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Managing the Conversation: How Sexual Minority Women Reveal Sexual Orientation

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ABSTRACT

Lesbian and bisexual women (LBW) are hesitant to reveal their sexual orientation in health care encounters for fear of discrimination and stigmatization, thus compromising their health care. The purpose of this grounded theory study was to construct a theoretical framework that depicts the process by which LBW reveal their sexual orientation to health care providers. Narratives obtained from interviews with 13 LBW were used to develop the theoretical framework. The central phenomenon, *Managing the Conversation*, includes having the conversation with oneself, not starting the conversation, starting the conversation, having the conversation started, and having the conversation with health care providers.

Keywords: disclosure, health care, health disparities, sexual minorities, sexual orientation

Lesbian and bisexual women (LBW) are members of a collective sexual minority group with no defining physiologic characteristics that differentiate them from heterosexual women. In the United States, it is reported that approximately 1.1% of women identify as lesbian, and 2.2% identify as bisexual, indicating that over 4 million women in the US are lesbian or bisexual.[1]

Health disparities in the LBW community constitute a significant public health problem.[2] When compared with heterosexual women, sexual minority women report more difficulties obtaining medical care and are less likely to be able to afford prescription medications.[3] LBW are less likely than heterosexual women to obtain routine or preventive care, including obtaining clinical breast examinations, Papanicolaou tests, and mammograms.[4–7] In part, because of these health care use issues, LBW are at an increased risk for chronic disease and preventable illness.[8,9] Lack of preventative care may result in elevated rates of obesity, coronary artery disease, hypertension, myocardial infarction, and pulmonary disorders.[2,10,11] Compared with heterosexual women, LBW are at a greater risk for breast, cervical, ovarian, and uterine cancers.[2]

LBW have high rates of sexual risk behaviors including unprotected sex, multiple sexual partners, and exposure to human immunodeficiency virus (HIV)-transmitting fluids.[12] LBW are more likely than women who have never had sex with women to engage in unprotected vaginal or anal intercourse with a male partner, sexual contact with homosexual or bisexual men, and sexual contact with an injection drug user, putting them at a greater risk for HIV infection and hepatitis B and C infections.[10] When compared with heterosexual women, LBW have higher rates of HIV and hepatitis C as well as self-reported gonorrhea.[11] Bisexual and heterosexual women are more likely to receive regular screening for sexually transmitted infections (STIs) than lesbian women.[10]

LBW are at a higher risk for mental health and substance abuse problems than heterosexual women.[13] In the LBW population, discrimination, stigmatization, and violence can lead to mental distress, suicidal ideation, and self-harm.[10,14,15]

When compared with heterosexual women, LBW are 3 times as likely to experience suicidal ideation,[16] more likely to experience mood and anxiety disorders,[17] and more likely to report 15 or more days of poor mental health in a 30-day period.[11] LBW report more heavy alcohol use; substance use, including marijuana, cocaine, heroin, and methamphetamines; and injection drug use than heterosexual women.[11,15,17-22] One third of lesbians and 50% of bisexual women report tobacco use.[11,14]

The high rates of health problems experienced by LBW are exacerbated by their reluctance to disclose pertinent health information, including sexual orientation, to health care providers (HCPs). Revealing one's sexual orientation is associated with positive health outcomes, but approximately 45% of LBW do not reveal their sexual orientation to HCPs,[23] often because of fear of stigmatization and discrimination.[8,24] Some LBW believe that revealing their sexual orientation may have an impact on the quality of care they receive[8,25] and view health care encounters as threatening and unsafe.[24,26] Therefore, LBW are challenged to decide whether and/or how to reveal their sexual orientation to HCPs.[24]

Despite the association between disclosure of sexual orientation to HCPs and positive health outcomes, little is known about the process of disclosure among LBW. Information about this process can inform HCPs so they may facilitate better health care and health outcomes for LBW. Therefore, the purpose of this grounded theory study was to construct a theoretical framework that depicts the process by which LBW reveal their sexual orientation to HCPs.

METHODS

Grounded theory was used to conduct this study and is based in symbolic interactionism, pragmatism, and social psychology.[27] Researchers using grounded theory systematically gather and analyze narrative data, with the goal of identifying the psychosocial process that individuals experience in response to a common problem.[28]

Sample

After receiving institutional review board approval, a purposive sample of women who self-identified as lesbian or bisexual, were over the age of 21 years, spoke and understood English, and who had accessed health care were recruited using flyers posted on Web sites, Listservs, and online support sites for LBW. Electronic communication technologies (Skype [Skype Communications SARI, Luxembourg] and FaceTime [Apple 1 Infinite Loop, Cupertino, CA]) were used for conducting interviews because participants were recruited nationally. Once participants verbally agreed to participate in the study, they were provided with the link to the online consent form housed in Qualtrics (Qualtrics Dr, Provo, UT), a secure online survey software.

The first author conducted semistructured interviews with all participants. All questions focused on their experiences of engaging with HCPs when accessing health care. Participants were asked to describe their health care experiences, how they felt during their health care encounters, and if they felt they received quality health care services. Interviews were recorded using a digital recorder and transcribed verbatim. In order to maintain confidentiality, all identifying information was kept on a secure server in a password-protected secure database; only the researchers had access to the data.

Data Analysis

Interviews were analyzed using constant comparison methods.[27] The research team who analyzed the data consisted of 2 doctorally prepared nurse researchers, 2 doctoral candidates, 1 master's-prepared nurse, and 2 master's students. The team met weekly to analyze narratives. Data related to any aspects of participants' health care experiences were highlighted on transcripts. Codes were assigned to text units by team members to capture their meaning. Constant comparison techniques[27] were used to develop higher-level categories, determine theoretical relationships among categories, and develop the theoretical framework. The core category, which is the central phenomenon uncovered in the data, was used to organize the framework.[29] *Managing the Conversation* was the label assigned to the core category. Data analysis continued until the