

Spring 2015

Identity disclosure in lesbian, gay, and bisexual patient-provider communication

Nicole Hudak
James Madison University

Follow this and additional works at: <https://commons.lib.jmu.edu/master201019>

 Part of the [Gender, Race, Sexuality, and Ethnicity in Communication Commons](#), and the [Health Communication Commons](#)

Recommended Citation

Hudak, Nicole, "Identity disclosure in lesbian, gay, and bisexual patient-provider communication" (2015). *Masters Theses*. 26.
<https://commons.lib.jmu.edu/master201019/26>

This Thesis is brought to you for free and open access by the The Graduate School at JMU Scholarly Commons. It has been accepted for inclusion in Masters Theses by an authorized administrator of JMU Scholarly Commons. For more information, please contact dc_admin@jmu.edu.

Identity Disclosure in Lesbian, Gay, and Bisexual
Patient-Provider Communication

Nicole Hudak

A thesis submitted to the Graduate Faculty of

JAMES MADISON UNIVERSITY

In

Partial Fulfillment of the Requirements

for the degree of

Master of Arts

Communication & Advocacy

May 2015

Acknowledgements

I would like to thank several people for their contributions to this thesis. First, I would like to thank my advisor, Dr. Carmack, for being there every step of the way and for giving me the extra nudge of encouragement when I needed it the most. Additionally, my committee has also been a key part of this process and without them I would not have a thesis to submit. The School of Communication Studies has been equally supportive in this process and deserves recognition as well.

Furthermore, I would like to thank my wonderful friends and family for their unconditional support throughout this process. Not only did they supply inspirational words, they also understood my limited communication with them when I was in the process of writing.

Finally, I could not have completed this thesis without my research participants. I cannot express enough gratitude for their willingness to speak with me about their experiences in healthcare.

Table of Contents

Acknowledgements	ii
List of Tables	v
Abstract	vi
Chapter 1: Introduction	1
Heterosexism.....	2
Medicalization of Homosexuality.....	3
Power and Discrimination of LGB Patients.....	4
Positionality and Preview.....	6
Chapter 2: Literature Review	10
Coming Out	10
Coming Out and Identity.....	11
History of LGB Health Research.....	15
Discrimination in Healthcare.....	17
Disclosure in Healthcare.....	19
Co-Cultural Theory.....	23
Assumptions.....	24
Communication practices.....	25
Strategy influencers.....	29
Co-cultural theory and the LGB community.....	33
Communication Privacy Management.....	34
Theoretical Suppositions.....	35
Private information.....	35
Privacy boundaries.....	36
Control and ownership.....	36

Levels of control: Privacy boundaries.....	37
Privacy management dialectics.....	38
Privacy Rule Management.....	38
Privacy rule foundations.....	38
Privacy Rule Attributes.....	42
Rule acquisition.....	42
Rule properties.....	43
CPM and Health Communication.....	44
Summary and Research Questions.....	46
Chapter 3: Methodology.....	47
Qualitative Inquiry.....	47
Positionality.....	49
Data Procedures.....	50
Recruitment.....	50
Participants.....	51
Data collections.....	51
Data Analysis.....	54
Evaluating Qualitative Research Rigor.....	55
Chapter 4: Results.....	58
Influences on Disclosure.....	58
Experience with family.....	58
Fear of gossip and connections.....	60
Provider refusal.....	62
Religion.....	64
Age.....	65
Level of trust.....	67
Identity vs. Practice.....	68
Sexual practice in healthcare.....	69

How to ask about sexuality.....	70
Relevancy.....	71
Heterosexism.....	72
Heterosexual assumptions.....	73
Limited knowledge.....	76
“Looking gay”.....	78
Barriers and Consequences.....	80
Legal implications.....	80
Insurance barriers.....	81
Distrusting the system.....	82
Limited options.....	84
Sexual promiscuity.....	85
Forced testing.....	86
Luck.....	88
Discrimination in mental healthcare.....	89
Provider discrimination.....	91
Chapter 5: Discussion.....	94
Research Question 1.....	94
Research Question 2.....	96
Practical Applications.....	99
Limitations.....	101
Future Studies.....	102
Reflection.....	103
Appendix A.....	105
Appendix B.....	107
Appendix C.....	109
Appendix D.....	110

List of Tables

Table 1: Co-Cultural Theory Communication Practices.....105

Abstract

Lesbian, gay, and bisexual individuals have encountered barriers in accessing healthcare. Barriers to accessing medical care can stem from discrimination within healthcare, which includes the medicalization of homosexuality. Literature demonstrates that both providers and LGB patients recognize that there are inefficiencies in the current healthcare system for LGB patients. This thesis sought to find how LGB individuals navigated the disclosure of their sexual identities with their providers and what types of communication barriers existed between them. Qualitative, in-depth interviews were conducted with 20 LGB identified participants. The recorded interviews were transcribed and analyzed using a constant comparative method. Four themes were found including: influences on disclosure, identity vs. practice, heterosexism, and barriers and consequences. The thesis concluded that how a LGB individual viewed their sexual identity impacted their choice to disclose to his or her provider and the communication barriers that occurred when a provider was discriminatory towards his or her LGB patient. In order to combat these discriminatory issues within healthcare, providers should undergo training on how to care for LGB patients.

CHAPTER 1: INTRODUCTION

Kate, a lesbian woman from California, had her own difficult health care encounter when seeing a new doctor for the first time. When filling out her intake form, she was asked standard gynecological questions such as, “Are you on birth control”, “What kind of contraception do you use?”, and “Are you pregnant?”. She filled out the form, indicating that she was sexually active, did not use any kind of contraception, and was not pregnant. When the nurse came into the exam room she asked her the same questions, and although she already filled out the answers on the form, and Kate restated that she was sexually active and was not using birth control. The nurse responded by giving Kate “a stare that was midway between shocked and judging” and then proceeded to say as she was leaving the room “You know you might want to consider birth control if you’re having regular sex. You don’t want any pregnancy scares!” When Kate simply stated that she was a lesbian, the nurse had an “awkward pause” and said, “I guess you’re okay then!” and quickly left the room (Boyden, 2014).

Kate is not alone in her experience, as lesbian, gay, and bisexual (LGB) individuals encounter a number of barriers when attempting to meet their health care needs and seek out health information, (Fish, 2006). These health care barriers have not gone unnoticed by providers, advocates, and health care professionals. Healthy People 2020, a ten year initiative for improving the health of Americans, has given some attention to the subject. The initiative’s overall goals include promoting longevity to American lives, eliminating disparities and improving health of all individuals, creating social and physical environments that promote good health, and promoting quality life throughout all stages of life (“Healthy People 2020”, 2013). Included in their

overarching goals for the program, the authors of Healthy People 2020 list certain topics and objectives that deserve special attention. The health of LGBT individuals has become a highlighted topic with the goal of improving the safety, health, and well-being of these individuals. Healthy People 2020 states, “Eliminating LGBT health disparities and enhancing efforts to improve LGBT health are necessary to ensure that LGBT individuals can lead long, healthy lives” (para. 5).

Heterosexism

One of the biggest barriers facing LGBT individuals’ health care is the perception of heterosexist attitudes from providers (Saulnier, 2002). The practice of heterosexism impacts LGBT individuals by blocking access to health care, decreasing the ability for the LGBT patient to adequately communicate with their health care provider, and decrease the quality of care that LGBT patients receive (DeHart, 2009; Saulnier, 2002). Although homophobia and heterosexism have been used interchangeably in past literature, there is a distinct difference between the two terms (Morrison & Dinkel, 2012). Scott, Pringle, and Lumsdaine (2004) defined homophobia as “An irrational fear and dislike of lesbian, gay and bisexual people, which can lead to hatred resulting in verbal and physical attacks and abuse” (p.31). Homophobia tends to be experienced on an individual level. Heterosexism, on the other hand, is a form of systematic discrimination where there is an underlying belief that heterosexuals are superior compared to other sexualities, which then marginalizes any non-heterosexuals (Morrison & Dinkel, 2012).

Health care is rampant with heterosexism; medical textbooks and resources even promote the idea that patients will follow a heterosexual trajectory of having a nuclear family (Zuzelo, 2014). The standard gynecological questions Kate was asked by her

nurse is a form of heterosexism because asking if Kate is on birth control after discovering that she is sexually active is based on the assumption that she is trying to prevent pregnancy because she is engaging in heterosexual intercourse. Saulnier (2002) discussed how lesbian and bisexual women noted the ways that they experienced heterosexism within their health care. The women explained that they were assumed to be heterosexual unless they stated their sexuality; medical forms did not provide a space to state their sexuality and their health care providers did not have relevant medical information for them, particularly referring to the transmitting of STIs. Heterosexism in health care might not only result in a patient feeling uncomfortable but might serve as a serious barrier to accessing adequate health care.

Medicalization of Homosexuality

The barriers that LGBT individuals encounter while seeking health care can stem from a discriminatory history. Homosexuality was labeled as a mental disorder in the Diagnostic and Statistical Manual of Mental Disorders (DSM) until 1986 (Herek, 2012). In the 1960's, psychiatrists medicalized homosexuality, discursively transforming a nonmedical issue into a medical problem in order to promote diagnosis and treatment (Carmack, 2014). Instead of thinking of homosexuality as a sinful act, psychiatrists proposed pharmacological and behavioral treatments (Carmack, 2014). One way that homosexuality was treated was through conversion therapies. Many psychologists believed that homosexuality stemmed from childhood issues. Blackwell (2008) explained that there were several different methods for conversion therapies, including "group social demand treatments, heterosexual responsiveness instruction, aversion conditioning, social learning training, covert sensitization, fantasy modifications, capacity

for heterosexual intercourse, training for abstinence and celibacy, drug treatment, and fundamental spiritual treatments” (p.655).

Beyond attempting to “fix” homosexuality with various treatments, researchers attempted to prove that lesbians, gays and bisexuals were inferior compared to heterosexuals. Fish (2006) explained the various ways that researchers attempted to prove that homosexuals were inferior compared to heterosexuals. One way that medical researchers tried to establish homosexual inferiority was by proving that homosexuals were biologically inferior. Biological inferiority of homosexuals was based on homosexual skull dimensions, postures, gestures, and mannerisms and how they compared to heterosexuals. There was also an attempt to claim hormonal imbalances, which was used to prove that lesbians were masculine and gay men were more feminine. Genetics were also used to demonstrate inferiority, including the identification of the ‘gay gene’. Moreover, researchers also tried to prove that homosexuals were inferior compared to heterosexuals by showing how homosexuals were psychologically, morally, emotionally, and sexually inferior as well as having a negative upbringing. These previous practices are the underlying foundation of medical practices and influence how our medical system functions to this day (Fish, 2006). Although homosexuality no longer exists as a psychological disorder, Fish (2006) explained that we do not simply erase our history and start over with a clean slate, but rather our present is influenced by the heterosexist practices within medicine.

Power and Discrimination of LGB Patients

Research on LGB medical discrimination is limited; however the research that has been conducted demonstrates heterosexism currently exists in medical care. LGB

patients typically have the ability to choose whether or not to disclose their sexuality to their health care provider (Parkhill, Mathews, Fearing, & Gainsburg, 2014), but the decision to reveal their sexuality can cause turbulence in the interaction. For instance, a gay patient mentioned his sexuality to his doctor during his appointment. His doctor “told him he had given more information” than “he needed to know” (Mimiaga, Goldhammer, Belanoff, Tetu, & Mayer, 2007, p.117). Furthermore, Mimiaga et al. (2007) reported a conversation between a lesbian woman and her doctor, during which the doctor gave the woman a lecture on her sexuality and made a crude sexual comment. Another lesbian woman explained that when she revealed her sexuality to her doctor, her doctor started to talk about AIDS (Politi, Clark, Armstrong, McGarry, & Sciamanna, 2009). A lesbian patient told Goins and Pye (2012) that a doctor asked her if she and her partner used objects during sex. Goins and Pye further explained that this type of question was grounded in heterosexual assumptions of sex needing to involve penetration of some kind. These examples of health care providers’ reactions to patients revealing their sexuality demonstrate that there is a need to research the (un)intended discriminatory communication which might exist between provider and patient.

One of the reasons that health care providers have the ability to be discriminatory towards patients is because they have power over their patients. Health care providers have more power than lay patients because they provide a service that others cannot easily live without (Beisecker, 1990). A patient cannot make adequate medical decisions or obtain essential medical services without interacting with health care providers and, therefore, will have to interact with a health care provider at some point in his or her life. Additionally, non-heterosexual patients have to deal with another layer of power because

health care providers have the ability to turn away patients because of the patients' sexuality without repercussions. However, patients may not be able to receive the medical attention that they need if their provider is not aware of their sexuality. This might force the non-heterosexual patients into a bind because if they reveal their sexuality, a health care provider may turn them away or create an uncomfortable or discriminatory situation (Fish, 2006). Due to this bind that LGB patients are placed into, health care providers have further power over them because they inevitably decide what medical attention they receive and how they will receive it.

Positionality and Preview

As a lesbian woman, I have experienced the difficult choice of how to interact with my own health care providers. I constantly debated how to negotiate the power that my health care providers had over me. After coming out, I was afraid of going to see a doctor because of a fear of discrimination. It took me two years to finally take care of a routine physical and once I made an appointment with a doctor, I immediately became anxious. I made the appointment in my hometown, which is very conservative but because of my health insurance, I had limited options. In preparation for my appointment, I began to think about how I would answer the question of "Are you or can you be pregnant?", which would most likely have follow-up questions, such as "Are you sexually active?" or "Do you use birth control?" I made the decision of answering in complete honesty and if that meant revealing my sexuality, I was okay with that. Before attending the appointment I assumed that if I did end up revealing my sexuality, he would be uncomfortable because of being in a conservative town. However, neither the nurse

nor the doctor asked me about my sexual health and I was not forced into a situation of revealing my sexuality.

Although I breathed a sigh of relief at the end of my physical examination, I still had to attend two different medical appointments that were also in my home town. My next appointment was with an allergist. After being diagnosed with an allergy to cats, the allergist asked if I had cats. When I said that I did have cats, he recommended that I try to rehome them. I explained that one of the cats was not mine; one was my partner's and she would never get rid of her cat. In that moment, I realized that I had disclosed to my doctor that I was in a same-sex partnership. I noticed that he immediately shut down and stopped any further conversation about the issue. Although I had expected discriminatory reactions when discussing sexual health, I did not expect to receive such reactions from my allergist.

It is easy to assume that sexuality only matters in a health care setting if the topic is about sexual health; however, sexuality is inherently tied to a person's identity and can be relevant in any medical situation. Although conversations about sexuality have become more relevant in United States due to the media coverage of marriage equality (Liasson, 2014), there has been a lack of focus as to the impact of discussing a person's sexual identity on his/her health care experiences. Using the theoretical lenses of co-cultural theory and communication privacy management, this qualitative thesis will explore how LGB individuals navigate their sexual identity with their health care provider and the potential communication barriers which arise when discussing sexual identity. Because of the lack of information on LGB health care, the collected interview

data will be analyzed through the use of grounded theory to allow for an exploratory study.

The focus of this thesis is specifically on lesbian, gay, and bisexual health care, which does not include trans identity. Past research on LGBT identity, specifically in relation to coming out, conflated both sexual orientation and gender identity; however, they are two separate forms of identity. When discussing disclosure of a particular identity, gender identity is not about revealing a particular gender identity but rather a type of gender history that describes the move from one gender to another (Manning, 2013). This distinction of disclosing identity is crucial when looking at health care because lesbian, gay, and bisexual individuals can choose whether to disclose their sexual orientation to their health care provider; however, if trans individuals want to receive adequate and appropriate health care, they have to disclose their trans status (Parkhill, Mathews, Fearing, & Gainsburg, 2014). In order to respect the distinction between the two identities of sexual orientation and gender, this thesis will focus only on LGB sexual orientation.

Chapter Two will lay a foundation to help frame the context of this thesis. First, an explanation of coming out as LGB and the impacts of coming out will be examined. Additionally, a history of research related to LGB health will be explored, with an emphasis on the role of patient-provider communication. After identifying the gaps in the research, disclosure and sexuality will be explored in order to understand the implications of disclosing sexuality in a health care setting. Chapter Two will also set up the theoretical framework. Co-cultural theory will be the driving theoretical force in this project; however, Communication Privacy Management will be combined with co-

cultural theory to present a health communication perspective on disclosing sexual identity.

In Chapter Three, the qualitative method for this thesis will be introduced. Specifically, I will explain why qualitative is an appropriate approach. I will also explain the proposed demographic of the participants, the interview protocol, and how interviews will be analyzed.

Chapter Four will present the findings of the thesis.

Finally, Chapter Five will discuss the conclusions and implications and thesis directions for future research.

CHAPTER 2: LITERATURE REVIEW

Kate's experience at the doctor's office, as well as my own experiences, do not exist within a vacuum and are embedded within the history of medical care. The current existing research related to LGB healthcare, while limited, can provide context for this thesis. In order to begin the discussion of previous LGB healthcare experiences, it is important to review important concepts that relate to LGB identity. The first part of this chapter focuses on what it means to come out and the coming out process in relation to identity. Next, I briefly discuss the history of LGB health research and the current research's limitations. Following this history, I explore issues of discrimination of LGB individuals in healthcare. Discrimination in healthcare is connected to the disclosure of identity to providers. The chapter then moves into discussions of my theoretical frameworks. Co-cultural theory and communication privacy management are explained, with an emphasis on how the theories will be used to assist in the framing of this thesis. Finally, I provide my guiding research questions.

Coming Out

Coming out refers to the process that non-heterosexual individuals experience when they not only recognize their sexual attractions to those of the same sex and label themselves as non-heterosexual, but also begin to share this new identity with others (Manning, 2015). A key concept of coming out is that coming out is not a singular act but composed of thousands of acts and conversations (Guisinger, 2014). Those communicative acts can vary from telling a family member for the first time that a person is gay or to being questioned about a partner, assuming that the partner is of the opposite

sex. Coming out is not something that is enacted once but can occur throughout people's lifetimes.

Manning (2014) developed a typology of types of coming out narrative conversations. He identified seven distinct and mutually exclusive categories of coming out conversations. Pre-planned conversations occur when a LGB individual plans out in advance that s/he is going to come out to an individual or a group of people. Emergent conversations are when the conversation with a LGB individual is already moving towards coming out so the LGB individual chooses to come out at that time. On the other hand, coaxed conversations occur when the LGB individual is nudged or hinted at that s/he is non-heterosexual and this triggers the discussion that leads to coming out. Romantic/sexual conversations are when an individual comes out to another person by expressing sexual attraction or offering sexual favors. Another way that LGB individuals come out is through educational/activist conversation, such as when a LGB individual comes out during an educational panel on the LGB community. Finally, mediated conversations are when individuals do not come out in person, but through mediated forms such as phone calls, letters, etc. These coming out narratives can be beneficial in studying LGB healthcare because LGB individuals may find themselves enacting one of these typologies when coming out to a healthcare provider.

Coming Out and Identity

Coming out has been connected to the formation of identity. In 1979, Vivienne Cass published an article proposing a theoretical model of homosexual identity formation. Her model relied on two assumptions: (1) identity is achieved through a

developmental process and stability and (2) change in behavior relies on interaction between a person and their environment (Cass, 1979). Cass's (1979) model provided an account for how individuals form a non-heterosexual identity. The model has six stages: identity confusion, identity comparison, identity tolerance, identity acceptance, identity pride, and identity synthesis.

The first stage, identity confusion, occurs when a non-heterosexual individual starts to be aware of his or her homosexual tendencies or feelings which can be overt acts, such as kissing someone of the same gender, or internal feelings, such as romantic thoughts about a person of the same gender. At this stage, a person does not start to explicitly identify as non-heterosexual, but rather entertains the potential that s/he may not be heterosexual. Another way a person can exist in this stage is if s/he recognizes his or her non-heterosexual tendencies but s/he thinks of the behavior as undesirable. In addition to feeling that the behaviors are undesirable, an individual can believe that the behaviors are incorrect but are not considered non-heterosexual. For example, kissing a person of the same gender does not mean s/he is a heterosexual (Cass, 1979).

Identity comparison is the second stage. In this stage, an individual starts to believe that s/he may be a non-heterosexual, which would mark the first time an individual would tentatively commit to being non-heterosexual. An individual may even state that s/he may be a non-heterosexual and start to realize that s/he is different from everyone else and may feel as though they are the only person in the world who is like him or her. S/he may feel as though s/he does not belong. Geographic location may further this thought if s/he feels isolated from others similar to him or her. This person

will then realize that behaviors exhibited by heterosexuals no longer apply to him or her and that s/he will have to create a new identity (Cass, 1979).

The third stage, identity tolerance, is when a person states that s/he is probably a non-heterosexual and this identity shift is not acceptance but the person merely tolerates his or her identity. In order to move towards a non-heterosexual identity, an individual will start to recognize his or her social, emotional, and sexual needs and will also attempt to seek out other non-heterosexuals for friendship in order to create emotional connections with seemingly similar individuals. The relationship formed with these non-heterosexuals can have a deep impact on the individual because any positive or negative experience can shape how s/he views non-heterosexuals as a whole (Cass, 1979).

Increasing the contact with other non-heterosexuals characterizes the fourth stage of identity acceptance. By being around other non-heterosexuals, an individual can start to feel normal about not being a heterosexual and can identify with a non-heterosexual way of life. Not only does a person start to identify with a non-heterosexual way of life, s/he begins to feel a preference for that way of life by interacting with other non-heterosexuals. During this stage, a person may still engage in passing, meaning s/he will outwardly perform a heterosexual identity to hide his or her non-heterosexual identity from other heterosexuals. The individual may decide to selectively come out to others as a non-heterosexual (Cass, 1979).

Identity pride is the fifth stage of Cass's model. In this stage, an individual feels an imbalance in his or her acceptance of the non-heterosexual identity and society's rejection of non-heterosexuals. An individual manages this imbalance by devaluing the

importance of heterosexual others (friends, family, etc.) and spending more time with non-heterosexuals. The individual will create a divide between heterosexuals and non-heterosexuals with an overt preference to non-heterosexuals. S/he can go against heterosexual values of marriage and family and adopt non-heterosexual values. The individual can become angry at heterosexual assumptions along with a mixture of pride in his or her non-heterosexual identity (Cass, 1979).

The final stage of identity synthesis is when the individual lets go of the mentality that heterosexuals are bad and non-heterosexuals are good. S/he begins to spend more time with supportive heterosexuals and de-values those who are not supportive. This person still may feel the anger felt in stage five, but on a smaller level and similar feelings of pride are still felt. The individual will recognize both the similarities and differences between him or her and heterosexuals. His or her identity as a non-heterosexual is now encompassed in every area of his or her life (Cass, 1979).

Although Cass's model was the basis for coming out models and understanding, the field of sexual science has started to move away from this model of coming out to create a more nuanced understanding of identity formation (Manning, 2014). Troiden (1989) operated under the assumption that individuals learn to identify and label their sexual feelings through experiences related to gender roles as well as taught sexual identities. He also explained the difference between self-concept and identity. Troiden (1989) defined self-concept as a person's mental image of themselves, what a person thinks s/he is like. On the other hand, identity is a person's perception of him or herself in specific social settings such as his or her work identity as a doctor. A non-heterosexual identity is considered an identity but it can exist as various types of identity

such as a perceived identity, a self-identity, and/or presented identity. Troiden (1989) recognized that his model is more of a set of ideal types rather than a stage model. He explained that the ideal types are not real but rather abstract representations based on observations. He stated that progression through various stages increase the likelihood of a non-heterosexual identity formation but does not determine an identity. The process is not linear, but instead functions as a horizontal spiral in which allows for overlapped stages or recurring stages.

History of LGB Health Research

Research on LGB healthcare has been limited and narrowly focused. Conron, Mimiaga, and Landers (2010) stated, “To date, most have reported on sexual orientation differences in the prevalence of psychiatric disorders, and a handful have explored other health issues (e.g., tobacco use, healthcare access, violence victimization, and chronic disease)” (p.1953). Researchers have focused on physical health differences between heterosexuals and non-heterosexuals. A further limitation of the current LGB health literature is that researchers have spent more writing about gay men and have paid less attention to lesbian women (Kuyper & Vanwesenbeeck, 2011). However, when discussing gay men’s health, a majority of the research specifically focuses on HIV/AIDS within the population (McNair, 2003).

Much of the research that explores sexual health concerning the LGB community focuses on HIV/AIDS and sexually transmitted diseases amongst gay males (Kuyper & Vanwesenbeeck, 2011). For example Mimiaga, Goldhammer, Belanoff, Tetu, and Mayer’s (2007) study focused on perceptions of sexual risk amongst men who have sex

with men and rationalized their study by having stated “Men who have sex with men (MSM) continue to be at increased risk for HIV infection and other sexually transmitted diseases” (pp.113). The problem with focusing in on STDs and HIV amongst the non-heterosexual population is that it can contribute to the perpetuation of sexual promiscuity. Haig (2006) explained that the media and social culture has portrayed gay and bisexual men as careless about sex and that they are forgoing condom use. Sexual health is not just about STDs and HIV but can also encompass issues surrounding sexual dysfunction and even sexual coercion. Moreover, sexual health does not have to be negatively skewed as there are positive implications such as sexual desire, arousal, and orgasms (Kuyper & Vanwesenbeeck, 2011). Sexual health and even health in general for the LGB population needs to be expanded on in order to get a more accurate and fair representation of this marginalized population.

Finally, researchers have focused on general health differences between heterosexuals and LGB individuals. Health issues that have been reported to be disproportionately associated with LGB individuals are substance abuse, being overweight, obesity, and tobacco use (Mayer et al., 2008). Coker, Austin, and Shuster (2010) also reported that LGB individuals are more likely to have substance abuse issues compared to heterosexuals. By focusing on measuring differences between heterosexuals and non-heterosexuals that demonstrate how non-heterosexuals have more poor health behaviors, the research could be used to frame how non-heterosexuals are inferior based on these negative health behaviors.

Conron et al. (2010) measured various differences between LGB individuals and heterosexuals. Bisexuals frequently dealt with mental health issues including tenseness,

sadness, and suicidal thoughts. Bisexual women also reported higher amounts of lifetime experiences of partner violence. Lesbian women had lower rates of two year pap exams. Additionally, Kuyper and Vanwesenbeeck (2011) explained that there are several studies that indicated that LGB individuals are at a greater risk of sexual coercion and violence compared to their heterosexual counterparts. Researchers have not been able to yet answer why there are measurable health differences within the LGB community. This current research on LGB sexual and general health is limited and there are holes in the research that need to be addressed. The current research on LGB health which includes STDs and HIV/AIDS, measurement of negative health behaviors, and mental health and partner violence highlighted only one area that is associated with a negative stigma for the LGB community.

Discrimination in Healthcare

Limited health research has also highlighted the ways in which LGB individuals have faced health-based discrimination. There are a variety of ways in which non-heterosexual individuals can experience discrimination during healthcare interactions. Rounds, McGrath, and Walsh (2013) explained that discrimination can take on multiple forms, from barring a LGB partner from a hospital room to ignoring a LGB individual's hospital call light. Discrimination can also be present in hospital and clinic paperwork, including medical intake forms. Goins and Pye (2012) described how under the category of "risk factors" on the intake form, the form had listed "same-sex partner" along with "unprotected sex". Goins and Pye (2012) argued that the intake form categorizes LGB individuals as people who are at risk by linking sexual identity to risky health behaviors.

Non-heterosexual patients may also experience multiple forms of discrimination in interpersonal healthcare interactions. For example, in Mimiaga et al.'s (2007) study, non-heterosexual men felt discrimination from their providers through various forms of communication. They cited clinicians who appeared to be judgmental based on body language and speaking style. Participants also reported providers who seemed shocked after the participants had come out to them. Rounds et al. (2013) elaborated on what non-heterosexual patients experienced in terms of discrimination. In their study, non-heterosexual individuals reported the feeling of being judged because of the belittling of their responses from providers, providers making assumptions about them, providers making stereotypical comments, and the refusal of provider acknowledgment of their health concerns. These forms of discrimination may have lasting impacts on LGB patients and how they choose to seek out healthcare.

One of the ways that discrimination impacts LGB individuals is that it can affect whether or not they seek out healthcare treatments. Lesbian women are less likely to seek routine healthcare, especially for gynecological screenings which include pap tests, clinical breast exams, and mammograms (Austin, 2013). Fredrikson-Goldsen et al. (2012) examined health issues surrounding LGB older adults (ages 50 and older) and found that lesbian and bisexual older women were less likely to have routine checkups compared to gay and bisexual men. These health disparities are largely affected by lifetime victimization and discrimination (Fredrikson-Goldsen et al., 2012). Mimiaga et al. (2007) identified fear of discrimination as a reason why non-heterosexual men do not get HIV testing because the men were nervous that providers would assume that the reason

they were being tested for HIV was because they identified as gay. The fear of discrimination has led LGB individuals to stop seeking the healthcare that they need.

Disclosure in Healthcare

For some LGB individuals, their sexuality is not apparent in their physical appearance. In these circumstances, if a LGB individual wants people to know his or her sexuality, s/he has to explicitly state it. The act of informing of a person's sexual orientation is called disclosure (Bjorkman & Malterud, 2007). Bjorkman and Malterud (2007) found that disclosure can be medically relevant because it could simplify an explanation of the medical circumstance. Disclosure can help decipher what medical steps should be taken, especially when dealing with sexual healthcare because sexual health is diverse between heterosexuals and non-heterosexuals. For example, lesbian women (and assumedly any LGB individual) who feel that their sexuality is not apparent face the challenge of having to decide whether or not to disclose their sexuality to their provider (Austin, 2013). Without disclosing, providers may offer poor medical advice, diagnosis, and treatment options to LGB patients.

Not all LGB patients choose to disclose their sexuality to their providers. The rate of actual disclosure is anywhere between 18-90% (Bjorkman & Malterud, 2007). In Austin's (2013) study, 40% of women chose not to disclose their sexuality to their doctor. Many lesbian women are anxious about whether or not to disclose their sexual orientation for fear that they will be mistreated or denied care (Austin, 2013). Klitzman and Greenberg's (2008) study examined the communication that occurred between gay and lesbian patients and their healthcare providers. They found that those who were the most

likely to disclose their sexuality to their health provider were gay white males. While it is unclear as to why certain LGB individuals choose to disclose and others choose not to, it is important to note that it is not always an easy choice.

Disclosure does not solely rely on the LGB individual; providers also have the opportunity to discuss sexuality, yet many do not as found by Kitts (2010) who surveyed doctors to discover certain barriers between doctors and LGBTQ adolescents. He found that 64% of doctors did ask about the gender of their patients' partners, 29% regularly talked about sexual orientation, 11% would discuss sexual attraction, and 8.5% would talk about gender identity. Kitts (2010) also surveyed doctors about their reasons for not talking about sexual orientation when discussing a patient's sexual history 42% of the respondents said it was not significant and 18% said they forgot to discuss it. Some doctors wrote in their own answers on the survey; they wrote that they let the patient bring up the topic, history makes sexual orientation obvious, they did not understand sexual orientation, and that it was obvious when they talked about STDs and birth control. Kitts (2010) also asked whether physicians felt they had the skills needed to discuss sexual orientation; 44% agreed or strongly agreed that they had the skills to discuss sexual orientation, 51% disagreed or strongly disagreed, and 6% reported that they did not know.

Regardless of whether or not providers feel as though they have the tools to discuss sexual orientation, the implementation of including non-heterosexuals within healthcare from the provider perspective is lacking. Labig and Peterson (2008) found that very few doctors included questions about sexual orientation in their patient profile and none of them had posted LGB related literature in their offices. Furthermore, less

than 20% of the physicians brought up medical conditions that were relevant to their patients' sexual practices. Healthcare providers might not ask about sexual orientation because they feel like they do not have time to discuss it, they may feel uncomfortable about the issue, have preconceived notions of sexuality, or just do not know how to work with this minority group (Mimiaga et al., 2007). Not only are LGB individuals not disclosing sexuality, but providers also struggle with bringing up sexuality within a healthcare context.

Disclosing sexuality to a healthcare provider has consequences. The current belief about disclosure in a medical setting is that disclosure will only benefit a situation while not disclosing only involves risks (Fish, 2006); however there are both benefits and risks for disclosing (Fish, 2006). One benefit that women found through disclosing to their doctor is that they believe their doctors see them as a whole person. This created a positive atmosphere for their healthcare visits and helped them feel more connected with their doctor (Bjorkman & Malterud, 2007). The impact of the positive atmosphere and satisfaction/connection with their doctor is that it can lead to more preventative health screening. On a similar note, for lesbian women, disclosure can be helpful for correctly diagnosing gynecological and reproductive medical issues (Austin, 2013). Finally, awareness of a patient's sexuality allows for a same-sex partner to be included in medical decision making (Fish, 2006). Disclosure can be very beneficial as Labig and Peterson (2008) found that 79% of their LGB participants disclosed their sexual orientation to their doctor and 86% of the total participants felt comfortable with their primary care physician and did not feel the need to change. These findings suggest that disclosure can lead to a positive relationship between doctor and patient.

Although disclosure is often framed as a mostly positive experience, there are still risks associated with disclosing sexuality to a healthcare provider. The risks of disclosure can be very high for LGB individuals, which include the refusal of healthcare (some states do not protect LGBTQ patients), intimidation by healthcare providers, breaches in confidentiality (i.e., a doctor could tell others about a patient's sexuality), and patient embarrassment over having to disclose their sexuality (Fish, 2006). Beyond these issues, LGB patients also fear disclosing to their healthcare provider because of the possibility of homophobic remarks which could have stemmed from previous past experiences (Mayer et al., 2008). Bjorkman and Malterud (2007) found that lesbian women identified one issue they had with disclosure which was that coming out to their doctor would turn the focus onto their sexuality instead of the medical problem at hand. LGB individuals fear basic discriminatory reactions from their doctors for disclosing their sexuality. For example, women have certain gendered expectations such as having long hair and wearing feminine clothing (dresses, skirts, etc.) and this expectation could influence how their doctor interacts with them. For women who do not fit into these expectations, there are concerns that they could experience confrontational, dismissive, or negative behaviors from their doctors (Austin, 2013). Lesbian women, in particular, may feel the need to disclose their sexuality to their doctor because they think their doctor may not be aware of their sexuality; however, they may also fear disclosing to their doctor because they are concerned about a negative reaction from their doctor based on historical medical discrimination. Another fear for lesbian women was that they could be seen as only lesbians, which could then affect how they would be treated (Bjorkman & Malterud,

2007). Negative associations with disclosure might prevent LGB individuals from revealing their sexuality to their provider.

The previously cited literature has established the need for further research on LGB healthcare, specifically research that goes beyond STDs and HIV/AIDS, and discussed that healthcare providers may not have the skills needed to provide appropriate healthcare to LGB individuals or are potentially just unwilling to. In order to conduct research on LGB healthcare, theoretical frameworks are needed and this thesis utilizes both co-cultural theory and communication privacy management for said framework.

Co-Cultural Theory

Mark Orbe's co-cultural theory intends to break down and explain interactions between individuals from marginalized groups and those who exist in socially dominant groups. Orbe (1998) explained that multiple marginalized groups can be analyzed through this theory, including people of color, women, non-heterosexuals, and those of lower socioeconomic backgrounds. The marginalized group is described as the co-cultural group (Littlejohn & Foss, 2011). The term co-cultural is used as the label for the marginalized group because the term is meant to replace any negative past descriptions that inferred an inferior connotation (i.e. subculture), while simultaneously acknowledging the diverse cultures that exists within the United States (Orbe, 1998). Orbe and Roberts (2012) discussed how they prefer the term theorizing over theory because for co-cultural theorizing, they believe that theories are not static entities but rather, they evolve over time. Essentially, although Orbe (1998) presented a theory with multiple tenets, he believes that the tenets can be added or subtracted to while using the

theory and the theory is alive, fluid, and constantly adapting. While co-cultural theory offers specific tenants, these tenants are not always applicable and more can always be added.

Assumptions. Co-cultural theory is based on five assumptions. The first assumption is that hierarchies exist in society that privileges certain groups over others. Groups can be based on ethnicity, gender, socioeconomic status, or other factors and exist within a hierarchy that provides power to the top most group. Power decreases as it moves down the hierarchy. Second, the people who are labeled within the dominant groups are privileged because they hold positions of power that allow them to create and maintain systems of empowerment. Those systems of empowerment grant those in power the ability to only take their experiences and perspectives into account, while ignoring those who fall outside of the dominant groups. Rules, regulations, and societal expectations are created by the dominant group based on their life experiences and preferences, with little or no regard for those with less power and status.

Third, the communication systems utilized by those in power is established to keep co-cultural members outside of the center of power. Essentially, the systems created by the groups in power does not want to lose their power so they create systems that prevent co-cultural members from obtaining power in order to change the current system. Fourth, although there are multiple co-cultural groups, they all hold marginalized positions within society. Co-cultural groups are diverse but they all lack power and are impacted by those who are in power. Finally, people within co-cultural groups strategically communicate with those in power to negotiate their own position within the dominant system. Co-cultural groups understand that they are not in a position of power

and will choose consciously or subconsciously how to communicate with those who do hold power in society (Littlejohn & Foss, 2011; Orbe, 1998; Orbe & Roberts, 2012).

Communication practices. Co-cultural theory outlines 26 communication practices that co-cultural group members use to negotiate their interactions with dominant group members (Orbe, 1998). These practices are not always used, but they have been documented as having been used in interactions between dominant and co-cultural group members (Orbe, 1998).

Emphasizing commonalities occurs when co-cultural individuals choose to focus on the similarities between dominant and co-cultural members while simultaneously avoiding the cultural differences. In healthcare, an LGB individual could choose to focus on a medical ailment that would not relate to his or her sexual identity, such as having a cold, and ignore any questions pertaining to the individual's sexual health. Developing positive face is when a co-cultural member chooses to be overly polite, considerate, and/or attentive to dominant group members. When discussing personal health information with a provider, a LGB individual might focus on the provider and ask questions such as, "how has your day been?" so that they may seem like a polite patient.

Censoring self involves the co-cultural member choosing to remain silent whenever a dominant member says something inappropriate, insulting, or offensive to the co-cultural member. An example of this would be if a provider made a sexual comment based on the LGB individual's sexuality and the individual would just remain silent and not respond. Averting controversy occurs when a co-cultural member navigates the conversation away from any controversial or presumably dangerous area of conversation.

This strategy could be used if a provider started asking about a LGB individual's relationship and the individual could provide a non-gendered answer about the partner and then change the conversation.

Extensive preparation is when a co-cultural member prepares extensively in advance before having to interact with a dominant group member. For example, before seeking out a doctor's appointment, an LGB individual may research providers to see if the providers are LGB friendly and/or ask for opinions from other LGB individuals about how to talk with providers.

Overcompensating is a strategy where a co-cultural member believes s/he is experiencing discrimination, and in response, attempts to exceed expectations of his or her co-cultural identity so that s/he can be the superstar of the group. For example, a LGB individual could believe that his or her provider adheres to the stereotype that LGB individuals are promiscuous so s/he does not reveal the number of his or her sexual partners.

Dissociating is when co-cultural members make an effort to disconnect themselves from a behavior that is typically associated with their co-cultural group. In this case, a LGB individual could choose to not dress a certain way (such as a lesbian dressing in masculine clothing) so that s/he is not automatically labeled as homosexual. Similarly, mirroring is a communicative strategy where the co-cultural member performs dominant group traits in order to hide his or her co-cultural identity. Continuing to use the example of appearance, instead of just avoiding certain clothing or appearances, the

LGB individual makes the effort to appear as straight (the lesbian would wear a dress to assert heteronormative femininity).

Ridiculing self occurs when a co-cultural member either actively or passively starts or participates in discourse that demeans co-cultural members. A LGB individual could make a joke about sexual practices of LGB individuals to his or her provider.

Increasing visibility is a communicative strategy where a co-cultural member strategically and covertly maintains a co-cultural identity and presence while participating in dominant structures. For example, a LGB patient would not change his or her physical appearance to appear straight while going to see a healthcare provider but would also not wear any paraphernalia that could be considered identifying, such as a t-shirt that states, “We’re here, we’re queer, get used to it”.

Dispelling stereotypes occurs when co-cultural members choose to perform as themselves which could then counter stereotypes associated with their co-cultural group. Instead of lying to a provider about the number of sexual partners or the gender, a LGB individual would state the actual number of partners along with the genders of the partners to show that LGB individuals have as many sexual partners as heterosexual individuals.

Communicating self occurs when a co-cultural member has a strong self-concept and then interacts with dominant group members in an open way. Essentially, this means that a LGB individual would have to be sure of him or herself and be open about who s/he is to a provider and not hold back information, all while not being confrontational.

Intragroup networking occurs when a co-cultural member chooses to look for and work with other co-cultural group members who share similar goals, philosophies, politics, identities, etc. For instance, a LGB individual could seek out a LGB identified healthcare provider. The communication strategy of utilizing liaisons would be very similar, expect that instead of finding another co-cultural member, the person would find a dominant group member that s/he could trust for support, guidance, and/or assistance. So instead of finding a LGB provider, the LGB individual would seek out a LGB friendly provider.

Educating others takes place when a co-cultural member becomes the teacher in the conversation when talking with dominant group members in order to enlighten others on co-cultural values, norms, customs, actions, etc. As an example, while interacting with a provider, a LGB individual could educate the provider on the types of sexual activity in which s/he would engage, in order to educate the provider so that the provider could offer information on what STDs the person could contract.

Gaining advantage is described as occurring when a co-cultural member chooses to provoke dominant group member reactions by discussing cultural oppressions in order to gain an advantage. For example, a LGB individual could bring up how the state that the LGB individual lives in does not provide marriage equality and after the healthcare provider made a homophobic remark, the LGB individual would point out the homophobia. This interaction could potentially give the LGB individual the upper hand in the conversation.

Avoiding is a strategy where co-cultural members would actively maintain a distance from dominant group members and stay away from places where the person would most likely interact with dominant group members. In the case of healthcare, LGB individuals could simply choose not to seek out treatment or care because of the fear of interacting with providers.

Attacking occurs when a co-cultural member psychologically inflicts pain upon dominant group members through personal attacks. In this strategy, a LGB individual could post an online review about a healthcare provider s/he encountered. The review would explain how homophobic the provider was and actively encourage others to not see this provider. could simply choose to use personal attacks on a provider.

While these are not all of the twenty six practices, these are best fitting strategies for the context of LGB healthcare interactions. For the full list of communicative practices see Appendix A.

Strategy influencers. Robe and Orbe (2012) explained that co-cultural group members do not just choose to use these communication strategies. There are six factors that can influence the process of choosing a communication strategy: preferred outcome, field of experience, abilities, situational context, perceived costs and rewards, and communication approaches.

Preferred outcome is when a co-cultural individual contemplates which communication behavior or strategy will produce the outcome that s/he desires. The outcomes refer to three specific outcomes that can occur for a co-cultural member: assimilation, accommodation, and separation. Assimilation occurs when a co-cultural

individual attempts to lose any distinctive characteristic or cultural difference with the intent of fitting into the dominant society. Those wishing to pursue accommodation hope to change dominant structures in society so that they allow for the life experiences and perspectives of co-cultural groups. Finally, separation is when a co-cultural member wants to break away from the dominant structures and embraces their co-cultural differences while living amongst their own co-cultural or other co-cultural groups (Orbe, 1998).

The last element of co-cultural theory is that there are communication approaches that coincide with the communication strategies. These communication approaches are labeled as nonassertive, assertive and aggressive. These approaches work alongside wanting to assimilate, accommodate or separate which means that a co-cultural member will want to assertively assimilate or non-assertively separate. The pursuit of a certain approach is put into action through the use of the 26 communication practices that were previously addressed (Orbe, 1998).

As discussed previously, assimilation is the desire to be a part of the dominant structure of society and assimilation is impacted by the different approaches. Nonassertive assimilation is the attempt to be a part of the dominant structure in a restrained manner and typically uses the communication practices of emphasizing commonalities, developing positive face, censoring self, and averting controversy. Assertive assimilation takes a more pronounced stand and uses the extensive preparation, overcompensating, manipulating stereotypes and bargaining approaches. Aggressive assimilation is when a co-cultural member takes a more forceful approach in an attempt

to fit in utilizing the dissociating, mirroring, strategic distancing, and ridiculing self-approaches (Orbe, 1998).

The other forms of communication approaches are nonassertive accommodation, assertive accommodation, and aggressive accommodation. Co-cultural members take a nonassertive accommodation approach when they want to have dominant structures recognize their perspective but in a constrained and non-confrontational manner by using approaches such as increasing visibility and dispelling stereotypes. In efforts to create a cooperative balance between dominant and co-cultural groups, some co-cultural members take an assertive accommodation approach by using strategies like communicating self, intragroup networking, utilizing liaisons and education others. Finally, aggressive accommodation is not just about being forceful in recognition of perspectives but this approach also wants to appear as separatists. However, this is still contained within the accommodation approach of wanting to have both dominant and co-cultural structures evident by using confronting and gaining advantage strategies (Orbe, 1998).

The last approach is centered on separation. Nonassertive separation is when co-cultural members subtly use communication strategies to promote existing outside of the dominant structures. This approach uses avoiding and maintaining interpersonal barriers, however, when physical avoidance of dominant members is not possible, co-cultural members may resort to embracing their existing expectations of their group. Those who use assertive separation tactics tend to be more self-assured in their attempts to create co-cultural structures by using approaches such as communication self, intragroup networking, exemplifying strengths and embracing stereotypes. Lastly, aggressive separation is used when co-cultural segregation is urgent and co-cultural members might

criticize those members who desire assimilation or accommodation. The strategies associated with this approach are attacking and sabotaging others (Orbe, 1998).

Field of experience is the second influence in utilizing communication strategies. This refers to the lived experiences of co-cultural individuals. Life experiences include learning how to use communication practices, learning which tactics work, and identifying which practices have negative consequences. “Through the multiplicity of incidents within their field of experience, co-cultural group members are engaged in a process of constructing, and subsequently deconstructing, the perceptions of what constitutes appropriate and effective communication with dominant group members” (Orbe, 1998, p.11). Whenever individuals communicate with dominant group members, they will be able to determine which strategies achieved the outcomes they desired and which strategies did not work. Additionally, the co-cultural members have watched how dominant group members have responded, as well as how other co-cultural members have responded to their use of certain strategies, all of which will help the co-cultural members further refine their strategies.

The third influence on communication strategies for co-cultural members is abilities. Abilities recognize that not every individual can enact each practice due to personal characteristics or certain situations. It is not possible to assume co-cultural members can utilize all of the practices without taking personality traits, such as a person being shy or outspoken, into consideration (Orbe, 1998). Along with abilities, situational context is the fourth factor when determining communication practices. Orbe (1998) explained that situational contexts are key to the process of co-cultural communication because it is not possible to use the same communication practice for every interaction

with dominant group members. Moreover, it is necessary to understand that the existence of others in the communication setting can impact the use of communication practices. This not only includes other dominant members but co-cultural members, as well, because this can impact the co-cultural member's viewpoint of his or her standing in the situation. The last factor is perceived costs and rewards. A focus on perceived costs and rewards recognizes that they are formed from particular social, cultural, and historical life circumstances and that there is not a definite lists of the costs and rewards (Orbe, 1998). Essentially, there is no master list of the exact costs and rewards co-cultural members go through when choosing communicative practices; rather each individual has their own concept of costs and rewards which are formed by their current circumstances.

Co-Cultural Theory and the LGB Community. After reviewing co-cultural theory, it is evident that this theory could be useful in analyzing the communication strategies and approaches LGB individuals use when communicating with their healthcare providers. Co-cultural theory has previously been used to analyze LGBT individuals in different organizational settings, such as educators within the classroom (Anderson & Giovanni, 2009; Dixon, 2009). Camara, Katznelson, Hilderbrandt-Sterling and Parker (2012) argued for the use of co-cultural theory in their study on heterosexism by stating that co-cultural theory is meant to examine how underprivileged groups navigate their communication with dominant groups. Those who do not identify as heterosexual are seen as an oppressed group because society favors a heterosexual identity. Camara et al. (2012) found that LGB individuals most commonly used assertive accommodation (40%) and more specifically, they mostly used the strategy of communicating self (67%). In Camara et al.'s (2012) study focused on relational and

situational context in a range of settings however this thesis specifically would explore co-cultural behaviors in a healthcare setting. Even with the shifting of focus, there could be potential similarities between Camara et al.'s (2012) findings and this thesis.

Co-cultural theory can illuminate how LGB individuals strategically communicate with their providers. However, co-cultural theory only looks at the perspective of the co-cultural member and does not take into account the delicacies of navigating disclosure of private information. Therefore in order to bridge power dynamics in conversations and the balancing of privacy disclosures, Communication Privacy Management will be utilized as another theory that can provide perspective for this thesis.

Communication Privacy Management

Sandra Petronio's communication theory, Communication Privacy Management (CPM) examines the tensions and dilemmas that exist in interpersonal relationships when dealing with the openness and privacy of information within the relationship (Littlejohn & Foss, 2011). The fundamental belief of the theory is that individuals have a right to own and regulate who has access to their private information (Petronio, 2002). Littlejohn and Foss (2011) explained that we are constantly making decisions about what private information we should reveal, who should be allowed to have this information, and the ways in which we should reveal this information. These tensions about private disclosure occur in every relationship because individuals express the need to share information, as well as protect themselves from certain information. Petronio (2002) stated that CPM uses the term boundaries to demonstrate how individuals create ownership lines around the information they deem to be private and the boundaries represent a line of access to

that information. CPM functions as a privacy management system which identifies the ways that privacy boundaries are coordinated between individuals.

Privacy boundaries contain the information that individuals choose to label as private and those boundaries are not set up solely by an individual but are constantly negotiated with others. There are certain cases where private information is never shared with others (Littlejohn & Foss, 2011). For example, an individual could have experienced abuse as a child and choose to never share that information with others. Then there are also situations when boundaries will shift, which can lead to the opening or closing of boundaries (Littlejohn & Foss, 2011). An example of this shifting would be if two people went from being friends to an intimate couple and would decide to share more intimate details of themselves with each other. A criterion of CMP is that private disclosures are viewed as dialectical, meaning that they require conversation and negotiation. Disclosure is not an individual's decision but rather it is regulated by a metaphorical relational contract where both individuals balance an equal number of costs and rewards (Littlejohn & Foss, 2011).

Theoretical suppositions.

Private information. The first theoretical supposition is based on private information. There is no set list of what is considered private information, rather each individual chooses what they believe is private information. Instead of viewing private disclosure as synonymous with intimacy, intimacy may be an outcome of disclosing private information. However, intimacy reflects all dimensions of a close relationship and disclosing private information does not guarantee intimacy in a relationship. Intimacy can be defined as the feeling of knowing someone on a deep physical,

psychological and emotional level because of the significant position they hold in someone's life (Petronio, 2002). "Private disclosure, on the other hand, concerns the *process* of telling and reflects the *content* of private information about others and us" (Petronio, 2002, p.6).

Privacy boundaries. CPM theory uses boundaries to demonstrate how people determine whether they view information as private or public. Boundaries are also created as a collective because an individual may not view the private information as solely their information. The collectively held boundaries are in existence because the information is not just about the self. Boundaries become blurry when the shared information is not just about the self but when others are involved. Additionally, boundaries can be weakened if events outside the control of the owner cause the information to be leaked. This can then create boundary turbulence, which is when boundary rules have been violated and that can cause rifts in relationships. Finally, boundaries can change over time. For example, children's conceptualizations of privacy boundaries are vastly different compared to adults' conceptualizations because they may not understand what should or should not be kept private. Adults have the biggest boundaries and children, as well as elderly adults, have smaller boundaries because of their lack of control over what should be kept private (Petronio, 2002).

Control and ownership. When a person feels as though someone shared information about him or herself that should not have been shared, s/he may claim that there was a violation of privacy. This feeling of ownership creates a need to control what information is shared and what is concealed. Control is crucial because there may be risks involved in the sharing of that private information. When an individual has

information shared without his or her control, s/he feels as though s/he has been personally violated (Petronio, 2006). For example, if an individual decided to tell his or her therapist about an affair s/he was having and the therapist told the receptionist in the office, the individual would feel as though their privacy was violated and could press charges or just go to another therapist.

There are two types of boundaries that we try to manage control over, personal and collective boundaries and both involve exercising levels of control. Boundaries that are shared are mutually controlled by those who are within the boundary as well as those who are privy to that same information. We can enter into these boundaries by simply having someone share information with us and once that information is shared, we enter into a contract with that person. The choice to share this information with others is based on a risk-benefit scenario for ourselves as well as those with whom we choose to share private information (Petronio, 2002).

Levels of control: Privacy boundaries. CPM is a rules-based management system and it depends on three management processes (Petronio, 2002). First, privacy rule foundations not only represent the way the rules are developed, but also the properties of the rules. The second process is how rules are regulated when people are managing their collective boundaries, which is called boundary coordination. Finally, boundary turbulence is caused when boundary coordination is not functioning in a synchronized way. There are times when people are not able to work together and create consistent boundary coordination, which then causes turbulence because of the lack of understanding of the appropriate boundaries (Petronio, 2002).

Privacy management dialectics. Dialectics refer to how, within a social life, people find tensions between opposites and contradictions. The basic elements of the theory are based in these opposing ideas such as, “disclosure-privacy, concealing-revealing, public-private, openness-closedness, and autonomy-connectedness” (p.12, Petronio, 2002). Although the degree to which information is considered private or public is difficult to identify, when information is disclosed, the information becomes more public than it does private. A majority of other research only considers looks at the revealing dimensions of self-disclosure without considering what a person is giving up when s/he discloses (Petronio, 2002). On the reverse side, a person can measure his or her degree of privacy based on how much they choose to publicly share personal information (Petronio, 2002). Petronio (2002) used the example of celebrities and how they realize that they have to control more of their private information in order to maintain their public persona. The more public a celebrity’s private information becomes, the narrower s/he is able to define his or her privacy. However, s/he will become more protective of the small amount of privacy they do get to keep.

Privacy rule management. CPM operates under privacy rule management processes. These rules of privacy determine how a person chooses to reveal or conceal information, who is able to receive the information, and how the information is shared. CPM identifies three rule management processes which are labeled as: privacy rule foundations, boundary coordination operations, and boundary turbulence (Petronio, 2002).

Privacy rule foundations. The rule foundations are comprised of two features: development and attributes. Development consists of criterion including cultural

expectations, gender, motivation, context of the situation, and risk-benefit scenario. Attributes refer to the specific dimensions of the privacy rules (Petronio, 2002). These are all used to establish privacy rules. Rules are either pre-existing rules or they are negotiated when people form new collective boundaries. CPM highly values rules because they tangibly show how people regulate and coordinate their privacy boundaries with others. Understanding these rules is crucial to understanding the main components of CPM (Petronio, 2002).

Culture plays an important role in determining a person's rules for disclosure. The cultural criterion is based on how a person's cultural expectations informs him or her of appropriate social behavior which then impacts how the boundary controls are established (Petronio, 2002). Each culture values disclosure differently and has its own sets of disclosure expectations. While all cultures have some degree of privacy expectations, the expected rules are different for each culture (Petronio, 2002). Boundary turbulence can occur if there are cultural differences because a person from one culture may have different expectations compared to the other person with whom s/he is disclosing (Petronio, 2002). To illustrate this, Petronio (2002) used the example of the United States and how, although the Constitution does not explicitly state that the citizens have a right to privacy, US citizens believe they have a fundamental right to privacy. The idea of a right to privacy is cultivated as a cultural expectation.

The gender criterion of CPM refers to the various way men and women view privacy (Petronio, 2002). Similarly to cultural expectations, men and women are taught through socialization how they should choose to disclose or not disclose private information. Although men and women may approach the expectations of privacy

management differently based on the societal assumptions of gender, they can work together to coordinate privacy boundary rules. Privacy disclosure is not just influenced based on the gender of the person disclosing the information, but could also be influenced by the gender to whom s/he is disclosing (Petronio, 2002).

Motivational factors can also contribute to the rule making process of privacy management. People may choose to open or close their boundaries based on the needs they currently have concerning privacy disclosure (Petronio, 2002). There are several factors that impact motivation to disclose. First, a person may have a desire to disclose in order to fulfill a need to discuss feelings and thoughts with others. Second, people might disclose in order to learn more about themselves. Furthermore, a person may engage in self-defense because s/he feels the risk is too great to disclose. Reciprocity can be an additional factor because if someone discloses information to another person, the other person feels the need to share disclose a similar amount of personal information back to them. Finally, attraction and liking of an individual can impact disclosure. If a person thinks another individual is attractive, they are more likely to disclose private information to that individual. People disclose more information to people that they like (Petronio, 2002).

Contextual criteria reference life events that may impact how a person discloses private information. Petronio (2002) groups life events into three major categories: traumatic events, therapeutic situations, and life circumstances. Traumatic events are disruptive situations that have the capability of changing an individual's expected life course. These events typically come without warning and require people to deal with highly stressful situations. Therapeutic situations refer to when people turn to therapists,

counselors, psychologists, or clinicians in order to cope with situations that are outside of their control. Disclosure is reshaped in these situations because a person may be disclosing in order to reach the goals of therapy or therapists may have to high of a demand for disclosure for the patient (Petronio, 2002). Finally, life circumstances are situations that are less stressful than traumatic events. However, they typically require a person to change their privacy boundaries. Examples of these situations are the dissolving of relationships, the loss of a job, acquiring a disability, or becoming a parent (Petronio, 2002).

The final element of privacy rule development is the risk-benefit ratio criterion. Petronio (2002) stated that individuals need to balance the risks and benefits of revealing or concealing private information. “Although there are potential gains in telling information, as a dialectic, there is a simultaneous pull to consider the risks” (p. 66). There are several ways to benefit from disclosing information, including the need to express oneself or feelings, clarifying thoughts, social validation, developing relationships, and social control. There are also potential risks to revealing private information. Individuals may feel there are security risks to revealing private information because it could take power away or jeopardize their or others’ safety. For example, if there is stigma attached to the private information, it could pose potential risk to an individual. Stigma risks are when the revealing of private information could discredit someone or their identity could be attacked, whereas face risks are more generic and refer to something that could embarrass a person (Petronio, 2002). Also, while disclosing could be beneficial to a relationship, it could also harm a relationship. Finally, role risks

occur when a person's job or position could be in danger if information was disclosed (Petronio, 2002).

Privacy rule attributes. There are two key dimensions to privacy rules: the way people acquire rules and the properties of rules. Acquiring rules occurs through the socialization of pre-existing rules or through the negotiation of new rules. Rule properties are either stable over time, develop into privacy orientations, or change (Petronio, 2002).

Rule acquisition. People do not always create new boundary rules every time they establish boundaries for themselves and others. Instead a person can learn rules through observing what is acceptable for privacy boundaries with society. In some situations, individuals will enter a group and are expected to learn the boundary rules of that group. Groups can be classified as being a member at a larger organization or simply being in a family, and a person is expected to maintain the privacy of the group by learning their boundary rules. They are able to maintain the privacy by working to learn the rules of the group (Petronio, 2002).

CPM argues that privacy boundaries are negotiated and coordinated through actions with others. Coordinated boundaries determine the rules that will regulate the collaborated boundaries. There are several variations on how boundary negotiations are exhibited: disclosure warnings, explicit rules, and implicit rules. Disclosure warnings occur when parameters are set for who can know what information. A disclosure warning can be explicit, where it is literally stated what the rules are for boundary management. Implicit rules explain boundary rules through hints or prompts, which can be more ambiguous and less articulated (Petronio, 2002).

Rule properties. Rule properties refer to the qualities of privacy rules and include routinization, orientation, change, and sanctions (Petronio, 2002). There are some rules that become so customary that they are used for routine actions, which are the routinized rules. Routinized rules are stable. Conversely, orientation rules are unbending. These are formed with the idea that they are very valuable and ingrained for the individual (Petronio, 2002). Although routinized and orientation rules can be good for individuals, sometimes boundary turbulence causes a need to change privacy rules. Finally, sanctions refer to the positive or negative consequences that can occur when others adequately perform appropriate privacy rules or breach the privacy rules (Petronio, 2002).

Petronio (2000) explained how disclosure can be found in health communication interactions by looking at the communication between doctors and their patients. Boundary coordination between doctors and patients does not follow the typical patterns of CPM because patients and doctors do not always see eye to eye on what private information should be revealed. A patient may not think that the number of sexual partners s/he has is appropriate or relevant to discuss with the doctor but the doctor may feel that the information is crucial to the person's healthcare. Therefore, the negotiation of boundary rules may lead to boundary turbulence because both the patient and doctor cannot find a way to come to equal terms; however Petronio (2000) stated that it is necessary that both the patient and doctor work together to meet the end goal of the patient's good health.

Co-cultural theory has not extensively been used as a theory in health communication research, but it has the potential to not only add to the field but can also be complimentary with CPM. Beisecker's (1990) article examined the power dynamics

between patients and their doctors. While the article mostly focused in on a patient's role in participating in medical decisions, there was also a brief mention of identity.

According to Beisecker (1990), sociodemographic characteristics can impact the power a patient has. Orbe's (1998) co-cultural theory can add to this point about patient power by elaborating on the ways in which patients who are part of a minority group have to negotiate power with their doctors. Seeing as, CPM has been used to look at how patients and doctors navigate disclosure boundaries (Petronio, 2000), co-cultural theory could add to that discussion to see how a person's co-cultural identity impacts the information s/he are willing to disclose to his or her doctor and the types of strategies the person utilizes in order to navigate those conversations.

CPM and Health Communication

CPM has already been used as a way to make sense of health communication experiences. Lewis, Matheson, and Brimacombe (2011) utilized CPM as a theoretical lens in their study on how the discussion of sex can be uncomfortable between a healthcare provider and a patient. The authors sought out to determine factors that impacted a patient's choice to disclose certain information while at a birth control clinic. In their surveys, they found two factors that contributed to disclosing of sexual issues. First, previous communication about the sexual issues impacted whether or not the patient disclosed the sexual information. Additionally, the characteristics of the physician influenced the patient's willingness to disclose.

Nichols (2012) also used CPM when looking at why college students would choose to either lie or fail to disclose important sexual health information to their sexual partners. Through the use of surveys, Nichols (2012) found that students believed that

their sexual information was considered private and that they had the right to regulate that information. Nichols (2012) contended that privacy management and deception should be defined separately; as the students did not believe they were trying to deceive others about their sexual history but thought that the information was theirs to control.

Kosenko's (2011) article examined communication about safe sex between trans adults, specifically about how they describe the process of communicating about safe sex. CPM was utilized to explain how there were not any clear privacy rules about how to disclose sexual information. Although the sexual information was viewed as something that should be considered private, there was a lack of clear communication and privacy rules.

In Petronio and Sargent's (2011) study, they looked at privacy management from the perspective of nurses at critical care and emergency units at a hospital. Their study demonstrated that nurses believed that they were stakeholders of information that was disclosed by their patients and families. Essentially, nurses were expected to keep their patients' information confidential and appreciated their co-ownership status of that information.

The previously mentioned studies establish the use of communication privacy management within health and healthcare settings. Perspectives on privacy management seem to be different for the patient and for the provider as nurses value their status as a co-owner of private information (Petronio & Sargent, 2011) however patients do not always feel comfortable sharing private information regarding their sexual health (Nichols, 2012). This thesis can provide another perspective on communication privacy

management by looking at how LGB individuals negotiate privacy management with their healthcare providers.

Summary and Research Questions

This representation of research from multiple fields pertaining to LGB healthcare further highlights the issues that LGB people face in all different facets of their health. By utilizing these theoretical lenses, it is possible that this thesis can present new ways of looking at sexual healthcare of LGB patients and how communication affects their healthcare. Therefore, this thesis will be guided by the following research questions:

RQ1: How do lesbian, gay and bisexual individuals navigate disclosure of their sexual identities with their healthcare providers?

RQ2: What type of communication barriers do lesbian, gay, and bisexual individuals encounter when communicating with their healthcare providers?

CHAPTER 3: METHODOLOGY

The literature review in Chapter 2 underscored the limited knowledge communication researchers have about LGB healthcare interactions and experiences, serving as a call to uncover more details of how LGB individuals disclose their sexuality to providers and what communication barriers they encounter with providers. Because of the limited understanding of LGB healthcare experiences, it is necessary to utilize a qualitative approach. Specifically, I conducted in-depth interviews to discover more about LGB healthcare experiences. Conducting in-depth interviews with LGB individuals about their healthcare experiences allows the participants to elaborate on what they feel is important or relevant to the conversation. In order to explain how the thesis research was conducted, I first, explain qualitative inquiry and in-depth interviewing. Second, I detail the interview collection and analysis process. Finally, I explain how I achieved qualitative rigor in order to support the findings presented in Chapter 4.

Qualitative Inquiry

Qualitative research is a vast field of inquiry used in multiple disciplines and used to study a wide variety of topics (Denzin & Lincoln, 2000). Qualitative research is concerned with understanding subject matters through the viewpoints of others; those viewpoints are presented to create representations of those individuals or groups of people (Denzin & Lincoln, 2000). There are two main components of qualitative inquiry: a commitment to an interpretive approach to the subject/topic being researched and the continuing of the critique of postpositivism (Denzin & Lincoln, 2000). Postpositivist researchers believe that humans interact in patterned ways and those behaviors are not

based on the individual, but in relation to others (Lindolf & Taylor, 2011). Interpretive qualitative scholars believe that there is not one reality and that individuals have unique realities (Lindolf & Taylor, 2011). Lindolf and Taylor (2011) used a broad definition of qualitative research in order to incorporate the multitude of qualitative methods; however, Denzin and Lincoln (2000) argued that it is a challenge to provide a set definition of qualitative research as there is no theory or paradigm that is clearly qualitative. Instead Denzin and Lincoln (2000) explained what qualitative scholars attempt to do: seek answers to questions about how social experiences create and give meaning.

The word qualitative, in the context of research methodologies, represents how information obtained from research is not measured in amounts or frequencies but rather emphasizes the nature of socially constructed reality and how situations shape what is found through the process (Denzin & Lincoln, 2000). Creswell (2014) explained that qualitative research focuses on the meanings participants provide and not what meanings the researcher wants them to have. Not only is qualitative research about understanding others' socially constructed realities, it also calls for researchers to recognize their own biases and help keep them from creating meanings for participants.

The process of qualitative research is meant to be formed inductively, meaning that there is a need to repeatedly test any explanation for phenomenon through ongoing interaction with those that they are studying before attempting to create any type of theory (Lindolf & Taylor, 2011). Testing of any explanation comes from the ability for qualitative research to be developed naturally. Although there is a tentative research plan in place before going into the field, qualitative researchers are ever evolving in their framework of strategies, tactics, and techniques (Lindolf & Taylor, 2011). Reflexivity is

an essential idea within qualitative research, which is the process of engaging in recognition of and adaptation with others allowing for flexibility within the research. When researchers are reflexive richer data is produced because the voices of the participants are heard more clearly (Lindolf & Taylor, 2011).

Qualitative research does not believe that it captures the entire scene as it unfolds. Instead, the research captures a more in depth look into a section of the scene, valuing the depth of the situation rather than the breadth that can be covered (Lindolf & Taylor, 2011). In order to capture that depth, sampling of participants has to occur. Random sampling has the baseline understanding that everyone in a population has an equal and independent chance of being chosen in order to generalize about the population. However, because of the desire to have in-depth understanding, qualitative researchers rarely take this approach. Qualitative research desires those who have experience in a certain area so that the area of research can have as much detail as possible (Lindolf & Taylor, 2011).

Positionality. As discussed previously, researchers are responsible for interpreting the meaning of the data produced by participants (Denzin & Lincoln, 2000). Therefore, the researcher's positionality can be influential to the process. The reflexivity that is engaged in qualitative research allows for the researcher to consider how their own identity and experiences impact the research process (Lindolf & Taylor, 2011). I am part of the LGB community because I identify as lesbian. Not only do I identify as part of the community but I also have had my own healthcare encounters influenced by my involvement in the community. Because of my negative experiences with my own healthcare providers I believed that every LGB individual had a similar experience.

Alongside assumed experiences, I also came into the research with the assumption that most LGB individuals would view sexual identity in the same way that I did. I believe that my sexuality is a crucial component of my identity and I do not believe in hiding who I am. This belief then creates the idea that everyone should disclose sexual identity to a healthcare provider unless the person views the situation as hostile or dangerous. Some of my questions were developed based on the idea that everyone viewed sexuality in the same way that I did and that each participant would have their own negative experiences to share. Moreover, even though I would constantly attempt to focus the attention of the interview solely on the participant I would end up sharing my own experiences with the interviewees with the intention of building rapport with the participant.

Data Procedures

Recruitment. Recruitment began after the approval of IRB (see Appendix B). This thesis is concerned with the healthcare experiences of LGB individuals; therefore, participants were recruited using criterion sampling. Criterion sampling specifically recruits those who meet a certain criterion in order to meet the needs of the research design (Lindolf & Taylor, 2011). The call for participants asked for self-identified lesbian, gay, or bisexual individuals between the ages of 18-60 years old (see Appendix C). Additionally, participants needed to have visited a provider to receive care within the past three years.

Participant recruiting occurred in two waves. The first round of recruitment occurred between November 2014 and December 2014 through two forms: a post for

participants was sent on a Mid-Atlantic university's LGBT faculty listserv and a call for participants on Facebook. The first call for participants only yielded eight participants, so a second wave of recruiting occurred in January 2015. In the second round of recruitment, I sent another post on the LGBT faculty listserv and on Facebook. The call for participants was also posted on CRTNET, the National Communication Association disciplinary listserv. Faculty listserv participants contacted the researcher via email to set up in-person interviews. The participants recruited via Facebook and CRTNET contacted the researcher via email to set up Skype or phone interviews.

Participants. A total of 20 people participated in this study. All of the participants identified as non-heterosexuals. Although the call for participants specifically requested lesbian, gay, and bisexual individuals, individuals who identified as queer or pansexual were allowed to participate in this study to better represent the non-heterosexual population. Each participant orally provided demographic information. Participants identified their sexuality as pansexual ($n = 1, 5\%$), bisexual ($n = 2, 10\%$), queer ($n = 2, 10\%$), lesbian ($n = 6, 30\%$), and gay ($n = 9, 45\%$). Participants' ages ranged from 22 to 51 ($M = 32.9$). Nineteen participants identified as Caucasian and one participant identified as African American. All of the participants lived in the United States. Nine of the participants were from the Mid-Atlantic (45%), four were from the Northeast (20%), one was from the Northwest Pacific (5%), one was from the Southeast (5%), three were from the Midwest (15%), and two were from the Southwest (10%).

Data collection. For this thesis, qualitative interviewing was used as the primary qualitative method. Qualitative interviews have the ability to go deeper and more broadly into a subject area, which is why interviewing is one of the preeminent methodologies in

communication studies (Lindolf & Taylor, 2011). There is the expectation that the interviewee will be discussing people, settings, events, and interactions that have occurred outside of the actual interview (Lindolf & Taylor, 2011). As the “digging tools” of social science, interviewing relies heavily on interpersonal and technical skills (Lindlof & Taylor, 2011). Interviewing comes with advantages such as the ability to collect data that cannot be observed in real time and that when questions are being asked, the researcher can dig deeper into the conversation and respond based on the answers that have been provided by the interviewee (Keyton, 2006).

There are several purposes for conducting qualitative interviews (Lindlof & Taylor, 2011). First, interviews are used to understand a person’s experience and his or her perspective in relation to a specific topic area. When conducting the interview and searching for the participant’s meaning, it is important to pay attention to the specific language the participant uses. Another purpose of interviewing is to gather information about things or processes that cannot be observed. To gather information, interviewers can ask interviewees to discuss past events or talk about information that has been obtained through other sources. The last crucial element of interviewing is to have efficiency in the collecting of the data. Efficiency refers to the number of hours not only spent in contact with participants, but also the amount of time engaging in the data, such as working with transcripts (Lindolf & Taylor, 2011).

For this thesis, individual in-depth interviews were conducted in order to gain rich information from interviewees (Johnson, 2002). A major difference between in-depth interviews and other interview forms is that in-depth interviews require more self-reflection from the researcher, as well as the need for the researcher to constantly adapt to

any unexpected turn that the interview might take (Johnson, 2002). An important ethical element of in-depth interviewing is that the “truth” is told; however the “truth” can be complicated because of the multiple viewpoints that come from both the participants and the researcher, resulting in a co-constructed experience (Johnson, 2002).

The interview protocol (see Appendix D) was semi-structured, meaning that there were specific questions created to guide the interview but there was still room for questions to emerge throughout the interview (Creswell, 2014). Questions in the protocol covered several different areas. The first questions were meant to gather demographic information about the participant. A second set of questions were developed to obtain what sort of healthcare the participants were seeking, how often they sought out those types of healthcare, and how satisfied they were with their current healthcare. After information was gained about their healthcare, the questions then moved into their sexuality disclosure experience. Additionally, questions were asked about their opinions on how to have discussions about sexuality with healthcare providers. The final set of questions revolved around romantic partner interaction within healthcare. Even with the protocol, questions emerged within each interview that was based on the individual’s experience.

Individual in-depth interviews were conducted both in person and on the phone or via Skype. Thirteen participants were interviewed in person in a private location. Five participants chose to conduct the interview over the phone and two of the participants were interviewed over Skype. All of the interviews were audio recorded. The length of the interviews ranged from 35-61 minutes. After all of the interviews had been completed, they were transcribed, resulting in 312 single-spaced typed pages of data.

Data Analysis

Grounded theory was used in this study to interpret the data. Grounded theory is a methodological approach that allows for people to be studied in natural settings and moves qualitative research away from positivism (Charmaz, 2001). Research that utilizes grounded theory moves with each step towards the development, refinement, and interrelation of concepts. The categories formed from grounded theory are inductive, meaning they emerged and are created from analysis of the collected data. A grounded theory approach must offer analytical explanations of what the actual problems are and how the process of analyzing the research was conducted (Charmaz, 2001). However, the flexibility of grounded theory allows for concepts to emerge naturally and allows for the changing on conditions as data are continually gathered. Grounded theory is excellent studying new topics as it does not need to subscribe to positivist or objectivist assumptions. Instead, grounded theory allows for studying empirical worlds without assuming that there is absolute truth in the analysis (Charmaz, 2001).

In order to analyze the data, I engaged in a constant comparative method of analysis (Glaser & Strauss, 1967). A constant comparative method is a type of grounded theory that requires researchers to continuously engage in and with the data of their project. The constant comparative method allowed researchers to identify recurring patterns of behavior and meaning in the participants' experiences that were discussed through the data collection process. The constant comparison of data continues until "theoretical saturation" has been achieved (Glaser & Strauss, 1967).

The constant comparative process begins with data “reduction” and “interpretation.” After reading all the transcripts, actual analysis of the data began. The analysis process begins by manually coding the transcripts. Constant comparison data analysis allows researchers to mark patterned regularities about participations and the ways in which they discuss and enact their experiences. I initially read the transcripts twice in its entirety, in order to immerse myself in the data and to make preliminary notes about potential themes. Reading the transcripts several times is done in order to gain a complete understanding of participants’ experiences and to ensure that any potential themes are grounded in the data. On the third read, I began to mark comments that addressed similar issues, relying on colored highlighters to keep ideas distinct.

I then began the integration stage, where I solidified concepts into representing themes and made notes about specific sub-ideas that the themes addressed. Finally, I engaged in dimensionalization, where I developed the arguments behind themes, and used those arguments to further develop the themes, supported by the interviews. Themes were supported by direct quotations from participants to mark recurrence (similar meaning was communicated but different words were used), repetition (the reiteration of key words and phrases), and forcefulness (indicated by vocal features such as inflection, volume, or pausing that set off certain portions of an account from others) (Owen, 1984).

Evaluating Qualitative Research Rigor

Tracy (2010) presented eight criteria for measuring the rigor of qualitative research. The purpose of these criteria is to have rules and guidelines for qualitative research. Tracy (2010) established the following eight criteria: worthy topic, rich rigor,

sensitivity, credibility, resonance, significant contribution, ethical, and meaningful coherence.

First, a worthy topic refers to whether or not the topic being researched is relevant, significant, and interesting. Furthermore, the study should point out surprises that could go against the assumptions of the researchers and readers. Most importantly, this criterion requires researchers to explore something that has not already been deeply examined (Tracy, 2010). Rich rigor focuses on the amount of data that is used to support the claims being made. However, quantity is not the overall goal; rather, rich rigor can be about the time spent gathering data. Also, rigor includes whether the sample was appropriate for the goals of the study and if appropriate procedures were used (Tracy, 2010).

Sensitivity requires researchers to be honest and transparent about their biases, goals, and how their reactions influenced the research (Tracy, 2010). For example, if a researcher has experienced discrimination from healthcare providers s/he would disclose that information to the participants and/or discuss that discrimination in their writing of the research. Self-reflexivity is fairly similar in that the researcher is constantly reflecting throughout the entire research process (Tracy, 2010). Reflecting could be done through the use of a journal or recognizing bias as it comes up during the research process.

Credibility is the fourth criterion. Credibility can be accomplished by using thick descriptions, which allows for the representation of participant voice instead of just the interpretations made by the researcher. Moreover, the descriptions should be from multiple voices rather than only referring to the same set of participants (Tracy, 2010).

Another criterion is conducting ethical research. Ethics can be established by going through the Institutional Review Board (IRB) process and disclosing that studies received IRB approval in research write-ups and publications (Tracy, 2010).

Resonance refers to how the audience or readers should be affected by what has been written (Tracy, 2010). For example, readers should feel as though they have learned something new and interesting and could be further impacted by the results. Finally, qualitative research should significantly contribute to the larger pool of research (Tracy, 2010). Having criteria for qualitative research allows for there to be a clear standard of what qualifies as “good” qualitative research and can help guide the research process.

This thesis has met several of the criteria needed to establish rigor in qualitative research. First, the topic was worthy of discussion because there is a lack of research on the topic and the topic can contribute to the larger discussion of LGB healthcare. Additionally, Healthy People 2020 labeled the LGB community as a priority focus concerning their healthcare and emphasized the need for further research (“Healthy People 2020”, 2013). Sensitivity was also established as I, the researcher, disclosed my own healthcare experiences in the thesis and how it might impact my understanding of participants’ experiences. The fourth criterion, credibility, was met by providing rich descriptions of the interviews and using multiple voices in developing and describing the themes of the thesis. Ethics was also met because the study was approved by my university’s IRB. Finally, the thesis will contribute to the larger pool of research in health communication as well as representing LGB research.

CHAPTER 4: RESULTS

Influences on Disclosure

LGB individuals make decisions on a regular basis about whether or not they want to come out to others and those decisions can be based on multiple factors. The same can be said for the choice of coming out to healthcare providers. Participants rationalized why they would disclose their sexuality to certain providers or why they would choose to remain silent. There was no single determinant of whether or not LGB individuals would disclose their sexuality to their provider; rather, there were multiple factors that influenced their decision to reveal their sexuality. Six influencing factors emerged from the data: experience with family, fear of gossip and connections, provider refusal, religion, age, and level of trust.

Experience with family. Participants discussed how they came out to their family and each person had a unique story; however, how family members reacted to the coming out conversations did have an impact on whether or not they felt comfortable coming out to their healthcare providers. If the participant did not have a positive coming out experience with his or her family, s/he was hesitant to discuss his or her sexuality with the provider. When Pete talked about his coming out experience with his parents, he said, “It was an accident they found out. It’s a pretty sad story... but they found out without my choosing and I didn’t come out for a while after that as a result.” Although Pete did not want to go into detail about his coming out experience with his parents, he explained that it is something that he is still dealing with. As a result, he actively chooses to either not come out to his provider or lie about the gender of his sexual partners when

asked. Grady was less detailed in his experience, but echoed a similar sentiment. When talking about his coming out process and how his family reacted he simply stated, “My family had issues with it for a while, that was family tension”. Similar to Pete, Grady did not come out to his providers, and just said “I’m not out to them” without explanation.

Coming out does not have to be entirely negative to have an impact. Even the smallest amount of negativity can impact how a person feels someone is going to react to him or her revealing his or her sexuality. Sonya’s parents told her that they were okay with her identifying as a lesbian but her extended family members may not be. Sonya explained:

My mom is, like, fairly sure they’re not going to be okay with it and I think well my mom, my mom said that she would talk to them but she still hasn’t so that’s kind of like, that’s, like, the only secret is, like, very extended family.

Although Sonya’s immediate family does not seem to have a problem with her sexuality, the hesitation to inform other family members seemed to impact how she thought her relationship with her medical provider would be affected by her coming out. She explained,

I do get a little bit of anxiety about, like, them asking about sexual orientation. Well not so much sexual orientation, but asking, asking about, like, being sexually active or things like that. Um, I, like, I’m a hard core people pleaser and I, like, hate making people, unhappy or making people awkward or whatever, so, like, more times than not I’m nervous that telling someone about being gay. It’s more, like, I mean, I understand there are people in the world who are not okay with it.

But it's more, like, I don't want to make things awkward. I don't want them to like not like me.

Although Sonya stated that she was not extremely worried about sexual orientation, she was still worried about potential negative reactions from providers about her non-heterosexual practices and if providers would dislike her for those practices. Those who had complicated coming out processes with their family showed similar hesitation in coming out to certain providers, suggesting that any reaction that stems from coming out to family members could impact whether or not LGB individuals disclose their sexuality to healthcare providers.

Just as having a negative coming out experience with family can create hesitation of coming out to providers, a positive experience with family can lead to a willingness to disclose. Amelia was very close to her grandfather and consequently he was one of the first people she came out to and she said that "he reacted really positively". In turn, Amelia was fairly open about her sexuality; when it came to her providers, she stated, "I can be really frank with them about, like, what my like, sexual health needs are, or like, my relationship status."

Most LGB individuals have deeply rooted relationships with their family members and the type of reaction their families have to coming out can impact how they come out to others when placed in a vulnerable position, such as the doctor's office.

Fear of gossip and connections. Several participants expressed that they were from small towns and had rooted connections to the healthcare providers in those areas, causing them to be more hesitant about disclosing their sexuality. They were concerned

that the providers might gossip about their sexual practices or sexual orientation to others in the area. Grady mentioned, “I come from a small town and there’s only, like, one doctor, so like, he doesn’t need to know all my business.” For Grady, it was not just about the small town but his connection to his provider’s son and how his provider was friends with his parents. He further stated, “I like not talking sex with my main healthcare provider, also cuz like, I’m friends with his son. We played soccer together when were young and my parents like, went out to dinner with them every couple of months.” This complex, connected relationship prevented Grady from being open about his sexual practices with his general practitioner which was one of the reasons he sought out STI testing from another medical source. Parental connections appeared fairly often for the participants who were in their twenties and it did not matter whether or not the parents already knew about their child’s sexuality. Sonya was nervous about revealing her sexuality to her provider because of a provider-parent connection. She stated:

Well I felt really awkward about it because I mean even though, even though my parents know, my parents go to the same doctor, so like, just because she like, knew the rest of my family, I was kind of a little nervous about saying to her.

Regardless of knowledge about a LGB individual’s sexuality, the fear about their providers discussing their sexuality or sexual information with people that they knew outside of the healthcare setting, made participants hesitant about revealing sexuality to their providers.

Providers do not have to have a direct connection to family members to impact disclosure. If a family member worked in the medical field, LGB individuals may

disclose based on how their family member views non-heterosexuality. Jeannette discussed how she felt when filling out forms with medical staff and that she would start looking for any potential reaction from the staff because her mother was a medical office manager. Jeannette explained, “I knew how desperately uncomfortable she is with this whole situation and I was imagining like, what it would be like, for her to be sitting across from me.” Jeannette imagined that the healthcare worker taking her information was similar to her mother, because her mother held a very similar work position. If participants had a relative in the medical field who was not entirely accepting of LGB individuals, they would associate medical workers to their non-accepting relatives, causing them to not trust the healthcare providers they were engaging with.

Provider refusal. When talking about coming out to providers, some participants made it a point to come out to their providers while others disclosed as a result of questions the providers asked. However, there were participants who explained that they did not come out because the provider did not attempt to approach the topic of sexuality. Additionally, some participants reported that providers would not even bring up the topic of sexual health. Danny described a great connection he had with his general practitioner, who he had grown very fond of; however, when I asked Danny if he had come out to his general practitioner, he realized that he had not. He just said, “I guess I was kind of waiting for her to ask.” Although Danny enjoyed the relationship he had with his provider, he did not feel as though he could bring up his sexuality without the provider creating space for that conversation.

Unlike Danny, Garrett did not have as strong of a connection with his provider and could not quite figure out whether or not he wanted to broach the topic with his

provider. Instead, he left that conversation up to his provider. Garrett stated, “I feel like if I was just seeing my general practitioner, it’s not something that I talk about and I feel sort of like, they could choose to bring it up if they wanted”. Although Garrett did not express interest in discussing his sexual health or sexuality with his general practitioner, he later explained that even if he wanted to talk about it, he did not have the power to do so.

You don’t really have the ability to just bring something up because you’re not in that position. They’re the doctor, they have like, you know, they have their MD, they’re treating you so they have like, the power in that situation to sort of choose what topics are relevant to your healthcare.

Garrett’s comment speaks directly to the power that providers have over their patients and how the provider may have the control over whether or not sexuality can be considered relevant to a person’s healthcare. Another participant, Clifton, eventually came out to his general practitioner, but during one of his earlier appointments when he sought medical advice that related to his sexual practices, the general practitioner did not engage in any kind of sexual health conversation. When asking Clifton if he came out to his provider before that more recent appointment, he stated:

I don’t think so... I actually, I had gone in because I was in a like, hypochondriac mood and I thought like, random bumps had appeared and I thought like, oh my gosh what are these bumps, I don’t know what these bumps are, so I like, I went in to go see him and they were nothing, but he at no point asked about my sexual activity or anything.

If providers do not engage in conversations with their patients about sexual health or sexuality, the patients may not feel as though they are able to ask relevant questions or even feel comfortable bringing up the conversation on their own.

Religion. Many of the participants expressed a previous religious background that they no longer identified with, yet religion still influenced their lives through others, including healthcare providers, expressing their religious beliefs. Garrett visited a provider in his hometown that could administer his allergy medication and became fairly uncomfortable with that provider because of how she expressed her religious beliefs in his appointments. He explained that he did not come out to the provider because of her religious beliefs and described a conversation where religion was brought up in her office.

I have a tattoo of a like prayer, a Buddhist prayer and like, this most recent time she was like, oh why do you have that like blah blah blah and I said something about, you know, getting it when I was younger because I wasn't really gonna, I didn't want to go into it with her and she was like, oh it was like, when you were younger and like, didn't like, know like, you know the right way or something like that and just like, feels a little invalidating sometimes.

While Garrett's provider never spoke specifically against LGB individuals, he felt that her religious influence was so strong that he could never broach that conversation with her. Even if a provider does not openly discuss his or her religious beliefs with patients, a simple religious symbol can deter LGB patients from disclosing their sexuality. When Grady was talking about discussing his sexual practices with his provider, he simply

stated, “I think the doctor had like, a big cross or something necklace and I was like, eh I’m not going to talk to you about this.”

Beyond identifying and expressing religious beliefs, healthcare providers may even alter their healthcare practices based on their religion, which was the case for Amelia. Amelia told the story of a past general practitioner she visited who had strict limitations on what type of medicine she would prescribe to her patients. She explained, “I didn’t realize until after I had started seeing her was, um a catholic in a way that she wouldn’t herself, like, prescribe any sort of like, birth control and that sort of thing.” Although Amelia did not need to receive birth control from her general practitioner, the provider made her wary. “I was concerned that she wouldn’t be able to like, really continue being my doctor and give me the best medical advice because it seemed to be such a barrier for her”. A strong religious expression can either keep LGB individuals from disclosing sexuality and sexual practices or prevent them from seeing that provider altogether.

Age. The participants varied greatly in age and that difference demonstrated how age can be an influencer on disclosing sexuality to healthcare providers. For participants in their twenties, most had only recently come out (within the past couple of years) and were more hesitant discussing healthcare, and more specifically, how their sexuality related to the healthcare they received. On the other hand, the older participants in their later thirties to early fifties were generally more open about their sexuality and expressed their sexuality with ease.

When discussing age in relation to healthcare, the younger participants would often remove themselves from the conversation and discuss the discomfort of disclosing from an impersonal stance. These participants made generalized comments about young LGB patients rather than speak directly about themselves and their experiences. In offering suggestions to healthcare providers, Pete stated, “Make sure they take the time to create the relationship because young, scared, confused teenagers are not going to disclose that unless they feel comfortable.” He did not want to discuss himself as a confused teenager but displaced those feelings onto fictitious future patients. Displacement was taken a step further when Pete was addressing those “adults” who have an easier time disclosing their sexuality. “...adults are just more comfortable in themselves and their bodies and who they are, they’ve had time to go through those awkward phases.” Sonya expressed her discomfort in being newer to the LGB community through talking about how her girlfriend has more confidence in just stating her sexuality.

...she has been out for like a long time, she’s, I’m trying to think, she’s 24 and she has been out since she was, I think 19, so she’s like a 110% comfortable in, like, openly saying it and doesn’t think anything of it.

Although Sonya would say things like, “if someone asked I would say it”, she separated herself from her partner and spoke of herself acting oppositely of her partner, suggesting that Sonya is not completely comfortable and open about her sexuality. Younger LGB individuals may have recently come out for the first time, and therefore, may be getting used to their newfound identity, creating a discomfort in openly disclosing their sexuality.

The participants who have been out for a significant period of time expressed how when they were younger they would not have been as comfortable as they are now discussing sexuality. Although the first questions were about how they currently view their healthcare, conversations shifted into their past experiences. When talking about disclosing to healthcare providers, Jeannette stated, “I don’t think I would have done that as a younger person as much as I was willing to do it as a more adult person”. Although Jeannette had some lingering hesitations, she still mentioned how her maturity aided her in her ability to disclose her sexuality to her provider. Kent further explained, “I think I certainly would have in my younger days, if a doctor had ever said anything absolutely I would have lied”. Younger LGB individuals, even if they were asked by a provider, may not just refuse to disclose, but may actively lie to a provider because of their discomfort in their sexuality.

Level of trust. Another significant influence on whether patients were willing to disclose sexuality to their providers related to whether or not they trusted their providers. Some of the participants explained that they needed to have a rapport established with their provider in order to create a sense of comfort with them. The comfort and trust was needed to disclose their sexuality. In discussing coming out to providers, Hannah explained, “if it was, like, someone I didn’t feel like, was very trustworthy, or just like, gave me a weird vibe or if maybe it was, like, a man I don’t know if I would have been as comfortable doing that.” Pete, who was already hesitant in coming out because of his experience with his parents, said “I was definitely wasn’t feeling the trust with my doctor to tell him that I identified as bisexual.” Hannah and Pete emphasized that they needed to

feel a sense of comfort and trust because they viewed their sexuality as something that could potentially be used against them.

For participants, trust was also associated with a level of comfort and welcoming at the provider's office because trust can never be established if LGB patients do not feel at ease. When talking about coming out to providers in broader sense, Greta stated, "if they [LGB individuals] don't sense a welcoming atmosphere, they're generally not going to disclose themselves if given the chance, um, to their provider." Whenever a positive rapport was established between a LGB individual and provider, there was a sense of trust and comfort that allowed for them to be open and honest about their sexuality. Tim put it best when he stated, "the comfort level that I have just in that particular environment, like I don't have to hide, I don't have to make things up, pretend I'm somebody I'm not."

Identity vs. Practice

When I conceptualize my lesbian identity it encompasses many other facets of my self, including my gender expression, my values, my sexual practices, etc. My lesbian identity is essential to who I am as a person, and my sexual practices are a smaller element of my identity that is connected to, and cannot be separated from, my sexuality. However, the participants in this study did not share my viewpoint. When discussing their sexuality in relation to their healthcare, there was a tension between how participants attempted to articulate and understand the difference between sexuality and sexual practice when receiving in healthcare. The dissonance between identity and

practice in terms of sexuality was felt in three particular areas: sexual practice in healthcare, how to ask about sexuality, and relevancy.

Sexual practice in healthcare. When participants discussed their coming out stories and processes, they often talked about their sexuality in terms of their identity. For most participants, sexuality was simply part of who they were. However, when the conversation narrowed to their healthcare experiences, sexuality started to be defined based on sexual practices, removing identity from the conversation. Some of the participants, such as Blake, were able to clearly articulate that there was a difference in how he viewed his sexuality within the context of his healthcare and in his day to day life. Blake had a very strong sense of gay identity, yet when asked about having providers initiate the conversation about sexuality, he explained that “it seems more likely for them to ask my sexual practices as opposed to my sexual identity, which I think are separate, they’re different.” Defining sexuality is technically contingent on the types of sexual practices that a person engages in; however, sexual practices do not inherently define a person’s sexual identity. While it is unclear why there needs to be a separation in healthcare settings for LGB individuals, the separation seems to create a sense of ease during the medical appointments.

Participants identified specific types of practitioners who were privy to the knowledge of sexual practices and/or sexual identity. Many of the participants only believed in discussing sexuality with their general practitioner, OB/GYN, or whoever was administering STI and/or HIV tests because those were the only providers who needed to know their sexual practices in order to deliver the appropriate medical care. In deliberating on who should know about her sexuality, Greta explained, “for my OB/GYN

healthcare, yeah I think so, I mean it's kind of important to know what kind of intimate sexual things are going on." Tim echoed this sentiment, explaining why sexuality can be important for general practitioners: "it's important now, I'll take the, you know, if you're single, if you're single gay man I think you should know your status, right your HIV status." Sexual orientation did not seem to matter when establishing relationships with providers who did not see their patients for sexual health reasons, because to the participants, the only part of their sexuality that mattered in a healthcare setting was their sexual practices.

How to ask about sexuality. The dissonance of whether or not sexuality or sexual practices are more important in healthcare caused the question of whether or not providers should ask about sexuality to become complicated. There was never a clear answer of how a provider should bring up the topic of sexuality. Blake stated:

Personally, I would want them to ask if I like, what my identity was, because for me the two are not different, like my sexual behaviors are aligned with my sexual identity because I identify as gay... but I say that recognizing that that's not true for everyone.

He was concerned about those who do not identify as anything other than straight, but engaged in sexual activities with those of the same sex and was unsure of how the provider could negotiate that complexity within an appointment. Hannah had a similar struggle in that she was concerned about those who were nervous about sharing information with their provider. She said, "It could be that they just want to make queer patients feel more like inclusive... I guess it would be kind of cool". Hannah then almost

retracted that statement, saying, “but I also would question like it’s, it would, I think it would be scary for some people, to have to put that down without, like, knowing the provider very well.” This type of conversation was not uncommon because even if participants felt comfortable in discussing their own sexuality with a provider, they were concerned about those who did not have the same level of comfort. For the participants who went back and forth on their level of comfort, they became more concerned about the intent the provider had for bringing up sexuality. Clifton explained:

I guess it depends on the context, like, there are ways he could bring it up that I would think he’s just being nosy, like mind your own business, but then if he, like, was genuinely concerned about, like, a risk to me, yeah I’d want him to bring it up.

The ambiguity of a provider’s intent created even more confusion about if participants believed there was a “right” way for providers to address sexual orientation. Therefore because the participants kept separating sexuality from sexual practices, they were unsure of how providers should address sexuality within a healthcare appointment.

Relevancy. Regardless of whether or not participants were secure in their sexual identity, they felt as though some providers could and should know about their sexuality while other providers did not need to know the information as it was not relevant to their healthcare. Even when attempting to engage in a conversation about the various types of healthcare participants sought out, certain types of providers did not warrant a discussion. In a quick thought, Hannah stated, “I just remembered that I had a dermatology appointment, but I mean, I didn’t come out to her, so, because that wasn’t relevant.”

There were certain providers that did not need to know about sexuality because it was not relevant to their medical needs. Greta explained, “I think if you’re just going in, for like an ER appointment, or you know, like emergency room, or just a general check-up or dental appointment, or you know anything like that, I don’t think it’s relevant at all.”

Unless the medical needs were strictly related to a person’s sexual practice most of the participants did not believe it was necessary to broach. Winston attempted to demonstrate this point:

obviously having a gay identity, or having a same-sex, you know, relationship or partners, or whatever, that changes your sexual practices, which in turn changes your sexual history and your health, and you know, your health risks, and all of those different things, you know, it affects your health generally... you know, identifying as gay or whatever, is not going to affect what you do with your teeth.

Although there were several participants who were certain on their stance of relevant healthcare, there were those who had a difficult time parsing out when a health need would be considered relevant as Lindsey initially reacted to having a provider question her sexuality, “my first reaction is that, like, why is that relevant? If I’m just going in to say I hurt my knee...” However, she then went onto say, “but at the same time, like, it could be relevant.” Regardless of the certain medical needs being addressed, it is important to LGB individuals if they believe their sexuality is pertinent to their healthcare, otherwise they may not be willing to address their sexuality.

Heterosexism

Heterosexism is the underlying belief that heterosexuality is the superior sexuality (Morrison & Dinkel, 2012). The way that the participants in this study experienced heterosexism was by their providers assuming that they were straight, based on the belief that all of their patients were heterosexual. Heterosexism occurred in three ways: heterosexual assumptions, limited knowledge, and “looking gay”.

Heterosexual assumptions. Often for women, providers assumed heterosexuality through the conversation of birth control use and the providers believed that the LGB patients were engaging in heterosexual sex only. When referring to an interaction with her provider, Amelia explained, “she just became really convinced that I was sexually active with a male and not using contraceptives.” This type of assumption can become discriminatory towards non-heterosexual women when the provider is confronted with their heterosexism. Lana’s narrative exemplifies this, when she described going to a gynecologist:

It was the gynecologist was actually doing my exam and asked me something, I think asked me if I was sexually active and I said yes and said are you using birth control and I said something or something, that was the gist of it I think and then they’re kind of like, well you know, are you concerned about getting pregnant? and I was kind of, well sometimes I’m not having sex with boys or whatever. I was pretty open at that point too in terms of talking about it and I just remember there’s kind of this silence... I felt like there was definitely a coldness there and it was sort of shut down the communication after that.

In Lana's case, the provider assumed that she was engaging in heterosexual sex. When female patients say they do not use birth control, it is automatically assumed that the patient is not engaging in safe heterosexual sex. When patients reveal that they do not have sex with men, providers may not know how to respond, which could make patients very uncomfortable.

A couple of the male participants in the study mentioned that they experienced heterosexism through conversations with their healthcare providers wherein which the providers made comments about sexual activity with women however they did not have the same reaction that the female participants described. The male participants expressed more annoyance about their providers' assumptions whereas the women felt more discriminated against. Nevertheless many of the participants described instances where they were assumed to be heterosexual and it was never discussed in a positive light.

Beyond conversations surrounding sexual practice, heterosexual assumptions occurred when talking about spouses or partners with healthcare providers. One way that participants came out to their providers was through intake forms that revealed their spouses; some participants experienced heterosexist assumptions based on the revealing of the gender of their spouses or partners. Celia discussed her emergency contact with a medical provider:

They're like, oh you know, who's your contact, she's like, oh we should probably update that, so she said la da da my spouse and then they said, she said my name and then they looked up like, your spouse?

Forms have become more accommodating for same-sex partners, yet the reactions from those receiving and processing the information have not caught up with the progressiveness of the forms. For Lana, it did not matter she revealed her same-sex partnership; the providers kept assuming that she was heterosexual. When on vacation, Lana had to visit the emergency room after having an accident but her wife was not with her and was waiting for the doctor to treat her:

I was on my phone, he left came back and said oh was that your husband? and I said, actually it was my wife, and then my cousin came who's this tall strapping attractive man, walks in and gives me this huge kiss starts holding my hand very sweet and then they started asking if it's my husband and I'm like no it's my cousin, my wife's cousin, you know, like, so then it's this whole thing all over again.

Even after repeatedly mentioning that her wife was not around, the providers kept assuming that not only was she straight but that her wife's cousin was her spouse. Although this assumption does not prevent patients from receiving healthcare, it can create an unwelcoming environment for LGB individuals because they may not feel as though they are accepted for whom they truly are. Blake spoke to this desire of acceptance when expressing his feelings of wanting a LGBT healthcare center:

Going to an LGBT healthcare center would eliminate the need to even think about those things, you know, because it's kind of like, whereas most of society is heteronormative a place, like, that would be homonormative where it would be just assumed that I am some kind of sexual minority and that assumption would

be accurate and then it would be, it would feel like just being a straight person living in a straight world, which is very comfortable.

Medical spaces can be a heteronormative environment that can create a level of discomfort for LGB individuals. A LGBT healthcare center would counteract the typical medical space because the providers would not assume that all of their patients were heterosexual, creating an open atmosphere for non-heterosexuals. Many of the participants liked the idea of a LGBT healthcare center because they felt they could be more open with their healthcare providers.

Limited knowledge. Due to providers constantly assuming that their patients were heterosexual, LGB patients may feel as though their providers are not aware that they have patients who are not straight. Lindsey described why she doubted her provider's awareness:

They like, sometimes not using neutral language, or like, saying something, like, oh do you and your boyfriend use condoms? or like, or just having a lot of emphasis, on like, on reproductive health that is, like, very focused on, you know, heteronormative stuff and I don't know, sometimes I just feel like, there's, they don't see very many clients who aren't straight.

When providers only offer care and treatment that emphasizes a heterosexual lifestyle, several things are occurring. First, heteronormative options tell the LGB patient that the provider assumes that all of their patients are heterosexual. Second, those options communicate that the provider may be uncomfortable if the LGB patient counters the heterosexual assumption. Finally, when the provider automatically assumes that their

patients are heterosexual it shows that they probably have not had a patient come out to them before, meaning that they may not know how to treat LGB individuals. The lack of knowledge can then be frustrating for a LGB patient because they are not receiving the care that is appropriate for their needs.

The perception of a lack of knowledge providers frustrated LGB patients because they recognized their providers' incompetency. Many times, it was not a single instance where a provider made a heterosexist assumption, but rather, incompetency was established by the provider making the same mistake. Celia had a gynecologist that she had seen for years, but whenever she visited her, she was always asked about birth control use. "I just can't even tell you how many times I have to explain to people why it is that I am sexually active but that I don't need birth control." Sometimes, lesbian participants had to explain to their providers why they do not need birth control because they just did not understand *why* they did not need birth control, which in turn made them wonder what else their providers did not understand. For instance, Lana explained her frustration of not being able to engage in conversations with her provider:

I mean, both of us are getting relatively to the age, [partner]'s six years older than me, so she just turned 50, um and there's things that come up, like, vaginal dryness or what, just like feel like there's not a lot of discussion about those kinds of things and maybe they don't want to go there, because they don't want to know what kind of sex we're having in our, how we're having sex, or whatever but I do think those things are important.

If providers do not know what type of sexual activity non-heterosexuals engage in, they may not have the appropriate knowledge to understand what types of STDs patients may be at risk for or what it means to be sexually healthy.

“Looking gay”. Although is it common for providers to assume heterosexuality, sometimes providers assumed that the patient is LGB. Participants discussed instances where their providers had assumed that they were not straight, based on stereotypes of what LGB individuals act and/or look like. In these instances, the providers did not ask sexual orientation, but instead relied on their perception of the patient and treated them based on that perception. The assumption that a person is LGB does not necessarily resound in proper and appropriate medical treatment and can actually result in discriminatory care. For instance, when Garrett was younger, he went in to get tested for mono, but the provider had something else in mind:

She was like, okay well nothing's coming up so I'm going to test you for AIDS, she didn't even say HIV, she said AIDS, um and I remember very explicitly telling her, like, well there's, like, no way that I could have HIV, um and she sort of just looked at me and raised her eyebrow and was, like, well I think we should test you.

Garrett's provider assumed that he was gay, even before he was completely aware of his sexual identity, and based on her assumption, she decided that his illness was related to his sexuality. Greta also experienced being labeled as a lesbian without self-identifying and she explained that it had to do with her appearance:

I'm evidently LGBT, right, I'm evidently queer. I can't walk into a room and someone not be like, oh my god, like, her sexuality is face value um so I, I think that that's important and because you that comes with discrimination

In one of Greta's other stories, she did end up experiencing discrimination while sitting in the waiting room:

I was sitting, waiting, just playing games on my phone and the, the nurse would come out and call people back, and the two or three people that she called back. She called by their first name according to their chart and so when she came out to the, the lobby to get me, it was me and like two other males, and then like the female that had already been seen, and was, had come back into the lobby, so she knew it wasn't her, and so she looked at the chart and she said last name [last name]? So I thought, that was interesting that she chose to use my last name instead of my first name, because I guess she didn't expect it to be me, um so I don't know, I think that's part of when my outward appearance, which signifies my sexuality.

When a person appears to be LGB, there is a fear of being labeled as non-heterosexual resulting in being discriminated against, as Pete explained:

Many people create this idea of who gays are in their head before they even meet them that I don't, I don't want that to happen in such a very intimate and important aspect of my life, which is health care

Labeling sexuality for a patient does not create an open and safe environment for LGB patients but instead can create doubt and potentially result in discriminatory healthcare.

Barriers and Consequences

Healthcare can create barriers for LGB individuals based on their sexuality. The barriers that LGB individuals experience can result in negative consequences that impact their overall healthcare experiences. Several barriers, including legal implications and insurance barriers, highlighted other areas of inequity, including a distrust in the medical system and how there are limited LGB friendly options. Consequences of revealing sexuality, potentially due to these barriers, included being labeled as sexually promiscuous which resulted in forced testing, feeling lucky for not receiving poor medical care, and discrimination in both general care and mental healthcare.

Legal implications. Questions of legal protection came up frequently when discussing healthcare access. Some participants were unsure of their current legal rights because of recent federal medical legal changes. However, because of their uncertainty, they were hesitant to make any firm statement about their legal rights or standings. There were still those who believed that consequences of revealing their sexuality to a healthcare provider could potentially result in the denial of healthcare. Winston explained his own doubts about being granted equitable care:

Texas, like, there's absolutely zero, like, you know, protection on the bases of sexuality, like, absolutely nothing and so it would be possible for, like, a provider to just say okay well you're gay, like, I'm not going to, to deal with you anymore, I'm not going to treat you anymore, I mean, I think that's possible, I think that person could invoke, you know, kind of religious freedom or whatever they would want, in order to justify that.

Although not all of the participants resided in a conservative of state, such as Texas, there were still insecurities expressed about other states passing laws that would allow for discrimination of any non-sexuality or non-gender conforming individual. Kent talked about potential ways for individuals to be discriminated against in healthcare, saying, “you know, you hear instances all the time that EMT workers refusing to give treatment to trans people, which I believe there’s actually a law in a state that just passed recently.” The threat of a lack of legal protection made certain participants wary about their own security in healthcare settings, with many participants acknowledging that there was a looming threat of being denied care.

Insurance barriers. Basic legal protection was not the only cause for concern. Participants were also nervous about being labeled as gay in any way on a legal/medical form because they feared that it would cause their insurance costs to increase. A stereotype that exists of non-heterosexuals, especially male non-heterosexuals, is that they are at an extreme risk of STDs and/or HIV because of sexual promiscuity. This perception of promiscuity links LGB individuals to being tested and treated for STDs/HIV, which would increase their insurances costs. Grady was too nervous to talk to his insurance about PrEP, a new HIV preventative medication.

If I tell them I want to get PrEP then will they, like, put that in my file, then I will like, they’ll be like, oh he’s gay and like, he wants PrEP, or he’ll get AIDs, or something like, then do I have to pay more money? I’m like paranoid on that.

The male participants were apprehensive about what would happen if they were labeled on medical forms and how that could be used as a justifiable reason to raise their insurance cost.

Along with the idea of insurance companies raising their prices, new marriage laws in the United States created concern for patients because they were worried that insurance cards may play a role in disclosing sexuality. Celia talked about how her new spouse was more wary around medical providers and was nervous about disclosing her sexuality. Celia explained how after they got married, her partner started using her insurance card because they now shared that benefit. “It puts her more in that situation, to have to explain why she’s using a card with somebody else’s name on it and typically the only way you could do that is if you’re a family member.” Each person in a family does not receive an insurance card with their own individual name on it. Instead it shows the name of the person who the insurance plan is under. Therefore, the only way for an adult woman (over the age of 26) to have an insurance card with the name of another woman on it is to be married to that individual. If that woman showed her insurance card to a medical staff it automatically discloses her sexuality.

Distrusting the system. Distrusting legal rights and insurance companies is embedded in the larger picture of how the participants had a general distrust of the medical system. Although most participants did not state outright that they did not trust the medical system, many talked about how they sought out advice as to which healthcare providers were LGB friendly. Amelia spoke directly to the need to seek out advice, stating, “recommendations from acquaintances and friends... intentionally filter my experiences... there’s no way, like, without that, that I would have felt comfortable just

picking someone in the area from the insurance listings... having those personal recommendations really helped reduce anxiety.” Amelia expressed her apprehension of the local healthcare providers by stating how she felt she needed recommendations to ensure that she would find a LGB friendly provider. Lana took the time to research and asked for the best provider she could find and said “so I feel like, I’ve learned in the last ten years probably, to do a lot of research before I even seek it out, so I haven’t had a lot of bad experiences.” Lana assumed that if she had not done the research, she would potentially have negative experiences with healthcare providers in relation to her sexuality. Kent did not even want to bother with risking any type of negative reaction, as he explained, “the first day I was here looking for a home, uh what doctors do you know of that are queer friendly, because I just want to cut right to the chase and just go to somebody like that.”

While Kent just wanted to find someone who was friendly, Celia cared more about having providers actively engage in conversations with her about her sexuality.

I actually switched OB/GYN offices based on some recommendations of people that said, you know, these people actually won’t ask you those foolish questions and talk to you about, maybe, some of the issues that might be more related to your sexuality.

For some of the participants, they may have wanted to simply find a provider who would not actively be discriminatory towards them based on their sexuality, while others were concerned more about receiving relevant health information from their providers. Either way, some of the participants expressed a need to find special providers, because they

were not sure if the regular healthcare providers would give the healthcare that they desired.

Limited options. Seeking out advice about medical care can only help if LGB individuals have the ability to access those providers. There were several barriers that prevented the participants from being able to see non-discriminatory healthcare providers. Because all of the participants were associated with various universities, there was a discussion of challenges that both students and faculty faced. Pete, a recent college graduate, stated that “as a college student, you know, your ability to seek out treatment is really only what’s in your area.” A number of structural and resource issues may impact patients’ abilities to seek out and visit a LGB friendly provider. For example, even if college students knew about LGB friendly providers in the city in which they were located, they may not have the transportation to physically get to the providers. However, from Amelia’s perspective as a university employee, LGB students had resources available to them on campus not available to other LGB individuals. When talking about the idea of having an LGBT healthcare center in her area, she said, “I just want to really support the idea of an LGBT health center in this area because I feel like there’s less of, a lot less of that for faculty and staff.” If there are no resources, on or off campus, LGB individuals are stuck with seeing a provider who may or may not be competent in working with non-heterosexual patients.

Although simply not having providers in the area is problematic, there are other barriers that prevent LGB individuals from switching from a problematic provider to a LGB friendly provider. Insurance companies may only list a few practices or providers that they are willing to cover, which in turn, prevents the ability to choose the best

provider for an individual. Garrett had difficulties changing providers after his allergist uncomfortably promoted her religious viewpoints during his appointments: “I am not able to switch allergists because I have to have it mixed there for insurance reasons”. Garrett does not have the ability to go to his insurance provider and say that he feels uncomfortable with his provider and request a change; instead, he is forced to remain in that environment until his treatment is completed. Insurance company regulations may unintentionally preventing their LGB customers from accessing non-discriminatory healthcare.

Sexual promiscuity. Assuming that non-heterosexual individuals are sexually promiscuous is a common stereotype. This stereotype was recognized by the participants, where they discussed how that stereotype impacted their healthcare. Pete was very aware of this assumption:

gay and bisexual men are perceived, are already perceived as being sexually promiscuous... I feel like if anyone is to apply those stereotypes it would be a doctor... so I definitely don't want to disclose to create an even more negative stigma about myself.

One of the reasons that Pete did not feel comfortable about disclosing his sexuality was because he was afraid that his providers would assume that he was sexually promiscuous. Pete even lied about the number and gender of his sexual partners to his providers to avoid the stereotype.

Pete's fear about being labeled as sexually risky was actualized through experiences that other participants had with their providers. There were two ways that

providers responded to the stereotype. First, providers would suggest that their LGB patients were sexually at risk. Garrett stated, “she assumed that I was gay, she was assuming I was sexually active and just not saying and so, like, implying that I was at risk.” Especially among gay or bisexual men, providers connected their sexuality to the stereotype that all gay or bisexual men liked to engage in frequent and unprotected sex. Second, providers may not simply imply sexual promiscuity; they may actively shame their patients for their behavior. When talking about his experience at a STD/HIV testing center, Grady explained, “they, like, do some, like, sex shaming during it, they’re like, you need to stop sleeping with people, get married, stop sleeping.” In Grady’s case, the medical providers actively promoted that he should be in a monogamous and committed relationship, which is not what the center is there to do.

Forced testing. One of the most surprising findings from the study involved LGB individuals being forced to participate in STD and/or HIV testing. Several participants discussed how they or someone they knew were assumed to have a STD because of their sexual identity and then were given tests either with or without their permission. Jeannette mentioned that her partner went to see her doctor to receive treatment for what she believed was a yeast infection. However, the doctor decided upon examination that it was not a yeast infection, although her partner was almost positive that it was; her partner was misdiagnosed because of the provider’s conviction that she needed to be tested for a STD. Jeannette explained, “he tested her for things that he, she did not authorize him to test for, which of course came back negative.” Not only was Jeannette’s partner charged for those unauthorized tests, she also felt disrespected by that provider and became more wary of her future healthcare providers.

Providers learning about their patient's sexuality can have several effects; unfortunately, one of the effects mentioned by participants was that the providers would mandate STD and/or HIV testing. Grady told the story of when he went to the hospital to receive minor surgery: "I asked that my partner at the time be there.... and the guy said no they can't allow that at [name] hospital and he then said I'd have to also get HIV tested before the surgery." Not only was Grady not allowed to have his partner check him in and out of the hospital, upon learning of his sexuality, the surgeon requested a HIV test because he assumed that because Grady was gay, he may have HIV.

It may not be all that uncommon to connect STD/HIV to non-heterosexuals. In Dereck's case, he explained, "I said that I identified myself as bisexual, so they gave me a batter of STD tests because they made the assumption that I was sexually active outside of my relationship, and they did that without my consent." A couple of stereotypes were being assumed in this instance. First, because Dereck was engaging in non-straight sexual activities, he was likely to have STDs. Second, because he identified as bisexual he was most likely not satisfied by a singular partner. Dereck was very frustrated by this situation because he knew he was being stereotyped but it did not end there. The tests were marked in his file so many years later after he had been married to his wife; he went to a new provider who asked about why he had all of those tests. He explained the situation to his provider and he was not met with the shock he had expected: "she said oh well it sounds like we should have another HIV test now." Dereck was very upset by the situation because as soon as he identified himself as bisexual to a provider, the provider immediately assumed that he was not monogamous and at risk for STDs/HIV.

Unfortunately, the discriminatory testing is not just about demanded testing but also how the tests are administered. In an attempt to be open with his doctor after newly coming out, Winston decided that he would like to receive STD testing but told his doctor that he had not really engaged in anal sex up to that point. His doctor did not believe that he had not engaged in that type of sexual activity and kept pushing that he needed to be tested through anal swabbing. Winston explained that he did not engage in anal sex because he found the experience to be very uncomfortable and the test was just as excruciating. “He could tell that I was in pain and that I was hurting, you know, and he’s like, I don’t know how you can find any pleasure in anal sex.” His doctor not only forced him to participate in an uncomfortable exam, he also did not listen to Winston’s sexual history, and then made a discriminatory remark while participating in the exam, which further shamed Winston.

Luck. The participants in the study were aware that LGB individuals could be discriminated against by their doctor. When participants would tell me their healthcare stories, it tended to be filtered through the lens of expecting to be discriminated against. In some instances, when participants would tell me a positive story, they would almost seem apologetic for not revealing a negative story, even though having a negative story was not a qualification for participating in the study.

However, the assumed discrimination did not stop at being apologetic; they also classified non-discriminatory healthcare as being lucky. When Amelia talked about her healthcare she said, “I really lucked out” and “I’ve been lucky in the past oh five or so years, I’ve had really, ah outstanding and really positive experiences in general.” Hannah also attributed her lack of negative healthcare experiences as luck as she stated, “I think

that part of me not experiencing anything bad has just been like luck as well.” It should not be considered lucky to have decent or even excellent healthcare; it should be an expectation.

The impact of expecting discriminatory healthcare was that LGB patients then believed that if it was not a negative experience then it would be considered a positive experience. Danny discussed how he was happy with a new provider, explaining, “he was so open and didn’t hold back his questions and he didn’t seem phased when I answered his questions, so that was pretty awesome too.” In this case, Danny was waiting for his provider to react negatively to his answers, and although this particular provider was not necessarily LGB friendly or supportive, the provider not acting in a poor manner made the provider “awesome”. Garrett provided a similar commentary: “my primary care provider, like, seems cool every time I go see him, and like, you know, like, not like hostile or anything, but it, you know, it’s part of his practice.” For Garrett, his provider was “cool” because he did not act hostile towards him. In conversations similar to Garrett’s, the participants would qualify their care positively based on the absence of negative treatment.

Discrimination in mental healthcare. LGB patients may experience discrimination related to specific areas of healthcare. Several participants who recounted discrimination that they faced related to their mental healthcare. Many of the participants believed that mental healthcare was an area where it was necessary to disclose their sexual identity because it was relevant to their care. However, through their disclosure, they ended up receiving discriminatory remarks or care. A common experience was that mental healthcare providers would attempt to find the cause of their sexuality. Sonya

talked about how when she revealed her sexuality to her provider, the provider wanted to keep talking about her sexuality in every conversation:

I felt like she kind of harped on that the whole rest of the time like I don't know it kind of seemed like she was like making it seem like that was where the root of it was coming from.

Other participants discussed similar situations, but their providers had specific ideas of why they identified as LGB. Amelia explained that her provider “tried to tie back um my sexual orientation to like family trauma and that sort of thing”.

In some cases, providers did not just attempt to tie sexuality to traumatic experiences but also claimed that they can convert back to being straight. Lana talked about her situation with a mental healthcare provider:

when I was dealing with being a rape survivor and sort of figuring out my sexuality like stupid things like well you probably want to sleep with women because you had such a horrible experience... it felt like it was like oh we can change this for you like we can make this better like we can get you to where you can have sex with men and it will be good.

Participants talked about their wariness of mental healthcare providers in their areas because they were concerned that providers assumed there is a cause for sexuality and that there was a way they could be “cured”. Although sexuality has been removed from the DSM as a clinical disorder, the impact of documenting sexuality as a disease was still relevant for some participants.

Provider Discrimination. Not every participant had an instance of provider discrimination. There were some positive stories about acceptance and support. However, most participants had stories of experiencing basic discrimination from healthcare providers in relation to their sexuality. In these instances of discrimination, either the participants had revealed their sexuality to their provider or the provider made the assumption that they were not straight, resulting in the providers having a negative reaction to their assumed or revealed sexuality.

Judgment surrounding sexuality and number of sexual partners was also a common instance of discrimination. Typically, participants described nonverbal reactions to them revealing sexuality, which they interpreted as being judged. In Jeannette's case, she was met with both verbal and nonverbal judgment:

I went in and she was asking me questions about my sexual history and she was clearly, clearly like judging what I was saying and making sounds... my honesty was definitely met with like absolute judgment... she was judging that I had more than like one sexual partner... she was clearly like oh god like what else are you going to tell me... it was like everything about what I was saying like disgusting her.

There was no blatant comment about Jeannette's action from her provider, however because of the provider's nonverbal expressions Jeannette felt uncomfortable having revealed necessary sexual health information. Moreover, Jeannette expressed that she was shocked by the treatment because she had assumed that a healthcare provider would be professional and not judge her sexual history.

In some cases, the perception of judgment from the provider(s) created an intense feeling of discomfort that would result in the participant from continuing to seek medical care. For several year, Greta lived in Texas, a state where she felt she experienced the most discrimination because of the conservativeness of the area.

I had to go to the ER because I was having severe stomach pains and I, there was, no, there was maybe two or three people in the waiting room and I waited for about 2 or 3 hours to be seen, and now I don't know if that's particularly tied to the fact, that it has anything to do with my sexuality, um but it just seemed kind of, like, well you know, there's only a couple of people in here and so I went back and the doctor was very short with me, and I mean, I saw him for maybe like 90 seconds and that was it, he walked in, he poked me really hard, it was very uncomfortable and you know, it's kind of difficult to, when someone says when I push on this tell me if you have pain, if they jab you in the stomach, well yeah you're causing me pain...I just felt very uncomfortable so much to the point that at one point I just got up and I left.

Luckily, Greta did not have any serious medical problems after leaving the ER; however she did not feel as though she received the care she needed. The provider may not have actively kicked her out of the medical facility, but the care she received may not have been welcomed in that space.

Stories about how providers accepted and welcomed same-sex partners in medical settings were discussed in several interviews, yet there was still evidence of discrimination against partners. In Dereck's case, he and his long-term male partner were

at their home when Dereck's partner went to the bathroom and discovered blood in the toilet. Panicked, they went to the ER to seek treatment; however, Dereck's partner was in shock over what was happening to him and was not able to communicate with the intake nurse. Dereck attempted to talk to the intake nurse but he was met with hostility:

The intake nurse kind of got really weird, got really sort of very short and said you know well he's the one that needed to be you know talking to me and I was like look at him you know he's in shock and she was like well who are you anyway? And I was like I'm his boyfriend and she was like oh okay now I see what's going on, yeah she had thought that there was some weird sexual thing and like you know he was injured as a result.

Dereck was upset that it took some time for the nurse to recognize that they were together, and upon finding out that they were a couple, she assumed that the injury was from a strange sexual act, regardless of the fact that it was not the reason for the medical incident.

CHAPTER 5: DISCUSSION

This thesis revealed the complexities of LGB participants' experiences with healthcare providers. Two research questions were developed for this thesis and helped guide the direction of the thesis. Four themes emerged from the participant interviews, focusing on influences on disclosure, identity versus sexual practice, heterosexism, and barriers and consequences. This final chapter examines how the research questions were answered and the implications of the findings, the practical applications for healthcare providers, limitations of the study, and direction for future research. Finally, I end the chapter with a brief reflection on the research experience.

Research Question 1

The study's first guiding research question asked how lesbian, gay, and bisexual individuals navigate disclosure of their sexual identities with healthcare providers. Participants identified a number of strategies to communicate sexual identity with providers. First, some LGB individuals believed that their sexuality is not separate, private information, but part of who they are. Because they did not believe that their sexual orientation was private information, they were not hesitant to disclose their sexuality to their provider. Petronio (2002) explained that in order for there to be boundary management, the person who is revealing the information has to view that information as private. However, it is possible that the LGB patients believed that their providers viewed sexuality as private information. CPM does not discuss what happens when the person receiving private information believes that the information should not be disclosed. If the person, who has the information, does not view that information as

private, that person will most likely not consider how to establish boundary management with the person they are sharing it to. However, the person receiving the information would believe that information should have at least been coordinated because they view the information as private, potentially creating a new kind of boundary turbulence because the boundary rules were never established.

Second, other LGB individuals did not feel that their sexuality was public information nor did they believe it was sensitive enough to be considered private; instead, sexuality resided somewhere in-between. These individuals were more concerned with how they should manage disclosing their sexuality with their provider and may have even waited for the provider to bring up the conversation. In these cases, they were attempting to coordinate boundary rules surrounding their sexuality. Boundary rules cannot be established by a singular person (Petronio, 2002), so non-heterosexual patients may have been waiting for the provider to initiate a conversation about sexuality or the gender(s) of their sexual partner(s). Certain participants openly recognized that their providers had the power in their appointments to determine what was allowed to be discussed. Even for those who did not openly address the issue of power, they still did not feel as though they had the ability to assert themselves in that doctor-patient relationship to request a conversation about their sexuality. Some patients feared they could be discriminated against by their doctor, or they would simply ruin the relationship that they had already established with their provider. If the provider did not bring up sexuality, it signaled to the participant that the provider was uncomfortable with the topic or just not knowledgeable. Therefore, if providers do not bring up the topic of sexuality or the

gender of sexual partners, LGB patients do not feel as though they have the ability to bring up their sexuality, even if it may be relevant to their health needs.

The final way LGB individuals navigated disclosure was that they chose not to disclose their sexuality. Some LGB participants believed their sexuality was private information and did not want to share that information with their providers. Those who did not share their sexuality may not have trusted their provider to be a co-owner of the information (Petronio, 2002). For example, mistrust was a primary factor for participants worried about personal connections between their healthcare providers and other family and friends. Petronio (2002) argued that if people feel like there is too great of a risk in disclosing private information, they will ultimately choose not to. This thesis identified two ways in which LGB individuals chose not to disclose: lying and manipulating language. If a provider asked about partners' gender, a LGB person who did not want to share that information simply lied, which then prevented the need to disclose. However, if the LGB individual did not want to lie, he or she attempted to use gender-neutral language so it was not a lie, just avoiding acknowledging the truth. Therefore, there was no need to worry about exchanging private information, having their providers being co-owners, and then potentially sharing that information with others (Petronio, 2002). Yet, there should be no need to worry about sharing private information with providers because they are not allowed to share private information with others. Distrust in revealing sexuality to providers potentially signals a crack in the medical system. Any patient, regardless of sexuality, should not have to worry about a provider discussing their healthcare outside of medical appointments.

Research Question 2

The second research question asked about the communication barriers LGB individuals encountered when communicating with healthcare providers. Several communication barriers between LGB patients and providers were identified. First, communication barriers occurred when LGB patients believed their providers held heterosexist assumptions about them. When the providers assumed that the patients were heterosexual, they would make medical recommendations based on heterosexual sexual behaviors. In some instances, the LGB patients contradicted the assumptions by hinting at or revealing their sexuality, however many of the providers did not understand the hints and continued with their heterosexual assumptions. When the LGB patients provided cues, they were attempting to signal to the providers that they were not straight without calling out the providers on their heterosexist beliefs. LGB patients do not feel as though they have the ability to call out a provider on their heterosexism because the provider still has the power because healthcare providers are the only ones who can tend to their healthcare needs (Beisecker, 1990). Therefore, because some LGB patients may not feel as though they can blatantly contradict healthcare providers' heterosexist assumptions, a communication barrier occurs, preventing them from receiving appropriate medical care in those situations.

Another communication barrier was the lack of disclosure because of the fear that providers would react poorly to their disclosure, or the fear that providers would share their sexuality with others. In these instances, patients would perform the co-cultural practice of averting controversy (Orbe, 1998) by shifting the conversation away from having to reveal their sexuality. Averting controversy was achieved when the LGB individuals did not engage in small talk that concerned their sexuality, such as discussing

a current same-sex partner. However, by averting the conversation, patients were not able to reveal potentially important information concerning their healthcare, further putting LGB patients in a marginalized place.

The final communication barrier that occurred was provider discrimination. While the discriminatory act was itself upsetting, a communication barrier would form when patients did not respond to providers after the action had occurred. The participants in this study often engaged in the communicative act of censoring self (Orbe, 1998) by choosing not to engage in further discussions with providers about why their actions were inappropriate and/or offensive. LGB patients chose to remain silent, which prevented patient-provider communication from moving forward after the discriminatory action occurred. In certain cases, LGB patients refused to see that provider again. Although it is not the responsibility of LGB individuals to confront discriminatory providers, communication potentially breaks down because LGB individuals feel discriminated against and the provider may not have any awareness of their actions.

In my own conversations outside of interviews with individuals about heterosexism in LGB patient-provider interaction, I have been told there should be training for LGB individuals to become self-advocates in their healthcare. Rooted in a Western value of personal responsibility, it was suggested that LGB patients should be provided with the skills and tools to choose how to navigate conversations about their sexuality with their providers. Self-advocacy involves heightened patient involvement in healthcare interactions and participation in making healthcare decisions (Brashers, Haas, & Neidig, 1999). However, this thesis revealed that LGB patients, for the most part, do not feel as though they have the power in their healthcare to disclose their sexuality for

fear that their provider may act in a discriminatory manner. LGB patients cannot control whether or not healthcare providers will continue to treat them with respect after disclosing sexuality; immediate reaction is solely up to the provider. Instead of asking LGB individuals to be advocates for sexual diversity, perhaps it is time for healthcare providers to take further responsibility for creating an inclusive environment conducive to appropriate disclosure expectations and allow for the patients to more simply focus on their healthcare needs.

Practical Applications

The answers to the research questions revealed that healthcare providers need to address their current communicative behaviors with their patients. Based on this thesis, there are a number of practical recommendations for healthcare providers. First, providers need to be educated on how to monitor their nonverbal responses. Several participants discussed how their providers would express their judgment or discomfort through their nonverbal expressions. While providers may know not to say anything that could be labeled as discriminatory, they may not be aware of how they nonverbally respond to their patients when they disclose their sexuality. Training on the impact of nonverbal responses and how to monitor nonverbal responses would be a good way to teach providers how to be nonverbally competent and appropriate. Providers need to learn to recognize how they are nonverbally communicating and find ways to use their nonverbal responses to communicate an open and safe space for LGB patients.

Second, providers should be educated on the medical differences and needs for LGB patients. Many of the participants discussed how their providers did not seem to be

aware of relevant medical knowledge for LGB patients. For example, several female participants discussed their frustration of providers assuming that they needed to be using birth control. It is important for providers to not only assume all of their female patients are engaging in heterosexual sex but to understand important non-heterosexual safe-sex knowledge such as safe-sex practices and STI risks for same-sex partners. Several female participants also mentioned the desire to become pregnant so it would also be helpful for providers to know what options their non-heterosexual female patients have for getting pregnant.

Third, providers should use gender neutral language when asking questions about sexual health. As revealed by the findings, there is no perfect way to bring up sexuality in a medical setting; however, some ways are better than others. Although an intake form might be the easiest for providers to incorporate into their current practice, many non-heterosexual men expressed hesitation to record their sexuality on an official form. It also bears reminding that not every LGB patient wants to reveal their sexuality and so asking patients outright to check a sexuality box on a form may make patients more uncomfortable. Instead, providers should create a space for LGB individuals to discuss their sexuality by utilizing gender neutral language when discussing sexual health and sexual partners. When discussing sexual history, providers should not assume the gender of their patients' partners and they can even ask the gender as points of clarification. These questions are one way to show LGB patients that they are not promoting a heterosexual experience and that they are open to treating non-heterosexual patients.

A final recommendation is that there is a need for healthcare providers to have training on how to work with LGB patients. It is possible that current healthcare

practitioners have not received training on communicating and treating LGB patients during medical school. Trainings on treating LGB patients should be required for providers and incorporate elements such as creating awareness of LGB patients, monitoring nonverbal communication, utilizing gender neutral language, and learning relevant medical knowledge for LGB patients. Many of the LGB participants stated that they would purposefully seek out LGB friendly providers if healthcare providers engaged in and promoted their LGB patient training.

Limitations

Although the study shed light on lesbian, gay, and bisexual healthcare, there were some limitations to the study. First, not all of the sexual identities were represented in the study. While there were a variety of sexualities within this study, including queer and pansexual, gay men represented the majority of the participants. Trans individuals were purposefully not recruited because of the specialized medical treatments associated with transitioning genders. A larger sampling of the various sexualities could lead to more commonalities and differences amongst the different sexualities. Furthermore, there was a lack of racial diversity in the sample. Only one of the participants identified as African-American, and although there was interesting content revealed by the African-American participant, there were no other African-American participants which to compare his perspective. Finally, all of the participants in the study were students, staff, or faculty at universities. Being a part of a university means LGB individuals may have access to LGBT resources and/or centers, which can then impact the healthcare experiences LGB individuals have. Moreover, many of the participants had spent time studying issues

surrounding sexuality or healthcare, allowing them to articulate their experiences in a certain way that those outside of academia may not.

Second, only the perspective of the LGB patient was examined in this study. While the LGB perspective is incredibly important as they are the ones in a marginalized position, having the provider perspectives could paint a more complex picture of how disclosure of sexuality is navigated in the patient-provider relationship and the possible communication barriers that occur. Providers may not even be aware that they have LGB patients; however, this study cannot completely recognize this as an issue because providers were never interviewed.

Future Studies

Based on the findings of this study, there are several directions for future studies. First, researchers need to examine the perspective of providers. Discovering providers' awareness of and interactions with LGB patients would allow for a deeper understanding of communicative barriers that occur in the LGB doctor-patient relationship. Along with inquiring about the awareness of LGB patients, it would be interesting to examine providers' knowledge, education, and training about treating LGB patients and how they view the importance of patients disclosing their sexuality.

Second, this study could be done again with a more diverse representation of sexuality. In this study, there could also be sampling from nonwhite populations that exist outside of academia. The diverse sampling would demonstrate a more common experience and having racial diversity would add an additional layer to the study.

Finally, gay and bisexual men consistently brought up the need to be tested for STDs and HIV, yet the women rarely mentioned the topic. Beyond examining the interaction between healthcare providers and LGB patients, future research should examine how lesbian and bisexual women communicate about STDs, the knowledge lesbian and bisexual women have of STDs, and how they negotiate safe-sex with their sexual partners. Understanding their perspectives could create a better understanding of lesbian and bisexual women's knowledge of STDs so that they can communicate relevant safe-sex information to their lesbian and bisexual women patients.

Reflection

As a member of the LGB community, I was connected to this study on a personal level. When I had initially expressed interest in studying LGB healthcare interactions, I had only been out as a lesbian woman for a year. My understanding of my own sexuality and the implications my sexuality has on my daily life were limited. As I started researching the subject, I expanded my knowledge of what it meant to be a lesbian woman and I was able to explore experiences that other LGB individuals had. I began to better articulate my thoughts and ideas by connecting the literature to myself and my own experiences.

However, reviewing the literature had such a small impact on my understanding of self, compared to the experience of interviewing my participants. Discussing sexuality and healthcare with LGB individuals from a wide range of age groups was difficult, insightful, and emotional. Surprisingly, the younger participants confused me the most as they seemed to have the hardest time embracing their sexual identity. When I came out

of the closet, I felt like I ran out. It was a time where I finally acknowledged why I felt so different compared to my family and peers. I gratefully adopted my new sexual identity, but not all of my participants had the same viewpoint. They reminded me of the challenges that LGB youth constantly face and that discrimination is not a thing of the past, but can happen to anyone of any age.

While the younger participants were, in a sense, more difficult to interview, the older participants reminded me of the importance of LGB community. I have somehow ignored most of the older LGB community because I typically do not interact with them on a regular basis. These interviews provided me with the chance to hear their stories and many times I would laugh with them over their experiences. I was reminded that the LGB community spans in age and that many people in the community want to aid in creating positive change. My participants were excited and appreciative of being able to participate in this study. It was a reminder of the need to continue to study other related topics concerning the LGB community.

Appendix A

Communication Practices

Emphasizing Commonalities	Focuses on similarities while under-emphasizing or avoiding co-cultural differences
Developing Positive Face	Overly polite, considerate and/or attentive to dominant group members
Censoring Self	Choosing to remain silent when a dominant group members says something inappropriate, indirectly insulting, or offensive
Averting Controversy	Navigating the conversation away from controversial or presumed dangerous areas of conversation
Extensive Preparation	Prepare an extensive amount of detailed preparation before having to interact with dominant group members
Overcompensating	Occurs when a co-cultural member believes they are experiencing discrimination in one (or multiple) areas. In response to this they attempt to exceed expectations in that area and become a “superstar”
Manipulating Stereotypes	Performing commonly accepted stereotypes of their co-cultural group as a strategy to exploit the beliefs for personal gain
Bargaining	Having an overt or covert argument with a dominant group member where both agree to ignore co-cultural differences
Dissociating	Making an effort to disconnect from behaviors that are typically associated with their co-cultural group
Mirroring	Performing dominant group traits in order to mask or hide their co-cultural identity
Strategic Distancing	Avoiding association with co-cultural group members in order to appear as a distinct individual
Ridiculing Self	Actively or passively, either starting or participating in discourse, the demeans co-cultural members
Increasing Visibility	Strategically and covertly maintaining a co-cultural identity and presence while participating in dominant structures
Dispelling Stereotypes	By performing as themselves, co-cultural members would be countering stereotypes associated with their co-cultural group
Communicating Self	Used by those who possess a strong self-concept and they interact with dominant group members in an open way

Intragroup Networking	Looking and purposefully working with other co-cultural group members who share goals, philosophies, etc.
Utilizing Liaisons	Finding dominant group members who they trust for support, guidance and assistance
Educating Others	Becoming the teacher in conversations with dominant group members to enlighten them on co-cultural values, norms, etc.
Confronting	Using necessary aggressive methods to assert their voice, even if they violate the rights of others
Gaining Advantage	Provoking dominant group member reactions by referencing co-cultural oppressions in order to gain an advantage
Avoiding	Purposefully maintaining a distance from dominant group members and places where interaction with dominant groups members is likely
Maintaining Barriers	Using verbal and nonverbal cues, a co-cultural member imposes a psychological distance from group members
Exemplifying Strengths	Promoting the recognition of co-cultural group strengths, including past accomplishments and contributions to society
Embracing Stereotypes	Taking pre-conceived stereotypes and using them as positive aspects of their co-cultural identity
Attacking	Psychologically inflicting pain upon dominant group members through personal attacks
Sabotaging Others	Undermining the ability that dominant group members have to take advantage of their privilege that exists in society

Appendix B

Dear Nicole,

I wanted to let you know that your IRB Protocol entitled, "*Lesbian, Gay, and Bisexual Health Care Communication*," has been approved effective from 11/19/2014 through 11/18/2015. The signed action of the board form, approval memo, and close-out form will be sent to you via campus mail. Your protocol has been assigned No. 15-0241. Thank you again for working with us to get your protocol approved.

All research must be conducted in accordance with this approved submission, meaning that you will follow the research plan you have outlined in your protocol, use approved materials, and follow university policies.

Please take special note of the following important aspects of your approval:

- Any changes made to your study require approval ***before*** they can be implemented as part of your study. Contact the Office of Research Integrity at researchintegrity@jmu.edu with your questions and/or proposed modifications. An addendum request form can be located at the following URL: <http://www.jmu.edu/researchintegrity/irb/forms/irbaddendum.doc>.
- As a condition of the IRB approval, your protocol is subject to annual review. Therefore, you are required to complete a Close-Out form before your project end date. You *must* complete the close-out form unless you intend to continue the project for another year. An electronic copy of the close-out form can be found at the following URL: <http://www.jmu.edu/researchintegrity/irb/forms/irbcloseout.doc>.
- If you wish to continue your study past the approved project end date, you must submit an Extension Request Form indicating a renewal, along with supporting information. An electronic copy of the close-out form can be found at the following URL: <http://www.jmu.edu/researchintegrity/irb/forms/irbextensionrequest.doc>.
- If there are in an adverse event and/or any unanticipated problems during your study, you must notify the Office of Research Integrity within 24 hours of the event or problem. You must also complete adverse event form, which can be located at the following URL: <http://www.jmu.edu/researchintegrity/irb/forms/irbadverseevent.doc>.

Although the IRB office sends reminders, it is ultimately ***your responsibility*** to submit the continuing review report in a timely fashion to ensure there is no lapse in IRB approval.

Thank you again for working with us to get your protocol approved. If you have any questions, please do not hesitate to contact me.

Best Wishes,

Cindy Morgan

Administrative Assistant, Office of Research Integrity

James Madison University

Blue Ridge Hall, Room # 342, MSC 5738

Harrisonburg, VA 22807

Phone: (540) 568-7025

FAX: (540) 568-6409

Email: morgancs@jmu.edu

Office Email: researchintegrity@jmu.edu

Appendix C

First Wave Call

“Hello my name is Nicole Hudak and I am currently a graduate student at James Madison University. I am conducting research on communication and health care for lesbian, gay, and bisexual individuals. As a lesbian woman, I am interested in researching critical issues for the LGB community. I am looking for participants who are self-identified as lesbian, gay, or bisexual and have been to a health care provider within the last 3 years. Participants will be asked to participate in a face to face interview that will be audio recorded and conducted in a private or semi-private area. If you would like to participate please contact me at hudaknc@dukes.jmu.edu. Thank you.

Second Wave Call

Hello my name is Nicole Hudak and I am currently a graduate student at James Madison University. I am conducting research on communication and health care for lesbian, gay, and bisexual individuals. As a lesbian woman, I am interested in researching critical issues for the LGB community. I am looking for participants who are self-identified as lesbian, gay, or bisexual and have been to a health care provider within the last 3 years. Participants will be asked to participate in a skype or phone interview that will require 45 minutes to an hour of their time and will be audio recorded only. If you would like to participate please contact me at hudaknc@dukes.jmu.edu. Thank you.

Appendix D

Hello, thank you for taking the time to participate in this interview. You should have signed a consent form stating that you understand what we will be discussing and that you are willing to participate in this study. Once again, if you do not want to participate, you are free to go at any time without consequences. Are you willing to begin the interview?

In order to record important information will you please state your age, ethnicity, region you are from and your self-identified sexuality?

When did you come out or start to self-identify as (insert sexuality)?

- Who did you first come out to?
 - Friend?
 - Family?
 - Partner?
 - Other?

Did you face any particular challenges when you came out?

- What were they?
- How did you deal with those challenges?
- Do you still face them?

What types of health care have you sought out in the past three years? (examples: routine check-up, specialized care, dental, eye care, etc)

- How often (yearly, every other year)?
- When was the most recent experience? What was the reason for that visit?

If you had to rate your overall health care experience on a scale of 1 to 10, 10 being excellent 1 being terrible, what would you rate it? Why did you provide this rating?

- Do you feel as though all of your health care needs are met? Why or why not?
- How do you feel about going to see a health care provider?
 - Do you enjoy seeing a health care provider?
 - Can you tell me about how you stay involved or informed in your health care? What sort of things do you do to stay involved? (ie: ask questions, keep up to date on health related appointments, etc)

Have you ever come out to a health care provider?

- If yes
 - How was your sexuality brought up to your provider(s)?
 - Can you tell me a bit about your comfort level in talking about your sexuality with your provider?
 - Is your sexuality a topic of conversation with your health care provider(s)?

- If not, do you feel as though it is relevant?
 - If so, how is your sexuality related to your health care?
 - How important is your sexuality in relation to your health care?
- If no
 - Has sexuality ever come up in health care conversations with providers?
 - If so, how did you respond? How did the providers respond?
 - If not, do you think your provider should bring it up?
 - Would you feel comfortable discussing your sexuality with your health care provider?
 - Why or why not?

Does or has your provider asked you about your sexual health?

Have you ever had a negative health care encounter with a provider related to your sexuality? Explain.

Have you ever had a positive health care encounter with a provider related to your sexuality? Explain.

Should sexuality be something that is asked about in a routine health screening?

- Why or why not?

How do you think your health care provider views you?

What do you believe are the consequences of revealing sexuality to a health care provider?

Has a current or previous romantic partner been with you while receiving health care?

- If yes, how did they participate in your health care? Were they welcomed?
- If no, why haven't they been? Do you wish that they were involved?

Do you think a romantic partner should be involved in health care decisions? Why or why not?

If there was a LGBT healthcare center in your area would you go there for your healthcare needs? Why or why not?

Is there anything else you would like to discuss in relation to sexuality and health care that has not previously been addressed?

Thank you for your time, and if you would like, you can provide contact information so that I may send you the results of the study.

References

- Anderson, K., & Giovanini. (2009). *The influence of instructor's sexual orientation on identity formation in the college classroom*. Paper presented at the annual meeting of the National Communication Association, Chicago, IL.
- Austin, E.L. (2013). Sexual orientation disclosure to health care providers among urban and non-urban southern lesbians. *Women & Health, 53*(1), 41-55.
- Beisecker, A. E. (1990). Patient power in doctor-patient communication: What do we know? *Health Communication, 2*(2), 105-122.
- Bjorkman, M., & Malterud, K. (2007). Being a lesbian: Does the doctor need to know? *Scandinavian Journal of Primary Health Care, 25*, 58-62.
- Blackwell, C. W. (2008). Nursing implications in the application of conversion therapies on gay, lesbian, bisexual, and transgender clients. *Issues in Mental Health Nursing, 29*, 651-665.
- Boyden, K. (2014, June 23). On being the lesbian in: The gynecologist. *SheWired*. Retrieved from <http://www.shewired.com/need-know/2014/06/23/being-lesbian-gynecologist>
- Brashers, D. E., Haas, S. M., & Neidig, J. L. (1999). The patient self-advocacy scale: Measuring patient involvement in health care decision-making. *Health Communication, 11*(2), 97-122.

- Camara, S.K., Katznelson, A., Hildebrandt-Sterling, J., & Parker, T. (2012). Heterosexism in context: Qualitative interaction effects of co-cultural responses. *Howard Journal of Communications*, 23(4), 312-331.
- Carmack, H. J. (2014). Medicalization. In T. Thompson (Ed.), *Encyclopedia of Health Communication* (pp. 845-846). Thousand Oaks, CA: Sage.
- Cass, V. C. (1979). Homosexual identity formation: A theoretical model. *Journal of Homosexuality*, 4(3), 219-235.
- Charmaz, K. (2001). Grounded theory. In R. M. Emerson (Ed.), *Contemporary field research: Perspectives and formulations* (pp. 335-352). Prospect Heights, IL: Waveland Press.
- Coker, T.R., Austin, S.B., & Schuster, M.A. (2010). The health and health care of lesbian, gay, and bisexual adolescents. *Annual Review of Public Health*, 31(1), 457-477.
- Conron, K.J., Mimiaga, M.J., & Landers, S.J. (2010). A population-based study of sexual orientation identity and gender differences in adult health. *American Journal of Public Health*, 100(10), 1953-1960.
- Creswell, J. W. (2014). *Research designs: Qualitative, quantitative, and mixed methods approaches* (4th ed.). Thousand Oaks, CA: Sage Publications, Inc.
- DeHart, D. D. (2009). Breast health behavior among lesbians: The role of health beliefs, heterosexism, and homophobia. *Women & Health*, 48(4), 409-427.

- Denzin, N. K., & Lincoln, Y. S. (2000). Introduction: The discipline and practice of qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed.) (pp. 1-29). Thousand Oaks, CA: Sage Publications.
- Dixon, J. (2009). *Coping with "normal:" Emerging themes in the negotiation of heteronormativity*. Paper presented at the annual meeting of the National Communication Association, Chicago, IL.
- Fish, J. (2006). *Heterosexism in health and social care*. New York: Palgrave Macmillan
- Fredriksen-Goldsen, K. I., Emlert, C.A., Kim, H., Muraco, A., Erosheva, E.A., Goldsen, J., & Hoy-Ellis, C.P. (2013). The physical and mental health of lesbian, gay male, and bisexual (LGB) older adults: The role of key health indicators and risk and protective factors. *Gerontologist, 53*(4), 664-675.
- Glaser, B., & Strauss, A. (1967). *Discovery of grounded theory*. Chicago: Aldine.
- Goins, E.S. & Pye, D. (2012). Check the box that best describes you: Reflexivity managing theory and praxis in LGBTQ health communication research. *Health Communication, 28*(4), 397-407.
- Guisinger, P. (2014). Coming out. *Fourth Genre: Explorations in Nonfiction, 16*(2), 51-62.
- Haig, T. (2006). Bareback sex: Masculinity, silence, and the dilemmas of gay health. *Canadian Journal of Communication, 31*, 859-877.

- Herek, G. M. (2012). *Facts about homosexuality and mental health*. Retrieved from http://psychology.ucdavis.edu/faculty_sites/rainbow/html/facts_mental_health.html
- Johnson, J. M. (2002). In-depth interviewing. In J. F. Gubrium & J. A. Holstein (Eds.), *Handbook of interview research: Context & method* (pp. 103- 119). Thousand Oaks, CA: Sage.
- Keyton, J. (2006). *Communication research: Asking questions, finding answers* (2nd ed.). New York, NY: McGraw-Hill.
- Kitts, R.L. (2010). Barriers to optimal care between physicians and lesbian, gay, bisexual, transgender, and questioning adolescent patients. *Journal of Homosexuality*, 57(6), 730-747.
- Klitzman, R.L., & Greenberg, J.D. (2008). Patterns of communication between gay and lesbian patients and their health care providers. *Journal of Homosexuality*, 42(4), 65-75.
- Kosenko, K. A. (2011). The safer sex communication of transgender adults: Processes and problems. *Journal of Communication*, 61(3), 476-495.
- Kuyper, L., & Vanwesenbeeck, I. (2011). Examining sexual health differences between lesbian, gay, bisexual, and heterosexual adults: The role of sociodemographics, sexual behavior characteristics, and minority stress. *Journal of Sex Research*, 48(2-3), 263-274.
- Labig Jr., C.E., & Peterson, T.O. (2006). Sexual minorities and selection of a primary care physician in a Midwestern U.S. city. *Journal of Homosexuality*, 51(3), 1-5.

- Lewis, C. C., Matheson, D. H., & Brimacombe, C. A. E. (2011). Factors influencing patient disclosure to physicians in birth control clinics: An application of the communication privacy management theory. *Health Communication, 26*(6), 502-511.
- Liasson, M. (2014, October 20). Turf shifts in culture wars as support for gay marriage rises. *NPR*. Retrieved from <http://www.npr.org/2014/10/20/357440359/turf-shifts-in-culture-wars-as-support-for-gay-marriage-rises>
- Lindolf, T. R., & Taylor, B. C. (2011). *Qualitative communication research methods* (3rd ed.). Thousand Oaks, CA: Sage Publications.
- Littlejohn, S. W., & Foss, K. A. (2011). *Theories of Human Communication*. Long Grove, IL: Waveland Press, Inc.
- Manning, J. (2013). Interpretive theorizing in the seductive world of sexuality and interpersonal communication: Getting guerilla with studies of sexting and purity rings. *International Journal of Communication, 7*, 2507-2520.
- Manning, J. (2015). Communicating sexual identities: A typology of coming out. *Sexuality & Culture, 19*, 122-138.
- Manning, J. (2015). Positive and negative communicative behaviors in coming-out conversations. *Journal of Homosexuality, 62*, 67-97.
- Mayer, K.H., Bradford, J.B., Makadon, H.J., Stall, R., Goldhammer, H., & Landers, S. (2008). Sexual and gender minority health: What we know and what needs to be done. *American Journal of Public Health, 98*(6), 989-995.

- McNair, R. (2003). Outing lesbian health in medical education. *Women & Health, 4*, 89-104.
- Mimiaga, M.J., Goldhammer, H., Belanoff, C., Tetu, A.M., & Mayer, K.H. (2007). Men who have sex with men: Perceptions about sexual risk, HIV and sexually transmitted disease testing, and provider communication. *Sexually Transmitted Diseases, 34*(2), 113-119.
- Morrison, S., & Dinkel, S. (2012). Heterosexism and health care: A conceptual analysis. *Nursing Forum, 47*(2), 123-130.
- Nichols, W. L. (2012). Deception versus privacy management in discussions of sexual history. *Atlantic Journal of Communication, 20*(2), 101-115.
- Orbe, M. P. (1998). From the standpoint(s) of traditionally muted groups: Explicating a co-cultural communication theoretical model. *Communication Theory, 8*(1), 1-26.
- Orbe, M. P., & Roberts, T. L. (2012). Co-cultural theorizing: Foundations, applications and extensions. *Howard Journal of Communications, 23*(4), 293-311.
- Owen, W. F. (1984). Interpretive themes in relational communication. *Quarterly Journal of Speech, 70*, 274-287. doi:10.1080/00335638409383697
- Parkhill, A. L., Mathews, J. L., Fearing, S., & Gainsburg, J. (2014). A transgender health care panel discussion in a required diversity course. *American Journal of Pharmaceutical Education, 78*(4), 1-7.
- Petronio, S. (2002). *Boundaries of privacy: Dialectics of disclosure*. Albany, NY: State University of New York Press.

- Petronio, S., & Sargent, J. (2011). Disclosure predicaments arising during the course of patient care: Nurses' privacy management. *Health Communication, 26*, 255-266.
- Politi, M.C., Clark, M.A., Armstrong, G., McGarry, K.A., & Sciamanna, C.N. (2009). Patient-provider communication about sexual health among unmarried middle-age and older women. *Journal of General Internal Medicine, 24*(4), 511-516.
- Rounds, K.E., McGrath, B.B., & Walsh, E. (2013). Perspectives on provider behaviors: A qualitative study of sexual and gender minorities regarding quality of care. *Contemporary Nurse, 44*(1), 99-110.
- Saulnier, C. F. (2002). Deciding who to see: Lesbians discuss their preferences in health and mental health care providers. *Social Work, 47*(4), 355-365.
- Scott, S., Pringle, A., & Lumsdaine, C. (2004). Sexual exclusion- Homophobia and health inequalities: A review. *UK Mens Health Network*. Retrieved from http://www.glhv.org.au/files/gmhn_report.pdf
- Shulman, J. (2010). Got a cerix? Get a pap. *Network Magazine of the Canadian Women's Health Network, 12*(2), 11-13.
- Tracy, S. J. (2010). Qualitative quality: Eight "big-tent" criteria for excellent qualitative research. *Qualitative Inquiry, 16*(10), 837-851.
- Troiden, R. R. (1989). The formation of homosexual identities. *Journal of Homosexuality, 17*(1-2), 43-73.
- United States Department of Health and Human Services. (2013, November 13). Lesbian, gay, bisexual and transgender health. Healthy People 2020. Retrieved from

<http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=25>

Zuzleo, P. R., (2014). Improving nursing care for lesbian, bisexual and transgender women. *Journal of obstetric, gynecological & neonatal nursing*, 43(4), 520-530.