Determining LGB Perceptions of and Trust in the Medical Establishment

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Abstract

This paper explores how individuals of varying sexual orientations hold different levels of trust in the medical establishment, as well as the health and identity-based effects of this phenomenon. Disclosure of sexuality to physicians is used as a proxy for trust. Linear regression analysis reveals that nondisclosure rates are three-fold higher within the bisexual community. We also find that dominance of LGB identity is directly related while degree of internalized homophobia is inversely related to disclosure. Finally, being out to one's doctor corresponds with clinical and identity-based benefits one year later. Clinical benefits include better psychological well-being, better mental health status, and lower depressive symptoms. Identity-based benefits include increased salience of LGB identity and lowered levels of internalized homophobia, both of which support our hypothesis that disclosure helps alleviate internal identity conflict. Doctors thus seem to play a more holistic role in patients' lives that transcends the purely clinical.

A Review of the Literature

Sexual Orientation as a Social Determinant of Health

Though significant research has been conducted on social determinants of health— the social and economic conditions that result in inequities in health status and outcomes of both individuals and groups—sexual orientation has been overlooked. Nonetheless, scholars have reached the consensus that LGB folks face numerous negative health risks and outcomes that their heterosexual counterparts do not; these findings hold true across community, regional, state, and national samples. LGB folks report higher rates of mental health issues, such as clinical depression, anxiety, self-harm, and suicidal ideation (Eskin, Kaynak-Demir, and Demir 2005; King et al. 2008). LGB individuals are also subject to increased physical health risks, including but not limited to cancer, cardiovascular disease, asthma, diabetes, and other chronic illnesses (Lick, Durso, and Johnson 2013). Due to the intrinsic role sexuality plays in determining inequities in health outcomes and risks, providing high-quality healthcare for the LGB population assumes paramount importance.

Mechanisms in Which Sexual Orientation Drives Health Outcomes

Trust

Trust is foundational to the doctor-patient relationship. Central to the cultivation and preservation of trust is transparency, open communication, and an honest exchange of information (Bending 2015). The prevailing scholarly conversation focuses on the flow of information from doctor to patient; indeed, in order for a patient to receive the highest possible

quality of care, the doctor must be able to foster a sense of comfort, security, and safety, to ask appropriate questions, to communicate complex medical jargon in an accessible manner, and to provide advice and treatment.

However, equally important is communication from the patient to the doctor. Communication is a two-way street—without contributions from one party, the relationship suffers. Roter and Hall (2006) argue that the usefulness of advice and treatment provided by doctors is partially dependent on the information disclosed by the patient (Roter and Hall 2006: 139). Deficiencies in communication have devastating consequences for the patient, for instance, inaccurate diagnoses and treatment, low doctor-patient satisfaction, and a lower quality of life overall (Roter and Hall 2006: 6). In this way, LGB distrust in doctors is a significant barrier to the provision of high-quality healthcare.

Nondisclosure of Sexuality to Healthcare Providers

Although there is a lack of academic research with the explicit focus on LGB trust in the medical establishment, literature exists on rates of disclosure of sexuality to healthcare providers. If we think of transparency, open communication, and an honest exchange of information as intrinsic to trust, then nondisclosure of sexuality to doctors can be used as a proxy for distrust.

Studies have reached a variety of conclusions on the rates of nondisclosure of sexuality to healthcare providers. Durso and Meyer (2013) find that bisexual men have the highest rate of nondisclosure to healthcare professionals at 39.3%, followed by bisexual women at 32.6%. Gay men have a nondisclosure rate of 10%, while lesbians have a nondisclosure rate of 12.9% (Durso and Meyer 2013). A different study found an even more concerning range of values: 65% of the overall sample of LGB individuals reported nondisclosure to physicians. Similar to Durso and

Meyer's conclusions, bisexual youth had higher rates of nondisclosure than gay and lesbians (Meckler et al. 2006). The scholarly consensus seems to point to significantly higher rates of nondisclosure among bisexual individuals, but none of the studies identify reasons for this difference.

Though scholars have identified many possible reasons for nondisclosure of sexuality to physicians, outcomes of nondisclosure are understudied. Durso and Meyer (2013) find that nondisclosure is linked to poor mental health one year later, but other studies fail to delve into the influence of nondisclosure on both clinical and non-clinical outcomes.

Stigma and Internalized Homophobia

Although non-heterosexuality is undeniably less stigmatized today than it was in the past, covert homophobia still permeates the medical institution (Fitzpatrick 2008). Few primary care physicians directly ask their patients about their sexualities (Meckler et al. 2006). This lack of communication between doctor and patient can be attributed to doctors' discomfort discussing sexuality with LGB youth, perhaps reflective of lingering stigma. Respondents of a study examining LGB disclosure of sexuality to healthcare providers stated that they felt threatened in healthcare environments (Eliason and Schope 2001), and thus distrusted the medical establishment.

Stigma against LGB folks manifests itself in yet another way—internalized homophobia. To Meyer and Dean (1998), internalized homophobia is the "gay person's direction of negative social attitudes toward the self, leading to a devaluation of the self and resultant internal conflicts and poor self-regard." Internalized homophobia results from living in a society in which

homophobia prevails and is inevitably assimilated within an LGB individual's subconscious, such that they begin to hold homophobic attitudes towards other LGB folks and themselves.

Levels of internalized homophobia have serious implications for the health of LGB folks (Williamson 2000). Though the role of physicians in both alleviating and causing stigma against LGB folks has been explored in the literature, the role of physicians in mediating internalized homophobia is unclear. Given the numerous negative health outcomes associated with internalized homophobia, a closer look into doctors' influence is important.

Summary of the Literature Review

LGB individuals face numerous negative health risks and outcomes that their heterosexual counterparts do not; understanding *how* these outcomes arise is crucial. One possible mechanism is sexual minorities' relative lack of trust in the medical establishment, reflected in high nondisclosure rates of sexuality to physicians and substantiated by historical and modern-day stigma. Given the centrality of trust to the doctor-patient relationship, we hypothesize that trust has a tangible effect on health outcomes and identity-based growth.

Data Description

We analyze a well-known dataset from Project STRIDE, an epidemiological study exploring the effects of minority identity status and stress on mental health outcomes. Conducted from 2004 to 2005, the study is a longitudinal survey that uses primarily quantitative and some supplementary qualitative measures. The sample size is 524 individuals of all genders between the ages of 18 and 59 living in New York City (Durso and Meyer 2013).

Table 1: Sample Description[1]

[1] As seen in Table 1, LGB includes everyone who self-reported their sexuality as "gay," "lesbian," "queer," "bisexual," "homosexual," or "other—LGB." The gay column includes those who identified as

	LGB (n = 396)	**Bisexual** (n = 71)	**Gay** (n = 320)
Black	33.1%	42.3%	30.9%
White	33.8%	19.7%	37.5%
Latino	33.1%	38.0%	31.6%

Participants were questioned via an interview protocol first in February of 2004, and then again in January of 2005. The baseline interviews lasted a mean of 3.82 hours (SD = 55 minutes), and follow-up interviews lasted a mean of 1.91 hours (SD = 30 minutes) (Meyer et al. n.d.). 94.3% of those who engaged in baseline interviews participated in follow-up interviews (Durso and Meyer 2013), which were utilized to track and analyze response changes over the duration of a year—for instance, changes in physical and mental health status.

Analyses

In order to analyze the Project STRIDE dataset, linear regression models are utilized. The fundamental linear regression model is as follows: $Y = a + bX_1 + cX_2 + dX_3 + eX_4 + \varepsilon$

Outcome variables explored in this study include disclosure of sexuality to physicians, strength of LGB group identity at the follow-up time, connectedness to LGB community at the follow-up time, internalized homophobia level at the follow-up time, psychological well-being at the follow-up time, social well-being at the follow-up time, mental health at the follow-up time, and depressive symptoms at the follow-up time.

X_1, the independent variable of interest, differs with each model. We explore bisexuality, strength of LGB group identity, connectedness to the LGB community, disclosure of sexuality to

"gay," "lesbian," "queer," and "homosexual." The 5 individuals who identified as "other—LGB" are excluded from both the gay and bisexual samples as their categorization is ambiguous; for this reason, the LGB category encompasses 5 more individuals than the sum of the bisexual and gay categories.

physicians, and internalized homophobia level as predictors. Meanwhile, X_2, X_3, and X_4 remain the same throughout every regression model—representing Black racial identity, Latino racial identity, and level of educational attainment. These three controls were chosen deliberately upon a thorough review of the pre-existing literature on factors that affect trust in healthcare providers.

In studying health-information seeking efforts and trust in the medical establishment, Richardson et al. (2012) concludes that Black and Hispanic individuals hold lower levels of trust in doctors than their white counterparts. We thus control for both Black and Latino racial identities in the linear regression models. Education and socioeconomic class are also found to be significant correlates of patient trust in physicians. For instance, Kayaniyil et al. (2009) finds that those of lower educational attainment are more likely to trust their doctors. Since education and socioeconomic class are intimately related and excess variables leads to increasing dimensionality and effect dilution, we choose to control for just education in the models.

Finally, our regression models all incorporate interaction effects on the independent variable of interest.[2] By incorporating interaction effects in our regression models, we come closer to identifying the "true" effect of each predictor variable on the outcome.

Statistical significance is assessed via the p-value with a cut-off of 0.05. We also use the Bonferroni correction to counteract the inevitable increase in observing a rare event that occurs whilst testing multiple hypothesis. This correction divides the alpha level by the number of hypotheses; thus, here, the Bonferroni correction tests each hypothesis at a value of 0.0071.

Results

Nondisclosure of Sexual Orientation

[2] These interaction effects are not shown in the above regression equation.

Table 1: Nondisclosure of sexual orientation rates among LGB, gay, and bisexual individuals within interpersonal relationships.

	LGB	Gay	Bisexual
Healthcare Providers	15.7%	11.6%	35.2%
Family	10.1%	7.2%	23.9%
LGB Friends	0.235%	0.0%	1.4%
Heterosexual Friends	5.80%	3.75%	14.1%
Coworkers	18.7%	13.1%	47.9%

Table 1 depicts nondisclosure rates of sexual orientation among LGB, gay, and bisexual individuals within interpersonal relationships. Rates of nondisclosure are highest to coworkers at 18.7% for the LGB community, closely followed by healthcare providers at 15.7%. Noteworthy is that rates of bisexual nondisclosure to doctors (35.2%) are approximately three-fold of gay nondisclosure (11.6%). Though peculiar, these results are consistent with previous studies.

Linear regression analysis confirms this difference between gay and bisexual populations. As shown in *Table 2,* in the simplest regression model, bisexuality is negatively correlated with disclosure of sexuality to physicians (coefficient = -0.852; $p < 0.001$). As race and educational attainment are added as controls, the negative correlation between bisexuality and disclosure remains statistically significant at the 0.001 level, fulfilling Bonferroni significance. Upon incorporating interaction effects, the effect is not statistically significant; however, this can likely be attributed to effect dilution. Bisexual individuals are less likely than gay individuals to report their sexuality to physicians—and LGB Trust in the

Table 2: Bisexual Disclosure of Sexuality to Physicians

	Dependent variable:			
	Disclosure to Physicians			
	(1)	(2)	(3)	(4)
Bisexuality	-0.852^{***}	-0.829^{***}	-0.826^{***}	-1.210^{+}
Black		-0.090	-0.075	-0.092
Latino		-0.212	-0.196	-0.270^{+}
Education			0.011	0.010
Bisexuality:Black				0.258
Bisexuality:Latino				0.528
Bisexuality:Education				0.013
Constant	3.401^{***}	3.497^{***}	3.414^{***}	3.444^{***}
Observations	395	395	395	395
R^2	0.079	0.084	0.085	0.089
Adjusted R^2	0.077	0.077	0.075	0.072

this discrepancy is largely attributable to sexual orientation.

Dominance of LGB Identity

Dominance of LGB identity is assessed through strength of LGB group identity and connectedness to the LGB community. Linear regression analysis (see *Table 3*) reveals that strength of LGB group identity is positively correlated to disclosure of sexuality to healthcare providers (coefficient = 0.181), significant at the 0.05 level, and thus not meeting the Bonferroni threshold. This positive correlation persists as race and educational attainment are added as controls. Upon adding interacting effects, strength of LGB identity is no longer a significant predictor of disclosure to physicians—this discrepancy, however, can again likely be explained by the model increasing in complexity and the effect becoming less apparent. Race plays a role in the equation worth noting; strength of LGB identity seems to have a stronger effect on Black individuals, though these folks start at a lower baseline trust level on average.

Table 3: Strength of LGB Identity and Disclosure of Sexuality to Physicians

	Dependent variable:			
	Disclosure to Physicians			
	(1)	(2)	(3)	(4)
Strength of LGB Identity	0.181*	0.192*	0.201*	0.118
Black		−0.196	−0.153	−1.536*
Latino		−0.318*	−0.276+	−0.589
Education			0.028	0.086
Strength:Black				0.449*
Strength:Latino				0.105
Strength:Education				−0.019
Constant	2.685***	2.821***	2.570***	2.827*
Observations	395	395	395	395
R^2	0.012	0.025	0.028	0.044
Adjusted R^2	0.010	0.018	0.018	0.026
Note:				+ p<0.1; * p<0.05; ** p<0.01; *** p<0.001

Connectedness to the LGB community is also positively correlated with disclosure of sexuality to healthcare providers (coefficient = 0.501, $p < 0.001$). This trend remains significant at the 0.001 level even after controlling for race and education level, thus meeting the Bonferroni test. Note that the significance disappears in the final model with the incorporation of interaction effects; this once again likely can be attributed to effect dilution as variables are added.

Table 4: Connectedness to LGB Community and Disclosure of Sexuality to Physicians

	Dependent variable:			
	Disclosure to Physicians			
	(1)	(2)	(3)	(4)
Connectedness to LGB Community	0.501***	0.507***	0.512***	0.046
Black		−0.202	−0.165	−1.047
Latino		−0.321*	−0.284+	−0.856
Education			0.025	−0.114
Connectedness:Black				0.269
Connectedness:Latino				0.176
Connectedness:Education				0.043
Constant	1.598***	1.753***	1.542***	3.066*
Observations	389	389	389	389
R^2	0.050	0.063	0.065	0.068
Adjusted R^2	0.047	0.055	0.055	0.051
Note:				+ p<0.1; * p<0.05; ** p<0.01; *** p<0.001

Linear regression analysis
Predictor variable of connectedness to LGB community
Outcome variable of disclosure of sexuality to doctors
Controlling for race and education, and incorporating interaction effects

Overall, we infer that dominance of LGB identity—comprised of strength of LGB group identity and connectedness to the LGB community—is directly related to disclosure of sexuality to physicians, controlling for Black racial identity, Latino racial identity, and education level. An individual who has a stronger LGB

group identity and is more connected to the LGB community is therefore more likely to be out to their physician.

Next, we explore the relationship between coming out to one's doctor and dominance of LGB identity one year later to test the hypothesis that disclosure of sexuality to doctors helps to alleviate internal conflict surrounding identity, and thus reflects in a more salient LGB identity. Regression analysis confirms these predictions; as seen in *Table 5* and *Table 6,* disclosure of sexuality to doctors is a statistically significant predictor for both strength of LGB identity ($p < 0.05$) as well as connectedness to the LGB community ($p < 0.001$) one year later even whilst controlling for racial identity and educational attainment. The former does not meet the Bonferroni threshold, while the latter does. For both models, the statistical significance of just strength of LGB identity or connectedness to the LGB community disappears upon incorporation of interaction effects.

Table 5: Disclosure of Sexuality to Physicians and Strength of LGB Identity at Time 2

	Dependent variable:			
	Strength of LGB Identity 2			
	(1)	(2)	(3)	(4)
Disclosure to Physicians	0.061*	0.064*	0.067*	−0.212
Black		0.108	0.059	−0.403
Latino		0.067	0.015	−0.412
Education			−0.032+	−0.125*
Disclosure:Black				0.138+
Disclosure:Latino				0.125
Disclosure:Education				0.028+
Constant	2.828***	2.761***	3.007***	3.942***
Observations	368	368	368	368
R^2	0.011	0.015	0.024	0.036
Adjusted R^2	0.008	0.007	0.013	0.018
Note:				+ p<0.1; * p<0.05; ** p<0.01; *** p<0.001

Linear regression analysis
Predictor variable of disclosure of sexuality to physicians
Outcome variable of strength of LGB identity one year later
Controlling for race and education, and incorporating interaction effects

Table 6: Disclosure of Sexuality to Physicians and Connectedness to LGB Community at Time 2

	Dependent variable:			
	Connectedness to LGB Community 2			
	(1)	(2)	(3)	(4)
Disclosure to Physicians	0.084***	0.086***	0.088***	−0.129
Black		0.125+	0.097	−0.400+
Latino		−0.0002	−0.029	−0.356
Education			−0.018	−0.083+
Disclosure:Black				0.149*
Disclosure:Latino				0.095
Disclosure:Education				0.019
Constant	2.957***	2.911***	3.050***	3.779***
Observations	368	368	368	368
R^2	0.034	0.046	0.051	0.068
Adjusted R^2	0.031	0.038	0.040	0.050
Note:				+ p<0.1; * p<0.05; ** p<0.01; *** p<0.001

Linear regression analysis
Predictor variable of disclosure of sexuality to physicians
Outcome variable of connectedness to LGB community one year later
Controlling for race and education, and incorporating interaction effects

Overall, from the results on strength of LGB identity and connectedness to the LGB community at the second time point, we conjecture that disclosure of sexuality to healthcare providers is conducive to strengthening sense of self and identity-based growth.

Internalized Homophobia

Durso and Meyer (2013) find an inverse relationship between level of internalized homophobia and disclosure of sexual orientation to physicians. In other words, a higher level of

Table 7: Internalized Homophobia Level and Disclosure of Sexuality to Physicians

	Dependent variable:			
	Disclosure to Physicians			
	(1)	(2)	(3)	(4)
Internalized Homophobia	−0.699***	−0.679***	−0.681***	−1.132*
Black		−0.081	−0.085	−0.339
Latino		−0.163	−0.166	−0.727+
Education			−0.003	−0.049
Internalized Homophobia:Black				0.202
Internalized Homophobia:Latino				0.411
Internalized Homophobia:Education				0.034
Constant	4.235***	4.287***	4.310***	4.912***
Observations	391	391	391	391
R^2	0.096	0.099	0.099	0.104
Adjusted R^2	0.094	0.092	0.090	0.088
Note:				+ p<0.1; * p<0.05; ** p<0.01; *** p<0.001

Linear regression analysis
Predictor variable of internalized homophobia level
Outcome variable of disclosure of sexuality to physicians
Controlling for race and education, and incorporating interaction effects

internalized homophobia is a statistically significant predictor for nondisclosure of sexuality to physicians. These results are consistent with the results obtained from linear regression analysis shown in *Table 7*. Indeed, a higher degree of internalized homophobia is negatively correlated with disclosure of sexuality to physicians (coefficient = -0.699; $p < 0.001$). This negative correlation remains significant at the 0.001 level when incorporating controls for Black and Latino racial identity and education level. Notably, the trend remains still upon adding interaction effects, though it no longer meets the Bonferroni threshold (coefficient = -1.132; $p < 0.05$).

We further the analysis by exploring if disclosure of sexual orientation to doctors is a predictor for levels of internalized homophobia one year later. The results are consistent with our hypothesis; in *Table 8,* disclosure of sexuality to physicians is negatively correlated with levels of internalized homophobia later (coefficient = -0.107), significant at the 0.001 level, meeting the Bonferroni threshold. In the final model, only disclosure of sexuality to physicians (coefficient = -0.196) and educational attainment (coefficient = -0.075) have statistically significant negative correlations with internalized homophobia at the follow-up time, though neither pass the Bonferroni test ($p < 0.05$ for both). Although it is difficult to make a claim about the true effect of race on internalized homophobia, disclosure of sexuality and education both have statistically significant negative correlations with internalized homophobia that persist throughout the models. Thus, disclosure of sexuality to doctors seems to influence one's sense of self.

Table 8: Disclosure of Sexuality to Physicians and Internalized Homophobia Level at Time 2

	Dependent variable:			
	Internalized Homophobia 2			
	(1)	(2)	(3)	(4)
Disclosure to Physicians	−0.107***	−0.100***	−0.097***	−0.196*
Black		0.158**	0.117*	0.198
Latino		0.197***	0.155**	0.055
Education			−0.027*	−0.075*
Disclosure:Black				−0.026
Disclosure:Latino				0.030
Disclosure:Education				0.015
Constant	1.715***	1.576***	1.778***	2.105***
Observations	367	367	367	367
R^2	0.074	0.109	0.122	0.131
Adjusted R^2	0.072	0.101	0.113	0.114
Note:				+ p<0.1; * p<0.05; ** p<0.01; *** p<0.001

Linear regression analysis
Predictor variable of disclosure of sexuality to physicians
Outcome variable of internalized homophobia level one year later
Controlling for race and education, and incorporating interaction effects

Mental Health and Well-Being

As shown in *Table 9*, coming out to one's doctor has a positive effect on psychological well-being one year later (coefficient = 0.098), significant at the 0.01 level. Notably, this positive correlation remains when controlling for racial identity and education level. None of these effects, however, meet the Bonferroni correction. In the final model, which incorporates interaction effects, no statistically significant predictors of psychological well-being exist, likely due to increasing dimensionality.

Table 9: Psychological Well-Being and Disclosure of Sexuality to Physicians at Time 2

	Dependent variable:			
	Psychological Well-Being 2			
	(1)	(2)	(3)	(4)
Disclosure to Physicians	0.098**	0.091**	0.086*	−0.134
Black		−0.129	−0.038	−0.582+
Latino		−0.214*	−0.119	−0.372
Education			0.061**	−0.007
Disclosure:Black				0.165+
Disclosure:Latino				0.071
Disclosure:Education				0.020
Constant	5.150***	5.284***	4.824***	5.557***
Observations	365	365	365	365
R^2	0.021	0.034	0.058	0.068
Adjusted R^2	0.019	0.026	0.048	0.050
Note:				+ p<0.1; * p<0.05; ** p<0.01; *** p<0.001

Linear regression analysis
Predictor variable of disclosure of sexuality to physicians
Outcome variable of psychological well-being one year later
Controlling for race and education, and incorporating interaction effects

A similar trend exists for social well-being at the follow-up interview time point, as shown in *Table 10*; these results are significant at the 0.001 level, meeting the Bonferroni threshold. Once again, the positive correlation between disclosure of sexuality to physicians and social well-being remains while controlling for racial identity and education level—though it no longer meets the Bonferroni threshold—but disappears upon adding interaction effects. Thus, if an LGB

individual comes out to their physician, they are more likely to have higher psychological and social well-beings one year later.

Table 10: Social Well-Being and Disclosure of Sexuality to Physicians at Time 2

	Dependent variable:			
	Social Well-Being 2			
	(1)	(2)	(3)	(4)
Disclosure to Physicians	0.120***	0.110**	0.108**	−0.033
Black		−0.213*	−0.162	−0.622+
Latino		−0.252*	−0.200+	−0.470
Education			0.034	0.002
Disclosure:Black				0.138
Disclosure:Latino				0.078
Disclosure:Education				0.009
Constant	4.445***	4.629***	4.373***	4.853***
Observations	367	367	367	367
R^2	0.030	0.048	0.055	0.060
Adjusted R^2	0.027	0.040	0.044	0.042
Note:				+ p<0.1; * p<0.05; ** p<0.01; *** p<0.001

Linear regression analysis
Predictor variable of disclosure of sexuality to physicians
Outcome variable of social well-being one year later
Controlling for race and education, and incorporating interaction effects

The validity of these results, specifically those related to psychological well-being, is verified using the Medical Outcomes Study Short Form (SF-12). A regression model predicting mental health at the second time point as a function of disclosure of sexuality to physicians shows a statistically significant direct relationship between the two variables at the 0.05 level (thereby not passing the Bonferroni test), controlling for Black and Latino racial identity and education level (see *Table 11*). Note that the relationship loses significance upon adding interaction effects. It can, however, be inferred that coming out to one's doctor correlates with a greater likelihood of better mental health status one year later.

Table 11: Mental Health and Disclosure of Sexuality to Physcians at Time 2

	Dependent variable:			
	Mental Health 2			
	(1)	(2)	(3)	(4)
Disclosure to Physicians	1.128*	1.094*	1.105*	2.540
Black		0.843	0.661	0.374
Latino		−1.469	−1.659	−2.204
Education			−0.122	0.643
Disclosure:Black				0.089
Disclosure:Latino				0.191
Disclosure:Education				−0.234
Constant	42.075***	42.366***	43.290***	38.623***
Observations	370	370	370	370
R^2	0.017	0.026	0.026	0.030
Adjusted R^2	0.014	0.018	0.016	0.011
Note:				+ p<0.1; * p<0.05; ** p<0.01; *** p<0.001

Linear regression analysis
Predictor variable of disclosure of sexuality to physicians

We turn our attention specifically to depression in *Table 12*. Regression analysis indicates that disclosure of sexuality to physicians correlates with less depressive symptoms at the follow-up time (coefficient = -0.056, $p < 0.05$). Even when controlling for racial identity and education, the correlation between disclosure and reduced depressive symptoms one year later remains statistically significant at the 0.05 level; these results do not pass the Bonferroni test. Notably, racial identity also seems to play a role in mediating depression—Black and Latino folks seem to suffer from more severe symptoms, and the effect for Latino folks meets the Bonferroni threshold. With interaction effects, these correlations do not hold. Finally, we explore the different experiences of gay and bisexual individuals through examination of the effect of being out to one's doctor on psychological and social well-being for each distinct group. Notably, linear regression models predicting psychological and social well-being of gay individuals based

Table 12: Depression and Disclosure of Sexuality to Physicians at Time 2

	Dependent variable:			
	Depression 2			
	(1)	(2)	(3)	(4)
Disclosure to Physicians	−0.056*	−0.047*	−0.046*	−0.109
Black		0.154*	0.128+	0.171
Latino		0.267***	0.240***	0.166
Education			−0.018	−0.048
Disclosure:Black				−0.014
Disclosure:Latino				0.022
Disclosure:Education				0.009
Constant	0.895***	0.728***	0.862***	1.073**
Observations	370	370	370	370
R^2	0.015	0.057	0.062	0.064
Adjusted R^2	0.013	0.049	0.051	0.046
Note:				+ p<0.1; * p<0.05; ** p<0.01; *** p<0.001

Linear regression analysis
Predictor variable of disclosure of sexuality to physicians
Outcome variable of depression one year later
Controlling for race and education, and incorporating interaction effects

on disclosure of gay identity to physicians were found to be statistically insignificant. However, as depicted in *Table 13,* being openly bisexual to one's doctor seems to be directly related to psychological well-being at the follow-up time, though significance of the results varies as controls and interaction effects are added and does not meet the Bonferroni threshold—the relationship is thus weak.

Table 13: Psychological Well-Being and Disclosure Amongst Bisexual Population at Time 2

	Dependent variable:			
	Psychological Well-Being 2			
	(1)	(2)	(3)	(4)
Disclosure to Physicians	0.148^{+}	0.157^{*}	0.146^{+}	-0.138
Black		-0.305	-0.131	-0.420
Latino		-0.474^{+}	-0.286	0.265
Education			0.069	-0.083
Disclosure:Black				0.102
Disclosure:Latino				-0.228
Disclosure:Education				0.053
Constant	4.852^{***}	5.132^{***}	4.575^{***}	5.437^{***}
Observations	64	64	64	64
R^2	0.054	0.097	0.125	0.216
Adjusted R^2	0.039	0.052	0.065	0.118
Note:				$+$ p<0.1; * p<0.05; ** p<0.01; *** p<0.001

Linear regression analysis
Predictor variable of disclosure of bisexuality to physicians
Outcome variable of psychological well-being one year later
Controlling for race and education, and incorporating interaction effects

Meanwhile, as seen in *Table 14,* the correlation between being openly bisexual to one's doctor and social well-being at the follow-up time is strong. Indeed, the two variables are positively correlated (coefficient = 0.139), significant at the 0.05 level. This relationship remains statistically significant at the 0.05 level upon controlling for race and educational attainment. The Bonferroni significance cutoff, however, is not met. When interaction effects are incorporated, no statistically significant predictor for social well-being at the second time point is evident; this is likely attributable to the rather small sample size in relation to the sheer number of variables.

Table 14: Social Well-Being and Disclosure Amongst Bisexual Population at Time 2

	Dependent variable:			
	Social Well-Being 2			
	(1)	(2)	(3)	(4)
Disclosure to Physicians	0.139^{*}	0.143^{*}	0.142^{*}	-0.172
Black		-0.399	-0.365	-0.440
Latino		-0.562^{*}	-0.528^{+}	-0.155
Education			0.012	-0.161
Disclosure:Black				0.015
Disclosure:Latino				-0.166
Disclosure:Education				0.060
Constant	4.105^{***}	4.472^{***}	4.368^{***}	5.333^{***}
Observations	64	64	64	64

Discussion

Through linear regression analysis, we explored two phenomena: (i) predictors of disclosure of sexuality to physicians and (ii) effects of disclosure of sexuality to physicians on clinical and identity-based outcomes.

Among this sample population of diverse NYC adults, nondisclosure of sexual orientation within interpersonal relationships is high, particularly to coworkers and healthcare providers. Noteworthy is that the nondisclosure rates are approximately three-fold higher within the bisexual community. Durso and Meyer (2013) attribute this discrepancy to unique issues that bisexual folks face. Though they fail to elaborate, other studies have identified issues that are specific to the bisexual community: internalized biphobia, interpersonal and societal erasure, monosexism, and bisexual stereotypes. A bisexual individual describes the erasure of identity he experienced: "My mom still won't accept that I'm bisexual. She referred to me as 'bi-curious' and said that she didn't understand how someone could be attracted to both genders, because men and women are so different" (Flanders et al. 2016). Thus, bisexual folks face unique discrimination at the institutional, interpersonal, and intrapersonal levels.

Notably, the source of discrimination against the bisexual community is not limited to straight folks. One woman recounts a harmful stereotype said by her lesbian friend, who proclaimed that she would never date a bisexual woman because "such a woman is either a lesbian in denial, or a straight person looking for attention" (Flanders et al. 2016).

It is clear how bisexual folks face a distinctive form of discrimination from all parts of society. We conjecture that it is this unique stigma that can explain the shockingly high nondisclosure rates within the bisexual community; however, further research is needed to establish causal relationships. Nonetheless, the data points to the urgency of establishing training programs for providers when caring for bisexual patients.

As established previously, nondisclosure of sexuality rates to physicians are also high for the LGB community as a whole. Since the implications of this nondisclosure are severe and far-reaching, isolating variables that contribute to it is of paramount importance. We find that dominance of LGB identity is directly related to disclosure of sexuality to physicians; in other words, LGB folks who have a stronger LGB group identity and feel more affiliated with the LGB community are more likely to disclose their sexuality to physicians. Race plays an interesting role in this equation. Black folks are less likely to be out to their doctors on average, consistent with previous literature on race and distrust of the medical institution (Halbert et al. 2006). However, we also find that Black folks who indicate strong identification with their LGB identity are *more* likely to be out to their doctors than folks of other races—strength of LGB identity thus seems to have a stronger effect on Black individuals.

Internalized homophobia is inversely related to disclosure of sexuality to physicians. Thus, an LGB individual with a high level of internalized homophobia is less likely to disclosure their sexuality to physicians, perhaps because they feel a deep sense of shame that is difficult to overcome. Overall, an LGB individual who feels more confident in, connected to, and comfortable with their identity is more likely to disclose their sexuality to their doctor.

Previous literature points to the mental health benefits of coming out to one's doctor. We corroborate these conclusions: coming out to one's doctor is related to better psychological well-being and mental health status one year later. Further, our analysis shows that disclosure of sexuality to physicians is linked to less depressive symptoms at the follow-up time. Overall, the mental health benefits of disclosure of sexuality to doctors are evident.

Perhaps most notable, however, are the non-clinical, identity-based benefits that accompany disclosure of sexuality to physicians. Data analysis shows that coming out to one's doctor is directly related to dominance of LGB identity—encompassing both strength of LGB group identity and degree of affiliation with the LGB community—one year later. Our hypothesis that disclosure of sexuality to doctors helps to alleviate internal conflict surrounding identity, reflecting in a more salient LGB identity, is thus confirmed. In a similar vein, disclosure of sexuality to physicians is negatively correlated with levels of internalized homophobia at the follow-up time point. We infer that a related mechanism is at play here as was present for dominance of LGB identity: disclosure of sexuality to physicians is conducive to alleviating internal conflict and lowering levels of internalized homophobia. Finally, our results point to a higher social well-being—indicating higher levels of social acceptance, actualization, coherence, contribution, and integration—at the second time point upon coming out to one's physician.

Enhancing trust levels between doctor and patient seems to have clinical benefits and plays a role in the identity-based growth of sexual minorities. This expansion beyond the clinical is critical, as we reconceptualize of the role of the physician not just as a healer of the body but also as a healer of the whole self.

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