Psychology of Sexual Orientation and Gender Diversity

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Characterizing Stereotypes That Perpetuate Sexual Minorities' Anticipated Stigma in Healthcare Settings

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Sexual minorities report avoiding disclosure of their sexual orientation to healthcare providers to prevent encounters with bias. The present work explores the unique anticipated stereotypes that sexual minorities in the United States expect from healthcare providers using open-text responses and novel machine learning methods to code anticipated stereotypes into stereotype content dimensions. Sexual minority participants ($N = 361$) reported the traits or characteristics that they would expect a healthcare provider to believe to be true about them under two conditions; one wherein they just met the provider and one wherein their sexual orientation was disclosed. As expected, the valence of expected stereotypes was more negative in the identity disclosed condition, and, critically, participants expected more morality and deviance-based stereotypes when their sexual orientation was known. Further, these stereotype dimensions differentially predicted healthcare visit expectations (i.e., anticipated treatment quality, anticipated concealment of health behaviors/symptoms, anticipated comfort disclosing sexual orientation) and healthcare avoidance. As sexual minority individuals may vary in the types of stereotypes that they expect from healthcare providers and in the valence of stereotypes that they expect from healthcare providers when their identity becomes known, research on anticipated healthcare stigma needs to capture unique stereotypes that should be targeted to reduce healthcare disparities.

Public Significance Statement

The present research utilizes text data analyses to document how sexual minority Americans' healthcare experiences may be impacted by their unique stereotype expectations. Findings suggest that unique stereotype expectations, like expectations of being perceived as immoral or deviant, differentially predicted sexual minority individuals' anticipated healthcare treatment quality and comfort in disclosing their sexual orientation to providers. Findings point to the importance of future interventions that target unique stereotype dimensions, for example, in provider bias training or in lesbian, gay, bisexual, transgender, and queer/questioning community outreach, to improve sexual minorities' quality of experiences in healthcare.

Keywords: healthcare, stereotypes, identity disclosure, lesbian, gay, bisexual, transgender, and queer/questioning, identity concealment

Supplemental materials: https://doi.org/10.1037/sgd0000822.supp

Sexual minority individuals (including lesbian, gay, and bisexual people and others with nonheterosexual romantic interests or attraction) report receiving poorer quality healthcare relative to their heterosexual counterparts (Clift & Kirby, 2012; Connors et al., 2020). Such differences have been documented by the Institute of Medicine (the National Institutes of Health as a barrier to population health (Institute of Medicine, 2011) and are described as a modifiable outcome (see Matsick et al., 2020). Importantly, these differences are proposed to originate primarily from social, rather than medical, causes, such as recurrent experiences of discrimination at structural and interpersonal levels (Hatzenbuehler et al., 2013; Penner et al., 2018; Ryan et al., 2017), and expectations of experiencing stigma (i.e., social devaluation, stereotyping, or discrimination) in healthcare settings (e.g., Durso & Meyer, 2013; Wang et al., 2018). Indeed, targeting stigma in healthcare settings has the potential to decrease healthcare disparities, including differences in healthcare utilization, with downstream effects on sexual minority population health disparities (e.g., mortality, substance use, suicide ideation; Cochran et al., 2016; Dovidio et al., 2017; Hatzenbuehler, 2010; Lick et al., 2013).

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Research suggests that prevalent bias against sexual minorities among healthcare providers (see Burke et al., 2015; Sabin et al., 2015) can be reduced by targeting institutional practices and individual practitioner's knowledge of issues faced by sexual minority groups (e.g., stereotype myths, disparities; see Sekoni et al., 2017). Healthcare providers continue to endorse negative stereotypes and misconceptions about sexual minorities (e.g., Mitchell et al., 2023; Morris et al., 2019) as reflected in reports of sexual minorities' dissatisfaction with healthcare (e.g., Ayhan et al., 2020; Malik et al., 2019). By engaging in efforts to lower sexual minority patients' expectations of encountering stigma in healthcare (e.g., through increasing healthcare provider training on sexual minority needs and issues; see Weingartner et al., 2019), we can improve sexual minorities' healthcare utilization and disclosure of health-relevant information (e.g., Burgess et al., 2010; Cipollina & Sanchez, 2019; Gessner et al., 2019; Louis et al., 2022; Politi et al., 2009; Ryan et al., 2017). Sexual minority patients who expect providers to stereotype them are more likely to conceal their sexual orientation from the provider (e.g., Cipollina & Sanchez, 2022; Durso & Meyer, 2013; Eliason & Schope, 2001; Steele et al., 2006), which has been linked to various negative outcomes, including lower healthcare satisfaction (Mosack et al., 2013), lower access to preventative treatments and screenings (e.g., preexposure prophlyaxis, anal exams; Kutner et al., 2022; Petroll & Mosack, 2011; Quinn et al., 2019), and poorer health (Fingerhut & Abdou, 2017; Ruben & Fullerton, 2018).

The present work is the first to document the unique stereotypes that sexual minorities anticipate from healthcare providers to initiate a more comprehensive conversation about the importance of targeting these unique stereotypes to reduce healthcare disparities. Specifically, the present work will examine sexual minorities' expectations of sociability, morality, ability, assertiveness, health, and deviancy stereotypes from healthcare providers and the relationship between these anticipated stereotype dimensions and healthcare interaction factors.

Prior Research on Stereotype Dimensions

According to well-established models of stereotype content (e.g., Fiske et al., 2018), people tend to evaluate social groups along a few primary dimensions. The first and most impactful of these dimensions is warmth: perceptions about other's morality and sociability (the two facets of warmth). The second primary dimension is competence: perceptions about other's ability and assertiveness (the two facets of competence). More recent models (Nicolas, Bai, & Fiske, 2022) have used open-ended measures of social group stereotypes and identified additional, prevalent, dimensions of content, including stereotypes about group health and deviance. Together, these dimensions allow perceivers to organize their behavior toward groups by understanding the groups' intentions and capability to enact those intentions. These dimensions have been shown to predict behavioral intentions, decision making, and general prejudices toward high- and low-status groups (Fiske et al., 2021; Nicolas, Fiske, et al., 2022). Many of these dimensions have also been discussed in prior research on sexual minority groups.

Decades of research have identified that sexual minority individuals are stereotyped as being deviant, unhealthy, diseased, and overly promiscuous (e.g., Calabrese et al., 2018; Rice et al., 2022). These stereotypes fall into stereotype content dimensions of health, deviance, and morality. However, research on specific sexual minority subgroups identifies different stereotype dimensions. For instance, stereotypes for gay men and lesbian women were found to follow what researchers termed "gender inversion theory" (see Kite & Deaux, 1987); such that gay men were stereotyped as being more like a stereotypical woman, being more warm, sociable, and agreeable, whereas lesbian women were stereotyped as being more like a stereotypical man, being more aggressive, assertive, and competent (e.g., Geiger et al., 2006).

A growing literature on bisexual and pansexual people again touches on stereotype content dimensions of morality, deviance, and assertiveness, such that they are viewed as being unsure about their sexual orientation, untrustworthy, pleasure-seekers, who are unable to commit to just one gender for a partner (e.g., Dyar et al., 2017; Maimon et al., 2021; McGorray & Petsko, 2023). Because of unique bisexual and pansexual stereotypes that these groups are unsure of what their identity truly is, bisexual and pansexual people report experiencing instances where their sexual identity is denied by both heterosexual and lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ) community members (Garr-Schultz & Gardner, 2021). Moreover, while less studied in the literature, stereotypes about people who identify as asexual or aromantic also fall into the assertiveness stereotype dimension such that they are perceived as being unsure about their identity or that their asexuality will be fleeting and is simply due to some transient bodily dysfunction (e.g., Foster et al., 2019).

Flipping Stereotype Research to Focus on Minority Perspectives

Most research into stereotypes focuses on outgroup members' stereotypes about a marginalized group, for example, heterosexual Americans' stereotypes about sexual minorities. However, metastereotypes or cognitions about the stereotypes that others in society have about one's marginalized ingroup, like a sexual minority individual's belief about what heterosexual people think about sexual minorities, may have a substantial influence on intergroup interactions. For instance, prior research suggests that intergroup interactions wherein stereotypes are expected tend to be of poorer quality (e.g., greater discomfort, less productive conversations, e.g., Shelton et al., 2005). Indeed, fears of confirming stereotypes influence marginalized individuals' behavior in intergroup interactions (e.g., Aronson et al., 2013) and can impair help-seeking behaviors (e.g., Wakefield et al., 2012). Recent research documents that bisexual and pansexual people vary in their beliefs that society questions or doubts their identity, and those who believe that society doubts their identity to a greater extent report poorer quality identity disclosure experiences (Cipollina et al., 2024). Thus, expected stereotypes likely impact sexual minorities' interactions with others, and sexual minority individuals may expect stereotypes that fall onto different stereotype dimensions.

Sexual Minority Stereotypes and Healthcare

While warmth and competence are indeed the two most studied stereotype dimensions (for a review, see Fiske et al., 2021), these stereotypes may not be most threatening for sexual minority people within healthcare settings. Stereotypes about poor health, like that sexual minority people are more likely to have sexually transmitted diseases and mental disorders (see Drescher, 2015), and stigma

surrounding sexual activities that sexual minority populations engage in, like anal sex, are highly salient in healthcare settings (Kutner et al., 2022). Indeed, talking to a healthcare provider about poor health symptoms (e.g., difficulty urinating) may open fears of confirming poor health/diseased stereotypes about sexual minorities. If sexual minority patients bring up mental health concerns to a healthcare provider, they may be stereotyped as being troubled because of their sexual identity (Cochran, 2001; Ojeda-Leitner & Lewis, 2021). Further, discussing sexual health or sex behaviors is especially difficult for sexual minorities who have greater past encounters with sexual orientation-based discrimination (e.g., Kutner et al., 2022). Sexual minorities' interactions with healthcare providers are fraught with the potential to confirm group stereotypes but each individual is likely to anticipate or fear different types of stereotypes from their healthcare provider, depending on factors such as their identity or the type of information they anticipate sharing with their provider.

Present Research

Critically, sexual minorities continue to report disparate experiences in healthcare including identity-related discrimination from providers (e.g., Malik et al., 2019). Indeed, sexual minorities' expectations of stereotypes from healthcare providers may be derived from prior stigmatizing experiences with healthcare providers. An individual's decision to conceal their sexual orientation from healthcare providers or avoid healthcare can be adaptive to reduce the likelihood of facing stereotypes and discrimination (Suen et al., 2022), though this decision confers health risk (e.g., Ruben & Fullerton, 2018). The present work collected data on sexual minorities' expectations of stereotypes from healthcare providers to improve the specificity of our understanding of predictors of sexual minority healthcare disparities.

Specifically, the current research uses open-ended response data and machine learning text analysis methods to study sexual minority individuals' anticipated stereotypes from healthcare providers and their influence on healthcare avoidance and expectations of healthcare interactions. This research is guided by two overarching research questions (RQs):

> *RQ1:* How does imagining sharing one's sexual minority identity with healthcare providers impact sexual minorities' anticipated stereotypes from healthcare providers?
>
> *RQ2:* Do stereotype dimensions (e.g., morality, ability) differentially predict healthcare outcomes known to contribute to sexual minority health disparities (e.g., avoidance of healthcare)?

To address the RQ1, we conducted four different analyses using novel text coding of participant responses. Participants reported traits that they expect from healthcare providers with open text responses under two conditions: (a) where their identity was disclosed to the provider and (b) where their identity was not disclosed to the provider.

- First, we examined if overall anticipated stereotypes from healthcare providers were more negatively valenced in the identity disclosed condition relative to a condition where participants' identity was imagined to not be disclosed. We hypothesized that the overall valence of stereotypes would be more negative in the identity disclosed condition.
- Second, we examined differences in the frequency of stereotype dimensions anticipated by participants across the two conditions (e.g., are anticipated stereotypes about morality more common in the identity disclosed condition than the not disclosed condition). We hypothesized that anticipated morality, deviance, and health stereotypes would be more frequent in the identity disclosed condition, as these dimensions are commonly reported by sexual minorities in healthcare settings (e.g., Kutner et al., 2022).
- Third, we examined differences in the direction of anticipated stereotypes dimensions across conditions, specifically, if stereotype dimensions in the identity disclosed condition were more unfavorable than those in the not disclosed condition. For example, we hypothesized that anticipations of being seen as diseased, sickly, and of ill health (i.e., low in health) would be more likely in the identity disclosed compared to the not disclosed condition. Conversely, we anticipated that participants' anticipation of deviance stereotypes would be greater in the identity disclosed condition (i.e., high in deviance) compared to the not disclosed condition.
- Finally, when examining the content of anticipated stereotypes in the identity disclosed condition, we conducted exploratory analyses of sexual minority subgroup differences stereotypes (e.g., are expectations of being seen as higher in deviance more common among bisexual/pansexual relative to lesbian/gay participants).

To answer the RQ2, we examined how anticipated stereotypes across these various dimensions are related to anticipated healthcare interactions and healthcare avoidance. In parsing apart anticipated stereotype dimensions (e.g., looking at the effect of anticipated sociability stereotypes separately from anticipated morality stereotypes) on each outcome, the present work sought to explore which stereotype dimensions had greater predictive power. We hypothesized that anticipated morality, deviance, and health stereotypes would predict the most variance in our outcomes, as these stereotype dimensions are commonly discussed by sexual minorities in this context. However, we did not have specific hypotheses about which of these stereotype dimensions would most strongly predict each of the healthcare outcomes. Instead, the present article explores the variance explained in each outcome by six different anticipated stereotype dimensions (i.e., ability, assertiveness, sociability, morality, deviance, and health) to highlight stereotype dimensions that may most impact sexual minorities' healthcare interactions.

Method

Participants

Participants were recruited and screened on Prolific's survey recruitment platform. To be eligible for the study, participants had to identify as having a sexual orientation that is not heterosexual as the primary goal of our research was to examine anticipated stereotypes when one's nonheterosexual sexual identity/orientation is revealed. In addition, participants needed to be 18 years or older and residing in the United States at the time of participation. Respondents who identified as heterosexual ($n = 35$), did not provide complete data ($n = 2$), or who failed two or more attention check questions (e.g., "select strongly disagree for this response," $n = 1$) were excluded. Six participants identified as transgender or gender nonbinary. These participants

were removed from the article's analyses because of concerns that their transgender identity may substantially impact the anticipated stereotypes they expect providers to have of them and the complexities that surround transgender identity disclosure in healthcare settings (see Friley & Venetis, 2022). Analyses including these participants are reported in the online supplemental materials.

Our final analytic sample consisted of 361 participants (M_{age} = 30.48, SD_{age} = 11.32, range 18–79) who primarily identified as cisgender women (65.7%; 34.1% cisgender men; and one participant did not disclose). A majority of the sample identified as bisexual (57.1%) with 36.0% of participants identifying as lesbian or gay, 5.8% of participants identifying as pansexual, and the remaining participants (1.1%) identified with another sexual orientation (e.g., queer, asexual). The majority of participants identified as non-Hispanic White/Caucasian (67.3%), with 9.7% of the sample identifying as South/East/Southeast Asian, 9.1% of the sample identifying as Black/Caribbean/African American, followed by 7.8% who identified as biracial or with more than one racial or ethnic group, 5.8% who identified as Hispanic/Latino/a/x, and one participant who identified as Native American/American Indian.

At the time of taking the survey, most participants reported having health insurance (84.2%), while 14.7% did not. About half of the participants (49.3%) indicated that they have a healthcare provider that they see regularly for continued treatment of a medical condition (mental or physical), and 71.4% of the sample reported seeing a provider (including visiting a walk-in clinic) sometime in the past year. Participant recruitment and treatment was conducted in accordance with an Institutional Review Board-approved protocol.

Materials and Procedure

Participants were invited to participate in our study on "Healthcare Perceptions" and were instructed that study procedures involved thinking about traits or characteristics that general healthcare providers believe to be true about a group of people. They were provided with the following example, "We may ask you to think of traits that healthcare providers believe athletes generally have and you may respond with any characteristics or traits that you think healthcare providers believe that group to have." They were informed that there are no right or wrong answers and instructed to provide answers that are one or two words long only.

In randomized order, participants reported the first six traits that came to mind under each condition. In the identity not-disclosed condition, participants listed traits that they anticipated general healthcare providers would believe to be true about them upon first meeting them. In the identity disclosed condition, participants listed traits they anticipated providers would believe to be true about them if they disclosed their sexual orientation. Participants were not provided any guiding information regarding the identities of the general healthcare providers they were imagining, such that no gender, race, or sexual orientation factors about the providers were discussed. Despite not explicitly providing this information, it is likely participants imagined heterosexual healthcare workers, given the predominance of heterosexual-identified healthcare providers in the healthcare industry (see Martos et al., 2018).

After providing open-text traits, participants were instructed to answer a series of questions assessing what they would anticipate in a novel interaction with a new healthcare provider (i.e., one they have not seen before). Participants reported on anticipated treatment quality, anticipated health behavior and symptom concealment, items assessing how they would act during this visit, comfort and likelihood of disclosing their sexual orientation to the provider followed by questions about themselves (e.g., is it easy for them to pass as heterosexual), the imagined provider (e.g., was the provider a man or woman), and their beliefs (e.g., do they harbor mistrust in medical providers) in that order. After completing survey measures, participants responded to additional demographic questions and were debriefed online.

Focal measures for the present article are described in detail below along with the strategy for coding open-text responses. All survey materials and article data are provided on the Open Science Foundation (https://osf.io/y2zt6/?view_only=f4e6e2980be04228aced6dbe8017e589; Cipollina & Nicolas, 2025).

Anticipated Treatment Quality

Participants answered five items adapted from Cipollina and Sanchez (2022, 2023) which assessed anticipated feelings of belonging and comfort during the imagined healthcare visit (e.g., "I would feel comfortable interacting with the healthcare provider") along with items of anticipated satisfaction in visit quality (e.g., "I would be satisfied with the quality of treatment I received from the provider"). All items were rated on a 1 (*not at all likely*) to 7 (*very likely*) Likert scale. The items loaded on one factor in exploratory factor analysis, had high reliability ($\alpha = .92$), and were averaged such that high scale values indicate better anticipated treatment quality ($M = 4.60$, $SD = 1.25$).

Anticipated Concealment of Symptoms and Health Behaviors

Participants answered five Principal Investigator-created items that assessed anticipated concealment of health behaviors and symptoms during the imagined healthcare visit (e.g., "I would not tell the provider the whole truth about my experience/health"). All items were rated on a 1 (*not at all likely*) to 7 (*very likely*) Likert scale. The items loaded on one factor in an exploratory factor analysis, had high reliability ($\alpha = .87$), and were averaged such that high scale values indicate greater health behavior/symptom concealment ($M = 3.18$, $SD = 1.41$).

Anticipated Disclosure Comfort

Participants answered two items adapted from Cipollina and Sanchez (2022) which assessed participant's anticipated comfort and likelihood of disclosing their sexual orientation to this new imagined healthcare provider. The two items were rated on a 1 (*not at all*) to 7 (*very*) Likert scale, were highly correlated, $r(361) = .81$, $p < .001$, and were averaged such that high scale values indicate greater anticipated disclosure comfort ($M = 3.91$, $SD = 1.83$).

Healthcare Avoidance

Participants answered four items assessing the extent to which they avoid healthcare visits. The items, for example, "I avoid scheduling healthcare visits even though I probably should schedule them," were rated on a 1 (*not at all true*) to 5 (*completely true*). The four items were reliable and were averaged so that higher values represent greater desire and tendencies to avoid healthcare visits ($M = 2.50$, $SD = 1.04$, $\alpha = .81$).

Coding Open-Text Responses Using Content Dictionaries

Open-ended responses are highly diverse, as participants are free to use any words they desire. However, many responses can be recoded into fewer dimensions by accounting for synonymy and content dimensions that include semantically related words. Thus, the present research used recently developed stereotype content dictionaries (Nicolas, Bai, & Fiske, 2022) to conduct a quantitative content analysis. These dictionaries consist of lists of words associated with different stereotype contents and have high reliability and convergent validity (Nicolas, Bai, & Fiske, 2022). To code participants' responses into the dictionaries, we first preprocessed them, including transforming text to lowercase, removing punctuation and symbols, and lemmatizing (e.g., removing inflectional endings). This initial step removes unimportant (e.g., syntactic) variation in responses. Then, we matched each response to the dictionaries (Nicolas, Bai, & Fiske, 2022; available at https://www.github.com/gandalfnicolas/SADCAT), resulting in a code, per response, of 0 (*absent*) or 1 (*present*) across the 14 content dimensions included in the dictionaries (e.g., sociability, morality, ability, assertiveness, health; see Nicolas, Bai, & Fiske, 2022 for all content dimensions). The dictionary was able to match over 93% of participants' open-text responses into a dimension; while the remaining responses were not coded, most often due to being nonsensical or failing to follow instructions.

Once each text entry was coded into a stereotype dimension, additional descriptive output about participants' anticipated stereotypes was computed. For instance, each participant's dimension prevalence/frequency score was a sum of each of the participants' six responses (range from 0 to 6). Valence of responses was also computed using a composite of sentiment dictionaries (available through R). Valence ranges from −1 (*negative*) to 1 (*positive*). For example, words such as attractive and righteous score high in valence, while words such as unfortunate and perverted score low. A similar variable for each stereotype dimension was examined, its direction. Dimension direction indicates whether the response is *low* (−1), *neutral* (0), or *high* (1) on the dictionary dimension. A direction score was created for each response coding. Some differences between valence and direction codings are worth noting; for most dimensions, these are highly correlated (e.g., high morality also implies positive valence morality), but not for all dimensions (e.g., some high assertiveness words are positively valenced, like being independent, while others are negative, like being aggressive). The coding method for dimension direction is more theory-driven, that being, which responses are high or low on a given dimension as discussed in past literature. As such, the present article presents, valence, dimension direction, and frequency data, with additional valence analyses presented in the online supplemental materials. Additional details about dictionary coding procedures are included in the online supplemental materials.

Analytic Plan

All analyses were run using SPSS or R packages lme4 (Bates et al., 2015) and lmerTest (Kuznetsova et al., 2017). The RQ1 was addressed with four different analyses. First, differences in the overall valence of anticipated stereotypes from healthcare providers were examined with a series of t tests derived from a linear mixed model with participant as a random intercept and either the intercept (mean valence) or condition (for pairwise comparisons) as predictor. Within-condition t tests were tested against zero (neutral valence). Mixed models were used to account for the within-subjects design. Second, differences in the frequency of stereotype dimensions anticipated by participants across the two conditions were examined with an F test (omnibus) and z tests (pairwise comparisons of conditions within each dimension) derived from a Poisson mixed model with participants as a random intercept and dimension, condition, and their interaction as predictors. A Poisson model was used to account for the count outcome (e.g., negative values are not possible for dimension frequencies). Third, differences in the direction of anticipated stereotype dimensions across conditions were examined with t tests (pairwise comparisons of conditions within each dimension). Finally, comparisons of anticipated stereotypes by sexual minority subgroups were conducted with a series of independent samples t tests.

To answer our RQ2 (how do anticipated stereotypes when one's identity is disclosed relate to healthcare interactions?), multiple regression analyses were conducted probing the effects of different reported stereotype dimensions in the identity-disclosed condition on healthcare outcomes. A series of linear models, regressing each outcome (i.e., anticipated treatment quality, behavior + symptom concealment, identity disclosure comfort, and healthcare avoidance) onto the six stereotype dimensions were conducted.

Results

RQ1 Analyses

Valence Difference Across Condition

While overall anticipated stereotype responses did not significantly differ in valence from neutral, $M = -0.002$, $t(355.68) = 0.085$, $p = .933$, $d = 0.004$, this pattern masked a large and significant difference between the identity disclosed and not disclosed conditions, $p < .001$, $d = 0.41$. Specifically, participants anticipated that perceptions of them would be significantly positive in the not disclosed condition, $M = 0.08$, $t(359) = 3.67$, $p < .001$, $d = 0.14$, but significantly negative in the identity disclosed condition, $M = -0.10$, $t(344) = 3.91$, $p < .001$, $d = 0.15$.

Stereotype Dimension Prevalence

Next, we examined the frequency of varied stereotype dimensions across participant responses each stereotype dimension by condition. The top reported anticipated traits by stereotype dimension are shown in Table 1, listed with their corresponding dimension (e.g., morality or sociability) and frequency in the open-text responses. Traits related to being warm (morality and sociability) and competent (ability and assertiveness) were frequently reported, in line with the larger person perception literature, while traits related to morality were the most frequently reported overall.

There were significant differences in the frequency of stereotype dimensions across conditions, $F(6,\ 5{,}026) = 12.17$, $p < .001$, $\eta^2 = .02$. Participants in the identity disclosed condition, relative to the not-disclosed condition, reported fewer overall traits related to their sociability (proportions = .25 vs. .17), $Z = 5.61$, $p < .001$, rate ratio (RR) = 0.686, and health (proportions = .13 vs. .11), $Z = 2.38$, $p = .017$, RR = 0.811. On the other hand, participants anticipated greater focus on their morality (.18 vs. .13), $Z = 4.26$, $p < .001$, RR = 1.40, and deviance (.07 vs. .04), $Z = 3.54$, $p < .001$,

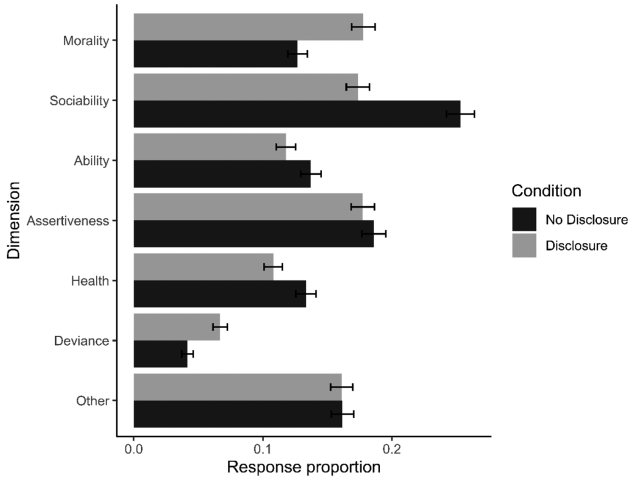
Table 1
Anticipated Top Traits by Stereotype Dimension and Condition

			Condition			
	Overall		Not disclosed		Disclosed	
Dimension	Trait	*n*	Trait	*n*	Trait	*n*
Morality	Promiscuous (−)	92	Kind (+)	40	Promiscuous (−)	80
	Honest (+)	47	Honest (+)	27	Honest (+)	20
	Caring (+)	23	Promiscuous (−)	12	Kind (+)	11
Sociability	Friendly (+)	81	Friendly (+)	48	Friendly (+)	33
	Quiet (−)	60	Quiet (−)	45	Open (+)	17
	Shy (−)	59	Shy (−)	45	Quiet (−)	15
Ability	Confused (−)	45	Intelligent (+)	31	Confused (−)	40
	Smart (+)	40	Smart (+)	24	Smart (+)	16
	Intelligent (+)	39	Educated (+)	14	Open-minded (+)	9
Assertiveness	Lazy (−)	23	Quiet (−)	45	Anxious (−)	18
	Active (+)	19	Nervous (−)	33	Quiet (−)	15
	Independent (+)	18	Lazy (−)	17	Risky (+)	15
Deviance	Weird (+)	28	Funny (+)	15	Weird (+)	22
	Average (−)	17	Average (−)	11	Different (+)	11
	Odd (+)	16	Normal (−)	7	Odd (+)	11
Health	Healthy (+)	61	Healthy (+)	45	Healthy (+)	16
	Unhealthy (−)	43	Unhealthy (−)	28	Unhealthy (−)	15
	Fit (+)	18	Fit (+)	11	Fit (+)	7

Note. Symbol + denotes that the trait is high in its respective dimension. Symbol − denotes that the trait is low in its respective dimension. Top traits overall differ from top traits examined within experimental conditions.

RR = 1.61 in the identity disclosed condition relative to the not-disclosed condition. There was not a significant difference in anticipated focus on ability ($p = .078$) or assertiveness ($p = .501$) traits across conditions. See Figure 1. As an example of condition difference, in the not disclosed condition, the trait promiscuous was reported 12 times, while in the identity disclosed condition this trait was reported 80 times.

Figure 1
Prevalence of Stereotype Dimensions Across Conditions



Note. The frequency of traits coded into ability, assertiveness, and other nonfocal stereotype dimensions (see the online supplemental materials) did not significantly differ between conditions. Error bars represent standard errors of the means.

Stereotype Dimension Direction

There were significant differences in the direction of stereotype dimensions across conditions (see Figure 2). When compared to the not disclosed condition, participants in the identity disclosed condition indicated they anticipated providers to see them as lower in morality (Ms = −0.5 vs. 0.06), $t(358) = 8.94$, $p < .001$, $d = 0.47$,[1] ability (Ms = 0.04 vs. 0.10), $t(358) = 5.22$, $p < .001$, $d = 0.27$, and health (Ms = −0.05 vs. −0.02), $t(358) = 3.76$, $p < .001$, $d = 0.20$, but higher in assertiveness (Ms = 0.05 vs. −0.04), $t(358) = 6.93$, $p < .001$, $d = 0.37$, and deviance (Ms = 0.04 vs. 0.01), $t(358) = 3.10$, $p = .046$, $d = 0.16$. The direction of reported sociability traits did not significantly differ between the two conditions ($p = .448$, $d = 0.007$).

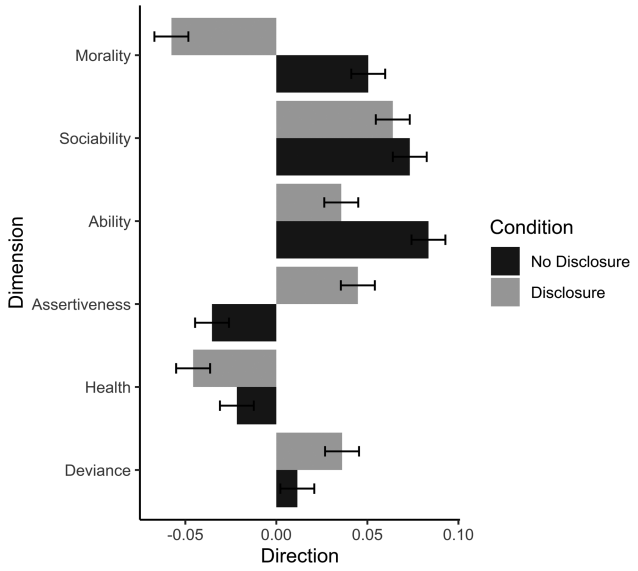
Anticipated Stereotype Dimensions by Demographic Group

Table 2 describes the different top traits reported across participants of different sexual orientations in the identity disclosed condition. Exploratory independent samples *t* tests examined differences in the direction of stereotype dimensions (e.g., the extent to which morality stereotypes were lower or higher in certain sexual minority subgroups). These results are presented in full in the online supplemental materials. There were no significant differences when comparing dimension codings from the identity disclosed condition among lesbian, gay ($n = 130$) and polysexual (i.e., sexual attraction/relationships with members of multiple genders; e.g., bisexual, pansexual, $n = 226$) participants, cisgender men ($n = 123$) and cisgender women ($n = 236$), and when comparing non-Hispanic White

[1] Degrees of freedom vary as some analytic tests account for multiple comparisons or unequal variance between comparison groups.

Figure 2

Trait Dimension Direction Across No Disclosure and Disclosure Conditions



Note. The *x* axis indicates the extent to which trait dimensions were coded to be low (−) or high (+). Error bars represent standard errors.

participants ($n = 242$) to participants of color ($n = 118$). A few statistically significant effects were found using dimension codings from the nondisclosed condition; such that polysexual participants expected to be perceived as higher in deviance ($p = .042$, $d = 0.21$) and lower in health ($p = .011$, $d = 0.28$) when compared to monosexual participants; cisgender women expected to be viewed as less assertive than cisgender men ($p = .007$, $d = 0.30$) and non-Hispanic White participants expected to be perceived as higher in deviance when compared to participants of color ($p = .036$, $d = 0.23$).

RQ2

Associations Between Stereotype Dimensions, Anticipated Visit Outcomes, and Avoidance

A series of multiple regressions regressing each outcome (i.e., anticipated treatment quality, behavior + symptom concealment, identity disclosure comfort, and healthcare avoidance) onto the six stereotype dimensions were conducted. See Table 2 for unstandardized regression coefficients and semipartial correlations (sr). Pearson's correlations between the stereotype direction codings and healthcare variables are presented in the online supplemental materials (Table 3).

A multiple regression revealed significant effects of stereotype dimension (direction variable) when predicting anticipated treatment quality, $R^2 = .17$, $F(6, 353) = 12.08$, $p < .001$. Specifically, sociability ($p = .005$), morality ($p < .001$), ability ($p = .002$), and deviance stereotypes ($p = .018$) were significant predictors of anticipated treatment quality, while the direction of assertiveness ($p = .57$) and health stereotypes ($p = .08$) were not. Together, suggesting that participants who anticipated being perceived as more sociable, more moral, higher in ability, and lower in deviance, anticipated greater treatment quality.

Results indicated significant effects of stereotype dimension (direction variable) when predicting anticipated health behavior and symptom concealment, $R^2 = .09$, $F(6, 353) = 5.60$, $p < .001$. Sociability ($p = .033$) and health stereotypes ($p = .002$) were significant predictors of anticipated health behavior and symptom concealment, while the direction of morality ($p = .16$), ability ($p = .05$), assertiveness ($p = .93$), and deviance ($p = .26$) stereotypes were not. Together this suggests that participants were more likely to anticipate concealing their health behaviors and symptoms when they anticipated being perceived as lower in sociability and health.

Analyses revealed significant effects of stereotype dimension (direction variable) when predicting anticipated identity disclosure comfort, $R^2 = .06$, $F(6, 353) = 3.51$, $p = .002$. Only morality ($p = .022$) and deviance ($p = .007$) stereotypes were significant predictors, while the direction of sociability ($p = .80$), ability ($p = .29$), assertiveness ($p = .31$), and health ($p = .15$) stereotypes were not. Together, suggesting that participants reported feeling more comfortable with disclosing their sexual orientation to the provider when they believed the provider would stereotype them as less immoral (or greater in morality) and as less deviant.

Finally, there were significant effects of stereotype dimension (direction variable) when predicting healthcare avoidance, $R^2 = .07$, $F(6, 353) = 4.36$, $p < .001$. Anticipated morality stereotypes were the only significant predictor, $p < .001$, with other dimensions not reaching significance, $ps > .24$, suggesting that anticipating being stereotyped as immoral by a healthcare provider predicted greater healthcare avoidance.

Discussion

The present article examined unique stereotype dimensions expected by sexual minority individuals in American healthcare settings. Expanding past literature which suggests that sexual minorities anticipate stereotypes from healthcare providers (e.g., Durso & Meyer, 2013; Fingerhut & Abdou, 2017), the present work documents that sexual minority participants anticipate being stereotyped as lower in morality and ability, and higher in assertiveness and deviance, when their sexual minority identity is disclosed relative to when their identity is not disclosed to a healthcare provider. Thus, disclosing a sexual minority identity in the healthcare context elicits heightened expectations of confirming specific negative sexual minority stereotypes (e.g., being untrustworthy, uncertain, diseased, aggressive, and strange). When participants imagined how healthcare providers would perceive them without their sexual orientation disclosed, participants anticipated significantly more positive stereotypes, than when they imagined their sexual identity being disclosed.

Critical findings identify anticipated stereotype dimensions that differentially predict anticipated healthcare interactions. For instance, sexual minority participants' expectations of treatment quality, including being respected by providers, were predicted by morality, ability, sociability, and deviance stereotype direction. While expectations of being seen as low in morality and high in deviance reduced anticipated treatment quality, expectations of being seen as higher in ability and sociability served as protective factors, bolstering expectations of treatment quality. However, participants' reports of avoiding healthcare were solely predicted by expectations of being seen as less

Table 2
Top Reported Traits by Dimension and Sexual Orientation by Gender Grouping

Dimension	Lesbian	*n*	Bisexual women	*n*	Bisexual men	*n*	Gay men	*n*	Pansexual, asexual, +	*n*
Morality	Promiscuous	8	Promiscuous	64	Promiscuous	11	Promiscuous	23	Promiscuous	2
	Honest	4	Kind	6	Kind	5	Clean	8	Honest	1
	Kind	4	Loose	5	Considerate	2	Dirty	3	Loose	1
	Caring	3	Slutty	5	Liars	2	Honest	3	Untrustworthy	1
Sociability	Nice	7	Friendly	10	Kind	5	Friendly	9	Annoying	1
	Friendly	4	Outgoing	8	Friendly	4	Nice	5	Nice	1
	Kind	4	Kind	6	Nice	3	Outgoing	4	Open	1
	Caring	3	Open	5	Outgoing	3	Loud	3	Straight-forward	1
Ability	Smart	3	Confused	30	Open-minded	4	Smart	3	Confused	3
	Athletic	2	Open-minded	10	Confused	3	Intelligent	2	Open-minded	2
	Immature	1	Curious	7	Fit	2	Open-minded	2	Competent	1
	Creative	1	Attention-seeking	4	Creative	2	Fashionable	1	Inexperienced	1
Assertiveness	Strong	8	Indecisive	15	Flamboyant	5	Risky	6	Adventurous	1
	Independent	6	Adventurous	8	Risky	3	Flamboyant	3	Anxious	1
	Confident	3	Risky	7	Active	2	Troubled	3	Determined	1
	Aggressive	2	Unsure	6	Adventurous	1	Active	2	Lazy	1
Deviance	Different	4	Normal	12	Odd	4	Funny	3	Different	1
	Abnormal	2	Different	9	Average	2	Different	2	Weird	1
	Weird	2	Curious	7	Normal	2	Curious	1		
	Atypical	1	Unique	4	Weird	2	Diverse	1		
Health	Unhealthy	5	Healthy	7	Healthy	3	HIV	6	Diseased	1
	Healthy	4	Unhealthy	4	Diseased	2	Healthy	3		
	Unstable	2	Crazy	2	Fit	2	Alcoholics	2		
	Diseased	1	Stressed	2	Drink	1	Weak	2		

Note. The top traits presented are from the identity disclosed condition. Pansexual, asexual, and other emerging sexual orientation identities (Watson et al., 2020) were not grouped by gender identity because of the small sample size. HIV = human immunodeficiency virus.

moral (e.g., as "promiscuous" or "irresponsible"). These findings add to prior research on the relationship between anticipating stereotypes, poor healthcare quality, and avoidance of healthcare (see Hsieh & Shuster, 2021) by highlighting key stereotype dimensions that predict these important healthcare factors.

Prior research on identity threat theory documents that expecting stereotypes can shape behavior, cognitive processes, and authenticity (see review Spencer et al., 2016), with potential implications of expecting stereotypes on patients' communication with healthcare providers (e.g., Cipollina & Sanchez, 2022; Fingerhut & Abdou, 2017). The present work is the first to document how sexual minorities' expectations of stereotypes from providers predict the concealment of health behaviors and symptoms, as well as the disclosure of one's sexual orientation. Specifically, sexual minority participants reported being more likely to conceal their health behaviors and symptoms when they anticipated providers to stereotype them as lower in sociability and health, and anticipated avoidance of sexual orientation disclosure was driven by expectations of providers seeing sexual minorities as immoral and deviant.

Participants' expectations of stereotypes from healthcare providers are likely derived from prior healthcare visits, awareness of

Table 3
Multiple Regression Output for Each Outcome

	Treatment quality						Behavior and symptom concealment				
Anticipated stereotype dimension	*B*	*SE*	*t*	95% CI	sr	VIF	*B*	*SE*	*t*	95% CI	sr
Sociability	**0.93**	0.33	2.80	[0.27, 1.58]	.14	1.19	**−0.84**	0.39	−2.15	[−1.61, −0.07]	−.11
Morality	**1.22**	0.30	4.03	[0.63, 1.82]	.20	1.17	−0.50	0.36	−1.41	[−1.21, 0.20]	−.07
Ability	**1.13**	0.36	3.11	[0.42, 1.85]	.15	1.13	−0.84	0.43	−1.96	[−1.69, 0.001]	−.10
Assertive	−0.18	0.31	−0.57	[−0.78, 0.43]	−.03	1.03	0.03	0.36	0.08	[−0.69, 0.75]	.004
Health	0.69	0.39	1.77	[−0.08, 1.45]	.09	1.04	**−1.41**	0.46	−3.07	[−2.31, −0.51]	−.16
Deviance	**−1.08**	0.46	−2.37	[−1.97, −0.18]	−.12	1.00	0.61	0.54	1.14	[−0.45, 1.67]	.06
	Identity disclosure comfort						Healthcare avoidance				
Sociability	−0.13	0.52	−0.26	[−1.15, 0.88]	−.01		−0.29	0.29	−1.00	[−0.86, 0.28]	−.05
Morality	**1.09**	0.47	2.30	[0.16, 2.02]	.12		**−0.98**	0.27	−3.66	[−1.51, −0.45]	−.19
Ability	0.60	0.57	1.06	[−0.52, 1.72]	.06		−0.38	0.32	−1.19	[−1.01, 0.25]	−.06
Assertive	0.49	0.48	1.02	[−0.46, 1.43]	.05		0.03	0.27	0.09	[−0.51, 0.56]	.005
Health	0.87	0.61	1.44	[−0.32, 2.06]	.07		−0.13	0.34	−0.39	[−0.81, 0.54]	−.02
Deviance	**−1.92**	0.71	−2.70	[−3.32, −0.52]	−.14		−0.39	0.40	−0.96	[−1.18, 0.40]	−.05

Note. Bolded coefficients are significant at a p value less than .05 as described in main text. CI = confidence interval; sr = semipartial correlation; VIF = variance inflation factor.

bias in healthcare settings, and broader societal stigma toward sexual minorities. Improvements in training in LGBTQ-affirmative physical and mental healthcare practices with brief intervention are feasible (Lelutiu-Weinberger et al., 2023), but oftentimes, providers lack this training, with medical school curricula that consider LGBTQ-topics supplemental/optional material (Nowaskie et al., 2020). These brief trainings (often ~3 hr) likely focus on preventing health disparities (Cipollina et al., 2024), resulting in less time on combatting stereotypes that promote sexual minorities' poor experiences in healthcare settings (Dean et al., 2016). The present work supports the need for healthcare provider training that targets sexual minority-specific stereotypes (e.g., deviance, immorality) that impact sexual minorities' expectations of healthcare interactions.

With proper training, healthcare providers can signal their inclusive ideology or LGBTQ-affirming practices to reduce would-be patients' expectations of stereotyping (see review, Cipollina & Sanchez, 2019). For example, magazines present in waiting rooms and the type of bathroom signs used can signal the culture of an office (Albuja et al., 2019; Chaney & Sanchez, 2018), and providers who espoused working with more diverse clientele were found to be perceived as less likely to be biased (Cipollina & Sanchez, 2022, 2023). Such cues could also shift expectations of unique stereotype dimensions that sexual minority patients expect from healthcare providers. For example, a provider's office with a "love is love" sign may target stereotypes that sexual minority people are deviant or immoral, and such cues may also shape patients' anticipations of other sexual minority stereotypes (e.g., poor health stereotypes).

As certain anticipated stereotype dimensions in the healthcare context are more or less correlated (see table in the online supplemental materials), targeting some dimensions of sexual minority stereotypes may be more effective in creating larger shifts in the perceived LGBTQ-friendly climate of healthcare offices. For example, in the present data, participants' anticipations of being seen as immoral were associated with anticipating being seen as less healthy and less sociable. At the same time, anticipated deviancy stereotypes were not significantly correlated with any other anticipated stereotype dimension, signaling that these expected stereotypes may need to be disconfirmed more explicitly. Thus, there are certain dimensions of stereotypes that when targeted by cues or through educational or emotional intervention may shape broader stereotypes about sexual minority groups when compared to other stereotypes that may need to be directly targeted to improve sexual minorities' beliefs about healthcare.

Limitations and Future Directions

The present work utilized open-text response data and machine learning methods to document sexual minority individuals' anticipated stereotypes from healthcare providers under different conditions. Our design choices, asking participants to imagine a novel healthcare provider for anticipated interaction outcomes (e.g., concealment) sought to curtail concerns about recall bias while enabling an exploration of how current expectations of providers may impact future healthcare interactions. While the utilized approach provides rich insights into the types of traits that sexual minorities may spontaneously think of when anticipating healthcare interactions, such anticipated traits may differ from stereotypes during real healthcare interactions. Future work could examine different stereotype expectations that arise when providers' identities or ideologies are provided (e.g., expectations of stereotypes from a straight or gay provider). Research conducted in healthcare settings should ask patients to report stereotypes they believed providers had of them to examine how stereotype dimensions differentially predict healthcare outcomes like their choice to disclose their sexual orientation, their ratings of treatment satisfaction, or their adherence to healthcare provider suggestions.

Importantly, the present work recruited individuals who did not identify as heterosexual and did not utilize stratified recruitment that would have been necessary to examine between-group differences for individuals with less common sexual orientations (e.g., pansexual relative to bisexual). Future research should include a more targeted recruitment strategy to make specific claims about how anticipated healthcare stereotypes vary across sexual minority groups, and for transgender and gender-diverse participants, as healthcare settings are noted as critical places in which gender-diverse groups experience discrimination (Grant et al., 2016; J. M. W. Hughto et al., 2015). Concerns of transgender and gender-diverse people regarding providers' reactions to their gender identity (Friley & Venetis, 2022) may be more salient than concerns regarding providers' beliefs about sexual minorities. As such future research should examine anticipated stereotypes and how they relate to healthcare visit interactions for sexual minority individuals who are also transgender.

Prior research indicates that sexual minority experiences in healthcare settings are also impacted by demographic factors (see Turan et al., 2019). Exploratory analyses conducted on the present data, see the online supplemental materials, suggest few differences in anticipated stereotype dimensions by group identity (i.e., polysexual participants expected being stereotyped as lower in health when their identity was disclosed). Taking an intersectional viewpoint, sexual minority people of color may expect different stereotypes from healthcare providers, when compared to non-Hispanic White sexual minority participants (see Bowleg, 2013; Kim & Fredriksen-Goldsen, 2012; Nicolas & Fiske, 2023; Remedios & Snyder, 2018) which was the largest group in our sample. Future work should consider that anticipated stereotypes for individuals of different racial groups are likely to differ on the stereotype dimensions examined in this work (see Jackson et al., 2020; Preddie & Biernat, 2021, for intersectional Black American stereotypes; see Kumashiro, 1999, for LGBTQ Asian American stereotypes; see Reid & Stay, 2020, for review of biracial sexual minority stereotypes). Different stereotypes may be more expected or salient depending on one's sexual minority identity, and racial, and gender identity (see Petsko et al., 2022; Preddie & Biernat, 2021).

Finally, other individual differences that may impact anticipated stereotypes in healthcare settings should be explored. For instance, individuals vary in the extent they see their sexual minority identity as concealable; for some sexual minority people one's sexual minority identity is viewed as less apparent or easier to conceal (Le Forestier et al., 2020). Thus, for some sexual minority people anticipated stereotypes may be more similar under conditions where one discusses or does not discuss their sexual minority identity or play less of a role in shaping anticipated healthcare visit interactions and outcomes if the identity is rated as easy to conceal. Moreover, other differences, like how masculine or feminine one presents (e.g., Scheer et al., 2022), one's sensitivity to rejection (J. M. Hughto et al., 2018; Maiolatesi et al., 2022), or mistrust in healthcare providers (Brenick et al., 2017) likely shape both the valence and frequency of anticipated stereotype dimensions. Future research could consider the impact of

past instances of discrimination in healthcare settings shaping future anticipated stereotypes.

Conclusion

The present work is the first to provide an overview of different anticipated stereotype dimensions that sexual minority Americans anticipate from healthcare providers in conditions where their identity is disclosed or not. Where past work suggests that anticipating stereotypes from providers results in factors like avoiding healthcare, the present work documents that certain stereotype dimensions (e.g., morality stereotypes) are stronger predictors of avoiding healthcare than others (e.g., ability stereotypes). In healthcare settings, varied stereotypes about sexual minorities are likely to become salient and expectations of these stereotypes become more frequent and negative when one's sexual orientation is imagined to be disclosed (vs. not disclosed). Overall, the study findings suggest that specific stereotype dimensions should be considered when designing interventions to improve sexual minority groups' experience in healthcare, with a particular emphasis on targeting morality and deviancy stereotypes to improve healthcare disclosure, utilization, and anticipated treatment quality.

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