

Sexual identity factors and minority stressors associated with healthcare stereotype threat and access to care among Black sexual minority women

By: Shemeka Thorpe, [Amanda E. Tanner](#), and Candice N. Hargons

Thorpe, S., Tanner, A.E., & Hargons, C.N. (2022). Sexual identity factors and minority stressors associated with healthcare stereotype threat and access to care among Black sexual minority women. *Journal of Gay & Lesbian Social Services*, DOI: [10.1080/10538720.2022.2056398](https://doi.org/10.1080/10538720.2022.2056398)

This is an Accepted Manuscript of an article published by Taylor & Francis in *Journal of Gay & Lesbian Social Services* on 30 March 2022, available at:

<http://www.tandfonline.com/10.1080/10538720.2022.2056398>. It is deposited under the terms of the Creative Commons Attribution-NonCommercial License (<http://creativecommons.org/licenses/by-nc/4.0/>), which permits non-commercial re-use, distribution, and reproduction in any medium, provided the original work is properly cited.

Abstract:

Black sexual minority women (SMW) are disproportionately impacted by negative health outcomes, healthcare discrimination, and provider bias. Therefore, the purpose of this study was to investigate which sexual identity characteristics and minority stressors are associated with healthcare stereotype threat and healthcare access for Black SMW. Using secondary data from the *Generations Study* data, $N = 142$ Black and/or biracial cisgender women were analyzed using bivariate correlations and stepwise regression models. Healthcare stereotype threat was positively associated with higher perceptions of stigma, sexual identity concealment, and reports of sexual identity centrality. Healthcare access was affected by bisexual identity, masculine gender presentation, and sexual identity concealment. Improving Black SMW's healthcare utilization and experiences in healthcare settings is crucial for promoting health equity. Implications for healthcare providers and discussed.

Keywords: access to care | Black women | healthcare stereotype threat | health disparities | quantitative methods | sexual minority

Article:

Introduction

Sexual minority women tend to have lower rates of healthcare utilization than their heterosexual counterparts (Whitehead, Shaver, & Stephenson, 2016). These disparities are also exacerbated by race. For example, Black sexual minority women (SMW) are more likely to report lower health-related quality of life compared to their White counterparts (Yette & Ahern, 2018). Research has shown that minority stressors such as discrimination based on race, gender, and sexual orientation influence how often people visit their healthcare providers. However, very little research has focused specifically on barriers to healthcare utilization and access at the intersection of these three marginalized identities: Black sexual minority women. Black SMW

are often less trusting of healthcare providers due to their experiences of racism, sexism, and homophobia (Seelman, Adams, & Poteat, 2017). Additionally, in healthcare settings providers often induce healthcare stereotype threat, a disruptive psychological stressor that people experience when they feel at risk for confirming negative stereotypes based on their social identities (e.g., race, gender, class, sexual orientation, etc.). However, despite research exploring the effects and predictors of healthcare stereotype threat among Black people (Abdou & Fingerhut, 2014; Aronson, Burgess, Phelan, & Juarez, 2013; Wheaton, Abdou, Roman, & Roberson, 2018), none of this research has specifically focused on sexual identity characteristics and minority stressors that may heighten healthcare stereotype threat for Black SMW. Exploring barriers to healthcare access and facilitators of healthcare stereotype threat will aid in reducing health disparities among this population.

Healthcare stereotype threat

Healthcare stereotype threat is fear of being reduced to group stereotypes that some healthcare providers believe (Abdou et al., 2016; Steele & Aronson, 1995). Stereotype threat is a stressor that people of marginalized identities may face, including Black SMW who are at “triple jeopardy” of discrimination due to their triple marginalized identities of race, gender, and sexual orientation. Qualitative studies have found that Black and Hispanic patients often feel like “second class citizens” unworthy of quality care and face more discrimination and disrespectful treatment than White patients (Burgess, Warren, Phelan, Dovidio, & Van Ryn, 2010; Gaston-Johansson, Hill-Briggs, Oguntomilade, Bradley, & Mason, 2007; Hatzfeld, Cody-Connor, Whitaker, & Gaston-Johansson, 2008). Specifically, compared to White patients, Black patients are more likely to report higher odds of race-related healthcare stereotype threat regardless of age and gender (Abdou et al., 2016). Thus, due to healthcare stereotype threat, Black SMW may stop or delay seeking care, which can have negative influences on their overall health and well-being (Burgess et al., 2010).

Due to the significant racial disparities in sexual and reproductive health disorders among Black women (Centers for Disease Control & Prevention, 2020), it is imperative that Black SMW have access to preventative care that is inclusive of queer identities. However, for Black SMW, heterosexism, racism, and classism intersect to create more reluctance to sexual identity disclosure due to fear of provider judgment or changes to their patient-provider relationship (Agénor, Bailey, Krieger, Austin, & Gottlieb, 2015; Bowleg et al., 2008). Further, racial-gendered stereotypes of Black women persist in the medical community and cause some Black women (regardless of sexual orientation) to fear medical mistreatment (Abdou & Fingerhut, 2014). While many Black SMW are aware of these stereotypical perceptions of medical providers (Abodu et al., 2016; Giscombé & Lobel, 2005), little research has focused on sexual identity characteristic stressors that increase healthcare stereotype threat and access to care.

Sexual identity characteristics

Not all SMW are comfortable disclosing their sexual identity (outness) given the potential for provider discrimination and stigma toward SMW. In a sample of Black, White, and Hispanic SMW, 12.9% of lesbian women and 32.6% of bisexual women had not disclosed their identity to

their healthcare provider (Durso & Meyer, 2013). SMW face more challenges than heterosexual women when seeking healthcare, including discrimination based on their sexual identity, difficulty finding supportive practitioners, homophobic attitudes in healthcare settings, and presumed heterosexuality (Hiestand, Horne, & Levitt, 2007). These challenges may be especially true for Black SMW who unable conceal their sexual identity. Thus, sexual identity disclosure varies based on sexual orientation. For example, previous research has shown that bisexual women are less likely to disclose their sexual identity to a healthcare provider (Cochran & Mays, 1998; Durso & Meyer, 2013; Kamen, Smith-Stoner, Heckler, Flannery, & Margolies, 2015), but this lack of disclosure and presumed heterosexuality may result in negative health consequences. For example, Black bisexual women have poorer mental, physical, and sexual health outcomes than other sexual minority women (Conron et al., 2010). Additionally, bisexual women have lower rates of sexual health screenings than heterosexual women do, however, lesbian women had the lowest of all (Charlton et al., 2011). For Black women, lesbian identity may also be linked to gender presentation (Moore, 2006, 2011).

Masculine presenting women (also known in the Black community as masculine of center women) are significantly more likely to be out to their medical providers compared to feminine presenting women; however, it is unknown if they are out because they disclosed their identity or because healthcare providers made assumptions based on their gender presentation (Hiestand et al., 2007). Gender presentation can include the way one dresses, hair styles, physical stance, and presence or absence of makeup (Moore, 2006). Often people are judged by the clothing they wear, which lets providers know how they choose to represent their gender as well as who they may be sexually attracted to (Moore, 2006). Mohr et al. (2013) suggest that when lesbian women present more masculine traits healthcare providers assume that they are less communicative and emotional and treat them as such. One associated outcome is that masculine of center women are less likely to attend gynecological visits regularly and seek out medical advice when sick, when compared to feminine SMW (Hiestand et al., 2007). Nearly 20% of masculine of center women reported not having visited a gynecologist in the last five years (Hiestand et al., 2007). Given the significant reproductive health disparities (e.g., cervical cancer, fibroids, polycystic ovary syndrome, etc.) among Black women, Black SMW (especially Black masculine of center women) are at particularly high risk due to the less frequent use of preventative gynecological healthcare, which can delay diagnosis and treatment of preventable illnesses. However, for women who are able to conceal their sexual identity, the importance of their sexual identity to their overall being (also known as identity centrality) may play a more critical role in their views of healthcare stereotype threat and healthcare experiences.

Lesbian, gay, bisexual (LGB) identity centrality is the extent to which a person defines themselves as a member of the LGB community and the degree to which they see it as a defining part of their identity (Quinn & Chaudoir, 2009). Identity centrality often underscores how much someone has processed their identities and the visibility of their identities to others. Black SMW often identify with their racial identity more than their sexual identity (Moore, 2006, 2011). However, Black SMW who have high LGB identity centrality may be more likely to fear discrimination and less likely to access healthcare. Yet, the relationship between identity centrality and healthcare outcomes is largely understudied among Black SMW.

Minority stressors

Minority stress theory is used to examine how stressors and stigma relative to having minority identities (e.g., racial, gender, sexual identity) influence the health and well-being of SMW (Meyer, 2003). Minority stress theory posits that exposure to prejudice, discrimination, and violence, are specific types of social stress that individuals of marginalized groups, like Black SMW, are exposed to as a result of one or more marginalized identities (Meyer, 1995; Meyer, 2003). There are three types of stressors: general stressors, distal stressors, and proximal stressors (Meyer, 2003). General stressors include stressors in the environment that might be exacerbated through minority stress (e.g., losing a job, grief) (Goldbach & Gibbs, 2017). Distal stressors include discrimination, stigma, and negative attitudes shown toward an individual due to their marginalized identities (Goldbach & Gibbs, 2017). Proximal stressors are internal and include expectations of rejection, stigma, and internalized homophobia (Goldbach & Gibbs, 2017). For the purposes of this analysis, we examine proximal stressors that may impact Black SMW healthcare utilization and perceived healthcare stereotype threat.

Stigma

Research has shown that increased levels of stigma are correlated with lower odds of sexual identity disclosure to healthcare providers (Austin, 2013) and lower rates of primary care utilization (Whitehead et al., 2016). Whitehead and colleagues (2016) identify three types of stigma: anticipated stigma (concern related to future discrimination), internalized stigma (devaluation of self-based on marginalized identities), and enacted stigma (actual instances of discrimination). Each stigma impacts healthcare practices differently. For example, anticipated stigma may lead Black SMW to avoid or delay seeking a provider (McCambridge & Consedine, 2014), internalized stigma may result in a Black SMW's participation in negative health behaviors including sexual risk behaviors (Herek, Gillis, Cogan, & Mallinckrodt, 2009), and enacted stigma may lead to Black SMW's poorer mental health outcomes and associated increased challenges in accessing health care (Herek, 2007). Anticipated and internalized stigma may be higher among Black SMW who have higher levels of internalized homophobia.

Internalized homophobia

Internalized homophobia is defined as negative attitude toward one's own sexual identity as well as negative attitudes toward homosexuality, other people's and their own sexual disclosure, and lack of connectedness to the LGB community (Meyer & Dean, 1998). Internalized homophobia is often informed by cultural values and religious beliefs, particularly among Black women—one of the most religious groups in the United States (Cox & Diamant, 2018). As a result, Black SMW are often exposed to more homophobic messages in religious settings than their White counterparts (Barnes & Meyer, 2012; Brooks, 2017), may internalize those messages, and then attempt to conceal their sexual identity. In fact, previous research on Black LGB college students at historically black college and universities found that they often refrain from disclosing their sexual identity and struggle to integrate their sexual identity with their Black identity in environments where they receive homophobic messages (McCready, 2004). The desire to respect cultural values, preserve family reputations, and fit into heterosexual scripts in order to refrain from being ostracized can increase internalized homophobia (Bowleg et al., 2003; Brooks, 2017;

Phillips, 2005). Internalized homophobia places Black SMW at higher risk of negative health outcomes due to its links to sexual identity non-disclosure to healthcare providers (Durso & Meyer, 2013; St. Pierre, 2012).

The current study

The purpose of this study was to examine the influence that sexual identity characteristics and minority stressors have on healthcare stereotype threat and healthcare access among Black SMW. Specifically, this study aims to address three research questions:

1. Which sexual identity characteristics and minority stressors are associated with healthcare stereotype threat among Black SMW?

Hypothesis 1: We hypothesize that Black SMW who can conceal their identity, have a more feminine gender presentation, have not disclosed their sexual identity to their healthcare providers, and have lower levels of identity centrality will report less worry about healthcare stereotype threat. Black SMW who report higher levels of stigma and internalized homophobia will report more worry about healthcare stereotype threat.

2. Which sexual identity characteristics and minority stressors are associated with healthcare access among Black SMW?

Hypothesis 2: We hypothesize that Black SMW who can conceal their identity, have more feminine gender presentation, have not disclosed their sexual identity to their healthcare providers, and have lower levels of identity centrality will be more likely to report healthcare access. Black SMW who report higher levels of stigma and internalized homophobia will report less likely to report healthcare access.

Materials and methods

Participants and procedures

The current study uses secondary data from Wave 1 of the *Generations Study* (Krueger et al., 2020), which assessed the impact of the changing social environment on the health and well-being of LGB individuals across three age cohorts in the US. The Generations Study explored similarities and differences in sexual identity, minority stress, resilience access to healthcare, and healthcare outcomes across generational cohorts. Participants were recruited by Gallup, Inc. a survey research consulting company. Informed consent was obtained from all participants. Participants received a \$25 incentive for completing a 45-minute survey. The current analysis includes $N = 142$ Black and/or biracial ($n = 48$) cisgender women who completed the Wave 1 baseline survey between 2016–2017. Study procedures were approved by the Institutional Review Board at the University of California, Los Angeles.

Measures

Demographics

Participants reported age, race, sexual identity, and educational attainment. Sexual identity was characterized as lesbian/gay, bisexual, or other sexual minority. Based on past research, dichotomous variable was created for women who were bisexual because bisexual women are less likely to come out to their providers and have poorer health outcomes than other sexual minority women. Educational attainment was coded as a dichotomous variable of greater than high school education and high school education or less.

Type of healthcare provider and insurance

Participants were asked about their current insurance status and the type of medical provider they utilize. This measure was modified from 2016 American Community Survey.

Sexual identity characteristics

Gender presentation was measured through the Wylie, Corliss, Boulanger, Prokop, and Austin (2010) measure of gender non-conformity in health disparities research. Participants answered two questions about gender presentation: (1) other people's perceptions of their description of appearance, style, and/or dress and (2) mannerisms. Participants were asked on "on average how do you think people would describe your appearance, style, or dress" and "on average how do you think people would describe your mannerisms?" Response options were on a 7-point Likert scale ranging from very feminine (1) to very masculine (7). Responses were summed to create a variable with possible scores ranging from 2 to 14. Higher scores indicated more masculine presentation.

LGB identity centrality subscale (Mohr & Kendra, 2011) is composed of five questions that identify how central their sexual identity is to their being (e.g., *My sexual identity is a central part of my identity*). Response options were on a 6-point Likert scale from disagree strongly to agree strongly; $\alpha = 0.72$. The reliability for the total Generations study sample was $\alpha = 0.72$, for female participants only $\alpha = 0.83$, and for Black participants $\alpha = 0.74$.

Outness to healthcare providers

Participants were asked "are you out to all, most, some, or none of your healthcare providers?" Response options ranged from none (0) to all (3). In the original scale participants were also asked about their outness to family, straight friends, and coworkers (Meyer et al., 2002).

Potential for concealed sexual identity

Participants were asked: *How often, if ever, can people tell you are LGB even if you don't tell them?* Response options ranged from never (0) to always (4).

Minority stressors

LGB stigma scale (Herek, 2009) was composed of three questions related to stigma perceptions (e.g., *Most people where I live think less of a person who is LGB*). Response options were on a 5-point Likert scale of strongly disagree to strongly agree; $\alpha = 0.65$. The reliability for the total Generations study sample was $\alpha = 0.70$, for female participants only $\alpha = 0.69$, and for Black participants $\alpha = 0.63$.

Internalized homophobia was measured using a revised scale by Herek et al. (2009), measured through five questions (e.g., *I tried to stop being attracted to people who are the same sex as me*). Response options were on a 5-point Likert scale of strongly disagree to strongly agree; $\alpha = 0.79$. The reliability for the total Generations study sample was $\alpha = 0.75$, for female participants only $\alpha = 0.73$, and for Black participants $\alpha = 0.77$.

Outcome variables

Healthcare stereotype threat was modified from Abdou and Fingerhut's (2014) healthcare scale to assess the degree to which participants worried about being negatively judged by or confirming stereotypes of LGB people with healthcare providers. It consists of four questions (e.g., *I worry about being negatively judged because of my sexual identity or gender identity, I worry that I might confirm negative stereotypes about LGBT people*). The scale score was created by summing the four questions and taking the mean. Response options were on a 5-point Likert scale of strongly disagree (1) to strongly agree (5) with possible scores ranging from 1–5. Higher scores indicated more worry about being judged or confirming stereotypes; $\alpha = 0.89$. The reliability for the total Generations study sample was $\alpha = 0.90$, for female participants only $\alpha = 0.89$, and for Black participants $\alpha = 0.90$.

Healthcare access

Participants were asked: *Is there a place that you usually go when you are sick or need advice about your health?* Response options were yes, there are one or more places (1) or no (0). This measure was listed as healthcare utilization in the National Health Interview Survey (2015) and Generations Study codebook, however because it does not ask how often or if participants visit their healthcare provider we conceptualized it healthcare access.

Analysis

Descriptive statistics and bivariate correlations were conducted using SPSS version 27. A correlation matrix provided correlations between sexual identity characteristics, minority stressors, healthcare stereotype threat, and healthcare access. To address research question 1, what is the association between sexual identity characteristics, minority stressors and healthcare stereotype threat, a stepwise regression model was conducted. To address research question 2, what is the association between sexual identity characteristics, minority stressors and healthcare access, a stepwise logistic regression was conducted. For both stepwise regressions, Model 1 included demographic variables (age, bisexual identity, and educational attainment), in Model 2 sexual identity characteristics were added, in Model 3 minority stressors were added. Imputed versions of each scale were created to account for missing data. The imputed version of each scale was used in these analyses.

Results

Participants ages ranged from 18 to 60 with a mean age of 29.3 years old. Participants reported bisexual (45.6%), lesbian/gay (40.8%), and other sexual minority (11.4%) identities. Of those who had a medical provider, 25.6% of participants were not out to their medical providers. Over one-fourth of participants (27.7%) reported never being able to conceal their sexual identity. Participants reported more neutral gender presentations neither extremely masculine nor feminine. Identity centrality was also moderate ($M = 4.00$, $SD = 1.08$). Overall, participants reported moderate amounts of stigma ($M = 2.76$, $SD = 0.90$) and low levels of internalized homophobia ($M = 1.66$, $SD = 0.81$). Participants reported moderate worry about healthcare stereotype threat (see more in Table 1).

Table 1. Demographics and characteristics.

	M ± SD (range) or N (%)
Demographics	
Age	29.3 ± 11.42 (18–60)
Sexual identity	
Lesbian/Gay	60 (40.8)
Bisexual	67 (45.6)
Other sexual minority identity	20 (13.6)
Education	
High school or less	47 (31.5)
Some college	59 (39.6)
College	26 (17.4)
Graduate/Professional degree	17 (11.4)
Sexual identity characteristics	
Potential for concealed sexual identity	
Always	17 (11.4)
Most of the time	22 (14.9)
Sometimes	32 (21.6)
Occasionally	36 (24.3)
Never	41 (27.7)
Gender presentation	3.27 ± 1.68 (1–7)
LGB Identity centrality	4.00 ± 1.08 (1–6)
Minority stressors	
LGB stigma	2.76 ± .90 (1–5)
Internalized homophobia	1.66 ± .81 (1–5)
Healthcare characteristics	
No healthcare insurance	18 (12.1)
Healthcare access	
Does not have a healthcare provider	43 (29.3)
Clinic or health center	20 (20.1)
Doctor’s office	46 (30.9)
Hospital emergency room	21 (14.1)
Hospital outpatient department	9 (6.0)
Some other place	4 (2.7)
Healthcare stereotype threat	2.42 ± 1.00 (1–5)

Results of the bivariate correlations showed that participants who had higher levels of internalized homophobia ($p < .001$), believed their LGB identity was central to who they were ($p = .02$), experienced higher perceptions of stigma ($p < .001$), and who were not out to their medical provider ($p = .04$), were more likely to be worried about healthcare stereotype threat. Gender presentation ($p < .001$) and low levels of sexual identity concealment ($p = .002$) were all associated with healthcare access. Participants who had more masculine traits and could not conceal their sexual identity were less likely to report access to healthcare (Table 2).

Table 2. Correlates of healthcare access and healthcare stereotype threat.

	1	2	3	4	5	6	7	8	9	10
1. Age										
2. Educational attainment	0.18*									
3. Bisexual	-0.09	-0.10								
4. Gender presentation	-0.09	-0.17*	-0.32***							
5. LGB identity centrality	-0.13	-0.16	-0.15	0.04						
6. LGB stigma	-0.06	-0.03	-0.04	0.10	0.11					
7. Internalized homophobia	-0.11	0.04	0.07	-0.14	-0.18*	0.16*				
8. Outness to healthcare provider	0.18*	-0.04	-0.39***	0.18*	0.26**	-0.09	-0.16			
9. Potential for concealed sexual identity	-0.02	-0.17*	-0.36***	0.53***	0.20*	0.07	-0.15	0.42***		
10. Healthcare stereotype threat	-0.05	0.10	0.02	-0.04	0.19*	0.44***	0.30***	-0.19*	0.02	
11. Healthcare access	0.05	0.07	0.26**	-0.31***	-0.08	-0.22**	-0.02	-0.11	-0.25**	-0.11

$p < .001$ ***; $p < .01$ **; $p < .05$ *

Although there was not a research question dedicated to exploring bisexual identity, it is important to note differences in minority stressors, sexual identity characteristics, healthcare stereotype threat, and healthcare access by sexual orientation. Participants who identified as bisexual were more likely to be more feminine ($p < .001$), were able to conceal their sexual identity ($p < .001$), and were less likely to be out to their medical providers ($p < .001$). Bisexual identity was also correlated with healthcare access ($p = .002$). Participants who were bisexual were more likely to report having access to a healthcare provider compared to those who were lesbian or other sexual minority. There were no significant correlations between bisexuality identity and internalized homophobia, identity centrality, stigma, or healthcare stereotype threat.

Healthcare stereotype threat

Results of the stepwise linear regression predicting healthcare stereotype threat (Table 3), showed that in Model 1 demographic factors including age, bisexual identity, and education were not significant predictors. In Model 2 sexual identity characteristics were added to the model. Contrary to our hypothesis, participants who were out to their healthcare providers were more likely to worry about healthcare stereotype threat ($\beta = -0.30$, $p = .01$). Also, participants who reported higher LGB identity centrality were more likely to worry about healthcare stereotype threat ($\beta = 0.25$, $p = .01$). Potential to conceal sexual identity and gender presentation were not significant. In Model 3 minority stressors were added. Participants who reported higher levels of stigma ($\beta = 0.41$, $p < .001$) and internalized homophobia ($\beta = 0.23$, $p = .04$) were more likely to report worry related to healthcare stereotype threat. Outness to healthcare providers ($\beta = -0.22$, $p = .02$) and LGB identity centrality ($\beta = 0.24$, $p = .01$) remained significant with the

addition of minority stressors. Overall, the R^2 increased as sexual identity characteristics and minority stressors were added to the model. Therefore, 33% of the variance of healthcare stereotype threat was explained by all factors included in Model 3.

Table 3. Stepwise linear regression predicting healthcare stereotype threat.

	Model 1			Model 2			Model 3		
	<i>B</i>	SE	<i>p</i> -Value	<i>B</i>	SE	<i>p</i> -Value	<i>B</i>	SE	<i>p</i> -Value
Age	-0.01	0.009	0.12	-0.03	0.01	.75	-0.30	0.01	0.72
Educational attainment	0.18	0.24	0.45	0.13	0.21	.17	0.16	0.19	0.06
Bisexual	0.06	0.20	0.77	0.08	0.21	.47	0.06	0.19	0.48
Outness to healthcare providers				-0.30*	0.08	.01	-0.22*	0.07	0.02
Potential for concealed sexual identity				0.20	0.08	.09	0.16	0.07	0.11
Gender presentation				0.00	0.06	.99	-0.01	0.05	0.91
LGB identity centrality				0.25*	0.09	.01	0.24**	0.08	0.01
LGB stigma							0.41***	0.09	<0.001
Internalized homophobia							0.23*	0.11	0.04
<i>R</i> square		0.02			0.12			0.33	

p<.001***, *p*<.01**, *p*<.05*.

Table 4. Stepwise logistic regression predicting access to care.

	Model 1			Model 2			Model 3		
	Exp (<i>B</i>)	<i>p</i> -Value	95% CI	Exp (<i>B</i>)	<i>p</i> -Value	95% CI	Exp (<i>B</i>)	<i>p</i> -Value	95% CI
Age	1.01	.53	0.98–1.06	1.01	.51	0.97–1.06	1.02	.46	0.97–1.06
Educational attainment	1.34	.55	0.51–3.46	0.80	.86	0.30–2.70	0.81	.72	0.26–2.56
Bisexual	3.41*	.01	1.36–8.56	1.86	.28	0.60–5.80	1.94	.26	0.61–6.21
Potential for concealed sexual identity				1.02	.91	0.67–1.57	0.96	.86	0.62–1.50
Outness to healthcare providers				0.86	.45	0.56–1.31	0.87	.56	0.56–1.38
Gender presentation				0.72*	.04	0.52–0.99	0.73	.06	0.52–1.01
LGB identity centrality				1.08	.75	0.68–1.72	1.22	.44	0.74–2.00
LGB stigma							0.57*	.03	0.33–0.95
Internalized homophobia							1.11	.76	0.59–2.09
Nagelkerke <i>R</i> square		0.10			0.19			0.24	

p<.05*

Healthcare access

In Model 1 of the stepwise logistic regression predicting healthcare access, bisexual identity was the only significant demographic factor ($\beta = 3.41$, $p = .008$) (Table 4). Participants who identified as bisexual were 3.41 times more likely to report having access to healthcare than those who identified as lesbian or another sexual minority status. In Model 2, sexual identity characteristics were added to the model. Participants with more masculine gender presentation were 0.72 less likely to report healthcare access ($\beta = 0.72$, $p = .04$) than those that were more feminine presenting. Potential to conceal sexual identity, outness to healthcare providers, and LGB identity centrality were not significant predictors of healthcare access. Once sexual identity characteristics were added to Model 2, bisexual identity was no longer significant. In Model 3, minority stressors were added. Participants who reported higher levels of stigma were 0.56 times less likely to report healthcare access ($\beta = 0.57$, $p = .03$). Internalized homophobia was not significant. Additionally, when minority stressors were added to the model gender presentation

was no longer significant. Overall, the R^2 increased as sexual identity characteristics and minority stressors were added to the model. Therefore, 24% of the variance in healthcare access was explained by all factors included in Model 3.

Discussion

This study examined how sexual identity characteristics and minority stressors were associated with healthcare stereotype threat and healthcare access among Black SMW. Healthcare stereotype threat was positively associated with higher perceptions of stigma, ability to conceal sexual identity, and higher reports of LGB identity centrality. Healthcare access was influenced by bisexual identity, masculine gender presentation, and sexual identity concealment. This study expands existing research on healthcare stereotype threat among Black women by focusing specifically on SMW with intersecting marginalized identities. These findings also highlight the influence of stigma and sexual identity characteristics on Black women's healthcare access, which affects their overall health (Li, Matthews, Aranda, Patel, & Patel, 2015).

To date, research on the relationship between SMW's femininity/masculinity and healthcare experiences has only included White samples or failed to include race as a variable (Pfeffer, 2014). To our knowledge, this is the first study focused on gender presentation, particularly gender non-conformity (masculine presentation), among Black SMW as a predictor of healthcare stereotype threat and access. Masculine of center Black SMW reported great worry related to healthcare stereotypes and lower access to healthcare. In turn, Black SMW who reported less ability to conceal their identity also reported more worry of being stereotyped and mistreated by healthcare providers. Research has shown that the Black community tend to be more accepting of highly masculine gendered presentations than other races (Moore, 2006; Wilson, 2009), but as a result they may face heightened risk of disapproval and discrimination associated with gender non-conformity (Everett, Steele, Matthews, & Hughes, 2019). An increased worry of healthcare stereotype threat could make them less likely to seek healthcare services, thus having fewer preventative screenings and delayed diagnoses and treatment.

In this study, Black bisexual women were less likely to experience stigma, healthcare stereotype threat, and were more likely to have access to healthcare. Bisexual identity was also strongly correlated with gender presentation and ability to conceal. Bisexual women may experience less stigma because medical providers may assume they are heterosexual based on their gender presentation, ability to conceal their identity, in addition to having male sex partners. Previous research has shown that bisexual women are at higher risk of negative sexual health outcomes for a number of reasons, including greater numbers of sexual partners (Tornello, Riskind, & Patterson, 2014), lower rates of condom use (Kerr, Ding, & Thompson, 2013), and higher rates of sexually transmitted infections (Everett, 2013). Based on our results these negative sexual health outcomes are not related to reduced access to care. Due to these potential risk behaviors, it is crucial that Black bisexual women have access to healthcare services, including preventative care. The potential for Black bisexual women to experience biphobia from their healthcare provider exists, thus it is important for providers to have bisexual specific training to support health equity and reduce bisexual erasure (Flanders, Ross, Dobinson, & Logie, 2017).

As previously mentioned, healthcare stereotype threat can have negative influences on people's overall health and well-being. In the current study internalized homophobia, outness, LGB identity centrality, and stigma were associated with healthcare stereotype threat. Previous research with White SMW showed that those who disclose their sexual identity feel an increase in patient-provider rapport and greater perceived attentiveness to care (Whitehead et al., 2016); the same may be true for our sample as Black SMW who were out to their providers were less likely to perceive healthcare stereotype threat. Additionally, disclosure of sexual orientation to healthcare providers has directly been linked to increased preventative care, including increased rates of pap smears among SMW (Tracy et al., 2013). However, if Black women fear disclosure they may not be able to gain the possible benefits such as increased patient-provider communication and increased preventative care. Therefore, addressing the stigma and internalized homophobia may be two ways to reduce healthcare stereotype threat and increase the rates of sexual identity disclosure to healthcare providers. Although healthcare stereotype threat can occur regardless of if the provider holds negative racial stereotypes or racial bias (Burgess et al., 2010), it is important to create interventions and programs to reduce Black SMW risk of healthcare stereotype threat. This includes addressing the root causes of internalized homophobia; institutionalized and cultural heterosexism and homonegativity (Williamson, 2000).

Limitations

These results should be situated within the study limitations. First, the healthcare access measure was originally conceptualized as healthcare utilization. However, this measure does not ask about the frequency or recency of healthcare visits, which would better measure healthcare utilization. Additionally, participants do not report reasons for not having a healthcare provider that they visit or seek advice from. For example, this lack of access could be attributed to geographical barriers (e.g., rural area), perceived need to seek a healthcare provider, or negative experiences with their previous healthcare provider. Qualitative research is needed to understand Black SMW's unique barriers to access to care. Although this is a unique generational sample of Black SMW, it remains relatively small thus may not be generalizable to all Black SMW women.

Implications

Trainings for healthcare providers should focus on anti-sexist, anti-heterosexist, and anti-racist patient-centered communication that addresses the unique needs of Black SMW. To optimize opportunities for Black SMW to disclose their sexual identity, medical providers should include questions related to patient sexual identity and their partner's gender on intake forms (Ejaife & Ho, 2019). Both healthcare providers and staff should be aware how a history of health-related discrimination, mistreatment, and experimentation create a foundation of understandable medical mistrust for Black people (Prather et al., 2018). Although, many providers have nondiscrimination policies, including protections based on sexual identity and gender identity, it is important for providers to make sure they are implementing policies by checking their biases and working toward culturally sensitive to support Black SMW (Ejaife & Ho, 2019). We also advise that healthcare providers follow the guidelines outlined by previous researchers (Aronson et al., 2013; Burgess et al., 2010), including focusing on the strengths and values of Black SMW,

checking in with patients when they feel anxious and distracted, working with patients to create treatment plans, ensuring that materials and office staff represent marginalized groups, and recruiting and retaining providers of marginalized identities. Additionally, healthcare providers should do targeted outreach for masculine of center Black women to make them feel welcomed and reassure that they will receive quality healthcare during their medical visits. Finally, healthcare providers should establish partnerships with organizations that serve Black SMW to increase their access to healthcare and reduce healthcare stereotype threat.

Conclusion

Understanding Black SMW's perceptions and experiences with healthcare-related discrimination is crucial for improving healthcare access, reducing health disparities, and informing culturally congruent and tailored interventions for Black SMW and healthcare providers. Strides toward improving Black SMW's access and experiences in healthcare settings will help promote health equity. Reducing minority stressors and addressing provider biases related to Black SMW sexual identity characteristics will increase their access to care, willingness to seek medical care, and reduce the anxiety surrounding healthcare stereotype threat.

Acknowledgments

The Generations investigators are Ilan H. Meyer, PhD (PI); David M. Frost, PhD; Phillip L. Hammack, PhD; Marguerita Lightfoot, PhD; Stephen T. Russell, PhD; and Bianca D.M. Wilson, PhD (all co-investigators and listed alphabetically).

Disclosure statement

No potential conflict of interest was reported by the author(s).

Funding

The Generations study was funded by a grant from the Eunice Kennedy Shriver National Institute of Child Health and Human Development [No. 1R01HD078526] and through supplemental grants from the National Institutes of Health Office of Behavioral and Social Sciences Research and Office of Research on Women's Health.

References

- Abdou, C.M., & Fingerhut, A.W. (2014). Stereotype threat among Black and White women in health care settings. *Cultural Diversity & Ethnic Minority Psychology, 20*(3). doi:<https://doi.org/10.1037/a0036946>
- Abdou, C. M., Fingerhut, A. W., Jackson, J. S., & Wheaton, F. (2016). Healthcare stereotype threat in older adults in the health and retirement study. *American Journal of Preventive Medicine, 50*(2), 191–198. doi:<https://doi.org/10.1016/j.amepre.2015.07.034>
- Agénor, M., Bailey, Z., Krieger, N., Austin, S. B., & Gottlieb, B. R. (2015). Exploring the cervical cancer screening experiences of Black lesbian, bisexual, and queer women: The

- role of patient-provider communication. *Women & Health*, 55(6), 717–736.
doi:<https://doi.org/10.1080/03630242.2015.1039182>
- Aronson, J., Burgess, D., Phelan, S. M., & Juarez, L. (2013). Unhealthy interactions: The role of stereotype threat in health disparities. *American Journal of Public Health*, 103(1), 50–56.
doi:<https://doi.org/10.2105/AJPH.2012.300828>
- Austin, E. L. (2013). Sexual identity disclosure to health care providers among urban and non-urban southern lesbians. *Women & Health*, 53(1), 41–55.
doi:<https://doi.org/10.1080/03630242.2012.743497>
- Barnes, D. M., & Meyer, I. H. (2012). Religious affiliation, internalized homophobia, and mental health in lesbians, gay men, and bisexuals. *The American Journal of Orthopsychiatry*, 82(4), 505–515. doi:<https://doi.org/10.1111/j.1939-0025.2012.01185.x>
- Bowleg, L. (2008). When Black + lesbian + woman ≠ Black lesbian woman: The methodological challenges of qualitative and quantitative intersectionality research. *Sex Roles*, 59(5–6), 312–325. doi:<https://doi.org/10.1007/s11199-008-9400-z>
- Bowleg, L., Huang, J., Brooks, K., Black, A., & Burkholder, G. (2003). Triple jeopardy and beyond: Multiple minority stress and resilience among Black lesbians. *Journal of Lesbian Studies*, 7(4), 87–108.
- Brooks, S. (2017). Black on Black love: Black lesbian and bisexual women, marriage, and symbolic meaning. *The Black Scholar*, 47(4), 32–46.
doi:<https://doi.org/10.1080/00064246.2017.1368065>
- Burgess, D. J., Warren, J., Phelan, S., Dovidio, J., & Van Ryn, M. (2010). Stereotype threat and health disparities: What medical educators and future physicians need to know. *Journal of General Internal Medicine*, 25(S2), 169–177. doi:<https://doi.org/10.1007/s11606-009-1221-4>
- Centers for Disease Control and Prevention. (2020). *African Americans/Blacks health disparities in HIV/AIDS, viral hepatitis, STDs, and TB*. <https://www.cdc.gov/nchhstp/healthdisparities/africanamericans.html>.
- Charlton, B. M., Corliss, H. L., Missmer, S. A., Frazier, A. L., Rosario, M., Kahn, J. A., & Austin, S. B. (2011). Reproductive health screening disparities and sexual orientation in a cohort study of US adolescent and young adult females. *Journal of Adolescent Health*, 49(5), 505–510. doi:<https://doi.org/10.1016/j.jadohealth.2011.03.013>
- Cochran, S.D., & Mays, V.M. (1998). Disclosure of sexual preference to physicians by Black lesbian and bisexual women. *Western Journal of Medicine*, 149(5), 616–619.
- Conron, K. J., Mimiaga, M. J., & Landers, S. J. (2010). A population-based study of sexual orientation identity and gender differences in adult health. *American Journal of Public Health*, 100(10), 1953–1960. doi:<https://doi.org/10.2105/AJPH.2009.174169>
- Cox, K., & Diament, J. (2018, September 26). *Black men are less religious than black women, but more religious than white women and men*. Retrieved from <https://www.pewresearch.org/fact-tank/2018/09/26/black-men-are-lessreligious-than-black-women-but-more-religious-than-white-womenand-men/>.

- Durso, L. E., & Meyer, I. H. (2013). Patterns and predictors of disclosure of sexual identity to healthcare providers among lesbians, gay men, and bisexuals. *Sexuality Research & Social Policy, 10*(1), 35–42.
- Ejaife, O. L., & Ho, I. K. (2019). Healthcare experiences of a Black lesbian in the United States. *Journal of Health Psychology, 24*(1), 52–64.
- Everett, B. G. (2013). Sexual orientation disparities in sexually transmitted infections: Examining the intersection between sexual identity and sexual behavior. *Archives of Sexual Behavior, 42*(2), 225–236. doi:<https://doi.org/10.1007/s10508-012-9902-1>
- Everett, B. G., Steele, S. M., Matthews, A. K., & Hughes, T. L. (2019). Gender, race, and minority stress among sexual minority women: An intersectional approach. *Archives of Sexual Behavior, 48*(5), 1505–1517.
- Flanders, C. E., Ross, L. E., Dobinson, C., & Logie, C. H. (2017). Sexual health among young bisexual women: A qualitative, community-based study. *Psychology & Sexuality, 8*(1–2), 104–117. doi:<https://doi.org/10.1080/19419899.2017.1296486>
- Gaston-Johansson, F., Hill-Briggs, F., Oguntomilade, L., Bradley, V., & Mason, P. (2007). Patient perspectives on disparities in healthcare from African-American, Asian, Hispanic, and native American samples including a secondary analysis of the Institute of Medicine focus group data. *Journal of National Black Nurses' Association, 18*(2), 43–52.
- Giscombé, C. L., & Lobel, M. (2005). Explaining disproportionately high rates of adverse birth outcomes among African Americans: The impact of stress, racism, and related factors in pregnancy. *Psychological Bulletin, 131*(5), 662–683. doi:<https://doi.org/10.1037/0033-2909.131.5.662>
- Goldbach, J. T., & Gibbs, J. J. (2017). A developmentally informed adaptation of minority stress for sexual minority adolescents. *Journal of Adolescence, 55*, 36–50.
- Greene, B. (1995). Lesbian women of color: Triple jeopardy. In L. Comas-Diaz, & B. Greene (Eds.) *Women of color: Integrating ethnic and gender identities in psychotherapy* (pp. 389–427). New York: Guilford
- Hatzfeld, J. J., Cody-Connor, C., Whitaker, V. B., & Gaston-Johansson, F. (2008). African-American perceptions of health disparities: A qualitative analysis. *Journal of National Black Nurses' Association: JNBNA, 19*(1), 34–41.
- Herek, G. M. (2007). Confronting sexual stigma and prejudice: Theory and practice. *Journal of Social Issues, 63*(4), 905–925. doi:<https://doi.org/10.1111/j.1540-4560.2007.00544.x>
- Herek, G. M. (2009). Hate crimes and stigma-related experiences among sexual minority adults in the United States. *Journal of Interpersonal Violence, 24*(1), 54–74. doi:<https://doi.org/10.1177/0886260508316477>
- Herek, G. M. (2009). Sexual stigma and sexual prejudice in the United States: A conceptual framework. In Hope, D. A. (Ed.). *Contemporary perspectives on lesbian, gay, and bisexual identities* (pp. 65–111). New York, NY: Springer.

- Herek, G.M., Gillis, J.R., Cogan, J.C., & Mallinckrodt, B. (2009). Internalized stigma among sexual minority adults: Insights from a social psychological perspective. *Journal of Counseling Psychology, 56*(1), 32–43. doi:<https://doi.org/10.1037/a0014672>
- Hiestand, K. R., Horne, S. G., & Levitt, H. M. (2007). Effects of gender identity on experiences of healthcare for sexual minority women. *Journal of LGBT Health Research, 3*(4), 15–27.
- Kamen, C.S., Smith-Stoner, M., Heckler, C.E., Flannery, M., & Margolies, L. (2015). Social support, self-rated health, and lesbian, gay, bisexual, and transgender identity disclosure to cancer care providers. *Oncology Nursing Forum, 42*(1), 44–51. doi:<https://doi.org/10.1188/15.ONF.44-51>
- Kerr, D. L., Ding, K., & Thompson, A. J. (2013). A comparison of lesbian, bisexual, and heterosexual female college undergraduate students on selected reproductive health screenings and sexual behaviors. *Women's Health Issues, 23*(6), e347–e355. doi:<https://doi.org/10.1016/j.whi.2013.09.003>
- Krueger, E. A., Lin, A., Kittle, K. R., & Meyer, I. H. (2020). *Generations –a study of the life and health of LGB people in a changing society* (Methodology and Technical Notes, Gallup Quantitative Survey). Los Angeles, CA: The Williams Institute.
- Li, C.C., Matthews, A.K., Aranda, F., Patel, C., & Patel, M. (2015). Predictors and consequences of negative patient-provider interactions among a sample of African American sexual minority women. *LGBT Health, 2*(2), 140–146. doi:<https://doi.org/10.1089/lgbt.2014.0127>
- McCambridge, S. A., & Consedine, N. S. (2014). For whom the bell tolls: Experimentally-manipulated disgust and embarrassment may cause anticipated sexual healthcare avoidance among some people. *Emotion, 14*(2), 407–415. doi:<https://doi.org/10.1037/a0035209>
- McCready, L. T. (2004). Some challenges facing queer youth programs in urban high schools: Racial segregation and de-normalizing whiteness. *Journal of Gay & Lesbian Issues in Education, 1*(3), 37–51. doi:https://doi.org/10.1300/J367v01n03_05
- Meyer, I. H. (1995). Minority stress and mental health in gay men. *Journal of Health and Social Behavior, 36*(1), 38–56. doi:<https://doi.org/10.2307/2137286>
- Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin, 129*(5), 674–697. doi:<https://doi.org/10.1037/0033-2909.129.5.674>
- Meyer, I. H., & Dean, L. (1998). Internalized homophobia, intimacy, and sexual behavior among gay and bisexual men. *Stigma and Sexual Orientation: Understanding Prejudice against Lesbians, Gay Men, and Bisexuals, 4*, 160–186.
- Meyer, I. H., Rossano, L., Ellis, J. M., & Bradford, J. (2002). A brief telephone interview to identify lesbian and bisexual women in random digit dialing sampling. *Journal of Sex Research, 39*(2), 139–144. doi:<https://doi.org/10.1080/00224490209552133>

- Mohr, J. J., Chopp, R. M., & Wong, S. J. (2013). Psychotherapists' stereotypes of heterosexual, gay, and bisexual men. *Journal of Gay & Lesbian Social Services, 25*(1), 37–55. doi:<https://doi.org/10.1080/10538720.2013.751885>
- Mohr, J. J., & Kendra, M. S. (2011). Revision and extension of a multidimensional measure of sexual minority identity: The Lesbian, Gay, and Bisexual Identity Scale. *Journal of Counseling Psychology, 58*(2), 234–245. doi:<https://doi.org/10.1037/a0022858>
- Moore, M. R. (2006). Lipstick or timberlands? Meanings of gender presentation in Black lesbian communities. *Signs: Journal of Women in Culture and Society, 32*(1), 113–139. doi:<https://doi.org/10.1086/505269>
- Moore, M. (2011). *Invisible families: Gay identities, relationships, and motherhood among Black women*. California: University of California Press.
- Pfeffer, C. A. (2014). “I don't like passing as a straight woman”: Queer negotiations of identity and social group membership. *American Journal of Sociology, 120*(1), 1–44. doi:<https://doi.org/10.1086/677197>
- Prather, C., Fuller, T. R., Jeffries, I. V., W. L., Marshall, K. J., Howell, A. V., Belyue-Umole, A., & King, W. (2018). Racism, African American women, and their sexual and reproductive health: A review of historical and contemporary evidence and implications for health equity. *Health Equity, 2*(1), 249–259. doi:<https://doi.org/10.1089/heq.2017.0045>
- Phillips, L. (2005). Deconstructing “down low” discourse: The politics of sexuality, gender, race, AIDS, and anxiety. *Journal of African American Studies, 9*(2), 3–15. doi:<https://doi.org/10.1007/s12111-005-1018-4>
- Quinn, D. M., & Chaudoir, S. R. (2009). Living with a concealable stigmatized identity: The impact of anticipated stigma, centrality, salience, and cultural stigma on psychological distress and health. *Journal of Personality and Social Psychology, 97*(4), 634–651. doi:<https://doi.org/10.1037/a0015815>
- Seelman, K. L., Adams, M. A., & Poteat, T. (2017). Interventions for healthy aging among mature Black lesbians: Recommendations gathered through community-based research. *Journal of Women & Aging, 29*(6), 530–542. doi:<https://doi.org/10.1080/08952841.2016.1256733>
- Steele, C. M., & Aronson, J. (1995). Stereotype threat and the intellectual test presentation of African Americans. *Journal of Personality and Social Psychology, 69*(5), 797–811. doi:<https://doi.org/10.1037/0022-3514.69.5.797>
- St. Pierre, M. (2012). Under what conditions do lesbians disclose their sexual identity to primary healthcare providers? A review of the literature. *Journal of Lesbian Studies, 16*(2), 199–219. doi:<https://doi.org/10.1080/10894160.2011.604837>
- Tornello, S. L., Riskind, R. G., & Patterson, C. J. (2014). Sexual identity and sexual and reproductive health among adolescent young women in the United States. *Journal of Adolescent Health, 54*(2), 160–168. doi:<https://doi.org/10.1016/j.jadohealth.2013.08.018>

- Tracy, J. K., Schluterman, N. H., & Greenberg, D. R. (2013). Understanding cervical cancer screening among lesbians: A national survey. *BMC Public Health*, *13*(1), 1–8. doi:<https://doi.org/10.1186/1471-2458-13-442>
- Wilson, B. D. (2009). Black lesbian gender and sexual culture: Celebration and resistance. *Culture, Health & Sexuality*, *11*(3), 297–313.
- Wheaton, F., Abdou, C., Roman, C., & Roberson, A. (2018). Race-related healthcare stereotype threat and affect among African Americans. *Innovation in Aging*, *2*(suppl_1), 649–649. doi:<https://doi.org/10.1093/geroni/igy023.2422>
- Whitehead, J., Shaver, J., & Stephenson, R. (2016). Outness, stigma, and primary health care utilization among rural LGBT populations. *PLoS One*, *11*(1), e0146139.
- Williamson, I. R. (2000). Internalized homophobia and health issues affecting lesbians and gay men. *Health Education Research*, *15*(1), 97–107. doi:<https://doi.org/10.1093/her/15.1.97>
- Wylie, S. A., Corliss, H. L., Boulanger, V., Prokop, L. A., & Austin, S. B. (2010). Socially assigned gender nonconformity: A brief measure for use in surveillance and investigation of health disparities. *Sex Roles*, *63*(3–4), 264–276. doi:<https://doi.org/10.1007/s11199-010-9798-y>
- Yette, E. M., & Ahern, J. (2018). Health-related quality of life among black sexual minority women. *American Journal of Preventive Medicine*, *55*(3), 281–289.