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Understanding Queer Women's Satisfaction with Healthcare Providers: The Role of Positive LGB Identity and Communication

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Abstract

Much research has explored the negative effects of having a queer identity in healthcare, such as stigmatization and discrimination, but little research examined the potential benefits of a positive LGBTQ identity in healthcare. This study investigated the relationship between having a positive LGBTQ identity and provider satisfaction through comfort communicating with a provider. This study also considered the potential effect of participants' fear of provider heterosexism in this relationship. Survey data were collected from 506 queer-identified women in the United States. Using moderated mediation, results found that more positive feelings associated with one's queer identity was associated with increased comfort communicating with a provider, and then enhanced satisfaction with a provider. Regardless of the extent of perceived homophobia, the relationship between communication and provider satisfaction was strong, meaning that a significant moderating-relationship was not identified. Overall, these findings suggest that communication plays an important role in patient satisfaction with providers, and this relationship is enhanced by positive LGBTQ+ identity.

***Keywords*:** provider satisfaction, patient provider communication, LGBTQ, positive identity

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A variety of factors, such as location, socioeconomic status, race, and more, influence a person's access to and experience with healthcare. An important aspect of healthcare experience is patients' satisfaction with their healthcare providers. A study with cancer survivors found that higher patient satisfaction was positively correlated with health outcomes and treatment effectiveness (Rai et al, 2018). Another study showed that greater satisfaction scores were correlated with patients' pain relief and overall improvement (Hirsh et al, 2005). Additionally, more satisfied patients were more likely to adhere to additional provider guidance and suggestions, which strengthened the trust and relationship between patients and providers (Hirsh et al, 2005). Unfortunately, some researchers have identified how provider satisfaction may be hindered for marginalized groups, including lesbian, gay, bisexual, transgender, and queer (LGBTQ+) patients. For instance, studies have found LGBTQ+ women perceived inappropriate or lesser care from their providers compared to heterosexual women (Goins & Pye, 2012). These concerns are unfortunately valid, as social stigma and discrimination against sexual minorities in healthcare can be responsible for provoking feelings of stress, increased prevalence of chronic health issues, and poor coping techniques (Malik et al, 2019).

Prior research identifies the importance of satisfaction with healthcare providers, and the importance of considering satisfaction for minority groups (e.g., LGBTQ+ women). The ways in which providers communicate with patients plays a key role in patients' satisfaction with their healthcare providers. Communication is essential in understanding expectations, having empathy, and building trust in healthcare settings. In the medical field, research has shown that

communication between providers and patients is beneficial for both parties and has a positive correlation with adherence to treatment (e.g., Hart et al, 2007; Rai et al, 2018). Greater patient-provider collaboration in communication also demonstrates a positive relationship with satisfaction (Hart et al, 2007). Some prior research has considered how communication can present a variety of challenges for the LGBTQ+ community, such as comfort discussing sexuality, fear of stigmatization and fear of homophobia or heterosexism, which introduce obstacles between patients and providers and how they communicate (Goins & Pye, 2012). Dahl and colleagues (2013) found that LGBTQ+ mothers were less likely to disclose their sexual identity due to anxiety regarding anticipated prejudice, poor provider confidentiality, or perception of being an incompetent parent. This further affected the mother's birthing experience, where women reported feeling less confident (Dahl et al, 2013).

While a lot of research has examined the ways an LGBTQ+ identity may hinder provider communication and satisfaction, less work has considered the way that having a positive LGBTQ+ identity can play a helpful role in patients' interaction and satisfaction with providers. A positive LGBTQ+ identity involves feelings of comfort and confidence with one's identity, a sense of connection with the LGBTQ+ community, but lacks feelings of shame, guilt, and negativity regarding their identity (Riggle et al, 2014). These increased feelings of ease and assurance may subsequently promote one's willingness to disclose their queer identity, granting better treatment options and outcomes upon communicating with a provider. Specifically, this study investigates the association between having a more positive LGBTQ+ identity (in terms of authenticity) and participant satisfaction with their provider, and how this relationship may be

indirectly explained by greater comfort communicating with a healthcare provider (as a mediating variable; Hayes, 2018).

Authenticity was studied in particular, because this term specifically examines the extent to which participants feel honest with themselves and others about their queer identity, are willing to share and embrace their identity with others and feel a sense of inner peace and comfort with their identity (Riggle et al, 2014). In contrast, those with decreased feelings of authenticity lack that sense of identity contentment and instead may feel embarrassed, guilty, or shameful about their sexual or gender minority status. Due to this internalized stigma, these individuals may be less likely to disclose their LGBTQ+ identity or share other important healthcare topics with their physician.

Although having a more positive LGBTQ+ identity may facilitate communication with healthcare providers, and in turn, increased satisfaction with providers, it is the case that expectations of heterosexist treatment may have an inhibitory effect on communication and satisfaction with one's provider. Research has found that concerns about homophobia and heterosexism can affect patients' communication and satisfaction (e.g., Goins & Pye, 2012). Therefore, we examined fear of homophobia/heterosexism from provider as a moderating variable between communication and satisfaction with a provider, as it may impact the strength of the relationship between these factors (e.g., greater concerns about homophobia/heterosexism will moderate the relationship between communication and satisfaction). In sum, we predicted that a more positive LGBTQ+ identity will be associated with participants' comfort communicating and indirectly predict greater satisfaction with their healthcare provider,

however, fear of heterosexism and homophobia may potentially mitigate the positive relationship between communication and provider satisfaction.

Method

Participants

Cisgender women comprised 82.2% of the sample with 416 participants, followed by 27 (5.3%) transgender women, 26 nonbinary (5.1%), 21 genderqueer/gender nonconforming (4.2%), 15 identifying with another gender identity (gender fluid, nonconforming woman, etc.) (3.0%). Bisexual participants represented the majority of this sample, with 165 participants (32.6%), followed closely by 153 lesbian participants (30.2%), 70 pansexual (13.8%), 64 queer (12.6%), 33 asexual (6.5%), 6 gay (1.2%), 4 unsure (0.8%), and the last 2.2% representing another sexual identity (asexual lesbian, polysexual, etc.) (n = 11). Nearly three-fourths of the sample were white (n = 372, 73.5%), with almost 12% biracial/multiracial (n = 60), and Asian/Asian American/Pacific Islander (n = 22), Latinx/Hispanic (n = 22), and African American/Black participants (n = 21) almost exactly splitting the next 12.8%. Middle Eastern/Arab/Turkish/Iranian (n = 4), Native American/American Indian/Indigenous (n = 3), or other racial/ethnic (n = 1) identities comprise the remaining 1.6% of the sample. Most participants completed at least some level of college education (n = 150), trailed by 123 participants (24.3%) with a bachelor's degree and 116 with a postgraduate degree (22.9%). The remaining sample consisted of 13.2% of participants with some postgraduate work (n =67), 5.1% with an associate degree (n = 26), 4.2% with a high school diploma (n = 21), and 0.4% with only a few years of high school (n = 2). Participants came from all 50 states and D.C., with the majority from California (n = 46), Illinois (n = 28), Indiana (n = 19), Maryland (n = 20),

Michigan (*n* = 24), Nebraska (*n* = 39), Oregon (*n* = 17), and Wisconsin (*n* = 18). The age range of this sample was between 18 and 74, with an average age of 29 years-old and a standard deviation of 10.12. Table 1 lists the sample demographics.

Table 1

Gender Identity	**N**	**%**
Woman (Cisgender)	416	82.4%
Woman (Transgender)	27	5.3%
Nonbinary	26	5.1%
Genderqueer/Gender Nonconforming	21	4.2%
Another Gender Identity, such as: Gender fluid, Demigirl, Transfeminine, Woman and trans, Woman-adjacent, Nonbinary woman, Nonconforming woman	14	2.8%
Transgender Man	1	0.2%
Sexual Identity	**N**	**%**
Bisexual	165	32.6%
Lesbian	153	30.2%
Pansexual	70	13.8%
Queer	64	12.6%
Asexual	33	6.5%
Another Sexual Identity, such as: Queer Asexual, Polysexual, Panromantic, Demisexual, Grey-asexual, Aromantic, Bi or Demisexual or Asexual Lesbian	11	2.2%
Gay	6	1.2%
Unsure/Questioning	4	0.8%
Race/Ethnicity		
White/Caucasian	372	73.7%
Biracial/Multiracial	60	11.9%
Asian/Asian American/ Pacific Islander	22	4.4%
Latinx/Hispanic	22	4.4%
African American/Black	21	4.2%
Middle Easter/Arab/Turkish/Iranian	4	0.8%
Native American/American Indian/Indigenous	3	0.6%
Another Racial or Ethnic Identity	1	0.2%

Education		
Some High School 2 0.4%	2	0.4%
Highschool Graduate 21 4.2%	21	4.2%
Some College 150 29.6%	150	29.7%
Associates Degree 26 5.1%	26	5.1%
Bachelor's Degree 123 24.3%	123	24.4%
Some Postgraduate Work 67 13.2%	67	13.3%
Postgraduate Degree 116 22.9%	116	23.0%
State of Residence		
California	46	9.9%
Illinois	28	6.0%
Indiana	19	4.1%
Maryland	20	4.3%
Michigan	24	5.2%
Nebraska	39	8.4%
Oregon	17	3.6%
Wisconsin	18	3.9%
Other	255	54.7%

Procedures

Participants met four specific criteria: 1) identified as a woman, 2) identified as a sexual minority, 3) were over the age of majority in their specific state of residence, and 4) were living in one of the 50 U.S. states or District of Columbia. Cisgender, transgender, and gender diverse women were included in criteria 1, and lesbian, gay, bisexual, pansexual, queer, or asexual identifying individuals were included in criteria 2. For all states except Nebraska and Alabama (whose age of majority is 19) and Mississippi (whose age of majority is 21), participants 18 and older were included in criteria 3.

Participants were recruited through a variety of methods. All U.S. LGBTQ+ centers at colleges and universities, 194 LGBTQ+ community centers, and LGBTQ+ national

organizations were contacted via email and asked to distribute the survey information as flyers to their members and in public spaces. LGBTQ+ community clubs were contacted via email through use of Gayellow Pages and recruitment information was made available on online forum-based websites whose subject matter primarily consisted of LGBTQ+ advocacy or research. Researchers encouraged friends and coworkers to spread recruitment information through word of mouth, social media, and other networks. Advertisements and flyers were posted in U.S. cities with a more prevalent LGBTQ+ population (New York City, Los Angeles, Chicago) as well as underrepresented states in the sample (New Hampshire, Alaska). A snowball sampling technique was also utilized to promote contacted sites, organizations, groups, and colleagues to share the recruitment information with people who may be interested.

The survey was accessible online through Qualtrics where participants self-verified their eligibility criteria through specific demographic questions. All participants gave informed consent prior to completing the survey and were made aware that no personal information was collected. Participants were given the opportunity to enter a raffle for one of twenty $50 Amazon gift cards in a second survey following the completion of the initial data collection survey. Participants were given the opportunity to receive a report of the findings and again informed that no personal data would be collected for research purposes upon completion of either survey. Gift card winners were chosen at random with an online number generator and notified through their provided email.

A total of 799 people accessed the survey link, but a sample size of 506 remained after excluding participants who failed to complete the study, missed attention checks, did not answer enough questions, or provided nonsensical responses to open and closed-ended questions.

Because some participants neglected to answer certain questions or some questions were automatically omitted due to inapplicability, some variable fields do not total to 506.

Measures

Positive LGB identity

The Lesbian, Gay, and Bisexual Positive Identity Measure (LGB-PIM) scale established by Riggle and colleagues (2014) identified five key elements in one's identity: self-awareness, authenticity, intimate relationships, belonging to the LGBT community, and commitment to social justice. This study specifically looks at authenticity in relation to a positive or negative identity. Authenticity is described as feeling content with and comfortable disclosing one's LGB identity. There are 24 items in this scale, such as "I feel I can be honest and share my LGB identity with others" and "I have a sense of inner peace about my LGB identity" (Riggle et al, 2014). This variable is quantified on a scale from 1 (*strongly disagree*) to 7 (*strongly agree*), and the 24 items are averaged, with scores with greater values indicating stronger feelings of LGB authenticity (alpha = 0.91).

Perceptions of Provider Heterosexism and Homophobia

Perceptions of heterosexism/homophobia were measured with a scale created in 2008 by Dana D. DeHart, where participants rank a series of five statements from 1 (*never*) to 5 (*always*). Example statements include, "My healthcare providers have assumed that I am heterosexual," and "If I come out to my healthcare providers, they won't treat my problems with as much care." Again, items were averaged, and a higher score illustrates more frequent perceptions of heterosexism and homophobia with providers (alpha = 0.73).

Provider Communication

PICS (Patient Perceived Involvement in Care Scale) was used to study the comfort level participants felt communicating with their provider (Lerman et al, 1999). Eight statements were evaluated by participants on a scale from 0 (*I could not do this*) to 5 (*very easy*), where higher scores indicated greater comfort communicating with healthcare providers. Statements used to gauge satisfaction include, "I could suggest a certain kind of medical treatment to a healthcare provider, if I wanted to," or "I could ask a healthcare provider to explain a treatment procedure to me in greater detail." These items were averaged to give an overall measure of participants' comfort communicating with their healthcare provider, with higher scores indicating more comfort communicating (alpha = 0.91).

Provider Satisfaction

Princess Margaret Hospital Patient Satisfaction with Doctor Questionnaire ***(PMH/PSQ-MD)*** scales were used to measure participants' satisfaction with their provider, information exchange, empathy, and quality of time (Loblaw et al, 1999). Participants were specifically questioned about preventative care experiences (e.g., STI testing, mammograms, pelvic exams) that occurred within the last 24 months. For information exchange, the extent to which participants agreed or disagreed with ten statements were measured on a scale from 1 (*strongly disagree*) to 5 (*strongly agree*). Examples of these statements include, "My provider explains the reasons why treatments are recommended for me," and "After talking with my provider, I have a good idea of what changes to expect in my health." The empathy subscale was evaluated on the same scale (from 1 to 5) using six statements (one positively-worded and five negatively-structured statements) specifically organized so that higher scores indicated greater

satisfaction with provider empathy. Examples of these statements include, "My provider considers my individual needs when treating my condition," and "My provider should show more interest." Quality of time was also scaled from 1 to 5, where five negatively-structured statements (e.g., "There isn't enough time to tell my provider everything I want") were specifically scored so that greater satisfaction with time was indicated by higher scores. The values of these subscales were averaged to obtain an overall score of participant satisfaction with their healthcare providers (alpha = 0.95).

Analysis Approach

Hypotheses were tested using moderated mediation. In a moderated mediation model, the independent variable (X) is modeled to predict the dependent variable (Y) directly and indirectly through a mediator variable (M) and at varying levels of a moderator variable (W) (i.e., Model 14 in Hayes, 2018). The values of the moderator for conditional indirect effects are at the 16th, 50th, and 84th percentile. In this model, the independent variable is LGBTQ+ identity authenticity (X), the dependent variable is satisfaction with provider (Y), the mediator is communication with provider (M), and the moderator is perceptions of heterosexism and homophobia from a provider (W). The analysis was conducted using PROCESS version 3.3 for SPSS, which tested an ordinary least squares path analysis using 95% bias-corrected confidence interval based on 10,000 bootstrap samples to test conditional indirect effects (Hayes, 2018).

Results

Descriptive Findings

Table 2

Means, Standard Deviations, and Correlations for Study Variables

Variables	Mean(SD)	Range	1	2	3	4
LGBTQ Identity Authenticity	5.56(1.30)	1-7	—			
Communication	3.38(0.95)	0-5	0.24***	—		
Perceptions of Homophobia	2.58(0.80)	1-5	-0.26***	-0.41***	—	
Satisfaction with Provider	3.48(0.71)	1-5	0.19***	0.51***	-0.45***	—

Note. SD = standard deviation.
***p < 0.001.

Table 2 includes the means, standard deviations, and correlations for study variables. In general, scores on the variables fell around the midpoint of each scale. Additionally, there were significant bivariate relationships between all the variables, and they were all in the expected directions. For instance, LGBTQ identity authenticity showed a positive significant correlation with comfort communicating with a provider and satisfaction with provider, and LGBTQ+ identity has a significant negative correlation with perceptions of provider homophobia. Communication showed a positive significant correlation with satisfaction with provider and a negative significant correlation with perceptions of provider homophobia. Perceptions of provider homophobia showed a negative significant correlation with satisfaction with provider.

Model Findings

Table 3

Model Coefficients

	Outcome Variable					
	Communication (mediator)			Satisfaction with Provider		
Predictors	*b*	*SE*	95% CI	*b*	*SE*	95% CI
LGBTQ Identity Authenticity	0.173***	0.032	[0.11, 0.23]	0.013	0.021	[-0.029, 0.054]
Communication	—	—	—	0.275**	0.092	[0.094, 0.457]
Perceptions of Homophobia	—	—	—	-0.272*	0.110	[-0.489, -0.056]
Comm X Perceptions	—	—	—	0.008	0.031	[-0.053, 0.069]
	$R^2 = 0.057$			$R^2 = 0.329$		
	$F(1, 496) = 29.91$, $p < 0.000$			$F(4, 493) = 60.49$, $p < .000$		

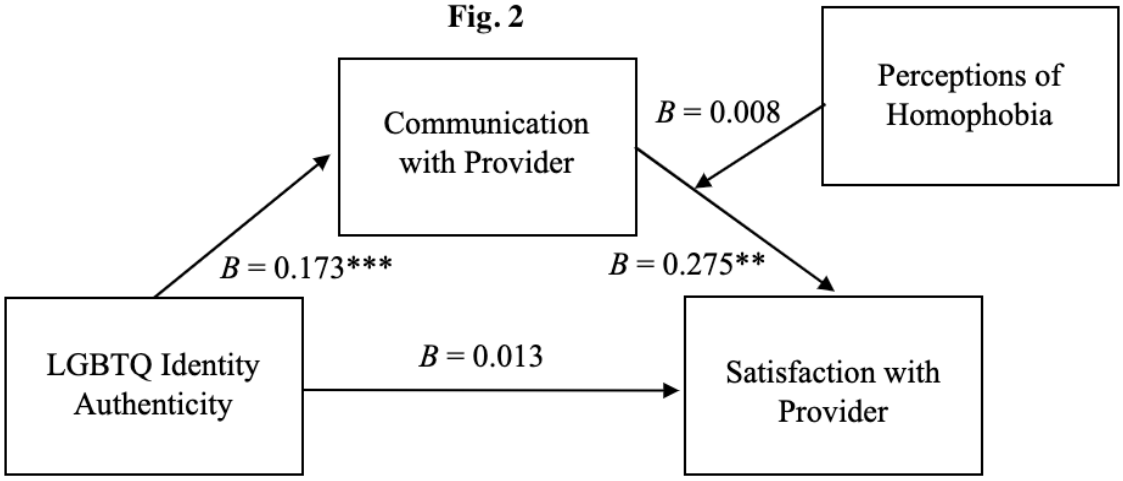
Note. n = 498. CI = confidence interval. Comm X Perceptions = interaction between communication with provider and perceptions of provider homophobia
*p < 0.05. **p < 0.01. ***p < 0.001.

Table 4

Conditional Indirect Effect of LGBTQ Identity at Values of Moderator

Perceptions of Homophobia	*effect*	*se*	95% CI
1.8 (16th percentile)	0.050	0.012	[0.029, 0.074]
2.6 (50th percentile)	0.051	0.011	[0.031, 0.074]
3.4 (84th percentile)	0.052	0.012	[0.030, 0.076]

Fig. 2



Indirect effect (16th) = 0.050, *SE* = 0.012, 95% CI [0.029, 0.074]
Indirect effect (50th) = 0.051, *SE* = 0.011, 95% CI [0.031, 0.074]
Indirect effect (84th) = 0.052, *SE* = 0.012, 95% CI [0.030, 0.076]

Again, LGBTQ identity authenticity was entered as the independent variable (X), communication with provider was the mediating variable (M), perceptions of provider homophobia was the moderating variable (W), and satisfaction with provider was the dependent variable (Y). Results for this model are presented in Table 3, Table 4, and Figure 2. The full model was significant and explained approximately 33% of the variance in provider satisfaction (see Table 3). Looking at the paths between study variables, the relationship between LGBTQ identity and communication with provider (X to M) was significant, with a more positive LGBTQ identity associated with more comfort communicating with a healthcare provider. As expected, there was also a significant relationship between communication with provider and

satisfaction with provider (M to Y), with more comfort communicating with provider associated with greater satisfaction with a provider. However, there was no significant interaction between perceptions of provider homophobia and communication in predicting satisfaction with provider and there was no evidence of moderated mediation (effect = 0.001; standard error = 0.006; 95%CI = -0.010, 0.012). That said, there was evidence of mediation. As shown in Table 4, at all levels of the moderator (16th, 50th, and 84th percentiles), the indirect effect of LGBTQ identity on provider satisfaction through communication was positive and significant. This suggests that regardless of the extent of a participants' perception of homophobia, there was a significant indirect effect of X (LGBTQ identity authenticity) on Y (satisfaction with provider) through M (communication with provider). Thus, communication with a provider appeared to have a strong relationship to provider satisfaction.

Discussion

In terms of LGBTQ+ identity authenticity, model findings found a significant relationship of a positive LGBTQ+ identity in facilitating communication with providers and indirectly promoting satisfaction with healthcare providers. While much research has focused on the barriers LGBTQ+ individuals face accessing healthcare, this study explored the benefits that a positive LGBTQ+ identity may have in healthcare: strengthening the patient-provider relationship through enabling communication and greater provider satisfaction. In other settings, researchers have similarly found that a positive LGBTQ+ identity can foster positive communication and wellbeing. For example, LGBTQ+ middle school students who reported coming out to classmates, family, teachers, and friends subsequently reported lower feelings of depression, greater self-esteem, and increased feelings of attachment to their school than their

counterparts who had not yet disclosed their sexual or gender identity (Kosciw et al, 2011). In another study, Legate et al (2012) found that members of sexual and gender minorities who expressed their identities in supportive situations reported reduced feelings of anger and depression and increased feelings of self-esteem (Legate et al, 2012). Our findings suggest that LGBTQ+ identity is not always an inhibitor of positive healthcare interactions, but can potentially be beneficial (e.g., in facilitating patient-provider communication).

It was expected that fear of heterosexism and homophobia from providers would affect the strength of the relationship between communication and satisfaction, however, model findings indicated that regardless of perceptions of heterosexism/homophobia, the relationship between communication and satisfaction with a healthcare provider was positive and significant. This finding further emphasizes the importance of open and consistent communication between providers and patients. As mentioned earlier, open communication between patients and healthcare professionals can have powerful positive effects on treatment effectiveness due to decreased pain relief and increased pain management, lessened anxiety, and boosted mutual trust (Rai et al, 2018). Because patients find their providers' recommendations and practice as holistic and successful, they followed successive provider directions in future appointments, with improved cognitive effects including greater recall and greater self-efficacy (Hart et al, 2007). Our findings also suggest that, regardless of queer women's concerns about heterosexism or homophobia from a provider, comfort communicating with a provider is associated with greater provider satisfaction. These findings further emphasize the extreme importance of communication within healthcare, even when accounting for participants' concerns of homophobia and heterosexism.

While we found comfort communicating may outweigh fear of heterosexism when predicting provider satisfaction, it is important to note that fear of heterosexism and homophobia was still significantly correlated with lower satisfaction with physicians (e.g., in the direct association between fears and satisfaction). This finding corroborates findings from prior research, such as from Rossman et al (2017), which highlighted negative experiences of LGBTQ individuals in healthcare settings (e.g., rude and/or verbally abusive language, assuming a heterosexual identity) and queer patients subsequently reported feeling unwelcomed, unlikely to follow-up with healthcare, and more likely to report feelings of dislike toward their physician (Rossman et al, 2017). In another model with another sample, fear of heterosexism may hinder communication more so than in our sample (largely queer cisgender women), but our findings generally suggest that communication is a chief predictor of patient satisfaction and that positive LGBTQ+ identity is indirectly related to increased satisfaction via communication.

Practice and Policy Implications

Using the results from this study and similar LGBTQ-centered research, providers, educators, researchers, and more, can learn to focus on positive—rather than just negative—effects of being a member of the queer community and work to reaffirm queer identities. Cahill and Makadon (2013) identified the first step that must be taken to recognize and eliminate health disparities queer patients face: acknowledge the existence of disparities and implement mechanisms to combat them. An important factor affecting the treatment efficacy in LGBTQ+ patients is nondisclosure to providers, often due to fear of heterosexism, leading to inadequate care (Cahill & Makadon, 2013). In addition, countless current providers lack training to appropriately treat, diagnose, and manage the needs unique to queer patients in a well-rounded

manner. For example, a recent study conducted by White et al (2015) exposed medical students feeling unprepared and uncomfortable addressing queer patients. In both allopathic and osteopathic medical schools, students felt that their education did not adequately cover caring for LGBTQ individuals, with 67.2% equating their queer-curriculum as "fair" or lesser (White et al., 2015).

It makes sense that this community faces disparities in healthcare when educational institutions are not preparing physicians to care for stigmatized groups and likely maintains—if not intensifies—the increased incidence of short-term and chronic infections and diseases in minority groups (White et al, 2015). With improved and thorough education and training for current and upcoming healthcare professionals, queer patients could reap the positive effects and feel reaffirmed in their identity by providers who can effectively communicate and care for their specific needs and act to eradicate current disparities in healthcare settings.

This also applies to members of the LGBTQ+ community. In terms of strengthening the patient-provider relationship, enhanced communication from the patient is a necessity, and assuming that our model holds true, positive queer identities correlate with this enhanced information exchange. To expand on the communication skills on the patient's end, training and advocacy programs for use in healthcare settings could potentially be beneficial for members of the queer community. Combining better education and communication practices for both patients and physicians, the strength of the patient-provider bond could flourish, with increased patient satisfaction and treatment efficacy following.

Fostering a positive LGBTQ identity does not start in healthcare alone but can be institutionalized to promote a sense of authenticity for queer individuals. Kosciw et al (2014),

studied this effect in middle schools, where students who came out to their peers and teachers reported better psychological health, especially in regard to their improved self-esteem and reduced depressive feelings. These positive responses were amplified when queer youth voluntarily disclosed their identity and were subsequently supported by their family, friends, and teachers (Kosciw et al, 2014). When perceived support was high, queer students reported reduced feelings of anger and depression upon disclosure compared to their counterparts. However, this relationship was not similar in young adults who disclosed in unsupportive environments, where benefits of disclosing did not necessarily outweigh the drawbacks (Legate et al, 2012). Promoting autonomous disclosure and providing support networks for queer individuals at a young age can potentially benefit the queer community by reaffirming their identity and promoting authenticity. In doing so, a more positive identity may promote more comfort communicating in healthcare, enhancing provider satisfaction, and boosting treatment effectiveness and health outcomes.

Limitations and Future Directions

There are limitations to this research that must be disclosed. All data collected and analyzed was completed using correlational effects, not causational effects. Significant associations and indirect effects were identified, but no variables were determined to cause a change in subsequent variables. A causational relationship would have to be pursued in future research which could establish direct effects between variables.

A strength of the study was the large sample of queer women; however, findings may not reflect experiences of other groups within the LGBTQ+ community. For example, our findings may not represent the experiences of queer men. In addition, while our sample included

transgender and gender diverse participants, there were not enough participants to explicitly analyze their specific experiences (e.g., how they may differ from cisgender queer women). Similarly, this research did not specifically identify differences in provider communication between sexual and gender minority groups (e.g., how a provider communicates with a bisexual woman partnered with a man compared to a bisexual woman partnered with a woman). Future research should pursue the effects of participants underrepresented in this sample, including transgender and gender diverse individuals, and provider communication variation between different sexual and gender minority groups. Future research could also consider how positive identity plays a role in similar and/or different ways across various sexual identities.

When analyzing the relationship between communication and satisfaction with healthcare providers, it is important to identify that this research was collecting information from participants in terms of providers in general, not one provider in particular. Because there was not a direct one-to-one relationship with a specific provider, participants had the freedom to submit responses regarding all providers with whom they may have interacted. Therefore, it could be beneficial for future research to examine participants' experiences with a specific provider, such as a primary care physician or gynecologist, to understand explicit mechanisms that benefit or harm the patient-provider relationship. Additionally, future research could collect a sample of individuals to report on behalf of one provider at a single clinic to again identify specific practices that may promote treatment outcomes and/or patient satisfaction.

Conclusion

While research has shown that being a member of the LGBTQ+ community can negatively impact patients' communication and satisfaction with providers, our findings suggest

how LGBTQ+ identity can be helpful as well. We found that having a greater sense of LGBTQ+ authenticity was associated with greater comfort communicating with healthcare providers, and, indirectly, greater provider satisfaction. Additionally, the relationship between comfort communicating and provider satisfaction was so strongly significant in our sample that evidence of moderated mediation was not identified at any level of fear of heterosexism and homophobia from a provider. Using information from this study, potential benefits could arise from implementing institutional efforts to reduce stigma and embrace queer identities.

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