Spring 5-19-2020

Patients' Disclosure of Sexual and Gender Minority Status: A Comparative, Multiple Case Study

Damon B. Cottrell
University of Texas at Tyler

PATIENTS' DISCLOSURE OF SEXUAL AND GENDER MINORITY STATUS:

A COMPARATIVE, MULTIPLE CASE STUDY

by

DAMON BURNS COTTRELL

A dissertation submitted in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy in Nursing
Department of Nursing

Beth Mastel-Smith, PhD, RN

College of Nursing and Health Sciences

The University of Texas at Tyler
May 2020

The University of Texas at Tyler
Tyler, Texas

This is to certify that the Doctoral Dissertation of

DAMON BURNS COTTRELL

has been approved for the dissertation requirement on
April 2, 2020

for the Doctor of Philosophy Nursing

Approvals:

DocuSigned by:
Beth Mastel-Smith
622902F7271840E...
Dissertation Chair: Beth Mastel-Smith

DocuSigned by:
Cathy Miller RN, PhD
59F4F2785C0F4C7...
Member: Cathy Miller RN, PhD

DocuSigned by:
Carmen Cruz
B140510C853944C...
Member: Carmen Cruz

DocuSigned by:
Barbara Haas
985A922F3BF54C7...
Chair, Department of Nursing

DocuSigned by:
Yong Tai Wang
BA526018E0B84E4...
Dean, College of Nursing and Health Sciences

Dedication

I dedicate this document, its contents, and my journey to my partner of 18 years, Dr. Phillip Todd Atchison. You did not complain about my lack of attention to many things during this endeavor. I love you and do not say that frequently enough. I appreciate your support and willingness to not be a focus, then stepping in and "taking care of business" in managing daily life as the time passed. You are an amazing man.

I also dedicate this work and my future efforts to those who are of a sexual or gender minority. I hope soon we will see the end of misunderstanding, poor treatment, discrimination, marginalization, and ultimately the end the subsequent disparate health outcomes. May the world change and find the way to embrace us. I hope this work provides a spark.

Acknowledgements

The journey through my program of study has introduced me to the exceptional faculty of the University of Texas at Tyler, School of Nursing. I would like to specifically acknowledge Dr. Jennifer Chilton. As the program director, her keen guidance through the intricacies of the program made the journey smooth and logical. Dr. Ellen Fineout-Overholt taught me the importance of sharpening my “something to say” and provided me with new skills in the fine art of dissemination.

I want to acknowledge my dissertation committee members, Dr. Cathy Miller and Dr. Carmen Cruz. I owe each great thanks for their generous gift of time, expertise, and willingness to contribute extremely valuable suggestions to my work. I would be remiss if I did not acknowledge Dr. Gloria Duke. Through this process, she has shared support, patience, and answered many questions. Additionally, her enthusiasm surrounding qualitative research has been infectious. My classmates are certainly worthy of acknowledgement. As a cohort, we have come together as a community of scholars. My dear sweet friend, colleague, and classmate, Eugenia (Gena) Welch has been by my side from the moment I said, “let’s do this!” You are such a kind and giving soul and I am so thankful for you.

Lastly, but most importantly, I must acknowledge Dr. Beth Mastel-Smith. Simply put, wow! You have shepherded my learning and played a significant role in shaping my training and future as a nurse scientist. You never quit challenging me. You never quit encouraging me. You never took it easy on me. I am pretty sure that you never quit believing in me, and for that, I am forever indebted to you. It is easy to think about this

dissertation as simply a deliverable in partial fulfillment of the degree requirements but you made it clear that it is only a starting point. I thank you for skillfully guiding me through this process. But most notably, you taught me to question and then think, design and then work, reason and then share in a way I have never imagined possible. I found a quote by Jack Kerouac, “One day I will find the right words, and they will be simple.” I know you will understand why it means a lot to me.

Table of Contents

List of Tables

List of Figures

Abstract

PATIENTS' DISCLOSURE OF SEXUAL AND GENDER MINORITY STATUS:
A COMPARATIVE, MULTIPLE CASE STUDY

Damon Burns Cottrell

Dissertation Chair: Dr. Beth Mastel-Smith

The University of Texas at Tyler
May 2020

This work explores the healthcare and related experiences of sexual and gender minority (SGM) people. This population faces unique challenges in addressing their health needs. In the context of these challenges, the health outcomes are often poorer than those of heterosexuals. SGM subpopulations experience unique disparities making healthcare needs more complex and necessitating an understanding of SGMs' being. Essential to addressing SGMs' healthcare needs is the healthcare provider's (HCP's) knowledge of sexual and gender minority status. The first manuscript in this portfolio dissertation, *Fostering Sexual and Gender Minority Status in Patients*, provides an overview of the issues surrounding disclosure to healthcare providers or lack thereof. The paper illustrates what the current literature suggests as strategies for successful disclosure. The second manuscript, *Considering the Needs of Older Sexual and Gender Minority People*, provides insight into the intricacies or nuanced needs specific to subpopulations of sexual and gender minority people. In this case, older sexual minority people. The third manuscript, *It's always a question for me…: Disclosing Sexual and Gender Minority Status*, represents the research undertaken. A comparative, multiple case

study was completed to further understand the phenomenon of sexual and gender minority disclosure to healthcare providers.

Chapter 1

Overview of the Research

Context for Doctoral Research Focus

A 2017 Gallup poll suggested that 4.5% of the U.S. population may be lesbian, gay, bisexual or transgender (LGBT); however, this is likely a very low estimation (Allen, 2017; Newport, 2018) because the historical approach to placing individuals in LGBT categories is incomplete. Identification within a sexual and gender minority (SGM) group is not explicit and incomplete survey options lack fluidity (Lawlis et al., 2019). The sociopolitical context of being an SGM remains problematic (Meyer, 2016; Valdiserri, Holtgrave, Poteat, & Beyrer, 2019) and stigma and discrimination faced by SGM people is compounded when the SGM is of a racial minority (Arlee, Cowperthwaite, & Ostermeyer, 2019). Stigma and discrimination may affect the way SGM people interact with healthcare. The results are manifested in terms of poor medical and mental health outcomes (Arlee et al., 2019; Jennings, Barcelos, McWilliams, & Malecki, 2019; Valdiserri et al., 2019). The experiences of SGMs have potential to be mitigated by health care providers (HCPs) such as Nurse Practitioners (NPs), Physicians, and Physician Assistants (PAs) whose education regarding SGM patient care is lacking (Greene et al., 2018; Moll, Krieger, Heron, Joyce, & Moreno-Walton, 2018).

Rates of non-disclosure of SGM identity to HCPs are as high as 39% (Durso & Meyer, 2013). Disclosure is essential to managing care and achieving desirable patient outcomes while depth of disclosure has the potential to further enhance care. Disclosure

of sensitive information such as SGM identity is necessary for a HCP to determine risk and relevant health screening based on health promotion standards by population.

Introduction of Manuscripts

The first manuscript, *Fostering Sexual and Gender Minority Status Disclosure in Patients*, provides an overview of the concept of disclosure in the context of disclosing SGM status to a healthcare provider (HCP). The manuscript discusses key factors that influence disclosure and delves into the impact of health policy and how it effects care for SGM people. The manuscript provides a backdrop including rate of disclosure and healthcare disparities then suggests strategies to foster disclosure. The manuscript was published in *The Nurse Practitioner*, a journal focused on Nurse Practitioner (NP) practice. An email confirmation of acceptance is located in Appendix A. Copyright permission to use the article in this dissertation is included in Appendix B. The work leading to this paper and its subsequent publication was key in understanding gaps in the literature and navigating a path to meaningful research.

The second manuscript, *Considering the Needs of Older Sexual and Gender Minority People*, explores the needs of SGM individuals and the context of their experiences. This manuscript was a foundational in understanding nuances and stratification of SGM subpopulations. This manuscript illustrated the necessity of intentional exploration of specific experiences of SGM subpopulations. The manuscript, *Considering the Needs of Older Sexual and Gender Minority People*, was published in *The Journal for Nurse Practitioners*, a peer-reviewed journal focused on clinical care, continuing education and original research of interest to NPs. An email confirmation of

acceptance is located in Appendix C and copyright permission to use in this dissertation is included in Appendix D.

The third manuscript, *It's always a question for me…: Disclosing Sexual and Gender Minority Status*, will be submitted to *The Nurse Practitioner* journal, This study was a comparative, multiple case study intended to examine disclosure of SGM identity during an encounter with a HCP. The study the usefulness of the Disclosure Processes Model (DPM) in explaining SGMs' disclosure of identity to a HCP. Permission to use the DPM was provided by the author. See Appendix E.

Chapter 2

Fostering Sexual and Gender Minority Status Disclosure in Patients

Abstract

Members of the sexual and gender minority (SGM) community face complex barriers to accessing quality healthcare. NPs have a responsibility to create welcoming care settings where patients can share a trusting provider–patient relationship to disclose their SGM status, an event shown to improve patient outcomes.

Fostering Sexual and Gender Minority Status Disclosure in Patients

Historically, terminology used for lesbian, gay, bisexual, transgender, and queer or questioning (LGBTQ) individuals attempted to describe the entire sexual and gender minority (SGM) population but has fallen short of including all SGM subgroups. Individuals within the SGM population who may not fit within the LGBTQ category include those who are intersex, gender-fluid, and others. There are reportedly as many as 14 groups for which the LGBTQ acronym is not fully representative (Lattimer, 2014; Human Rights Campaign, 2018). More contemporary references suggest the term SGM as being fully inclusive of those who are not explicitly within the LGBTQ groupings but are non-heterosexual or whose gender identity does not match their birth sex (Lattimer, 2014; Mayer et al., 2008).

SGM individuals represent a significant portion of the US population, but it is difficult to tally this population's exact size because of a lack of options to self-identify within national or state surveys (Office of Disease Prevention and Health Promotion, 2016). A 2018 Gallup poll indicates the percentage of the US population by state who identified as LGBTQ varies from 2% in South Dakota to 8.6% in the District of Columbia, with estimates at 4.5% for the total US population (Newport, 2018).

As with other patient populations, care for the SGM patient is dependent on the quality of information disclosed during provider–patient interactions. The dynamic interpersonal interaction of NPs with this patient population is as important as the clinical knowledge necessary for appropriate care. SGM individuals have unique healthcare needs specific to their known health disparities (McNamara & Ng, 2016). To address

these unique needs, clinician identification of patients as SGM individuals is fundamental to achieving optimal patient outcomes. Additionally, NPs must be appropriately educated and competent in creating a trusting environment for patients. Although this is true for all patients, there are distinct considerations for the SGM population that require additional practitioner knowledge.

Key Factors Influencing Disclosure

SGM patients may find it difficult to share information they perceive as intimate or sensitive with their primary care providers (PCPs). Such sensitive information is often necessary for PCPs to properly implement or suggest relative interventions for appropriate care. It may be challenging for patients to share relevant information or specific health conditions that carry stigma because of perceived social implications. These conditions can include mental health disorders, skin conditions, erectile dysfunction, obesity, bowel disorders, human papilloma virus, and HIV (Pellegrini, 2014; Pappas, 2011). Patient disclosure of this important information is pivotal to ensuring that PCPs do not miss opportunities to suitably manage disease and preventive aspects of care. The literature clearly identifies the challenge of patient disclosure of SGM status as a distinct barrier to addressing preventive health needs and management of existing health issues (Abel, Collier, Deming, Dolan, & Dooling, 2017). As opposed to a purely medical approach, NPs are keenly armed with a holistic, patient-centered care focus and uniquely positioned to address many of the issues of care for the SGM population.

Provider-Patient Relationship

The relationship between PCPs and SGM patients is vital to providing both culturally competent and clinically appropriate care and is associated with positive health outcomes. Patients perceive continuity of the relationship, likely driven by trust and respect, as important (Jackson, MacKean, Cooke, & Laahtinen, 2017). The history or subjective portion of a PCP–patient encounter enables the provider to discern elements of social history that may impact patient health. Great interview skills are necessary to uncover and process all relevant findings. The subjective portion of a history and physical exam alone can identify between 70% and 90% of medical diagnoses (Muhrer, 2014). Failure to ask or failure to disclose information may be problematic and could affect patient outcomes.

Policy's Influence on Disclosure

The sociopolitical context and stigma surrounding the SGM community can create barriers to quality healthcare. Although evidence indicates a changing landscape, negative attitudes toward SGM individuals still exist and may be driven by the political environment. From a policy standpoint, states vary in acknowledgment of the need for equal treatment for SGM individuals (Pellegrini, 2014). The Movement Advancement Project evaluated states according to their policies specific to sexual orientation and gender identity and ranked them as a high equality state indicating a higher number of policies protective of sexual orientation and gender identity to a negative equality state where few, if any, policies exist that are protective of the SGM population (Movement Advancement Project, 2019). Twenty-six states were ranked as having problematic

policies for the SGM population (Movement Advancement Project, 2019). For example, approximately 36 states have no law ensuring inclusive insurance protection for SGM individuals (Movement Advancement Project, 2019). Some states have laws that support discrimination against the SGM population. At present, there are 30 states in which individuals can be fired for being transgender (Out and Equal Workplace Advocates, 2017). These facts represent a rationale for the fear of disclosure because many SGM individuals are covered by employer-sponsored health insurance. The NP should acknowledge that this can be problematic and approach the documentation in a manner that is descriptive of the patient and clinical problem.

Health Disparities

The SGM population and its subgroups experience poor health outcomes compared with heterosexuals (Ard & Makadon, 2012; Dahlhamer, Galinsky, Joestl, & Ward, 2016). Policies that discriminate against SGM individuals lead to inequity in overall treatment and health disparities. Studies suggest some health disparities experienced by the SGM community emerge because of stress, depression, victimization, and discrimination (Bennett & Rechter, 2014; Blosnich, Bossarte, Silver, & Silenzio, 2013; Blosnich, Farmer, Lee, Silenzio, & Bowen, 2014; Fredriksen-Goldsen, Kim, Shui, & Bryan, 2017). These disparities manifest in both physical and mental health pathology and vary extensively among individuals.

Tobacco use is more prevalent in SGM patients (Bennett & Rechter, 2014; Blosnich, Bossarte, Silver, & Silenzio, 2013; Blosnich, Farmer, Lee, Silenzio, & Bowen, 2014; Gonzales & Henning-Smith, 2017; Mereish, O-Cleirigh, & Bradford, 2014).

Substance use varies by subpopulation, although there is higher risk overall compared with heterosexuals. Compared with SGM men, sexual and gender minority women appear to be at an increased risk for lifetime substance use problems, particularly when they have experienced LGBTQ victimization (Friedman et al., 2014). Men who have sex with men continue to be disproportionately affected by HIV (Prejean,et al., 2011; Sullivan, 2014; Farmer, Bucholz, Flick, Burroughs, & Bowen, 2013). SGM men are at increased risk for cardiovascular disease (Farmer, Bucholz, Flick, Burroughs & Bowen, 2013). Bisexual men are twice as likely as heterosexual men to have asthma, and SGM men in general are disproportionately diagnosed with angina and cancer (Blosnich, Farmer, Lee, Silenzio, & Bowen, 2014; Fredriksen-Goldsen, Kim, Shui, & Bryan, 2017).

One study found that SGM women have greater all-cause mortality than heterosexual women (Lehavot et al., 2016). There are documented health disparities in asthma, obesity, cardiovascular disease, arthritis, and overall global ratings of health in SGM women (Fredriksen-Goldsen, Kim, Shui, &Bryan, 2017; Caceres et al., 2017; Simoni, Smith, Oost, Lehavot, &Fredriksen-Goldsen, 2017). Military veteran SGM women have been shown to have higher risk of mental distress and tobacco use and a threefold increase in risk of being in overall poor physical health (Blosnich, Farmer, Lee, Silenzio, &Bowen, 2014; Blosnich, Foynes, &Shipherd, 2013). Studies examining health services use in terms of sexually transmitted infection (STI) screening found sexual minority women were screened less often than heterosexual women (Agenor, Krieger, Austin, Haneuse, &Gottlieb, 2014a; Agenor, Krieger, Austin, Haneuse, &Gottlieb, 2014b). These tests include HIV and cervical cancer screening via Pap testing.

Negative healthcare experiences of SGM individuals can be attributed to low levels of support and discrimination (Steele et al., 2017). These experiences are manifested by untreated depression and are likely linked to anxiety and other unmet needs for mental health care (Steele et al., 2017). Mental health outcomes for SGM patients are poorer than outcomes for heterosexuals (Blosnich, Farmer, Lee, Silenzio, &Bowen, 2014). There are documented unmet mental health care needs, and this is even more prevalent in the transgender subgroup (Steele et al., 2017; Reisner, Katz-Wise, Gordon, Corliss, &Austin, 2016; Reisner et al., 2015). Suicidality and self-injury rates are very concerning in this population. The lifetime prevalence of suicide attempts is high in SGM patients, with attempts potentially occurring in as much as 20% of the SGM population (Hottes, Gogaert, Rhodes, Brennan, &Gesink, 2016). Risk of self-injury, not including suicide, in SGM individuals is also higher than it is for heterosexual individuals (Jackman, Honig, &Bockting, 2016). Understanding these facts may increase the realization of the need for providers to foster SGM status disclosure by their patients.

Track Record for Disclosure

In a 2013 study of 396 individuals living in New York City, the nondisclosure rates in bisexual men and women were 39.3% and 32.6%, respectively, 12.9% in lesbians, and 10% in gay men (Durso & Meyer, 2013).

A recent meta-analysis of disclosure and health outcomes identified that the disclosure rate of SGM individuals to their healthcare provider (HCP) varies based on type of HCP, geographic location, and patient demographics (Ruben & Fullerton, 2018). Further, successful disclosure yielded positive health outcomes (Maragh-Bass et al.,

2017). Improvements were seen in patient satisfaction, health screening rates—including STI screening—routine physical exam rates, and mental health indices. An intervention that may have elevated overall disclosure rates is grouping general HCPs with specialty providers or mental health providers. In this study, North America ranked higher in the proportion of successful disclosure than did Europe and Asia but ranked lower than the continents of Oceania (Maragh-Bass et al., 2017).

Despite reduced rates of SGM status disclosure in many SGM subpopulations, disclosure rates may be as high as 80% in transgender individuals for whom the perception of importance in disclosing gender identity outweighs the fear of stigmatization often felt by non-transgender SGM individuals (Maragh-Bass et al., 2017). Although higher rates of disclosure exist, researchers found that transgender patients were more likely to delay care or endure negative healthcare experiences because of an aversion to disclosure of their SGM status to an HCP (Maragh-Bass et al., 2017). Diagnosis may influence the choice to disclose. For example, in one study of patients with cancer, approximately 80% of the patients with cancer disclosed their SGM status to cancer care providers and reported improved self-rated perception of health (Macapagal, Bhatia, &Greene, 2016).

In studies of SGM men, particularly gay men, HCPs who are PCPs appear to attempt to encourage disclosure, although it looks as if the rate of disclosure is often reduced (Kamen, Smith-Stoner, Heckler, Flannery, & Margolies, 2015; Chavez et al., 2018). Also in SGM men, particularly those who may engage in risky behavior, such as sex work, mistrust and discrimination are reported as a rationale to not disclose

(Stupiansky et al., 2017). Young men have lower rates of disclosure, which is concerning considering their risk of STIs is higher with lower rates of appropriate STI screening being undertaken (Chavez et al., 2018; Stupiansky et al., 2017). A study of active-duty SGM males indicated a rate of dis closure within the sample to be between 40% and 60%, and those who did disclose would only do so when the military HCP asked specifically if they were an SGM (Underhill et al., 2015).

SGM women have comparable issues surrounding disclosure. Satisfaction with care appears to be lower in SGM women who have apprehension or fail to disclosure sexual minority status to their HCPs (Biddix, Fogel, &Black, 2013). There also appears to be a higher rate of nondisclosure in SGM women who live in rural areas as opposed to nonrural areas, indicating less communication with HCPs, fewer healthcare options, and higher rates of a previous negative experience with an HCP (Mosack, Brouwer, &Petroll, 2013). Additionally, a patient's approach to disclosure may depend on their interpretation of who should initiate the discussion, which ultimately influences the decision to have the conversation with an HCP or not (Barefoot, Smalley, &Warren, 2016).

Implications for NP Practice

Advocacy is key in addressing healthcare needs for all, but there are certainly nuances specific to treating SGM individuals. NPs are appropriately positioned to make a positive impact in the health of their SGM patients. Although there is much to do in terms of the sociopolitical context surrounding patients' SGM status disclosure, continued advocacy by NPs is critical. NPs and other providers should take steps to prepare and improve their clinical competency in caring for SGM patients.

It is necessary for NPs to become aware of the nuances of sexuality and gender as they affect the SGM population. Sex is considered in terms of an individual's biologic state. Intersex individuals may be confounded with atypical development of sexual characteristics that blur the lines between male and female (Cicero & Wesp, 2017). Sexuality can include physical, psychological, and interpersonal concepts, which can be manifested and exhibited differently by each individual. Gender represents traits or behaviors considered masculine or feminine. Gender is a social construct.

NPs should strive to understand the fluid nature of each patient's sexuality and gender identification and to gain an improved perspective of the complexity within the SGM population. This complexity is somewhat illustrated by confusion in terminology frequently used by and to describe SGM individuals. Some of these terms include cisgender, gender-fluid, gender nonconforming, genderqueer, intersex, nonbinary, transman, and transwoman. (Table 1). An understanding of these terms and their connotations are invaluable in supporting dialogue with an SGM patient. An NP's use of the proper language and terminology may help cue SGM patients that the environment is welcoming and it will be safe to disclose SGM status.

Table 1 - Selected SGM Terminology

Term	Definition
Cisgender	Sex identified at birth conforms with gender identity
Gender	Identifies the traditional view of either of two sexes being male and female. Often connotes that traits and behaviors are typically considered to be masculine or feminine. Is a social construct.
Gender fluid	Flexibility of flow between identity as male or female
Gender non-conforming	One whose gender is outside societal norms

Genderqueer	One whose gender at birth is not like their gender identity that may be neither male nor female
Intersex	Individuals may have sex chromosome anomalies, or genitalia or reproductive anatomy that is not clearly identified as either male or female
Nonbinary	Those individuals who do not identify as male or female, similar to gender-queer
Sex	Considered in terms of an individual's biologic state
Transgender	Term describing one whose gender differs from the sex assigned at birth
Transman	Transgender individual who was assigned female at birth and identifies as male
Tanswoman	Transgender individual who was assigned male at birth and identifies as female

Human Rights Campaign (2018). Fenway Health (2010).

Some SGM individuals are uncomfortable with typical pronouns used in general conversation. Traditional pronouns based on assumption do not always fit; if indicated, avoid the pronouns, "he," or "she" for patients based on their preferences (Cicero & Wesp, 2017). For example, when caring for a transwoman patient, the NP may struggle with whether to use the pronouns "he" or "she," or "him" or "her." Simply asking which pronouns and what first name the patient prefers is a relatively easy way to approach the issue. It may be helpful to acknowledge unfamiliarity with pronoun use and apologize if a mistake or misstatement is made.

NPs must educate themselves regarding both approaches to the SGM population and its subgroups and the clinical implications of care specific to the population. It is beneficial for the NP to recognize the difference between sexual minorities and gender minorities. The NP should be able to explore and ask about sexual practices, body parts, and appropriate screening parameters, and know how to complete a comprehensive history and physical exam for a transgender patient.

The Gay and Lesbian Medical Association (GLMA) has published guidelines for caring for SGM patients. NPs should evaluate their clinic environment and consider displaying brochures specific to SGM health disparities, such as those focused on safe sex and HIV, displaying a nondiscrimination statement, and posting unisex bathroom signs or other SGM-friendly symbols (Gay and Lesbian Medical Association, N.D.). NPs can also consider advertising their clinics in the GLMA directory to promote their clinics as safe spaces for the SGM community (Gay and Lesbian Medical Association, N.D.).

Another strategy is to revise or design patient intake forms using SGM-sensitive terminology. The Fenway Institute has a sample form that uses demographic options that are fully inclusive (The Fenway Institute, 2017) (Table 2). According to the American Nurses Association, all nurses must provide culturally congruent, competent, safe care and advocate for all LGBTQ patients (American Nurses Association Center for Ethics and Human Rights, 2018). NPs engaged in academia can participate in studies exploring SGM disparities and interventions that may improve overall health as well as rates of SGM status disclosure. Almost no literature exists on the topic of including SGM content in NP programs of study. NPs in academic roles should evaluate their curricula to determine appropriate content to prepare their students to treat this patient population. Those who participate in policy can continue work in advocacy to remove barriers to care through efforts to improve the sociopolitical context of care. NPs who are adept at caring for SGM patients and have achieved specific training combined with experience in SGM care should disseminate their experiences through teaching and precepting students, as well as presenting successful strategies to new and experienced NPs.

Table 2 - Resources for NPs Caring for SGM Patients

Suggested focus of resources	Resource	URL
Resource for creating policy and procedure and use as a resource for organizational readiness for caring for SGM patients.	Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care for the Lesbian, Gay, Bisexual, and Transgender (LGBT) Community: A Field Guide	www.jointcommission.org/assets/1/18/LGBTFieldGuide_WEB_LINKED_VER.pdf
Source of data specific to sub-populations of SGMs. Data are available and there are links to many resources for the provision of care.	Centers for Disease Control and Prevention: Lesbian, Gay, Bisexual, and Transgender Health	www.cdc.gov/lgbthealth/index.htm
Landmark publication calling for a research agenda for the SGM population. Provides background data and information about the population.	The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundatino for Better Understanding	www.healthypeople.gov/2020/topics-objectives/topic/lesbiangay-bisexual-and-transgenderhealth
HealthyPeople 2020 supplement focused on Lesbian, Gay, Bisexual and Transgender health.	HealthyPeople 2020 – Lesbian, Gay, Bisexual, and Transgender Health	https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health
Sample client registration form that is inclusive of SGM population descriptors.	Fenway Health Client Registration Form	https://fenwayhealth.org/wp-content/uploads/FenwayRegistration-Formv13oct2017_clean.pdf
Discusses the importance of prohibiting discrimination, improving data collection, and furthering research and access to care.	U. S. Department of Health and Human Services: Advanding LGBT Health & Well-Being	https://www.hhs.gov/sites/default/files/2016-report-with-cover.pdf
SGM Terminology and Definitions	Human Rights Campaign	https://www.hrc.org/resources/glossary-of-terms

Internet based program/project focused on prevention of SGM youth suicide prevention. Contains a download of a comprehensive glossary of SGM terms.	It Gets Better Project: LGBTQ+ Glossary	https://itgetsbetter.org/lesson/glossary/
Resources with specific training or other practice-related materials for providers		
Resource and action items for creating a LGBTQ-friendly practice. There are links to care guidelines, The Fenway Institute, and a sample nondiscrimination policy.	American Medical Association: Creating an LGBTQ-Friendly Practice	https://www.ama-assn.org/delivering-care/creating-lgbtq-friendly-practice
Provides links to webinars and other learning resources.	National LGBT Health Education Center	https://www.lgbthealtheducation.org/
Professional organization that encourages members from multiple disciplines.	Gay and Lesbian Medical Association	http://www.glma.org/
Patient-Centered Transgender Health – A Toolkit for Nurse Practitioner Faculty and Clinicians	National Organization of Nurse Practitioner Faculties	https://cdn.ymaws.com/www.nonpf.org/resource/resmgr/files/transgender_toolkit_final.pdf
The guidelines include information about patient care, creating a welcoming environment, language use, and staff sensitivity training.	Gay and Lesbian Medical Association: Guidelines for Care of Lesbian, Gay, Bisexual, and Transgender Patients	http://glma.org/_data/n_0001/resources/live/GLMA%20guidelines%202006%20FINAL.pdf
Provides continuing education for providers working with SGM patients.	Center of Excellence on Racial and Ethnic Minority Young Men Who Have Sex with Men and Other Lesbian, Gay, Bisexual, and Transgender Populations: Continuing Education Webinars	http://www.ymsmlgbt.org/webinars/

Conclusions

SGM patients have complex healthcare needs. The issues faced are matrixed with stigma and discrimination, which translate to barriers to care that can lead to the development of specific healthcare problems. SGM status disclosure is critical to

improving a patient's health. It is apparent that healthcare disparities exist within SGM and that patients are hesitant to disclose SGM status to the HCP. Clear communication from NPs and the creation of a welcoming environment may play a significant role in improving health for the SGM population.

References

Abel, L., Collier, D., Deming, S., Dolan, M., & Dooling, J. (2017). Improved patient engagement for LGBT populations. *Journal of the American Health Information Management Association*, 34-39.

Agénor, M., Krieger, N., Austin, S. B., Haneuse, S., & Gottlieb, B. R. (2014). At the intersection of sexual orientation, race/ethnicity, and cervical cancer screening: assessing Pap test use disparities by sex of sexual partners among black, Latina, and white US women. *Social Science & Medicine, 116*, 110-118.

Agénor, M., Krieger, N., Austin, S. B., Haneuse, S., & Gottlieb, B. R. (2014). Sexual orientation disparities in Papanicolaou test use among US women: the role of sexual and reproductive health services. *American Journal of Public Health*, *104*(2), e68-e73.

American Nurses Association for Ethics and Human Rights. (2018). Position statement: Nursing advocacy for LGBTQ+ populations. Retrieved from https://www.nursingworld.org/~49866e/globalassets/practiceandpolicy/ethics/nursing-advocacy-for-lgbtq-populations.pdf

Ard, K. L., & Makadon, H. J. (2012). *Improving the health care of lesbian, gay, bisexual and transgender (LGBT) people: Understanding and eliminating health disparities.* Boston, MA: The Fenway Institute.

Barefoot, K. N., Smalley, K. B., & Warren, J. C. (2017). A quantitative comparison of the health-care disclosure experiences of rural and nonrural lesbians. *Stigma and Health*, *2*(3), 195.

Bennett, C. M., & Rechter, J. (2014). Moving university campuses tobacco-free: Collective responsibility and collaboration the key to a healthier Victoria. *Australian and New Zealand Journal of Public Health, 38*(6), 593.

Biddix, J. M., Fogel, C. I., & Perry Black, B. (2013). Comfort levels of active duty gay/bisexual male service members in the military healthcare system. *Military Medicine, 178*(12), 1335-1340.

Blosnich, J., Bossarte, R., Silver, E., & Silenzio, V. (2013). Health care utilization and health indicators among a national sample of US veterans in same-sex partnerships. *Military Medicine, 178*(2), 207-212.

Blosnich, J. R., Farmer, G. W., Lee, J. G., Silenzio, V. M., & Bowen, D. J. (2014). Health inequalities among sexual minority adults: evidence from ten US states, 2010. *American Journal of Preventive Medicine, 46*(4), 337-349.

Blosnich, J., Foynes, M. M., & Shipherd, J. C. (2013). Health disparities among sexual minority women veterans. *Journal of Women's Health, 22*(7), 631-636.

Caceres, B. A., Brody, A., Luscombe, R. E., Primiano, J. E., Marusca, P., Sitts, E. M., & Chyun, D. (2017). A systematic review of cardiovascular disease in sexual minorities. *American Journal of Public Health, 107*(4), e13-e21.

Chávez, P. R., Wesolowski, L. G., Peters, P. J., Johnson, C. H., Nasrullah, M., Oraka, E., ... & DiNenno, E. (2018). How well are US primary care providers assessing whether their male patients have male sex partners? *Preventive Medicine, 107*, 75-80.

Cicero, E. C., & Wesp, L. M. (2017). Supporting the health and well-being of transgender students. *The Journal of School Nursing*, *33*(2), 95-108.

Dahlhamer, J. M., Galinsky, A. M., Joestl, S. S., & Ward, B. W. (2016). Barriers to health care among adults identifying as sexual minorities: A US national study. *American Journal of Public Health*, *106*(6), 1116-1122.

Durso, L. E., & Meyer, I. H. (2013). Patterns and predictors of disclosure of sexual orientation to healthcare providers among lesbians, gay men, and bisexuals. *Sexuality Research and Social Policy*, *10*(1), 35-42.

Farmer, G. W., Bucholz, K. K., Flick, L. H., Burroughs, T. E., & Bowen, D. J. (2013). CVD risk among men participating in the National Health and Nutrition Examination Survey (NHANES) from 2001 to 2010: Differences by sexual minority status. *Journal of Epidemiology and Community Health*, *67*(9), 772-778.

Fenway Health. (2010). Glossary of gender and transgender terms. Retrieved from https://fenwayhealth.org/documents/the-fenway-institute/handouts/Handout_7-C_Glossary_of_Gender_and_Transgender_Terms__fi.pdf

Fenway Health. (N.D.). *Fenway health client registration*. Retrieved from https://fenway-health.org/wp-content/uploads/FenwayRegistration-Formv13oct2017_clean.pdf

Fredriksen-Goldsen, K. I., Kim, H. J., Shui, C., & Bryan, A. E. (2017). Chronic health conditions and key health indicators among lesbian, gay, and bisexual older US adults, 2013–2014. *American Journal of Public Health*, *107*(8), 1332-1338.

Friedman, M. R., Wei, C., Klem, M. L., Silvestre, A. J., Markovic, N., & Stall, R. (2014). HIV infection and sexual risk among men who have sex with men and women (MSMW): A systematic review and meta-analysis. *PloS one*, *9*(1), e87139.

Gay and Lesbian Medical Association. (2006). *Guidelines for care of lesbian, gay, bisexual, and transgender patients.* Retrieved from http://glma.org/_data/n_0001/resources/live/GLMA%20guidelines%202006%20FINAL.pdf

Gonzales, G., & Henning-Smith, C. (2017). Health disparities by sexual orientation: Results and implications from the behavioral risk factor surveillance system. *Journal of Community Health*, *42*(6), 1163-1172.

Hottes, T. S., Bogaert, L., Rhodes, A. E., Brennan, D. J., & Gesink, D. (2016). Lifetime prevalence of suicide attempts among sexual minority adults by study sampling strategies: A systematic review and meta-analysis. *American Journal of Public Health*, *106*(5), e1-e12.

Human Rights Campaign. (2018). *Glossary of terms*. Retrieved from https://www.hrc.org/resources/glossary-of-terms

Jackman, K., Honig, J., & Bockting, W. (2016). Nonsuicidal self-injury among lesbian, gay, bisexual and transgender populations: An integrative review. *Journal of Clinical nNursing*, *25*(23-24), 3438-3453.

Jackson, J., MacKean, G., Cooke, T., & Lahtinen, M. (2017). Patient and provider experiences with relationship, information, and management continuity. *Patient Experience Journal*, *4*(3), 38-47.

Kamen, C. S., Smith-Stoner, M., Heckler, C. E., Flannery, M., & Margolies, L. (2015, January). Social support, self-rated health, and lesbian, gay, bisexual, and transgender identity disclosure to cancer care providers. In *Oncology Nursing Forum* (Vol. 42, No. 1, p. 44). NIH Public Access.

Lattimer, J. (2014). GSM acronym better than LGBT alphabet soup. Collegiate Times. Retrieved from http://www.collegiatetimes.com/opinion/gsm-acronym-better-than-lgbt-alphabet-soup/article_f7a325a4-5acd-11e4-bf0d-001a4bcf6878.html

Lehavot, K., Rillamas-Sun, E., Weitlauf, J., Kimerling, R., Wallace, R. B., Sadler, A. G., ... & Stefanick, M. L. (2016). Mortality in postmenopausal women by sexual orientation and veteran status. *The Gerontologist*, *56*(Suppl_1), S150-S162.

Macapagal, K., Bhatia, R., & Greene, G. J. (2016). Differences in healthcare access, use, and experiences within a community sample of racially diverse lesbian, gay, bisexual, transgender, and questioning emerging adults. *LGBT Health*, *3*(6), 434-442.

Maragh-Bass, A. C., Torain, M., Adler, R., Ranjit, A., Schneider, E., Shields, R. Y., ... & Schuur, J. (2017). Is it okay to ask: Transgender patient perspectives on sexual orientation and gender identity collection in healthcare. *Academic Emergency Medicine*, *24*(6), 655-667.

Mayer, K. H., Bradford, J. B., Makadon, H. J., Stall, R., Goldhammer, H., & Landers, S. (2008). Sexual and gender minority health: What we know and what needs to be done. *American Journal of Public Health*, *98*(6), 989-995.

McNamara, M., & NG, H. (2016). Best practices in LGBT care: A guide for primary care physicians. *Cleveland Clinic Journal of Medicine*, *83*(7), 531.

Mereish, E. H., O'Cleirigh, C., & Bradford, J. B. (2014). Interrelationships between LGBT-based victimization, suicide, and substance use problems in a diverse sample of sexual and gender minorities. *Psychology, Health & Medicine*, *19*(1), 1-13.

Mosack, K. E., Brouwer, A. M., & Petroll, A. E. (2013). Sexual identity, identity disclosure, and health care experiences: is there evidence for differential homophobia in primary care practice? *Women's Health Issues*, *23*(6), e341-e346.

Movement Advancement Project. (2019). *Equality maps: Overall policy tally*. Retrieved from http://www.lgbtmap.org/equality-maps/

Muhrer, J. C. (2014). The importance of the history and physical in diagnosis. *The Nurse Practitioner*, *39*(4), 30-35.

Newport, F. (2018). *In U.S., estimate of LGBT population rises to 4.5%*. Gallup. Retrieved from https://news.gallup.com/poll/234863/estimate-lgbt-population-rises.aspx

Office of Disease Prevention and Health Promotion. (2016). Lesbian, gay, bisexual, and transgender health. U.S. Department of Health and Human Services. Retrieved from https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health

Out and Equal Workplace Advocates. (2017). Workplace equality fact sheet 2017. Retrieved from https://outandequal.org/2017-workplace-equality-fact-sheet

Pappas, S. (2011). *Top 10 stigmatized health disorders*. Live Science. Retrieved from https://www.livescience.com/14424-top-10-stigmatized-health-disorders.html

Pellegrini, C. (2013). Mental illness stigma in health care settings a barrier to care. *Canadian Medical Association Journal*, cmaj-109.

Prejean, J., Song, R., Hernandez, A., Ziebell, R., Green, T., Walker, F., ... & Hall, H. I. (2011). Estimated HIV incidence in the United States, 2006–2009. *PloS one*, *6*(8), e17502.

Reisner, S. L., Katz-Wise, S. L., Gordon, A. R., Corliss, H. L., & Austin, S. B. (2016). Social epidemiology of depression and anxiety by gender identity. *Journal of Adolescent Health*, *59*(2), 203-208.

Reisner, S. L., Vetters, R., Leclerc, M., Zaslow, S., Wolfrum, S., Shumer, D., & Mimiaga, M. J. (2015). Mental health of transgender youth in care at an adolescent urban community health center: A matched retrospective cohort study. *Journal of Adolescent Health*, *56*(3), 274-279.

Ruben, M. A., & Fullerton, M. (2018). Proportion of patients who disclose their sexual orientation to healthcare providers and its relationship to patient outcomes: A meta-analysis and review. *Patient Education and Counseling*, *101*(9), 1549-1560.

Simoni, J. M., Smith, L., Oost, K. M., Lehavot, K., & Fredriksen-Goldsen, K. (2017). Disparities in physical health conditions among lesbian and bisexual women: A systematic review of population-based studies. *Journal of Homosexuality*, *64*(1), 32-44.

Steele, L. S., Daley, A., Curling, D., Gibson, M. F., Green, D. C., Williams, C. C., & Ross, L. E. (2017). LGBT identity, untreated depression, and unmet need for mental health services by sexual minority women and trans-identified people. *Journal of Women's Health*, *26*(2), 116-127.

Stupiansky, N. W., Liau, A., Rosenberger, J., Rosenthal, S. L., Tu, W., Xiao, S., ... & Zimet, G. D. (2017). Young men's disclosure of same sex behaviors to healthcare providers and the impact on health: Results from a US national sample of young men who have sex with men. *AIDS Patient Care and STDs*, *31*(8), 342-347.

Sullivan, P. S., Peterson, J., Rosenberg, E. S., Kelley, C. F., Cooper, H., Vaughan, A., ... & Del Rio, C. (2014). Understanding racial HIV/STI disparities in black and white men who have sex with men: a multilevel approach. *PloS one*, *9*(3), e90514.

Underhill, K., Morrow, K. M., Colleran, C., Holcomb, R., Calabrese, S. K., Operario, D., ... & Mayer, K. H. (2015). A qualitative study of medical mistrust, perceived discrimination, and risk behavior disclosure to clinicians by US male sex workers and other men who have sex with men: implications for biomedical HIV prevention. *Journal of Urban Health*, *92*(4), 667-686.

Chapter 3

Considering the Needs of Older Sexual and Gender Minority People

Abstract

Sexual and gender minority older adults face unique challenges in health care and are at greater risk for poor health outcomes. The aging population is growing significantly. Nurse practitioners have an opportunity to address the specific challenges associated with family and social support, unique relationships, sexuality and its implications, the lack of community resources, housing including long-term care, end-of-life and palliative care disparities for these populations.

Considering the Needs of Older Sexual and Gender Minority People

Sexual and gender minority (SGM) is an umbrella term inclusive of those who are lesbian, gay, bisexual and transgender (LGBT) and other groups who are not cisgender, an individual whose gender identity matches their physical sex at birth, or heterosexual. Gender can be described in terms of identity: male, female, gender fluid (one who does not identify with a specific gender), gender non-conforming (one whose actions, dress or other characteristics are not aligned with that expected) or other (Human Rights Campaign, 2019). Gender is also a function of expression. One may express their gender in terms of masculinity, femininity or in between. In order to provide quality, appropriate health care for SGMs, the concepts of identity, behavior, and attraction must be considered. It is easy to assume an individual ascribes to a single category; however, this is not always the case (Institute of Medicine, 2011). For example, being transgender is not an indicator of sexual orientation (Gay and Lesbian Alliance Against Defamation, 2019). Due to the nuances of the subpopulations within this group, SGM is the commonly accepted terminology when referring to this population. Older SGM individuals are at greater risk for poor health and health-related outcomes (Cloyes, 2016). Prevalence of disability, physical limitation, the rate of disease, and mental health problems including depressive symptoms are higher than aged heterosexual or cisgender individuals (Adams, 2016; Choi & Meyer, 2061). Economic disparities and discrimination based upon their SGM status are common among this population (American Psychological Association, N.D.). A lifetime of discrimination, barriers to care, lower levels of social support such as living alone without children to provide care, and financial instability contribute to poor

health outcomes (Choi & Meyer, 2016; Adams, 2016; Emlet, 2016). The 2030s will be significant for the aging population in the United States. The entire Baby Boomer population will have aged to 65 years and aged individuals will, for the first time in history, outnumber children (U.S. Census Bureau, 2018). Census data specific to the aged sexual and gender minority population in the U.S. does not exist (Choi & Meyer, 2016). However, estimates suggest there will be five million SGM aged 50 and older with up to four million aged 60 and older by 2030 (Choi & Meyer, 2016). Nurse Practitioners (NPs) are uniquely poised to care for older SGMs and reduce the myriad of health care disparities they face.

Family and Social Support

Biological families are frequently the primary source of support for most heterosexual cisgender older people (Zelle & Arms, 2015). This is in direct contrast to SGM older people who are twice as likely to live alone, four times as likely to not have children, and are more likely to be estranged from their biological families (Zelle & Arms, 2015). NPs must be aware of the differences in family support structures and the challenges that may have led to that difference. Due to the dynamics of family, older SGMs may be more likely to have developed chosen versus biological families within their social support structures.

Older SGMs experience abuse and neglect, social isolation and lack legal protections similar to heterosexuals (National Center on Elder Abuse, 2013). Most of this is attributed to ongoing stigma, discrimination and victimization. Social stigma, discrimination, and victimization have negative and positive effects on SGMs social

networks (Emlet, 2016). The makeup of an older SGM's social network is varied. Five types of social networks for SGM adults aged 50 and older were identified in order of greatest to lowest support (Kim et al., 2017): diverse networks with no children, diverse with children, immediate family-focused, primarily friends, and restricted or limited (Kim et al., 2017). Older SGMs affected by human immunodeficiency virus (HIV) are socially isolated and face dual or multifaceted stigma (Cahill & Valadez, 2013). This is a situation in which an SGM individual may look to peers to form families of choice. However, there is concern that with the health challenges associated with aging and HIV, peers as family may pose problems in assisting others due to their own poor health and the ability to be present or visit in certain care environments (Karpiak & Havlik, 2017).

Relationships

Most SGM older adults are single and live alone (Fredriksen-Goldsen, &Espinoza, 2014; Knauer, 2014). For those in relationships, marriage may be similarly protective of physical and mental health as it is for those in heterosexual relationships (Fredriksen-Goldsen, &Espinoza, 2014). The landmark civil rights case, United States v. Windsor, decided in 2013 has changed the face of same-sex marriage in the U.S. but the uncertainty of the legal landscape persists (Knauer, 2014). It is important to realize that while marriage equality may have some effect upon the overall social norm, SGMs ability to marry will not, in and of itself address other pressing issues such as health disparities, bias, discrimination or economic security (Knauer, 2014). Additionally, healthcare providers should consider same-sex spouses or partners when caring for SGM

older adults who may have concerns due to previous negative experiences (Moone, Croghan, & Olson, 2016).

Sexuality and Implications

Approximately half of SGMs up to 75 years and one-quarter of those between 75 and 85 are sexually active (Simone et al., 2015). Providers, therefore, must complete a comprehensive sexual history even in older adulthood. Prostate, cervical and breast cancer screenings are necessary. Concerns for sexual dysfunction and risk for sexually transmitted infection (STI) exist. The risk for HIV is greater because older SGM males are less likely to use condoms than younger SGMs (Simone et al., 2015) clearly calling for a need for further and continuing professional education.

Lesbian, bisexual women and transgender people have specific healthcare needs (Committee on Health Care for Underserved Women, 2018). Many lesbian women have engaged in intercourse with both men and women through their lifespan and require HIV and other STI screenings (Simone et al., 2015). However, it is important to be aware that for women who only have sex with women, STI screening is also important. It is suggested that the STI and the sexual behavior or practice must be considered in terms of STI risk (Frieden, Jaffe, &Cano, 2015). Examples include human papilloma virus (HPV), and bacterial vaginosis (BV) which are common in women who have sex with women and herpes simplex virus two (HSV-2) infection is inefficient, but does occur (Frieden, Jaffe, &Cano, 2015). Transgender women have a higher risk of being HIV positive (Simone et al., 2015).

Sex is a function of physiology, performance, functioning, and attraction (Taylor & Gosney, 2011; Abed et al., 2019; Hiedemann & Brodoff, 2013; Lyons et al., 2014). Discussions about sexual practices are sensitive and can be awkward for both the provider and patient. However, providers should address the patient's concerns cautiously so as not to over-sexualize or over-medicalize the aging process (Taylor & Gosney, 2011). Addressing sexuality is more complex for a SGM patient and requires inquiry into both content and context of a complaint or problem. Unfortunately, the gathering of sexual history is missed up to half the time in the context of general care (Eckstrand, Lomis, &Rawn, 2012). For example, this can occur in an acute visit where exploration of a genitourinary review of systems may not fit clearly in a focused clinical visit. Preparation for taking a history specific to SGMs is lacking leading to failure to address opportunities for risk reduction counseling and specific care (Eckstrand, Lomis, &Rawn, 2012).

Community Resources, Housing, and Long-Term Care

Older SGMs experience discrimination and economic challenges acquiring adequate and safe housing (Choi & Meyer, 2016; Bostic, N.D.). Long-term (LTC) placement presents additional problems. Older SGMs in a situation of loss of independence, potential exposure to ageism, and in a facility that potentially restricts the expression of intimacy and sexuality (Simpson et al., 2017).

Housing for SGM older adults is a significant concern considering the context of family and social support. Housing for aging SGM individuals presents a significant challenge. There are economic, legal and related challenges within the reality of the

likelihood of aging alone and without biological family for support. There are limited community resources to support SGM older adults ability to age in place, particularly in rural areas. As a result, premature placement in institutional care may occur (Adams, 2016). A 2017 study searched independent living, assisted living and long-term care facilities found only 10 LGBT-specific housing options within the U.S. and potentially as many as 11 more in development (Johnston & Meyer, 2017).

SGMs experience issues in the long-term care setting. Heterosexism, or untoward thinking and beliefs leading to discrimination of those who are not heterosexual (Calabrese et al., 2018), exists in LTC settings and results in discrimination, further stigma and negative experiences. LTC employees may lack knowledge and understanding of SGM lifetime experiences and unique needs (Schwinn & Dinkel, 2015; Cacares et al., 2019). Older LTC SGM residents are typically concerned about visitation rights by those who are their chosen versus biological families and negative attitudes toward same-sex relations in older adults (Caceres et al., 2019). Providers must be aware of potential bias, discrimination, and lack of staff training in cultural humility and the unique needs of SGMs when recommending LTC placement of older SGMs. Placement in LTC facilities may represent not only loss of independence, but a disconnect from existing social or family support, increased exposure to cultural insensitivity, exposure to discrimination and potentially, an increased risk of physical harm due to an unsafe environment.

End-of-Life and Palliative Care

Addressing concerns about the end-of-life are often left unattended or discussed by healthcare providers. In the case of SGMs, having the conversation is compounded by a noted lack of partners or children. Consider the context of poorer overall health, lack of biological family, being single and potentially few social resources. As a result, SGMs may have greater anxiety about palliative care and decisions related to the end-of-life (de Vries & Gutman, 2016). Nearly one-third of gay men and transgender persons are unable to identify a caregiver if the need occurred (de Vries & Gutman, 2016).

Palliative and end-of-life care present unique situations. A recent case study illustrated a case of a transgender male patient who required palliative and hospice care for terminal metastatic ovarian cancer (Stevens & Abrahm, 2019). The complexity of managing physiologic care not congruent with traditional thoughts about gender and illness in the context of complex family situations can be tenuous to navigate. Maintaining a focus on culturally competent care requires specific knowledge regarding the SGM population and how to integrate psychosocial and even spiritual needs simultaneously (Stevens & Abrahm, 2019). For SGMs who are partnered or married facing end-of-life issues, it is important to recognize the sociopolitical context in which they may not feel welcome in the process. This highlights the potentially unrecognized needs of a surviving spouse or partner. Validation of this relationship is essential for the provision of holistic care (Simone et al., 2015).

Implications: The NP's Role

Providing care for older SGMs is an issue of content and context. It is important to understand that although SGMs face similar health concerns and situations as their cisgender and heterosexual counterparts do, there are specific challenges to their care. When engaging care of an aging patient, providers must actively work to avoid the heterosexual, cisgender assumption. Another assumption to avoid is that of heteronormativity or the assumption that heterosexuality is the primary or "normal" sexual orientation. Specific strategies can help.

Why NPs?

Nursing practice is holistic and acknowledges the uniqueness of individuals. NPs strengths allow for challenging paradigms, embracing education, and ultimately being good humans to assist in crossing the distinct barriers challenging the health of this vulnerable population. The unfortunate reality is that many providers in general lack experience in the care of SGM patients. There is opportunity at this juncture and these are threshold times where NPs have an opportunity to change the trajectory and move to a new approach in the of care to older SGMs

Tips for Best Practice

Tip #1 - Create an environment that communicates safety.

The literature suggests visual cues to a welcoming environment when caring for SGM patients. Some of the suggestions include brochures, training opportunities, posters or signs that demonstrate an attention to diversity (Gay and Lesbian Medical Association, 2005). The guidelines also suggest simple changes in terminology for intake forms and

other documents such as adding an option for transgender then male or female boxes. The written language should be supported by use of questioning that is supportive and includes rationale for questions. The patient should be assured of confidentiality. Always consider the SGM equivalent in nuances of care for cisgender, heterosexual patients. For example, providers are typically not concerned about a straight woman's desire to have a female provider. As such, consider that gay men may not be comfortable with a female provider. The key is communication, explanation, and accommodation whenever reasonable and appropriate.

Tip #2 - Seek to understand the culture of SGM patients and the contextual experiences.

Providers must understand that within the backdrop of an older SGM's life is often a history of exposure to harassment, discrimination, violence, stigma, and a political structure that continues to change. The reality of the likelihood of negative experiences can set a weariness or distrust of a healthcare system. In aged SGMs, interaction with the healthcare system will be necessary at some juncture. Therefore, the burden is largely on the provider to ensure care in an accepting and culturally appropriate manner.

Understanding another culture requires time, experience, and most importantly engaging in continuing education. While working to achieve this recommendation, it is important to be practical. Use of the same set of problem-solving skills employed in day-to-day care with humility. If a mistake or misstatement is made, simple acknowledgement and apology illustrates sincerity.

The variances in subpopulations of SGMs are complex. It is helpful to ask patients about what pronoun is preferred. Additionally, lack of knowledge can be confounded by assumptions. For example, transgender men and women are not necessarily gay, straight, or bisexual. The assumption of gay can be quite problematic leading to irrelevant questions or actions for the particular patient situation. The bottom line is that providers should avoid assumption on many levels.

Social Support. Providers must consider the potential for lack of social support and when present, the diverse types of social or family support. This is particularly necessary when recommendations are highly dependent upon a social structure to ensure compliance with treatment recommendations. Trusted friends of older SGMs may be just as important to involve in care planning as biological family members (Blieszner & Ogletre, 2017). Issues surrounding independence, social isolation, declining health, housing and the need for institutionalized care are clear concerns for this population. Including friends, significant others or the patient's family of choice may assist in averting many of the potential barriers faced by the SGM. Resources available to aid in understanding the aging SGM population are found in Table 3.

Table 3 - Resources for Nurse Practitioners Caring for Older Sexual and Gender Minority (SGM) Patients

Resource	**URL**
The National Resource Center on LGBT Aging provides a myriad of resources from education and training to timely and relevant news affecting aging LGBT people	https://www.lgbtagingcenter.org/
The American Society on Aging provides specific resources focused on LGBTQ people. There are links to a resources clearinghouse and other organizations with specific resources in caring for older SGM people. There is also a LGBT Aging	https://www.asaging.org/

Issues Network site focused on increasing awareness of concerns of this population.	
The Sage Advocacy and Services for LGBT Elders website provides a comprehensive list of resources focused on issues surrounding aging as a SGM.	https://www.sageusa.org/
The Natinoal LGBT Health Education Center is a program of the Fenway Institute. This site provides education opportunities, some of which are focused on LGBT aging.	https://lgbthealtheducation.org/topic/lgbt-older-adults/
The Williams Institute from the UCLA School of Law has published a report titled ”LGBT Aging: A Review of Research Findings, Needs, and Policy Implications” that outlines current needs. Among very helpful data and calls to action, there is a table listing 10 core competencies providers can use in caring for older SGM adults.	https://williamsinstitute.law.ucla.edu/wp-content/uploads/LGBT-Aging-A-Review.pdf

Tip #3 - Consider medical necessity.

Avoid the conundrum of desire to know versus gaining medically necessary information. There is a line between curiosity and gaining information necessary to direct or guide care (National LGBT Health Education Center, 2005). Questions of older SGM clients should be focused with a clear link to necessity in terms of outcome or treatment. Be considerate of the potential for an older SGM's desire to separate their personal life privacy (National LGBT Health Education Center, 2005). This separation can be tricky. The National LGBT Health Education Center suggests addressing the need-to-know perspective during a patient encounter while attending to a need for context through education at a later time (National LGBT Health Education Center, 2005). This distinction of prioritizing needed information, highlights the need for ongoing education to address competency in caring for SGMs.

Tip #4 - Provide appropriate resources.

Evaluate and list SGM specific or inclusive resources in your practice area. Older SGM patients can need referrals for specialist care. Referrals for palliative, mental health including bereavement care and spiritual needs may exist. Identifying what is and is not present in your practice area and engaging in a multidisciplinary collaborative practice approach will ultimately benefit all those involved. Identify resources in terms of health care, disability, legal support, housing, and community-based options (National Resource Center on LGBT Aging, 2019). Some resources may lead to more specific options within practice communities. The Gay and Lesbian Medical Association has a provider directory that is very helpful in making appropriate referrals (Gay and Lesbian Medical Association, N.D.).

Advance care planning considerations. Discuss advance care planning with SGM patients. This will provide an opportunity to examine potential barriers to decision making including both social and financial concerns. Whenever appropriate, biological families or families of choice should be invited to participate in the discussion.

Tip #5 - Engage in health policy opportunities.

Engagement in opportunities to address health policy needs is also a helpful strategy in addressing the needs of the SGM population. Opportunities to address policy based on known needs should be taken by all those involved in care of older SGM's. Current policy needs include development of competencies for individuals working in LTC, options for housing, and allocation of funding for community-based services (Espinoza, 2016). There is a clear need for prioritization of funding as there is an

identified social need associated with being a SGM (Choi & Meyer, 2016). Further research should inform policy and legislators.

Tip #6 - Participate in research.

Current evidence regarding aging SGM populations is lacking. Research regarding healthcare and factors that impact social determinants of health are needed. Many studies are small and not representative of all subgroups within the SGM population. The effect of interventions to improve both the identification of concerns and delivery of care are essential. Knowledge generated will address disparities and improve the lives of SGMs.

Conclusions

Aging SGMs face unique challenges. NPs' are absolutely poised to provide comprehensive care to this population. Many providers and poorly prepared and lack experience in caring for SGM patients calling for a clear need for education and awareness of health and social concerns of diverse populations, specifically SGM. Services specific to SGM patients are limited and often inadequate. Facilities such as long-term care lack staff preparation for the nuances of care specific to older SGMs. Until these issues are explored and addressed, substandard care will continue to negatively affect this population that has already faced a lifetime of stigma, discrimination, and lack of clinically relevant care.

References

Abed, E. C., Schudson, Z. C., Gunther, O. D., Beischel, W. J., & van Anders, S. M. (2019). Sexual and Gender Diversity Among Sexual and Gender/Sex Majorities: Insights via Sexual Configurations Theory. *Archives of Sexual Behavior*, 1-19.

Adams, M. (2016). An intersectional approach to services and care for LGBT elders. *Generations*, *40*(2), 94-100.

American College of Obstetricians and Gynecologists. (2012). Health care for lesbians and bisexual women. Committee opinion No. 525. *Obstetrics & Gynecology*, *119*, 1077-1080.

American Psychological Association. (N.D.). Lesbian, gay, bisexual and transgender aging. Retrieved from https://www.apa.org/pi/lgbt/resources/aging

Blieszner, R., & Ogletree, A. M. (2017). We get by with a little help from our friends. *Generations*, *41*(2), 55-62.

Bostic, R. (N.D.). A message from the assistant secretary: LGBT elders. Retrieved from https://www.huduser.gov/portal/pdredge/pdr_edge_frm_asst_sec_011312.html

Caceres, B. A., Travers, J., Primiano, J. E., Luscombe, R. E., & Dorsen, C. (2019). Provider and LGBT Individuals' Perspectives on LGBT Issues in Long-Term Care: A Systematic Review. *The Gerontologist*.

Cahill, S., & Valadéz, R. (2013). Growing older with HIV/AIDS: new public health challenges. *American Journal of Public Health*, *103*(3), e7-e15.

Calabrese, S. K., Earnshaw, V. A., Krakower, D. S., Underhill, K., Vincent, W., Magnus, M., ... & Dovidio, J. F. (2018). A closer look at racism and heterosexism in

medical students' clinical decision-making related to HIV pre-exposure prophylaxis (PrEP): Implications for PrEP education. *AIDS and Behavior*, *22*(4), 1122-1138.

Choi, S. K., & Meyer, I. H. (2016). *LGBT aging: A review of research findings, needs, and policy implications*. The Williams Institute. Los Angeles.

Cloyes, K. G. (2015). The silence of our science: Nursing research on LGBT older adult health. *Research in Gerontological Nursing*, *9*(2), 92-104.

de Vries, B., & Gutman, G. (2016). End-of-life preparations among LGBT older adults. *Generations*, *40*(2), 46-48.

Eckstrand, K., Lomis, K., & Rawn, L. (2012). An LGBTI-inclusive sexual history taking standardized patient case. *MedEdPORTAL Publications*, *8*, 9218.

Emlet, C. A. (2016). Social, economic, and health disparities among LGBT older adults. *Generations*, *40*(2), 16-22.

Espinoza, R. (2016). Protecting and ensuring the well-being of LGBT older adults: A policy roadmap. *Generations*, *40*(2), 87-93.

Fredriksen-Goldsen, K. I., & Espinoza, R. (2014). Time for transformation: Public policy must change to achieve health equity for LGBT older adults. *Generations (San Francisco, Calif.)*, *38*(4), 97.

Frieden, T., Cono J, Richards C, & M. Iademarco. (2015). *Sexually transmitted diseases treatment guidelines*. Centers for Disease Control and Prevention. Atlanta, GA.

Gay and Lesbian Medical Association. (2006). *Guidelines for care of lesbian, gay, bisexual, and transgender patients*. San Francisco, CA: Gay and Lesbian Medical Association.

Hiedemann, B., & Brodoff, L. (2013). Increased risks of needing long-term care among older adults living with same-sex partners. *American Journal of Public Health*, *103*(8), e27-e33.

Human Rights Campaign. (2019). Glossary of terms. Retrieved from https://www.hrc.org/resources/glossary-of-terms

Gay and Lesbian Alliance Against Defamation. (N.D.). *Transgender FAQ*. Retrieved from https://www.glaad.org/transgender/transfaq

Gay and Lesbian Medical Association. (N.D). *Find a provider*. Retrieved from http://www.glma.org/index.cfm?fuseaction=Page.ViewPage&PageID=939

Graham, R., Berkowitz, B., Blum, R., Bockting, W., Bradford, J., de Vries, B., & Makadon, H. (2011). The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding. *Washington, DC: Institute of Medicine*, 89-139.

Johnston, T. R., & Meyer, H. (2017). LGBT-specific housing in the USA. *Housing, Care and Support*, *20*(3), 121-127.

Karpiak, S. E., & Havlik, R. (2017). Are HIV-Infected Older Adults Aging Differently? In *HIV and aging* (Vol. 42, pp. 11-27). Karger Publishers.

Kim, H. J., Fredriksen-Goldsen, K. I., Bryan, A. E., & Muraco, A. (2017). Social network types and mental health among LGBT older adults. *The Gerontologist*, *57*(suppl_1), S84-S94.

Knauer, N. J. (2014). LGBT Elders in a Post-Windsor World: The Promise and Limits of Marriage Equality. *Texas Journal of Women, Gender & Law*, *24*, 1.

Lyons, A., Croy, S., Barrett, C., & Whyte, C. (2015). Growing old as a gay man: How life has changed for the gay liberation generation. *Ageing & Society*, *35*(10), 2229-2250.

Moone, R. P., Croghan, C. F., & Olson, A. M. (2016). Why and how providers must build culturally competent, welcoming practices to serve LGBT elders. *Generations*, *40*(2), 73-77.

National Center on Elder Abuse. (2013). *Mistreatment of lesbian, gay, bisexual, and transgender (LGBT) elders.* Retrieved from https://ncea.acl.gov/NCEA/media/Publication/Mistreatment-of-Lesbian-Gay-Bisexual-and-Transgender-LGBT-Elders-2013.pdf

National LGBT Health Education Center. (N.D.). *Providing inclusive services and care for LGBT people: A guide for health care staff.* Boston, MA. The Fenway Institute. Retrieved from https://www.lgbthealtheducation.org/wp-content/uploads/Providing-Inclusive-Services-and-Care-for-LGBT-People.pdf

National Resource Center on LGBT Aging. (2019). *Other LGBT and aging resources*. Retrieved from https://www.lgbtagingcenter.org/resources/areamore.cfm

Schwinn, S., & Dinkel, S. (2015). Changing the culture of long-term care: Combating heterosexism. *OJIN: The Online Journal of Issues in Nursing*, *20*(2).

Simone, M. J., Meyer, H., Eskildsen, M. A., & Appelbaum, J. S. (2015). Caring for LGBT older adults. *Fenway Guide to Lesbian, Gay, Bisexual, and Transgender Health, 2nd ed, Makadon HJ, Mayer KH, Potter J, Goldhammer H (Eds), American College of Physicians, Philadelphia*, 133-158.

Simpson, P., Horne, M., Brown, L. J. E., Dickinson, T., & Torkington, K. (2017). Older care home residents, intimacy and sexuality. *Ageing and Society 37(2), 243-265.*

Stevens, E. E., & Abrahm, J. L. (2019). Adding silver to the rainbow: palliative and end-of-life care for the geriatric LGBTQ patient. *Journal of Palliative Medicine*, *22*(5), 602-606.

Taylor, A., & Gosney, M. A. (2011). Sexuality in older age: essential considerations for healthcare professionals. *Age and Ageing*, *40*(5), 538-543.

United States Census Bureau. (2018). Older people projected to outnumber children for first time in U.S. history. Retrieved from https://www.census.gov/newsroom/press-releases/2018/cb18-41-population-projections.html

Zelle, A., & Arms, T. (2015). Psychosocial effects of health disparities of lesbian, gay, bisexual, and transgender older adults. *Journal of Psychosocial Nursing and Mental Health Services, 53*(7), 25-30.

Chapter 4

It's always a question for me…: Disclosing Sexual and Gender Minority Status

Abstract

Disclosure of sexual and gender minority (SGM) identity is problematic for patients seeking care through an encounter with a healthcare provider (HCP). Non-disclosure may result in inadequate health outcomes. Previous research addressed rates of disclosure by SGM subpopulations and defined prevalence of healthcare disparities faced by this vulnerable population. The purpose of this study was to examine disclosure of SGM identity during an encounter with an HCP, explore factors that contributed to the decision-making process as well as experiences of both SGM and HCP informants. The Disclosure Processes Model guided the study in an attempt to explain disclosure and evaluate the model's usefulness. A comparative, multiple case study examined 12 SGM and seven HCP informants' perspectives. Using the DPM components as an overarching approach, the DPM was beneficial in framing the informant cases. The themes provided rich data surrounding the phenomenon of disclosure and recommendations for care from organizations such as the Gay and Lesbian Medical Association were supported by the data.

It's always a question for me…: Disclosing Sexual and Gender Minority Status

Members of sexual or gender minorities (SGMs) have difficulty disclosing their identity to healthcare providers (HCPs) (Barefoot, Smalley, & Warren, 2016; Durso & Meyer, 2013; Rossman, Salamanca, & Macapagal, 2017a). This difficulty is problematic and effectively negates the ability of HCPs to address healthcare needs specific to this population. The myriad of health disparities experienced by SGM individuals have the potential to be mitigated by appropriate and timely intervention of a Nurse Practitioner (NP). Disclosure of SGM identity is critical to proper intervention. No knowledge of the patient's SGM status, or incorrectly assuming heterosexuality results in missed opportunities to address relevant health needs.

Disclosure of sexual orientation to a provider was associated with positive outcomes such as improved psychological well-being, increased satisfaction and more frequent routine health screenings (Ruben & Fullerton, 2018). The decision to disclose SGM affiliation was influenced by fear of negative consequences and may be more prevalent in rural areas (Barefoot et al., 2016; Bjarnadottir, Bockting, & Dowding, 2016). Failure to disclose was most problematic in bisexual men and women nearing 40% and 33% respectively, while rates are between 10% and 12% for gay men and lesbians (Durso & Meyer, 2013).

Given the challenges to successful disclosure and the positive impact disclosure might have on health outcomes, it is essential to understand the disclosure event by SGMs to HCPs. Exploration of the event of disclosure at the intersect of the HCP and

SGM patient interaction may lead to interventions that will facilitate communication and improve the healthcare delivery and health outcomes.

Background

NPs encounter lesbian, gay, bisexual, transgender and other SGMs in practice and must be aware that this population and sub-populations have unique healthcare needs (McNamara & Ng, 2016). Categories and descriptors related to the SGM population are evolving. Terms such as non-binary, queer, agender and genderqueer are terms used to connote how an individual distinguishes their gender and or sex. Identities delineate both sexuality and gender identity and do not always fit cleanly into a single category. Thus, understanding the nuances of sex and gender are critical.

Healthcare problems experienced may be similar to other groups, but risk factors and prevalence of disease are often more pronounced in SGM people. Compared to heterosexuals, SGMs experience poorer health outcomes (Ard & Makadon, 2012; Baptiste-Roberts, Oranuba, Werts, & Edwards, 2017; Blosnich, Farmer, Lee, Silenzio, & Bowen, 2014; Dahlhamer, Galinsky, Joestl, & Ward, 2014; Gonzales, Przedworski, & Henning-Smith, 2016; Simoni, Smith, Oost, Lehavot, & Fredriksen-Goldsen, 2017). Substance use and abuse is more prevalent in the SGM population as opposed to heterosexuals (Demant, Hides, White, & Kavanagh, 2018; Dentato, Kelly, Lloyd, & Busch, 2017; Mericle et al., 2018). There are higher rates of Human Immunodeficiency Virus (HIV) in men who have sex with men compared with heterosexuals (Friedman et al., 2014; Prejean et al., 2011; Sullivan et al., 2014). SGM men and women have greater risk for cardiac disease (Farmer, Bucholz, Flick, Burroughs, & Bowen, 2013), asthma,

obesity, and arthritis (Caceres et al., 2017; Fredriksen-Goldsen, Kim, Shui, & Bryan, 2017; Simoni et al., 2017) compared with heterosexuals. Mental health disparities were also problematic; transgender individuals are at increased risk for unmet mental healthcare needs (Reisner, Katz-Wise, Gordon, Corliss, & Austin, 2016; Reisner et al., 2015; Steele et al., 2017). While the lifetime prevalence of suicide attempts in SGMs is four times lower than that of heterosexuals (Centers for Disease Control and Prevention, 2015; Hottes, Bogaert, Rhodes, Brennan, & Gesink, 2016), the risk of self-injury, not including suicide, in SGMs is higher (Jackman, Honig, & Bockting, 2016).

SGMs, Stigma and Structural Stigma

Being an SGM is associated with stigma or that of being different and often stereotyped, a constant in the lives of SGM individuals. Stigma exists on many levels and affects health via increasing the chance of substance abuse and psychological distress (Benz, Palm Reed, & Bishop, 2019). An SGM individual might be of another stigmatized identity such as that of people of color thus compounding the effect (Benz et al., 2019; English, Rendina, & Parsons, 2018; Ouch & Moradi, 2019; Porter, Brennan-Ing, Burr, Dugan, & Karpiak, 2019).

Structural stigma defined as cultural norms or practices within an institution or other social context, creates barriers for stigmatized peoples (Hatzenbuehler & Link, 2014). An example includes state rights which can affect the level of SGM stigma experienced (Doyle & Molix, 2015). These structural issues, along with the lack of affirming policy, and hostile cultural norms negatively affect the health of SGM people (Hubach et al., 2019).

Provider Preparedness for SGM Care

HCPs are not prepared to care for the SGM population. Preparedness is related to the amount, content, context, and quality of education received. Some primary care providers harbor stigma toward SGM patients; however, this appears to be the minority (Aleshire, Ashford, Fallin-Bennett, & Hatcher, 2018). Medical student and physician education focused on readiness to care for SGMs produced varied results. Physicians and medical students remain woefully unprepared in terms of cultural competency training for LGBT patients (Bonvicini, 2017; Nama, MacPherson, Sampson, & McMillan, 2017; Schvey, Blubaugh, Morettini, & Klein, 2017). The NP's readiness or preparedness to care for SGM individuals impacts patients' willingness to disclose sexual identity. NPs must understand the nuance of being an SGM in addition to the potential impact of the care environment. No research into NPs' preparation to care for SGMs was located.

Content and Context of Disclosure

It is important to consider the content or depth of information within the context of disclosure. When disclosure occurs, it is often within introductions or in general discussion (Venetis et al., 2017). Superficial interaction can include insufficient information for appropriate health decision making (Venetis et al., 2017). Therefore, the amount of information disclosed is important to assuring proper care delivery.

SGM patients chose not to disclose identity for a variety of reasons. Non-disclosure occurred when SGMs perceived that the risk of revealing their sexual identity outweighed the potential health benefit related to a health problem (Maragh-Bass et al., 2017). SGM young adults reported fear, stigma and failure to disclose because they

believed their reason for seeking care was not relevant to their minority status (Rossman, Salamanca, & Macapagal, 2017b). Mistrust and fear of discrimination by HCPs were clear deterrents for disclosure for SGM men who were sex workers (Underhill et al., 2015). Non-disclosure of SGM identity by women was associated with poor satisfaction with the healthcare experience and difficulty in discussing care with healthcare providers (Mosack, Brouwer, & Petroll, 2013). Sexual health discussions were problematic for SGM women and complicated by how disclosure occurred when it did happen (Youatt, Harris, Harper, Janz, & Bauermeister, 2017). For lesbians, there were apparent geographic considerations indicating higher rates of non-disclosure in rural areas compared with non-rural locations (Barefoot et al., 2016). Those who were transgender disclosed most frequently of the subpopulations, but there was a higher likelihood of a negative experience and higher frequency of delaying care (Macapagal, Bhatia, & Greene, 2016). When SGMs were diagnosed with cancer, they were more likely to disclose their SGM identity (Kamen, Smith-Stoner, Heckler, Flannery, & Margolies, 2015). When disclosure occurred, physician response ranged from discrimination to affirmation (Rossman et al., 2017b).

Disclosure is essential to timely and appropriate healthcare. A large proportion of SGMs do not disclose, yet disclosure promotes positive health outcomes. There is a lack of understanding regarding factors that promote disclosure among SGMs. The provision of appropriate care for SGM patients is in need of further examination and intervention. The population and sub-populations are complex and provider preparedness is lacking.

The sociopolitical context of being SGM creates barriers and negative social influences setting a stage for non-disclosure.

Purpose

The purpose of this qualitative study was to examine disclosure of SGM identity during a healthcare provider and SGM patient interaction. A secondary aim was to identify and explore the factors that contributed to the decision-making process and experiences of SGM persons and HCPs surrounding disclosure.

Theoretical Framework

This study used a comparative, multiple case study design to understand if the Disclosure Processes Model (DPM) (Chaudoir & Fisher, 2010) derived from psychology, was supported by qualitative data obtained from SGM patients and HCPs. See Figure 1. The model was developed for use in any concealable stigmatized identity. The DPM overlays a stigmatized identity, risk and benefit of disclosure of personal or sensitive information with the goal being successful disclosure leading to positive outcomes. The DPM proposes a continuum beginning with the decision-making process through outcomes. Within that continuum, there are five major components: (a) antecedent goals, (b) disclosure event, (c) mediating processes (d) outcomes and (e) feedback loops (Chaudoir & Fisher, 2010).

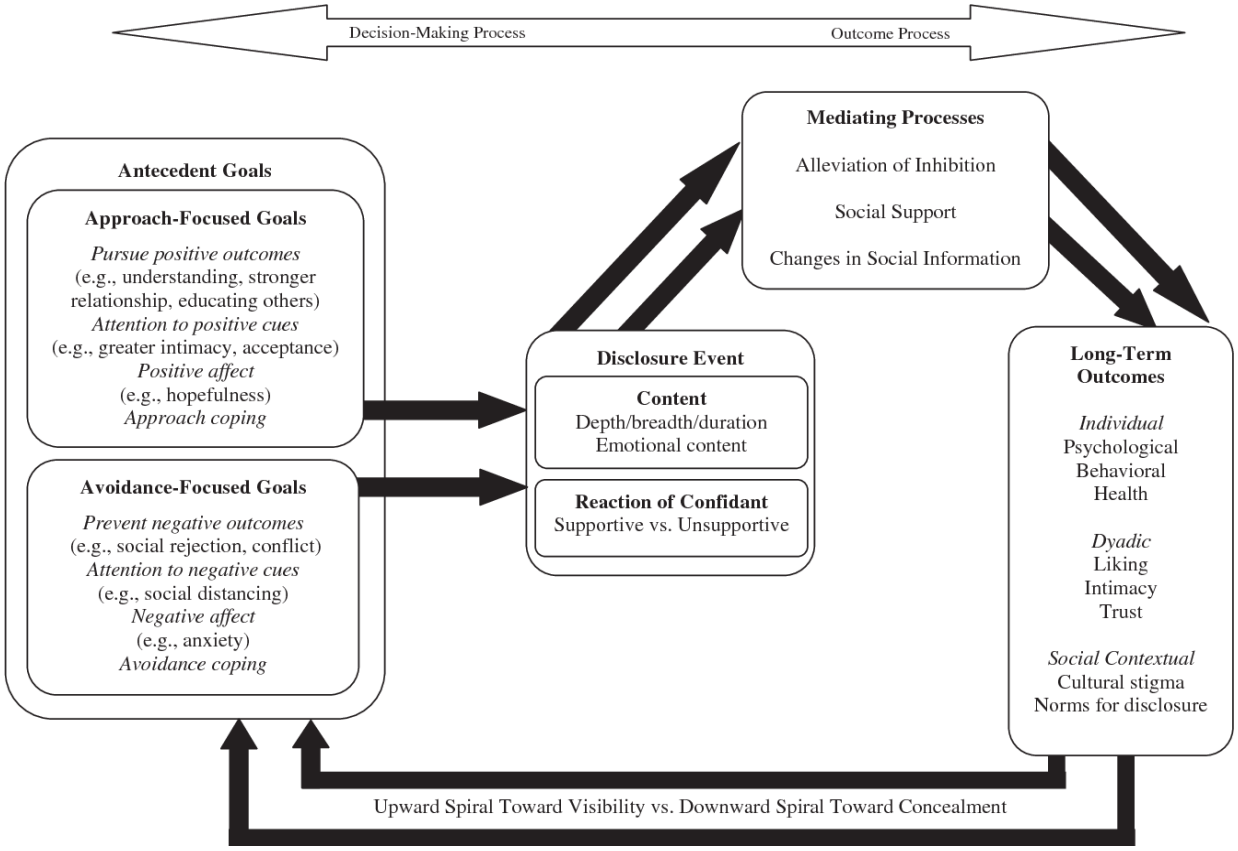

Figure 1 - Disclosure Processes Model. Chaudoir, S., & Fisher, J., 2010. Psychological Bulletin, 136(2), p. 37. Used with permission.

Antecedent goals are specific to driving disclosure or nondisclosure. Goals are either approach-focused or avoidance-focused and pursue positive outcomes or prevent negative outcomes respectively (Chaudoir & Fisher, 2010). Avoidance-focused goals are those aimed at preventing stigma or rejection thus inhibiting SGM identity. As applied to this study, avoidance-focused goals related to non-disclosure of SGM identity for the purpose of avoiding stigma and discrimination. For this study, approach-focused goals were related to a SGM individual's goal for resolving a health concern thus encouraging disclosure. Approach-focused goals are not always applicable when considering disclosure in the context of the healthcare encounter. The benefits of disclosure must be

clear in order to outweigh perceived risks. The DPM suggests that the decision-making process is key when an individual considers whether or not to disclose in a given situation (Chaudoir & Fisher, 2010). Affect plays a role in antecedent goals. The DPM suggests those pursuing approach focused goals may be attuned to positive stimuli or a positive affect (Chaudoir & Fisher, 2010). Coping strategies may also be used. For example, the DPM suggests individuals may suppress SGM identity as an avoidant coping strategy. Alternately, in the case of approach focused coping strategies, the patient might become more open mitigating the psychological consequences of disclosure (Chaudoir & Fisher, 2010).

Disclosure encompasses the person disclosing and the confident, the culmination of cues and the decision-making process leading to the disclosure event, and is the moment in which an individual makes a conscious decision to share personal or sensitive information. Disclosure occurs in the context of content and reaction of the confident as a one-time event, or may be approached as a way to "test the waters", a less direct method, prior to full disclosure (Chaudoir & Fisher, 2010, p. 6). Content represents the amount and detail as well as emotional substance that are shared related to being a SGM. From this, flows the reaction of the provider which may be supportive, negative or indifferent.

Mediating processes constitute the third component of the DPM of which there are three; alleviation of inhibition, social support and changes in social information (Chaudoir & Fisher, 2010). Alleviation of inhibition, or an SGM's feeling of relief from expressing suppressed emotion or concerns can result from disclosure and might lead to full realization of potential benefits if the provider is supportive (Chaudoir & Fisher,

2010). Alleviation of inhibition is a direct result of approach-focused, antecedent goals (Chaudoir & Fisher, 2010). Social support includes having a network of friends or others who provide a structure to enhance well-being. In cases of the SGM and HCP relationship, a positive reaction to disclosure can enhance the relationship. Disclosure and antecedent goals promote social support; however, failure to disclose or a negative reaction to disclosure may inhibit social support (Chaudoir & Fisher, 2010). Changes in the HCP's understanding of social information, such as the extent of the SGM's social network, signifies a change in social interaction between the HCP and SGM, and results when disclosure occurs. The confidant, the HCP, has new information which can significantly impact behavior as the concealable stigmatized identity is revealed (Chaudoir & Fisher, 2010). Social information is not directly affected by the provider reaction and it is important to note that when disclosure occurs, the SGM identity would be "in the open" and may affect the context of a social environment (Chaudoir & Fisher, 2010). Within this construct, the model clearly identifies why disclosure may or may not be beneficial and considers the SGM patient's stigmatized identity.

Long-term outcomes represent an individual or dyadic perspective and might contain social contextual outcomes (Chaudoir & Fisher, 2010). Individual outcomes may be psychological or behavioral and may relate to distress, functioning, progression or resolution of illness. Dyadic outcomes are interpersonal and include intimacy and trust (Chaudoir & Fisher, 2010). Social contextual outcomes are related to culture and stigma and those that define the normal context of disclosure (Chaudoir & Fisher, 2010). For example, a patient who disclosed their SGM identity and experienced a positive reaction

by the HCP might receive culturally relevant and clinically appropriate care including referral to a community agency and enhanced social support. Together, this combination of long-term outcomes may lead to positive health outcomes.

Lastly, a feedback loop supports the dynamic process of disclosure and is represented by two main schemas. First, an upward spiral moving through the process enhances disclosure, while a downward spiral results in concealment. The DPM guided the exploration of SGM and providers' experiences and perceptions related to disclosure of SGM identity during a healthcare encounter.

Research Questions and Propositions

Research questions were:

For SGM informants:

- To what extent does the DPM explain disclosure of SGM identity to HCPs?
- How do DPM concepts explain disclosure of SGM identity to a HCPs?
- How do SGMs perceive the provider's response to disclosure of SGM status?

For HCPs:

- How does the provider perceive disclosure of SGM identity was facilitated during a patient encounter?
- How did SGM identity affect patient care?
- How do HCPs respond to disclosure of SGM identity?

Theoretical propositions serve to guide a study (Yin, 2018). Theoretical propositions examined during analysis of the data included: (a) SGMs who have approach-focused antecedent goals are more likely to disclose SGM identity; (b)

variation in outcomes from disclosure of SGM status to a HCP are affected by mediating processes; (c) as a mediating process, alleviation of inhibition can lead to improved psychological and health outcomes; (d) as a mediating process, social support and alleviation of inhibition are linked and can lead to improved health outcomes; (e) as a mediating process, changes in social information occur when disclosure occurs having a direct impact upon behavior of both the SGM and HCP; and (f) long-term outcomes from successful disclosure of SGM status to a HCP are a product of antecedent goals, the disclosure event, mediating processes and the continuous interplay of each.

Methods

This study used a comparative, multiple case design. A case study is appropriate when a research question logically forms into the how or why a particular phenomenon occurs (Yin, 2018) and was used to explore disclosure of SGM status during the health care encounter. A multiple, comparative case study offered the advantage of being able to understand contextually and inform regarding the complexity of the event from the perspectives of both SGMs and HCPs and allows for exploration of differences between cases where comparisons can be drawn (Baxter & Jack, 2008; Yin, 2018). As one of the central constructs within the DPM, the disclosure event was examined and resultant themes from the study were applied considering goals, mediating processes, the decision-making process and outcomes. The multiple case study approach provided perspectives from a variety of SGM sub-group informants, physicians, physician assistants and NPs. The cases were examined individually, as a group, and then compared.

Ethical Considerations

This study focused on a vulnerable population and explored the highly sensitive phenomenon of disclosure of SGM status to a healthcare provider. Institutional Review Board (IRB) approval was obtained from the universities where the first author was enrolled and employed. See Appendix F and G. Informants provided signed consent.

Cases and Setting

Yin (2018) suggests that for case study design the number of case replications be considered rather than actual sample size. Two or three cases are acceptable when the theory is straightforward. For the purpose of this study two cases, SGMs and HCPs were deemed sufficient and each case included subgroups. Twelve SGM and seven HCP informants were interviewed. A recruitment flyer (Appendix H) was circulated through community organizations serving SGMs. SGM individuals were interviewed to explore their individual experiences of disclosure and the context in which it occurred. Snowball sampling followed to maximize the ability of the researcher to reach a variety of informants from each group. HCP informants comprised a convenience sample and were recruited via a recruitment script (Appendix I). A twenty-five-dollar gift card in a gesture of appreciation for participation was provided to all participants. Interviews took place at locations convenient for the informants while assuring comfort and allowances for privacy.

Measures

Demographic information was gathered from both SGM and HCP informants (Appendices J and K). Members of SGM and HCP were interviewed using semi-structured interview guides specific to each group. See Appendices L and M.

Procedures

A high-quality, digital audio recorder was used, and recordings were professionally transcribed and verified by the first author. Field notes and a reflective journal were kept. The interviews occurred in one sitting. After the interview, member checking validated results; informants were asked to reflect on what was said, and clarify as needed. The researcher contacted one informant for additional information.

Attention to four suggested tests enhanced rigor (Yin, 2018). Construct validity was enhanced by the predetermined identification of issues or concerns prior to data collection. A code book was created to illustrate themes. A clear operational definition of disclosure, the event of disclosing SGM status to a provider in that moment of care, was used. Internal validity was enhanced through data triangulation. Multiple sub-groups of SGMs shared experiences and data was be compared to that elicited from HCPs. This process allowed for exploration and understanding of the relationships and events from both perspectives. Investigator triangulation was assisted through the coding and evaluation of the data by an experienced qualitative researcher. External validity was considered through the variation in informants. Triangulation increased credibility and inclusion of subpopulations of informant type promotes transferability. Reliability, or dependability was addressed through both triangulation and through the use of coding with clear documentation. During the readings of the data and through data analysis, as

themes were identified, alternate themes and explanations were considered.

Data Analysis

Analysis was conducted concurrently with data collection and facilitated by NVivo software allowing for visualization of data in different presentations, evaluation of frequency and chronology of events, all suggested analysis strategies (Yin, 2018). As cases were analyzed, data categorization and coding were undertaken to identify patterns. All reasonable efforts to avoid researcher inference or presupposition were considered. Several readings of each transcript occurred.

Findings

Demographics for the SGM and HCP informants appear in Tables 4 and 5. This study sought to elicit SGM and HCP perceptions related to disclosure of SGM identity during a healthcare encounter. Table 3 aligns themes and categories with the DPM concepts and concept components. Data supported some of the DPM concepts and propositions but not all. SGM informants identified Approach-Focused Goals which resulted in disclosure, how positive outcomes were pursued and positive cues that suggested identity disclosure was safe. SGMs also identified Avoidance-Focused Goals to prevent negative outcomes and cues which inhibited disclosure. Disclosure content and HCPs' reactions providers' perspectives were described as well as the Mediating Process, alleviation of inhibition. Alleviation of inhibition suggested positive long-term outcomes and were identified by both SGMs and HCPs such as the potential for improved health. When disclosure was successful and positive, upward spirals illustrated long-standing HCP-SGM relationships. Downward spirals were not fully explored in this

study as SGM informants sought care from a different provider when the threat of stigma or rejection occurred.

Table 4 - SGM Characteristics

	Frequency	Percent
Age (*m* = 34.3, *SD* = 10.2)*		
18-29	4	36.4
30-39	4	36.4
40-49	1	9.1
50-60	2	18.2
Race		
American Indian or Alaska Native		
Asian or Asian American	1	8.3
Black or African American	2	16.7
Hispanic or Latino	1	8.3
Non-Hispanic White	8	66.7
Sexual Orientation**		
Lesbian	2	15.4
Gay	4	30.8
Bisexual	1	7.7
Pansexual	3	23.1
Asexual	2	15.4
Other: Queer	1	7.7
Gender Identity**		
Cisgender female	4	28.6
Cisgender male	4	28.6
Transgender	2	14.3
Non-binary	3	21.4
Genderqueer	1	7.1
Sex assigned at birth		
Female	8	33.3
Male	4	66.7
Relationship status		
Single	8	66.7
Married	2	16.7
Partnered	1	8.3
Divorced	1	8.3
Employment status**		
Self-employed	2	15.4
Full-time	9	69.2
Part-time	1	7.7
Unemployed		
Student	1	7.7
Education*		

College 1 year to 3 years (Some college or technical school)	2	18.2
College 4 years (College graduate)	3	27.3
Graduate school (Advance degree)	6	54.5
Income*		
$0 to $24,999	3	27.3
$25,00 to $49,999	3	27.3
$50,000 to $74,999	2	18.2
$75,000 to $99,999	1	9.1
$100,000 to $149,999	1	9.1
$150,000 or more	1	9.1

*One informant refused to answer
**Informant(s) answered in more than one category

Table 5 - HCP Characteristics

Age*		
31-40	3	42.9
41-50	1	14.3
51-60	1	14.3
61-70	1	14.3
Race		
Non-Hispanic White	7	100
Sexual Orientation		
Heterosexual	7	100
Gender Identity		
Cisgender female	4	57.1
Cisgender male	3	42.9
Sex assigned at birth		
Female	4	57.1
Male	3	42.9
Relationship status		
Single	1	14.3
Married	5	71.4
Widowed	1	14.3
Employment status		
Full-time	6	85.7
Part-time	1	14.3
Preparation		
Nurse Practitioner	5	71.4
Physician	1	14.3
Physician Assistant	1	14.3
Practice type		

Private – solo provider	2	28.6
Community Clinic	2	28.6
Private – 5 or more providers	2	28.6
Private – 2-4 providers	1	14.3
Years in role (m=9.6, SD=6.9)		
0-5	3	42.9
6-10	1	14.3
11-20	2	28.6
20 or more	1	14.3

* One informant refused to answer

Decision-Making and Outcomes Processes

The question of whether or not to disclose one's SGM identity was a common occurrence. One SGM stated, "You're always coming out to someone; every new job, every new friend, every new club, every new class, every new everything. You're constantly coming out. And there's always that little bit of like worry for a second, you know?" However, the process of coming out to an HCP was a unique situation. For SGMs, disclosure of identity to an HCP was a process of weighing risks versus benefits. When disclosure occurred and was positive, the stage was set for positive health outcomes through appropriate sharing. One SGM said:

> It made me feel like I was just a regular person who was talking about my ailments and just trying to get the help that I need. At the end of the day, I think that it's talking about how do I, as an individual, disclose the information that I need? And so, like this is all the deal. 'I'm giving you everything. Here's all my cards.'

Antecedent Approach-Focused Goals

In an effort to achieve approach-focused goals, SGM informants identified several factors that impacted their decision to disclose identity including seeking referrals, considering relevance of SGM identity to the chief complaint and situational factors. In support of the DPM, SGMs also attended to positive cues from the environment and the HCP and described positive affect and approach coping.

Pursue Positive Outcomes

Referrals. Referrals served to support Approach-Focused Goals. Informants asked friends or family members for referrals to HCPs known to be supportive by "asking people" or sought partners' or spouses recommendations, "I went there because that's where my girlfriend at the time went and so she, I was just like, well if she goes there, then again, I'm already kind of trusting." One informant developed a positive relationship with their HCP. As a result, when the HCP referred them to a specialist, the patient, by extension, trusted the new provider. Referrals came via word-of-mouth and searching online. One informant mentioned using Google "…just looking up like low-income trans healthcare…" and social media platforms such as Facebook to communicate with others who had positive experiences with an HCP.

Perceived Relevance of SGM Identity to Chief Complaint. SGMs weighed the perceived relevance of their identity to the chief complaint against potential negative HCP responses when contemplating disclosure. Genitourinary complaints were perceived relevant and prompted disclosure, "…there was a concern that there may be an STD or

something like that you know, or maybe I had unprotected sex or whatever the case may be."

Situational Factors. Situational factors contributed to SGM patients' decision-making. One informant gave providers the benefit of the doubt and disclosed with "good faith" that the provider would respond supportively. Disclosure might not occur on the first visit but after years of going to the same HCP. One SGM indicated she did not disclose her identity during the first visits; however, reported, "I've been going to her since I was, well I've been going to her for over a decade now." However, repeated visits to the same HCP did not guarantee disclosure; some SGMs were still hesitant, "Unless it was a doctor I've been seeing and I was like comfortable with, that I'm not seeing for the first time, I would probably mention it. But I can't be sure of that." Another SGM said:

> I had gone to her for probably three or four years before that and … the only thing I had was physicals, so there was no reason to…we hadn't gotten to anything that might be a cause or you know something that she would need to know.

Attention to Positive Cues. SGMs looked for and identified various cues when deciding whether or not to disclose their identity, "I'm looking for sort of visual cues as well as how somebody talks to me". Visual cues such as materials that referenced SGM health, a flag or posted statements of non-discrimination within the office space were indications that disclosure may be safe, "that's usually my test, though, is like, once I go into an office, I look at it like 'Let me see what's around me.'" The verbiage used on demographic forms demonstrated an understanding of the complexity of SGM identity and perceived as a positive cue, "I mean they actually have non-binary now." Encounters

with clinic staff before HCP interactions provided additional cues as to the likelihood of a positive or negative encounter. However, while there were concerns about staff, it was not as significant as the actual HCP-SGM patient encounter. One SGM individual indicated:

> (Staff interactions) don't play as big of a role to me as my actual meeting with the doctor or whoever, like the PA or the nurse practitioner, whoever ends up coming to see me. If that interaction (with the HCP) feels too tense for me or not open enough or comfortable enough, then that's enough for me to be like, 'I'll probably find somewhere else instead.'

Clinic reputation or previous positive experiences positively impacted decision-making. Planned Parenthood was viewed by SGMs as catering to women and transgender SGMs that have female genitourinary anatomy and as a safe place to receive care. "I think … Planned Parenthood has been across the board really, really great."

Warmth and friendliness served as positive cues towards disclosure. "It helps when everyone generally has a more positive attitude" said one SGM. During the HCP encounter interpersonal cues led to disclosure. One SGM informant said, "And that made me get, 'oh, okay, like she's (NP) open to it. She's okay with the idea of me not having a male partner" thus opening up the dialogue between the SGM and HCP about a genitourinary complaint. The NP assured the SGM patient's comfort and shared explanations and education throughout the exam facilitating continued dialogue.

Positive Affect. Positive affect as applied to SGMs' feelings or emotions about a HCP encounter during which they disclosed their identity was evident. One informant

stated, “I mean, she was very like non-threatening about it so I mean I think that put me at ease. You know, it was not, there were no judgments or anything else like that.” Another said:

> She came in and of course she was super friendly, she walked me through everything and she just made sure like from that point, from the point of meeting me, she was ensuring that I was comfortable with the whole process.

Approach Coping. Approach coping was described. One SGM who identified as pansexual and listed sex at birth as female said, “I was married for a number of years to a woman and we did try to have a baby. And, in doing that, required the help of several doctors.” She moved on to describe the prelude to one of those encounters, “And so, I remember us having like a pep talk beforehand and like being in the car (my partner said), ‘It’s gonna be okay. And even if they’re jerks, we’ll just go somewhere else and we’ll find someone.”

Antecedent Avoidance-Focused Goals

Prevent Negative Outcomes

SGMs who held avoidance focused goals believed that the risk of rejection or judgment by the HCP if they disclosed outweighed inadequate or inappropriate treatment if they did not disclose their identity. These informants, focused on preventing negative outcomes, described anticipated HCP negative reactions, safety concerns, non-relevance of identity to chief complaint and assumptions about the HCP. The environment, communication, and geographic location contributed to negative cues. SGMs also shared negative affect and avoidance coping.

Anticipated HCP Negative Reactions. SGMs reported that anticipated HCP messages of shame and disapproval served as a deterrent to disclosure and recognized care might be delayed: “So then, I was just like, alright you know, it’s going to deter me from moving forward in a probably medically necessary pace if I feel harmed by the words or shunned or shamed.” Another SGM stated, “But for some reason, in this case, I just felt, I don’t know, maybe I felt like I was going to be judged or treated differently, or unfairly.”

Safety Concerns. There was a resounding concern that disclosure might jeopardize safety. References to the current sociopolitical environment were evident, “There are people who outright hate gay folks, that’s their thing. It happens, legit.” The statements were even more pronounced when transgender and non-binary references were made: “I think that’s why if we look at the mortality rate of well, transwomen of color but also women of color in general, that they don’t get the support that they need” and “I think it’s because for trans folks, especially, it’s just so scary out there.” Informants felt threatened emotionally and physically, “there are still people who react badly and there is still a lot of violence and hate and judgment and things that happen” and medically, that is, whether they would receive safe care. Non-binary and transgender informants were concerned whether hormone therapy and other medications were safe if taken together. Fear escalated when the provider was unable to answer questions but asked to be informed of “any problems.” One SGM stated, “I mean, I’m mostly just worried that I’m gonna end up like taking something that’s not going to go well with all of this stuff. So, I just, I don’t know.”

Perceived Non-Relevance of Identity to Chief Complaint and Illness Severity. If the SGM did not perceive that SGM identity impacted health or reason for the visit, they did not risk disclosure and an unsupportive response. This SGM said:

> I guess it just (extended pause) I guess I just didn't see how being gay was important for having, you know, a cold or some sickness or illness. I didn't see a connection there and it (identity) felt like a personal thing so it's like something that I wouldn't have brought up.

Another SGM considered severity of illness when weighing the cost and benefits of disclosure. This informant, perceiving they had the flu felt terrible and in seeking treatment reported they would "choose my battles" opting for non-disclosure.

Relevance to Healthcare Visit. Relevance of SGM identity to the patient's chief complaint was a consideration for disclosure. One SGM said:

> Now I also, to add mud to the water of this, I'm gray asexual, so I'm…and pansexual, so I'm not usually attracted to other people. But when I am, it could be anybody, is basically how I explain it. So for me, as well, just the whole idea of what sexuality or sex is not generally on my brain anyway. And since I'm not firmly sexually active it's, again it's doubly not on my brain at all…So I think I'm doubly like insulated from it being relevant because it's like it's just not a thing that even occurs to me a lot of the time.

An HCP stated their perspective in a similar circumstance:

> Everyone on the establish care visit is asked about…last menstrual cycle. (I) noted in the chart patient was not on any contraceptive, wanted to rule out

> pregnancy, asked patient form of contraception. (The) patient told me then, 'don't worry about it.' Then I asked patient…explained to patient if you are sexually active without contraception you may get pregnant. Patient said, 'I don't have sex.'

In some cases, SGMs were aware there was a need to disclose due to direct relevance of identity to the reason for encounter such as the case of mastectomy, the SGM said, "And then, in addition, somebody else who had top surgery was saying they had drain problems and needed to go back," for care.

SGM Assumptions and Expectations about HCP Encounters. SGMs expected providers to lack understanding regarding SGM healthcare issues, encounter outcomes and the HCP-SGM relationship. "You (HCP) should be able to help them (SGMs). And with that, that means that you (HCP) should at least understand the kind of community that they are coming from." Transgender informants experienced this more distinctly; "…people are still trying to wrap their heads around what transgender is and that it can have so many faces" and thus had low expectations of HCPs. Repeated untoward experiences with a HCP resulted in low expectations, "So I could see how that could be detrimental in someone else, but me, I don't know, it just is a fact to where I don't even think about it anymore." This SGM further described seeking care elsewhere when expectations were not met.

Assumptions were sometimes related to ongoing care. In one case, a transgender informant assumed that if they educated a surgeon as to their identity the physician would still "do a good job, that's his oath" but continued saying, "But still those are some of the

worries (that the HCP will not provide adequate care) that play in your mind." This narrative illustrates SGMs' assumption that HCPs will provide appropriate ongoing care, yet there is always a bit of apprehension.

Attention to Negative Cues. The physical environment, HCP communication and geographic location were negative cues SGMs identified.

Physical Environment. Various environmental cues served to inhibit disclosure. Religious symbols or jewelry and conservative magazines or pamphlets were not conducive to disclosure. One SGM informant reported seeing a religious symbol in the office suite, "And I can remember being like, 'Oh, maybe this provider's very religious if this stuff is everywhere' and thinking that created a barrier, also for me, in like disclosing if I wanted to…'"

HCP Communication. SGMs focused on how a HCP communicated with them. One HCP reportedly used the terms "dude" and "bro" when trying to make a transmale patient comfortable. This informant described their preferred outward appearance as masculine yet identified as non-binary in terms of gender. The HCP's communication illustrates a failed affirmation attempt deemed inappropriate and uncomfortable by the SGM. Failed attempts at affirmation by a HCP resulted in a perceived misfocusing of the attention to the HCP rather than the SGM. One SGM explained:

> I think people (HCPs), like me to over apologize when somebody says, Oh, you messed up. And then it's just like, I'm sorry, I'm sorry, and again, I'm sorry. And so having to sit through that where emotions and affect then get re-centered on the

person (HCP) who made the mistake instead of it being centered on me, at the receiving end.

This type of communication was viewed as uninformed and a barrier to disclosure. SGMs gave credit when there is an authentic attempt; one SGM said, “And bless their heart for trying but still getting it wrong.”

Geographic Location. Geographic location of the clinic and HCP practice influenced disclosure. Texas and the South were seen as challenging; “moving from California to Texas, I was very nervous about finding a doctor” and “in Texas the way people can be very friendly and nice but then still their judgements or biases come through in things they say”. Another informant commented, “I grew up in a military community in southeast Georgia, a very southern environment, very Christian oriented.” This SGM shared how the south is perceived as a non-disclosure-friendly environment.

Negative Affect & Avoidance Coping. SGMs that experienced negative cues experienced negative emotions, which, at times resulted in avoidance coping or not seeking care when sick. One SGM who disclosed their identity only to have the HCP dismiss their healthcare concern as being a valid complaint said:

> I was so outraged (by the HCP’s response) and also felt just so small and just like concerned. And, I just felt like I needed to get out of there as quickly as possible ‘cause it was just so uncomfortable.”

Negative affect had healthcare implications, simply put by one transgender patient:

> So you end up becoming more introverted in a way and suffering internally and allowing yourself to suffer medically because you’re like, ‘I’m sure I can like go

get this cold checked out but like I really don't want to put myself through that emotional turmoil of feeling so alienated and having to put my old birth name, put my old gender, and all of those things' so it becomes very upsetting.

Other informants simply avoided opportunities for disclosure. Rationales such as "and I just chalked it up to, 'I'm just too busy with work that I don't have time to find a doctor right now'" were used. Another SGM described her strategy, "Well, if I just don't say I have a girlfriend, then they're not really gonna pry too much into it."

Disclosure Event

The disclosure event as illustrated by SGM cases highlighted similar themes. Depth, breadth and duration of disclosure and HCP responses were described. The determination of relevance to SGM visit and reaction of the HCP also were shared. SGM informants did not identify emotional content related to the disclosure event.

Depth, Breadth, and Duration of Content

HCPs stated that SGM patients, "…use terms like partner or spouse" or "a coded language almost which can be a useful cue" but may also be a method of testing the HCP's response. In cases of transgender or non-binary identities, SGMs may disclose identity, but the necessity of disclosing transition status is more difficult. One HCP said, "And it was challenging whether to figure out if the patient had identified as a male and was born female or was born female and identified as a male." When the duration and breadth information disclosure happened over repeated visits one HCP said, "I think there's, I'd say, relief that they feel comfortable telling me. And so then I can therefore

move forward and help them completely with whatever their needs may be, why they're here." The comfort disclosing extended breadth as well as duration of information shared.

HCPs and Disclosure

HCP reactions were reported as warm, negative or neutral. HCPs used the chief complaint, assessment, intake forms, and asking questions in response to the disclosure or non-disclosure event. HCP described the need for disclosure, disclosure, and non-disclosure events. Responses included **"**I would ask if I think it became pertinent to the discussion or the course of diagnosis and treatment" and "Being in urgent care, a lot of times it doesn't matter, cause I'm here for an urgent condition that's usually related to frequently upper respiratory or digestive."

HCP Reactions. SGMs described three HCP reactions: warm, negative, or neutral in response to disclosure. One SGM spoke to a negative response from the HCP and staff, "I mean I had other bad experiences that day there, that were not related to this specifically, but I was just, I was so angry. Because I've had it happen multiple times…" A positive response after disclosure was illustrated by this SGM's comment, "I think, okay like this is my first go-round with all of this and she's making sure every step of the way I'm okay. That helped."

A neutral response was not found helpful by SGMs; however, SGM informants inferred situational insight into the HCPs perspective. One SGM commented:

> But when I come out to somebody, specifically, and what I get back from them is a sense of neutrality like that. I don't read it as negative, but I don't read it as positive, so it feels neutral. It feels more like, Okay, they're just being

> professional and doing their job and they're not, there's no extra sense of like personal warmth or like trying to make me feel comfortable.

SGM informants also understood the realities of healthcare as one noted "(the HCP) … is probably trying to do the best that they can within 10-15 minutes" when explaining a seemingly equivocal reaction.

HCPs' responses were both personal and empathetic towards SGM patients, "I felt grateful that he was honest about it, and then I felt empathetic to him because I'm sure that there is a stigma and he needed to be treated properly." Another HCP commented:

> It made me feel good about myself that I had an individual that was open minded to disclose that information to me and trusted me as a provider to help take care of him...having that patient come in and choose you, you know, it just kinda gives you a little reassurance that you're on the right track in that particular situation. I felt great about it. And then after the visit, I left there (work) with a good feeling inside.

In the context of providing care, HCPs described emotional reactions or responses and were indicative of satisfaction in providing appropriate care. HCPs expressed gratitude for the SGMs' honesty:

> At least that's how it made me (HCP) feel because I would want somebody (the patient) to see me and I wouldn't want to be reflected on as a judgmental person…I felt great about it.

Assessment. In the context of disclosure or non-disclosure, HCPs found assessment of SGM identity challenging. An illustration of this was offered by one HCP when reflecting upon an encounter where disclosure successfully occurred, "I didn't know if the patient was male and identifying, was born a male identifying as a female or was born a female identifying as a male. It was just difficult to assess just by putting eyes on it."

Intake Forms. Disclosure was sometimes facilitated when the HCP reviewed intake forms although one HCP said, "I think we have a long ways to go on refining the questions on the forms." Another HCP indicated disclosure occurred because of charted information which was incomplete and unclear and said to the patient, "Hey, you know I understand that you identify as a male, but let's talk about your biological anatomy." HCPs recognized the need for education about verbiage on intake forms and how to ask questions to obtain a full understanding, "I personally believe that other than definitions of LGBT, educational-wise that you could probably do better in the curriculum on how to approach some clientele."

Chief Complaint and Symptoms. Identification of potential SGM status was prefaced by the chief complaint(s), particularly those of a genitourinary nature. HCP comments such as "I approached that from the high likelihood that there was some kind of like a penile-anal intercourse that was going on and that they were worried about this particular exposure". The HCP went on, "Based on symptoms (provided by this) young male and it was for rectal herpes. I didn't know the male prior and so that felt, you know, I felt based on his symptoms, it gave me more reassurance to ask the question." However,

HCPs were concerned about being perceived as offensive in asking questions of a sensitive nature. This concern was mitigated however, when there was a need to address a chief complaint associated with a high-risk behavior: “And, I felt confident asking the question versus being offensive.”

Asking Questions. HCPs indicated that inquiring about SGM identity was challenging. One offered “But I think the hardest thing for me is how do you break that barrier in a conversation?” Others said, “even though you’ve identified (SGM identity) prior to going into the assessment, feeling comfortable on the appropriate questions to ask is a big deal” and “…should I go out and outright ask them?” Various approaches were shared “I try to use very neutral language with everybody”. When the best method of questioning was not clear an alternate approach was undertaken. For example, one HCP described a situation where an SGM identity was assumed, but knowing which question to ask to confirm was problematic. Only by reviewing the medication profile which included hormone therapy did the HCP realize that the patient identified as transmale

Mediating Processes

Alleviation of Inhibition. When alleviation of inhibition occurred, it was a positive experience. Informants indicated even after repeated visits, there was relief when disclosure occurred and the HCP’s response was positive, “she did all the rights things for me, at least, to want to open up and be, feel comfortable and be okay.” As another SGM informant stated, “Okay, now we can focus on the problem at hand.” Supportive responses from HCPs after disclosure resulted in making future encounters easier to navigate, “It felt nice. And that’s like the best way for me to put it” and “That was by far,

like probably the best and only appointment that I can think of (when I disclosed) and I refer back to in my mind of like that was probably the best type of appointment I ever had." One provider reported, "I think there's, I'd say, relief that they feel comfortable telling me. And so then I can therefore move forward and help them completely with whatever their needs may be."

Social Support and Changes of Social Information. Lack of disclosure prevented social support while social support was facilitated by disclosure. One SGM stated, "…she kind of talked to me in a way that I found condescending" which prohibited disclosure for this patient as well as a sense of social support and change in social information: "I left feeling like she didn't know me". On the other hand, another SGM reported "I shared with him that I was gay and he was so cool. I felt like we really connected and he understood where I was coming from."

Social information impacted perceptions of HCPS and SGMS. One SGM had a negative experience with a new HCP in the clinic owned by her PCP. This SGM shared her concerns with her PCP at the next visit, and explained, "it didn't turn me off from going to my doctor's office because I love my doctor." In this case, the SGM described an ongoing relationship with the HCP and subsequent good health outcomes. Social information impacted one HCP's behavior and interactions with one SGM. The patient never overtly disclosed that he was gay; however, the physician inferred identity based on the chief complaint of anal discomfort diagnosed as anal herpes. This social information led the HCP to question the patient "This is all consensual you are not doing this for any other reason than that's just a lifestyle you chose to practice".

Disclosure and Long-Term Outcomes

Individual, Psychological and Behavioral Health Outcomes. Recognition of the impact of disclosure on health outcomes was evident. In discussing physical and mental health outcomes based on the knowledge of existing disparities, one HCP stated, "But as far as their health and holistic human wellbeing, I just want to be able to help them where they are now" and "if that information (SGM identity) is not disclosed then I think it puts them at higher risk for poor outcomes." There was an acknowledgement of life's circumstance in being of a SGM and how that affected care from both physical and mental health perspectives. For example, a HCP related his concern for a transfemale patient:

> My biggest concern for her was knowing that there was probably going to be more of a struggle with some of the psychological aspects, you know, to make sure that there wasn't any issues with, severe issues with anxiety. Most importantly, I mean more importantly, with depression and any thoughts of suicidal ideation.

From the SGM perspective, good experiences fostered ease in seeking care. One transgender SGM said, "So, I've had lots of experiences where clearly they've been trained or they have just tons of experience with trans folks and it's been really, really good. So, for the most part, my care has been pretty good!"

Dyadic Outcomes. Dyadic outcomes were specific to liking, intimacy and trust. The HCP informants clearly articulated a positive relationship between disclosure and connecting with the patient. Comments such as "when they do disclose the information, I

think that lets down a huge barrier" suggesting a sense of trust and intimacy. One SGM described his ongoing relationship with his NP and a discussion about pre-exposure HIV prophylaxis for which he had a contraindication, "And we've had that conversation, too, in the past…All that kind of stuff, she's gone through all that in the past. But she's like, you still need to wear condoms." In this case, the SGM trusted the HCP and thus felt comfortable having a conversation about an intimate topic. A SGM who had disclosed their identity stated, "well, I've been going to her for over a decade now" signifying a level of trust in the provider.

Social Contextual Outcomes. Social contextual outcomes relate to stigma. The data from both types of informants indicated a willingness to learn, accept and understand. One HCP provider said:

> And so I think the hardest point in that situation is knowing what questions, what neutral or unbiased questions to ask without trying to offend anybody. I don't know if being offensive is the right terminology, but being able to assess them and offering the care that they deserve but being able to identify their sexual orientation because that plays an important role….

HCPs were aware of health disparities faced by SGM patients. One HCP described a young gay male who had repeated visits related to unprotected anal sex. While addressing risk through educating the young man about sexually transmitted disease including human immunodeficiency virus, the HCP addressed an additional concern about the behavior by "asking if it's consensual." In this case, the HCP was

concerned about the amount of sexual activity and wanted to be sure that the SGM was not being victimized.

SGMs are aware their identities are sometimes complex or complicated. One SGM explained:

> And so what we see is that oftentimes, even when people move us out of the cisgender of binary or man and woman, what feels natural to them or really what is blurred to be comfortable is that they just automatically from cisgender man and women if they agree to transgender man, woman. And so they continue these binaries even when we get outside of this heteronormative man or woman box….I walk into your office and you're like, 'wait, I don't understand. Okay now I gotta go back to the books.' And then you go back to the books and there's nothing in the books.

Feedback Loops

Feedback loops provided opportunities for further disclosure. When SGM-HCP encounters were neutral, repeated visits resulted in deeper levels of disclosure and SGM-HCP relationships. One SGM informant stated, "They (the HCP) still looked a little perplexed but they moved on and decided to prescribe me the meds that I needed to feel better" when describing an encounter where transgender identity was disclosed. Another, SGM who identified as lesbian, shared positive outcomes and experiences with her HCP "My doctor and Nurse Practitioner were amazing the whole time." Data did not address the negative feedback loop described within the DPM. In most cases, if a negative experience occurred, the SGM would not return, but would seek care elsewhere.

Additional and Unexpected Findings

The narratives from both SGMs and HCPs shared themes and included geography, language and communication. SGMs identified geographic location as a criterion in referral and was a factor when weighing risks and benefits of disclosure. HCPs were aware of the social context of rural environments and the possibility of providing a level of protection, "…that (being seen in a small town) kind of gave her some anonymity because she wasn't around, she wasn't so much close to her family at that point."

Intake forms were discussed across informants. Inclusive intake forms were a cue to SGMs that the environment was safe or open; however, SGMs pointed out that the HCP must make use of the tool. HCPs were aware of how assessment including intake forms contributed to identification of SGM status.

Both groups struggled with different sides of the disclosure issue. SGMs struggled with the question of whether or not to disclose identity:

> It's kind of complicated because, uh 'cause I feel like it's something important to me and if it was necessary that they should have asked me and they didn't then I'd just be confused because I feel like I would want to say something but don't know that I would in the situation…I would feel weird bringing it up.

HCPs struggled with the dilemma of whether or not and how to ask about SGM identity. An HCP described a case where he was very sure of a SGM identity but stated, "I'm afraid if I just straight out ask them they may want to lie to me" and went on to say "So I'd rather assume that it (a SGM identity) might be there" in an effort to provide

appropriate care. Both SGMs and HCPs recognized the benefits of disclosure and desire for it to occur. HCPs were aware and sensitive to SGMs' needs while SGMs were willing to adapt to HCPs' competency deficiencies while expecting HCPs to engage in learning. This is illustrated by a SGM comment, "non-binary folks are well practiced at having to give people grace and compassion more than sometimes what they earn from us."

Both SGMs and HCPs recognized that HCPs lacked education and competencies to care for this population. One SGM commented as a suggestion to HCPs, "Attend an hourly training. Go work with health educators to know like what issues, what does the gay community go through?" After an encounter with an SGM, one HCP commented regarding her lack of knowledge:

> The rest of the day, it's kind of…she was the one that made me go out and look and research and see if I was missing on any piece of that puzzle for-in order to provide comprehensive care. I just don't think we're educated enough on how to approach it with unbiased questions…I think the education in the actual school is probably lacking…provider should be well versed in that verbiage, other than definitions of LGBT.

Another HCP said, "…we can help students learn how to approach that in a non-offensive, caring and non-biased way." The HCPs also indicated the need for education on soft skills along with clinically relevant care, "we should learn more about the effects of the medications that are used in, particularly transgender, but you know the disparities with screening, chronic screenings."

HCPs and Cultural Humility. HCPs portrayed cultural humility. “It has to do with personal feelings and beliefs that people bring into their everyday practice. And again, understanding that those have no place in what we do” stated one HCP when describing caring for SGM patients. It appears, “the key is to be open minded and to approach that patient in an unbiased way because if you don’t, they will close off and then they won’t take the advice or recommendations that you give them” and illustrates the relationship between approach and outcome. Some HCPs recognized personal biases, “I also have stereotypes that I am guilty of”, “we’re all judgmental” and finally, “I think realizing that’s (personal biases) the first step and then I think making steps to improve that and that’s something that you continue to work on for the rest of your life.” Cultural humility was positively illustrated when one HCP told a SGM patient, “I don’t have expertise in this, but I want to open up a friendly environment for you.”

HCPs are Concerned about Offending All Patients. One HCP described being concerned about shutting down dialogue with a heterosexual patient if they incorrectly assumed that the patient belongs to a SGM. This HCP spoke to this difficulty in communication when he said:

> How do you approach it? Do you say you know? Do you use you know gender inclusive language? Or whether or not it is yours to know? Are you in a romantic relationship? Or, do you have a partner? versus, are you married? And so, I just…and then I think we talked about it briefly, I think and then you go in to the 60-year-old males who’s (assumed) heterosexual and ask them if they’re married? And you know, offensive to them as well. So I think it’s a tough situation.

Strengths and Limitations

The exploration of multiple cases from both the SGM patient and HCP perspectives is a significant strength of this study. The methodology of multiple case study can enhance credibility of findings (Hentz, 2012). Use of both SGM and HCP informants and inclusion of sub-groups provided triangulation. Additionally, this approach offered a unique perspective of the disclosure event when evaluating the event from both SGM and HCP perspectives. Use of the DPM as a theoretical framework is another strength (Chaudoir & Fisher, 2010). Examining the event of disclosure within the context or backdrop of the model's paradigm afforded a contextual frame of reference for the narratives of the experiences of the SGM and HCP informants.

Two cases, SGMs and HCPs and subgroups within each case, provided replication. Twelve SGM informants provided a variety of cases in age, sexual orientation and gender identity. However, the cases were largely non-Hispanic white, and sex assigned at birth, female. The SGMs were also largely educated at the college or graduate level. Seven HCP informants were mostly NPs with one physician and one physician assistant. These cases provided a mean of 9.6 years in the provider role with a mix of gender, and practice type. HCP informants were also non-Hispanic white and heterosexual. The HCPs were willing to discuss SGMs suggesting they were more open and aware and sensitive to SGM identities and health issues. The informants were recruited from a large metropolitan area which limits transferability. The qualitative and case study approach does not provide for explanation of causality.

Discussion

The DPM was applied to explore disclosure from both the SGM patient and HCP perspectives. The DPM supposes a confidant within the disclosure event construct (Chaudoir & Fisher, 2010). Study findings largely supported the DPM. The data supported the DPM's perspective from the stigmatized identity, in this case, the SGM patient. While inclusion of the HCP allowed for a more robust evaluation of the disclosure event, the model appears insufficient in explaining the full context of the HCP perspective outside of the disclosure event. Further models should be explored for inclusion of both the concealable stigmatized identity and confidant perspectives. The study examined perspectives of both yielding themes from both explored similarities and shared themes; however, not all findings were represented in the model and not all model constructs were evident in the data.

As SGM informants navigated the disclosure process, antecedent goals were considered and the data supported the DPM constructs of approach or avoidance focused goals. Approach or avoidance goals were evaluated including geographic location, relevance of SGM identity to the chief complaint, observation and evaluation of environmental and interpersonal cues, threats, communication, and provider characteristics. The data supported the pursuit of positive outcomes, a positive affect and approach coping as themes which are each consistent with the model's approach focused goals. Themes suggesting avoidance focused goals were clear in terms of prevention of negative outcomes, that is, SGMs' attention to negative cues, a negative affect and

avoidance coping. Ultimately, SGM patients weighed the risk of negative HCP response with potential benefits of positive health outcomes.

The DPM disclosure event illustrates the encounter between by an SGM to an HCP. SGMs may fully disclose or "test the waters" incrementally dependent upon cues. Additionally, the depth of disclosure was dependent upon the negative or positive response of the HCP. In many cases, a neutral response from the HCP was difficult for SGMs to interpret; was the response truly neutral, or negative?

The construct of mediating processes was also supported. Once successful disclosure occurred, there was an alleviation of inhibition for some SGMs. Based on the data, social support or changes in social information components of the model were not as clearly evident.

Long-Term Outcomes represented in the DPM were described by both SGMs and HCPs. Improved physical and mental health were suggested; however, concrete examples were not described. Dyadic outcomes involve liking, trust and intimacy between the SGM and HCP. An ongoing SGM-HCP relationship does not an assure liking, trust and intimacy; however, data suggested sufficient levels that encouraged the SGM to return for future visits.

Study findings suggested geography was a precursor to disclosure. It appears the sociopolitical context of being SGM in conservative states or regions of the country may translate to the SGMs' unwillingness to disclose. One previous study of disclosure among rural versus non-rural lesbians found those in rural settings had higher rates of non-disclosure (Barefoot et al., 2016). Providing a welcoming, safe environment might help

compensate for geographic location. Efforts to address discrimination and structural stigma should be targeted by individuals and professional organizations via policy efforts such as antidiscrimination policies specific to the healthcare delivery. For example, strategies to enhance diversity in HCP education, requiring education and training about SGM populations, and specific strategies to addressing known disparities in housing and violence prevention.

Consistent with the literature was the need for further education surrounding SGM cultural and clinical competencies and efforts to promote cultural humility. Lack of education must be addressed and begs the question of when institutions will address curriculum changes. There is an urgent need for further research and continuing professional education related to SGM healthcare needs.

Moving Forward

The results of this study support recommendations from organizations such as the Gay and Lesbian Medical Association's published guidelines for caring for SGM patients (Gay and Lesbian Medical Association, N.D.). These guidelines suggest many of the strategies found within the narratives of the SGM informants such as staff sensitivity, inclusionary intake forms, and creating a welcoming environment with affirming cues. HCPs should review the guidelines and implement them within their clinic settings as much as possible. Interpersonal cues affected informants' decision-making regarding disclosure. Findings support previous research which suggested that the environment can be enhanced by the use of language, a warm affirming attitude toward SGM clients, and clinical competence (Keuroghlian, Ard, & Makadon, 2017). SGM sensitive brochures,

signs or posters and a clearly visible non-discrimination statement provide cues that it is safe to disclose identity (Gay and Lesbian Medical Association, N.D.).

The cases provided rich data surrounding the phenomenon of disclosure of SGM identity. Further research is necessary. More research with diverse sub-groups of SGMs should be considered. Alternate geographical locations should also be explored. While this qualitative study provided much insight, it is clear that research on specific interventions to increase disclosure and enhance HCP-SGM relationships is critically important in closing the gaps in health disparities and improving health outcomes. While the DPM was supported, other theories embedded in interaction should be considered when evaluating the decision-making process as applied to disclosure of SGM identity.

The phenomenon of disclosure as experienced by members of SGM groups and through the experiences of healthcare providers is a critical juncture to achieving maximum health outcomes through the HCP-SGM patient relationship. Data indicated there were connections to health disparities within the SGM groups as a whole and within subgroups. To reduce health disparities, SGM patients must be able to disclose their status to healthcare providers. Then, the healthcare providers can tailor culturally competent care with an appropriate approach to the provider-patient interaction.

References

Aleshire, M. E., Ashford, K., Fallin-Bennett, A., & Hatcher, J. (2018). Primary Care Providers' Attitudes Related to LGBTQ People: A Narrative Literature Review. *Health Promotion Practice*, 1524839918778835. doi:10.1177/1524839918778835

Ard, K., & Makadon, H. (2012). *Improving the healthcare of lesbian, gay, bisexual and transgender people: Understanding and eliminating health disparities*. In T. F. Institute (Ed.). Boston, MA.

Baptiste-Roberts, K., Oranuba, E., Werts, N., & Edwards, L. V. (2017). Addressing Health Care Disparities Among Sexual Minorities. *Obstetrics & Gynecology Clinics of North America, 44*(1), 71-80. doi:10.1016/j.ogc.2016.11.003

Barefoot, K. N., Smalley, K. B., & Warren, J. C. (2016). A quantitative comparison of health-care disclosure experiences of rural and nonrural lesbians. *Stigma and Health, 2*(3), 195-207.

Baxter, P., & Jack, S. (2008). Qualitative case study methodology: Study design and implementation for novice researchers. *The Qualitative Report, 13*(4), 544-559.

Benz, M. B., Palm Reed, K., & Bishop, L. S. (2019). Stigma and help-seeking: The interplay of substance use and gender and sexual minority identity. *Addictive Behavior, 97*, 63-69. doi:10.1016/j.addbeh.2019.05.023

Bjarnadottir, R. I., Bockting, W., & Dowding, D. (2016). Patient perspectives on answering questions about sexual orientation and gender identity: An integrative review. *Journal of Clinical Nursing, 26*, 1814-1833.

Blosnich, J., Farmer, G., Lee, J., Silenzio, V., & Bowen, D. J. (2014). Health inequalities among sexual minority adults: evidence from ten U.S. states, 2010. *American Journal of Preventative Medicine, 46*(4), 337-349. doi:10.1016/j.amepre.2013.11.010

Bonvicini, K. A. (2017). LGBT healthcare disparities: What progress have we made? *Patient Education and Counseling, 100*(12), 2357-2361. doi:10.1016/j.pec.2017.06.003

Caceres, B. A., Brody, A., Luscombe, R. E., Primiano, J. E., Marusca, P., Sitts, E. M., & Chyun, D. (2017). A Systematic Review of Cardiovascular Disease in Sexual Minorities. *American Journal of Public Health, 107*(4), e13-e21. doi:10.2105/AJPH.2016.303630

Centers for Disease Control and Prevention. (2015). *Suicide: Facts at a Glance*. Atlanta, GA: Centers for Disease Control and Prevention. Retreived from: https://www.cdc.gov/violenceprevention/pdf/suicide-datasheet-a.pdf

Chaudoir, S. R., & Fisher, J. D. (2010). The disclosure processes model: understanding disclosure decision making and postdisclosure outcomes among people living with a concealable stigmatized identity. *Psychological Bulletin, 136*(2), 236-256. doi:10.1037/a0018193

Dahlhamer, J. M., Galinsky, A. M., Joestl, S. S., & Ward, B. W. (2014). Sexual orientation in the 2013 national health interview survey: a quality assessment. *Vital and Health Statistics. Series 2: Data Evaluation and Methods Research*(169), 1-32.

Demant, D., Hides, L., White, K. M., & Kavanagh, D. J. (2018). Effects of participation in and connectedness to the LGBT community on substance use involvement of sexual minority young people. *Addictive Behaviors, 81*, 167-174. doi:10.1016/j.addbeh.2018.01.028

Dentato, M., Kelly, B., Lloyd, M., & Busch, N. (2017). Preparing Social Workers for Practice with LGBT Populations Affected by Substance Use: Perceptions from Students, Alumni, and Service Providers. *The International Journal of Social Work Education, 37*(3), 294-314.

Doyle, D. M., & Molix, L. (2015). Perceived Discrimination and Social Relationship Functioning among Sexual Minorities: Structural Stigma as a Moderating Factor. *Analyses of Social Issues & Public Policy, 15*(1), 357-381. doi:10.1111/asap.12098

Durso, L. E., & Meyer, I. H. (2013). Patterns and Predictors of Disclosure of Sexual Orientation to Healthcare Providers among Lesbians, Gay Men, and Bisexuals. *Sexuality Research & Social Policy, 10*(1), 35-42. doi:10.1007/s13178-012-0105-2

English, D., Rendina, H. J., & Parsons, J. T. (2018). The Effects of Intersecting Stigma: A Longitudinal Examination of Minority Stress, Mental Health, and Substance Use among Black, Latino, and Multiracial Gay and Bisexual Men. *Psychology of Violence, 8*(6), 669-679. doi:10.1037/vio0000218

Farmer, G. W., Bucholz, K. K., Flick, L. H., Burroughs, T. E., & Bowen, D. J. (2013). CVD risk among men participating in the National Health and Nutrition

Examination Survey (NHANES) from 2001 to 2010: differences by sexual minority status. *Journal of Epidemiology and Community Health, 67*(9), 772-778. doi:10.1136/jech-2013-202658

Fredriksen-Goldsen, K. I., Kim, H. J., Shui, C., & Bryan, A. E. B. (2017). Chronic Health Conditions and Key Health Indicators Among Lesbian, Gay, and Bisexual Older US Adults, 2013-2014. *American Journal of Public Health, 107*(8), 1332-1338. doi:10.2105/AJPH.2017.303922

Friedman, M. R., Wei, C., Klem, M. L., Silvestre, A. J., Markovic, N., & Stall, R. (2014). HIV infection and sexual risk among men who have sex with men and women (MSMW): A systematic review and meta-analysis. *PloS One, 9*(1), e87139. doi:10.1371/journal.pone.0087139

Gay and Lesbian Medical Association. (N.D.). *Guidelines for Care of Lesbian, Gay, Bisexual, and Transgender Patients*. San Francisco, CA: Gay and Lesbian Medical Association. Retreived from: http://glma.org/_data/n_0001/resources/live/GLMA%20guidelines%202006%20FINAL.pdf

Gonzales, G., Przedworski, J., & Henning-Smith, C. (2016). Comparison of Health and Health Risk Factors Between Lesbian, Gay, and Bisexual Adults and Heterosexual Adults in the United States: Results From the National Health Interview Survey. *JAMA Internal Medicine, 176*(9), 1344-1351. doi:10.1001/jamainternmed.2016.3432

Hatzenbuehler, M. L., & Link, B. G. (2014). Introduction to the special issue on structural stigma and health. *Social Science & Medicine, 103,* 1-6. doi:10.1016/j.socscimed.2013.12.017

Hentz, P. (2012). Case Study: The Method. In P. L. Munhall (Ed.), *Nursing Research: A Qualitative Perspective* (5th ed., pp. 359-370). Sudbury, MA.: Jones & Bartlett Learning, LLC.

Hottes, T. S., Bogaert, L., Rhodes, A. E., Brennan, D. J., & Gesink, D. (2016). Lifetime Prevalence of Suicide Attempts Among Sexual Minority Adults by Study Sampling Strategies: A Systematic Review and Meta-Analysis. *American Journal of Public Health, 106*(5), e1-12. doi:10.2105/AJPH.2016.303088

Hubach, R. D., Currin, J. M., Giano, Z., Meyers, H. J., DeBoy, K. R., Wheeler, D. L., & Croff, J. M. (2019). Experiences of Stigma by Gay and Bisexual Men in Rural Oklahoma. *Health Equity, 3*(1), 231-237. doi:10.1089/heq.2018.0095

Jackman, K., Honig, J., & Bockting, W. (2016). Nonsuicidal self-injury among lesbian, gay, bisexual and transgender populations: An integrative review. *Journal of Clinical Nursing, 25*(23-24), 3438-3453. doi:10.1111/jocn.13236

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:10.1188/15.ONF.44-51

Keuroghlian, A. S., Ard, K. L., & Makadon, H. J. (2017). Advancing health equity for lesbian, gay, bisexual and transgender (LGBT) people through sexual health

education and LGBT-affirming health care environments. *Sexual Health, 14*(1), 119-122. doi:10.1071/SH16145

Macapagal, K., Bhatia, R., & Greene, G. J. (2016). Differences in Healthcare Access, Use, and Experiences Within a Community Sample of Racially Diverse Lesbian, Gay, Bisexual, Transgender, and Questioning Emerging Adults. *LGBT Health, 3*(6), 434-442. doi:10.1089/lgbt.2015.0124

Maragh-Bass, A. C., Torain, M., Adler, R., Ranjit, A., Schneider, E., Shields, R. Y., . . . Haider, A. H. (2017). Is It Okay To Ask: Transgender Patient Perspectives on Sexual Orientation and Gender Identity Collection in Healthcare. *Academic Emergency Medicine, 24*(6), 655-667. doi:10.1111/acem.13182

McNamara, M. C., & Ng, H. (2016). Best practices in LGBT care: A guide for primary care physicians. *Cleveland Clinic Journal of Medicine, 83*(7), 531-541. doi:10.3949/ccjm.83a.15148

Mericle, A. A., de Guzman, R., Hemberg, J., Yette, E., Drabble, L., & Trocki, K. (2018). Delivering LGBT-sensitive substance use treatment to sexual minority women. *Journal of Gay & Lesbian Social Services, 30*(4), 393-408. doi:10.1080/10538720.2018.1512435

Mosack, K. E., Brouwer, A. M., & Petroll, A. E. (2013). Sexual identity, identity disclosure, and health care experiences: is there evidence for differential homophobia in primary care practice? *Women's Health Issues, 23*(6), e341-346. doi:10.1016/j.whi.2013.07.004

Nama, N., MacPherson, P., Sampson, M., & McMillan, H. J. (2017). Medical students' perception of lesbian, gay, bisexual, and transgender (LGBT) discrimination in their learning environment and their self-reported comfort level for caring for LGBT patients: A survey study. *Medical Education Online, 22*(1), 1368850. doi:10.1080/10872981.2017.1368850

Ouch, S., & Moradi, B. (2019). Cognitive and affective expectation of stigma, coping efficacy, and psychological distress among sexual minority people of color. *Journal of Counseling Psychology, 66*(4), 424-436. doi:10.1037/cou0000360

Porter, K. E., Brennan-Ing, M., Burr, J. A., Dugan, E., & Karpiak, S. E. (2019). HIV Stigma and Older Men's Psychological Well-Being: Do Coping Resources Differ for Gay/Bisexual and Straight Men? *Journals Gerontology Series B Psychological Sciences and Social Sciences, 74*(4), 685-693. doi:10.1093/geronb/gbx101

Prejean, J., Song, R., Hernandez, A., Ziebell, R., Green, T., Walker, F., . . . Group, H. I. V. I. S. (2011). Estimated HIV incidence in the United States, 2006-2009. *PloS One, 6*(8), e17502. doi:10.1371/journal.pone.0017502

Reisner, S. L., Katz-Wise, S. L., Gordon, A. R., Corliss, H. L., & Austin, S. B. (2016). Social Epidemiology of Depression and Anxiety by Gender Identity. *Journal of Adolescent Health, 59*(2), 203-208. doi:10.1016/j.jadohealth.2016.04.006

Reisner, S. L., Vetters, R., Leclerc, M., Zaslow, S., Wolfrum, S., Shumer, D., & Mimiaga, M. J. (2015). Mental health of transgender youth in care at an adolescent urban community health center: a matched retrospective cohort study.

Journal of Adolescent Health, 56(3), 274-279. doi:10.1016/j.jadohealth.2014.10.264

Rossman, K., Salamanca, P., & Macapagal, K. (2017a). "The doctor said I didn't look gay": Young adults' experiences of disclosure and non-disclosure of LGBTQ identity to healthcare providers. *Journal of Homosexuality, 64*(10), 1390-1410.

Rossman, K., Salamanca, P., & Macapagal, K. (2017b). A Qualitative Study Examining Young Adults' Experiences of Disclosure and Nondisclosure of LGBTQ Identity to Health Care Providers. *Journal of Homosexuality, 64*(10), 1390-1410. doi:10.1080/00918369.2017.1321379

Ruben, M. A., & Fullerton, M. (2018). Proportion of patients who disclose their sexual orientation to healthcare providers and its relationship to patient outcomes: A meta-analysis and review. *Patient Education and Counseling*. doi:10.1016/j.pec.2018.05.001

Schvey, N. A., Blubaugh, I., Morettini, A., & Klein, D. A. (2017). Military Family Physicians' Readiness for Treating Patients With Gender Dysphoria. *JAMA Intern Med, 177*(5), 727-729. doi:10.1001/jamainternmed.2017.0136

Simoni, J. M., Smith, L., Oost, K. M., Lehavot, K., & Fredriksen-Goldsen, K. (2017). Disparities in Physical Health Conditions Among Lesbian and Bisexual Women: A Systematic Review of Population-Based Studies. *Journal of Homosexuality, 64*(1), 32-44. doi:10.1080/00918369.2016.1174021

Steele, L. S., Daley, A., Curling, D., Gibson, M. F., Green, D. C., Williams, C. C., & Ross, L. E. (2017). LGBT Identity, Untreated Depression, and Unmet Need for

Mental Health Services by Sexual Minority Women and Trans-Identified People. *J Womens Health (Larchmt), 26*(2), 116-127. doi:10.1089/jwh.2015.5677

Sullivan, P. S., Peterson, J., Rosenberg, E. S., Kelley, C. F., Cooper, H., Vaughan, A., . . . Sanchez, T. H. (2014). Understanding racial HIV/STI disparities in black and white men who have sex with men: A multilevel approach. *PloS One, 9*(3), e90514. doi:10.1371/journal.pone.0090514

Underhill, K., Morrow, K. M., Colleran, C., Holcomb, R., Calabrese, S. K., Operario, D., . . . Mayer, K. H. (2015). A Qualitative Study of Medical Mistrust, Perceived Discrimination, and Risk Behavior Disclosure to Clinicians by U.S. Male Sex Workers and Other Men Who Have Sex with Men: Implications for Biomedical HIV Prevention. *Journal of Urban Health, 92*(4), 667-686. doi:10.1007/s11524-015-9961-4

Venetis, M. K., Meyerson, B. E., Friley, L. B., Gillespie, A., Ohmit, A., & Shields, C. G. (2017). Characterizing Sexual Orientation Disclosure to Health Care Providers: Lesbian, Gay, and Bisexual Perspectives. *Health Commun, 32*(5), 578-586. doi:10.1080/10410236.2016.1144147

Yin, R. (2018). *Case study research and applications: Design and methods* (6th ed.). Los Angeles, CA: Sage.

Youatt, E. J., Harris, L. H., Harper, G. W., Janz, N. K., & Bauermeister, J. A. (2017). Sexual Health Care Services among Young Adult Sexual Minority Women. *Sexuality Research and Social Policy, 14*(3), 345-357. doi:10.1007/s13178-017-0277-x

Chapter 5

Conclusions and Recommendations

Three manuscripts compose this portfolio. Each of the manuscripts provides insight into healthcare for SGM people. SGM subpopulations experience health disparities that can be mitigated by a skilled HCP. Unfortunately, disclosure of SGM identity is problematic and SGMs face barriers in seeking appropriate care.

The first manuscript, *Fostering Sexual and Gender Minority Status Disclosure in Patients,* provided an overview of the concept of disclosure in the context of disclosing SGM status to a healthcare provider (HCP) and provided a backdrop for the study completed. The literature reviewed in preparation of this manuscript allowed the researcher to consider what is known about disclosure from the perspective of SGMs. Issues surrounding disclosure from the HCP perspective in terms of educational preparation and preparedness to care for SGM patients were presented.

The second manuscript, *Considering the Needs of Older Sexual and Gender Minority People,* explored the needs of aging SGMs and the context of their experiences. Development of this manuscript provided understanding of SGMs subpopulations' needs. The manuscript was also intended to inform NPs about care of this population and their specific needs.

The third manuscript, *It's always a question for me…: Disclosing Sexual and Gender Minority Status,* is a report of the research study completed. This study was a comparative, multiple case study which examined disclosure of SGM identity during an encounter with an HCP. The study used the DPM as a framework evaluated the DPM's

usefulness. The DPM proved a reasonable framework for evaluating disclosure in the context of an SGM-HCP healthcare encounter. However, the context of disclosure from both SGM and HCP perspectives was not fully described and there may be opportunities for further exploration of rival theories to explain decision-making of SGMs when weighing the risks and benefits of disclosure to their HCP. Additionally, the current research study did not fully elaborate on the long-term outcomes associated with disclosure in terms of a downward spiral. More work is needed to examine that construct.

The research study provides a foundation for continued research into disclosure of SGM identity in the context of a healthcare encounter. The research also demonstrates opportunities to further explore the similarities and possible disconnects between the SGM and HCP perspectives. While the data suggests similarities overall, the perspectives are indeed different. The researcher plans to continue examining SGM health disparities, effects of interventions aimed at increasing disclosure, and within subpopulations.

References

Allen, S. (2017). Just how many LGBT Americans are there? *The Daily Beast*. Retreived from: https://www.thedailybeast.com/just-how-many-lgbt-americans-are-there

Arlee, L., Cowperthwaite, R., & Ostermeyer, B. (2019). Facing stigma and discrimination as both a racial and sexual minority member of the LGBTQ+ Community. *49, 10,* 441-445.

Durso, L. E., & Meyer, I. H. (2013). Patterns and Predictors of Disclosure of Sexual Orientation to Healthcare Providers among Lesbians, Gay Men, and Bisexuals. *Sexuality Research & Social Policy, 10*(1), 35-42. doi:10.1007/s13178-012-0105-2

Greene, M. Z., France, K., Kreider, E. F., Wolfe-Roubatis, E., Chen, K. D., Wu, A., & Yehia, B. R. (2018). Comparing medical, dental, and nursing students' preparedness to address lesbian, gay, bisexual, transgender, and queer health. *PLoS One, 13*(9), e0204104. doi:10.1371/journal.pone.0204104

Jennings, L., Barcelos, C., McWilliams, C., & Malecki, K. (2019). Inequalities in lesbian, gay, bisexual, and transgender (LGBT) health and health care access and utilization in Wisconsin. *Preventative Medicine Reports, 14,* 100864. doi:10.1016/j.pmedr.2019.100864

Lawlis, S., Watson, K., Hawks, E., Lewis, A., Hester, L., Ostermeyer, B., & Middleman, A. (2019). Health Services for LGBTQ+ Patients. *Psychiatric Annals, 49*(10), 426-435.

Meyer, I. H. (2016). The Elusive Promise of LGBT Equality. *American Journal of Public Health, 106*(8), 1356-1358. doi:10.2105/AJPH.2016.303221

Moll, J., Krieger, P., Heron, S., Joyce, C., & Moreno-Walton, L. (2018). Attitudes, behavior, and comfort of emergency medicine residents in caring for LGBT patients: What do we know? *AEM Education and Training: A Global Journal of Emergency Care, 3*(2), 129-135.

Newport, F. (2018). *In U.S., Estimate of LGBT Population Rises to 4.5%*. Retrieved from https://news.gallup.com/poll/234863/estimate-lgbt-population-rises.aspx

Valdiserri, R. O., Holtgrave, D. R., Poteat, T. C., & Beyrer, C. (2019). Unraveling Health Disparities Among Sexual and Gender Minorities: A Commentary on the Persistent Impact of Stigma. *Journal of Homosexuality, 66*(5), 571-589. doi:10.1080/00918369.2017.1422944

Appendix A: Evidence of Manuscript Acceptance in The Nurse Practitioner

Date: Jan 25 2019 04:04:36:407PM
To: "Damon Burns Cottrell" damoncottrell@outlook.com
From: "LWW E-Submissions" andrei.greska@wolterskluwer.com
Subject: The Nurse Practitioner Decision

Jan 25 2019 04:04:30:281PM

RE: lwwesubmissions-D-18-00581R1, entitled "The Event of Disclosure of Sexual and Gender Minority Status: Implications for Nurse Practitioners"

Dear Dr. Cottrell,

After carefully reviewing your manuscript, we're happy to inform you that we feel it will make a valuable contribution to The Nurse Practitioner journal, and that we plan to use it in a future issue.

Prior to publication, we'll send you a copy of the edited version for your approval. Although this may be 12 months or more from now, in most cases it signals that your article has been tentatively scheduled for an issue.

You will also receive complimentary copies of the issue and a small honorarium to share with your co-authors upon publication.

OPEN ACCESS
If you indicated in the revision stage that you would like your submission, if accepted, to be made open access, please go directly to step 2. If you have not yet indicated that you would like your accepted article to be open access, please follow the steps below to complete the process:
1. Notify the journal office via email that you would like this article to be available open access. Please send your Email to Andrei.Greska@wolterskluwer.com. Please include your article title and manuscript number.
2. A License to Publish (LTP) form must be completed for your submission to be made available open access. Please download the form from http://links.lww.com/LWW-ES/A49, sign it, and Email the completed form to the journal office.
3. **Within 48 hours of receiving this e-mail:** Go to http://wolterskluwer.qconnect.com to pay for open access. If you have not previously used this site to place an order, you will need to register for an account (your login will be different from your Editorial Manager login). When placing your order, you will be asked for the following information. Please enter exactly as shown:
a. Article Title - The Event of Disclosure of Sexual and Gender Minority Status: Implications for Nurse Practitioners
b. Manuscript Number - lwwesubmissions-D-18-00581R1

Thank you for your interest in the journal. We look forward to working with you.

https://www.editorialmanager.com/lwwesubmissions/

Your username is: ********
****

With Kind Regards,

Andrei Greska
Publishing Assistant
The Nurse Practitioner

In compliance with data protection regulations, please contact the publication office if you would like to have your personal information removed from the database.

Appendix B: Evidence of Copyright Approval for Dissertation Publication from The Nurse Practitioner

Damon Cottrell

From: "RLP - Journal Permissions" <journalpermissions@lww.com> <journalpermissions@lww.com>
Sent: Monday, December 16, 2019 10:15 AM
To: Damon Cottrell
Subject: FW: Case #00951176 - Request [Case # 02232699] [ref:_00Dd0dixc._5003w1MYeut:_00D30oeGz._5000c1wDolA:ref]

Hello Damon,

Thank you for contacting Wolters Kluwer Permissions Team. Nothing was attached with your original email. Has your article already published?

As the author of the article, you are permitted to use the **final peer reviewed manuscript** (*post peer-review and acceptance for publication, but prior to publisher's copyediting and formatting*) in your thesis/dissertation.

If your thesis/dissertation is being posted to an institutional repository, please ensure the following as per below:

- Post only the final peer reviewed manuscript after the embargo period has elapsed (12 months after publication)
- A link to the final article with the proper citation is included along with the following disclaimer: This is a non-final version of an article published in final form in (full journal citation) *ex: Thomson, Imogen Do Good Medical Students Really Make Good Doctors, Academic Medicine, Volume 92, Issue 6, June 2017, http://journals.lww.com/academicmedicine/Fulltext/2017/06000/Do__Good__Medical_Students_Really_Make_Good.22.aspx*

For additional information, please review the Author's Permission Document

If you have any further questions, please let us know.

Thank You,
Chandreyi

Wolters Kluwer Permissions Team
Health Learning, Research & Practice
permissions@lww.com

Appendix C: Evidence of Manuscript Acceptance in The Journal for Nurse Practitioners

-----Original Message-----
From: em.tjnp.0.6728db.c1cfbf7a@editorialmanager.com <em.tjnp.0.6728db.c1cfbf7a@editorialmanager.com> On Behalf Of The Journal for Nurse Practitioners
Sent: Saturday, November 9, 2019 6:17 AM
To: Damon Cottrell <damoncottrell@outlook.com>
Subject: Decision on submission to The Journal for Nurse Practitioners

Manuscript Number: JNP_2019_265R2

Considering the Needs of Older Sexual and Gender Minority People

Dear Dr Cottrell,

Thank you for submitting your manuscript to The Journal for Nurse Practitioners.

I am pleased to inform you that your manuscript has been accepted for publication.

My comments, and any reviewer comments, are below. Your accepted manuscript will now be transferred to our production department. We will create a proof which you will be asked to heck, and you will also be asked to complete a number of online forms required for publication. If we need additional information from you during the production process, we will contact you irectly.

We appreciate you submitting your manuscript to The Journal for Nurse Practitioners and hope you will consider us again for future submissions.

Kind regards,
Julee Waldrop
Editor-in-Chief

The Journal for Nurse Practitioners

Appendix D: Evidence of Copyright Approval for Dissertation Publication from The Journal for Nurse Practitioners

Re: Permissions Request [200112-000524]

PH Permissions Helpdesk <permissionshelpdesk@elsevier.com>
To Damon Cottrell
1/14/2020

ELSEVIER

Dear Damon Cottrell,

Thank you for your query.

Please note that, as one of the authors of this article, you retain the right to reuse it in your thesis/dissertation. You do not require formal permission to do so. You are permitted to post this Elsevier article online if it is embedded within your thesis. You are also permitted to post your Author Accepted Manuscript online.

However posting of the final published article is prohibited.

*"As per our Sharing Policy, authors are permitted to post the Accepted version of their article on their institutional repository – as long as it is for **internal institutional use only.***

It can only be shared publicly on that site once the journal-specific embargo period has lapsed. For a list of embargo periods please see: Embargo List.

You are not permitted to post the Published Journal Article (PJA) on the repository."

Please feel free to contact me if you have any queries.

Regards,

Kaveri

Permissions Helpdesk
ELSEVIER |Operations

Appendix E: Permission for Use of the Disclosure Processes Model

Damon Cottrell

From: Chaudoir, Stephenie <schaudoi@holycross.edu>
Sent: Monday, July 22, 2019 6:54 PM
To: Damon Cottrell
Subject: Re: Permission to Use

Thanks for reaching out, Damon. You may use the Disclosure Processes Model graphic as long as you cite the associated reference.

Best of luck with your dissertation!
Stephenie

On Sun, Jul 21, 2019 at 12:18 PM Damon Cottrell <dcottrell2@patriots.uttyler.edu> wrote:

> Dr. Chaudoir,
>
> I hope this email finds you well and wrapping up a fantastic weekend! My name is Damon Cottrell and I am in a PhD program at the University of Texas at Tyler. I am about to enter dissertation and am moving forward with a study about disclosure of sexual and gender minority status to healthcare providers.
>
> I am planning a comparative, multiple case study about the event of disclosure in order to explore the decision making in the moments of the provider/patient interaction. This is all within the backdrop of the myriad of healthcare disparities experienced by sexual and gender minorities, the data on "readiness" and preparation to care for them by healthcare providers (MD, DO, NP, PA).
>
> I am hoping to use the Disclosure Processes Model as a framework for my study as it seems a clear fit within the topic and methodology I have chosen. I am seeking your permission to use the model graphic in my dissertation work.
>
> I hope you will consider my request and I am very appreciative of your time.
>
> Respectfully,
>
> Damon Cottrell

Appendix F: University of Texas at Tyler Institutional Review Board Approval

The University of Texas at TYLER

Office of Research and Scholarship

INSTITUTIONAL REVIEW BOARD

uttyler.edu/research ▪ 903-565-5858

November 6, 2019

Dear Mr. Cottrell,

Your request to conduct the study, *Patients' Disclosure of Sexual and Gender Minority Status: A Comparative, Multiple Case Study* IRB #F2019-21 has been approved by The University of Texas at Tyler Institutional Review Board under expedited review, Category 7. This approval includes written informed consent, and your assurance of participant knowledge of the following prior to study participation: this is a research study; participation is completely voluntary with no obligations to continue participating, and with no adverse consequences for non-participation; and assurance of confidentiality of their data.

In addition, please ensure that any research assistants are knowledgeable about research ethics and confidentiality, and any co-investigators have completed human protection training within the past three years, and have forwarded their certificates to the Office of Research and Scholarship (research@uttyler.edu).

Please review the UT Tyler IRB Principal Investigator Responsibilities, and acknowledge your understanding of these responsibilities and the following through return of this email to the IRB Chair within one week after receipt of this approval letter:

- Prompt reporting to the UT Tyler IRB of any proposed changes to this research activity.
- **Prompt reporting to the UT Tyler IRB and academic department administration will be done of any unanticipated problems involving risks to subjects or others.**
- Suspension or termination of approval may be done if there is evidence of any serious or continuing noncompliance with Federal Regulations or any aberrations in original proposal.
- Any change in proposal procedures must be promptly reported to the IRB prior to implementing any changes except when necessary to eliminate apparent immediate hazards to the subject.
- If you are using student emails to distribute surveys, always BCC them to facilitate confidentiality.
- Ensure that any online consent form, whether anonymous or not, always has the IRB# and approval date.
- Submit Progress Report when study is concluded.

Best of luck in your research, and do not hesitate to contact me if you need any further assistance.

Sincerely,

DocuSigned by:
Danita Alfred
2048A99B75A44D...

Danita Alfred, PhD, RN
Professor, School of Nursing
The University of Texas at Tyler

Appendix G: Texas Woman's University Institutional Review Board Approval

Cottrell, Damon

From: irb@twu.edu
Sent: Tuesday, November 12, 2019 9:32 AM
To: Cottrell, Damon
Subject: IRB-FY2020-105 - Initial: IAA Notification Letter

Follow Up Flag: Follow up
Flag Status: Flagged

Texas Woman's University
Institutional Review Board (IRB)
irb@twu.edu
https://www.twu.edu/institutional-review-board-irb/

November 12, 2019

Damon Cottrell
Nursing - Denton

Re: Initial - IRB-FY2020-105 Patients' Disclosure of Sexual and Gender Minority Status: A Comparative, Multiple Case Study

Dear Damon Cottrell,

An IAA for the above referenced study between Texas Woman's University (TWU) and the University of Texas at Tyler (UT-Tyler) has been processed as an expedited study. The UT-Tyler IRB is the designated IRB providing review for this study. According to our records, this protocol was most recently approved by the UT-Tyler IRB on November 6, 2019.

A current protocol file with all correspondence between the researcher and the UT-Tyler IRB must be maintained at TWU. Therefore, you are required to place on file any documentation regarding this study including modifications, extensions, notifications of adverse events, etc.

Although there is no expiration date for this study, TWU is requesting an administrative check-in date of November 5, 2020. A reminder will be sent 45 days prior to this check-in date. If the study is ongoing, you will be asked to submit documentation regarding the status of the study. When the study is complete, a close request may be submitted to close the study file.

If you have any questions or need additional information, please contact the IRB analyst indicated on your application in Cayuse or refer to the IRB website at http://www.twu.edu/institutional-review-board-irb/.

Sincerely,

TWU IRB - Denton

Appendix H: SGM Recruitment Flyer

Appendix I: HCP Recruitment Script

Colleagues,

I am here to invite you to participate in a research study titled: Patients' Disclosure of Sexual and Gender Minority Status: A Comparative, Multiple Case Study. My name is Dr. Damon Cottrell and I am conducting this study as my doctoral dissertation through the University of Texas at Tyler.

The purpose of this study is to examine your experiences and the circumstances around a patient's disclosure of SGM identity during a health care visit with you.

You were selected as a potential informant because you are a practicing healthcare provider. Remember, this study is completely voluntary. You can choose to be in the study or not.

If you choose to participate, please read the consent form carefully and let me know if you have any questions. Your information will be kept on a coding sheet that is stored with a password.

For questions regarding the study, please email me at dcottrell2@patriots.uttyler.edu

Thank you very much.

Dr. Cottrell

Appendix J: SGM Demographic Questionnaire

Demographic Survey for SGM Informants

Please complete the following:

Please write your age in years: _____

Check ONE box that best describes you:

- □ American Indian or Alaska Native
- □ Hawaiian or Other Pacific Islander
- □ Asian or Asian American
- □ Black or African American
- □ Hispanic or Latino
- □ Non-Hispanic White

What is your sexual orientation?

- □ Lesbian
- □ Gay
- □ Bisexual
- □ Pansexual
- □ Asexual
- □ Other: (Please describe) _____

What is your gender?

- □ Cisgender female
- □ Cisgender male
- □ Transgender
- □ Non-binary
- □ Genderqueer
- □ Genderfluid
- □ Other: (Please describe) _____

What was your sex assigned at birth?

- □ Female
- □ Male

Are you?

- □ Single
- □ Married

- Partnered
- Widowed
- Divorced
- Separated
- Other: (Please describe) _____

Are you currently:

- Self-employed
- Employed (full-time)
- Employed (part-time)
- Unemployed
- Student
- Retired
- Other: (Please describe) _____

What is the highest grade or year of school you completed?

- Never attended school or only attended kindergarten
- Grades 1 through 8 (Elementary)
- Grades 9 through 11 (Some high school)
- Grade 12 or GED (High school graduate)
- College 1 year to 3 years (Some college or technical school)
- College 4 years (College graduate)
- Graduate School (Advance Degree)

What is your occupation? _____

Describe your annual income:

- $0 to $24,999
- $25,000 to $49,999
- $50,000 to $74,999
- $75,000 to $99,999
- $100,000 to $149,999
- $150,000 or more

Appendix K: HCP Demographic Questionnaire

Demographic Survey for Provider Informants

Please complete the following to the best of your ability:

Please write your age in years: _____

Check ONE box that best describes you:

- □ American Indian or Alaska Native
- □ Hawaiian or Other Pacific Islander
- □ Asian or Asian American
- □ Black or African American
- □ Hispanic or Latino
- □ Non-Hispanic White

What is your sexual orientation?

- □ Lesbian
- □ Gay
- □ Bisexual
- □ Pansexual
- □ Asexual
- □ Other: (Please describe) _____

What is your gender?

- □ Cisgender female
- □ Cisgender male
- □ Transgender
- □ Non-binary
- □ Genderqueer
- □ Genderfluid
- □ Other: (Please describe) _____

What was your sex assigned at birth?

- □ Female
- □ Male

Are you?

- ☐ Single
- ☐ Married
- ☐ Partnered
- ☐ Widowed
- ☐ Divorced
- ☐ Separated
- ☐ Other: (Please describe) _____

Are you currently:

- ☐ Self-employed
- ☐ Employed (full-time)
- ☐ Employed (part-time)
- ☐ Unemployed
- ☐ Retired
- ☐ Other: (Please describe) _____

What is your title?

- ☐ Medical Doctor
- ☐ Doctor of Osteopathy
- ☐ Advanced Registered Nurse Practitioner
- ☐ Physician Assistant

How many years have you been in your current role? _____

Type of practice:

- ☐ Private Practice: Solo provider
- ☐ Private Practice: 1-4 Providers
- ☐ Private Practice: 5 or more Providers
- ☐ Community clinic or health center
- ☐ Hospital based clinic
- ☐ Other: (Please describe) _____

Please estimate the percent of time you spend in direct patient care: _____

Appendix L: SGM Semi-Structured Questionnaire

Semi-structured Interview Guide: Sexual or Gender Minority Informant

Theoretical Concept	Conceptual Definition	Operational Definition	Interview Guide Question(s)
Please remember back to when you had an encounter with a physician, nurse practitioner, or physician assistant and you did not share your sexual or gender minority status.			
Antecedent goals	• Approach-focused goals • Avoidance-focused goals	Approach-focused dependent upon intent/need and considers risk. Avoidance-focused, intent of preventing negative outcomes.	a. What were the circumstances leading up to the encounter?
Disclosure event	• Content of disclosure and reaction of confidant (HCP)	To or not to disclose.	b. How did the encounter begin? c. What was said or communicated? d. How did you come to the decision NOT to disclose your sexual or gender minority status?
Mediating processes	• Alleviation of inhibition • Social support • Changes in social information	Effect upon alleviation of inhibition, encourages or discourages social support within the context of social information or the environment.	e. How did that make you feel? f. Did you feel supported? g. How did this change your perspective of the visit, clinic or situation?
Long-term Outcomes	• Individual, dyadic and social contextual outcomes	Effect on behavioral health, physical health, intimacy, trust, cultural stigma effects.	h. What are your thoughts about what happened? i. How did this event affect you? j. How did you feel about the interaction? The physician, nurse practitioner, or

			physician assistant and their response?
k. Is there anything else you would like to add regarding disclosing your sexual identity to a health care provider?			
I would like to think about an encounter with a physician, nurse practitioner, or physician assistant where you DID share your sexual or gender minority status.			
Antecedent goals	• Approach-focused goals • Avoidance-focused goals	Approach-focused dependent upon intent/need and considers risk. Avoidance-focused, intent of preventing negative outcomes.	a. What were the circumstances leading up to the encounter?
Disclosure event	• Content of disclosure and reaction of confidant (HCP)	When disclosed, includes amount and detail with emotional context. Considers reaction of HCP if disclosed in terms of support.	b. How did the encounter begin? c. What was said or communicated? d. How did you come to the decision TO disclose?
Mediating processes	• Alleviation of inhibition • Social support • Changes in social information	Effect upon alleviation of inhibition, encourages or discourages social support within the context of social information or the environment.	e. What was it like to disclose your sexual identity to the provider? f. How did you feel during the remainder of the office visit? g. How did you feel after the office visit had concluded?
Long-term Outcomes	• Individual, dyadic and social contextual outcomes	Effect on behavioral health, intimacy, trust, cultural stigma effects.	h. What are your thoughts about what happened? i. How did this event affect you? j. How did you feel about the interaction? The physician, nurse practitioner, or

			physician assistant and their response?
k. Is there anything else you would like to add regarding disclosing your sexual identity to a health care provider?			

Appendix M: HCP Semi-Structured Questionnaire

Semi-structured Interview Guide: Health Care Provider Informant

Theoretical Concept	Conceptual Definition	Operational Definition	Interview Guide Question(s)
Question 1: Please remember back to when you had an encounter with a patient who was assumed to be a sexual or gender minority and the patient didn't share their status.			
Antecedent goals	• Approach-focused goals • Avoidance-focused goals	• Approach-focused dependent upon intent/need and considers risk. • Avoidance-focused, intent of preventing negative outcomes.	a. What were the circumstances leading up to the encounter?
Disclosure event	• Content of disclosure and reaction of confidant (HCP)	• To or not to disclose.	b. How did you come to the assumption of the individual's sexual or gender minority status? c. How did the encounter begin? d. Describe the encounter.
Mediating processes	• Alleviation of inhibition • Social support • Changes in social information	• Effect upon alleviation of inhibition, encourages or discourages social support within the context of social information or the environment.	e. How did you feel about the encounter?
Long-term Outcomes	• Individual, dyadic and social contextual outcomes	• Effect on behavioral health, intimacy, trust, cultural stigma effects.	f. What are your thoughts about what happened? g. How did this event affect you?

			h. What are your perceptions of possible patient outcomes in this situation?
(Researcher will probe for psychological, social, sexual and gender related context.) Question 2: Now, I would like to think about an encounter with a patient from a sexual or gender minority that did share their status with you.			
Antecedent goals	• Approach-focused or • Avoidance-focused goals	• Approach-focused dependent upon intent/need and considers risk. • If avoidance-focused, intent of preventing negative outcomes.	i. What were the circumstances leading up to the encounter?
Disclosure event	• Content of disclosure and reaction of confidant (HCP)	When disclosed, includes amount and detail with emotional context. Considers reaction of HCP if disclosed in terms of support.	j. How did the encounter begin? k. What factors do you think may have promoted the patient TO disclose their SGM identity? l. What do you think the SGM might have been thinking about or considering during disclosure?
Mediating processes	• Alleviation of inhibition, social support, changes in social information	Effect upon alleviation of inhibition, encourages or discourages social support within the context of social information or the environment.	m. How did you feel at the time of disclosure? n. How did you feel during the remainder of the office visit? o. How did you feel after the

			office visit had concluded?
Long-term Outcomes	• Individual, dyadic and social contextual outcomes	• Effect on behavioral health, intimacy, trust, cultural stigma effects.	p. What are your perceptions of possible patient outcomes in this situation? q. Tell me about other encounters with sexual or gender minority patients that come to your memory when they chose to disclose their status?
r. Is there anything else you would like to add regarding a patient's disclosure of SGM status?			

Appendix N - Biographical Sketch

NAME: Damon B. Cottrell

POSITION TITLE: Assistant Dean & Clinical Professor

EDUCATION/TRAINING

INSTITUTION AND LOCATION	DEGREE	END DATE	FIELD OF STUDY
Baptist Memorial Hospital System School of Professional Nursing, San Antonio, Texas	Diploma	1988	Nursing
Texas Woman's University, Dallas, Texas	BS	1997	Nursing
Texas Woman's University, Dallas, Texas	MS	1999	Advanced Practice Nursing – CNS
Robert Morris University, Moon Township, Pennsylvania	DNP	2010	Nursing
Indiana State University, Terre Haute, Indiana	Post-Master's Certificate	2011	Advanced Practice Nursing – FNP
University of Texas at Tyler, Tyler, Texas	PhD	2020	Nursing

Personal Statement

My experience spans over three decades and includes practice as a Registered Nurse and Advanced Practice Registered Nurse within emergency, acute, and primary care settings. My experience extends to a myriad of roles including Staff Nurse, Clinical Coordinator, Supervisor, Clinical Nurse Specialist, Nurse Practitioner, Director, faculty and academic administrative roles. I hold licensure as an adult Clinical Nurse Specialist and as a Family Nurse Practitioner. I am a past national Chair of the American Association of Critical Care Nurses, Certification Corporation. I have published multiple articles and presented at the local, regional and national levels about various topics in clinical practice I hold three advanced practice certifications. My program of research is focused on the health of sexual and gender minority people in an effort to mitigate the myriad of healthcare disparities they encounter through their healthcare experiences.

Positions and Honors (Previous 10 years)

Positions and Employment

2016 –	Assistant Dean & Clinical Professor, Texas Woman's University, Denton, TX
2007 –	Adjunct Assistant Professor, Georgetown University, Washington, DC
2014 – 2016	Clinical Associate Professor, Texas Woman's University, Dallas, TX
2016 –	Nurse Practitioner, Per Diem, CareNow, Dallas/Fort Worth, TX
2010 – 2016	Nurse Practitioner and Supervisor, St. Mary's Regional Medical Center, Lewiston, ME

Other Experience and Professional Memberships

2019 –	Member, American Association of College of Nursing, Organizational Leadership Network
1999 –	American Association of Critical Care Nurses
2010 –	American Association of Nurse Practitioners
2017 –	American/Texas Nurses Association
2017 –	Gay and Lesbian Medical Association
2014 –	National League for Nursing
2016 –	National Organization of Nurse Practitioner Faculties
2002 –	Sigma Theta Tau International Honor Society of Nursing
2019 –	Southern Nursing Research Society

Honors

2020 –	Excellence in Nursing Awards, Education and Research Category, D Magazine
2015 –	Outstanding Peer Reviewer/Peer Reviewer of the Year, The Nurse Practitioner, Wolters Kluwer
2012 –	Lifetime Member Award, American Association of Critical Care Nurses

Contribution to Science (Previous 10 years)

Accepted Articles in Press, Refereed

a. Scott Tilley, D., Kolodetsky, A., Cottrell, D. & A. Tilton. Correlates of increased risk of sexual assault and sexual harassment among LGBT+ university students. *The Journal of Forensic Nursing*.

Published Articles in Journals, Refereed

a. Cottrell, D. (2020). Considering the needs of older sexual and gender minority people. *The Journal for Nurse Practitioners, 16(2), 146-150*.

b. Cottrell, D. (2019). Fostering sexual and gender minority status disclosure in patients. The Nurse Practitioner, 44(7), 43-49.
c. Culbertson, A. & Cottrell, D. (2017). A 49-year-old female with a sore and swollen throat. Journal of Emergency Nursing, 43(3), 266-267.
d. Cottrell, D. & J. Williams. (2016). Eating disorders in men. The Nurse Practitioner, 41(9), 49-55.
e. Cottrell, D. & E. Welch. (2016). An older adult with headache and visual blurring. Journal of Emergency Nursing, 42(4), 348-349.
f. Scher, H., Drew, M., & Cottrell, D. (2015). Treatment of resistant hypertension in the patient with chronic kidney disease. *The Journal for Nurse Practitioners,* 11(6), 597-604.
g. Sherieh, M., Cottrell, D. & Mancuso, P. (2015). First trimester vaginal bleeding: Molar pregnancy. *Advance for NPs and PAs.* Retrieved from: http://nurse-practitioners-and-physician-assistants.advanceweb.com/Columns/Case-Files/First-Trimester-Vaginal-Bleeding.aspx.
h. Sherieh, M., Cottrell, D., Mancuso, P., & Ferguson, L. (2014). Medical management of ectopic pregnancy: Early diagnosis is key. *Clinician Reviews: A Journal for Physician Assistants and Nurse Practitioners Reporting on the latest Advances in Medicine*, 24(7), 29-38. [July]
i. Cottrell, D. & Ridlon, T. (2012). The value of clinical feedback: Poor communication can lead to errors - Here's how to speak up and listen gracefully. *Nursing Critical Care, 7 (6),* 44-47.
j. Cottrell, D. (2012). Clinical Queries: Managing hyperkalemia urgently. *Nursing: The Voice and Vision of Nursing, 42 (10),* 68.
k. Cottrell, D. (2010). Action stat: Iatrogenic Pneumothorax. *Nursing: The Voice and Vision of Nursing, 40 (3),* 72.
l. Cottrell, D. & Kendall, S. (2010). Are you ready to move into critical care? *American Journal of Nursing, 110 (1),* 20-21.