

# Sexual Minority Women's Experiences With Sexual Identity Disclosure in Contraceptive Care

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**OBJECTIVE:** To describe a group of young sexual minority women's experiences with and preferences for sexual identity disclosure in the context of contraceptive care.

**METHODS:** In Chicago, Illinois, Salt Lake City, Utah, and Madison, Wisconsin, investigators conducted five focus groups (n=22) and 11 interviews with women aged 20–30 years who identified as something other than heterosexual. Focus groups explored social norms regarding contraceptive care; interviews documented individual experiences with contraceptive care. Using a qualitative descriptive approach and combined deductive and inductive content analysis, investigators coded tran-

scripts for themes related to disclosing sexual orientation to contraceptive providers.

**RESULTS:** Participants described the process of sexual identity disclosure in contraceptive care in three stages: 1) listening for whether, when, and how health care providers asked about sexual orientation, 2) deciding whether or not to disclose sexual identity to providers, and 3) evaluating responses from providers after disclosure. Participants wanted providers to: avoid assumptions and ask about both sexual identity and sexual behaviors, signal their openness and competence around the health of sexual minority women during contraceptive encounters, and focus discussions on the individual patient's priorities and needs for contraceptive care.

**CONCLUSION:** Decisions made by sexual minority women about sexual identity disclosure in contraceptive contexts are influenced by previous and current interactions with health care providers. Contraceptive providers should ask all patients about sexual identity and sexual behavior, avoid assumptions about use of and need for contraception, and acknowledge the prevalence of marginalization, discrimination, and stigma experienced by sexual minority women and their communities in health care contexts.

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gender identity have also been found to be highly acceptable among heterosexual patients.<sup>8,15</sup> However, disclosure can also place an individual in danger of both overt and subtle forms of discrimination,<sup>15–18</sup> influencing the decisions made by sexual minority women to disclose.

Sexual orientation disclosure may be more consequential in contraceptive care than in other health care contexts.<sup>19</sup> Sexual minority women commonly use contraceptive technologies and comprise a large portion of contraceptive clients,<sup>20–23</sup> though certain groups of sexual minority women may use contraception less often or use less effective methods than heterosexual women.<sup>24</sup> These trends may contribute to recently documented high rates of unintended pregnancy among sexual minority women.<sup>25,26</sup> Little research has documented disclosure in contraceptive care settings specifically, though some evidence suggests that contraceptive care is heteronormative and does not meet the needs of sexual minority women.<sup>27,28</sup>

Because health care providers have little formal preparation regarding sexual minority populations' health and health care needs, they may not be prepared to respond effectively to the contraceptive needs of sexual minority women.<sup>29</sup> Additionally, simply collecting data on patients' sexual orientation will not address root causes of disparities such as misinformation about the health care needs of sexual minority women. This study fills existing gaps in knowledge by aiming to describe the experiences of a group of young sexual minority women with and preferences for sexual identity disclosure in the context of contraceptive care.

## METHODS

The parent study's original aim was to describe social norms about contraception and contexts of contraceptive use among young sexual minority women using a qualitative descriptive approach.<sup>30</sup> The intended outcome of this analysis was to generate insights about the preferences of sexual minority women and needs when interacting with health care providers about contraception choices. We first conducted five focus groups; focus groups are specifically beneficial for generating data on social norms and values and allowed us to focus on contraception-related social norms, expectations, and values among groups of young sexual minority women living in the same area.<sup>31</sup> We then conducted 11 one-on-one interviews with sexual minority women. Individual interviews are appropriate to generate individual-level data about particular experiences and beliefs. Focus groups

and interviews took place between August 2017 and April 2018. Institutional review boards at the Universities of Wisconsin-Madison, Chicago, and Utah reviewed and either waived (Wisconsin) or approved (Chicago, Utah) the study design and instruments.

We recruited young adult sexual minority women (age 20–30 years) in three cities: Chicago, Illinois; Salt Lake City, Utah; and Madison, Wisconsin. We selected this age group because they experience the highest rates of unintended pregnancies.<sup>26,32</sup> Inclusion criteria for focus groups were 1) identifying as something other than heterosexual, 2) being assigned female sex at birth, and 3) being between the ages of 20 and 30 years. We recruited participants primarily through social media (eg, Facebook), placing targeted advertisements in sexual minority advocacy and social groups, and secondarily through participant referral. To establish eligibility, interested participants answered inclusion criteria questions using a brief online survey, and eligible participants were contacted for enrollment and scheduled for a focus group. Once all focus groups were complete, additional participants were recruited for individual interviews using the same inclusion criteria plus having penile-vaginal intercourse at least once in the previous year. Recruitment was closed when the study team identified theoretical data saturation by continuously reviewing interview memos.

The study team developed semistructured guides for focus groups and interviews using both the previously identified study aims (to describe social norms about contraception and contexts of contraceptive use) and topics identified in existing literature as described above. Focus group and interview items included questions such as:

- When queer women do have sex that could lead to pregnancy, they're less likely to use contraception than heterosexual women. Why do you think this happens?
- How do you/have you talked about your sexual identity and contraception with your provider?

Focus groups were conducted in person and facilitated by the second author and another member of the study team local to each city. Focus groups took place in conference rooms on each campus location, contained between two and seven participants, and lasted between 2 and 2.5 hours. We planned to conduct two focus groups in each city, but, owing to recruitment and scheduling issues, conducted one focus group in Chicago. The second author also conducted all individual interviews; those in Madison took place face-to-face in private community rooms in local libraries, and those in Chicago and Salt Lake



City took place on Zoom, a secure online videoconferencing program with recording capabilities. Interviews lasted between 60 and 90 minutes. Interview recruitment ended when we reached theoretical data saturation; that is, after we conducted several interviews that did not generate new subcodes or major ideas.

At the conclusion of the focus group or interview, each participant received \$40 in cash or an online gift card and \$5.00 for transportation costs if needed. All focus groups and interviews were audio-recorded and transcribed by either a study team member or an independent transcription service. The interviewer wrote 1–2 page memos after each focus group and interview, summarizing the discussion and highlighting relevant themes or stories.

Investigators used a combined inductive and deductive approach. We established potential themes from previous literature and research questions and allowed additional themes to emerge from the data during open coding. Six trained study team members coded the first focus group transcript, to further refine the codebook and to establish consistency in applying the codes. Two coders independently coded each subsequent transcript and discussed coding decisions until reaching 100% agreement. Coding discrepancies that could not be resolved were then discussed by the entire six-person study team until agreement was reached. The codebook was continually refined and edited throughout the coding process. Coding was completed using Atlas.ti 8, a software package for managing and analyzing qualitative data.

For the current analysis, the investigators focused on the preestablished codes “Receiving sexual and reproductive health care services” and “Interactions with health care providers.” Subcodes that emerged during analysis included “positive interactions with providers,” “negative interactions with providers,” and “ideas about improving sexual and reproductive health care.” Once all interviews and focus groups were coded, all team members read over the relevant coding reports and made note of preliminary themes and subthemes. “Managing sexual orientation disclosure” was the primary theme that emerged across these codes. As themes such as “assumptions of heterosexuality” and “evaluating safety in real time” emerged, the study team began to organize them by time, corresponding to what might happen in a typical health care encounter. Although the participants did not specifically categorize their experiences this way, their reflections on having to disclose multiple times, planning before clinical encounters and evaluating them in real time, and specific references to how pro-

viders respond after disclosure suggested that this organization reflected participants’ experiences.

## RESULTS

A total of 33 sexual minority women participated in our study; 22 individuals participated in focus groups and 11 in individual interviews. Table 1 displays demographic characteristics of the sample. Of note, 26 out of 33 participants were white. All but two participants had previously sought contraceptive care. Participants’ motivations for seeking contraceptive care included reliable pregnancy prevention, emergency contraception, menstrual symptom management, and other noncontraceptive benefits. Participants described three stages of sexual orientation disclosure when seeking contraceptive services: 1) listening for whether, when, and how health care providers asked about sexual orientation, 2) deciding whether or not to disclose sexual identity to providers, and 3) evaluating responses from providers after disclosure. Table 2 summarizes the relevant themes from each stage, and provides illustrative participant quotes (names are pseudonyms).

Participants’ accounts revealed that listening for whether, when, and how health care providers asked about sexual orientation or behavior was a first step in managing sexual orientation disclosure in contraceptive contexts. Participants stressed the importance of distinguishing and addressing both sexual orientation and sexual behavior, and suggested that providers should clearly communicate the clinical rationale for their questions.

Our results reveal that at least some providers still fail to ask sexual orientation questions despite consensus that sexual orientation information is critical to effective, patient-centered care. Health care providers’ assumptions of heterosexuality emerged in our data as a significant barrier to achieving contraceptive care goals. Many participants reported that health care providers infrequently or never asked about their sexual orientation. For example, Julianna (23, demisexual) said:

I don’t feel like I’ve ever been asked explicitly. I feel like I’ve been asked, “How many sexual partners have you had in the last 6 months?,” but I don’t know if I’ve ever been asked, “What is the gender of your sexual partners?”

Participants described how sexual activity and sexual health questions were vague or implied assumptions of heterosexuality. Questions such as “Are you sexually active?” were interpreted as heteronormative and stigmatizing to several participants



**Table 1. Demographic Characteristics of the Participants (N=33)**

Characteristic	Value
Age (y)	23.8±2.77
Sexual orientation*	
Lesbian or gay	4
Bisexual	6
Queer	10
Queer and other	7
Other identities	6
Race-ethnicity <sup>†</sup>	
White	26
Hispanic or Latina	2
Other	5
Education	
High school or high school equivalency certificate	1
Some college	12
Completed college	20
Recruitment location	
Madison, Wisconsin	16
Chicago, Illinois	8
Salt Lake City, Utah	9

Data are mean±SD or n.

\* The “queer and other” identity group is comprised of participants who reported using multiple identity words to describe their orientation, including “queer” but also others. The “other identities” group includes participants who identified as pansexual, gay, fluid, or “not straight.”

<sup>†</sup> “Other” racial and ethnic identities include participants who described themselves as Asian American, Arab-American, and mixed race.

who did not know how to answer them. Their experiences highlighted the various ways assumptions of heteronormativity could influence or derail the encounter from relevant clinical concerns and contribute to poor patient-provider communication. Joan (25, lesbian/bisexual) woman, explained:

If they’re giving me advice—medical advice or whatever—assuming that I’m a certain way...even if it’s still is good advice I’m not gonna take it wholeheartedly unless I know that it’s directed at me. [If] they don’t know my identity then it just feels like they’re spitting out words, you know?

Our data show that when health care providers assume that patients are heterosexual or ask questions that imply cisgender male sexual partners, they substantiate fears of discrimination that sexual minority women may already have and influence the level of trust of sexual minority women in the provider’s contraceptive care or advice.

The women in our study overwhelmingly agreed that providers should ask patients about both their sexual identity and sexual behavior. Participants articulated how understanding both sexual orientation

and behavior histories could reveal important aspects of the patient’s needs. Asking about both sexual behavior and identity could specifically benefit queer women who were questioning their identities, described their identities as “fluid,” or had transgender partners. In these cases, sexual behavior could be more relevant to the individual’s contraceptive needs and more comfortable to discuss with providers. Jane (29, queer/lesbian) explained that women who were questioning or exploring their sexuality may avoid contraceptive care altogether to avoid questions that solely focused on identity.

I think some women might also go off of contraception because while their identity is changing, they may feel less comfortable talking to a provider to get their prescription renewed, especially if at that time you were questioning your sexuality. It might be a more difficult conversation to have.

Our findings suggest that asking patients about both their sexual identity and sexual behavior is important for meeting the contraceptive needs of sexual minority women, and specifically for sexual minority women with fluid or changing identities and those with transgender partners.

Despite many stories of difficult and stigmatizing encounters, participants also shared examples of strategies to ask about sexual identity that avoided heteronormative assumptions and thereby encouraged disclosure. Our participants stressed that it was important for providers to consider how they ask about sexual history and identity and not only whether they asked. Rachel (24, queer), explained how straightforward communication from the provider helped prevent confusion and created a safer space for the patient and provider to work together to address the patients’ needs. She explained:

I would appreciate if they asked me in a straightforward way. Like, “Describe your sex life in a way that’s comfortable to you.” And if they have more questions, then ask, “Okay, what do you mean by that? What do you mean by this kind of sex?” Then I could explain that. I think a lot of times, the clinical language that’s used is just so off-putting and at times can be confusing...I think it should be more, “What’s important to you? Let’s talk about how those things impact you and your well-being.”

Rachel described how asking open-ended questions about sexuality may help providers avoid further stigmatizing sexual minority women, and allow patients to disclose what they are comfortable with. Key



**Table 2. Themes and Subthemes With Illustrating Quotes From Participants\***

Theme and Illustrating Quote	Subtheme	Examples
<p><b>Stage 1: Whether and how health care providers ask about sexual orientation</b></p> <p><i>Assumptions of heterosexuality</i>—"I don't feel like I've ever been asked explicitly. I feel like I've been asked, 'How many sexual partners have you had in the last 6 months?', but I don't know if I've ever been asked, 'What is the gender of your sexual partners?'"—Julianna (23, demisexual)</p>	<p>Participants were less likely to take advice that was not responsive to sexual identity.</p> <p>Heteronormative sexual health questions were off-putting and confusing.</p> <p>Heteronormative contraceptive questions can be irrelevant to participants' experience.</p>	<p>"If they're giving me advice—medical advice or whatever—assuming that I'm a certain way...even if it's still is good advice I'm not gonna take it wholeheartedly unless I know that it's directed at me. [If] they don't know my identity then it just feels like they're spitting out words, you know?"—Joan (25, lesbian/bisexual)</p> <p>"I think there must be some age where pediatricians ask if you're sexually active, probably twelve or whatever. And, my questions was always like, 'what does that mean?' I wasn't having penis-in-vagina sex...but I was definitely hooking up with people. And I would say that I was sexually active but, I didn't know if that meant the same thing for us. I felt like there was a real conflict of words. It was really unclear whether we were speaking the same language."—Addison (26, queer)</p> <p>"I don't like the way that doctors usually ask about [sexual activity]...They shouldn't assume immediately that you're having penis-vagina sex, but at least in my experience they always do, every time."—Jo (21, queer/bisexual)</p> <p>"I get the 'Well you're on birth control, so you must obviously have a boyfriend' [assumption]. I got an IUD and when I first got it inserted and went back for a follow up, they didn't even ask who my partner was and then asked, 'Can your partner feel it?' And...[laughter from others]."—Andrea (25, bisexual)</p>
<p><i>Asking about both identity and behavior</i>—"I was thinking too about that, with the behavior and identity stuff. I think that if they're only asking one, it makes more sense to ask about behavior. But I think I would appreciate something that asks about identity too, even if it was on the questionnaire, just putting how you identify. Like particularly for people who are bisexual or queer...you don't know immediately if they are having sex that can lead to pregnancy. Um, so I guess in my ideal world, you would ask both."—Sofia (25, bisexual/queer)</p>	<p>Being attentive to sexual identity can reveal important clinical needs.</p> <p>Asking about identity and behavior acknowledges questioning and fluid identities and transgender partners.</p>	<p>Logan: "So, because it was a sexual assault they had to call a guardian or someone to come sit with me through the process, and she asked me about my identity."</p> <p>Interviewer: "Did you find that helpful that she asked?"</p> <p>Logan: "Yeah, because this is the first time I had ever had sex with a guy or someone who could get me pregnant. So yeah, it was kind of comforting."—Logan (25, lesbian)</p> <p>"At [the clinic], they asked me who I was having sex with and all they asked was female-bodied or male-bodied people, and I said female-bodied. Now they are always assuming that I'm dating a woman, like they say 'she' and 'her' and I'm like, no my partner is actually a [trans]man."—Sonya (22, queer)</p> <p>"I think some women might also go off of contraception because while their identity is changing, they may feel less comfortable talking to a provider to get their prescription renewed, especially if at that time you were questioning your sexuality. It might be a more difficult conversation to have."—Jane (29, queer/lesbian)</p>

(continued)



**Table 2. Themes and Subthemes With Illustrating Quotes From Participants\* (continued)**

Theme and Illustrating Quote	Subtheme	Examples
<p><i>Clarity and clinical rationale</i>                      —“I would appreciate if they asked me in a straightforward way. Like, ‘Describe your sex life in a way that’s comfortable to you.’ And if they have more questions, then ask, ‘okay, what do you mean by that? What do you mean by this kind of sex?’ Then I could explain that. I think a lot of times, the clinical language that’s used is just so off-putting and at times can be confusing...I think it should be more, ‘What’s important to you? Let’s talk about how those things impact you and your well-being.’”—Rachel (24, queer)</p>	<p>Providers can explain the rationale for their sexual history questions.</p> <p>Providers admitting that they might make mistakes and asking for the patient’s expertise can encourage good communication about contraceptive needs.</p>	<p>“[A doctor I shadowed] phrased it ‘I want to know who you have sex with to better care for you.’ So adding the personal aspect when asking a very personal question could help make patients more comfortable.”—Priya (20, queer)</p> <p>“I would appreciate if the doctor would say up front, ‘If there’s any language or tone that I use throughout our visit today [that doesn’t work for you], please let me know what you prefer...’ You know, if they say that up front, and the doctor admits their own vulnerability, then I can’t imagine that a patient would not respond in a positive way.”—Rachel (24, queer)</p>
<p><b>Stage 2: Making disclosure decisions</b></p>		
<p><i>Expectations of discrimination</i>                      —“When I’m talking about things [like contraception] I think “Well, is it worth to disclose it to the person?” My immediate answer is no, and to lie to get what I need and then get out.”—Jules (23, queer)</p>	<p>Having to disclose to multiple people during a health care encounter is stressful.</p> <p>Participants might choose a clinic based on its queer-positive reputation.</p>	<p>“When you go to the doctor, you don’t just see the doctor. You usually see an MA and then you see an RN and then you see a doctor... You always have to explain the same thing three times, so I’m more worried about the personal interaction. You have to come out three times in one visit, and that is a barrier to doing anything.”—Jane (29, queer/lesbian)</p> <p>“I’d say it depends on where you go. Like if your primary is just a s**tshow, it’s a terrible [conversation], but if you go to Planned Parenthood or a clinic that’s known to be LGBTQ competent...you’ll receive more LGBTQ competent treatment.”—Renée (23, bisexual)</p> <p>“I had heard that some of the providers identified as queer. So, there was this little whispered network of “There are queer providers here.” And going in with that knowledge, I just felt safer. And even in questions about my history or identity, I felt they were validated in that space.”—Vanessa (30, queer)</p>

(continued)



**Table 2. Themes and Subthemes With Illustrating Quotes From Participants\* (continued)**

Theme and Illustrating Quote	Subtheme	Examples
<i>Evaluating safety in real time</i> —“When you go to any new environment, but definitely somewhere where you’re as vulnerable as a doctor’s office, you’re kind of doing the vibe test and [assessing], ‘Is this a safe place for me to come out? How much do I reveal?’”—Addison (26, queer)	Visual signs of inclusivity could encourage disclosure.  Provider’s own visible identities could affect disclosure decisions, though sometimes assumptions were proven wrong.	“Even have visual identifiers walking into the space. Like, think about something as cliché as the rainbow flag or something like that...indicators that this space is welcoming and validating of all identities.”—Vanessa (30, queer) “My doctor is someone I see like once a year maybe, who is, like, a really old man...there’s probably some big gap between that and being comfortable with your doctor.”—Emily (21, bisexual) “The best experience I ever had was the most unexpected, because I always felt more comfortable with a woman OBGYN and I had never been to a man before. I was like, “okay; I have to have this appointment, I’m just gonna do it.” And it was the best OBGYN experience I ever had. I felt that because he was a man he was trying extra hard to be culturally sensitive and just sensitive to me as a person. He was going really slow and explaining everything that he was gonna do, and I felt that his answers to my questions were really genuine.”—Joan (25, lesbian/bisexual)
<i>Awareness of structural inequality</i> —“I think I’ve done enough queer organizing...that I have a very antagonistic relationship with health care. Not even from my own experience, but all of my trans [gender] friends and every single thing they’ve had to endure at the hands of the medical care system, really does make me have very little faith in any health care providers.”—Jules (23, queer)	Participants had fears of being mistreated if they challenged providers.	“My bone doctor laughed at me [when I came out]... I don’t know if [they were] laughing at my comment or what was going on, but I was just like, “I’m going to not [respond].” I don’t like to get in fights with doctors because they’re still the one caring for me.”—Rachel (24, queer)
<b>Stage 3: Providers responding to nonheterosexual identity disclosure</b> <i>Discomfort and awkwardness</i> —“It makes both of us feel really awkward when I tell them I’m gay or I sleep with girls. And then like it’s just like a really awkward encounter...we both just kind of sit there staring at each other. And they’re like, ‘okay...’ and I’m like, ‘Yeah...’”—Logan (25, lesbian)	Awkward and nonverbal responses to disclosure could affect patient’s comfort.	“I was trying to establish primary care. When [the nurse] asked the sexual orientation question and I told her my answer, she just like stalled her fingers. And I don’t know if she did it intentionally, but she did. And then she just went back to typing and went on. And then it was that nurse that was in there when [the doctor] was doing the actual exam. And he didn’t do anything wrong, it was just awkward and uncomfortable all the way around and I never went back.”—Sam (24, bisexual)

*(continued)*

**Table 2. Themes and Subthemes With Illustrating Quotes From Participants\* (continued)**

Theme and Illustrating Quote	Subtheme	Examples
<i>Misinformation about reproductive health care needs of sexual minority women</i> —"It goes one way or the other, where either they're like 'Why aren't you on contraception?' because they don't know or they assume that you're straight, [or they] go the opposite direction, where they're like 'Oh, you're queer' and then they completely ignore [contraception]. So it seems black and white from my experiences..."—Beatrice (21, bisexual)	Providers were unaware of other sexual and reproductive health needs of sexual minority women.	"I could see it changing things in the doctor's office, if you disclose your sexuality to your doctor and your doctor then takes that as "oh well, because of this you can't get pregnant or there's zero STI risk," which is false. You can still get a STI from sex with someone else who has a vulva. I don't know why doctors say you can't."—Renée (23, bisexual)
<i>Suggestions for effective responses to disclosure</i>	Providers should respond to disclosure with a conversation about how identity affects health.	"I don't think it should be a checklist: 'What's your sexuality? What's your gender? What's your race? What's your ethnicity? What's this, this, and this?' I think it should be more, "What's important to you? " And, 'Let's talk about how those things impact you and your well-being.'"—Rachel (24, queer) "Just be willing to have that conversation with patients where they say, 'What does X term actually mean to you? I saw you marked 'queer' on this sheet. What does that mean to you? Are you currently sexually active? Okay, so what does that mean to you as a queer woman?' I know there's a lot of fear about getting it wrong...but there doesn't really need to be."—Addison (26, queer)
	Disclosure is an opportunity to get information in an otherwise heteronormative and sex-negative world.	"I personally found [talking to my provider] useful because we didn't talk about contraception [in school]...I thought the implant was the only thing that you could get. Until [my provider] told me there's other things like pills and stuff like that, I didn't even know other contraception existed, let alone that it could be used for other things. So it was good for me to hear about and learn that there were other options out there."—Sonya (22, queer) "I think if the providers framed it as, "These are important conversations we want to have with everyone and important questions we want to ask all folks who come in our door...and if these things don't apply to you, feel free to say 'pass.'" But framing it in that way, honoring identity and also saying "We want to have these conversations with everyone because we realize folks may not have had these conversations before" would probably be a good way to frame it. Or at least I would be receptive to that."—Vanessa (30, queer)

LGBTQ, lesbian, gay, bisexual, transgender, queer.  
\*Names are pseudonyms.



aspects of successful strategies for asking about sexual orientation included using open-ended questions, straightforwardness and frankness, and explaining the clinical rationale for questions.

Our participants described a nuanced process for deciding whether or not, and to what extent, to disclose their sexual identities in contraceptive care settings. Virtually all the participants described thinking seriously about whether or not to disclose their identities in health care contexts, and many reported that their decisions or strategies about disclosure were situation-specific. Participants described having expectations of discrimination, taking the provider's reputation into account, and evaluating the safety of disclosure in real time during contraceptive care visits.

Expectations of discrimination or judgment from providers and expectations that providers would not be able to meet the reproductive health care needs of sexual minority women were commonly mentioned by participants. In this way, hesitance to disclose or decisions not to disclose were a logical and self-protective response to personal and community histories of discrimination. Some participants expressed that the benefits of discussing sexual identity with a provider were simply "not worth" risking discrimination, and that they preferred to strategically not disclose. Jules (23, queer) explained:

When I'm talking about things [like contraception] I think "Well, is it worth to disclose it to the person?" My immediate answer is no, and to lie to get what I need and then get out.

Expectations of discrimination could vary based on what the participant knew about the provider or clinic before the encounter. Several participants mentioned Planned Parenthood and local lesbian, gay, bisexual, transgender, and queer-focused clinics as safe places to have affirming and nonjudgmental conversations about contraception and sexual health.

In addition to using previous knowledge to plan disclosure decisions, participants discussed how they evaluated the atmosphere of the health care setting and the tone set by the provider during the visit before making a real-time decision about whether, or how much, to disclose. Addison (26, queer) put it this way:

When you go to any new environment, but definitely somewhere where you're as vulnerable as a doctor's office, you're kind of doing the vibe test and [assessing], "Is this a safe place for me to come out? How much do I reveal?"

In some cases, participants discussed forming impressions of the safety of disclosure based on the provider's own identity, including their age and gen-

der. Several participants expressed a preference for younger and female providers, or more discomfort disclosing their sexual orientation to older, male providers. Though our participants' disclosure decisions were strategic and sometimes self-protective, their experiences also demonstrate it is possible for contraceptive providers to overcome negative expectations.

Participants were highly aware of the structural and systemic barriers to health care for sexual and gender minorities, and often referred to these larger issues as playing a role in their own personal disclosure decisions. A few participants considered themselves "lucky" to not have experienced severe discrimination in a health care setting and identified their own privileges that made it safer for them to disclose, such as being cisgender, white, or well educated. The power dynamics inherent in clinical encounters loomed large in how participants decided whether to disclose or discuss sexual orientation with providers. These dynamics could make participants feel that if they corrected or demanded more from providers, they were risking judgement, refusal of care, or further marginalization. Participants agreed that all types of health care encounters influenced expectations and decisions across health care contexts including contraceptive care. Sexual minority women's expectations of discrimination, real-time experiences with individual providers, and knowledge of historical trauma and systemic barriers to care can strongly influence their individual decisions about disclosure in contraceptive settings.

Finally, our results demonstrate that when participants did disclose their sexual orientation, health care providers were generally unprepared to respond effectively. Echoing their preferences for sexual orientation questions, the women in our sample stressed the need for responses to disclosure to be clinically relevant and focused on their health priorities and health care needs.

Unfortunately, many participants had experienced provider responses to disclosure that reflected awkwardness, discomfort, or confusion. For example, Logan (25, lesbian) shared this common experience:

It makes both of us feel really awkward when I tell them I'm gay or I sleep with girls. And then like it's just like a really awkward encounter...we both just kind of sit there staring at each other. And they're like, "Okay..." and I'm like, "Yeah..."

Because sexual and reproductive health care encounters can be particularly sensitive, even when



these responses were subtle, they had important consequences for the way the interaction proceeded.

Providers' expressions of surprise or discomfort after sexual orientation disclosure could feel strongly stigmatizing to the sexual minority women in our sample.

Many participants reported experiences that revealed health care providers' incompetence around the sexual and reproductive health needs of sexual minority women. For example, when women were assumed to be heterosexual, providers were very concerned with contraception. When they disclosed a different sexual identity, however, providers made assumptions that their patients did not need or were not interested in contraception. This phenomenon could be experienced as a double jeopardy: being invisible as sexual minority women and then having their needs rejected once visible. Beatrice (21, bisexual) described this reaction to disclosure:

It goes one way or the other, where either they're like "Why aren't you on contraception?" because they don't know or they assume that you're straight, [or they] go the opposite direction, where they're like "Oh you're queer" and then they completely ignore [contraception]. So it seems black and white from my experiences...

Participants had specific ideas about potentially productive and affirming responses to disclosure. They expressed their wishes for providers to meaningfully engage in conversations about sexual identity and behavior with patients after disclosure. Addison (26, queer) suggested:

Just be willing to have that conversation with patients where they say, "What does X term actually mean to you? I saw you marked "queer" on this sheet. What does that mean to you? Are you currently sexually active? Okay, so what does that mean to you as a queer woman?" I know there's a lot of fear about getting it wrong...but there doesn't really need to be.

Other suggestions demonstrated how health care providers could be a reliable source of information in an otherwise heteronormative and sex-negative world. These suggestions for positive responses highlighted how providers can enact their role as a partner in sexual minority patients' health.

## DISCUSSION

Overall, our findings demonstrate that sexual minority women make nuanced decisions about sexual orientation disclosure in contraceptive health care settings. The young sexual minority women in our sample often expected discrimination

or misinformation from providers and gathered contextual clues about the safety of disclosure in particular encounters. These expectations are informed by previous experiences and knowledge of structural and systemic barriers to health care for sexual and gender minorities. The way that contraceptive providers frame questions about sexual orientation and sexual behaviors is an important clue to these young sexual minority women about the safety of disclosure. Moreover, providers' responses to disclosure can be experienced as affirming and helpful, or further stigmatizing and deterring future contraceptive care.

Importantly, expectations about stigma and participants' decisions about how to approach potentially difficult encounters may be strongly influenced by other components of identity that are stigmatized. Our sample was overwhelmingly white and well-educated, which can shift the power dynamics that exist in health care. Sexual minority women of color may make different choices about disclosure in terms of willingness to risk further discrimination than do white women. Although the few nonwhite women in our sample did not have overtly different perspectives than white participants, a more racially and ethnically diverse sample would facilitate analysis of these factors.

This study makes a significant contribution to the literature by focusing specifically on the experiences of sexual minority women in contraceptive care. Patterns of sexual orientation disclosure may be different across health care encounter types, and sexual orientation and behavior may be especially important information for contraceptive providers. Our findings support previous literature that suggests that access to contraceptive care and dynamics in contraceptive encounters may be important contributing factors to high rates of unintended pregnancy among young sexual minority women.<sup>20,24,25</sup> Assumptions and misinformation about the contraceptive needs of sexual minority women, limited understanding of the multiple dimensions of sexuality, and health care avoidance owing to fears and past experiences of stigma and discrimination all contributed significantly in our data to poor experiences with contraceptive care.

A primary limitation of this study is the homogeneity of the sample, particularly in terms of racial and ethnic identity and educational attainment. The study's convenience sampling approach was driven by the research team's aim to maximize the heterogeneity of the sample in terms of sexual identity. Though we recruited participants primarily from social media postings in community-oriented groups,



holding the focus groups in on-campus locations may have also biased our sample towards individuals who were already affiliated with the universities. The fact that most of our participants were white and well-educated is likely to affect the point at which we reached saturation and the commonalities across participants' experiences in contraceptive care. Our findings may also be limited by the role of investigator bias in interviews. Study team members who conducted focus groups and individual interviews aimed to establish trust with participants and respond non-judgmentally, but reporting may have been selective based on the inherent power imbalances between research participants and investigator.

Our results highlight several immediately actionable steps that contraceptive providers can take to better meet the contraceptive needs of sexual minority women. First, our findings suggest that providers should ask all patients about sexual orientation<sup>8,11,13</sup> and not exclude conversations about contraception with sexual minority women. Specifically, our findings suggest that providers need to be careful to ask about both sexual identity and sexual behaviors, and that these questions should be open-ended and highlight the health-specific rationale. We suggest as one possible strategy the approach proposed by one participant; providers can follow up on intake forms where patients indicate their sexual orientation by asking, "I saw you marked 'X' on this sheet. What does that mean to you?" Such open-ended strategies can help providers collect clinically relevant information about a patient's sexual identity and behaviors and affirm the patients' identity simultaneously. Additionally, contraceptive providers should acknowledge the experiences of marginalization, discrimination, and stigma in health care that sexual minority women experience as part of a marginalized community. Some strategies for demonstrating this awareness can include being cognizant of body language and discomfort with particular topics or identities, providing visual and verbal cues of willingness to include sexual minority women in your practice and meet their needs, and ensuring that all clinical staff is ready to care for sexual minority women.<sup>33,34</sup>

Our findings also highlight the need for dissemination and implementation of research findings and best practices related to the health of sexual minority women. There were clear distinctions between participant accounts of successful and unsuccessful contraceptive care encounters, suggesting that some health care settings and providers have been able to implement some or all of the above strategies, whereas others have not. Investigators should aim to better

disseminate evidence-based practices related to the sexual and reproductive health of sexual minority women. Additionally, very few interventions designed to improve access to appropriate care among sexual minority women and to improve providers' knowledge and behaviors with sexual minority patients have been studied.<sup>35</sup> Investigators should begin to develop, test, and implement such interventions so that improved contraceptive care for sexual minority women is widely available.

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## PEER REVIEW HISTORY

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