Stigma, Access to Care, and Sexual Minority Women’s Health

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Chapter 1

Introduction

Adolescents and adults who identify as lesbian, gay, bisexual, and transgender (LGBT) in the U.S. face a great deal of discrimination despite the rapid and significant changes in attitudes about those with minority sexual orientation and gender identity over the last couple of decades. Stories about violence against LGBT youth and businesses that refuse to serve gay and lesbian adults accompany news about the legalization of same-sex marriage and the widespread support of popular transgender actors and television shows. Culture and policy in the U.S. has changed for the better in significant ways for many who identify as sexual and gender minorities, but in some ways there is a long journey ahead. Indeed, physical and mental health disparities experienced by sexual minority populations have only recently gained attention of government agencies that fund large-scale research and despite a significant body of research pointing to their existence (Collins, 2013).

While the health of gay men gained important focus and crucial funding during and following the initial AIDS epidemic of the 1980s and 1990s, other sexual and gender minority groups have not received similar focused attention. Sexual minority women face a number of physical and mental health disparities compared to their heterosexual peers. At the intersection of multiple marginalized identities, lesbian, bisexual, and other non-heterosexual women experience disparities in multiple areas, including general mental health (e.g. Case et al., 2004;
Koh & Ross, 2006; Valanis et al., 2000), suicidal behavior and self injury (Blosnich & Bossarte, 2012; Blosnich, Bossarte, & Silenzio, 2012; Gilman et al., 2001), distress (Blosnich, Foynes, & Shipherd, 2013), depression (Cochran, Mays, Alegria, Ortega, & Takeuchi, 2007), anxiety and mood disorders (Gilman, et al., 2001), poor self-reported physical health (Blosnich, et al., 2013; Diamant & Wold, 2003; Liu, Reczek, & Brown, 2013), obesity and overweight (Aaron, Markovic, Danielson, & Honnold, 2001; Boehmer, Bowen, & Bauer, 2007; Cochran et al., 2001; Fredriksen-Goldsen, et al., 2013), risk factors for cardiovascular disease (Case, et al., 2004; Diamant & Wold, 2003; Farmer, Jabson, Bucholz, & Bowen, 2013; Fredriksen-Goldsen, et al., 2013; Valanis, et al., 2000), risk factors for cancer (Case, et al., 2004; Valanis, et al., 2000), and risk for disability (Fredriksen-Goldsen, et al., 2013). In addition to significant differences in mental and physical health, sexual minority women also access less health care. In fact, sexual minority women are less likely than heterosexual women to get pap smears and pelvic exams (Aaron, Markovic, Danielson, & Honnold, 2001; Charlton et al., 2011; Cochran et al., 2001; Diamant, Wold, Spritzer, & Gelberg, 2000; Powers, Bowen, & White, 2001), mammograms (Cochran, et al., 2001; Diamant, et al., 2000; Koh, 2000; Powers, et al., 2001), and cholesterol screenings (Koh, 2000). They are also less likely to have health insurance and more likely to have difficulty accessing care than heterosexual women (Diamant, et al., 2000).

There is a need for research that examines the mechanisms that explain these significant differences in mental health, physical health, and access to care for sexual minority women. In particular, there is a need for research grounded in the experiences of those who experience these disparities. The goal of this three-paper dissertation is to examine the impact that stigma, a fundamental cause of health disparities (Hatzenbuehler, Phelan, & Link, 2013), has on the physical and mental health of women who identify as sexual minority, with particular attention
to the role of access to care. This mixed-methods endeavor draws on literature from multiple disciplines and included a focus on multiple ecological contexts, including individual, community, and society (Bronfenbrenner, 1979).

The next chapter, Chapter 2, addresses the theoretical literature relevant to this project, as well as definitions of key terms. The history of the study of health disparities is briefly covered, followed a review of relevant social science literature on stigma and access to care. The overarching model on which this work is based is also described in Chapter 2.

The first study, presented in Chapter 3, is a qualitative exploration of the experiences of sexual minority women living in a metropolitan area in the southern U.S. The goal of this study was to gain a better understanding of the ways in which members of the population of interest describe their experiences of stigma, access to care, and health. This chapter also grounded the two studies that follow in the accounts of women experiencing stigma related to sexual orientation, an important focus of the feminist inquiry that drives this work. As Sandra Harding noted:

Anyone who starts out thinking about science funding, or environmental destruction, or medical research from the perspective of the lives of those who bear a disproportionate share of the costs of these activities can learn to ‘follow the interests’ of the latter to arrive at less partial and distorted accounts of science and technology institutions and practices (1998, p. 155-156).

A goal of these studies was to focus on issues of interest to participants and I did this by beginning with a qualitative exploration of women’s experiences of sexuality-related stigma and accounts of accessing care.
The second study, presented in Chapter 4, sought to fill a gap in the literature on barriers to accessing care. The goal of this study was to identify demographic, or predisposing, factors that are predictors of access to care among sexual minority women.

Finally, the third study, presented in Chapter 5, tests two hypotheses related to the relationship between stigma, access to care, and physical and mental health among sexual minority women.

In Chapter 6, the final chapter, I discuss how these studies fit together to address important gaps in the literature. In addition, I present implications for practice, policy, and future research on sexual minority women’s health.

This dissertation seeks to fill a gap in the literature by examining the ways in which stigma affects the health of sexual minority women, particularly through access to adequate and effective physical and mental health care. With a qualitative grounding in the lived experiences of women and a focus on multiple ecological contexts and multiple modes of inquiry, this dissertation uncovers new evidence about a social injustice affecting a marginalized population.
References


Chapter 2

Relevant Definitions and Theories

A substantial and growing body of literature has documented numerous physical and mental health disparities between sexual minority and heterosexual women (for review, see Mann, in preparation). In order to design interventions and inform policies aimed at closing the gaps in health, there is a need to better understand the mechanisms that explain them. This mixed-method dissertation explored the ways in which stigma affects the health of sexual minority women, with special attention to access to culturally-appropriate physical and mental healthcare and the role that access to care plays in this relationship. The goals of this dissertation were: 1) to delve into the narratives of sexual minority women to better understand the ways in which they experience stigma in health and mental healthcare settings; 2) to examine demographic predictors of access to care, and 3) to test two hypotheses connecting access to care, stigma, and physical and mental health outcomes. This research was rooted in rich bodies of theoretical literature on health disparities, stigma, and access to care.

The health disparities literature traditionally examines patterns in health outcomes that reflect a system that favors those with racial/ethnic, socioeconomic, and other forms of privilege (Krieger, 1999; Williams, Yan, Jackson, & Anderson, 1997). Stressors, such as stigma, are unevenly distributed in the population and can result in significantly worse outcomes in health for those who experience higher stress and have fewer resources (Link & Phelan, 1995). One
mechanism through which stigma can affect health is access to care, which can directly impact physical and mental health in multiple ways (U.S. Department of Health and Human Services, 2015). In this chapter I a) review foundations of health disparities research and existing theories related to the stress process model and sexual minority health disparities; b) review definitions and theories related to stigma, both in general and specifically pertaining to sexual orientation; c) discuss the literature on the definitions and theories related to access to care, and d) present the theoretical framework for this dissertation.

Health Disparities: Definitions and Theories

Out of the epidemiological commitment to reduce human suffering, we can extend our discipline’s scope to elucidate how oppression, exploitation, and degradation of human dignity harms health - and, simultaneously, further knowledge and inspire action illuminating how social justice is the foundation of public health. Embodying equality should be our goal for all. (Krieger, 1999, p. 336)

Health disparities are patterns of outcomes in physical and mental health in which minority groups fare worse than those in the majority. Health disparities research has its foundations in the study of differences in health outcomes by race and socioeconomic status (Krieger, 1999; Williams, et al., 1997). Differences in health outcomes between White and Black populations in the U.S. persist when controlling for socioeconomic status (Williams, et al., 1997). Empirical research has shown that a combination of socioeconomic status and stressors related to structural and interpersonal racism accounts for a significant amount of the disparities in health outcomes. Disparities literature has focused on differences that are a result of racism, sexism, heterosexism, ableism, ageism, and class bias (Krieger, 1999). Examination of
differences in physical and mental health between heterosexual and sexual minority populations have recently begun to gain increased attention in health disparities literature (Collins, 2013; Committee on Lesbian Gay Bisexual and Transgender Health Issues and Research Gaps and Opportunities, 2011).

Theories and frameworks that address these disparities have included a wide range of predictors and numerous outcome variables at multiple levels. One type of model that addresses multiple predictors and outcomes of health disparities focuses on the stress process. Stress process models contain social characteristics (e.g. Race, SES, gender, sexual orientation), stressors (e.g. stigma), mediating resources (e.g. social support, self-esteem, sense of control), and health and mental health outcomes (Pearlin, Lieberman, Menaghan, & Mullan, 1981, p. 241). Researchers have emphasized the need to (a) to construct theory and conduct research on stress not just in terms of discrete stressful events and long-term factors, but systems of stressors and the ways in which they affect groups over time and (b) to measure a wide range of health and mental health outcomes (Aneshensel, 2005; Cassel, 1995; Pearlin, 1989). One example of the stress process is the notion of weathering, which refers to the cumulative effects of experiences of racism on the health of African Americans (Geronimus, 1992). In an effort to operationalize the concept of weathering, researchers came up with the concept of allostatic load, a physiological measure of the impact of stress from many sources on individuals (McEwen, 1998; McEwen & Seeman, 1999).

Previous heterosexist research attributed poor mental health outcomes in sexual minority populations to the minority sexual orientation itself, which at one point was classified as disorder in the Diagnostic and Statistical Manual (Herek, 2010). More recent theoretical literature, however, has tied differences in outcomes for sexual minority populations to multiple stressors
(Meyer, 2003; Hatzenbuehler, 2009), one of which is stigma. In Meyer’s model, mental health outcomes were the result of a number of stressors specific to those with minority sexual orientation (e.g. lesbian, gay, or bisexual). “Stigma, prejudice, and discrimination create a hostile and stressful social environment that causes mental health problems” for sexual minorities (Meyer, 2003, p. 674). Meyer referred to four processes contributing to sexual minority stress: objective sources of stress, such as events and conditions; the stress of anticipating these stressful events; acceptance or internalization of stigmatized ideas, attitudes, and beliefs; and the stress of concealing the stigmatized status. This model has also been applied to physical health outcomes (Frost, Lehavot, & Meyer, 2015).

In order to inform policy, practice, and future research related to reducing health disparities, this dissertation aimed to examine factors that predict physical and mental health outcomes. The particular factors of focus in these studies were stigma and access to care.

**Stigma**

Though there are many stressors included in models of health disparities, the stressor of interest in this dissertation was *stigma*. This section covers definitions of stigma, both as they apply to other populations (such as those with mental illness) and sexual minority population; and theories related to the impacts of stigma.

**Definitions of Stigma**

Erving Goffman’s oft-quoted definition of stigma has served as the basis for describing this important and influential social phenomenon in the decades since his book’s publication. Goffman (1963) defined stigma quite literally as a “mark” that indicates something undesirable
about its owner, referring to the word’s Greek origin. He also described stigma as something experienced *between* people, “a language of relationships, not attributes”, as opposed to having a basis in the perceptions of one person (Goffman, 1963, p. 3). Though the majority make reference to this original definition of social stigma, several researchers have addressed, refined, shifted, and expanded upon Goffman’s original definition. These frameworks and definitions do overlap but they also differ in key ways.

Nearly 40 years after Goffman, Link and Phelan expanded upon and refined the definition of stigma to include five key components: “…when elements of labeling, stereotyping, separation, status loss, and discrimination co-occur in a power situation that allows [them] to unfold” (p.367). As illustrated in the quoted text, in addition to its five components, Link and Phelan included the presence of *power* in their definition, arguing that those who are stigmatized are subject to compounding effects of a power differential based on their stigmatized status or statuses and that those in power will seek to keep their power, in part through the act of stigmatizing. “The amount of stigma that people experience will be profoundly shaped by the relative power of the stigmatized and the stigmatizer” (Link & Phelan, 2001, p. 378).

A social psychological examination of stigma also noted that it involves power, is multifaceted, and multi-leveled (Major & O'Brien, 2005). These authors outlined four mechanisms of stigma: negative treatment and discrimination; self-fulfilling prophecies that can occur when a stigmatized person is treated differently based on his or her status; changes in behavior that can occur when a stereotype based on a stigmatized status is activated; and identity threat. “Identity threat results when an individual appraises the demands imposed by a stigma-relevant stressor as potentially harmful to his or her social identity, and as exceeding his or her resources to cope with those demands” (pp. 398-399). As opposed to a *threat* to identity,
however, a *challenge* occurs when a person with a stigmatized status has adequate coping resources to incur the stigmatized treatment.

Other researchers have attempted to bridge the disconnect across stigma research on various socio-ecological levels, describing stigma as an intersection of an individual (with a stigmatized status) and a community (with stigmatizing ideas, beliefs, and attitudes) (Pescosolido, Martin, Lang, & Olafsdottir, 2008). “To date, there have been few attempts to consider influences shaping stigma, in part because they are often conceptualized and measured at different levels of analysis, use different methods of analysis, and draw from different research traditions” (p.433).

Another issue in the revisited stigma literature is the distinction between stigma and prejudice. Researchers analyzed 18 published models of prejudice and stigma and attempted to determine the degree to which other researchers were referring to different concepts or the same concept when they used the terms, concluding that the terms were applied somewhat differently to the same overlying concept (Phelan, Link, & Dovidio, 2008). *Prejudice*, the authors determined, is more commonly used to refer to issues involving race, ethnicity, and nationality, while *stigma* is applied to illness, disability, behavior, and issues of identity. They also identified three *functions* of both stigma and prejudice found in the models they analyzed: exploitation and domination; enforcement of social norms; and avoidance of disease, which they referred to, alternatively, as “keeping people down; keeping people in; and keeping people away” (p. 362).

**Sexual minority stigma.** Sexual minority stigma can be defined as the labeling, stereotyping, separation, status loss, and discrimination experienced by those who identify as (or are assumed to be) lesbian, gay, bisexual, transgender, or other, based on this identity. Herek (2004) elaborated on this concept and defined terms describing stigma specific to sexual
minority populations. *Sexual stigma, heterosexism,* and *sexual prejudice* are terms used to refer to specific forms of sexual minority stigma and resist the notion that there is one clear in-group and out-group, rather than a continuum of sexuality that we all experience differently and is subject to change over time.

**Theories**

There are several relevant and testable theories regarding the effects of both the broader concept of stigma and sexual-minority-specific stigma on physical and mental health. Reviewed here are those most relevant to this dissertation proposal, separated into three major categories: individual level, community level, and societal or institutional level. These ecological contexts do not exist in a vacuum, but rather affect one another (Bronfenbrenner, 1979). For instance, though stigma is perceived by individuals, stigmatizing attitudes, ideas, and beliefs are expressed by one’s peers in the context of communities and institutions. For this reason, some overlap between these categories is apparent in the descriptions below.

**Individual level stigma theory.** Building on Meyer’s (1995) work in which he conceptualizes stigma towards sexual minorities as *minority stress,* Williamson (2000) reviewed the impact of *internalized homophobia* on health outcomes from gay men and lesbians, concluding that the connection is understudied and necessary to include in models of sexual minority health. As Williamson pointed out, internalized homophobia is one component of Meyer’s definition of minority stress, which Meyer’s data indicated was a predictor of disparities in mental health outcomes of a sample of gay men. Despite being included in several studies of sexual minority mental health, the term has not been widely accepted by researchers as
synonymous with stigma or as an important predictor of physical and mental health outcomes (Williamson, 2000).

In addition to experiencing negative physical and mental health consequences, those who experience sexual minority stigma may respond by engaging in both beneficial and less helpful modes of coping, such as avoiding the source of the stigma and seeking social support from sexual minority peers (Frost, 2011). Frost presented a model of stigma and its consequences in which coping and support strategies, and meaning-making strategies mediated the relationship between experiencing stressors related to stigma and either negative or positive outcomes at multiple levels.

Crocker and Major (1989) outlined the relationship between stigma and individuals’ self esteem, defining stigmatized persons as “individuals who by virtue of their membership in a social category are vulnerable to being labeled as deviant, are targets of prejudice or victims of discrimination, or have negative economic or interpersonal outcomes” (Crocker & Major, 1989, p. 609). They theorized that there are multiple avenues by which those who are stigmatized will suffer from low self esteem: (a) they may internalize the negative attitudes that others have towards them, (b) as the result of being treated differently because of their stigmatized status, they may begin to act in a way that meets others’ expectations, and (c) experiences of being devalued can lead to feelings of inefficacy and low self worth.

The authors also described resilience factors, or methods of active coping, that may help those who are stigmatized to protect their self-esteem, including (a) attributing the negative treatment from others to their stigmatized beliefs, (b) comparing one’s outcomes only to others who share their stigmatized status, and (c) giving less value to traits negatively affected by something associated with one’s stigmatized status and more value to unrelated traits. In
addition, Crocker and Major mentioned several moderators of the relationship between stigma and self-esteem: the amount of time that a person has lived with a stigmatized status, the degree to which the status can be concealed, the degree to which a person accepts the stigmatizers’ ideas, beliefs, and attitudes, where a person believes the responsibility for having the stigmatized status lies, and the degree to which one’s stigmatized status is central to his or her identity.

Finally, while Meyer (1995) and others connected stigma and physical and mental health outcomes in sexual minority populations, Hatzenbeuhler (2009) provided a closer look at the mechanisms that translate the experience of stigma into mental health outcomes, unpacking the assumptions inherent in other theories connecting stigma to mental health outcomes. The author proposed that stigma affects coping, interpersonal relations, and cognition, which in turn affect mental health outcomes. Other mediating factors included group-specific stigma responses, which both mediate the relationship between stigma and mental health and affect the other psychological processes mentioned. Hatzenbeuhler’s model also pointed to potential moderators both of stigma and psychological processes, such as race, sex, age, and sexual-minority-specific processes, including how central sexual orientation is to one’s identity.

**Community level stigma theory.** Some researchers have theorized that concealability from others, including those in one’s community is an asset to those with a concealable stigmatized status (such as sexuality, mental health issues, HIV, unemployment, etc…). However, persons with a concealable status engage in frequent management of who knows, who they suspect may know, and to whom to disclose their stigmatized status, which is an added stressor that can have negative effects on mental health (Pachankis, 2007). Frost (2011) also noted that concealing a stigmatized status is a double-edged sword. “Although concealing one’s stigmatized status from others can be protective, in that it may allow one to avoid discrimination,
stigma concealment is stressful because it produces cognitive burden resulting from fear of discovery” p. 827.

**Societal or institutional level stigma theory.** Rather than examining proximal causes of physical health (e.g. the relationship between smoking cigarettes and developing cardiovascular disease), Link and Phelan (1995) argued that researchers would be more effective if they concentrated on the social conditions, such as socioeconomic status and social support, that put people at greater risk for experiencing those proximal causes. In an updated version of this theory, the authors (joined by stigma researcher, Mark Hatzenbuehler), pointed to stigma as one of those fundamental causes of health disparities (Hatzenbuehler, Phelan, & Link, 2013). In addition to differential exposure to stress, stigmatized individuals may exhibit different health behaviors as a way of coping with stress (Major, Mendes, & Dovidio, 2013).

Finally, Hatzenbuehler, Phelan, and Link (2013) highlight the *persistent* nature of stigma, such that when avenues of stigmatizing are eliminated but the culturally-pervasive motivation to stigmatize is still present, that new means of stigmatizing will arise in the place of those that were eliminated (Hatzenbuehler, Phelan, & Link, 2013). The persistent and evolving nature of stigma and its fundamental impact on health outcomes requires that stigma be considered not only as multi-level but also as a factor more frequently than it currently is, and that large-scale, interdisciplinary efforts are needed to embark on more thorough examinations of stigma’s impact on health inequalities.

**Complexities of a multi-level model of overlapping identities.** Although the model presented in this chapter depicts stigma at three distinct levels, the boundaries of these levels are not always clear and levels do not occur in isolation, rather, they sometimes overlap and affect one another (Bronfenbrenner, 1979). In addition, though most of the theory related to sexual
minority populations reviewed above pertains to all sexual minority populations (i.e. gay men, lesbian women, and bisexual men and women), the focus of interest in this dissertation is cisgender (their gender at birth corresponds with their gender identity) sexual minority (lesbian, bisexual, or some other non-heterosexual sexual orientation) women. These populations experience the intersection of multiple marginalized identities: being female, having a minority sexual orientation, and possibly additional marginalization based on race/ethnicity, socioeconomic status, ability, or others. Intersectionality, as explored by Patricia Hill Collins (1990) and other feminist scholars, emphasizes the complexity of the intersection of multiple marginalized identities. Indeed, one cannot add up the experience of being a woman and the experience of having a minority sexual orientation in order to better understand the unique experiences of lesbian women, just as one could not add the experience of being black to being a lesbian to better understand the lives of black lesbian women. This dissertation addressed the intersectional nature of multiple marginalized identities experienced by sexual minority women based on just on sexual orientation, sex, and gender, but also race/ethnicity, socioeconomic status, immigration status, and others. It was not the goal of any of these studies to disentangle the experiences of these identities, but rather to recognize the complex nature of the experiences of the women who participated in these studies.

**Access to Care**

There are several definitions of “access to care” in the literature. The Healthy People 2020 report published by the U.S. Department of Health and Human Services outlines three key steps to accessing health services: 1) getting access to the healthcare system, 2) getting to the physical location of healthcare service, and 3) connecting with a healthcare provider with whom
the patient feels she can speak openly (2015). While the financial barriers to this first step and geographical barriers to the second step have been widely addressed, the third step, which requires that a healthcare provider be trained in cultural competence, is often overlooked, and unmeasured.

The CDC estimates that 86.8% of people in the U.S. have a “usual place to go for medical care”, and that only 6.5% of the population cannot get care for financial reasons (Centers for Disease Control and Prevention, 2011). However, these figures vary significantly among population subgroups. Moreover, although the majority of people in the U.S. report having access to quality physical and mental healthcare, these resources are unevenly distributed. Being young, male, having immigrated to the U.S., having a lower income level, and belonging to a racial or ethnic minority group are each predictive of less access to care (Agency for Healthcare Research and Quality, 2011; U.S. Dept of Health and Human Services, 2015). Though young men may be voluntarily opting out of accessing care, unequal distribution of resources restricts the choices of those with less financial means and acts as a barrier to seeking and receiving care. Furthermore, a portion of those who access care do not receive adequate care because they do not have a relationship with a healthcare provider with whom they can communicate effectively. A lack of trust between patient and healthcare provider can lead to not sharing important health information and diminishing the quality of care provided (Thiede, 2005).

Aday and Andersen’s framework of access to care focused on multiple domains of variables at multiple levels, including both the patient and the healthcare system (Aday & Andersen, 1974). The authors have also outlined issues in the ethics of equal access to care, including: (1) everyone has a right to healthcare; (2) the amount of available healthcare resources
is limited; (3) access to healthcare is a matter of social justice (Aday & Andersen, 1981). Equal access to care does not necessarily translate into equal treatment or equal health outcomes (Goddard & Smith, 2001). These authors noted that in the more limited definitions of access to care and certainly in much of the measurement of access to care,

…equity of access is purely a supply side consideration in the sense that equal services are made available to patients in equal need. In contrast, variations in treatment arise from the interaction between supply and demand which depend on the preferences, perceptions and prejudices of both patient and health care provider (p.1150).

Significant differences in the definition of healthcare access are particularly important because they lead to significant differences in measurement of access to care. Studies that define access to care solely in terms of ability to pay for care or ability to physically get to an office will fail to include patients who receive inadequate care due to lack of open communication with their healthcare provider. Poor communication could stem from lack of trust on the part of the patient or lack of cultural competence of the provider (Thiede, 2005). Absence of an understanding of sexual minority issues can lead to heteronormative assumptions and barriers to disclosure of sexual orientation by patients, both of which limit the quality of physical and mental health care received (Barbara, Quandt, & Anderson, 2001).

Aday and Andersen’s foundational theory included three attributes of the population in need of care that they called predisposing, enabling, and need. Predisposing are demographic factors like sex, race, age, and, (although they did not point this out) sexual orientation that a person has regardless of their health condition. Enabling attributes include personal resources one might use to get care, and the availability of that care, as well as personal and community or societal barriers (disabling attributes). In the context of the theoretical model presented in this
chapter, stigma is an enabling factor (Polaha, Williams, Heflinger, & Studts, 2015). Need is the type and severity of health impairment experienced by an individual (Aday & Andersen, 1974). The authors presented a framework for examining healthcare access that assumes health policy affects both (a) the providers of healthcare and (b) the attributes of the population in need of care; both of which, in turn, affect (c) service use and (d) the users’ assessment of the quality of their care.

As Mackian, Bedri, and Lovel (2004) discussed, there are models of healthcare access that emphasize “pathways,” or a series of individual behaviors related to seeking services; and there are those that examine determinants, the social and environmental factors that influence access to care. Another distinction is that there are models that emphasize interaction with a formal healthcare system as an outcome, and those that emphasize healthful behaviors as outcomes resulting from interaction with the healthcare system (i.e. individuals behaving in a way that may positively impact their health status) (Mackian, Bedri, & Lovel, 2004). There are also theoretical models that focus on individual, community, and societal level access issues, though these categories often are said to influence one another.

**Individual Level Access**

Though many empirical studies focus on individual-level measurement of access to care, few theories focus only on individual-level access. One such theory posits that patient trust of practitioners can play an important role in access to care. Trust of the healthcare provider creates a need for particular attention to open, honest, and effective communication between those who seek and use healthcare services and those who provide healthcare (Thiede, 2005).
Community-Level Variables Affecting Access

Several researchers specifically addressed community-level variables in theoretical work building on Andersen and Aday’s model (Davidson, Andersen, Wyn, & Brown, 2004; Mackian, Bedri, & Lovel, 2004; Phillips, Morrison, Andersen, & Aday, 1998). Though multiple ecological contexts were present in the Aday and Andersen model (e.g. the policy level, the healthcare system, population characteristics, and individual outcomes), other researchers have explicitly recommend community-level variables to enhance our understanding of how and why people access care. For example, Davidson, Andersen, Wyn, and Brown (2004) adapted the original model by adding a number of “community characteristics” that are related to the ways in which people with low income access care.

Authors also suggested that researchers should look at the ways in which populations interact with the systems that provide care, paying particular attention to community-level enabling factors, such as reflexive communities (Mackian, et al., 2004). The term reflexive communities refers to the ways in which people’s understandings of others in their environment affect their health seeking behaviors. In the context of access to healthcare, the reactions one anticipates from her healthcare system may affect the way she seeks care. These reactions happen on the level of the individual, but may be based on population characteristics such as race, class, gender, or sexual orientation (Mackian, et al., 2004)

Societal/Institutional Level

Looking beyond community-level and practitioner variables there is also a need for the inclusion of social or cultural variables in addition to those related to financial accessibility, organizational barriers, and availability of care (Gulliford, 2002). Phillips, Morrison, Andersen,
and Aday (1998) included attributes of the healthcare delivery system, and societal factors such as presence of practitioners in the community in their updated model. The authors’ updated analysis also included practitioner-related variables, though not formally in their model. Practitioners, or the “supply side”, affect access to care mainly in their interactions with potential healthcare users. The availability and appropriateness of their care can affect whether patients seek or obtain care (Phillips, et al., 1998).

It is clear from the sizable body of existing literature that presented theoretical frameworks regarding access to healthcare that a multi-level model is necessary. Empirical studies of either individual behavior or systemic barriers alone provide insufficient information about why patterns in physical and mental healthcare access exist and what can be done to strive for the goal of equity in access. A gap in the theoretical literature on access to care, however, is its inattention to the healthcare access issues facing sexual minority populations.

A Model of Physical and Mental Health Outcomes of Sexual Minority Women

Drawing from the literature on health disparities, stigma, and access to care from multiple disciplines, the following is a multi-level model of influences on physical and mental health of sexual minority women. The model depicted in Figure 1 (below) includes three constructs: 1) stigma, 2) access to care, and 3) health. Some constructs are depicted with multiple social ecological contexts, represented by concentric circles.

Independent and Dependent

The importance of ecological contexts for the health of individuals, or ecological systems theory, is explicated in the work of Bronfenbrenner (1979), who posited that individuals are
situated within nested settings, each of which affects both the individual and the other settings. This dissertation model includes two multi-level constructs: stigma and access to care. Stigma and access to care each contain three levels in the model (individual, community, and society/institution). Physical and mental health outcomes in this study are assessed at the level of the individual.

1) **Stigma.** Stigma on an individual level is often measured as internalized stigma and other individual-level reactions to stigma (e.g. concealment, shame, fear of reinforcing stereotypes). In Study 1, stigma on the individual, community, and societal/institutional levels are examined through individual narratives elicited by open-ended questions. In Study 3, one quantitative measure is used to assess individual level consciousness of sexuality-related stigma (e.g. “I almost never think about the fact that I am homosexual when I interact with heterosexuals”).

2) **Access to care.** The National Healthcare Disparities Report (2002) included three levels of access to care measures: ability of provider to address patient needs, structural barriers within the system, and access to the healthcare system. These three levels correspond with the individual, community, and society/institution levels in the dissertation model presented in this chapter. Study 2 focused on access to care and included measures of access at all three levels. Individual-level access to care includes several subcategories, including patient-physician communication and cultural competency (e.g. “does your provider listen carefully”). Community-level access includes both barriers to access within the system and qualities of the system, such as availability of transportation to care and cleanliness and safety of the site of service (e.g. “the healthcare site is clean”). Society or institutional-level access includes having health insurance and having access to a provider (e.g. “I have a choice of having an LGBT
3) **Physical and mental health outcomes.** Physical and mental health were assessed on an individual level in this dissertation. In Study 1, participants were asked about how they perceive and define their own health via open-ended interview questions. In Study 3, physical health information was collected with a self-report measure of physical health (e.g. “in general, would you say your health is excellent, very good, good, fair, or poor?”), and mental health is assessed using a measure of self esteem.

**Relationships Among Variables**

In Figure 1, relationships among independent and dependent variables are represented by lines labeled with letters. Each of the relationships among variables in the broader model is conceptual, though each were explored in one or more of the studies included in this dissertation. For a thorough review of the relevant literature with empirical studies on each of the relationships presented in the model, see Mann (in preparation).

Line $a$ connects stigma and access to care and is bidirectional, indicating that stigma and access to care affect one another. On an individual level, stigma can serve as a barrier to seeking care via poor patient-physician communication (Thiede, 2005). On a community level, stigma consciousness can impact the way one seeks and receives healthcare (Barbara, Quandt, & Anderson, 2001). In addition, on a societal level, laws prohibiting same-sex marriage may serve as barriers to obtaining health insurance through one’s spouse, which can affect access to care (O’Hanlan, 1996). This relationship is bidirectional in the model because stigma outside the care setting can affect access, though experiences in a care setting can also affect one’s perceptions of stigma.
Figure 1. Multi-level influences on sexual minority women’s health
Line \( b \) connects access to care to physical and mental health outcomes, and points towards health and mental health outcomes only. Individual-level, community-level, and institutional-level access to care can each impact health and mental health outcomes (U.S. Department of Health and Human Services, 2015).

Line \( c \) connects stigma to physical and mental health outcomes, with an arrow towards health and mental health outcomes only, indicating that this relationship goes in one direction only, such that stigma affects health and mental health outcomes. Stigma on an individual level has been shown to affect mental health (e.g. Frost, Lehavot, & Meyer, 2015), as has community-level stigma (e.g. Lewis, Derlega, Giffin, & Krowinski, 2003). Institutional stigma can also affect mental health (e.g. Hatzenbuehler, 2009).

This Dissertation

The model presented in this chapter serves as the overarching conceptual model for the three studies described in the next three chapters. The first empirical paper, presented in Chapter 3, qualitatively addressed the relationships among all three variables, delving into narratives about stigmatized experiences in everyday lives of sexual minority women and their experiences seeking and receiving physical and mental healthcare. From this work, emerged information on which the second empirical paper was partially based. In this second paper, presented in Chapter 4, I examined demographic predictors of access to care, such as race/ethnicity, age, and openness about one’s sexuality. In the third empirical paper, presented in Chapter 5, I tested two hypotheses related to the relationship between access to care, stigma, and physical and mental health outcomes. These studies were aimed at gathering evidence to better understand the mechanisms at work in creating sexual minority women’s health disparities. This model,
therefore, depicts multi-level influences on the physical and mental health of sexual minority women.

**Conclusions**

Sexual minority women experience a number of physical and mental health disparities, including poorer self-rated health (Blosnich, Foynes, & Shipherd, 2013; Diamant & Wold, 2003; Liu, Reczek, & Brown, 2013) and worse general mental health (e.g. (Case et al., 2004; Koh & Ross, 2006; Valanis et al., 2000), among others (for a review of the literature, see Mann, in preparation). Health disparities literature has pointed to discrimination based on to race/ethnicity (Krieger, 1999; Williams, et al., 1997) and identity (Pearlin, 1981) as the source of stress that leads to these differences in physical and mental health outcomes. Stigma based on identity is one stressor that can act as a fundamental source of health disparities (Link & Phelan, 1995). One setting in which this stigma can be observed is physical and mental healthcare, the quality of which can be diminished by stigma, which, in turn, can lead to negative physical and mental health outcomes for patients with a stigmatized status, whether or not this status is visible to healthcare practitioners (U.S. Department of Health and Human Services, 2015).

The model of multi-level influences on the health of sexual minority women presented in this chapter fills some gaps in the theoretical literature. This multidimensional conceptualization of factors related to health has been influenced by theories across multiple disciplines and combines concepts from psychology, sociology, public health, and women’s and gender studies. Despite this large body of theory and empirical research, the mechanisms that cause systematic gaps in health and mental health outcomes are not fully understood (Krieger 1997; Williams 1999).

By examining the model in three separate studies, my goal was to uncover new
information about how stigma affects the physical and mental health of this population through access to care. Each study addressed implications for practice, policy, and future research.
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Chapter 3

A Qualitative Examination of Sexual Minority Women’s Healthcare Experiences

Many researchers have examined health disparities -- differences in measurable indicators of health, both physical and mental, that result in disproportionate rates of illness in a marginalized group -- based on race, ethnicity, socioeconomic status (Williams, Mohammed, Leavell, & Collins, 2010), sex (World Health Organization, 2009), geographic location (Hartley, 2004), immigration status (Lasser, Himmelstein, & Woolhandler, 2006), and education (Winkleby, Jatulis, Frank, & Fortmann, 1992). Disparities based on sexual orientation, however have recently begun to gain increased attention of researchers and policy makers. In fact, the Healthy People 2020 report included a number of goals specific to the physical and mental health of sexual minority populations, as well as a focus on more accurate and systematic data collection (U.S. Department of Health and Human Services, 2015).

Several disparities in mental health, physical health, substance use, and access to care between sexual minority and heterosexual women have been documented in peer-reviewed studies across multiple disciplines. The largest portion of these studies points to disparities in mental health between sexual minority and heterosexual women. Several researchers’ analyses indicate that sexual minority women experience worse general mental health than heterosexual women (Case et al., 2004; Chakraborty, McManus, Brugha, Bebbington, & King, 2011; Cochran, Sullivan, & Mays, 2003; Diamant & Wold, 2003; Fredriksen-Goldsen, Kim, Barkan,
Muraco, & Hoy-Ellis, 2013; Koh & Ross, 2006; Sandfort, de Graaf, Bijl, & Schnabel, 2001; Valanis et al., 2000). Findings also reveal higher rates of suicidal behavior and self injury (Blosnich & Bossarte, 2012), suicidal ideation (Blosnich, Bossarte, & Silenzio, 2012; Gilman et al., 2001), and risk for suicide (Matthews, Hughes, Johnson, Razzano, & Cassidy, 2002; Ploderl & Fartacek, 2005) among sexual minority women when compared to their heterosexual peers. Other studies show disparities in distress (Blosnich, Foynes, & Shipherd, 2013), depression in the last year and over lifetime (Cochran, Mays, Alegria, Ortega, & Takeuchi, 2007), and anxiety and mood disorders (Gilman, et al., 2001). Sexual minority women also report having less social and emotional support than heterosexual women (Blosnich, et al., 2012; Blosnich, et al., 2013; Ploderl & Fartacek, 2005; Valanis, et al., 2000); and higher rates of psychological stressors (Ploderl & Fartacek, 2005).

Some researchers have found that that sexual minority women are more likely to have generally poor self-reported physical health (Blosnich, et al., 2013; Diamant & Wold, 2003; Liu, Reczek, & Brown, 2013) when compared to heterosexual women. There are also documented disparities in obesity and overweight (Aaron, Markovic, Danielson, & Honnold, 2001; Boehmer, Bowen, & Bauer, 2007; Cochran et al., 2001; Fredriksen-Goldsen, et al., 2013), risk factors for cardiovascular disease (Case, et al., 2004; Diamant & Wold, 2003; Farmer, Jabson, Bucholz, & Bowen, 2013; Fredriksen-Goldsen, et al., 2013; Valanis, et al., 2000), risk factors for cancer (Case, et al., 2004; Valanis, et al., 2000), and risk for disability (Fredriksen-Goldsen, et al., 2013) between sexual minority and heterosexual women.

A few studies have focused on reproductive health disparities, including one in which sexual minority women reported significantly higher rates of sexually-transmitted infections than heterosexual women (Charlton et al., 2011), and another found that women who had sex with
women reported higher rates of hepatitis C, bacterial vaginosis, herpes, and genital warts than women who had sex exclusively with men (Fethers, Marks, Mindel, & Estcourt, 2000). In addition, sexual minority women have reported significantly higher rates of smoking and tobacco use (Aaron, et al., 2001; Blosnich, et al., 2013; Burgard, Cochran, & Mays, 2005; Cochran, Ackerman, Mays, & Ross, 2004; Cochran, et al., 2001; Diamant, Wold, Spritzer, & Gelberg, 2000; Farmer, et al., 2013; Tang et al., 2004; Valanis, et al., 2000); alcohol use and dependence (Aaron, et al., 2001; Cochran, Keenan, Schober, & Mays, 2000; Cochran & Mays, 2000; Cochran, et al., 2001; Diamant, et al., 2000; Drabble, Midanik, & Trocki, 2005; Farmer, et al., 2013; Valanis, et al., 2000); and substance use and dependence (Cochran, et al., 2004; Cochran & Mays, 2000; Farmer, et al., 2013; Koh, 2000) than heterosexual women.

One of the hypothesized causes of these disparities in health is that sexual minority women have difficulty accessing healthcare. Several studies have demonstrated that sexual minority women are less likely to get pap smears and pelvic exams than heterosexual women (Aaron, et al., 2001; Charlton, et al., 2011; Cochran, et al., 2001; Diamant, et al., 2000; Powers, Bowen, & White, 2001). They are also less likely to get mammograms (Cochran, et al., 2001; Diamant, et al., 2000; Koh, 2000; Powers, et al., 2001) and cholesterol screenings (Koh, 2000) than heterosexual women. One study’s results indicated that sexual minority women are less likely to have health insurance and more likely to have difficulty accessing care than heterosexual women (Diamant, et al., 2000). Higher rates, however, of accessing mental healthcare (Cochran & Mays, 2000; Cochran, et al., 2003) have been documented among sexual minority women compared to heterosexual women, which may reflect both higher rates of mental health issues in this population and resilience factors that lead to improved outcomes for some.
The underlying mechanisms for these relationships have not been well explained using quantitative methods and qualitative approaches offer a way to closely examine the effects of minority stress. Qualitative methods have been used to examine the relationship between stigma and relationship quality for sexual minority adults (Frost, 2011), risk related to sexual practice among sexual minority women (Marrazzo, Coffey, & Bingham, 2005), lesbian and bisexual women’s attitudes about weight (Bowen, Balsam, Diergaarde, Russo, & Escamilla, 2006; Roberts, Stuart-Shor, & Oppenheimer, 2010), health service needs of older sexual minority men and women (Brotman, Ryan, & Cormier, 2003), predictors of bisexual mental health, and HIV risk for sexual minority women (Ross, Dobinson, & Eady, 2010; Young, Friedman, & Case, 2008). However, to date, there is little in-depth qualitative research examining the complexities of the experiences that sexual minority women have accessing healthcare and none published to date that uses interviews to examine the role of stigma in quality of care for sexual minority women. This study explored the minority stress model, by examining narratives of sexual minority women’s experiences with stigma and healthcare in order to elicit information about sexual minority women’s experiences in their own words.

**Theoretical Model**

The minority stress model posits that proximal and distal stressors related to minority sexual orientation status contribute to outcomes in health both in negative and positive ways (Meyer, 2003). Some of these stressors may occur in healthcare settings, affecting the quality of healthcare delivery, and, therefore, acting as a barrier to accessing adequate care (Aday & Andersen, 1974). Several researchers have published evidence of systematic differences in physical and mental health outcomes favoring heterosexual women, though fewer have carried
out empirical studies examining the mechanisms that connect stigma to health outcomes and healthcare access. A smaller body of evidence points of stigma concealment (Frost & Bastone, 2007), gay-related stressors (Lewis, Derlega, Griffin, & Krowinski, 2003) and internalized homophobia (Herek, 1998) as predictors of depression, policy-level discrimination as a predictor of psychopathology (Hatzenbuehler, Keyes, & Hasin, 2009; Hatzenbuehler, McLaughlin, Keyes, & Hasin, 2010), and experiencing prejudice as a predictor of physical health problems (Frost, Lehavot, & Meyer, 2015).

The theoretical model driving this work, presented in Figure 1, is in line with Meyer’s (2003) minority stress model, in that it includes stigma as a factor (stressor) contributing to physical and mental health. Stigma transpires “…when elements of labeling, stereotyping, separation, status loss, and discrimination co-occur in a power situation that allows [them] to unfold” (Link & Phelan, 2001, p.367). In this model, stigma is specific to sexual minority status and serves as a negative influence on physical and mental health both proximally (for example, via internalized negative attitudes about one’s sexual orientation) and distally (for example, via stigmatizing events). Stigma in this model has both a direct and an indirect effect on health, partially mediated by access to care. In this sense, stigma acts as a barrier to accessing effective and culturally appropriate healthcare.

Access to care in this model includes 1) getting access to the healthcare system, 2) getting to the physical location of healthcare service, and 3) connecting with a healthcare provider with whom the patient feels she can speak openly (U.S. Department of Health and Human Services, 2015). Stigmatizing policies may prevent sexual minority individuals from obtaining health insurance either through their partners employers or their own (Wight, Lelanc, & Lee Badgett, 2013). Stigma can also play a role in the relationship between a sexual minority patient and a
provider. A patient may feel uncomfortable disclosing information to a provider who she perceives as having a negative attitude about minority sexual orientation, leading to an ineffective relationship between patient and provider (Thiede, 2005). Limited access to care, in turn, may have an impact on physical and mental health outcomes (U.S. Department of Health and Human Services, 2015).

Figure 1. Sexual minority stigma, access to care, and health

In the model, both stigma and access to healthcare directly affect the outcomes, here referred to as health. Stigma affects health of sexual minority women as described above, as it is an identity-specific stressor. Access to care, in this model, depicted as “getting care” and “physician/patient relationship”. These represent access to care in two different ecological
contexts. Stigma may affect one’s ability to find culturally-appropriate healthcare (“getting care”) or one’s ability to be open about one’s sexuality with a healthcare provider (affecting the physician/patient relationship). Stigma exists in the context of a society, a community, or between individuals and it affects the healthcare environment, impeding one’s ability to obtain adequate and appropriate treatment.

In this study, questions were aimed at eliciting information about experiences of accessing healthcare as a sexual minority woman. In exploring participants’ experiences of healthcare, the goal of this study was to focus on participants’ first-hand accounts of seeking and receiving care. The model above is grounded in the initial accounts obtained in pilot interview data in which participants were asked about stigma, and access to care emerged as a recurrent theme.

Methods

This qualitative study was conducted with women who lived in a metropolitan area in the southern U.S. and who identified as sexual minority (i.e. lesbian, bisexual, or another category that is not heterosexual). This study was reviewed and approved by the Vanderbilt University Institutional Review Board.

Participants and Sampling Method

Eligible participants self identified as cisgender (their gender at birth corresponded with their gender identity at the time of the study) sexual minority (lesbian, bisexual, or other non-heterosexual sexual orientation) women, lived in a particular county in the southern U.S., and were 22 years of age or older. Participants were recruited using flyers in LGBT-friendly
businesses, and referrals from other participants (i.e. snowball sampling). Grounded theory sampling was used in this study and the goal of this sampling approach was to saturate interview themes rather than demographic categories of participants (Charmaz, 2014). Therefore, interview data were collected until no new themes were brought up during the course of the interviews. For this study, that occurred after sixteen participants were interviewed in depth.

**Interview Procedure**

Qualitative interviews were conducted face-to-face in a location agreed upon by the participant and interviewer that allowed for privacy (e.g. private room at a public library or participant’s home). All interviews were conducted one-on-one by the author. Each semi-structured interview took 30 to 90 minutes and was audio recorded with participant permission. The semi-structured interview protocol was aimed at eliciting information about participants’ experiences with stigma based on their sexual orientation, especially in physical or mental healthcare settings. The initial wave of interviews was conducted in the spring of 2013 and the second wave of interviews was conducted in the summer of 2015. After pilot testing the protocol, minor adjustments were made to unclear, double-barreled, or otherwise ineffective questions, and the interview was edited to include more questions that would elicit information about particular kinds of experiences in physical or mental healthcare settings. The revised interview protocol included 34 questions, including demographic questions and those aimed at recruiting additional participants. Pilot interviews were included in the data analyzed for this study.
Analysis

Interviews were transcribed word-for-word by the author and subsequently entered into NVivo version 10 (QSR International Pty Ltd). After transcription, I conducted initial coding and wrote memos addressing emergent themes (Charmaz, 2014). In the second phase of coding, I created a codebook focused on themes related to access to care and applied it to the data. During the collection of data, I wrote reflexivity memos in order to deeply explore my position in the research process. These memos were written after each interview, between interviews, and during interview transcription. Memos were used in the creation and revision of the coding scheme that was used in the analysis of transcribed interview data. This process is also described by Charmaz (2014). Coding methods were developed based on grounded theory and relied on the standpoint and interpretation of the researcher. Therefore, a second coder was not used in order to confirm the reliability of the coding scheme.

Results

All sixteen participants were cisgender women who described their sexual orientation as lesbian, bisexual, or other non-heterosexual category. Some participants resisted labeling their sexual orientation, though all described their relationship history as including relationships with people of the same sex. Participants ranged in age from 22 to 50, with a mean age of 29. Ten identified as White, three as Latina, one as Black, and two as mixed race. Two participants’ highest level of education was a high school degree, three had attended some college, 10 had college degrees, and one had attended some graduate school.

Access to physical and mental healthcare was discussed in each interview. There were two main themes that emerged in participants’ responses: getting care and participants’
relationships with healthcare practitioners. There were 10 sub-themes within these two main themes, five related to getting care and five related to relationships between patients and providers. Table 1 summarizes each of the emergent themes.

**Getting Care**

Issues related to seeking and receiving healthcare came up in every interview. Participants discussed obstacles they encountered getting care, successes they had in getting care, and their feelings and observations about this process. The five sub-themes within this category were finding a provider, healthcare avoidance, healthcare costs, health insurance, and healthcare policies or laws.

**Finding a provider.** When talking about the process of finding a provider, participants mentioned either looking for someone on their own or asking trusted friends for either an acute or non-urgent health need.

I would ask some of my friends who are bisexual, queer whatever the ones who I know have gone to therapy if they have anything if they have anybody they’d recommend um usually - I am part of a Facebook group for like lesbians or whatever and I’ve asked them before and I got a lot of different responses.

Participants mentioned seeking a provider who is "accepting" and someone who will not make assumptions about their sexual orientation. “…before I go to a doctor, kinda same way I do with a church, I kinda try to feel out and see if they have a reputation for being accepting.”

Evidence of a potentially acceptable provider included others having found them helpful or having an office in a location that participants feel is friendlier.
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<tr>
<th>Theme</th>
<th>Category/Subcategory</th>
<th>Brief Description</th>
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<tbody>
<tr>
<td>Getting Care</td>
<td>Finding a provider</td>
<td>Looking for an accepting provider either through trusted friends or social networks. Considering reputation and location when choosing a provider.</td>
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<td></td>
<td>Healthcare avoidance</td>
<td>Not seeking and/or receiving services either due to a range of barriers to care a preference for non-traditional care.</td>
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<td></td>
<td>Health insurance</td>
<td>The role of insurance in either getting or not getting care.</td>
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<td>Healthcare costs</td>
<td>Expenses related to healthcare as a barrier to seeking, receiving, or following up on healthcare</td>
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<td>Healthcare laws/policies</td>
<td>Sexuality-related structural barriers to care</td>
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<td>Physician/Patient</td>
<td>Disclosure to healthcare provider</td>
<td>Degree to which participants are open with providers about their sexuality; experiences of disclosing or withholding one’s sexual orientation to or from providers</td>
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<td>Relationship</td>
<td>Healthcare stigma</td>
<td>Experiences of discrimination based on one’s sexuality orientation within healthcare settings</td>
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<td>Anticipation of healthcare stigma</td>
<td>Worrying about the possibility of being discriminated against in a healthcare setting based one sexual orientation</td>
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<td>Practitioner cultural</td>
<td>The degree to which staff and practitioners are knowledgeable about issues of sexual orientation</td>
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<td>Vulnerability in a</td>
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I think it would depend on the location of the doctor so let’s say that I would probably feel like, I had to pick like a specialist or private doctor it would have to be someone, for example if I had the choice between [suburb] and [metropolitan area], [metropolitan area], because [suburb] is not as open-minded, maybe?

One participant was connected with mental healthcare through clergy at her church when I was first first first you know starting dealing with all of this kind of thing [referring to sexuality] I went to my priest and um she recommended going to see somebody and um she just gave me like a place that does like pastoral counseling and stuff and when I talked to their intake person they set me up with somebody who I guess was interning…

Two participants reported feeling general stress related to the process of seeking healthcare. One mentioned that the it was stressful and that she was “glad it was worth it,” while the other talked about feeling stressed about the possibility of seeking care and finding out she has a health problem. In addition, two participants mentioned that they had gone to a sexual-minority friendly support group (al-anon) where they had positive experiences and found help coping with the drug or alcohol use of a loved one.

Healthcare avoidance. Several participants talked about putting off seeking healthcare or generally preferring to not seek traditional physical or mental healthcare services for a wide range of reasons. Some talked about feeling that a provider would not understand issues related to their sexuality or felt that the system and the provider assumed they were heterosexual.

I mean, I wouldn’t like go to the doctor unless I’m sick I guess, cuz that’s like one more time that they could want to know stuff that…are- I mean I just uhh, like the paperwork tends to be designed for straight people um and like and so it’s just, it’s to avoid the
awkwardness of saying, like having to explain again and again um that this is what my, my body is like and how it works and like that’s enough for me to avoid and not go to the doctor unless I’m sick.

Some participants talked about seeking care after previously avoiding care either because of a poor relationship with a provider, new health insurance, a new job, or other circumstances that made seeking and receiving care easier.

It’s the – this is the first time since I moved to [metropolitan area in southern U.S.] I felt far more comfortable talking to doctors than I did in [southern state]. I think it’s just because I didn’t like my doctor. I think that’s what it was, I just did not feel comfortable with my doctor. I just felt like he was just way too old school and just like, I dunno, I just didn’t feel comfortable with the guy, so it’s just kinda like I dreaded going to the doctor.

Several participants talked about not seeking traditional healthcare because of a preference to treat health issues themselves or a preference for non-traditional medical remedies.

“I’ve grown up in an environment where we knew how to treat things at home, so like certain symptoms that show up, I know what to do for them.” “…like in my family we work things out on our own and we don’t go to the doctor.”

Participant: no I’ve never been diagnosed and I will very rarely been to a doctor, I went to a doctor a handful of times in my lifetime Interviewer: why is that? P:…well I never felt a need um my grandmother was very much in to alternative health when we were kids and she had you know a kitchen table full of vitamins and herbs so it was one of those situations where we were very versed and we became somewhat versed through her and we knew what to do for different things and I’m pretty hearty all in all.
Health insurance. The next most commonly mentioned issue related to accessing healthcare was insurance, either as a bridge to care (i.e. recently having gotten insurance, participant talks about getting care) or a barrier to care (i.e. not getting care because they do not have insurance). “…’cuz I could I have insurance, first time having insurance in, like, you know… like all I had to pay was a copay”

There was also general discussion of how having or not having insurance makes participants feel. “Interviewer: Do you have health insurance through your job? Participant: No, I have no health insurance. Interviewer: And your girlfriend doesn’t have health insurance either? Participant: No, it’s scary”. In addition, more than one participant was lacking important information about coverage - one could have been covered by her parents' insurance but was not and did not know that was an option.

One participant talked about the changing status of the coverage of mental healthcare on an insurance plan she purchased via the Affordable Care Act (ACA) healthcare exchange. Interviewer: have you sought mental healthcare here? Participant: not yet cuz my…under the ACA Blue Cross said it wasn’t part of that for the plan that I was getting but…my new plan that’s starting in July they do some mental health so I’m excited to explore that um and I also could have sought some sliding scale stuff but I haven’t gotten around to it.

Healthcare costs. Several participants also talked about the cost of healthcare. Some mentioned cost as a reason why they had not yet received care or not even sought care.

So all these bills start rolling in…I work on commission and um, and 9 dollars an hour and um, pay for everything on my own and just, I was…I was drawing on…it was over, it was over 1,500 dollars worth of money from tests…before I could even get the medicine and then finding out the medicine’s $5000 for a box…
Cost of treatment was also a reason for delaying treatment, not following up with recommended treatment, or not continuing to receive treatment. Participants also mentioned looking for inexpensive care as a reason why that have yet to get care. “…but um I don’t have a lot of financial resources right now so I’m trying to find places that are cheap.”

**Healthcare laws and policies.** A couple of participants mentioned the roles that laws or policies played in their ability to get healthcare.

…oh yeah, um, well you know there’s, there’s you know you’ve heard the story, there’s over a thousand laws that discriminate against, you know um LGBT people and you know that’s a big deal and um right now my partner’s going without health insurance because my very progressive company doesn’t make a very progressive decision, in fact I’m, I’m in conversations with them because in our employee manual it talks about how they don’t discriminate against LGBT um or sexual orientation but I’m bringing to their attention that they really do and um they actually had an opportunity to buy a policy that provided domestic partner benefits and they made a financial decision not to get that policy because it was more expensive and you know it’s really having a big impact on, on our life. My partner’s been without health insurance since February and is dealing with cancer and that’s a big deal.

**Participant’s Relationship with Provider**

The next major theme that emerged was the relationship between a participant and her healthcare provider. Talking about a wide range of settings, including primary care, urgent care, and mental healthcare, participants discussed issues related to trust and perceived cultural competence of their providers. Sub-themes within this category included disclosure of sexual
orientation to providers, experiences of stigma in healthcare settings, anticipation of stigma, cultural competence of the provider, and feelings of vulnerability in healthcare settings.

**Disclosure of sexual orientation to healthcare provider.** Several participants mentioned talking to providers about their sexual orientation. Some did not feel the needed to disclose their sexual orientation. “I don’t really see a need for sexuality to ever come up with a general practitioner, like if I go in for a chest cold, that shouldn’t come up”. Some were glad the option was present on office paperwork, and some had positive experiences discussing sexual orientation with providers.

They didn’t even ask. So, it wasn’t, it wasn’t a big deal, but with my primary care doctor, I did. Um, because for a short time I was on birth control. Um, which was somewhat needless, and, uh, she so she asked and I disclosed it and she was fine.

Others had a difficult time disclosing, either encountering assumptions of heterosexuality or sensing disdain on the part of the provider.

…like the form was good it said like are you sexually active, it said yes or no and it said primarily men, women, or both, and like I circled all the stuff that would indicate that I was gay but like did they read the form clearly? Obviously not cuz they’re asking, they’re freaking out that I’m pregnant

**Healthcare stigma.** Next, some participants brought up experiences of sexual minority stigma in healthcare settings. “The nurse that brought me in there was not really cool with it but the gynecologist was fine…she was fine”. “I mean I just uhh, like the paperwork tends to be designed for straight people.”
Anticipation of healthcare stigma. Two anticipated encountering stigma in healthcare settings. One was worried that healthcare providers might treat her differently than they would treat heterosexual patients.

Sometimes you can’t help but wonder if their…if their own personal experiences are gonna sort of make them treat you differently than they would treat someone who’s like them and so um I mean that’s what it was like in undergrad, when I got mono my doctor told me to stop kissing my boyfriend and I was like “OK!” HA! I guess I’ll kiss my girlfriend instead! Who I got it from!

Another participant talked about feeling worried that she would be mocked because of her sexuality.

And she was like laughing at me the nurse was making little jokes and laughin’ and I thought this maybe because she remembers me or something but I tried not – I try not to be paranoid, like thinking…but the thought it’s weird cuz before I came out…the thought occurs like pops up in my head a lot like…are they doing this because I’m gay? Do they know I’m gay?

Practitioner cultural competence. A couple of participants also talked about the cultural competence of providers. One participant mentioned that her primary care provider was particularly knowledgeable about sexual minority women’s health issues. Another talked about a helpful and culturally competent mental healthcare provider.

…and she hooked me up with a very wonderful therapist…and she, she just helped me kinda work through it and like “you’re gay, stop being stubborn” and I was like “alright fine” and that’s when I decided I’d tell my parents.
Another participant mentioned encountering a provider who lacked knowledge, as evidenced by the fact that the office only had resources about gay men and did not have any targeted to lesbians.

**Vulnerability in a healthcare setting.** One participant explicitly mentioned feeling vulnerable seeking healthcare.

…but you know it was sort of a way of answering that question where I didn’t have to…disclose…anything I didn’t want to disclose…um…you know cuz that’s a very vulnerable…seeking healthcare for your body is a very vulnerable place and it wasn’t always a safe place

**Discussion**

This study’s findings indicate that access to healthcare is a significant stigma-related concern for sexual minority women. As proposed in the theoretical framework for this study, sexual minority stigma, a stressor, can have a negative impact on the health of sexual minority women. In this case, when asked about settings in which they encountered sexual minority stigma, participants in this study spoke about their experiences related to obtaining healthcare and the quality of their relationships with healthcare providers. Sexual minority stigma acted as a barrier to seeking and receiving healthcare and a negative influence on health in two ecological contexts: outside of healthcare settings and within healthcare settings. Outside healthcare settings, in the process of getting care, stigma played a role in finding a provider, the preference of some to avoid healthcare, the ability of participants to obtain insurance, cost as a barrier to getting care, and laws and policies that facilitate or act as barriers to care. Within healthcare settings, stigma played a role in participants’ decisions to disclose their sexual orientation to their
provider—patients experienced stigmatizing interactions with providers, anticipated these types of interactions, perceived providers as having a range of sexuality-related cultural competence, and recognized their own vulnerability in healthcare settings.

A common concern for many of the women in the study was obtaining healthcare. Indeed, this concern is reflected by the existence of healthcare use disparities between sexual minority and heterosexual women covered earlier in this paper. Several participants talked about the process of finding a provider, including the use of social networks, a method used by many (Braine, 2014) and preference for “accepting” providers. Notably, participants did not mention using any publically-available lists of LGBT-friendly providers in the area, which were hard to come by at the time this paper was written.

Avoidance of healthcare settings was another predominant theme, with several participants reporting that they generally did not seek care or that they sought alternative healthcare only. This behavior may be one of several factors that lead to disparities in preventative care between sexual minority and heterosexual women (Barefoot, Smalley, & Warren, 2015). In addition, participants mentioned that insurance, the cost of healthcare, and discriminatory laws and policies serve as barriers to their accessing care. While there is evidence in the literature that insurance (Operario, 2015) and discriminatory laws and policies (Mansh, Garcia, & Lunn, 2015) pose a barrier to sexual minority women’s access to care, healthcare costs are, unfortunately, a barrier for many women in the U.S. regardless of sexual orientation (Shartzer, Long, & Benatar, 2015). Though some participants talked about laws and policies that affect their access to healthcare, such as access to insurance made possible by the ACA, there was a wide range in knowledge about the system among participants. Some participants were unaware that under the ACA they had access to insurance through their parents’ policies while
they were under age 26. On the contrary, a couple of participants spoke at length about the potential impact that legalization of same-sex marriage would have on their or their partners’ abilities to access insurance and other rights.

Having a positive relationship with a healthcare professional was another important theme that emerged in the analysis of the interviews conducted for this study. Most participants talked about the process of coming out to their physician, which is often an important predictor of the quality of a relationship between a sexual minority patient and a provider (see St. Pierre, 2015 for review). Some expressed anxiety about stigma as an outcome of disclosure, while others feared the awkwardness of the conversation, and others sought to avoid it all together. A couple of participants recounted experiences of stigma and discrimination in healthcare settings and two more mentioned fearing that they will have such experiences. Indeed, a small body of research findings indicates that lesbian women perceive stigma in healthcare settings (e.g. Seaver et al., 2008), and that this stigma can lead to avoidance of care (Facione & Facione, 2007).

Participants also discussed the cultural competence of healthcare providers regarding sexual minority issues. Though a growing number of studies call for healthcare providers to be trained in sexual minority health issues (e.g. Compton & Whitehead, 2015), none examines the current level of cultural competence among providers or the role that knowledge of sexual minority issues may play in the quality of the relationship between sexual minority patients and providers. In addition, one participant’s comments about her feelings of vulnerability as a lesbian patient reflect the need for healthcare providers to recognize the multiple stigmatized statuses of some of their patients and get appropriate training in sexual minority issues in order to form quality relationship with patients.
Several of the themes that emerged from the analysis of this interview data are specific to sexual minority women. For instance, disclosure of one’s sexuality to a healthcare provider, experiences of and anticipation of sexuality-related stigma, sexuality-related laws and policies, and sexuality-related cultural competence of healthcare providers are all issues specific to sexual orientation. Other themes, such as avoidance of healthcare, issues related to health insurance, and healthcare costs, are relevant to most people who interact with the healthcare system in the U.S. These interviews, however, were conducted exclusively with sexual minority women and focused predominantly on issues specific to this population. It is impossible to tease out which experiences with, for instance, cost-related barriers to obtaining healthcare, were specific to sexuality, gender, socioeconomic status, or race/ethnicity of participants. Indeed, participants’ experiences are affected by the intersection of all of these identities and others, such as immigration status, nationality, relationship status, education, and more (Cole, 2009). This study’s focus is on experiences common to sexual minority women in a metropolitan area in the southern U.S., the only characteristics common to all participants. The focus on issues related to sexuality is not meant to preclude the influence of other factors on the healthcare experiences of the participants or to deny the intersectional experiences of participants. Instead, this analysis highlights experiences common to this group that are, in part, related to stigma towards women who identify as sexual minority.

Limitations and Future Research

There are a few notable limitations to this research. First, it is important to note that this sample is not meant to be demographically representative of the population of sexual minority women in the U.S. Rather, interviews were conducted with the goal of reaching a point of
saturation of themes related to access to care rather than identities. That being said, this study
does not contain a sample of sexual minority women representative of the population and
findings are not meant to be generalized to this population. In addition, this research was
conducted both before and immediately after the legalization of same sex marriage and does not
reflect changes in access created by this policy shift. Future research should examine the effects
of this change. Future research should also utilize the findings of this study to more closely
examine the effects of the quality of relationships between patients and providers on getting care
and on health.

Conclusions

The present study examined sexual minority women’s accounts of their experiences
related to healthcare. Women who participated in this study spoke about seeking, receiving, and
avoiding healthcare. They talked about difficulties and successes in disclosing their sexual
orientation to providers and having or not having the financial resources to access care. They
also spoke about experiences of discrimination and fears of stigma in healthcare settings. The
study seeks to add the voices of sexual minority women to the growing body of evidence
regarding barriers to access to care for this population. The women whose stories are shared in
this study experienced both barriers to care and success in getting care. They had varied
experiences in seeking and receiving a wide range of services and they had complex and mixed
feelings about those experiences.

The results of this study have implications for research, practice, and policy. With the
recent legalization of same-sex marriage, the access to care terrain for this population is
changing rapidly and warrants continued close examination with a focus on those factors that
predict resilience. Moreover, additional research efforts should be aimed at better understanding the ways in which stigma affects health outcomes for sexual minority women. Several studies present guidelines for training practitioners on sexual and gender minority issues in order to increase cultural competence of providers (e.g. Gendron et al., 2013), though there is little data on the extent to which these types of programs have been implemented and less regarding their effects. Though same-sex marriage is now legal in all 50 states and many more same-sex spouses now, theoretically, have access to insurance through their spouses’ employers, the size of this newly-insured population is unknown. Despite this progress, in response to this expansion of rights, challenges to new laws are beginning to pop up that would allow employers to discriminate against employees on the basis of sexual orientation or gender identity, potentially impeding their access to care. There is a need for ongoing attention to policies that can increase access to healthcare and enhance the quality of healthcare for sexual minority women.
References


Predictors of Sexual Minority Women’s Access to Care

Sexual minority women experience physical and mental health disparities compared to their heterosexual peers (See Mann, in preparation, for review). Access to care is one factor that has been linked to the creation and exacerbation of these health disparities (Agency for Healthcare Research and Quality, 2008). Healthy People 2020 outlines three elements of health services access: 1) getting access to the healthcare system, 2) getting to the physical location of healthcare service, and 3) connecting with a healthcare provider with whom the patient feels he or she can speak openly (U.S. Department of Health and Human Services, 2015a). Access to care is seldom measured using a wide range of indicators addressing care across multiple ecological contexts.

A growing body of research indicates that there are disparities not only in health but also in access to care between sexual minority and heterosexual women. Several studies have demonstrated that sexual minority women are less likely to get pap smears and pelvic exams (Aaron, et al., 2001; Charlton, et al., 2011; Cochran, et al., 2001; Diamant, et al., 2000; Powers, Bowen, & White, 2001), mammograms (Cochran, et al., 2001; Diamant, et al., 2000; Koh, 2000; Powers, et al., 2001), and cholesterol screenings (Koh, 2000) than heterosexual women. One study’s results indicate that sexual minority women are less likely to have health insurance and more likely to have difficulty accessing care than heterosexual women (Diamant, et al., 2000).
While sexual minority women in rural areas were more likely to report mental health care needs than their heterosexual peers, they were more likely to report system-level barriers to access, within-system barriers, and low levels of provider trust (Barefoot, Smalley, & Warren, 2015).

Several researchers have identified barriers to care for sexual minority women in Canada and the U.S. that may be causing these disparities in access, including a lack of attention to individual-focused care that takes a person’s sexual orientation into account, insufficient funding for sexual-minority-specific services (McIntyre, Daley, Rutherford, & Ross, 2011), feelings of invisibility, and a history of experiences of discrimination, (Brotman, Ryan, & Cormier, 2003).

Interviews of sexual minority study participants in a rural area of the U.S. revealed that a dearth of available mental healthcare lead many to conceal their sexual orientation in order to find care through potentially-discriminating social networks and local care options (Willging, Salvador, & Kano, 2006). A study of sexual minority women who use illegal drugs revealed similar barriers to receiving care, though researchers also noted that social networks can provide access to culturally competent providers (Braine, 2014), a finding echoed in research with sexual minority women in a metropolitan area in the southern U.S. (Mann, in progress). The likelihood of sexual minority women in the military accessing mental healthcare has also been associated with their fear of a lack of understanding of sexual minority issues by military mental healthcare providers (Mount, Steelman, & Hertlein, 2015). Another barrier to care is lack of disclosure of one’s sexual orientation to a care provider (for review, see St.Pierre, 2012). Lack of disclosure is both an indicator of patients’ trust of providers and a mechanism that can prevent patients from receiving appropriate and effective care. In a qualitative examination of stigmatized experiences of sexual minority women, Mann (in preparation, see Chapter 3) found that participants often mentioned healthcare settings as sites of potential stigma and discrimination.
Access to care issues specific to a number of populations, including veterans (e.g. Fasoli, Glickman, & Eisan, 2010), immigrants (e.g. Lee, Choi, & Lee, 2014), and homeless adults (e.g. Stein, Andersen, Roberston, & Gelberg, 2012), have been examined by researchers in recent years. However, issues of access specific to sexual minority women are under studied. One important outlier is a study of the healthcare preferences of sexual minority youth (Ginsburg et al., 2002) in which several important factors for accessing care for sexual minority populations were examined. In addition to a need for more research examining access to care issues specific to sexual minority women, an important gap in the literature is the lack of empirical studies examining the quality of physical and mental health care received by sexual minority women. Although equal access to care might not necessarily result in equal physical or mental health outcomes (Goddard & Smith, 2001), a trusting relationship with a culturally competent provider may lead to better care (Thiede, 2005). Ultimately, an examination of multiple factors of the healthcare access specific to sexual minority women sheds new light on this multi-dimensional concept.

In this study, I examined predictors of sexual minority women’s access to care in three ecological contexts (access to the system, access within the system, and the patient/provider relationship) within a sample of sexual minority women in a metropolitan area in a southern part of the U.S. The goal of this study was to identify demographic predictors, or what Aday and Andersen (1974) refer to as predisposing factors, of receiving adequate and effective physical and mental healthcare among sexual minority women. In addressing Aday and Andersen’s five components of healthcare access, this study seeks to set a standard for comprehensive and culturally-appropriate measurement of access. Furthermore, by determining which predisposing
characteristics result in differences in access to care within this population, this study seeks to identify targets for future research, practice, and policy.

**Theoretical Model**

Andersen and Aday (1974) consider five components of access: utilization of health services, characteristics of the health delivery system, consumer satisfaction, characteristics of the population at risk, and health policy. This study incorporates elements of all five of those components with attention to the social ecological context of each (Bronfenbrenner, 1979). The first three of Andersen and Aday’s five components of access were examined via survey data. Utilization of health services represents macro-level access, characteristics of the health delivery system represents meso-level access, and consumer satisfaction represents micro-level access. The two remaining components, characteristics of the population at risk and health policy, were inherent to the overall study (see discussion for more on health policy implications).

Aday and Andersen (1981), among others (e.g. Day, 2010; Weisz, 2009), stated that everyone has a right to healthcare. They pointed out that healthcare is a finite resource that is distributed unevenly across the population, and, therefore, that access to care is a matter of social justice. The current study examined predisposing factors, including race/ethnicity, socioeconomic status, age, and outness, that predict Aday and Andersen’s components of access. The goal of this examination was to highlight differences within this population and make clear opportunities for policies and interventions that can increase access to care and, in turn, benefit the physical and mental health of sexual minority women.
Methods

Participants completed an online survey that included a screener to ensure eligibility, demographic characteristics, and access to care measure in addition to other measures that were part of a larger related study of sexual minority women. This study was reviewed and approved by the Vanderbilt University Institutional Review Board.

Sampling Procedure

Participants were recruited through multiple sources and a combination of snowball sampling and respondent-driven sampling (Gile & Handcock, 2010) was used. First, participants of an earlier qualitative study were invited, via email, to complete the survey. Second, advertisements were sent to lesbian, gay, bisexual, or transgender (LGBT) friendly groups in Nashville, Tennessee. Third, an advertisement for the study was posted on Research Match, an online database that connects researchers with volunteers interested in participating in studies. Participants were given a $10 gift card for participating and $5 gift card for recruiting additional participants. Although recruitment materials indicated that participants must be sexual minority women, 22 or older, and live in a particular metropolitan area in the southern U.S., a series of questions at the beginning of the survey was used to screen participants and ensure eligibility.

Data Collection

The survey was available both online, using REDCap (Harris et al., 2009), or on paper (mailed or in person). The online survey link was emailed to participants and listed on advertisements. The survey took 20-30 minutes to complete and participants were given the
option to save and return to the survey to complete it later. All participants opted to complete the online version of the survey.

**Measures and Covariates**

Participants answered questions about their demographic characteristics and their access to healthcare. There were also a few closing questions used to gather information about how to contact participants in order to deliver incentives, and about their willingness to recruit additional participants and/or be recruited for future research themselves.

**Participant characteristics.** Women (n=100) age 22 years of age or older who identified as sexual minority and lived in a particular metropolitan area in the southern U.S. completed the survey. Participants were asked about their sex, gender identity, sexual orientation, time in the metropolitan area, race/ethnicity, country of origin, state in which person grew up if in U.S., relationship status, education, and employment. There was also a measure of outness in which participants were asked to indicate the degree to which they are open about their sexual orientation with each of 11 individuals (Mohr & Fassinger, 2000). Sample characteristics are presented in detail in Table A1 in Appendix A.

**Access to care measures.** Although multiple ecological contexts are considered, all items in this study’s survey are at the level of the individual. The survey contained two sections on access to healthcare that assessed access across three ecological levels (macro, meso, and micro) and four domains. See Table 1 for a visual representation of the ways in which these components correspond to items in the survey.
Table 1 *Access to care factors and components*

<table>
<thead>
<tr>
<th>Aday and Andersen’s Components of Access</th>
<th>Measure Origin</th>
<th>Survey Section</th>
<th>Survey Subsection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Utilization of Health Services (Macro level)</td>
<td>National Healthcare Quality Report</td>
<td>Access to the Healthcare System</td>
<td>Health Insurance Coverage</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Usual Source of Care</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Unmet Need</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Mental Health /Substance Abuse</td>
</tr>
<tr>
<td>Characteristics of the health delivery system (Meso level)</td>
<td>National Healthcare Quality Report</td>
<td>Structural Barriers within the System</td>
<td>Transportation</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Getting Care</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Waiting Times</td>
</tr>
<tr>
<td>Consumer satisfaction (Micro level)</td>
<td>National Healthcare Quality Report</td>
<td>Ability of Provider to Address Patient Needs</td>
<td>Patient-Physician Communication</td>
</tr>
<tr>
<td></td>
<td>Ginsburg et al. (2002)</td>
<td></td>
<td>Patient-Physician Relationship</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Cultural Competency</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Qualities of Interactions with Providers</td>
</tr>
</tbody>
</table>

The first section of the survey, which was based on items used in the National Healthcare Disparities Report (2002), contained three subsections. The first subsection was access to the healthcare system (macro level). Items were drawn from: the National Health Interview Survey or NHIS (Centers for Disease Control and Prevention, 2015), the Medical Expenditure Panel Survey or MEPS (U.S. Department of Health and Human Services, 2015b), the Commonwealth Fund Healthcare Quality Survey (Commonwealth Fund, 2001), and National Survey on Drug Abuse or NSDA (U.S. Department of Health and Human Services, 2015c). The second subsection was structural barriers within the system (meso level). The third subsection was the ability of providers to address patients’ needs (micro level), Table B1 in Appendix B lists the variables included, including all items and the database that was the source of each item. The second section contained items adapted from a measure of healthcare access for sexual minority
youth (Ginsburg, et al., 2002). Items from this measure that addressed sexual-minority-specific qualities of interactions between patients and providers were included in this analysis. Items were adapted to reflect the healthcare needs and desires of female adults instead of the LGBT youth and teens to which the original measure was targeted. These items, which were rated on a scale from 1 (strongly disagree) to 5 (strongly agree), included: “The provider does not assume that I’m heterosexual/straight” and “The provider seems like the kind of person who is willing to talk about issues around sex”.

**Analysis**

Data were entered into STATA Version 14 (StataCorp, 2012) and assessed for missingness. Analysis focused on describing each of the predictor and outcome variables and using multiple regression analyses to assess demographic predictors of four domains of access to care.

**Results**

Sample members were diverse in age, sexual orientation, race/ethnicity, rurality, education, income, and outness. Participants ranged in age from 22 to 68, with a mean of 35.22 and standard deviation of 11.96. About half of the sample identified as lesbian (46%) and half as bisexual (50%), while the remaining participants (4%) used another term to describe their sexual orientation. The majority of the sample (74%) identified as White, the next largest represented group was African American (20%) and the remaining participants were distributed across other racial/ethnic groups. This is close to the proportions of the county in which the data were collected that identify with each of these racial/ethnic categories (65% white and 28% African
American) (U.S. Census Bureau, 2016). About half of the sample reported being from a suburban area, about a third from an urban area, and a fifth from a rural area. The sample was relatively highly educated, with all participants reporting having graduated from high school and more than two thirds reporting having a college degree. More than two thirds of the sample were employed full time at the time they completed the survey, and most made between $10,000 and $50,000. For more detailed information about the sample, see Table A1 in Appendix A.

Participants’ mean level of outness, or the degree to which they were open with others about their sexual orientation, was 4.05 (SD 1.85) when taking all those about whom participants responded into account. On the scale from 1 (not open with anyone about one’s sexual orientation) to 7 (completely open), a 4 indicated that the respondent feels others know about their sexual orientation but that it is rarely discussed. Participants reporting being most out to their friends (mean 4.71, SD 1.95) and slightly less so with their families (mean 4.29, SD 2.12). Participants were significantly less out with people with whom they worked (mean 3.72, SD 2.26), and even less so with those in religious settings (mean 2.97, SD 2.39).

On a scale from 1 (low access) to 10 (high access), participants’ mean score of access to the system was 8.50 with a standard deviation of 1.16 and ranged from 4.33 to 10. All means for access domains were skewed towards scores indicating higher access and there were no very low scores in any domain. Chronbach’s alpha for the sexual-minority-specific qualities of interactions with providers was 0.83. See Table 2 for all outcomes by domain. Due to some missing data, the total number of participants for whom there were data in each domain varied.
Table 2. *Access to care domain outcomes*

<table>
<thead>
<tr>
<th>Domain</th>
<th>n</th>
<th>Mean</th>
<th>SD</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Access to the Healthcare System</td>
<td>87</td>
<td>8.50</td>
<td>1.16</td>
<td>4.33-10</td>
</tr>
<tr>
<td>2. Access within the System</td>
<td>88</td>
<td>4.60</td>
<td>1.07</td>
<td>1.24-7</td>
</tr>
<tr>
<td>3. Ability of Provider to Address Patient Needs</td>
<td>90</td>
<td>19.56</td>
<td>3.60</td>
<td>6.16-24</td>
</tr>
<tr>
<td>4. Sexual-Minority-Specific Qualities of Interactions with Providers</td>
<td>78</td>
<td>4.11</td>
<td>0.64</td>
<td>2.86-5</td>
</tr>
</tbody>
</table>

Multiple regression analyses revealed significant predictors of each of the four domains of access, in four separate regression models (see Table C1 in Appendix C for complete results of analysis). Model 1 contained potential predictors of access to the system but indicators of the fit of the overall model were non-significant. Model 1 was not a good fit for predicting differences in access to the system (macro level), which might be because the sample had relatively high access to care at the system level. In fact, 89% of the sample reported having health insurance, 93% reported having a usual source of care, only 10% reported having been unable to get care they thought necessary in the last year, and 59% reporting seeking and receiving mental health or substance abuse services. In addition, Model 3, assessing predictors of patient/provider relationships was also non-significant. Despite that model not explaining differences in access, having more education was a significant predictor of higher ratings of patient/provider relationships (p<.01).

Results of Model 2 indicated that being older \( b = 0.02, t(81)= 1.74, p=.09 \), and having more education \( b = 0.84, t(81)= 3.32, p=.001 \) were each significant predictors of higher access within the healthcare system, holding all other variables constant. The overall model was significant \( p<.01 \) and explained 19% of the variance in the outcome. Model 4 assessed
predictors of sexual-minority-specific aspects of the patient/provider relationship. Analysis indicated that being more out was a significant predictor of increased satisfaction with sexual-minority specific aspects of the relationship with one’s healthcare provider \((b = .11, t(71) = 2.78, p = .007)\). The overall model was significant \((p < .05)\) and explained 15% of the variance in the outcome.

**Discussion**

This study’s findings point to some demographic factors that were significant predictors of multiple domains of access to care within a sample of sexual minority women. There were no differences in access to the system component variables based on age, race, education, income, or outness in the first model. As mentioned above, this may be due to the fact that access to the system was high in this sample. Race and income were not predictive of any level of access and it is unclear why this was the case in this sample, as these variables are consistently predictive of system-level access in nationally-representative samples (e.g. Lasser, Himmelstein, & Woolhandler, 2006).

Being older and having a graduate degree were significant predictors of access within the system (meso level) when controlling for other factors. This finding is mirrored in the access to care literature (e.g. Carlson & Blustein, 2003). Within-system-level indicators include having reliable transportation of the site of care, ease in getting an appointment, and less waiting time. Being older may result in having more experience navigating within-system issues, such as getting an appointment at a convenient time and finding an office with shorter wait times. In addition, having more education may account for certain skills or experience navigating the healthcare system, especially if those with higher education had graduate degrees in health-
related fields (this information was not included in the survey results). The overall good fit of Model 2 indicates that these predisposing factors are, in fact, predictive of differences in within-system access across this sample. Moreover, age and education were predictive of within-system access regardless of income, perhaps indicating that experience or familiarity with the system may be more useful than financial resources in gaining this type of access to care.

Next, the model predicting the quality of the relationship between patients and providers (micro level) was not a good fit and did not explain a significant amount of the variance in the outcome. However, one predictor, education, was a significant predictor of more positive ratings of the relationship between patient and provider. This finding is mirrored in the literature on patient/provider relationships (e.g. Spooner, Salemi, Salihu, & Zoorob, 2015).

Finally, the model predicting sexual-minority-specific aspects of the relationship between patients and providers predicted was statistically significant. In addition, outness was a significant predictor of positive ratings of the sexuality-related aspects of the patient provider relationship. This may be because those who are more open with others about their sexual orientation are more likely to specifically seek out culturally-competent providers. Furthermore, those who are more open about their sexuality may have more sexual minority social connections who connect them to culturally-competent providers than those who are less open.

Overall, within this diverse sample of sexual minority women, age, education, and outness were significant predictors of access to care, though race and income were not. In addition, access to care outcomes in each domain were high in this sample. Each mean domain score had a limited lower range and all distributions were skewed towards scores indicating higher access. This was especially true of access to the system, as mentioned above. There was also a limited range in the mean score of and of participants’ ratings of sexual minority-specific
aspects of patient/provider relationships, in which the mean score of 4.11 indicates that, on average, participants “agree” with most items about sexuality-related cultural competence of care providers, and a minimum mean score of 2.85 is between “disagree” and “neutral”, and quite close to “neutral”. Certainly within a sample with a less limited range of outcomes, we would be able to examine predictors not just of differences in access to care, but of low access.

This examination points to the intersection of multiple marginalized statuses experienced by sexual minority women who are marginalized both in terms of gender and sexual orientation, but also, for some, by race, age, and/or socioeconomic status. Being at the intersection of these statuses can result in several layers of barriers to care that cannot be fully understood by broadly examining differences between sexual minority and heterosexual populations. Instead, these layers of marginalization may be more effectively examined with a closer look at multiple demographic factors within a population of sexual minority women. Indeed, among sexual minority women in this sample, those who were younger, had less education, and were less open about their sexual orientation had lower levels of access to care. It is important to identify groups among sexual minority women who have less access to care in order to highlight areas of need within this population at the system level, the within-system level, and the provider level.

**Conclusions and Next Steps**

Though some previous research has examined barriers to access to care for sexual minority women, none has examined multiple domains of access across three ecological contexts and none has integrated sexual-minority-specific items in a sample of adult women. The recent ruling by the United Stated Supreme Court legalizing same-sex marriage paved the way for greater access to the healthcare system for sexual minority women who can now legally marry
spouses and get health insurance benefits through their employers. We have yet to measure the size of the effect of this change on system-level access, but it is sure to be positive. This study examined a sample of women who had high access to the system and there is little research published that examines predictors of, for instance, not having health insurance, within sexual minority populations. There is a need for further examination of a sample that contains sexual minority women with low access to the system.

There a few health policy implications to be made from the analysis of these data. There is a need for better access to health insurance through employers and spousal benefits (now made more widely available by the legalization of same-sex marriage) and a need for greater availability of mental health and substance use services specific to sexual minority adults. There is also a need for better training of healthcare providers and staff on issues specific to sexual orientation, which would improve both access within the system and patient-provider relationships (Mansh, Garcia, & Lunn, 2015). In addition, there is a need for the collection of more data on sexual orientation and gender identity on national surveys that address healthcare needs in the U.S. (Cahill & Makadon, 2014).

There is also a need for greater attention to barriers within the healthcare system. McClain, Hawkins, and Yehia (2016) recently examined the cultural competence of the healthcare environment for LGBT patients, pointing to the strengths and weaknesses of two types of models: LGBT-specific clinics (those whose central mission is to treat sexual and gender minority patients) and LGBT-embedded (either clinics that have some LGBT-focused physicians or LGBT-specific clinics that are grouped with non-LGBT specific clinics). Additional similar examinations of environmental or within-system access to care are needed in order to identify and dismantle barriers.
Finally, efforts to improve the relationships among sexual minority women and their physical and mental healthcare providers may greatly improve trust and patient care, in primary care and beyond (Rounds, McGrath, & Walsh, 2013). A 2007 study found that sexual minority participants were more likely than heterosexual participants to report having visited the emergency department in the last year, calling attention to the need for cultural competence of emergency medical providers (Sanchez, Hailpern, Lowe, & Calderon, 2007). Several studies provide guidelines and additional information for training healthcare providers to be culturally competent in issues related to sexuality (e.g. Compton & Whitehead, 2015; Gendron et al., 2013; Shipherd, 2015). Women in the current study who were more open about their sexual orientation may be more likely to seek out culturally-appropriate care, so culturally-competent providers might consider advertising their expertise broadly, so as to reach those whose low levels of outness (or generally low levels of social connection) isolate them from networks through which to locate providers.

In a 1996 study, lesbian participants believed they were less likely than heterosexual or bisexual women to get cervical cancer, despite the fact that 79% of lesbian participants reported having had sex with a man (Price, Easton, Telljohann, & Wallace, 1996). Improving patient/provider trust can also help providers disseminate pertinent information about sexual minority women’s health.

Future research might also make use of the measure of access to care used in this study. This measure of access to care that takes multiple ecological contexts into account could be used to examine the ways in which each context has an effect on physical or mental health outcomes. It could also be used to examine the ways in which contexts affect one another. In this study, the goal was to gain a better understanding of how demographic factors might predict individual
access in each context. Replication of this study might shed light on how predictors of access to care are different based on sample composition.

An important weakness of this study is the limited range in outcome variables, as mentioned above. Participants, overall, reported high access to care, especially access to the system. The examination of a larger sample that includes more sexual minority women who report low access to care might reveal more about the predictors of access within the population examined in the present study. In addition, it is important to note the goal of studying access is to inform policies and interventions that aim to improve access and eliminate the disparity in this area that exists between sexual minority and heterosexual women. However, equal access, especially at only one level, does not always translate into equal outcomes. As Goddard and Smith note:

…equity of access is purely a supply side consideration in the sense that equal services are made available to patients in equal need. In contrast, variations in treatment arise from the interaction between supply and demand which depend on the preferences, perceptions and prejudices of both patient and health care provider. (2001, p.1150)

In order to improve health, there is a need for attention to all elements of access to care and a close examination of the ways in which access translates into outcomes for this population.
References


Goddard, M., & Smith, P. (2001). Equity of access to health care services: Theory and evidence from the UK. *Social Science and Medicine, 53*(9), 1149-1162.


StataCorp, L. (2012). *Stata Statistical Software: Release 14*. College Station, TX: StataCorp LP.


### Table A1. Sample demographic characteristics

<table>
<thead>
<tr>
<th>Variable</th>
<th>Sample Statistics</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>35.22</td>
</tr>
<tr>
<td>SD</td>
<td>11.96</td>
</tr>
<tr>
<td>Range</td>
<td>22-68</td>
</tr>
<tr>
<td><strong>Gender identity</strong></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>96% (96)</td>
</tr>
<tr>
<td>Genderqueer</td>
<td>4% (4)</td>
</tr>
<tr>
<td><strong>Sexual orientation</strong></td>
<td></td>
</tr>
<tr>
<td>LGB</td>
<td>46% (46)</td>
</tr>
<tr>
<td>Bisexual</td>
<td>50% (50)</td>
</tr>
<tr>
<td>Additional</td>
<td>4% (4)</td>
</tr>
<tr>
<td>Don’t know</td>
<td>5% (5)</td>
</tr>
<tr>
<td><strong>Years in Nashville</strong></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>13.27</td>
</tr>
<tr>
<td>SD</td>
<td>14.08</td>
</tr>
<tr>
<td>Range</td>
<td>0-56</td>
</tr>
<tr>
<td><strong>Race/ethnicity</strong></td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td>20% (20)</td>
</tr>
<tr>
<td>Native American</td>
<td>5% (5)</td>
</tr>
<tr>
<td>Asian</td>
<td>6% (6)</td>
</tr>
<tr>
<td>White</td>
<td>74% (74)</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>4% (4)</td>
</tr>
<tr>
<td>Hawaiian/Pacific Islander</td>
<td>2% (2)</td>
</tr>
<tr>
<td>Additional Category</td>
<td>2% (2)</td>
</tr>
<tr>
<td><strong>Rurality</strong></td>
<td></td>
</tr>
<tr>
<td>Rural</td>
<td>18% (18)</td>
</tr>
<tr>
<td>Urban</td>
<td>31% (31)</td>
</tr>
<tr>
<td>Suburban</td>
<td>53% (53)</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
</tr>
<tr>
<td>HS or GED</td>
<td>5% (5)</td>
</tr>
<tr>
<td>some college</td>
<td>17% (17)</td>
</tr>
<tr>
<td>Associates</td>
<td>9% (9)</td>
</tr>
<tr>
<td>BA</td>
<td>43% (43)</td>
</tr>
<tr>
<td>Masters</td>
<td>19% (19)</td>
</tr>
<tr>
<td>MD/PHD</td>
<td>6% (6)</td>
</tr>
<tr>
<td>other</td>
<td>1% (1)</td>
</tr>
<tr>
<td><strong>Employment</strong></td>
<td></td>
</tr>
<tr>
<td>part time</td>
<td>7% (7)</td>
</tr>
<tr>
<td>full time</td>
<td>67% (67)</td>
</tr>
<tr>
<td>self</td>
<td>2% (2)</td>
</tr>
<tr>
<td>out for 1+</td>
<td>1% (1)</td>
</tr>
<tr>
<td>out for &lt;1</td>
<td>3% (3)</td>
</tr>
<tr>
<td>student</td>
<td>12% (12)</td>
</tr>
<tr>
<td>retired</td>
<td>3% (3)</td>
</tr>
<tr>
<td>unable</td>
<td>4% (4)</td>
</tr>
<tr>
<td><strong>Income</strong></td>
<td></td>
</tr>
<tr>
<td>&lt;10,000</td>
<td>8% (8)</td>
</tr>
<tr>
<td>$10,001-29,999</td>
<td>36% (35)</td>
</tr>
<tr>
<td>$30,000-49,999</td>
<td>33% (32)</td>
</tr>
<tr>
<td>$50,000-69,999</td>
<td>16% (16)</td>
</tr>
<tr>
<td>$70,000-89,999</td>
<td>4% (4)</td>
</tr>
<tr>
<td>&gt;$90,000</td>
<td>3% (3)</td>
</tr>
<tr>
<td><strong>Outness</strong></td>
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</tr>
<tr>
<td>Mean</td>
<td>4.05</td>
</tr>
<tr>
<td>SD</td>
<td>1.85</td>
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<tr>
<td>Range</td>
<td>1-7</td>
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## Appendix B

### Table B1. Access to care items from National Healthcare Disparities Report

<table>
<thead>
<tr>
<th>Section</th>
<th>Subsection</th>
<th>Item</th>
<th>National Database Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to the Healthcare System</td>
<td>Health Insurance Coverage</td>
<td>1) Are you covered by any kind of health insurance or some other kind of health care plan?</td>
<td>NHIS^1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2) If you are covered, what kind of health insurance or health care coverage do you have?</td>
<td>NHIS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3) During the last 12 months, for approximately how many months did you have health insurance?</td>
<td>MEPS</td>
</tr>
<tr>
<td></td>
<td>Usual Source of Care</td>
<td>4) What kind of place do you USUALLY go to when you need routine or preventive care, such as a physical examination or check-up?</td>
<td>NHIS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6) At any time IN THE PAST 12 MONTHS did you CHANGE the place(s) to which you USUALLY goes for health care?</td>
<td>NHIS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7) DURING THE PAST 12 MONTHS, did you have any trouble finding a general doctor or provider who would see you?</td>
<td>NHIS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>9) If you do not have a usual source of care, what is the main reason you do not have a usual source of health care?</td>
<td>MEPS^2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>8) Where do you usually go when you are sick or need health care?</td>
<td>Common wealth^3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5) How long have you been going to this place for health care?</td>
<td>Common wealth</td>
</tr>
<tr>
<td></td>
<td>Unmet Need</td>
<td>10) In the last 12 months, were you unable to get medical care, tests, or treatments you or a doctor believed necessary?</td>
<td>MEPS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>11) Which of these best describes the main reason you were unable to get medical care, tests, or treatments you or a doctor believed necessary?</td>
<td>MEPS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>12) In the last 12 months, were you delayed in getting medical care, tests, or treatments you or a doctor believed necessary?</td>
<td>MEPS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>13) Which of these best describes the main reason you were delayed in getting medical care, tests, or treatments you or a doctor believed necessary?</td>
<td>MEPS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>14) Overall, how satisfied are you that you can get health care if you need it?</td>
<td>MEPS</td>
</tr>
<tr>
<td></td>
<td>Mental Health / Substance Abuse</td>
<td>15) During the past 12 months, did you seek or desire any outpatient treatment or counseling for any problem you were having with your emotions, nerves, or mental health?</td>
<td>NSDA^4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>16) During the past 12 months, did you receive any outpatient treatment or counseling for any problem you were having with your emotions, nerves, or mental health at any of the places listed below?</td>
<td>NSDA</td>
</tr>
<tr>
<td></td>
<td></td>
<td>17) During the past 12 months, seek or desire treatment or counseling for your use of alcohol or any drug, not counting cigarettes?</td>
<td>NSDA</td>
</tr>
<tr>
<td></td>
<td></td>
<td>18) During the past 12 months, have you received treatment or counseling for your use of alcohol or any drug, not counting cigarettes?</td>
<td>NSDA</td>
</tr>
<tr>
<td></td>
<td></td>
<td>19) If you answered yes to the previous question: During the past 12 months when you received treatment, was the treatment for alcohol use only, drug use only, or both alcohol and drug use?</td>
<td>NSDA</td>
</tr>
<tr>
<td>Structural Barriers within the System</td>
<td>Transportation</td>
<td>20) How do you usually get to your healthcare provider?</td>
<td>MEPS</td>
</tr>
<tr>
<td></td>
<td>Getting Care</td>
<td>21) Does your healthcare provider have office hours at night or on weekends?</td>
<td>MEPS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>22) How difficult is it to get appointments with your healthcare provider on short notice, for example, within one or two days?</td>
<td>MEPS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>23) How difficult is it to contact your healthcare provider during regular business hours over the telephone about a health problem?</td>
<td>MEPS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>24) How difficult is it for you to get a referral to see a specialist?</td>
<td>MEPS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>25) How satisfied are they with your healthcare provider’s professional staff?</td>
<td>MEPS</td>
</tr>
<tr>
<td>Waiting Times</td>
<td>26) If you arrive on time for an appointment, about how long do you usually have to wait before seeing your healthcare provider?</td>
<td>MEPS</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>Ability of Provider to Address Patient Needs</td>
<td>27) Does your healthcare provider generally listen to you and give you the information you need about health and health care?</td>
<td>MEPS</td>
<td></td>
</tr>
<tr>
<td></td>
<td>28) Does your healthcare provider usually ask about prescription medications and treatments other doctors may give you?</td>
<td>MEPS</td>
<td></td>
</tr>
<tr>
<td></td>
<td>29) In the last 12 months, how often did doctors or other health providers listen carefully to you?</td>
<td>MEPS</td>
<td></td>
</tr>
<tr>
<td></td>
<td>30) Does someone at your healthcare provider’s office present and explain all options to you?</td>
<td>MEPS</td>
<td></td>
</tr>
<tr>
<td></td>
<td>31) In the last 12 months, how often did your health provider show respect for what you had to say?</td>
<td>MEPS</td>
<td></td>
</tr>
<tr>
<td></td>
<td>32) The last time you visited a healthcare provider, how much of what you had to say did he or she listen to?</td>
<td>Common wealth</td>
<td></td>
</tr>
<tr>
<td></td>
<td>33) During your last visit, how much of what your provider said did you understand? everything the doctor said, most of what the doctor said, some, or only a little of what the doctor said?</td>
<td>Common wealth</td>
<td></td>
</tr>
<tr>
<td></td>
<td>34) Did you have questions about your care or treatment that you wanted to discuss, but did not?</td>
<td>Common wealth</td>
<td></td>
</tr>
<tr>
<td>Patient-Physician Communication</td>
<td>35) Overall, how satisfied are you with the quality of care you received from your healthcare provider?</td>
<td>MEPS</td>
<td></td>
</tr>
<tr>
<td></td>
<td>36) Are you confident in your healthcare provider’s ability to help when you have a medical problem?</td>
<td>MEPS</td>
<td></td>
</tr>
<tr>
<td></td>
<td>37) In the last 12 months, how often did your healthcare provider spend enough time with you?</td>
<td>MEPS</td>
<td></td>
</tr>
<tr>
<td></td>
<td>38) To what degree does your healthcare provider treat you respect and dignity?</td>
<td>Common wealth</td>
<td></td>
</tr>
<tr>
<td></td>
<td>39) To what degree does your healthcare provider involve you in decisions about your care?</td>
<td>Common wealth</td>
<td></td>
</tr>
<tr>
<td></td>
<td>40) To what degree does your healthcare provider spend as much time with you as you’d like?</td>
<td>Common wealth</td>
<td></td>
</tr>
<tr>
<td></td>
<td>41) Has there been a time in the last two years when you didn’t follow your healthcare provider’s advice, or treatment plan, get a recommended test or see a referred doctor?</td>
<td>Common wealth</td>
<td></td>
</tr>
<tr>
<td></td>
<td>42) Have you ever gotten sick or gotten worse as a result of going to the doctor’s office or being hospitalized?</td>
<td>Common wealth</td>
<td></td>
</tr>
<tr>
<td></td>
<td>43) If you answered yes to the previous question, do you think this was due to a mistake made at the doctor’s office or hospital?</td>
<td>Common wealth</td>
<td></td>
</tr>
<tr>
<td>Cultural Competency</td>
<td>44) Do you think there was ever a time when you would have gotten better medical care if you had a different sexual orientation?</td>
<td>Common wealth</td>
<td></td>
</tr>
<tr>
<td></td>
<td>45) Thinking about all of the experiences you have had with health care visits in the last two years, have you ever felt that the doctor or medical staff you saw judged you unfairly or treated you with disrespect because of your sexual orientation?</td>
<td>Common wealth</td>
<td></td>
</tr>
<tr>
<td></td>
<td>46) To what degree do you agree or disagree with the following statement? I feel that my healthcare provider understands my background and values.</td>
<td>Common wealth</td>
<td></td>
</tr>
<tr>
<td></td>
<td>47) How often have you (gone to x source) for information about health and medicine—very often, somewhat often, not too often, or not at all?</td>
<td>Common wealth</td>
<td></td>
</tr>
</tbody>
</table>

1 National Health Interview Survey 2 Medical Expenditure Panel Survey 3 Commonwealth Fund Healthcare Quality Survey 4 National Survey on Drug Abuse
## Appendix C

Table C1. *Predictors of Access to Care*

<table>
<thead>
<tr>
<th>Covariates</th>
<th>Model 1 Access to System</th>
<th>Model 2 Access within System</th>
<th>Model 3 Patient/Provider</th>
<th>Model 4 SM Patient/Provider</th>
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<tr>
<td>F (df)</td>
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<td><strong>3.70 (5, 81)</strong></td>
<td>1.65 (5, 83)</td>
<td><strong>2.42 (5, 71)</strong></td>
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</table>
| R²                  | 0.09    | **0.19*** | 0.09    | **0.15****

***p<.01; **p<.05; *p<.10
Chapter 5

Sexual Minority Stigma, Culturally Appropriate Healthcare, Physical and Mental Health

Minority stress theory points to stigma as a cause of mental health disparities in sexual minority adults, positing that stigma and discrimination specific to one’s sexual orientation act as stressors that impact mental health both distally and proximally (Meyer, 2003). Stigma has also been highlighted by researchers as a fundamental cause of physical health disparities, as its effects are both on the individual and structural levels, making it particularly pervasive (Hatzenbuehler, Phelan, & Link, 2013). Evaluating predictors of physical and mental health, such as stigma, among sexual minority women is integral to addressing the numerous health disparities experienced by this population. Furthermore, examining mechanisms through which stigma affects health, such as culturally appropriate healthcare, could point to clear actions through which health can be improved, including interventions and policies.

Sexual minority stigma is the labeling, stereotyping, separation, status loss, and discrimination experienced by those who identify as (or are assumed to be) lesbian, gay, bisexual, transgender, or other, based on this identity. Sexual minority stigma includes sexual stigma, heterosexism, and sexual prejudice, terms that refer to specific forms of sexual minority stigma and resist the notion that there is one clear in-group and out-group, rather than a continuum of sexuality that we all experience differently and is subject to change over time (Herek, 2004).
Culturally appropriate healthcare is that in which providers are “aware of and responsive to patients’ cultural perspectives” (Betancourt, Green, & Carillo, 2002, p. 3) and is a key component in the quality healthcare access (U.S. Department of Health and Human Services, 2015). Access to culturally appropriate healthcare plays an important role in the quality of care for sexual minority women (see Mann, in preparation, for review).

Sexual Minority Health Disparities

Several disparities in mental health, physical health, substance use, and access to healthcare between sexual minority and heterosexual women have been documented in peer-reviewed studies across multiple disciplines. Several researchers’ analyses indicate that sexual minority women experience worse general mental health than heterosexual women (Case et al., 2004; Chakraborty, McManus, Brugha, Bebbington, & King, 2011; Cochran, Sullivan, & Mays, 2003; Diamant & Wold, 2003; Fredriksen-Goldsen, Kim, Barkan, Muraco, & Hoy-Ellis, 2013; Koh & Ross, 2006; Sandfort, de Graaf, Bijl, & Schnabel, 2001; Valanis et al., 2000). Findings also reveal higher rates of suicidal behavior and self injury (Blosnich & Bossarte, 2012), suicidal ideation (Blosnich, Bossarte, & Silenzio, 2012; Gilman et al., 2001), and risk for suicide (Matthews, Hughes, Johnson, Razzano, & Cassidy, 2002; Ploderl & Fartacek, 2005) among sexual minority women when compared to their heterosexual peers. Other studies show disparities in distress (Blosnich, Foynes, & Shipherd, 2013); depression in the last year and over lifetime (Cochran, Mays, Alegria, Ortega, & Takeuchi, 2007); and anxiety and mood disorders (Gilman, et al., 2001). Sexual minority women also report having less social and emotional support than heterosexual women (Blosnich, et al., 2012; Blosnich, et al., 2013; Ploderl & Fartacek, 2005; Valanis, et al., 2000); and higher rates of psychological stressors (Ploderl &
Some researchers have found that that sexual minority women are more likely to have generally poor self-reported physical health (Blonsnich, et al., 2013; Diamant & Wold, 2003; Liu, Reczek, & Brown, 2013) when compared to heterosexual women. There are also documented disparities in obesity and overweight (Aaron, Markovic, Danielson, & Honnold, 2001; Boehmer, Bowen, & Bauer, 2007; Cochran et al., 2001; Fredriksen-Goldsen, et al., 2013), risk factors for cardiovascular disease (Case, et al., 2004; Diamant & Wold, 2003; Farmer, Jabson, Bucholz, & Bowen, 2013; Fredriksen-Goldsen, et al., 2013; Valanis, et al., 2000), risk factors for cancer (Case, et al., 2004; Valanis, et al., 2000), and risk for disability (Fredriksen-Goldsen, et al., 2013) between sexual minority and heterosexual women.

A few studies have focused on reproductive health disparities, including one in which sexual minority women reported significantly higher rates of sexually transmitted infections (STI) than heterosexual women (Charlton et al., 2011), and another found that women who had sex with women reported higher rates of hepatitis C, bacterial vaginosis, herpes, and genital warts than women who had sex exclusively with men (Fethers, Marks, Mindel, & Estcourt, 2000). In addition, sexual minority women have reported significantly higher rates of smoking and tobacco use (Aaron, et al., 2001; Blonsnich, et al., 2013; Burgard, Cochran, & Mays, 2005; Cochran, Ackerman, Mays, & Ross, 2004; Cochran, et al., 2001; Diamant, Wold, Spritzer, & Gelberg, 2000; Farmer, et al., 2013; Tang et al., 2004; Valanis, et al., 2000), alcohol use and dependence (Aaron, et al., 2001; Cochran, Keenan, Schober, & Mays, 2000; Cochran & Mays, 2000; Cochran, et al., 2001; Diamant, et al., 2000; Drabble, Midanik, & Trocki, 2005; Farmer, et al., 2013; Valanis, et al., 2000), and substance use and dependence (Cochran, et al., 2004; Cochran & Mays, 2000; Farmer, et al., 2013; Koh, 2000) than heterosexual women.
There is also evidence that sexual minority women have difficulty accessing healthcare. Several studies have demonstrated that sexual minority women are less likely to get pap smears and pelvic exams than heterosexual women (Aaron, et al., 2001; Charlton, et al., 2011; Cochran, et al., 2001; Diamant, et al., 2000; Powers, Bowen, & White, 2001). They are also less likely to get mammograms (Cochran, et al., 2001; Diamant, et al., 2000; Koh, 2000; Powers, et al., 2001) and cholesterol screenings (Koh, 2000). One study’s results indicate that sexual minority women are less likely to have health insurance and more likely to have difficulty accessing healthcare than heterosexual women (Diamant, et al., 2000). Higher rates of accessing mental healthcare (Cochran & Mays, 2000; Cochran, Sullivan, & Mays, 2003) among sexual minority women compared to heterosexual women, however, have been documented and may reflect both higher rates of mental health issues in this population and resilience factors that lead to improved outcomes for some.

Predictors of Physical and Mental Health

While researchers have published evidence of systematic differences in physical and mental health outcomes favoring heterosexual women, fewer have carried out empirical studies examining the mechanisms that connect stigma to physical and mental health outcomes. This smaller body of evidence points to stigma concealment (Frost & Bastone, 2007), gay-related stressors (Lewis, Derlega, Griffin, & Krowinski, 2003) and internalized homophobia (Herek, 1998) as predictors of depression; policy-level discrimination as a predictor of psychopathology (Hatzenbuehler, Keyes, & Hasin, 2009; Hatzenbuehler, McLaughlin, Keyes, & Hasin, 2010); and experiencing prejudice as a predictor of physical health problems (Frost, Lehavot, & Meyer, 2015). I found no previously-published studies examining the connection between sexual
minority patients’ perceptions of their healthcare providers’ cultural competence regarding issues of sexuality with physical or mental health outcomes. The goal of this study is to gain a better understanding of variables that predict physical and mental health outcomes for sexual minority women in order to make recommendations for practice, policy, and additional research that can work together to eliminate disparities in health experienced by this population.

Theoretical Model

Minority stress theory (Meyer, 2003) posits that sexual minority individuals are exposed to stressors related to their sexual orientation, that manifest both proximally (such as internalization of homophobia) and distally (such as discriminatory events), and result in a negative impact on mental health. Minority stress theory covers a wide range of potential stressors. Stigma, one such stressor, occurs “…when elements of labeling, stereotyping, separation, status loss, and discrimination co-occur in a power situation that allows [them] to unfold” (Link and Phelan, 2001, p.367). Stigma is, of course, perceived and often internalized by individuals, but enacted in the context of communities, organizations, and cultures. As described above, there is some evidence that sexual minority stigma, as depicted in the model in Figure 1, affects both mental (Meyer, 1995) and physical health (Frost, Lehavot, & Meyer, 2015).

The definition of access to care includes 1) getting access to the healthcare system, 2) getting to the physical location of healthcare service, and 3) connecting with a healthcare provider with whom the patient feels they can speak openly (U.S. Department of Health and Human Services, 2015). In this study, access to care includes individuals’ perceptions of their providers’ sexuality-related cultural competence.

Figure 1 depicts a guiding theoretical model that includes access to healthcare (culturally
appropriate healthcare) and stigma as predictors of physical and mental health. The model also leaves room for a direct relationship between these two predictors. The social ecological context of stigma may be in the community, at the societal level, or between individuals. In this model, stigma is depicted at the individual level though connected to the participants’ social context. Similarly, the cultural appropriateness of healthcare is depicted at the individual level, but community and societal factors influence both the perceptions of patient participants and the ideas, attitudes, and behaviors of healthcare practitioners.

*Figure 1. Theoretical model depicting effects of stigma and access to healthcare on physical and mental health.*
Current Study

The purpose of this study was to test a series of two hypotheses that addressed the relationship between stigma, culturally appropriate healthcare, and physical and mental health of sexual minority women. The first hypothesis was that higher ratings of culturally appropriate healthcare were predictive of higher self-rated physical health when controlling for stigma and demographic factors. The second hypothesis was that higher ratings of culturally appropriate care were predictive of higher self-rated mental health when controlling for stigma and demographic factors.

Methods

Participants completed a survey that included a screener to determine eligibility, demographic characteristics, measures of variables of interest (stigma, access to healthcare, physical and mental health), and a closing page that asks about recruiting additional participants. This study was reviewed and approved by the Vanderbilt University Institutional Review Board.

Sampling Procedure

Participants were recruited through multiple sources and snowball sampling. First, participants of an earlier qualitative study were invited, via email, to complete the survey. Second, advertisements were sent to lesbian, gay, bisexual, and transgender (LGBT) friendly groups in a metropolitan area in the southern U.S. Third, an advertisement for the study was posted on Research Match, an online database that connects researchers with volunteers interested in participating in studies. Participants were given a $10 gift card for participating and $5 gift card for recruiting additional participants. Though recruitment materials indicated that
participants must be sexual minority women, 22 or older, a series of questions at the beginning of the survey was used to screen participants and ensure eligibility.

Data Collection

The survey was available both online, using REDCap (Harris et al., 2009), or on paper (mailed or in person). The online survey link was emailed to participants and listed on advertisements. The survey took 20-30 minutes to complete and participants were given the option to save and return to the survey to complete it later. All participants opted to complete the online version of the survey.

Measures and Covariates

The survey had four main parts: participant characteristics, stigma, access to care, and physical and mental health. The entire survey is available in the appendix to this dissertation.

Participant characteristics. The participant characteristics included were age, sex, gender identity, sexual orientation, race/ethnicity, and education. There was also a measure of outness in which participants were asked to indicate the degree to which they are open about their sexual orientation with each of 11 individuals (Mohr & Fassinger, 2000). Sample characteristics are presented in detail in Table A1 in Appendix A.

Stigma. The Stigma Consciousness Questionnaire (SCQ) (Pinel, 1999) asked participants to rate the extent to which they agreed or disagreed with 10 statements about stigma towards sexual minority people. Statements included “Most heterosexuals do not judge homosexuals on the basis of their sexual preference” and “My being homosexual does not influence how people act with me”. Prompts were rated on a scale from 1 (strongly disagree) to 7 (strongly agree).
Several items were reverse coded to ensure that a higher score indicated a higher level of stigma consistently.

**Culturally appropriate healthcare.** A measure of LGBT adolescents’ healthcare preferences (Ginsburg et al., 2002) was adapted to reflect preferences of adult sexual minority women. Participants were asked to rate eight prompts on a scale from 1 (strongly disagree) to 5 (strongly agree). A higher score indicated a more positive rating of sexuality-related provider cultural competence. Prompts included “The provider is aware and educated about lesbian or bisexual issues.” and “The provider does not assume that I’m heterosexual/straight”.

**Physical and Mental Health.** Self-rated physical health was assessed using the general health subscale of the Rand 36 (Hays & Morales, 2001), a health-related quality of life instrument with 36 items assessing self-rated physical health and mental health. Five items were included in this subscale. The first item asked participants to rate their health on a scale from 1 (poor) to 5 (excellent). The next four prompts were also rated from 1 (definitely true) to 5 (definitely false) and included items such as “I am as healthy as anybody I know” and “My health is excellent”. Items were recoded such that a higher score indicated better health.

Mental health was assessed using the Rosenberg Self Esteem Scale (Rosenberg, 1965), a 10-item measure in which participants are asked to rate prompts on a scale from 1 (strongly disagree) to 5 (strongly agree). Items include “On the whole, I am satisfied with myself” and “I feel I have a number of good qualities”. Items were recoded such that a higher score indicated higher self esteem.

**Analysis**

Data were downloaded from REDCap and entered into STATA Version 13 for analysis.
(StataCorp, 2012). Descriptive statistics were used to report demographic characteristics of the sample (see table 1) and assess the independent and dependent variables. Multiple regression analysis was used to test each of the hypotheses posed in the current study. In addition to the independent variables (stigma and culturally appropriate care) and the dependent variables (physical and mental health) each model included demographic covariates (age, race/ethnicity, outness, and education).

**Results**

Participants (n=100) ranged in age from 22 to 68, with a mean age of 35.22 and standard deviation of 11.96. About half of the sample identified as lesbian (46%) and half as bisexual (50%), with the remaining (4%) using another term to describe their sexual orientation. The majority of the sample (74%) identified as White, the next largest represented group was African American (20%), and the remaining participants were distributed across other racial/ethnic groups. This is close to the proportions the population of the county in which the data were collected that identify with each of these racial/ethnic categories (65% white and 28% African American) (U.S. Census Bureau, 2016). The sample was relatively highly educated, with all participants reporting having graduated from high school and more than two thirds reporting having a college degree. For additional detailed information about the sample, see Table A1 in Appendix A.

Participants’ mean level of outness, or the degree to which they were open with others about their sexual orientation, was 4.05 (SD 1.85) when taking all those about whom participants responded into account. On the scale from 1 (not open with anyone about one’s sexual orientation) to 7 (completely open), a 4 indicated that the respondent feels others know about
their sexual orientation but that it is rarely discussed. Chronbach’s alpha for this scale was 0.95. Participants reported being most open about their sexuality with their friends (mean 4.71, SD 1.95) and slightly less so with their families (mean 4.29, SD 2.12). Participants were significantly less open about their sexuality with people with whom they worked (mean 3.72, SD 2.26), and even less so with those in religious settings (mean 2.97, SD 2.39).

**Independent Variables**

A score for stigma was calculated by taking the mean score of the 10 items related to participants’ perceptions of sexuality-related stigma that were each rated on a scale from 1 (strongly disagree) to 7 (strongly agree). A higher score indicated more stigma. Chronbach’s alpha for this scale was 0.77. Stigma scores ranged from 1.5 to 5.9 with a mean of 3.99 (closest to neutral on the 7-point scale) and standard deviation of 0.91.

A score for cultural appropriateness of healthcare was calculated by taking the mean score of eight items related to participants ratings of the cultural competence of their physician that were each rated on a scale from 1 (strongly disagree) to 5 (strongly agree). A higher score indicated a more culturally-competent provider. Chronbach’s alpha for this scale was 0.85. Scores ranged from 2.88 to 5 with a mean of 4.06 (closest to agree on the 5-point scale) and standard deviation of 0.64.

Analysis of the relationship between the independent variables revealed that the variables were not significantly correlated. In other words, there was not a significant amount of shared variance between stigma and culturally appropriate healthcare.
**Dependent Variables**

A score for physical health was calculated by taking the mean score of the five items on the 36-item short form survey from the RAND Medical Outcomes Study related to general health. Items were re-scored according to scoring guidelines provided by the creator of the measure (Hays & Morales, 2001). Chronbach’s alpha for this scale was 0.78. Physical health scores ranged from 20 to 100 with a mean of 66.61 and standard deviation of 19.44. There was some variation in physical health scores by racial/ethnic category of respondents such that African American participants’ self-rated health was higher than that of other groups. See Table B1 in Appendix B of this chapter for physical and mental health outcomes by race/ethnicity.

A score for mental health was calculated by taking the mean score of the 10 items on the Rosenberg Self-Esteem Scale. Chronbach’s alpha for this scale was 0.90. Mean scores ranged from 1.2 to 5, with a mean of 3.81 and standard deviation of 0.76.

**Physical Health**

Model 1 was used to predict physical health. Both race (being White) and participants’ ratings of their providers’ cultural competence were significant predictors of physical health, though stigma, age, outness, and education were not. Being White was a significant predictor of worse physical health when controlling for all other variables, $b = -0.41, t (60) = -3.53, p = .001$. Participants’ ratings of providers as more culturally competent was a significant predictor of better physical health, $b = 0.22, t (60) = 1.75, p = .085$. The overall model was significant and explained 24% of the variation in physical health, $R^2 = 0.24, F(6, 60) = 3.22, p = 0.008$. See table C1 in Appendix C for complete results of model 1.
Mental Health

Model 2 was used to predict mental health. In this model, the four covariates and both independent variables were included. Both age (being older) and participants’ ratings of their providers’ cultural competence were significant predictors while stigma, race, outness, and education were not. Being older was a significant predictor of better mental health when controlling for all other variables, \( b = 0.36, t(57) = 2.92, p = .005 \). Participants’ ratings of providers as more culturally competent was a significant predictor of better mental health, \( b = 0.24, t(57) = 1.92, p = .06 \). The overall model was significant and explained 25% of the variation in mental health, \( R^2 = 0.25, F(6, 57) = 3.19, p = 0.009 \). See table B1 for complete results of model 2.

Discussion

Results indicate that the sexuality-related cultural competence of healthcare providers was a significant predictor of sexual minority women’s physical and mental health. Specifically, higher ratings by participants of healthcare providers as more aware of and attentive to sexuality-related issues were significant predictors of better physical and mental health. This relationship also held true when stigma was included in the models, though that variable was not a significant predictor on its own, indicating that regardless of participants’ perceptions of general stigma toward sexual minority individuals, culturally competent healthcare was a significant predictor of physical and mental health.

Preliminary analyses included stigma as a predictor without culturally competent healthcare in the models. In these analyses, stigma was also not a significant predictor of physical or mental health when controlling for demographic factors. Stigma was, however, a significant predictor of mental health, such that higher perceived stigma was predictive of lower
mental health scores \((p=.08)\) when included in the model on its own, but not with demographic factors. This finding is only partially consistent with the theoretical model presented in this study, based on which, one would hypothesize that stigma would be a significant predictor of physical and mental health. The lack of a significant finding regarding the relationship between stigma and health may be particular to this sample and warrants further examination. In addition, there was a lack of significant relationship between stigma and cultural competence of providers, also predicted in the model. It appears that, in this sample, perceiving a high level of sexuality-related stigma was not related to perceptions about one’s providers’ level of cultural competence with sexuality-related issues.

Findings suggest that sexual minority women who see their providers as being more attuned to issues related to their sexual orientation have more positive perceptions of their physical and mental health. Indeed, research suggests that a positive and trusting relationship between a provider and a patient may result in better health outcomes (Thiede, 2005). This study is the first to demonstrate the effect of the cultural competence of sexual minority women’s healthcare providers on participants’ physical or mental health outcomes.

In model 1, race was a significant predictor of physical health such that being white was a predictor of lower self-rated health. This contradicts research indicating that racial minority groups tend to report lower self-rated health (Franks, Gold, & Fiscella, 2003), so this finding may be particular to this sample in which African American participants, 20% of the sample, reported significantly higher physical health on average (see Table C1 in Appendix C).

In model 2, age was a significant predictor of mental health such that being older was a predictor of higher mental health, in this case using the Rosenberg Self-Esteem scale. Though previous research using this measure does indicate that self esteem changes over the course of a
lifetime, findings are inconsistent as to whether self esteem increases or decreases with age (Shaw, Liang, & Krause, 2010). Some research indicates that self-esteem peaks at age 60 (Orth, Trzesniewski, & Robins, 2010), which may explain the findings in this study, as only six participants were older than 60 and self esteem did increase steadily with age in the sample.

Limitations

The findings related to the relationship between stigma and health were non-significant, indicating a lack of support for the minority stress theory in this sample. It may be that stigma consciousness, the measure used in this study, is not a robust enough indicator of this stressor to fully capture the effects of sexual minority stigma. Another possibility is that because the measure contained language about “homosexuals” rather than lesbian or bisexual women, participants may not have read it as relevant to them. It may also be that participants in this sample had access to resources that resulted in resilience. In other words, perhaps participants, regardless of their perceptions of and experiences of sexuality-related stigma, relied on resources such as social support, as a buffer to the deleterious effects of this stressor.

In addition, while the sample was demographically diverse, there was a limited range in some of the independent and dependent variables. Participants’ mean ratings of stigma only went as high as 5.9 on a 7-point scale, indicating that responses to statements about stigma was short of “agree” on average. Participants’ also generally agreed that their providers were culturally competent, as the low range of mean ratings of providers was a 2.88 on a 5-point scale, which is closest to “neutral”. Furthermore, participants’ mean ratings of their physical health were only as low as 20 on a scale from 0 to 100 and mean ratings of self esteem were only as low as 1.2 on a scale from 1 to 5. One area in which the sample was not particularly diverse was education, as
participants were more highly-educated than the general population. A sample that includes participants who are less educated, perceive higher levels of stigma, lower levels of culturally-appropriate healthcare, and worse physical health and self esteem may yield different results.

Finally, there is an assumption in the results discussed above that cultural competence of providers affects physical and mental health outcomes, when in fact the effect may go in the opposite direction. Due to the cross sectional nature of these data, it is possible that having better physical or mental health may result in rating one’s healthcare provider as more culturally competent. A longitudinal replication of this study would aid in confirming the direction of this effect.

**Conclusion**

Findings of this study indicate that healthcare providers’ increased awareness of and attention to issues related to sexuality may have a significant effect on the health of their sexual minority patients. Increasing understanding of and sensitivity to issues that sexual minority patients experience may improve patient outcomes and alleviate health disparities experienced by this population. Findings point to several implications for practice, policy, and further research.

Several researchers have put forth guidelines for training healthcare practitioners on sexuality-related issues in order to improve their cultural competence in this area (e.g. Compton & Whitehead, 2013; Gendron et al., 2013). Training practitioners in population-specific health issues may serve to improve competence in the short term with members of particular populations. However, more general and continuous training that helps providers develop or
support existing awareness of and sensitivity to minority health issues across populations may be more effective.

Policies that support training of healthcare providers on sexual minority issues are needed in order to start this shift toward better understanding with a generation of young practitioners. In addition, policy changes that encourage the collection of data regarding sexual orientation and gender identity on nationally representative surveys will help researchers gain a better understanding of sexual and gender minority health in the U.S. (Cahill, 2014), as well as to access to care, and a host of other variables. Increased data collection will give researchers much-needed information about the extent and nature of health disparities experienced by these populations.

There is also a need for additional research that examines the relationship between multiple aspects of access to healthcare and healthcare utilization by sexual minority women in order to better understand disparities experienced by this population. Though there is a good deal of research that describes disparities in accessing particular kinds of care, such as pap smears and mammograms (as presented above), there is a need for additional research that examines predictors of seeking and receiving physical and mental healthcare among sexual minority women.
References


StataCorp, L. (2012). *Stata Statistical Software: Release 14*. College Station, TX: StataCorp LP.


**Appendix A**

Table A1. *Sample Demographic Characteristics*

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<td>Additional</td>
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<td>6% (6)</td>
</tr>
<tr>
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<td>46% (46)</td>
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<tr>
<td>Bisexual</td>
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<tr>
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<tr>
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<td>Native American</td>
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</table>
### Appendix B

Table B1. *Physical and Mental Health Outcomes by Race/Ethnicity*

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>% of sample (n)</th>
<th>Physical Health Mean (SD)</th>
<th>Mental Health Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>African American</td>
<td>20% (20)</td>
<td>73.75 (19.86)</td>
<td>3.91 (0.74)</td>
</tr>
<tr>
<td>Native American</td>
<td>5% (5)</td>
<td>63.33 (37.53)</td>
<td>3.97 (0.15)</td>
</tr>
<tr>
<td>Asian</td>
<td>6% (6)</td>
<td>62.50 (6.89)</td>
<td>3.70 (0.47)</td>
</tr>
<tr>
<td>White</td>
<td>74% (74)</td>
<td>62.69 (19.20)</td>
<td>3.75 (0.77)</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>4% (4)</td>
<td>65.00 (22.73)</td>
<td>3.48 (1.04)</td>
</tr>
<tr>
<td>Hawaiian/Pacific Islander</td>
<td>2% (2)</td>
<td>65.00 (na)</td>
<td>3.90 (na)</td>
</tr>
<tr>
<td>Additional Category</td>
<td>2% (2)</td>
<td>62.5 (24.75)</td>
<td>3.65 (0.78)</td>
</tr>
</tbody>
</table>

nb: number of respondents to physical and mental health items was, in some cases, smaller than the number of total respondents within each race/ethnicity subgroup.
Appendix C

Table C1. Predictors of Physical and Mental Health

<table>
<thead>
<tr>
<th></th>
<th>Model 1: Physical Health</th>
<th>Model 2: Mental Health</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B (SE)</td>
<td>β</td>
</tr>
<tr>
<td>Age</td>
<td>0.12 (0.21)</td>
<td>0.07</td>
</tr>
<tr>
<td>Race (White)</td>
<td>-19.21 (5.44)***</td>
<td>-0.41</td>
</tr>
<tr>
<td>Outness</td>
<td>0.76 (1.43)</td>
<td>0.07</td>
</tr>
<tr>
<td>Education</td>
<td>0.65 (1.87)</td>
<td>0.04</td>
</tr>
<tr>
<td>Stigma</td>
<td>-2.01 (2.48)</td>
<td>-0.10</td>
</tr>
<tr>
<td>Culturally-Appropriate Care</td>
<td>7.01 (4.01)*</td>
<td>0.22</td>
</tr>
<tr>
<td>F (df)</td>
<td>3.22 (6, 60)</td>
<td></td>
</tr>
<tr>
<td>R²</td>
<td>0.24***</td>
<td></td>
</tr>
</tbody>
</table>

***p<.01; **p<.05; *p<.10
Chapter 6

Conclusion

The physical and mental health of sexual minority women in the U.S. is the focus of a growing body of academic literature. Significant differences between sexual minority and heterosexual women’s mental health, physical health, sexual and reproductive health, substance use, and access to care warrant serious attention (see Mann, in preparation, for review). One way to address these health disparities is through gaining a better understanding of the mechanisms that create and exacerbate the problem. This dissertation serves as an attempt to closely examine the role that stigma and access to care play in the health of sexual minority women by filling three gaps in the literature.

A Theory Connecting Stigma, Access to Care, and Health

Meyer’s (2003) minority stress model posits that proximal and distal stressors related to minority sexual orientation status contribute to outcomes in health both in negative and positive ways. The model addressed in this dissertation focuses on a particular stressor, stigma, its role in a particular setting, healthcare, and the influence of that stressor on both physical and mental health of a particular subset of the sexual minority population: women. In addition to connecting these three variables, this model takes multiple social ecological contexts into account. Sexual minority stigma was measured on an individual level in this dissertation, but it was enacted in
community settings and exacerbated by institutional policies. Access to care was also measured at the individual level, but was closely linked to community-level variables such as social networks that participants used to find providers, and institutional policies such as the changing laws related to same-sex marriage and LGBT discrimination. Each of the three studies in this dissertation addressed a part of this model: study 1 (see Chapter 3) examined stigma within and beyond healthcare settings and its connection with participants’ health, study 2 (see Chapter 4) closely examined predictors of access to care, and study 3 (see Chapter 5) tested the stigma and access to care as predictors of physical and mental health. There was mixed support for this theory in the empirical findings.

**Empirical Findings**

Study 1 grounded the project in the lived experiences of sexual minority women. To date, no published study of which the author is aware has done the work of eliciting stories about the stigmatized experiences of sexual minority women in order to ground a study of health in the lives of the women at the focus of inquiry. By starting with the first-hand accounts of women, this study sought to value the knowledge of those whose knowledge is often devalued (Hesse-Biber, Leavy, & Yaiser, 2004). Participants’ experiences of stigma in healthcare settings were explored in this study in order to shed light on the complex realities of stigma based on intersectional marginalized identities. Findings indicated that participants felt obtaining healthcare and participants’ relationships with their providers were important issues and that each was affected by stigma within and beyond healthcare settings.

Study 2 sought to fill a need for a close examination of access to care issues experienced by adult sexual minority women. Through the assessment of demographic predictors of access to
care, this study aimed to identify differences in access within this population. Findings indicated that being older, having more education, and being open with others about one’s sexuality were significant predictors of access to care within this population.

In Study 3, two models predicting sexual minority women’s physical and mental health were tested. One model was used to examine the relationships among stigma, access to care, and mental health and another was used to examine the relationships among stigma, access to care, and physical health. The goal of this study was to add to the evidence base that connects stigma and access to care to the health of sexual minority women. Findings indicated that access to more culturally appropriate healthcare was predictive of both better physical and mental health.

This three-study mixed-methods dissertation took into account multiple ecological contexts at each stage in order to shed light on the roles of individuals, community settings, organizations, and policies in the relationship between stigma and sexual minority women’s health. In gaining a deeper understanding of the mechanisms that explain differences in physical and mental health, the goal of this project was to inform efforts in practice, policy, and future research aimed at reducing and eliminating sexual minority health disparities.

**Implications**

The findings from this dissertation can inform practice related to addressing health care needs of sexual minority women, policy related to health of sexual minority groups, and future research on stigma, health disparities, and access to care for sexual minority women.
Implications for Practice

Access to care includes 1) getting access to the healthcare system, 2) getting to the physical location of healthcare service, and 3) connecting with a healthcare provider with whom the patient feels they can speak openly (U.S. Department of Health and Human Services, 2015). This third element is one that often goes overlooked in studies of access. Although some research has highlighted issues related to the cultural competence of healthcare professionals (Murphy, 1991) and their attitudes about sexuality (Mathews, Booth, Turner, & Kessler, 1986), there is little evidence about the role that the quality of the relationship between patient and provider plays in sexual minority health outcomes. These studies indicate a need for practitioners, both in the communities of the participants and beyond, to pay attention to the specific physical and mental health needs of their sexual minority patients. In addition, this research highlights a need for culturally competent practitioners to connect with sexual minority patients.

Implications for Policy

There are also some policy implications to be made from these results. First of all, though individual healthcare practitioner and staff training programs might include information about issues related to sexual orientation, results of these studies may also point to adding to national educational guidelines for training health and mental health practitioners working with sexual minority patients. Secondly, while there has been a marked decrease in stigma and discrimination towards those who identify as sexual minority in the U.S., there is still a need to increase awareness of the impact of stigma on the health of these and other marginalized populations. In addition, as the march beyond marriage equality moves forward, it is important to look towards next steps. Prioritizing marriage equality over other important policy goals that
affect sexual minority groups in the U.S. drew attention away from policy issues such as workplace discrimination, adoption laws, housing discrimination, inclusive immigration reform, and access to health insurance for non-married sexual minority adults. Each of these issues has the potential to affect the physical and mental health of sexual minority women. Highlighting access to care issues as connected to a wide web of policies is key to breaking down policy-level barriers to access.

**Implications for Future Research**

National databases that include health and mental health data have not historically included information about sexual orientation or gender identity (Cahill, 2014). Moreover, as surveys do begin to include items asking participants for this information, there is a need for standardization of questions that are inclusive and elicit clear responses. In addition to nationally-representative studies, there is a need for more attention to issues of sexual orientation in access to care research, as this population does has not received much attention in this literature to date.

There are a few potential extensions to this project. First, the addition of a sample of heterosexual women would facilitate the examination of differences in this model based on sexual orientation, adding to the physical and mental health disparities literature. Second, the collection of data from physical and mental health care practitioners would add to our understanding of the stigmatizing attitudes of this population and inform interventions aimed at improving the relationships between sexual minority patients and their healthcare providers. Third, multi-site data collection would help us uncover potential regional differences in the presence and effects of sexual minority stigma in the U.S. Better understanding regional
differences may help inform practitioners and policy makers target areas of relatively high stigma and understand factors contributing to lower stigma in some settings.
References


Appendix

Sexual Minority Women’s Health Survey

Confidentiality

The information you provide on this form will be shared only with the researcher screening participants for this study (see contact information below). Any identifying information you provide will not be shared with anyone else. (Consent form attached here.)

Please enter the following information

<table>
<thead>
<tr>
<th>Date of birth</th>
<th>MM/DD/YYYY</th>
</tr>
</thead>
</table>
| What sex were you assigned at birth | ☐ Male  
Female  
Prefer not to answer |
| What is your current gender identity? | Male  
Female  
Transgender Man/Transman  
Transgender Woman/Transwoman  
Genderqueer;  
Additional category ______  
Prefer not to answer |
| Do you think of yourself as... | Lesbian, gay, or homosexual  
Straight or heterosexual  
Bisexual  
Something else ________  
Don’t know |
| Please enter the zipcode of the home in which you currently reside | _ _ _ _ _ |
| Please enter the email address to which you would like your survey link emailed OR street address to which you would like a paper version of the survey mailed (return envelope and stamp will be provided). | |

Thank you for completing this form. If you are eligible to participate in this study, you will be contacted within 3-5 business days. If you have any questions, please contact Abbey Mann at abbey.k.mann@vanderbilt.edu or (615) 457-2671. If you have any concerns, you can also contact the Vanderbilt Internal Review Board at (615) 322-2981.
## Section I

### Demographics

<table>
<thead>
<tr>
<th>Date of birth</th>
<th>MM/DD/YYYY</th>
</tr>
</thead>
</table>
| What sex were you assigned at birth? | Male  
Female  
Prefer not to answer |
| What is your current gender identity? | Male  
Female  
Transgender Man/Transman  
Transgender Woman/Transwoman  
Genderqueer;  
Additional category ______  
Prefer not to answer |
| Do you think of yourself as… | Lesbian, gay, or homosexual  
Straight or heterosexual  
Bisexual  
Something else _________  
Don’t know |
| How long have you lived in the city in which you currently reside? | Less than six months  
Six months to one year  
1-2 years  
3-5 years  
more than 5 years |
| Which while racial/ethnic group(s) do you identify? (check all that apply) | African American/Black  
Native American  
Asian  
White/Caucasian  
Hispanic/Latino  
Native Hawaiian or Pacific Islander  
Other ________ |
| How would you classify the area in which you grew up? | Rural  
Urban  
Suburban |
| How many years of school did you complete? (Mark the highest grade you completed) | 7th  
8th  
9th  
10th  
11th  
High school degree or GED  
Some college  
Associates or other professional degree  
Bachelor’s degree  
Master’s degree  
MD/PhD |
What is your current employment status?  
Other____________________

<table>
<thead>
<tr>
<th>Annual income</th>
<th>Other____________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>1, &lt;$10,000</td>
<td>Employed for wages</td>
</tr>
<tr>
<td>2, $10,001-$29,999</td>
<td>Self employed</td>
</tr>
<tr>
<td>3, $30,000-$49,999</td>
<td>Out of work for 1 year or more</td>
</tr>
<tr>
<td>4, $50,000-$69,999</td>
<td>Out of work for less than 1 year</td>
</tr>
<tr>
<td>5, $70,000-$89,999</td>
<td>A homemaker</td>
</tr>
<tr>
<td>6, &gt;$90,000</td>
<td>A student</td>
</tr>
<tr>
<td></td>
<td>Retired</td>
</tr>
<tr>
<td></td>
<td>Unable to work</td>
</tr>
</tbody>
</table>

### Outness (Mohr & Fassinger, 2000)

Use the following rating scale to indicate how open you are about your sexual orientation to the people listed below. Try to respond to all of the items, but leave items blank if they do not apply to you.

1. mother
2. father
3. siblings (sisters, brothers)
4. extended family/relatives
5. my new straight friends
6. my work peers
7. my work supervisor(s)
8. members of my religious community (e.g., church, temple)
9. leaders of my religious community (e.g., church, temple)
10. strangers, new acquaintances
11. my old heterosexual friends

<table>
<thead>
<tr>
<th>1. mother</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. father</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>3. siblings (sisters, brothers)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>4. extended family/relatives</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>5. my new straight friends</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>6. my work peers</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>7. my work supervisor(s)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>8. members of my religious community (e.g., church, temple)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>9. leaders of my religious community (e.g., church, temple)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>10. strangers, new acquaintances</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>11. my old heterosexual friends</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>
# Stigma

## Stigma Consciousness Questionnaire (Pinel, 1999)

Please indicate the extent to which you agree or disagree with the following statements:

<table>
<thead>
<tr>
<th></th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Disagree somewhat</th>
<th>Neither agree or disagree</th>
<th>Agree somewhat</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Stereotypes about homosexuals have not affected me personally.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>I never worry that my behaviors will be viewed as stereotypical of homosexuals.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>When interacting with heterosexuals who know of my sexual preference, I feel like they interpret all my behaviors in terms of the fact that I am a homosexual.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Most heterosexuals do not judge homosexuals on the basis of their sexual preference.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>My being homosexual does not influence how homosexuals act with me.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>I almost never think about the fact that I am homosexual when I interact with heterosexuals.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>My being homosexual does not influence how people act with me.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Most heterosexuals have a lot more homophobic thoughts than they actually express.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>I often think that heterosexuals are unfairly accused of being homophobic.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>Most heterosexuals have a problem viewing homosexuals as equals.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Section III

Access to Care

(see Chapter 4, Table 1 for item sources)

SECTION 1
1) Are you covered by any kind of health insurance or some other kind of health care plan?
   Yes  No

2) If you are covered, what kind of health insurance or health care coverage do you have?
   INCLUDE those that pay for only one type of service (nursing home care, accidents, or dental care),
   exclude private plans that only provide extra cash while hospitalized.
   Private health insurance plan from employer or workplace
   Private health insurance plan purchased directly
   Private health insurance plan through a state or local government or community program
   Medicare
   Medi-Gap
   Medicaid
   CHIP (Children’s Health Insurance Program)
   Military health care/VA
   TRICARE/CHAMPUS/CHAMP-VA
   Indian Health Service
   State-sponsored health plan (TennCare)
   Other government program
   Single Service Plan (e.g. dental, vision, prescriptions)
   No coverage of any type
   OTHER ____________________________

3) During the last 12 months, for approximately how many months did you have health insurance?
   0  1  2  3  4  5  6  7  8  9  10  11  12

4) What kind of place do you USUALLY go to when you need routine or preventive care, such as a
   physical examination or check-up?
   I don’t get preventive care anywhere
   Clinic or health center
   Doctor’s office or HMO
   Hospital emergency room
   Hospital outpatient department
   Some other place
   I don’t go to one place most often
5) How long have you been going to this place for health care?
   Less than 1 year   1 to 2 years   3 to 5 years   More than 5 years

6) At any time IN THE PAST 12 MONTHS did you CHANGE the place(s) to which you
   USUALLY goes for health care?
   Yes   No

7) DURING THE PAST 12 MONTHS, did you have any trouble finding a general doctor or provider
   who would see you?
   Yes   No

8) Where do you usually go when you are sick or need health care?
   Doctor’s office or private clinic
   Community health center or other public clinic
   Hospital outpatient department
   Hospital emergency room
   Some other place
   No regular place of care

9) If you do not have a usual source of care, what is the main reason you do not have a usual source
   of health care?
   Seldom or never get sick
   Recently moved into area
   Don’t know where to go for care
   Usual source of medical care in this area is no longer available
   I like to go to different places for different health needs
   Just changed insurance plans
   Don’t use doctors/treat myself
   Cost of medical care
   Other reason ______________________________

10) In the last 12 months, were you unable to get medical care, tests, or treatments you or a doctor
    believed necessary?
    Yes   No

11) Which of these best describes the main reason you were unable to get medical care, tests, or
    treatments you or a doctor believed necessary?
    Couldn’t afford care
    Insurance company wouldn’t approve, cover, or pay for care
    Doctor refused to accept insurance plan
    Problems getting to doctor’s office
    Couldn’t get time off work
    Didn’t know where to go to get care
    Was refused services
    Couldn’t get child care
    Didn’t have time or took too long
    Other ______________________________
12) In the last 12 months, were you delayed in getting medical care, tests, or treatments you or a doctor believed necessary?
   Yes  No

13) Which of these best describes the main reason you were delayed in getting medical care, tests, or treatments you or a doctor believed necessary?
   - Couldn’t afford care
   - Insurance company wouldn’t approve, cover, or pay for care
   - Doctor refused to accept insurance plan
   - Problems getting to doctor’s office
   - Couldn’t get time off work
   - Didn’t know where to go to get care
   - Was refused services
   - Couldn’t get child care
   - Didn’t have time or took too long
   - Other ______________________________
   - Don’t know

14) Overall, how satisfied are you that you can get health care if you need it?
   - Very satisfied
   - Somewhat satisfied
   - Not too satisfied
   - Not at all satisfied

15) During the past 12 months, did you seek or desire any outpatient treatment or counseling for any problem you were having with your emotions, nerves, or mental health? Please do not include treatment for alcohol or drug use.
   - Yes, I thought about it
   - Yes, I looked for a provider
   - No

16) During the past 12 months, did you receive any outpatient treatment or counseling for any problem you were having with your emotions, nerves, or mental health at any of the places listed below? Please do not include treatment for alcohol or drug use.
   - An outpatient mental health clinic or center
   - The office of a private therapist, psychologist, psychiatrist, social worker, or counselor that was not part of a clinic
   - A doctor’s office that was not part of a clinic
   - An outpatient medical clinic
   - A partial day hospital or day treatment program
   - Some other place

17) During the past 12 months, seek or desire treatment or counseling for your use of alcohol or any drug, not counting cigarettes?
   - Yes, I thought about it
   - Yes, I looked for a provider
   - No

18) During the past 12 months, have you received treatment or counseling for your use of alcohol or any drug, not counting cigarettes?
   - Yes
   - No

19) If you answered yes to the previous question: During the past 12 months when you received treatment, was the treatment for alcohol use only, drug use only, or both alcohol and drug use?
   - Alcohol use only
   - Drug use only
   - Both alcohol and drug use
20) How you do usually get to your healthcare provider?
   Drive    I get a ride from someone    Taxi, bus, train, or other public transportation    Walk

21) Does your healthcare provider have office hours at night or on weekends?
   Yes        No        Don’t know

22) How difficult is it to get appointments with your healthcare provider on short notice, for example, within one or two days?
   Very difficult    Somewhat difficult    Not too difficult    Not at all difficult

23) How difficult is it to contact your healthcare provider during regular business hours over the telephone about a health problem?
   Very difficult    Somewhat difficult    Not too difficult    Not at all difficult

24) How difficult is it for you to get a referral to see a specialist?
   Very difficult    Somewhat difficult    Not too difficult    Not at all difficult

25) How satisfied are you with your healthcare provider’s professional staff?
   Very satisfied    Somewhat satisfied    Not too satisfied    Not at all satisfied

26) If you arrive on time for an appointment, about how long do you usually have to wait before seeing your healthcare provider?
   Less than 5 minutes
   5 to 15 minutes
   16 to 30 minutes
   31 to 59 minutes
   1 to 2 hours
   More than 2 hours
   Don’t know

27) Does your healthcare provider generally listen to you and give you the information you need about health and health care?
   Yes        No

28) Does you healthcare provider usually ask about prescription medications and treatments other doctors may give you?
   Yes        No

29) In the last 12 months, how often did doctors or other health providers listen carefully to you?
   Never    Sometimes    Usually    Always

30) Does someone at your healthcare provider’s office present and explain all options to you?
   Yes        No

31) In the last 12 months, how often did your health provider show respect for what you had to say?
   Never    Sometimes    Usually    Always

32) The last time you visited a healthcare provider, how much of what you had to say did he or she listen to?
   Everything    Most    Some    Only a little    Don’t know
33) During your last visit, how much of what your provider said did you understand? everything the doctor said, most of what the doctor said, some, or only a little of what the doctor said?  
   Everything  Most  Some  Only a little  Don’t know  

34) Did you have questions about your care or treatment that you wanted to discuss, but did not?  
   Yes  No  

35) Overall, how satisfied are you with the quality of care you received from your healthcare provider?  
   Very satisfied  Somewhat satisfied  Not too satisfied  Not at all satisfied  

36) Are you confident in your healthcare provider’s ability to help when you have a medical problem?  
   Yes  No  

37) In the last 12 months, how often did your healthcare provider spend enough time with you?  
   Never  Sometimes  Usually  Always 

38) To what degree does your healthcare provider treat you respect and dignity? 
   Great deal  A fair amount  Not too much  None at all  

39) To what degree does your healthcare provider involve you in decisions about your care?  
   As much as wanted  Almost as much as wanted  Less than wanted  A lot less than wanted  More than I wanted  

40) To what degree does your healthcare provider spend as much time with you as you’d like?  
   As much as wanted  Almost as much  Less than wanted  A lot less than wanted  More than I wanted  

41) Has there been a time in the last two years when you didn’t follow your healthcare provider’s advice, or treatment plan, get a recommended test or see a referred doctor?  
   Yes, has been a time  No, has not been such a time  Don’t know  

42) Have you ever gotten sick or gotten worse as a result of going to the doctor’s office or being hospitalized?  
   Yes  No  Don’t know  

43) If you answered yes to the previous question, do you think this was due to a mistake made at the doctor’s office or hospital?  
   Yes, it was due to a mistake at doctor’s or hospital  
   No, it was not due to a mistake at doctor’s or hospital  
   Don’t know
44) Do you think there was ever a time when you would have gotten better medical care if you had a different sexual orientation?
   Yes  No  Don’t know

45) Thinking about all of the experiences you have had with health care visits in the last two years, have you ever felt that the doctor or medical staff you saw judged you unfairly or treated you with disrespect because of your sexual orientation?
   Yes  No  Don’t know

46) To what degree do you agree or disagree with the following statement?
I feel that my healthcare provider understands my background and values.
   Strongly agree  Somewhat agree  Somewhat disagree  Strongly disagree  Don’t have a doctor

47) How often have you (Insert) for information about health and medicine—very often, somewhat often, not too often, or not at all?
a gone on the internet
b looked through books or other printed information
c called a doctor or other health care provider
d asked friends or family
e asked a pharmacist
f visited a community health fair
Very often  Somewhat often  Not too often  Not at all

SECTION 2

(Adapted from Ginsburg, 2002)
Please indicate the extent to which you agree with the following statements about your healthcare provider and site.

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neither agree or disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
<th>Don’t know/not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>The health care site, the instruments, and provider are clean.</td>
<td></td>
<td></td>
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<tr>
<td>2.</td>
<td>I know the my information will be kept private and confidential.</td>
<td></td>
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<tr>
<td>3.</td>
<td>I will be treated with respect.</td>
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<tr>
<td>4.</td>
<td>The provider is medically well-educated.</td>
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<td>5.</td>
<td>People will be honest and up-front with</td>
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</tr>
<tr>
<td>6</td>
<td>The provider doesn’t talk down to me.</td>
<td></td>
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<tr>
<td>7</td>
<td>The provider is a good listener.</td>
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<td>8</td>
<td>The provider does not downplay or dismiss my fears.</td>
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<tr>
<td>9</td>
<td>The provider is open-minded and nonjudgmental of my sexual orientation.</td>
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<tr>
<td>10</td>
<td>The provider is professional.</td>
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<tr>
<td>11</td>
<td>I will be treated with sensitivity.</td>
<td></td>
<td></td>
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<tr>
<td>12</td>
<td>The provider does not assume that my sexual behavior is dangerous or painful.</td>
<td></td>
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<tr>
<td>13</td>
<td>I know that the provider is able to get me help/counseling when I need it.</td>
<td></td>
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<tr>
<td>14</td>
<td>The provider is aware and educated about lesbian or bisexual issues.</td>
<td></td>
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<tr>
<td>15</td>
<td>Everyone at the site is friendly.</td>
<td></td>
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<tr>
<td>16</td>
<td>Patient information is not discussed in patient/public areas.</td>
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<tr>
<td>17</td>
<td>Staff is discreet and they are sensitive to the issue of being lesbian or bisexual.</td>
<td></td>
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<tr>
<td>18</td>
<td>The provider seems like the kind of person who is willing to talk about issues around sex.</td>
<td></td>
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<tr>
<td>19</td>
<td>I am able to choose a male or female provider.</td>
<td></td>
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<tr>
<td>20</td>
<td>The staff is racially/ethnically diverse.</td>
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<tr>
<td>21</td>
<td>I may choose to be open with one provider without fearing they will tell other staff or providers.</td>
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<tr>
<td>22</td>
<td>The site is in a safe area and there is security at the site.</td>
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<tr>
<td>23</td>
<td>Posters and health information at the site include LGBTQ issues.</td>
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<tr>
<td>24</td>
<td>I have a choice of having an LGBT provider.</td>
<td></td>
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<tr>
<td>25</td>
<td>The site offers services that focus on lesbian or bisexual adults.</td>
<td></td>
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<tr>
<td>26</td>
<td>The provider doesn’t seem like he or she is too into using labels.</td>
<td></td>
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<tr>
<td>27</td>
<td>The site has some openly gay or lesbian providers.</td>
<td></td>
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<tr>
<td>28</td>
<td>The provider does not assume that I’m heterosexual/straight.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>29</td>
<td>The site has a sticker clearly displayed that says this site is comfortable with LGBTQ issues (like a pink triangle or</td>
<td></td>
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</tbody>
</table>
|rainbow). 30. There are magazines in the waiting room for LGBTQ people. 31. Health information (pamphlets, brochures, etc.) is offered in a private place.
Section IV

Physical and Mental Health

RAND-36 (Hayes & Morales, 2001)
1. In general, would you say your health is:
   Excellent        Very good        Good        Fair        Poor

2. Compared to one year ago, how would you rate your health in general now?
   Much better now than one year ago
   Somewhat better now than one year ago
   About the same
   Somewhat worse now than one year ago
   Much worse now than one year ago

3. The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

   a. Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports

   b. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf

   c. Lifting or carrying groceries

   d. Climbing several flights of stairs

   e. Climbing one flight of stairs

   f. Bending, kneeling, or stooping

   g. Walking more than a mile

   h. Walking several blocks

   i. Walking one block

   j. Bathing or dressing yourself

4. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?
1. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

<table>
<thead>
<tr>
<th>Problem Description</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Cut down the amount of time you spent on work or other activities</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>b. Accomplished less than you would like</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>c. Were limited in the kind of work or other activities</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>d. Had difficulty performing the work or other activities (for example, it took extra effort)</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

5. During the past 4 weeks, what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

<table>
<thead>
<tr>
<th>Extent of Interference</th>
<th>Not at all</th>
<th>Slightly</th>
<th>Moderately</th>
<th>Quite a bit</th>
<th>Extremely</th>
</tr>
</thead>
</table>

6. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

<table>
<thead>
<tr>
<th>Extent of Interference</th>
<th>Not at all</th>
<th>A little bit</th>
<th>Moderately</th>
<th>Quite a bit</th>
<th>Extremely</th>
</tr>
</thead>
</table>

7. How much bodily pain have you had during the past 4 weeks?

<table>
<thead>
<tr>
<th>Extent of Pain</th>
<th>None</th>
<th>Very mild</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
<th>Very severe</th>
</tr>
</thead>
</table>

8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

<table>
<thead>
<tr>
<th>Extent of Interference</th>
<th>Not at all</th>
<th>A little bit</th>
<th>Moderately</th>
<th>Quite a bit</th>
<th>Extremely</th>
</tr>
</thead>
</table>

9. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

<table>
<thead>
<tr>
<th>Feeling Description</th>
<th>All of the Time</th>
<th>Most of the Time</th>
<th>A Good Bit of the Time</th>
<th>Some of the Time</th>
<th>A Little of the Time</th>
<th>None of the Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Did you feel full of pep?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>b. Have you been a very nervous person?</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Have you felt so down in the dumps that nothing could cheer you up?</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Have you felt calm and peaceful?</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Did you have a lot of energy?</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

141
f. Have you felt downhearted and blue? 1 2 3 4 5 6

g. Did you feel worn out? 1 2 3 4 5 6

h. Have you been a happy person? 1 2 3 4 5 6

i. Did you feel tired? 1 2 3 4 5 6

10. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?
   All of the time
   Most of the time
   Some of the time
   A little of the time
   None of the time

11. How TRUE or FALSE is each of the following statements for you.

<table>
<thead>
<tr>
<th></th>
<th>Definitely True</th>
<th>Mostly True</th>
<th>Don't Know</th>
<th>Mostly False</th>
<th>Definitely False</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. I seem to get sick a little easier than other people</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>b. I am as healthy as anybody I know</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>c. I expect my health to get worse</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>d. My health is excellent</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Self esteem (Rosenberg, 1965)

Please indicate the extent to which you agree or disagree with the following statements.

<table>
<thead>
<tr>
<th></th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Neither agree or disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. On the whole, I am satisfied with myself.</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>b. At times I think I am no good at all.</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>c. I feel that I have a number of good qualities.</td>
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</tr>
<tr>
<td>d. I am able to do things as well as most other people.</td>
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<td></td>
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<tr>
<td>e. I feel I do not have much to be proud of.</td>
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<tr>
<td>f. I certainly feel useless at times.</td>
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<tr>
<td>g. I feel that I'm a person of worth, at least on an equal plane with others.</td>
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<tr>
<td>h. I wish I could have more respect for myself.</td>
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<tr>
<td>i. All in all, I am inclined to feel that I am a failure.</td>
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<tr>
<td>10. I take a positive attitude toward myself.</td>
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</tbody>
</table>
## Closing Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>How did you learn about this study?</td>
<td></td>
</tr>
<tr>
<td>Would you be willing to be contacted for a follow-up study in the future?</td>
<td>Yes, No</td>
</tr>
<tr>
<td>If yes, how would you prefer to be contacted?</td>
<td>Phone, email, mail</td>
</tr>
<tr>
<td>Would you be willing to tell others about this survey?</td>
<td>Yes, No, Maybe</td>
</tr>
<tr>
<td>If yes, how many people would you be willing to tell about this study?</td>
<td></td>
</tr>
<tr>
<td>If you recruit an eligible participant, you will receive a $5 Wal-Mart gift card as a thank you for UP TO 5 participants.</td>
<td></td>
</tr>
<tr>
<td>Would you be willing to participant in a 1-2 hour interview (additional compensation provided)?</td>
<td>Yes, No, Maybe</td>
</tr>
<tr>
<td>For your participation, you will be sent a $10 gift card. For which business would you like this card?</td>
<td>Kroger, Target, Subway</td>
</tr>
<tr>
<td>Please enter the address to which you would like your gift card mailed. This information will be used ONLY to mail your gift card and will not be shared with anyone but the researcher.</td>
<td></td>
</tr>
</tbody>
</table>

Thank you for your participation.