.” Additionally, participants noted that their providers treated them with Friendliness, Respect, and Professionalism following disclosure. While Johnson and Nemeth identified the subtheme of Disrespectful to describe negative attitudes of providers towards patients, in our analysis these negative experiences were better understood as Discriminatory Actions. The experiences described in Discriminatory Actions were more severe than those described in other subthemes (e.g., Microaggressions) and often included discriminatory behaviors occurring towards participants that impacted their care. For example, one participant noted that “Some doctors/providers have been rude, dismissive, or verbally abusive after learning of my trans status” (24 year old, White, queer, transguy). For some, these experiences were so upsetting that participants described feeling discouraged from utilizing healthcare. As one participant described, “It became very uncomfortable and he proceeded to discuss how specific STDs afflict ‘my kind.’ I didn’t even care about my sickness; I just wanted to leave” (25 year old, Black, queer cisgender woman).

Patient Expectations of Providers—Johnson and Nemeth’s (2014) model proposed that expectations of providers were part of a pre-interaction stage occurring before the disclosure process to providers. However, in the present study, the *Patient Expectations of Provider* theme suggests that anticipated stigma was part of the disclosure process and impacted how participants interpreted the experience of disclosing to their provider concurrently. Under the theme Patient Expectations of Providers, there were two subthemes: Lack of Negative Reaction and Still Received Treatment. In the Lack of Negative Reaction subtheme, participants’ responses indicated that they were anticipating negative reactions and noted that providers were “not shocked or surprised,” that reactions were “not too bad,” “non-condemning,” or “non-judgmental” following their identity disclosure. An analogous sentiment is found in the Still Received Treatment subtheme. Here, participants highlighted that despite their disclosure, providers continued with treatment. This idea is best epitomized by the participant who excitedly stated, “My doctor didn’t care that I was gay he [still] treated me!!!!” (23 year old, Black, gay, stud). For this participant and others, the fact that they were able to get treatment was seen as exciting and revelatory. This suggests that some LGBTQ young adults have very low expectations of their providers and may enter into situations involving identity disclosure expecting negative experiences.

Discussion

This article is among the first to describe the experiences of identity disclosure and non-disclosure for LGBTQ young adults accessing medical care. This study provides insights into participants’ understandings of why they fail to disclose their identities to medical providers and their perceptions of interactions with medical providers when they do disclose.

Overall, 63% of participants disclosed their LGBTQ identity to healthcare providers, suggesting that young adults may disclose at rates akin to older adults as opposed to adolescents (Durso & Meyer 2013; Meckler et al., 2006). Of those who disclosed, a majority of participants reported that they perceived their providers' responses ranging from neutral to positive. Unfortunately, some participants described experiences that reflected deficits in their providers' ability to provide appropriate healthcare to LGBTQ patients. Moreover, a substantial minority of participants had not disclosed and attributed this to personal factors as well as provider-specific reasons. Together, these findings have important implications for healthcare providers working with LGBTQ patients.

Consistent with past literature, the most significant barrier to disclosure was providers' not asking about LGBTQ identity (St. Pierre, 2012). This barrier to disclosure can be addressed in several ways. Inclusion of LGBTQ identities into paperwork and electronic records has been highlighted by both the Institute of Medicine (Cahill & Makadon, 2014) and the World Professional Association for Transgender Health (Deutsch et al., 2013) as an essential step in addressing health disparities for LGBTQ patients. Inclusion of LGBTQ identity in electronic medical records decreases the burden on patients to disclose multiple times or in multiple settings to providers within the same network. Paperwork that is LGBTQ inclusive, especially paperwork that allows for open-ended responses, can provide LGBTQ patients more agency and control in how they disclose and can communicate to patients that the provider is conscious of LGBTQ patients. In addition to administrative changes, trainings should be provided to healthcare providers and trainees to help them inquire about patients' LGBTQ identities respectfully, respond to disclosures skillfully, and deliver tailored interventions to patients.

Barriers to disclosure also occurred on multiple inter- and intrapersonal levels. For example, participants discussed not disclosing due to fears of encountering stigma from providers following disclosure and due to the belief that disclosing their identity was not relevant to their healthcare. Providers should be made aware of the fears of discrimination that LGBTQ patients face in medical settings and understand how this impacts health outcomes. Providers should work to be prepared to create more affirming environments for patients through advocacy for patients, inclusion of LGBTQ-related healthcare, and policy change. Given that some patients may not see a connection between LGBTQ identity and health, providing education to LGBTQ populations on the links between identity and health may be essential in creating more intrinsic motivation for LGBTQ individuals to disclose their identities to providers. LGBTQ community members and providers should work to create a more expansive view of LGBTQ health, including the needs of sexual minorities beyond lesbians and gay men, the needs of transgender individuals and/or of racial/ethnic minority populations.

Findings from participants who had disclosed to providers largely supported Johnson and Nemeth's (2014) model, though several new subthemes emerged reflecting a wider array of provider attitudes and reactions to participants' LGBTQ identity disclosure. The findings indicate that affirmative provider interactions following disclosure of LGBTQ involve providers demonstrating knowledge of LGBTQ health and understanding of LGBTQ identities. In addition, providers may display a wider array of reactions—both positive and

negative—than previously thought. Our analysis uncovered additional provider reactions not found in Johnson and Nemeth's (2014) model, such as professionalism, friendliness, and discriminatory actions. Some of these findings are in contrast to much of the research on healthcare experiences among LGBTQ patients, which focused on negative patient-provider interactions.

A key finding was that young adults frequently reported that providers had no reaction to their identity disclosure. While not reacting to LGBTQ identity disclosure may help providers avoid negative interactions with patients, it is also a missed opportunity for providers to build connections with and offer support to patients who have just disclosed their identity. These findings suggest a gap in current training and a possible new area for development in provider training on LGBTQ issues – specifically, cultivating interpersonal skills to create positive environments that promote identity disclosure among LGBTQ patients. One way to do this is to utilize role-playing to improve providers' comfort and skill surrounding asking patients about their identities. Training programs could also elicit members of the LGBTQ community to be standardized patients and use the feedback from these individuals to teach providers how to create affirming environments for LGBTQ patients. Overall, our findings support the idea that future training to conceptually shift from simply avoiding negative interactions with LGBTQ patients towards helping providers intentionally create an affirming healthcare environment.

In the complete model proposed by Johnson and Nemeth (2014), expectations of providers were conceptualized as occurring prior to interacting with providers. In contrast, our analyses suggested that patients' expectations of providers were concurrent with the actual disclosure process. The fact that participants' expectations framed how they described their providers' reactions indicates just how ubiquitous concerns about provider reactions are during the disclosure process. This analysis indicates that LGBTQ patients may be expecting a negative reaction from providers; furthermore, patients may have such low expectations about their providers' reaction to disclosure that situations such as simply not being rejected from care seem noteworthy or like an accomplishment.

Results from this study also suggest that anticipation of negative interactions with providers impacts the disclosure process, and that some participants in this study did indeed experience discrimination and microaggressions from health professionals. Training programs for healthcare providers should continue to facilitate a better understanding of how microaggressions and discrimination may manifest in clinical practice, as well as tools for providers to explore their personal assumptions about LGBTQ populations (Eliason, 2015). The Association of American Medical Colleges (AAMC) has a range of videos and resources about LGBTQ health that can be used for training purposes or for individual providers seeking to gain skills and information about LGBTQ populations. Additionally, professionals who work with medical providers, such as mental health providers and case managers, can assist in promoting affirming care through awareness of these barriers to treatment and disclosure with their colleagues and through working with patients directly. For example, mental health professionals who work with LGBTQ populations should be aware of possible stressors that occur from interacting with medical systems and should inquire about them. In addition, mental health care providers can also serve as advocates for

their clients by collaborating with medical professionals to help patients have more positive experiences, and by being knowledgeable about their local LGBTQ community in order to provide referrals to affirming healthcare providers.

Strengths and Limitations

This study provides insight into the experiences of young adults with a diversity of racial, ethnic, sexual, and gender identities, and has provided support for and expanded on Johnson and Nemeth's (2014) model of LGBTQ young adults' disclosure to healthcare providers. Additionally, we obtained participants' own reasons for non-disclosure, which has received limited attention in the literature. Yet, our study also had several limitations. The sample was not large enough to enable quantitative examinations of disclosure experiences by LGBTQ identity and/or racial/ethnic identity. For example, although the results of the qualitative analysis suggested significant differences in healthcare experiences for transgender participants, quantitative examinations of these differences were unable to be ascertained due to sample limitations. Given that the measures used in this study were administered in the context of a much larger longitudinal study, rather than a standalone study focused on young adults' healthcare experiences, the open-ended items we administered yielded relatively brief participant responses, which limited the depth of the analysis. Moreover, our findings provided general information on the experiences of disclosure and nondisclosure to providers, and we did not gather data on the specific types of providers to whom our participants did and did not disclose. Finally, most participants in this study lived in a large metropolitan area in the U.S. with multiple LGBTQ-serving places of care, and as such our findings should not be generalized to those living in rural areas.

Future Directions

Future research on LGBTQ young adults should focus on gaining more in-depth information about disclosure and how it relates to their healthcare decision-making. Essential areas for exploration include when LGBTQ young adults decide to seek care, how they identify affirming providers, if provider-patient identity congruence facilitates healthcare outcomes, and the impact of positive and negative experiences of disclosure for future health seeking. In addition, evaluating the types of providers to whom LGBTQ young adults are likely to disclose their identity, as well as provider characteristics, which could help facilitate disclosure. Relatedly, different medical settings and/or health issues could impact both disclosure and patients' experiences with providers, and this also warrants further investigation. For example, LGBTQ young adults may have significantly different expectations of care when seeking services in an LGBT-focused clinic versus a general primary care setting. A better understanding of LGBTQ young adults' healthcare experiences in different settings with different providers could inform trainings that ensure LGBTQ young adults have affirming experiences regardless of where they choose to seek care.

Additionally, specific sub-populations of LGBTQ young adults deserve further research attention. Non-binary gender and sexual minorities (e.g., list a few examples here) likely demonstrate specific challenges in the identity disclosure process, such as... (maybe list one challenge or two here) and these processes should be further explored. Moreover,

transgender participants in this study presented difficulties and concerns related to their gender identity/expression and/or intersecting gender and sexual minority identities, which appeared to differ substantially from sexual minority participants. Continued exploration into challenges in healthcare settings for transgender young adults is an essential area for future directions.

Conclusion

The current study shed light on factors impacting non-disclosure and experiences following identity disclosure for a racially diverse sample of LGBTQ young adults. Participants did not disclose their LGBTQ identity due to providers not asking, internalized stigma, and belief that health and LGBTQ identity were not related. When participants did disclose, they encountered both positive and negative reactions from providers, but most often, providers did not react to their disclosure. These findings can directly inform how healthcare providers are trained to work with LGBTQ young adults and support continued emphasis on improving provider-patient interactions.

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Table 1

Demographics (N=206)

Variable	n	%
Race/ethnicity		
Black/African American	116	56.3
White	28	13.6
Hispanic/Latino/a	25	12.1
Multi-Racial	24	11.7
Asian or Pacific Islander	3	1.5
Native American	2	1.0
Other	8	3.9
Gender Identity		
Female	112	54.4
Male	80	38.8
Transwoman	9	4.4
Transman	2	1.0
No Response	3	1.5
Sexual Identity		
Gay	72	35.0
Lesbian	54	26.2
Bisexual	52	25.2
Heterosexual	10	4.9
Questioning/Unsure	8	3.9
No Response	10	4.9
Education		
Less than High School	22	10.7
High School	60	29.1
Partial College	81	39.3
College Graduate	42	20.4
No Response	1	0.5

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Table 2

Health and Healthcare Access (N=206)

Variable	n	%
HIV Status		
Negative	165	80.1
Positive	16	7.8
Do Not Know/Do Not Want to Answer	25	12.1
Easy of Access		
Somewhat/Very Difficult	63	30.6
Somewhat/Very Easy	141	68.4
No Response	2	1
Insurance Type		
Public	50	24.3
Private	66	32.0
None (self-pay/free)	88	42.7
No Response	2	1.0
Time Since Last Checkup		
<1 year	141	68.4
>1 year	62	30.1
Do Not Know/Not Sure	1	0.5
No Responses	2	1.0
Usual Place of Care		
Public	95	46.1
Private	56	27.2
ER/No Regular Care	53	25.7
No Response	2	1.0

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Table 3

Themes for Non-Disclosure of LGBTQ Identity to Providers

Themes/Subthemes	Description	Count
Provider Factors in Non-Disclosure		32
Lack of Inquiry	Providers not asking about LGBTQ identity	27
Provider/Patient Relationship	Factors in the patient/provider relationship that impact disclosure	5
Resistance to Disclosure		29
Discretion	Reason for non-disclosure was that LGBTQ identity was personal information	13
Stigma	Reason for non-disclosure was concerns of negative reactions from providers	10
Ambivalence	Patients were unsure of their reasons for not disclosing	3
Conditional Disclosure	Patients indicated that they would disclose identity under certain circumstances	3
Identity and Healthcare		21
Not Relevant	Patients indicate that their identity is not relevant to their health	21

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Table 4

Themes for Disclosure of LGBTQ Identity to Providers

Themes/Subthemes	Description	Count
Provider Knowledge		18
LGBTQ Affirmative Knowledge	Providers giving information that reflect knowledge of LGBTQ health	5
Lack of LGBTQ Knowledge	Providers indicating that they have a lack of knowledge of LGBTQ health	9
Communication		87
Comfortable	Providers indicate their comfort with patient disclosure	8
Uncomfortable	Providers indicate their discomfort with patient disclosure	16
*Positive Reaction	Patients feel that providers reacted positively to disclosure	21
*Absence of Reaction	Provider did not react to patient disclosure	38
*Provider LGBTQ Identified	Providers were also LGBTQ identified	4
*Microaggressions	Providers indicate negative feelings about LGBTQ identity through verbal or nonverbal communication	9
Provider Attitude		35
Acceptance	Providers behave in an accepting manner after disclosure	12
*Professionalism	Providers behave in a professional manner attitude after disclosure	6
Respect	Providers behave in a respectful manner after disclosure	4
*Friendliness	Providers behave in a friendly manner after disclosure	5
*Discriminatory Actions	Providers behave in a discriminatory manner following disclosure	8
*Patient Expectations of Providers		20
*Lack of Negative Reaction	Patients reflect that providers react in a negative way to disclosure	13
*Still Received Treatment	Patients reflect that providers still provide care despite disclosure	7

* Themes and subthemes not present in Johnson and Nemeth's (2014) model

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