ABSTRACT

GUERRANT, MARY TERESA. Sense of Coherence and (Sexual) Health among LBQ Latinx Women: The Role of Prior Healthcare Experiences and Comfort Communicating with Providers. (Under the direction of Dr. Craig Brookins and Dr. Mary Wyer).

The present study focused on the impact of sense of coherence on shaping overall and sexual health, and the role of prior experiences communicating with healthcare providers and comfort communicating needs. A number of studies have demonstrated the role of sense of coherence – which describes how people understand and adapt following adversity – as having a significant impact on one’s health. Additionally, multiple studies highlight the role of patient-provider communication as contributing to patient experiences and frequency of seeking care, in terms of overall health and sexual health (e.g. STIs, HIV, breast and gynecological cancers) among both Latina women and non-heterosexual women. However, no studies currently exist addressing how identifying as woman, Latinx, and non-heterosexual intersects to shape sexual health. The present study sought to explore this gap by addressing the following research questions: (1) How does sense of coherence predict overall and sexual health? (2) How is the relationship between sense of coherence and health mediated and/or moderated by ones prior experiences communicating with a healthcare provider and ones self-reported comfort communicating with healthcare providers about their overall and sexual health needs? (3) How does sexual orientation, gender identity, and gender presentation shape these relationships? The study utilized a cross-sectional, online survey to collect data from a national sample of LBQ Latinx women ($n = 186$) recruited through purposive and convenience sampling. The survey was available in both English and Spanish, and contained quantitative items regarding sense of coherence, overall health, sexual health, prior experiences communicating with healthcare providers, and comfort communicating.
with healthcare providers about overall and sexual health needs. Utilizing moderation, mediation, and moderated mediation analyses, it was revealed that a higher sense of coherence significantly predicts higher overall health, with this relationship being partially mediated by an individual’s experiences communicating with a provider. This significant relationship remained when controlling for sexual orientation, gender identity, and gender presentation. No direct or mediating relationship was found between sense of coherence and sexual health. Of particular interest was finding a significant moderated mediation for overall health, such that the effect of sense of coherence on overall health via communication experiences depends on the individual’s comfort in communicating overall health needs. These findings reinforce the importance of both communication and sense of coherence as important influences on health. Unrelated to sense of coherence, patterns of overall and sexual health differed according to sexual orientation, gender identity, and gender presentation. Taken in combination, findings highlight a number of future directions for research and practice to address health disparities among cisgender LBQ Latinx women.
Sense of Coherence and (Sexual) Health among LBQ Latinx Women: The Role of Prior Healthcare Experiences and Comfort Communicating with Providers

by
Mary Teresa Guerrant

A dissertation submitted to the Graduate Faculty of North Carolina State University in partial fulfillment of the requirements for the degree of Doctor of Philosophy Psychology

Raleigh, North Carolina
2017

APPROVED BY:

_______________________________
Dr. Craig Brookins
Committee Co-Chair

_______________________________
Dr. Mary Wyer
Committee Co-Chair

_______________________________
Dr. Sarah Desmarais

_______________________________
Dr. Kim Stansbury
DEDICATION

This work is dedicated to those marginalized within the LGBTQ+ community who continue to inform my work and inspire my passion for working toward equity, particularly Selena, Natalia, and Neena.
BIOGRAPHY

Mary T. Guerrant grew up in rural Oklahoma with her parents and younger sister. After graduating high school, she attended Centenary College of Louisiana and graduated in 2008 with a B.A. in Psychology (with honors) and a B.M. in Music Performance. In 2012, Mary began graduate school in the Applied Social and Community Psychology Ph.D. program at North Carolina State University. She earned an MS in psychology in 2014, with her thesis focused on acculturation and psychological well-being among LGBTQ+ immigrants to the United States. Mary’s professional interests center on intersectional identities of ethnicity, race, gender, and sexuality. Her primary focus is health equity for LGBTQ+ ethnic minority populations. She’s also conducted research on the mentoring needs of LGBTQ+ graduate students, the experiences of LGBTQ+ students in STEM, and skills necessary for identifying and addressing microaggressions targeted toward LGBTQ+ students, faculty, and staff in higher education. Mary has held a number of leadership positions within professional organizations, including her current role as the chair of the APAGS Committee on Sexual Orientation and Gender Diversity. In addition to research and professional service, Mary currently teaches in the Department of Psychology and the Department of Women’s and Gender Studies at North Carolina State University. Mary is passionate about incorporating diversity and experiential learning into the classroom, and looks forward to pursuing these passions as a tenure-track assistant professor of psychology following the completion of her PhD.
ACKNOWLEDGMENTS

I would like to thank my parents for their continued encouragement and support – not just during my education but all aspects of my life. To Elizabeth, my younger sister, thank you for inspiring me to pursue my dreams without letting anything stand in my way. Thank you to my partner, Whitney, for providing unconditional love and support throughout my graduate training, pursuit of faculty positions, and the long hours of writing this dissertation. Finally, thank you to all who’ve shaped my educational training, especially my undergraduate advisor, Dr. Amy Hammond, my graduate advisors, Dr. Craig Brookins and Dr. Mary Wyer, and Dr. Sarah Desmarais and Dr. Kim Stansbury for their guidance while serving on my dissertation committee.
TABLE OF CONTENTS

LIST OF TABLES .................................................................................................................................................. vii
LIST OF FIGURES ........................................................................................................................................... viii
CHAPTER 1 - INTRODUCTION .............................................................................................................................. 1
CHAPTER 2 - LITERATURE REVIEW ...................................................................................................................... 9
    Conceptual Frameworks ................................................................................................................................. 9
    Latina Women’s Sexual Health ....................................................................................................................... 15
    LBQ Women’s Sexual Health ....................................................................................................................... 21
    Sense of Coherence and Health ................................................................................................................... 25
    Summary ....................................................................................................................................................... 31
CHAPTER 3 - METHODS ...................................................................................................................................... 33
    Design and Variables .................................................................................................................................. 33
    Community Advisors .................................................................................................................................. 35
    Participants and Sampling ............................................................................................................................... 37
    Procedures .................................................................................................................................................... 39
    Measures ....................................................................................................................................................... 41
CHAPTER 4 - RESULTS ....................................................................................................................................... 46
CHAPTER 5 - DISCUSSION .................................................................................................................................. 59
    Limitations .................................................................................................................................................... 74
CHAPTER 6 - CONCLUSIONS AND FUTURE DIRECTIONS ................................................................................... 77
REFERENCES ..................................................................................................................................................... 87
APPENDICES ...................................................................................................................................................... 102
    A: Consent Form and Screening Questionnaire ......................................................................................... 103
    B: Demographics Questionnaire .................................................................................................................. 105
    C: Healthcare Experiences Questionnaire .................................................................................................... 108
    D: Sense of Coherence Questionnaire .......................................................................................................... 120
E: Overall and Sexual Health Questionnaire .................................................129
F: Participant Recruitment Message ............................................................136
LIST OF TABLES

Table 1. Frequency table for major demographic variables ..................................38

Table 2. Example items from healthcare experience questionnaire, compared
to existing CAHPS experience items ....................................................................43

Table 3. Factor loadings and communalities based on principle components analysis with
oblimin rotation for 15 items measuring communication experiences with healthcare
providers ..................................................................................................................47

Table 4. Correlations between sexual orientation and overall and sexual health ..........50

Table 5. Correlations between gender identity and overall and sexual health ..........51

Table 6. Correlations between sense of coherence, sexual orientation, gender presentation,
and gender identity ................................................................................................52

Table 7. Correlations between sense of coherence, overall health, sexual health, prior
communication experiences, and comfort communicating with providers ..........54
LIST OF FIGURES

Figure 1. Disparities in healthcare access according to race/ethnicity and income......4

Figure 2. Sexual health indicators among women aged 18-44 years, by sexual identity, 2006-2010 ........................................................................................................................................5

Figure 3. Mediation model for effects of communication experiences on sense of coherence and overall health........................................................................................................56

Figure 4. Moderated mediation model for effects of communication on sense of coherence and overall health........................................................................................................59
CHAPTER 1 - INTRODUCTION

Health disparities are defined as adverse health outcomes for communities that have, as a result of “social, economic, and environmental disadvantage, systematically experiences greater obstacles to health” (U.S. Department of Health and Human Services, 2010). There’s no shortage of data showing the breadth of health disparities within the United States, with research showing disparities impacting disenfranchised populations on virtually every health outcome imaginable. Certainly, the existence of health disparities is undeniable across many dimensions and the costs—both in terms of population health and national economy—are devastating. As the United States becomes increasingly heterogeneous, it becomes even more important to understand how health disparities impact uniquely diverse populations.

Increased research and data collection efforts are necessary first steps toward understanding the social determinants of health which shape the existence of these disparities, and ultimately toward implementing an array of prevention and multilevel initiatives to increase health equity in populations currently facing disparities.

The National Institute of Health’s Healthy People 2020 lists LGBT people as an at-risk population, while the Institute of Medicine (2011) recognizes the lack of attention to gender identity and sexual orientation has created extreme disparities in health for the LGBT community (U.S. Department of Health and Human Services, 2014). This focus on disparities reduction is fitting given stark statistics showing increased rates of physical and mental illness and health-related challenges resulting from factors such as stress and stigma within the LGBT community (e.g. Herek, Gillis, & Cogan, 2009; Frost, Lehavot, & Meyer, 2015) and among sexual minority women in particular (e.g. Diamant & Wold, 2003). In addition to a focus on LGBT health disparities reduction, the National Institute of Health Office of
Research on Women’s Health (2015) and the U.S. Department of Health and Human Services Office of Minority Health (2016) indicate that women and ethnic minority persons also face health disparities and are detrimentally impacted by social determinants of health.

Intersectionality theory posits that these health-related challenges uniquely shape health equity in populations for whom multiple marginalized identities exist—such as lesbian, bisexual, and queer Latina women. A recent report from the Williams Institute shows a number of health-related disparities for LGBTQ+ Latina women—who constitute an estimate 700,000 of U.S. Latina adults—including higher rates of unemployment and lower rates of health insurance (Kastanis & Gates, 2013). While the impact of structural inequality and multilevel marginalization arguably shapes all types of health outcomes for LGBTQ+ Latina women, existing data suggest that this population is perhaps especially disparate in regards to sexual health (Mays et al., 2002).

Rates of mortality and morbidity from breast and gynecological cancers, sexually transmitted infections, and HIV/AIDS are significantly higher for Latina women as compared to their white counterparts (American Cancer Society, 2012; Centers for Disease Control and Prevention, 2015). Although less understood, research documents the increased risk faced by sexual minority women for these same diagnoses (American Cancer Society, 2016). These startling rates of diagnoses and death are not surprising given prevailing societal discrimination faced by both lesbian and bisexual women and Latinx women. Individual factors such as negative experiences with healthcare providers and fear of discrimination combine with structural factors such as lower rates of insurance and lower socioeconomic status to decrease the likelihood of lesbian and bisexual women seeking routine sexual health care (such as cancer screening tests and sexual health exams) compared to heterosexual
women. In addition to the negative impacts on population health, these disparities cost society millions of dollars for treatment every year and exemplify the devastating nature of prevailing oppression and injustice for sexual and ethnic minority women within the United States. Sexual and gender identity questions are not asked on most medical forms or national/state surveys, making it difficult to estimate the true breadth of LGBTQ health disparities, especially for lesbian and bisexual Latinx women as virtually no data exists specific to this population. However, statistics do show increased health disparities for both Latina women and lesbian and bisexual women.

As shown in Figure 1, Hispanics experience worse access to health care compared to white persons than any other ethnic minority group, with this disparity even higher for low-income persons (Agency for Healthcare Research and Quality, 2015). This latter point is important considering unemployment rates are higher for Latino/a individuals who identify as LGBT compared to non-LGBT individuals (14% vs. 11%) (Kastanis & Gates, 2013).
As shown in Figure 2, homosexual, gay, or lesbian women and bisexual women have rates higher than heterosexual women of obesity, smoking, and binge drinking (Chandra, Copen, & Stephen, 2013). They are also less likely to report excellent or very good health status and having received a pap smear in the past 12 months—all risk factors for diagnoses such as cancer, sexually transmitted infections, and HIV.

Figure 1. Disparities in Healthcare Access According to Race/Ethnicity and Income
Existing research supports this data, suggesting that non-heterosexual women are at a higher risk than heterosexual women for a number of factors inadvertently impacting sexual health, including alcohol use (e.g. McCabe, Hughes, Bostwick, West, & Boyd, 2000), cigarette smoking (e.g. Johnson et al., 2016), illicit drug use (e.g. Hughes & Eliason, 2002), and higher body mass index and rates of obesity which can lead to heart disease, strokes, and cancer (e.g. Conron, Mimiaga, & Landers, 2010). These findings are well-documented among sexual minority women.

Research by Fish and Wilkinson (2003) suggests that lesbian women are at a higher risk for many sexual health concerns, such as breast cancer, due to a diminished likelihood of going through pregnancy and childbirth, and the associated hormonal changes of pregnancy that appear to reduce the risk of breast cancer. Kuyper and Vanwesenbeeck (2011) found similar sexual differences between heterosexual persons and LGB-identified men and
women, indicating that homosexual and bisexual persons across the board reported a higher need for sexual health care than their heterosexual counterparts. Factors such as internalized homonegativity or negative social reactions related to non-heterosexual orientation played a large role in these unmet needs (Kuyper & Vanwesenbeeck, 2011). Lesbian women (and bisexual women, although less documented) are also less likely to practice breast self-examinations than heterosexual women, compounding breast cancer risk (e.g. Fish & Wilkinson, 2003; Wells, Bimbi, Tider, Van Ora, and Parsons (2007). Research by Charlton et al. (2011) suggests that sexual minority women underutilize reproductive health screenings, including Pap smears and STI tests, with bisexual females having 30% lower odds of having a Pap rest within the last year and almost 40% higher odds of being diagnosed with an STI as compared to completely heterosexual women. The odds of having ever had a Pap test or having had a Pap test within the last year were even lower for lesbian women compared to their heterosexual counterparts (Charlton et al., 2011).

Given this overall picture of health disparities being more prevalent in non-heterosexual Latina woman as compared to their heterosexual or white counterparts, by extension it is likely that sexual health disparities among non-heterosexual Latina women pose a significant—yet understudied—threat to individual, community, and societal health and well-being. Understanding the nature of sexual health disparities for non-heterosexual Latinx women specifically is worthwhile because of the need for research on how determinants of health overlap and thus differently shape health disparities in populations with multiple marginalized identities.

The present study seeks to address a gap in the literature regarding health experiences and sexual health behaviors among a sample of cisgender, lesbian, bisexual, and queer-
identified Latinx women. Before delving into specific research questions and hypotheses, however, certain terms must be defined. The term cisgender, both within the context of the current study and more broadly, refers to a person “whose sense of personal [gender] identity corresponds with their birth [anatomical] sex” (as compared to the term ‘transgender’.) Given this study’s focus on sexual health, acknowledging the biological relevance of sexual genitalia in the context of same-sex behaviors and shaping sexual health outcomes is pertinent.

Moving beyond sexual anatomy, the terms lesbian, bisexual, and queer are intended to capture the sexual orientations of non-heterosexual cisgender women who are attracted to or who engage in sexual behaviors with other cisgender women. Therefore, the phrase ‘cisgender women’ is intended to describe a population of women whose sex is anatomically female and whose gender identity is woman. Lesbian refers to a woman who identifies as sexually attracted to other women, bisexual refers to a woman who identifies as sexually attracted to both men and women, and queer—within the context of this study—is used to refer to women who identify as neither lesbian nor bisexual, but who also do not identify as heterosexual. Latinx is used to describe persons from Latin America, including those who speak Spanish but excluding persons from Spain. The intentional choice to describe persons as Latinx within the context of the current, as compared to the traditional Latina (used in much of the existing literature), is used as a more inclusive, gender-neutral alternative to the gendered Latino/Latina terminology.

Sexual health is used broadly within the context of the current study—given the lack of existing literature which might indicate certain aspects of sexual health more important for the study’s specific population—and includes health in the context of anything which might
be distinct to women’s health, such as breast cancer, gynecological cancers, STIs, and HIV/AIDS. Sense of coherence, another variable of primary interest within the present study, addresses how people comprehend and perceive themselves as able to cope in stressful situations (Aspinwall & Tedeschi, 2010). In short, sense of coherence is focused on both how people resist adversity and how people bounce back from adversity.

With these definitions in mind, the current study seeks to address the following research questions:

1. How do demographic variables relate to primary variables of interest – including sense of coherence, self-reported health (overall and sexual), experiences communicating with providers, and comfort communicating ones health (overall and sexual) needs with healthcare providers – within a sample of cisgender, LGB Latinx women?

2. Does sense of coherence predict overall health? Sexual health?

3. How is the relationship between sense of coherence and (sexual) health moderated and/or mediated by ones experiences communicating with healthcare providers and ones comfort communicating health needs (overall and sexual) with providers?

CHAPTER 2 – LITERATURE REVIEW

In approaching the aforementioned research questions, the literature review which follows will address a number of bodies of research essential to the current study. Discussed first are the basic conceptual frameworks within which the study is situated, including intersectionality and Fredriksen-Goldsen et al.’s (2014) Health Equity Promotion Model. Provided next will be an overview of factors shown to impact sexual health among Latina women and LBQ cisgender women, followed by a more detailed discussion of how these factors tie into healthcare experiences, communication, and overall and sexual health.
Finally, I will discuss sense of coherence, supporting the study’s focus on how sense of coherence is associated with overall and sexual health, healthcare experiences, and communication with providers.

**Conceptual Frameworks: Intersectionality and the Health Equity Promotion Model**

Intersectionality can be described as an “embodiment in theory of the real-world fact that systems of inequality, from the experiential to the structural, are interdependent” (Warner & Shields, 2013, p. 804). Intersectionality “…focuses on examining how social locations and structural forces interact to shape and influence human experiences” (Hankivisky, 2012, p. 1713). Intersectionality attempts to move beyond blanket labels such as ‘women and minorities’, in order to acknowledge that two (or more) categories might intersect and “cut across [these] diverse realisms of experiences” (Bowleg, 2012, p. 1267). As Bowleg (2012) states: “Acknowledging the existence of multiple intersecting identities is an initial step in understanding the complexities [of health disparities] for populations from multiple historically oppressed groups. The other critical step is recognizing how systems of privilege and oppression that result in multiple social inequalities (e.g. racism, heterosexism, sexism, classism) intersect at the macro social-structural level to maintain health disparities” (p. 1267).

Bowleg proceeds to describe three core tenants of intersectionality which are particularly relevant to public health: (1) Social identities are not independent and unidimensional but multiple and intersecting (as compared to additive; Hankivsky, 2012); (2) People from multiple historically oppressed and marginalized groups are the focal or starting point, and should be studied from their vantage point rather than as a deviation from the norms of White middle-class people; and (3) Multiple social identities at the micro level (e.g.
intersections of race, gender, and SES) intersect with macro level structural factors (e.g. poverty, racism, and sexism) to illustrate or produce disparate health outcomes and support the use of multilevel analysis (Bowleg, 2012; Hankivsky, 2012).

Similarly, Viruell-Fuentes, Miranda, and Abdulrahim (2012) encourage researchers to use an intersectionality framework when considering the role of structural factors in producing health inequalities among Latino/a persons. Examining both the individual-level factors and societal factors—especially in marginalized populations for whom privilege and oppression are particularly salient—shifts the onus of blame for disparities in health from individual cultural traits to structural level impacts (i.e. racial ideologies, policies, and day-to-day “othering” practices that serve to assign privilege to some groups and strip others from health-promoting resources). Additionally, Viruell-Fuentes, Miranda, and Abdulrahim encourage researchers to consider socio-historical contexts of migration, racialization, low socioeconomic position, institutional patterns of unequal treatment, and the role these and other factors have across all ecological levels on social integration of Latina persons (and the subsequent impact on health disparities). The inclusion of structural analyses of power and oppression also allows a more positivist approach to research questions, including increased focus on the collective strategies that targeted groups develop to cope and resist effects of structural racism.

The work of both Bowleg (2012) and Viruell-Fuentes, Miranda, and Abdulrahim (2012)—and intersectionality theorists more broadly—serves as an important part of the current study’s conceptual framework. The current study does not seek to disentangle participants’ intersecting identities and their unique impact on sexual healthcare experiences and behaviors on an individual level, as doing so is in opposition to the very idea of
intersectionality. Rather, the current study focuses on a specific group at the intersection of Latina womanhood and non-heterosexual orientation, and the cumulative effects of privilege and power as related to these broader intersecting identities. It seems virtually impossible to assume these intersecting identities shape health in a vacuum, but rather are heavily influenced by both macro and micro-level discrimination and other health-adverse factors which intersect to produce disparate sexual health outcomes for LBQ Latina women.

Situated within the context of an intersectionality framework, Fredriksen-Goldsen et al.’s (2014) Health Equity Promotion Model examines health from a lifespan approach, focusing on how minority status relates to identity and how this impacts health over time. This life course perspective takes into account historical and sociopolitical contexts shared by cohorts and how these influence needs and adaptation, while acknowledging that individual life trajectory is important to understanding current health outcomes. The Model emphasizes the importance of structural and environmental factors (e.g. social exclusion, discrimination, and victimization) as well as community and individual level determinants of health (e.g. socioeconomic status, age, race/ethnicity), while also highlighting intersecting identities and their influence on power and privilege and acknowledging both inter- and intra-group variability. The model also acknowledges the interplay of health promoting and adverse pathways (behavioral, social, psychological, and biological processes) across multiple levels and intersecting identities which influence the continuum of health outcomes in LGBT communities.

The Health Equity Promotion Model addresses pathways through which to observe disparities as situated within an intersectionality, or “social positions” framework. Understanding, or at minimum being aware of, how unique social positions interact to
promote both strengths and weaknesses explains how LGBT health is differentiated by social position (e.g. Latino/a, education level, gay versus transgender, etc.) and culture (e.g. Latino “top” and bottom” terminology). On an individual level, these factors can include microaggressions, discrimination, victimization, and abuse—factors particularly influential in the health outcomes of LGBT, ethnic minority persons. On a structural level, factors influencing health include cultural and institutional oppressions, discriminatory laws and policies, societal stigma, and religious intolerance which support an entangled context of marginalization and oppression for populations such as the LGBT and Latina communities.

Behavioral pathways are described as observable acts by an individual or group of individuals to change or maintain health and can be both positive (e.g. preventative care) or negative (e.g. smoking). Framing behavior as both a direct and an indirect pathway is beneficial because it supports existing literature showing the direct impact of behavioral factors such as exercise on health outcomes such as obesity, while also leaving open the impact of interaction with social and historical marginalization as well as community norms and expectations among LGBT populations. While the model does not fully capture the complex ways behaviors and community norms interact to impact health in both positive and negative ways, positing that this relationship is influential prompts researchers to consider how findings might be impacted by multi-level contexts beyond behavior (Fredrickson-Goldsen et al., 2014).

Social pathways are described as the effects of interrelationships with others on health, with social relations and networks shaped throughout life and differentiated by personal and social factors. An example of a direct social pathway impacting health is the finding—supported by several bodies of literature—that factors such as living in a place with
more same-sex couples and developing ‘chosen family’ have positive impacts on both social support (indirectly influencing health) and direct health outcomes, such as psychological well-being (Hatzenbuehler, Keyes, & McLaughlin, 2011, as cited in Fredrickson-Goldsen et al., 2014).

Psychological pathways include coping and minority specific processes such as internalized homophobia and identity concealment/disclosure. These processes can take the form of both health reducing and health promoting, as shown by Hash and Rogers (2013) who found that a certain amount of psychological stress can help improve coping in certain populations (as cited in Fredrickson-Goldsen et al., 2014). These findings are also supported by Morales, Corbin-Gutierrez, and Wang (2013) who found that participants from a sample of Latino LGBT persons reported feelings of increased discrimination and stigma due to their marginalized identities, but also reported feeling stronger and more able to cope as a result of dealing with adversity. Biological pathways encompass physiological responses (to chronic stressors) as predictive of health, often connected to psychological pathways (e.g. ‘mind-body connection’). Biological pathways can also be connected to behavioral pathways in that behaviors such as exercise influencing biological stress responses which in turn impact health outcomes.

Although the present study is not longitudinal in nature, and thus cannot account for cumulative effects of experiences in shaping health, the Health Equity Promotion Model does provide a number of important implications for studying positive and negative means in which various multi-level factors influence health adverse and health promoting mechanisms among LBQ Latina women. The first lesson to be learned from the Model’s focus on both positive and negative health impacts is the importance of avoiding a purely negative,
pathologizing approach to minority health. Rather than focusing on all the factors promoting health disparities, the Health Equity Promotion Model points to factors such as human agency and resistance of LGBT people to be defined by potentially negative circumstances in seeking positive health outcomes. Second, the Model encourages researchers to be aware of intersecting identities and how these influence contextual and dynamic experiences of privilege and oppression, especially in interaction with behavioral, social, psychological, and biological factors (e.g. health outcomes for transgender individuals and LGBT people of color). Finally, the Model reminds researchers to address their own biases regarding LGBT people and explain how these biases ultimately shape research outcomes as applied to addressing health disparities (Fredrickson-Goldsen et al., 2014).

Factors Influencing Sexual Health for Latina Women

Rates of mortality and morbidity associated with sexual health-related illnesses, such as breast cancers, gynecological cancers, sexually transmitted infections (STIs), and HIV, are significantly higher among Latina women than their white counterparts, and are well-documented. Research shows a number of multilevel factors which shape these disparities in sexual health, ranging from a lack of knowledge about sexual health to shame and embarrassment to more systemic factors such as language barriers, lack of provider education and cultural humility, and lower rates of insurance coverage and lower socioeconomic status. Certain demographic factors, such as older age, more years of education, a personal history of cancer, having health insurance, and visiting a primary care provider on a regular basis have been found to shape sexual health by increasing the likelihood of screening for breast and gynecological cancers (Gorin & Heck, 2005). The ability to fluently speak English has also been shown to positively influence certain screening patterns such as mammograms and
Pap smears and reduce health risks such as drinking, smoking, and unhealthy body mass index (Lim, 2010). Factors influencing sexual health disparities can be broken into three broad categories: communication challenges, structural inequality, and cultural barriers.

Communication challenges contribute to negative experiences for patients and decrease the likelihood of utilizing preventative care and screening for breast and gynecological cancers and STIs/HIV. Providers are less likely to recommend certain sexual health screenings, such as mammograms, to Latina women as compared to white women (Blackman & Massi, 2006). Simultaneously, providers are less likely to effectively communicate the importance of follow-up care which—compounded with potential linguistic barriers and health literacy levels—reduces the likelihood of seeking such care. Across the board, Latina women report greater levels of dissatisfaction with patient-provider interactions and overall communication, especially regarding treatment decisions and perceived lack of provider cultural competency (e.g. Hawley, Janz, Hamilton, et al., 2008; Janz, Mujahid, Hawley, Griggs, Hamilton, & Katz, 2008). Greater levels of dissatisfaction shape perceptions of healthcare experiences as more negative, which ultimately shapes both likelihood of utilizing preventative care in the future as well as treatment adherence and overall sexual health behaviors.

Structural inequality can be described as the barriers to health that exist for Latina women, such as lower rates of health insurance and lower socioeconomic status, inadequate publically funded health clinics and an overall lack of culturally competent care available for Latina women (e.g. Freedman, Virgo, He et al., 2011). These structural inequalities often exist in parallel with cultural barriers, such as language differences, women’s self-perceptions of themselves relative to the needs and interests of others (e.g. marianismo),
issues of sex being seen as culturally taboo and fear and embarrassment during physical examinations, and disapproval from male partners or family members for seeking sexual health care (Timmins, 2002; Molina, Thompson, Espinoza, and Ceballos, 2013).

Cashman, Eng, Siman, and Rhodes (2011) exemplify themes described throughout other studies examining specific sexual health outcomes such as breast cancer, gynecological cancers, and STIs/HIV for Latina [immigrant] women. Through a grounded theory approach, seven themes emerged: (1) sexual health is a priority for immigrant Latinas, (2) Latinas value health screenings and disease and pregnancy prevention strategies, (3) Latinas cite a lack of available information about sexual health, (4) misinformation and myths about sexual health may be pervasive, (5) multiple barriers exist that prevent immigrant Latinas from meeting sexual health priorities and needs, (6) Latinas consider communication key to facilitate sexual health, and (7) Latinas recommend that a sexual health intervention include fundamental reproductive information and be broad in scope (Cashman et al., 2011).

The finding that Latinas place sexual health as a priority and value health screenings and disease and pregnancy prevention strategies, while not necessarily surprising, is important taken in combination with the finding that women believed there was not enough available information about sexual health. This finding highlights the importance of the present study, which seeks to develop a better understanding of how sexual healthcare experiences and other factors shape sexual health behaviors in a way which seeks to contribute to literature for shaping sexual health interventions in this population. Perhaps more significant in shaping the present study is the mention that discussions about sex may be culturally taboo within some Latino families, especially among Latina women, and this taboo often contributes to misinformation about sexual health—particularly risks of STI/HIV
transmission and proper use of sexual protection—which is passed within social networks. Additionally, women cited a range of challenges associated with addressing sexual health priorities.

Themes of embarrassment and fear during physical examinations, especially when seeing a male practitioner, were mentioned, as well as fear due to anti-immigration policies. Women also cited disapproval from male partners as a potential barrier to seeking sexual healthcare. On a systemic level, women described discomfort and hesitation with seeking care due to perceptions of pervasive discrimination against Latino/a persons and immigrants, compounded by the fear of language barriers and facing discrimination due to ones English abilities. Finally, women discussed environmental factors such as an inability to access and utilize sexual health services for which they were eligible, lack of transportation, inconvenient clinic hours in relation to work schedules, lack of child care, and issues related to a lack of health insurance and inability to afford care or difficulties related to immigration status and documentation.

The final point discussed by participants is that women consider communication about sexual health with partners, medical and health providers, children, and friends to be critical in facilitating better sexual health. Given studies suggesting the lack of communication between patients and providers regarding sexual health concerns and risks, this finding supports the importance of examining the impact of sexual healthcare experiences on sexual health behaviors as communication is certainly a significant factor shaping healthcare experiences for Latina women.

Another study by Torres, Erwin, Treviño, and Jandorf (2013) found a number of similarities to Cashman et al. (2011) which shape breast and cervical cancer screening
behaviors by diverse Latina women. Through qualitative interviews, Torres et al. discovered themes of (1) social capital, (2) screening utilization, (3) health care provider communication, and (4) social networks. Almost identical to Cashman et al.’s findings were the roles of limited financial resources and health insurance, transportation, child care-related costs, and difficulties in scheduling appointments in shaping the likelihood of screening, including breast cancer screening adherence and Pap smear screening adherence (Torres et al., 2013). Also similar to previous findings was participants’ mention of issues regarding communication with health care providers—such as distrust and language barriers, limited recommendations for screening and intimidation regarding asking questions. Finally, social networks—particularly the existence of social support—were significantly influential in increased adherence to breast and cervical cancer screening behaviors for Latina women in the study (Torres et al., 2013).

Similar findings were also revealed by Roman et al. (2014), who quantitatively examined differences in breast and cervical cancer screening among underserved Black, Latina, and Arab women. In addition to the influence of risk factors such as lower socioeconomic status, lower education, and lack of health insurance which universally affected likelihood of screening for all three groups of women, as well as pragmatic challenges such as child care, juggling clinic hours with ones work schedule, and lack of transportation, Latina women cited the most important factor shaping whether or not they received regular breast exams, mammograms, and pap smears was whether or not it was recommended by a physician (Roman et al., 2014). Although not explicitly mentioned in this study, findings fit with previous studies (e.g. Molina, Thompson, Espinoza, and Ceballos,
2013) suggesting positive patient-provider communication—including recommendations for screening—is crucial for addressing sexual health disparities among Latina women.

The reality of factors shaping Latina women’s sexual health beliefs and practices, as described by Cashman et al. (2011) and Torres et al. (2012), is supported by Foulkes et al. (2005) who summarized Census data and other sources to highlight a number of pertinent statistics. Latina women are more likely than the general population to be low-income and are less likely to have health insurance. While publicly funded clinics do exist to address such women’s basic sexual and reproductive health needs, these clinics often fall short in terms of appointment availability and culturally and linguistically competent services (Foulkes et al., 2005). Factors such as feeling inferior to ones provider or a lack of trained, on-site interpreters can promote awkward situations and communication barriers, compromising the extent to which women feel understood by providers, the extent to which they feel needs are adequately and sensitively addressed, and the quality of information women receive. These factors are often compounded by both real and perceived discrimination from healthcare providers as interpreted by Latina women patients. Such reasons may explain why Latina women often report being dissatisfied with their visits to sexual or reproductive health providers (Foulkes et al., 2005).

The present study seeks to better understand how sexual healthcare experiences, such as those in which patients report dissatisfaction, shape future sexual health beliefs and behaviors. As evidenced by the aforementioned literature review, multiple individual, community, and structural-level factors interact to produce disparities in sexual health (specifically breast and gynecological cancers, STIs, and HIV) for Latina women.
Intersectionality posits that these multilevel factors are compounded by other identities, such as ones sexual orientation and gender identity.

Factors Influencing Sexual Health for Non-Heterosexual Women

Despite the relative availability of literature examining sexual health for Latina women, there appears to be virtually no existing research focused on sexual health for non-heterosexual Latina women specifically. In terms of healthcare more broadly, sexual minority women experience unique obstacles to care such as discrimination based on their sexual orientation, lack of inclusion and heteronormativity on intake forms, and presumed heterosexuality on the part of healthcare providers and staff (e.g. Fish & Wilkinson, 2003; O’Hanlan, Dibble, Hagan, & Davids, 2004). Existing research suggests that lesbian and bisexual women may face these and other challenges in regards to sexual health screening that differ from those experienced by heterosexual women. Within this literature, four key themes emerge to explain sexual health among non-heterosexual women: demographic factors (such as age and gender presentation), cultural factors (such as perceived awareness of risk and LGBT norms regarding sex), general negative prior experiences with healthcare providers, and a fear of discrimination or discomfort due to presumed heteronormativity or lack of provider cultural competence regarding non-heterosexual intercourse.

Matthews et al. (2004) sought to understand cervical cancer risk factors, screening patterns, and predictors of screening adherence among lesbian and heterosexual women. Findings revealed several differences in sexual behavior risk factors for cervical cancer between the two groups, including significant differences between onset of sexual activity, number of sexual partners, and use of safer sex activities. Lesbian women reported earlier onset of sexual activity, more sexual partners, and lower use of safer sex activities.
Heterosexual and lesbian women reported similar likelihood of having ever received a Pap test, although lesbian were significantly less likely to report annual of routine testing (Matthews et al., 2004).

Multivariate analyses indicated patterns of screening underutilization predictors, such as younger age, lower income, and not receiving annual medical visits. Although the rates of gynecological cancer screening among lesbians did not exceed rates of heterosexual women, regular utilization of Pap tests was increased among older lesbian women and those with higher incomes and more education. Furthermore, lower utilization of cervical cancer screening tests was associated with lower perceived cancer risk and negative experiences in health care settings (Matthews et al., 2004). The connection between lower utilization of screening tests and negative experiences in health care settings is well-documented (Price et al., 1996).

Another study looking at sexual minority women’s health examined the effects of gender identity and its impact on healthcare experiences among butch and femme identified lesbian and bisexual women. Researchers found that, across the board, butch women reported significantly less frequent gynecological exams, less satisfaction with their treatment in healthcare settings, and had more difficulty findings LGBT-positive medical doctors (Hiestand, Horne, & Levitt, 2007). Butch women were more likely to be out within healthcare settings, and placed more value on seeking care from LGBT-positive healthcare providers. These differences in screening patterns between heterosexual women and lesbian and bisexual women are similar to those of Cochran et al. (2001), who found that lesbian and bisexual women were less likely than heterosexual women to have had a recent pelvic examination or mammogram, and Powers, Bowen, and White (2001), who found that
lesbians received mammograms and Pap testing at significantly lower levels than bisexual and heterosexual women. Similar patterns were seen by Rankow and Tessaro (1998), who indicated the disparity in likelihood of cervical cancer screening among lesbian and bisexual women as compared to their heterosexual counterparts.

Mercier, Harold, Dimond, and Berlin (2013) found similar factors influencing healthcare for lesbian and bisexual women, including financial barriers (both related to income and insurance coverage), difficulty finding an LGBT-affirming provider, and homophobic attitudes in healthcare settings when compared to heterosexual women. Neville and Henriskson (2006) found that significantly more women than men reported that their healthcare provider assumed they were heterosexual. Assumptions of heterosexuality prompt an uncomfortable dynamic for non-heterosexual women who are asked if they were sexually active and, if so, what birth control they are using (Rankow, 1995). O’Hanlan et al. (2004) found that lesbians who experience discrimination (or perceive discrimination from healthcare settings) are less likely to seek preventative care in the future. Awareness of perceived risk regarding safer sexual behaviors and sexual health information also impacts likelihood of seeking preventative sexual health care, with research suggesting lesbian and bisexual women often underestimate their risk for STIs because they are excluded from dominant sexual scripts and health promotion campaigns that inform the negotiations of safer sexual practices and screenings and are often targeted toward gay men or heterosexual women (Power, McNair, & Carr, 2009). This lack of perceived risk for sexually transmitted disease translates into infrequent use of preventative measures for safer-sex between women who have sex with women which in turn increases women’s risks of STI development (Marrazzo, Coffey, & Bingham, 2005).
From a general health practitioner perspective, Hinchcliff, Gott, and Galena (2005) collected qualitative data from general practitioners in the UK regarding difficulties they faced when discussing sexual health issues with lesbian and gay patients. Results indicated that non-heterosexual patient orientation could form a barrier to discussing sexual health matters for almost half of the sample, as well as provider homophobic attitudes (although not always explicit attitudes). Providers cited reasons such as ignorance of gay and lesbian lifestyles and sexual practices, and concerns about the appropriate language to use when communicating about sexual health with non-heterosexual patients as significant sources of provider discomfort. Stott (2013) found similar findings with a sample of general practitioners in Ireland, highlighting that participants rarely discussed sexual health topics or felt knowledgeable on the specific sexual health needs of LGB patients.

These and other factors identified in existing research as barriers to access, treatment, and preventative care among non-heterosexual women highlight the importance of increasing knowledge of sexual minority women’s health needs and developing cultural sensitivity and competence in communication and care, and “creating practice environments that convey respect, acceptance, and welcome to all women, regardless of sexual orientation” (Hutchinson, Thompson, & Cederbaum, 2006, p. 393). The present study builds upon existing literature demonstrating a plethora of factors across patient, provider, and health care systems levels which contribute to disparities in health care practices among sexual minority women. More specifically, the present study focuses on the impact of patient-provider interactions and healthcare experiences in shaping future preventative health practices among cisgender, non-heterosexual (Latinx) women.

*The Role of Salutogenesis and Sense of Coherence (SOC) on Health*
There is no shortage of research looking at various aspects of negative outcomes resulting from prevailing discriminatory practices and attitudes toward LGBT and/or ethnic minority persons. While there is nothing inherently wrong with studies focused on the negative experiences and health outcomes associated with being a minority—the question remains: how do we learn about improving health if we simply focus on factors which inhibit health? Antonovsky (1996) highlights both the prevalence of risk-focused literature and the need to break from the pathogenic orientation historically employed in the health and medical sciences, utilizing a salutogenic orientation instead. This approach, asserts Antonovsky, attributes health not to “being low on risk factors” (p. 14) for a specific disease or diagnosis, but to salutary factors which actively promote health. The focus of a salutogenic orientation is a focus on understanding factors which promote overall health in a person or within a community—despite the existence of risk. Using a salutogenic approach allows a much more holistic understanding of the individual or population being studied by asking the question “How can this person be moved toward greater health?” rather than seeing just the disease or the immediate health problem (p. 14).

Generalized resistance resources (GRRs) – particularly the concept of sense of coherence— are at the core of the salutogenic orientation. Defined by Antonovsky (1996), GRRs refer to “a property of a person, a collective, or a situation which...facilitates successful coping with the inherent stressors of human existence” (p. 15). It is well-documented that both Latina women and cisgender, non-heterosexual women face multiple barriers in terms of sexual health, and that such women often report poorer experiences in healthcare settings and when interacting with providers. However, it is also important to note that Latina women and cisgender, non-heterosexual women – and moreover Latina women
who identify as cisgender, non-heterosexual women such as those at the focus of the present study – also possess unique strengths afforded to them by their intersecting identities. This acknowledgement, that all persons and populations experience both health-promoting and health-adverse factors despite the prevailing focus on the latter, is at the core of Antonovksy’s salutogenic orientation (and fits with the intersectional framework within which the present study is situated).

Confronted with a stressor, those with a strong sense of coherence will be motivated to cope (meaningfulness), believe that the challenge is understood (comprehensibility), and believe that resources to cope are available (manageability) (Antonovsky, 1996). However, these constructs are not culturally-bound. As Antonovsky describes:

“What gives one a sense of meaningfulness, which type or style of resource one thinks is appropriate to apply to a given problem, in whose hands the resources are, as long as they are in the hands of someone ‘on my side’ (e.g. God, a friend); how much information one thinks one needs to comprehend – the substantive answers to these questions may vary greatly from culture to culture, from situation to situation. What matters is that one has had the life experiences which lead to a strong sense of coherence; this, in turn, allows one to ‘reach out’ in any given situation, and apply the resources appropriate to that stressor. (Of course, there can be mistakes and failures; but the person with a strong SOC learns from these, and is not doomed to repeat them.)” (1996; p. 15).

Sense of coherence develops through one’s social position and culture – influenced heavily by one’s family structure and a range of other factors from gender and ethnicity to change and genetics (Antonovsky, 1996). As such, exploring the concept of sense of coherence with
a uniquely intersectional population such as the present study’s focus on cisgender, non-heterosexual Latina women is worthy of merit. The present study also seeks to examine two secondary research questions posed by Antonyvosky which remain relatively unanswered: 1) “does the SOC act primarily as a buffer, being particularly important for those at higher stressor levels, or is it of importance straight down the line?” 2) “Is there a linear relationships between SOC and health, or is having a particularly weak (or a particularly strong) SOC what matters?” (p. 16). While the bulk of literature suggests SOC cannot be drastically changed in and of itself at the individual level, research does suggest that SOC can be inadvertently altered at the broader community or structural level through programs and interventions which might strengthen the resources available to persons when reacting to or responding following a stressor.

In a systematic review of empirical findings on the salutogenic concept of sense of coherence, Eriksson and Lindstrom (2006) found that sense of coherence is strongly related to perceived health, with higher sense of coherence tied to better perceived health among populations regardless of age, sex, ethnicity, nationality, and study design. While sense of coherence seems able to predict health and have a main, moderating, or mediating role in the explanation of health, sense of coherence along does not explain the overall health (Eriksson & Lindstrom, 2006). These findings are important to the present study because they highlight the importance of sense of coherence in impacting health cross-culturally, while it appears the present study would be the first to look at the impact of sense of coherence on a sexual minority sample, specifically.

Aspinwall and Tedeschi (2012) provide a great level of insight on the role of positive psychology, specifically sense of coherence, in understanding (and ultimately eliminating)
minority health disparities. Rather than focusing on negative outcomes, Aspinwall and Tedeschi advocate for examining multiple avenues through which positive concepts relate to health outcomes, including etiology, progression, and management of illness. Sense of coherence, also coined salutongenesis, is the avenue on which the present study will focus. Sense of coherence addresses how people comprehend and perceive themselves as able to cope in stressful situations, perhaps more eloquently described “…meaningfulness may be found in the most unfortunate circumstance…driving people to understand and manage events, and therefore, playing a role as the most important aspect of sense of coherence” (Aspinwall & Tedeschi, p. 5). In short, sense of coherence is focused on both how people resist adversity and how people bounce back from adversity. The concept of sense of coherence is supported by Morales, Corbin-Gutierrez, and Wang (2013) who conducted a study looking at the relationships between a number of factors, including oppression, and coping techniques in a sample of LGBT Latino/a persons. While nearly all of the participants reported experiences of discrimination and feelings of frustration from insults such as “you are gay and a Mexican...” due to intersecting identities, nearly all also cited their intersecting abilities as a unique source of social support and recognized their personal strengths as gay and Latino/a.

Building upon literature suggesting sense of coherence is a useful resource for countering negative effects of discrimination, Baron-Epel, Beradri, Bellettiere, and Shalata (2016) sought to understand how sense of coherence moderates the relationship between self-reported experiences of discrimination and physical heath/mental health among an ethnically-diverse sample in Israel. Findings revealed mixed patterns between ethnic groups, suggesting that whereas discrimination was related directly to health among only one ethnic group
(Jews), sense of coherence was related to health in all ethnic groups in the study. These findings suggest that sense of coherence may be a more generalizable measure associated with health than reported discrimination and that improving sense of coherence may decrease health inequities among such populations. The researchers conclude with a call for increased efforts to understand and increase sense of coherence, as it may have important impacts on both discrimination and the impact of such discrimination on population health (Baron-Epel, Beradri, Bellettiere, & Shalata, 2016).

Another study by Lam (2007) examining the mediating impact of sense of coherence on perceived racial discrimination and collective stress to psychological distress among Vietnamese-American college students yield similar results. Path analysis revealed that sense of coherence partially mediated the relationship between perceived racial discrimination and psychological distress, with persons reporting a higher sense of coherence reporting lower levels of depression and anxiety (Lam, 2007). Similar findings can be seen in other studies looking at sense of coherence and health among stigmatized populations or those facing social rejection, such as those looking at persons with mental illness (e.g. Lundberg, Hansson, Wentz, & Bkorkman, 2009), older adults (Giglio, Rodriguez-Blazquez, de Pedro-Cuesta, & Forjaz, 2015) and minority women (Nyamathi, 1993), among others. Taken in combination, these studies highlight the importance of sense of coherence in understanding how to reduce the impact of negative health experiences on health, particularly among a sample of racially/ethnically diverse or otherwise minority persons such as the lesbian, bisexual, and queer Latina women in the present study. Research doesn’t seem to have examined the impact of sense of coherence on health for sexual minority populations, making
the present study’s focus on sense of coherence doubly interesting to advancing literature on this topic.

Perhaps the biggest challenge when approaching health disparate outcomes is the very nature of the word ‘disparity’ which suggests a lack or otherwise negative connotation. It’s easy for researchers to miss positive changes if not specifically asking about them, and instead focus on the negative outcomes perhaps more readily apparent (or at least more emphasized as a focus in traditional health and psychology fields). As Aspinwall and Tedeschi assert: “By focusing on concepts such as sense of coherence… that have been adopted by the field of health psychology…we can see ways in which our discipline can become better informed about the role that these constructs play in resistance to illness, managing illness, and healing processes. The use of prospective, process-oriented, and where possible, experimental designs to examine the relation of positive phenomena to multiple health outcomes will be essential to advancing our understanding of these processes” (p. 11).

Summary

This literature review has addressed three key areas necessary for understanding the purpose and methodology of the present study:

A. Theoretical frameworks of the Health Equity Promotion Model and intersectionality

B. Factors influencing sexual health for Latina and LBQ women

C. The role of generalized resistance resources – particularly sense of coherence – in shaping health

Each of these key areas served as an orienting lens to shape the researcher’s choice of questions, research design, statistical analyses, and the implications that might be made from
the present study. Better understanding of sense of coherence and the unique healthcare experiences – particularly communication experiences - for LBQ Latinx women is necessary for understanding and improving overall and sexual health outcomes for this population. However, as exemplified by the aforementioned literature review, research specifically examining LBQ Latinx women’s experiences and health is lacking.

The present study provides an introduction to this gap in the literature regarding the relationships between overall and sexual health, sense of coherence, prior experiences communicating with healthcare providers, and comfort communicating with healthcare providers. The current study seeks to address the following research questions:

1. How do demographic variables relate to primary variables of interest – including sense of coherence, self-reported health (overall and sexual), experiences communicating with providers, and comfort communicating ones health (overall and sexual) needs with healthcare providers – within a sample of cisgender, LGB Latinx women?

2. Does sense of coherence predict overall health? Sexual health?

3. How is the relationship between sense of coherence and (sexual) health moderated and/or mediated by ones experiences communicating with healthcare providers and ones comfort communicating health needs (overall and sexual) with providers?

CHAPTER 3 - METHODS

Design and Variables

The researcher addressed the aforementioned research questions and hypotheses using a cross-sectional survey design. The design served as a basis for descriptive analysis and generating hypotheses, both components crucial in a study such as this one for which no existing research exists to explain the variables/outcome/population of interest. Cross-
sectional surveys are more feasible as compared to longitudinal or successive independent samples designs because data on all variables is only collected once, requiring no long periods of follow-up and very little commitment for participants who complete the survey.

The advantage of an Internet-based, cross-sectional survey design specifically is that it allows nationwide sampling and easier polling of people that fit a certain profile (i.e. cisgender, non-heterosexual identified Latina women) compared to mail, phone, or in-person surveys. These considerations are particularly relevant for the present study because they allow for a larger and more representative sample of the target population. Finally, the use of completely Internet-based surveys promotes greater feelings of anonymity amongst participants, which is an especially important consideration given the taboo nature of gender identity and sexual expression (especially LGBTQ) and sexual health. Participants also have the freedom to complete the Internet survey virtually anywhere with web access. These strengths — the ability to collect data from a specific population, to conduct descriptive analyses to generate hypotheses, and to increase sample sizes with a more diverse, nationwide survey — plausibly outweigh the limitations of cross-sectional sampling for this particular study population (see Limitations section for further discussion).

The present study utilized cross-sectional, online survey methods (e.g. Qualtrics) and recruitment through national organizations to collect data from a sample of cisgender, lesbian, bisexual, and queer (LBQ) identified Latina women at least 18 years of age. The survey was designed for access across both web and mobile devices, and to ensure maximum user friendliness according to the guidelines outlined by Dillman et al. (2014) for web questionnaire design. The survey was tested using a variety of devices prior to distribution to ensure items were accessible and coded correctly, per the Millar and Dillman (2011)
guidelines for designing web and mobile surveys. Implementation of the survey also followed the Dillman et al. (2014) method for contacting potential participants and organizations via email, tracking who responded, and monitoring the survey’s progress. Specific guidelines included focusing on personalizing contacts to respondents, using multiple organizational contacts and varying the message across them, and intentionally timing all contacts with the population in mind. All correspondence was tracked using an electronic spreadsheet, and a web-based mail merge service which tracked dates emails were sent and whether or not they were opened. Each contact was sent three separate, unique requests for participation over a two-month period of time.

Participants were recruited through purposive and convenience sampling via social media and various organizations serving LGBTQ and Latino/a populations. This was done via email and phone calls discussing the researcher’s reason for pursuing said research topic, providing a very brief overview of the research (or lack thereof) related to LBQ Latina women’s health, and sharing details of the research design and measures. Social media in the form of Facebook and Twitter was also a significant means of recruiting participants, as was asking participants to share the survey information with others among their contacts who fit the target population (i.e. snowball sampling). See Appendix F for the participant recruitment message format.

Community Advisors

In an effort to best meet the needs of the population – cisgender LGBQ+ Latina women – the researcher involved community advisors at each stage of the research process. While this involvement was relatively informal, occurring predominantly through email, phone, and video conference conversations, it did serve to resemble community-based
participatory research (CBPR). Community advisors did not have specific roles, but worked collaboratively with the researcher as needed. Primary foci of collaboration included survey item development and translation, and participant recruitment. The frequency of contact tended to be on a biweekly basis during survey development and participant recruitment, with individual correspondence between meetings occurring as needed. CBPR is based on the premise that persons within the community for whom the research is designed to help should be included throughout the research process (Minkler & Wallerstein, 2011). The use of a community advisory board (CAB) to provide the opportunity for community member collaboration and enhancing the clinical relevance of research by leveraging the personal experiences of individuals affected by the phenomena being studied is well-documented (e.g. Delaney et al., 2012; Newman et al., 2011). This study sought to replicate some elements of CBPR and the use of a CAB, albeit in a much more informal and time-conscious manner. Community advisors were also included to ensure the study appropriately captured the experiences of a population to which the researcher did not themselves belong.

The community advisors consisted of three cisgender Latinx women with whom the researcher had formed relationships from a prior qualitative study on LGBQ+ Latina women’s health. All three native Spanish-speaking women reside in the southeastern United States and are college graduates between 22-28 years old, and in previous interviews all three identified sexual health as an area which they felt to be especially important for Latina women who also identify as LBQ. Beyond these similarities, the women exemplify a variety of intersecting identities in regards to nativity, health status, specific Latina ethnicity, gender presentation, socioeconomic status, and other identities disclosed (e.g. feminist, ‘survivor’ of sexual assault, first-generation college student). One of the women identifies as a femme-
presenting lesbian, another as a lesbian with masculine-of-center presentation, and the third identifies as bisexual with a predominantly androgynous gender presentation. These three women were invaluable in translating survey items and assuring questions accurately reflected the needs of LGBQ+ Latina women.

*Participants and Sampling*

The participants were 186 cisgender women, aged 18-64 years (85.6% between 18-44 years of age), who identified themselves as lesbian, queer, or bisexual. Of the participants, 26.3% identified as lesbian, 30.6% identified as queer, and 39.8% identified as bisexual. The remaining 3.2% of participants identified themselves as other, specifying this mean they identified as pansexual. 73.1% of the sample identified their gender identity as female, with the remaining 26.9% identifying as gender queer or non-binary. In terms of gender presentation on a scale of ‘very masculine/butch’ to ‘very feminine/femme’, 4.8% presented themselves as very masculine/butch, 4.3% as somewhat masculine/butch, 17.2% as neither masculine nor feminine (e.g. androgynous), 35.5% presented as somewhat feminine/femme, and 38.2% identified as very feminine/femme. 95.2% indicated they currently were sexually active or had been sexually active at some point.

9.1% were first-generation immigrants (individual immigrated to the US themselves), 24.2% were second-generation (individual is the US-born child of at least one foreign parent), and 66.7% were third-generation (US-born child of two US-born parents, with at least one foreign-born grandparent). In terms of education, all were high school graduates (3.2%) with 22.1% completing at least some college or earning a two-year degree, 33.3% had graduated from a four-year college, 22.6% had earned a master’s degree, and 18.8% had earned a professional or doctoral degree. Participants reported their English proficiency on a
scale of 1 (very weak) to 5 (very strong), with 96.2% describing their writing and reading proficiency as very strong, and 93% describing their speaking proficiency as very strong. The remaining participants all identified their English proficiency as somewhat strong, with none indicating their proficiency as fair, somewhat weak, or weak. 90.9% indicated they currently had health insurance, with 26.9% indicating they had been without health insurance at some point within the last 12 months. Participants were also asked to indicate what percentage of healthcare providers they’d told about their sexual orientation since ‘coming out’ as non-heterosexual. 30.1% of women were out to none of their providers, 21% were out to less than 25% of providers, 19.4% were out to between 25-50% of providers, 15.1% were out to 50-75% of providers, and 14.5% were out to 75-100% of their healthcare providers.

Table 1. Frequency table for major demographic variables (n = 186).

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Currently have health insurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>169</td>
<td>90.9</td>
</tr>
<tr>
<td>No</td>
<td>17</td>
<td>9.1</td>
</tr>
<tr>
<td>Sexual orientation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lesbian</td>
<td>49</td>
<td>26.3</td>
</tr>
<tr>
<td>Queer</td>
<td>57</td>
<td>30.6</td>
</tr>
<tr>
<td>Bisexual</td>
<td>74</td>
<td>39.8</td>
</tr>
<tr>
<td>Other - pansexual</td>
<td>6</td>
<td>3.2</td>
</tr>
<tr>
<td>Gender identity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>136</td>
<td>73.1</td>
</tr>
<tr>
<td>Gender queer or non-binary</td>
<td>50</td>
<td>26.9</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High school graduate</td>
<td>6</td>
<td>3.2</td>
</tr>
<tr>
<td>Some college</td>
<td>26</td>
<td>14.0</td>
</tr>
<tr>
<td>2 year degree</td>
<td>15</td>
<td>8.1</td>
</tr>
<tr>
<td>4 year degree</td>
<td>62</td>
<td>33.3</td>
</tr>
<tr>
<td>Master’s Degree</td>
<td>42</td>
<td>22.6</td>
</tr>
<tr>
<td>Professional or Doctoral Degree</td>
<td>35</td>
<td>18.8</td>
</tr>
</tbody>
</table>
Participants resided in 40 out of 50 states in the United States, plus the District of Columbia, making this sample quite nationally representative. Alaska, Iowa, Kansas, Nebraska, Nevada, North Dakota, Oregon, South Dakota, Oregon, Washington, and Wisconsin were the states in which no participants lived. States representing the greatest percentage of participants included California (8%), New York (9%), North Carolina (8%), and Texas (14%).

**Procedures**

The survey was available in both English and Spanish, with participants able to switch between the two languages at any point in the survey. Translation occurred through a process of forward and backward translation, and generally followed the procedures outlined.
by Beaton, Bombardier, Guillemin, and Ferraz (2002). Two bilingual persons were asked to
translate the consent form and survey into Spanish. These Spanish versions were then shared
with two separate bilingual persons, who were asked to translate the consent form and survey
into English. An English-speaking research assistant was then asked to compare the
translated English survey with the original survey. Any discrepancies between these surveys,
or between the bilingual translation into Spanish, were discussed with the community
advisors involved in the current study for the purpose of consolidating translations into the
final survey measures. Both English and Spanish version of the final survey were pretested
among a sample of 10 persons, none of whom represented the target population of LBQ
Latinx women (due to lack of availability and not wanting to borrow from the study’s
recruitment resources) but all of whom identified as an LBQ or Latinx woman.

Participants were asked screening questions regarding age, sexual orientation, gender
identity, sex at birth, and whether or not they identify as Latina. See Appendix A for
screening questions with response options. Persons who did not fit the intended population
were directed to the end of the survey and thanked for their interest in participation. Persons
who, as self-reported via the screening questions, identify as cisgender LBQ-identified Latina
women were directed to a consent form. Following completion of the screening questions
and consent form, participants were directed to a number of quantitative questions regarding
healthcare experiences, sense of coherence, sexual health screening and prevention-related
behaviors, and demographic questions. Participants were then directed to a message thanking
them for their participation and debriefing the research goals, particularly clarifying the focus
on understanding how sense of coherence was associated with healthcare experiences and
health among cisgender, LBQ Latinx women.
Finally, participants were directed to a separate, optional survey – the results of which were completely separate from the initial data collection survey – which served to collect email addresses from participants to be entered into a drawing for one of ten $20 Visa gift cards. The gift card drawing was in lieu of individual participation incentives, which were not offered due to financial limitations. Within a week of concluding data collection, winners of the gift cards were identified through the use of a random number generator, with five numbers randomly identified and the email addresses corresponding with these numbers in order of completion chosen. These winners were contacted via email with a web link to access their electronic gift card, and the researcher’s contact information should any issues arise with using the card. Receipts from the Visa gift card site confirmed that all ten gift card winners received their cards, and none contacted the researcher indicating issues accessing the funds.

*Measures*

*Demographic and Background Variables*

Demographic variables including sexual orientation, gender identity, whether participants currently have health insurance (and if not, why), whether participants been without health insurance for any period of time in the last 12 months, immigration status, highest level of education, age, English proficiency (writing, reading, and speaking), whether or not participants are sexually active (and if so, with partners of which biological sex or sexes), self-reported gender presentation (e.g. masculine / “butch”, androgynous, feminine / “femme”), and general history of sexual and women’s health among family, close friends, and self were measured. Participants were also asked to indicate the state within which they
currently resided. See Appendix B for more details regarding measurement of these variables.

**Healthcare Experiences**

Participants’ healthcare experiences were measured using items inspired by the Consumer Assessment of Healthcare Providers and Systems (CAHPS) 3.0, which covers topics such as the communication skills of providers, patient-provider trust, helpfulness of staff, and cultural competency. This scale had demonstrated robustness for use across multiple healthcare environments and populations. However, it merely served as a framework for structuring questions in the current study, as most questions were significantly altered to better address sexual health and the unique experiences of Latinx and LBQ women. All items were devised exclusively for use in the current study, as no such measures exist to capture the healthcare experiences – particularly regarding sexual health – of Latinx or LGBTQ populations. Table 1 shows example items most closely related to the initial CAHPS items. See Appendix C for full measures.

**Table 2.** Example items for healthcare experiences questionnaire, compared to existing CAHPS experience items.

<table>
<thead>
<tr>
<th>Item as included in the CAHPS</th>
<th>Adapted version of the item</th>
<th>Response format</th>
</tr>
</thead>
<tbody>
<tr>
<td>In the past 12 months, how often have you been treated unfairly at this provider’s office because of your race or ethnicity?</td>
<td>a. How often have you been treated unfairly by a healthcare provider because of your race or ethnicity?</td>
<td>Never</td>
</tr>
<tr>
<td></td>
<td>b. How often have you been treated unfairly by a healthcare provider because of your sexual orientation or gender identity?</td>
<td>Sometimes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Usually</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Always</td>
</tr>
</tbody>
</table>
In the past 12 months, did you feel you could tell this provider anything, even things that you might not tell anyone else?

<table>
<thead>
<tr>
<th>Question</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. How often have you felt comfortable disclosing your sexual orientation or gender identity to a healthcare provider?</td>
<td>Never, Sometimes, Usually, Always</td>
</tr>
<tr>
<td>b. How often have you felt comfortable disclosing (non-hetero)sexual activities to a healthcare provider?</td>
<td>Never, Sometimes, Usually, Always</td>
</tr>
</tbody>
</table>

In the past 12 months, how often did this provider encourage you to ask questions?

<table>
<thead>
<tr>
<th>Question</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. How often do healthcare providers encourage you to ask questions about your sexual health?</td>
<td>Never, Sometimes, Usually, Always</td>
</tr>
</tbody>
</table>

In the past 12 months, how often did this provider give you an easy to understand explanation about the next steps for those health questions or concerns?

<table>
<thead>
<tr>
<th>Question</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. When you have asked a healthcare provider a question about your sexual health, how often were you satisfied with the answer given?</td>
<td>Never, Sometimes, Usually, Always</td>
</tr>
</tbody>
</table>

Additional items were then added to the overall healthcare experiences measure. These items addressed things such as experiences related to sexual orientation, gender identity, and gender presentation, interactions with healthcare providers and staff as a Latinx LBQ person, and representation of diverse persons on healthcare materials.

Ultimately, items were compiled and structured to represent four unique subscales – communication experiences (e.g. “How often do providers talk too fast when talking with you?”), provider recommendations for preventative care (e.g. “How often do healthcare providers talk to you about mammograms?”), interactions with healthcare staff and the healthcare environment (“How often have you felt welcomed by clinic front desk staff?”), and experiences related explicitly to sexual orientation, gender identity, and gender presentation (e.g. “How often have you felt judged by a healthcare provider for your sexual
orientation?”). All items were translated into Spanish using the process of forward – backward translation and community adviser review described previously. Scores were combined and items reverse coded as needed, with a higher overall total score reflecting greater overall satisfaction in prior healthcare experiences.

**Sense of Coherence**

Sense of coherence (SOC) was measured using Antonovsky’s 29-item semantic differential questionnaire, which has yielded the Cronbach alpha measure of internal consistency ranging from 0.82-0.95 across studies conducted in 20 countries (Antonovsky, 1987). The scale includes such questions as “How often do you have confusing thoughts and ideas?” and “Do you have a feeling that things you are involved in your daily life do not have meaning”. See Appendix D for full version of this questionnaire (in English). The response scale ranges from very frequently (1) to never (7), with some items reversed so a higher score corresponds with better SOC. A total score for overall sense of coherence was calculated for each respondent, with a higher score indicating a higher sense of coherence. Participants with a higher sense of coherence, as measured using the Antonovsky (1987) scale, are considered higher in their motivation to cope (meaningfulness) following a stressful event, more likely to understand the stressful event (comprehensibility), and having greater beliefs that resources to cope are available (manageability) (Antonovsky, 1987). Cronbach’s alpha yielded a reliability estimate of .904 for Antonovsky’s 29-item semantic differential questionnaire with this study’s sample of LBQ Latina women.

**Overall and Sexual Health**

A number of measures were used to access overall health, sexual health, and factors existing literature and conceptual models (e.g. the Health Beliefs Model) suggest are likely
tied to health within the target population. These items were developed by the researcher in conjunction with community advisors for specific use in the current study. It’s important to note that existing measures were not used due to the lack of scales which fit the study’s focus on sexual health in a broad sense, encompassing breast cancer, gynecological cancers, and sexually transmitted infections (STIs) including HIV/AIDS. Additionally, existing scales fail to allow for use with non-heterosexual women, with most scales focused on heterosexual persons and a few focused exclusively on gay, bisexual, or other men who have sex with men. All items were quantitative and framed as Likert scale questions. Items included: self-rated overall health; self-rated sexual health; perceived risk for HIV, STIs, and breast and gynecological cancers; perceived knowledge of sexual risk (e.g. likelihood of HIV/AIDS or other STI diagnosis, likelihood of breast and gynecological cancer diagnosis); date of last mammogram, breast self-exam, pap smear, HIV test, and visits to providers (for any reason; for a women’s or sexual health reason; visit to a gynecologist, specifically); percentage of providers to whom the participant is ‘out’; likelihood of disclosing sexual orientation to healthcare provider; and comfort communicating ones general health needs and sexual health needs with providers. Participants were also given the opportunity to answer an open-ended question sharing any additional information they wished to share about their experiences related to health. See Appendix E for full questionnaire.

CHAPTER 4 - RESULTS

Data were examined using a series of analyses, as detailed throughout Chapter 4. Initial analyses focus on scale reliability and validity. Reliability analyses were conducted for Antonovsky’s Sense of Coherence Semantic Differential Questionnaire. Multiple iterations of factor analysis were used to examine the validity of the measure of one’s experiences
communicating with healthcare providers, followed by reliability analyses. Next, analyses were conducted to examine overall frequency distributions for demographic variables, and to examine relationships between variables of interest. Finally, mediation and moderated mediation analyses were used to explore relationships between significantly correlated variables of interest, and to understand factors which mediated and served as moderated mediators on the relationship between sense of coherence and health.

*Scale Reliability and Validity*

Because none of the measures included in the survey had been utilized with this specific population of cisgender Latina women, reliability analyses and factor analyses were conducted for sense of coherence and healthcare experiences scales. The Cronbach’s Alpha reliability estimate for sense of coherence in the present study was examined in comparison to the reliability estimates provided in prior usages of scales for other populations.

Antonovsky’s Sense of Coherence Semantic Differential Questionnaire (n = 29 items) yielded an Alpha score of .904 consistent with other usages across diverse samples yielding alphas of 0.82-0.95 across studies conducted in 20 countries (Antonovsky, 1987). This indicates Antonovsky’s 29-Item Semantic Differential Questionnaire is a reliable measure of sense of coherence among the study’s sample of cisgender, LBQ Latinx women.

The factorability of the fifteen healthcare communication experience items were examined using several well-recognized criteria for the factorability of a correlation. The Kaiser-Meyer-Olkin measure of sampling adequacy was .714, above the commonly recommended value of .6, and Bartlett’s test of sphericity was significant (χ² (105) = 1151.327, p < .001). All communalities were above .5 (Table 3), further confirming that each
item shared some common variance with other items. Given these overall indicators, factor analysis was deemed suitable with all 15 items.

Table 3. Factor loadings and communalities based on principle components analysis with oblimin rotation for 15 items measuring communication experiences with healthcare providers (n = 186).

<table>
<thead>
<tr>
<th>Comp. 1</th>
<th>Comp. 2</th>
<th>Comp. 3</th>
<th>Communality</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>.660</td>
<td></td>
<td>.591</td>
</tr>
<tr>
<td>2</td>
<td>.520</td>
<td></td>
<td>.605</td>
</tr>
<tr>
<td>3</td>
<td>.542</td>
<td></td>
<td>.534</td>
</tr>
<tr>
<td>4</td>
<td>.567</td>
<td></td>
<td>.518</td>
</tr>
<tr>
<td>5</td>
<td>.699</td>
<td></td>
<td>.607</td>
</tr>
<tr>
<td>6</td>
<td>.821</td>
<td></td>
<td>.713</td>
</tr>
<tr>
<td>7</td>
<td>.576</td>
<td></td>
<td>.656</td>
</tr>
<tr>
<td>8</td>
<td>.698</td>
<td></td>
<td>.772</td>
</tr>
<tr>
<td>9</td>
<td>.728</td>
<td></td>
<td>.759</td>
</tr>
<tr>
<td>10</td>
<td></td>
<td>.625</td>
<td>.654</td>
</tr>
<tr>
<td>11</td>
<td></td>
<td>.692</td>
<td>.628</td>
</tr>
<tr>
<td>12</td>
<td>.620</td>
<td></td>
<td>.669</td>
</tr>
<tr>
<td>13</td>
<td></td>
<td>.574</td>
<td>.668</td>
</tr>
<tr>
<td>14</td>
<td>.640</td>
<td></td>
<td>.657</td>
</tr>
<tr>
<td>15</td>
<td></td>
<td>.744</td>
<td>.587</td>
</tr>
</tbody>
</table>

Principle components analysis was then used to determine initial eigenvalues, indicating that the first three factors explained 29%, 17%, and 11% of the variance respectively. The fourth factor had eigenvalues which explained just over 7% of the variance, with factors five through fifteen indicating between 6% and .99% of the variance, respectively. Solutions for three and four factors were each examined using oblimin rotations of the factor loading matrix. The three factor solution, which explained 58% of the variance, was preferred due to the “leveling off” of eigenvalues on the scree plot after three factors and the lack of primary loadings associated with the fourth factor and subsequent factors. No items were eliminated
as a result of factor analysis, since all fifteen items maintained a minimum of .52 for primary factor loadings with cross-loadings clearly lower. Internal consistency for each of the components was examined using Cronbach’s alpha, yielding scores of .87 for Component 1 (9 items), .81 for Component 2 (3 items), and .84 for Component 3 (3 items). No substantial increases in alpha for any of the components could have been achieved by eliminating more items. Reliability estimates for the full fifteen-item measure of experiences communicating with providers yielded an Alpha score of .864. Reliability estimates were examined according to standard ranges of acceptable values for internal consistency in the psychological sciences (Field, 2009). Although the current study’s measure for communication experiences had not been utilized prior to this study, these analyses suggest it is a valid and reliable measure of one’s experiences communicating with healthcare providers, at least within the current study’s population.

Following factor and reliability analyses, simple frequency analyses were conducted to examine overall frequency distributions. Correlation matrices for demographic variables and health-related variables of interest were also calculated. A series of point-biserial and bivariate correlations were used to examine any noteworthy relationships between demographic variables, sense of coherence, overall health, sexual health, experiences communicating with providers, and comfort communicating with providers. These analyses were conducted to determine the appropriateness of conducting mediation and/or moderation analyses with these variables.

Demographic Variables and Health

In terms of demographic variables, no significant relationships were found between age, generation of immigration, education, gender presentation, and sexual or overall health.
Additional variables, such as English proficiency or having health insurance were excluded from analyses due to very limited sample variability. Sexual orientation was dummy coded into a dichotomous variable, such that three different yes/no variables were created for identifying as lesbian, bisexual, or queer. Although ‘other’ was initially a response option, only 3.2% of participants chose this option and identified themselves as pansexual. Given this small sample size and research suggesting a number of similarities between bisexual and pansexual persons’ health (e.g. Smalley, Warren, & Barefoot, 2016) and identities (e.g. Morandini, 2016), these participants were collapsed into the ‘bisexual’ category for analysis. Point-biserial analyses revealed significant patterns associated with both overall and sexual health, such that identifying as bisexual correlated with more positive self-report overall and sexual health compared to lesbian or queer-identified women in the study. See Table 4 for full statistics.

<table>
<thead>
<tr>
<th></th>
<th>Lesbian</th>
<th>Bisexual</th>
<th>Queer</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overall health</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pearson’s r</td>
<td>-.149*</td>
<td>.290**</td>
<td>-.161*</td>
</tr>
<tr>
<td>*p</td>
<td>.042</td>
<td>.000</td>
<td>.028</td>
</tr>
<tr>
<td><strong>Sexual health</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pearson’s r</td>
<td>-.062</td>
<td>.161*</td>
<td>-.108</td>
</tr>
<tr>
<td>*p</td>
<td>.400</td>
<td>.029</td>
<td>.141</td>
</tr>
</tbody>
</table>

*Significant at the p < .05 level.*

Gender identity was also dummy coded, such that two different yes/no variables were created for female and gender queer or non-binary. Point-biserial analyses revealed significant inverse relationships between gender identity and both overall and sexual health,
such that identifying as female was correlated with more positive overall and sexual health. Identifying as gender queer or non-binary was significantly associated with more negative overall and sexual health. See Table 5 for full statistics.

Table 5. Correlations between gender identity and overall and sexual health (n = 186).

<table>
<thead>
<tr>
<th></th>
<th>Female</th>
<th>Gender queer or non-binary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall health</td>
<td>Pearson’s r</td>
<td>.249**</td>
</tr>
<tr>
<td></td>
<td>p</td>
<td>.001</td>
</tr>
<tr>
<td>Sexual health</td>
<td>Pearson’s r</td>
<td>.203**</td>
</tr>
<tr>
<td></td>
<td>p</td>
<td>.005</td>
</tr>
</tbody>
</table>

**Significant at the p <.01 level.

Demographic Variables and Sense of Coherence

Correlations were also used to examine the relationship between demographic variables and sense of coherence. Again, no significant relationships were found between sense of coherence and age, education, or generation of immigration. Point-biserial correlations with the dummy coded sexual orientation, gender identity, and gender presentation variables did indicate a number of significant relationships. In regards to sexual orientation, findings revealed that bisexual persons possessed significantly more positive sense of coherence scores (Pearson’s r = .157, p = .032). Persons who indicated their gender presentation as feminine also possessed significantly more positive sense of coherence scores (Pearson’s r = .227, p = .002), while androgynous presenting persons scored lower on sense of coherence (Pearson’s r = -.241, p = .001). Significant findings for gender identity revealed that female-identified persons scored significantly higher on sense of coherence (Pearson’s r
= .177, p = .015) compared to their gender queer or non-binary identified counterparts. See Table 6 for full statistics.

Table 6. Correlations between sense of coherence (SOC), sexual orientation (SO), gender presentation (GP), and gender identity (n = 186).

<table>
<thead>
<tr>
<th></th>
<th>Pearson’s r</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lesbian (SO)</td>
<td>-.028</td>
<td>.704</td>
</tr>
<tr>
<td>Queer (SO)</td>
<td>-.137</td>
<td>.063</td>
</tr>
<tr>
<td>Bisexual (SO)</td>
<td>.157*</td>
<td>.032</td>
</tr>
<tr>
<td>Masculine (GP)</td>
<td>-.030</td>
<td>.681</td>
</tr>
<tr>
<td>Feminine (GP)</td>
<td>.227**</td>
<td>.002</td>
</tr>
<tr>
<td>Androgynous (GP)</td>
<td>-.241***</td>
<td>.001</td>
</tr>
<tr>
<td>Female (GI)</td>
<td>.177*</td>
<td>.015</td>
</tr>
<tr>
<td>Gender queer or non-binary (GI)</td>
<td>-.177*</td>
<td>.015</td>
</tr>
</tbody>
</table>

Demographic Variables and Communication Experiences

Additional correlational analyses were used to examine the relationship between demographic variables and communication experiences. No significant relationships were found between sense of coherence and age or education. Generation of immigration was dummy coded into three separate items (e.g. first generation – yes or no; second generation –
yes or no; third generation – yes or no) and point-biserial correlations calculated. Findings revealed no significant relationship between identifying as a first generation immigrant and communication experiences. Identifying as a second generation immigrant was significantly associated with sense of coherence, such that being a second generation immigrant was related to lower sense of coherence scores (Pearson’s r = -.170, \( p = .020 \)).Identifying as a third generation immigrant was associated with higher sense of coherence (Pearson’s r = .172, \( p = .019 \)). Although interesting, generation of immigration was not significantly related to any other independent or dependent variables in the study (nor identified as a primary variable of interest at the study’s onset) merited its exclusion from subsequent mediation analyses. Point-biserial correlations with the dummy coded sexual orientation, gender identity, and gender presentation variables indicated few significant relationships with communication experiences. In terms of sexual orientation, persons who identified as lesbian reported significantly more positive experiences communicating with providers (Pearson’s r = .205, \( p = .005 \)). Gender identity and gender presentation was not significantly correlated with an individual’s prior experiences communicating with healthcare providers.

**Sense of Coherence, Health, and Communication**

Finally, bivariate correlations were conducted to determine the relationships between sense of coherence, overall health, sexual health, communication experiences, and comfort communicating with providers. Analyses revealed a significant positive correlation between sense of coherence and overall health (Pearson’s r = .336, \( p < .001 \)), such that persons possessing a higher sense of coherence reported better overall health. The relationship between sense of coherence and sexual health was non-significant. Interestingly, however, the relationship between overall health and sexual health was significant (Pearson’s r = .500,
such that participants who reported better overall health also reported better sexual health. Sense of coherence was positively associated with prior experiences communicating with providers (Pearson’s $r = .459, p < .001$), such that participants with higher sense of coherence perceived their experiences communicating with providers as more positive. Persons with higher sense of coherence also reported feeling more comfortable communicating with healthcare providers about their overall health needs (Pearson’s $r = .251, p = .001$) and their sexual health needs (Pearson’s $r = .209, p = .004$). See Table 7 for full statistics. These correlational analyses – paired with existing literature – were used to inform additional analyses.

Table 7. Correlations between sense of coherence (SOC), overall health, sexual health, prior communication experiences, and comfort communicating with providers ($n = 186$).

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>SOC</td>
<td>Pearson’s $r$</td>
<td>$0.336^{**}$</td>
<td>$0.085$</td>
<td>$0.459^{**}$</td>
<td>$0.251^{**}$</td>
</tr>
<tr>
<td></td>
<td>$P$</td>
<td>$0.000$</td>
<td>$0.249$</td>
<td>$0.000$</td>
<td>$0.001$</td>
</tr>
<tr>
<td>Overall health</td>
<td>Pearson’s $r$</td>
<td>-</td>
<td>$0.500^{**}$</td>
<td>$0.037$</td>
<td>$0.042$</td>
</tr>
<tr>
<td></td>
<td>$P$</td>
<td>-</td>
<td>$0.000$</td>
<td>$0.614$</td>
<td>$0.570$</td>
</tr>
<tr>
<td>Sexual health</td>
<td>Pearson’s $r$</td>
<td>$0.500^{**}$</td>
<td>-</td>
<td>$0.058$</td>
<td>$0.298^{**}$</td>
</tr>
<tr>
<td></td>
<td>$P$</td>
<td>$0.000$</td>
<td>-</td>
<td>$0.434$</td>
<td>$0.00$</td>
</tr>
<tr>
<td>Communication</td>
<td>Pearson’s $r$</td>
<td>$0.037$</td>
<td>$0.058$</td>
<td>-</td>
<td>$0.021$</td>
</tr>
<tr>
<td>experiences</td>
<td>$P$</td>
<td>$0.614$</td>
<td>$0.434$</td>
<td>-</td>
<td>$0.773$</td>
</tr>
<tr>
<td>Comfort communicating</td>
<td>Pearson’s $r$</td>
<td>$0.042$</td>
<td>$0.298^{**}$</td>
<td>$0.021$</td>
<td>-</td>
</tr>
<tr>
<td>health needs</td>
<td>$P$</td>
<td>$0.570$</td>
<td>$0.000$</td>
<td>$0.773$</td>
<td>-</td>
</tr>
<tr>
<td>Comfort communicating</td>
<td>Pearson’s $r$</td>
<td>$0.047$</td>
<td>$0.136$</td>
<td>$0.006$</td>
<td>$0.497^{**}$</td>
</tr>
<tr>
<td>sexual health needs</td>
<td>$P$</td>
<td>$0.525$</td>
<td>$0.064$</td>
<td>$0.932$</td>
<td>$0.000$</td>
</tr>
</tbody>
</table>

**Significant at the $p < .01$ level.
Mediation analyses were used to explore whether communication experiences serve as a mediating variable on the relationship between sense of coherence and overall health and sense of coherence and sexual health. All mediation analyses were conducted using the Hayes (2013) PROCESS procedure for SPSS. Using Model 4, two separate sets of analyses were conducted – the first for overall health, and the second for sexual health. Subsequent models were utilized with sexual orientation and gender identity included as covariates, as discussed below.

The first analysis was conducted to determine if the effect of sense of coherence on overall health was mediated by prior experiences communicating with a healthcare provider. Analyses yielded a significant relationship, \( t (184) = 2.33, p = .021 \), between sense of coherence and communication experiences as shown in prior analyses using bivariate correlation, and between communication experiences and overall health, \( t (184) = 5.66, p = .002 \). Indirect effects of sense of coherence (X) on overall health (Y) were significantly different from zero, with a 95% confidence interval from .0038 to .0007, suggesting that communication experience (M) does indeed mediate the relationship between sense of coherence and overall health. However, a significant direct effect of sense of coherence (X) and overall health (Y) also remained, \( t (184) = 5.87, p < .001 \), indicating that communication experiences only partially mediates this relationship. This model is shown in Figure 3 below.

This significant partial mediation remained when including sexual orientation, gender identity, and gender presentation – variables correlated with overall health and/or sense of coherence – as covariates in the mediation model.
Additional analyses were conducted to examine the role of communication experiences as a mediating variable on the direct relationship between sense of coherence and sexual health. As expected based on prior non-significant findings regarding sense of coherence and sexual health, there was no direct effect of sense of coherence (X) on sexual health (Y). Although a significant relationship did exist between sense of coherence and communication experiences, $t(184) = 7.016, p < .001$, no such relationship existed between communication experiences and sexual health, $t(184) = 1.488, p = .138$. These findings indicate that no indirect effects exist to suggest communication experiences significantly impact the relationship between sense of coherence and sexual health. That is, communication experiences do not mediate between sense of coherence and sexual health. This non-significant relationship remained when including sexual orientation, gender identity, and gender presentation as covariates in the mediation model.

*Moderated Mediation Analyses for Sense of Coherence, Communication, and Health*
Finally, Hayes’s PROCESS Model 7 was used to examine the potential role of comfort communicating health needs with providers as a moderator on the relationship between sense of coherence (X) and communication experiences (M) – that is, a moderated mediation. Previous analyses yielded a significant partial mediation, such that healthcare communication experiences partially explained the relationship between sense of coherence and overall health. However, a direct relationship remained between sense of coherence and overall health even with communication experiences included in the model, suggesting some other variable(s) likely influenced the mediation relationship. Conceptually, it made sense that comfort communicating health needs might be one potential variable having an impact on the relationship between sense of coherence and communication experiences. As such, moderation mediation was utilized to examine how comfort communicating health needs might shape the significant partial mediation found between sense of coherence and overall health.

Analyses yielded a significant relationship, $t(182) = 2.33, p = .021$, between sense of coherence and communication experiences, between communication experiences and overall health, $t(182) = 3.19, p = .002$, and between sense of coherence and overall health, $t(182) = 5.87, p < .001$. The interaction term between sense of coherence, comfort communicating, and communication experiences was also significant, $t(182) = 5.46, p < .001$, indicating that an individual’s comfort communicating about their health needs significantly influences the relationship between sense of coherence and communication experiences. That is, the more comfortable communicating their health needs one is, the more positive will be the relationship between their sense of coherence and their communication experiences. Results indicated that the overall moderated mediation model was significant (95% confidence
interval from .0038 to .0007), such that the effect of sense of coherence on overall health via communication experiences depends on an individual’s comfort communicating their overall health needs. See Figure 4 below.

This moderated mediation model remained significant with sexual orientation and gender identity included as covariates. Conducting additional moderated mediation analyses structured similar to Figure 4 but with sexual health as an outcome was non-significant. These findings indicate that perhaps additional latent variables are at play, making the relationship between sense of coherence and overall health somehow different from the relationship between sense of coherence and sexual health for this population.

CHAPTER 5 – DISCUSSION

Demographics and Health
Data analyses showed that – contrary to the findings of other studies (e.g. Lam Yip, & Gee, 2012; Hiestand, Horne, & Levitt, 2007) – age, generation of immigration, education, and gender presentation were not significantly associated with sexual or overall health. Considering these demographic variables often interact with other variables (e.g. socioeconomic status) not explored in this study, the lack of significant findings for such variables are relatively unsurprising. It’s also probable that a lack of variability, particularly regarding age and education, in the current study’s sample limited statistical power toward significant findings. Also contrary to other national population health studies (e.g. Conron et al., 2010), comparing general health according to sexual orientation was the current study’s finding that cisgender women who identified as bisexual reported more positive self-reported overall health compared to lesbian or queer-identified women in the study. The question which arises, given these inverse findings, is how Latinx identity and cultural norms uniquely shape beliefs about bisexuality and homosexuality among women within Latino/a/x communities. Again, a gap in the literature emerges, with existing studies of LGBT population health focusing primarily on comparing LGBT and heterosexual health rather than examining differences in LGBT health according to race or ethnic identity. The few studies that do focus specifically on health differences within the LGBT community taking into account race or ethnic identity seem to focus exclusively on HIV/AIDS or male samples. However, given data (Pew Research Center, 2013) which suggests greater acceptance of LGBTQ+ persons among whites (58%) as compared to non-whites (42%), it is plausible that bisexual Latinx women fare better than lesbian or queer Latinx women because they fit more closely within traditional heterosexual norms (or perhaps identify as bisexual but pass as heterosexual due to having an opposite-sex partner). More conservative ideals regarding
homosexuality could also be tied to the greater prevalence of Catholic religious affiliation among Latino/a persons compared to their white counterparts, with 37% of non-white LGBT persons reporting conflict between their sexual orientation and religion compared to 20% of white LGBT persons (Pew Research Center, 2013). Further research should explore potentially differing perceptions of LGBTQ+ persons within Latino/a communities to determine how these perceptions might ultimately impact health within such populations.

Bisexual women also reported more positive sexual health compared to lesbian or queer-identified women in the study. This finding is generally consistent with existing literature, suggesting that bisexual women – particularly those engaging in heterosexual intercourse or sexual acts – perceived themselves as at greater risk for sexually transmitted infections, HIV/AIDS, and certain gynecological cancers. As such, bisexuals are more likely than lesbians (or heterosexuals, according to most studies) to have regular gynecological examinations, perform a breast self-exam, and have an HIV test (e.g. Kerr, Ding, & Thompson, 2013; Powers, Bowen, & White, 2001).

Gender identity also had a significant impact on self-reported overall health and sexual health. Cisgender women who identified as female reported more positive overall and sexual health, while cisgender women identifying as gender queer or non-binary reported more negative overall and sexual health. This finding is perhaps associated with the findings of Tate, Bettergarcia, and Brent (2015), who examined the influence of gender typicality on self-esteem among cisgender adults. While researchers did not focus explicitly on health, nor did they assess the relationship between self-esteem and health in their sample, findings did show significantly higher self-esteem among gender typical men and women compared to gender queer, cisgender men and women. In terms of health, specifically, a gap emerges in
the current literature focused on gender identity and health. Existing studies focus exclusively on binary gender identities (e.g. male or female) or cisgender vs. non-cisgender identities. No research seems to focus specifically on the differential health impacts associated with identifying as a cisgender woman compared to identifying as a non-binary or gender-queer person who is also a cisgender woman.

While identifying as a non-binary or gender-queer person is not the same as identifying as transgender, perhaps some parallels can be drawn between identifying as a cisgender woman (or male) versus identifying beyond the traditional gender binary (regardless of sexual orientation). Almost universally, existing literature comparing transgender health with health among cisgender male and female-identified persons shows significantly worse overall health outcomes for transgender persons. These same findings – however limited – are true in regards to sexual health (e.g. Peitzmeier, Khullar, Reisner, & Potter, 2014), although extrapolating these findings to the current study is not truly appropriate given the influence of anatomy on sexual health differences (and the influence of anatomy in further impacting potentially stressful or transphobic interactions with sexual healthcare providers). Still, the current study’s findings that non-binary or gender-queer persons fare worse regarding both overall health and sexual health highlights prevailing binary conceptions of gender identity and the detrimental impact such conceptions have on health for non-binary-identified persons.

Demographics and Sense of Coherence

The findings of other studies (e.g. Nilsson, Leppert, Simonsson, & Starrin, 2010; Barnard, 2013) are relatively mixed regarding the impact of age and education, both found to be non-significant in the current study. No studies seem to exist examining the relationship
between generation of immigration and sense of coherence, also found non-significant in the current study. Research specifically examining the relationship between these variables and sense of coherence among an exclusively Latinx or non-heterosexual sample has yet to be conducted and is worth further exploration.

Findings from the current study highlighted a gap in the current literature by examining the differences between sense of coherence according to sexual orientation, gender presentation, and gender identity. At present, the only published study examining sense of coherence in an LGBTQ+ specific study focused exclusively on sense of coherence as a protective factor for psychological distress among gay men in Australia (Lyons, Pitts, & Grierson, 2014). Not only was this study an exclusively male sample, but it did not take into account factors beyond orientation such as gender presentation and identity. As such, the current study broke new ground by exploring how demographic variables beyond those previously studied might impact sense of coherence within the (female, Latinx) LGBTQ+ population. Cisgender women who identified as bisexual had a significantly higher sense of coherence compared to their lesbian or queer-identified counterparts. Women who described their gender presentation as feminine also possessed a higher sense of coherence, while androgynous presenting persons scored lower on sense of coherence. Regarding gender identity, female-identified persons scored significantly higher on sense of coherence compared to their gender queer or non-binary identified counterparts.

Taken in combination, these findings suggest that sense of coherence is likely higher for women who fit conventional norms of femininity by holding a gender identity which matches their sex at birth and presenting as traditionally feminine. The same is true for bisexual persons, who arguably match more closely with heterosexual orientations than their
exclusively homosexually-oriented counterparts. While there seems to exist no published literature to explain these findings specifically, these findings do pose an interesting theoretical question. If sense of coherence is said to addresses how people comprehend and perceive themselves as able to cope in stressful situations (Aspinwall and Tedeschi, 2012), is there a potential connection between long-term discriminatory experiences (real or perceived) which reduces sense of coherence for those who do not most closely match heterocentric conventional norms of femininity? Certainly, further research is needed to understand the current study’s findings in terms of sense of coherence being more positively associated with bisexual, female-identified, feminine-presenting women as compared to those who identify as lesbian or queer, gender non-conforming, or masculine/androgynous-presenting.

**Demographics and Communication Experiences**

In this study, age and education had no significant impact on an individual’s prior experiences communicating with a healthcare provider. Generation of immigration did impact an individual’s experiences communicating with providers, but only for second and third generation immigrants. Both second and third generation immigrants had significantly better experiences communicating compared to first-generation participants, perhaps because second and third generation immigrants were likely more acculturated to mainstream American cultural norms. Existing research supports this potential explanation, with findings showing higher mainstream acculturation for second and third generation immigrants and higher mainstream acculturation being associated with better verbal and non-verbal communication (e.g. Sam & Berry, 2010). Although not a focus of the present study, the role of generation of immigration in shaping communication certainly merits further research. In
terms of sexual orientation, persons who identified as lesbian reported significantly more positive experiences communicating with providers. Gender identity and gender presentation did not have a significant association with experiences communicating with healthcare providers in the current study.

Given the lack of existing literature looking exclusively at the relationship between demographic variables – particularly sexual orientation, gender identity, and gender presentation – and experiences communicating with healthcare providers, it’s hard to interpret exactly how the current study’s findings might compare to other studies. However, the impact of communication experiences as a partial mediator between sense of coherence and overall health suggests its importance as a potential factor influencing health, particularly among minority populations. While not focused explicitly on the relationship between demographic variables and experiences communicating with healthcare providers, existing research does emphasize the importance of communication with providers as contributing toward health for both Latina women and non-heterosexual women.

Communication challenges contribute to negative experiences for patients and decrease the likelihood of utilizing preventative care and screening for breast and gynecological cancers and STIs/HIV. These challenges can include providers being less likely to recommend certain sexual health screenings, such as mammograms, and less likely to communicate the importance of follow-up care to Latina women as compared to white women (Blackman & Massi, 2006). Across the board, Latina women report greater levels of dissatisfaction with patient-provider interactions and overall communication, especially regarding treatment decisions and perceived lack of provider cultural competency (e.g. Hawley, Janz, Hamilton, et al., 2008; Janz, Mujahid, Hawley, Griggs, Hamilton, & Katz,
Greater levels of dissatisfaction shape perceptions of healthcare experiences as more negative, which ultimately shapes both likelihood of utilizing preventative care in the future as well as treatment adherence and overall sexual health behaviors. For non-heterosexual women, communication challenges are often manifested through providers feeling uncomfortable discussing non-heterosexual women’s health needs and communication which is perceived as derogatory or sometimes blatantly homophobic (e.g. Fish & Wilkinson, 2003; O’Hanlan, Dibble, Hagan, & Davids, 2004; Hinchcliff, Gott, & Galena, 2005). Taken in combination, the current study’s findings compounded with existing literature suggest that the impact of experiences communicating with healthcare providers is especially important when studying the needs of intersectional minority persons, such as LBQ Latinx women.

**Sense of Coherence and Health**

Previous literature highlights the role of sense of coherence in shaping health (e.g. Eriksson and Lindstrom, 2006; Lundberg, Hansson, Wentz, & Bkorkman, 2009; Giglio, Rodriguez-Blazquez, de Pedro-Cuesta, & Forjaz, 2015; Nyamathi, 1993). These findings are supported by the current study which found that persons with higher sense of coherence had better self-reported overall health. However, none of these previous studies have examined the relationship between sense of coherence and sexual health, specifically, nor have they examined the impact of sense of coherence on health among a sample of LGBTQ+ or otherwise explicitly non-heterosexual persons. Findings from the current study supported existing research in demonstrating that higher sense of coherence is associated with improved self-reported health overall. Not only do these findings support those of prior studies looking at the relationship between sense of coherence and health (e.g. Eriksson and Lindstrom, 2006; Lundberg, Hansson, Wentz, & Bkorkman, 2009; Giglio, Rodriguez-Blazquez, de
Pedro-Cuesta, & Forjaz, 2015; Nyamathi, 1993), but also they introduce a key element to such existing literature. The present study shows sense of coherence continues to influence overall health regardless of differing sexual orientation and/or gender identity and expression between cisgender, LGB Latinx women and their heterosexual counterparts. This same relationship was not found for sexual health, which was not found to significantly associated with sense of coherence. Interestingly, however, the relationship between overall health and sexual health was significant, such that participants who reported better overall health also reported better sexual health. These findings highlight an interesting gap in the current literature, which examines sense of coherence in the context of overall health but not sexual health, specifically. More specifically, the current findings suggest that the relationship between sense of coherence and sexual health is perhaps an indirect one, with some other latent variable(s) mediating and/or moderating this relationship. Future research should continue to explore the relationship between sense of coherence and sexual health to determine the nature of this relationship and identify additional factors which might interact to influence sexual health. A better understanding of the potential role of sense of coherence in shaping sexual health could be employed to improve sexual health outcomes through educational and social support interventions, similar to studies with sense of coherence and occupational health (e.g. Lindstrom, 2014) or oral health (e.g. Nammontri, Robinson, & Baker, 2012).

**Sense of Coherence and Communication**

Sense of coherence was positively associated with prior experiences communicating with providers, such that participants with higher sense of coherence perceived their experiences communicating with providers as more positive. Persons with higher sense of
coherence also reported feeling more comfortable communicating with healthcare providers about their overall health needs and their sexual health needs. Beyond the current study, no research has specifically explored the relationship between sense of coherence and communication. Instead, much of the existing research focuses on the relationship between sense of coherence and health (described prior) and the relationships between sense of coherence, quality of life, and psychological well-being. Throughout these studies, findings highlight the theme that sense of coherence is an important contributor for improved health, better quality of life, and higher psychological well-being. However, researchers also—without exception—make a point to note that sense of coherence is likely influenced by other variables not measured in their study.

The current study sought to explore how communication experiences with healthcare providers might be one such variable influencing the relationship between sense of coherence and health. While exploratory, the relationship between sense of coherence and communication healthcare experiences seems plausible given existing literature. Sense of coherence appears to be a universal concept, with samples from international, immigrant, and diverse domestic populations all finding that sense of coherence relates to health (Eriksson & Lindstrom, 2006). As such, it would make sense that the relationship between sense of coherence and health remains in the current study’s population. Literature on factors influencing health—particularly sexual health—for both Latina and non-heterosexual women suggests that healthcare experiences can have a significant impact on health for these populations (e.g. Cashman et al., 2011; Torres, Erwin, Treviño, & Jandorf, 2013; Foulkes et al., 2005; Fish & Wilkinson, 2003; O’Hanlan, Dibble, Hagan, & Davids, 2004). Most notable, existing research highlights communication experiences as significantly contributing
to one’s overall experiences in healthcare settings (e.g. Molina, Thompson, Espinoza, & Ceballos, 2013; Torres et al., 2013; Hiestand, Horne, & Levitt, 2007). However, these communication experiences are a two-way street.

The current study proposes that sense of coherence, associated with how one perceives and engages during a stressful situation, influences how patients interact with and interpret communication with healthcare providers. The same is true for participants’ comfort communicating with healthcare providers about their needs, with higher sense of coherence being associated with more comfort communicating healthcare needs to a provider. These relationships – supported by the current study’s findings – make sense in the context of existing literature suggesting that seeing a healthcare provider is stressful, particularly for members of marginalized populations.

Although sense of coherence is not the same construct as dispositional optimism, the two constructs are similar in that both are associated with how stressful or potentially negative experiences are perceived and both are considered individual traits that remain relatively stable across the lifespan. Dispositional optimism is associated with more positive healthcare communication experiences, such that dispositional optimism (IV) significantly predicted experiences communicating with healthcare providers (DV) (Jensen, King, Guntzviller, & Davis, 2010). The conceptual framework of Jensen, King, Guntzviller, and Davis (2010) and similar studies which suggest that an individual trait, considered generally stable across the lifespan, can predict communication experiences supports the current study’s exploration of the relationship between sense of coherence and communication experiences in shaping health outcomes.

*Communication Experiences Mediate Between Sense of Coherence and Health*
Analyses conducted to examine the role of communication experiences as a mediating variable on the direct relationship between sense of coherence and overall health revealed a significant partial mediation. That is, sense of coherence significantly affects overall health. However, the relationship between sense of coherence and overall health is impacted – i.e. mediated – by an individual’s prior experiences communicating with healthcare providers. These findings are important because they emphasize the importance of positive experiences when communicating with healthcare providers, as these experiences – along with sense of coherence – can have a significant impact on overall health. Interestingly, these findings remained significant when controlling for sexual orientation, gender identity, and gender presentation indicating that these variables (within the context of an exclusively non-heterosexual sample) did not directly influence the relationship between sense of coherence and health. However, no existing studies specifically compare differences in sense of coherence – or more importantly differential impacts of sense of coherence on health – between heterosexual and non-heterosexual samples. This gap in the literature is worthy of further examination, as a better understanding of how communication experiences shape health perhaps differently for heterosexual and non-heterosexual persons could be hugely useful for designing LGBTQ-specific cultural competency trainings for healthcare providers. The finding that communication experiences partially mediated the relationship is noteworthy because communication has not been examined in previous studies examining the relationship between sense of coherence and health. This unique contribution to the literature highlights that the effects of sense of coherence can be shaped by both internal factors (perceptions of communication experiences) and external factors (ways healthcare providers communicate).
Communication experiences did not significantly mediate between sense of coherence and sexual health, with or without controlling for sexual orientation, gender identity, and gender presentation. This finding is particularly interesting, and highlights a potentially different pathway between sense of coherence and health according to specific realms of health. Determining which latent variables might impact the relationship between sense of coherence and sexual health would have important implications for learning how to improve sexual health, particularly among populations such as Latina women and non-heterosexual women for whom disparities in sexual health are often misunderstood and overlooked.

**Comfort Communicating Moderates the Mediating Effects of Communication Experiences**

Finally, analyses were conducted to examine the potential role of comfort communicating health needs with providers as a moderator on the relationship between sense of coherence (X) and communication experiences (M) – that is, a moderated mediation. Results indicated that the overall moderated mediation model was significant, such that the effect of sense of coherence on overall health via communication experiences depends on an individual’s comfort communicating their overall health needs. Ultimately, both sense of coherence and communication experiences – as moderated by comfort communicating with providers, influence overall health as an independent variable and mediating variable, respectively. Put more simply, sense of coherence is significantly associated with health, such that persons with higher sense of coherence will have better overall health. Persons with higher sense of coherence and more positive experiences communicating with healthcare providers will continue to have better health overall. This latter scenario is particularly true among persons high in sense of coherence, more comfortable communicating their overall
healthcare needs with providers, and who have had positive prior experiences communicating with healthcare providers.

Taken in combination, the moderated mediation findings further highlight relationships between (1) sense of coherence and communication, and (2) communication and overall health. The current study demonstrated the important role of sense of coherence in shaping how participants communicated with and perceived communication experiences with their healthcare providers. This relationship was demonstrated by the significant partial mediation described prior. However, findings from the moderated mediation go a step further in suggesting that the relationship between sense of coherence and participant experiences communicating with healthcare providers is also impacted (i.e. moderated) by how comfortable one is asking questions about their health needs to a provider. Existing literature has only minimally explored the connection between sense of coherence and communication. At face value, however, it makes sense that persons who are more adaptive in spite of stressful situations (e.g. possess higher sense of coherence) and more comfortable communicating their needs with providers would be those most likely to report positive experiences communicating with healthcare providers – factors which ultimately translate into better overall health.

Limitations

As with any research design, certain challenges arise when using a cross-sectional survey design. Given challenges faced in gathering participants who identified as cisgender, LBQ Latinx women, the ability to generalize findings from the present study’s sample to the population could be difficult, as this depends on the representativeness of the sample. As established in frequency data taken from the Participants and Sampling section, this study
employed a sample which was diverse according to sexual orientation (26% lesbian, 31% queer, 43% bisexual) and gender identity (73% female, 27% gender queer or non-binary). However, certain other demographics were less varied within the sample. Nearly 76% of the participants in this sample had earned at least a four-year college degree, and 96% reported their writing and reading English proficiencies as ‘very strong’ with 93% describing their speaking proficiency as ‘very strong’. Ninety-one percent (91%) of participants indicated they currently had health insurance, suggesting future research should use caution when generalizing the current study’s findings to samples without health insurance. In terms of gender presentation, this sample was also predominantly feminine or ‘femme’ with 74% of the sample identifying as such. Given research suggesting health experiences and outcomes can differ according to gender presentation, it’s worth considering how findings might differ with a sample who presented as more androgynous (compared to current sample, 17%) or more masculine (compared to the current sample, 9%). With these demographics in mind, it is arguable that the present study reached a sector of the cisgender, LBQ Latinx women perhaps not fully representative of the assumed diversity present within the broader population. Certainly, further research into sense of coherence, communication experiences, and LBQ Latinx women’s sexual and overall health should seek to reach a more diverse sample and thus more readily generalizable.

Bias—specifically social desirability, selection bias, and sample bias—can also be a potential issue in self-report cross-sectional survey designs (Bethlehem, 2010). In the case of the present study, social desirability bias is perhaps the biggest threat to individuals accurately self-reporting their gender identity/sexual orientation, potentially leading LBQ Latinx women not yet “out” to not participate in the survey. Similarly, selection bias can
occur when some significant aspect of the population is over or underrepresented (e.g. the over-representation of highly educated individuals and the under-representation of masculine or “butch” presenting women). Self-selection also limits the responses of participants who are uncomfortable with the subject area of sexuality and thus decline to participate in the study. Finally, sample bias is a limitation in Internet-based survey research, such that not everyone has easy access to a computer, potentially limiting samples according to socioeconomic status (including availability of transportation, hours spent working, and education inequality). Sample bias could have also occurred through the current study’s recruitment methods, such that persons and organizations contacted were those clearly connected to the Latino/a community, the LGBTQ community, or both. This means of recruitment made it potentially more unlikely that persons not associated with such organizations – or perhaps persons with less time to participate, such as parents or those of lower socioeconomic status – were involved. This sampling bias according to recruitment sources also potentially explains this sample’s relatively young age and above average education. Each of these types of potential bias could be at fault in limiting the diversity of the sample as addressed above. Future studies should strive for more diverse samples, particularly in terms of age and level of education, as multiple bodies of research (e.g. Cloyes, 2016; Emlet, 2016) suggest that LGBT experiences change according to age and education – both factors also shown to influence health (e.g. Lodi-Smith et al., 2010; Jia-Rong et al., 2015).

In addition to the potential challenges of biases and sample representativeness, the nature of cross-sectional Internet based survey data inhibits the ability to control the environment in which participants complete the survey (Bethlehem, 2010). Pitfalls of this
lack of control can include results from multiple completers of the same survey, an inability to assess whether participants complete the survey in a serious manner, and the lack of potential for clarification on questions which might confuse participants (especially given the nature of working with first and second generation immigrants and potential linguistic challenges). Non-responders can also be a problem, particularly when the characteristics of non-responders differ from those of responders (e.g. openness regarding one’s sexuality or gender identity and impact on measured acculturation outcomes). As such, alternative forms of recruitment should be considered in subsequent studies with this population.

Finally, the current study suggests a number of areas for improvement regarding the measurement of healthcare experiences. Although items were adapted from the CAHPS assessment, some items were ultimately altered fairly significantly from the original items to include a focus on sexual health and the experiences of LBQ Latinx women. Items intended to capture subthemes such as the unique experiences of non-heterosexual persons in healthcare settings, experiences associated with healthcare environments and non-medical staff, and elements of trust were ultimately excluded from the current study’s analyses due to poor reliability and factor loadings. Existing literature on the health of Latina women and non-heterosexual women suggests these themes likely have a significant impact on the overall health experiences and outcomes of both populations (and those who identify as LBQ Latinx women). However, measurement limitations did not permit the current study to examine such relationships as originally hoped despite the fact such measures were designed in conjunction with community advisors. Future research should continue to delve into the complexities of understanding how healthcare experiences shape sense of coherence and
health for minority populations, and all measures should be pilot tested for specific use with
the target population prior to inclusion.

CHAPTER 6 – CONCLUSIONS AND FUTURE DIRECTIONS

This study contributes a number of insights to the research on cisgender, LBQ Latinx
women, despite the limitations of sample size, design, and measurement issues. These
contributions include the validation of Antonovsky’s 29-Item Semantic Differential
Questionnaire within a new study population, empirical research on this understudied and
hard to find population using a nationwide sample diverse in terms of sexual orientation and
gender identity, significant relationships among variables of interest and findings that
highlight gaps in the current literature, new data on the unique health experiences of LBQ
Latinx women, and refinement of the research agenda to inform the theoretical framework
and methodological design for future studies with this population.

The ability to reach a relatively large nationally representative sample of cisgender,
LBQ Latinx women—for which the population as a whole is limited and not without a
plethora of challenges in identifying potential participants—is certainly worth mention.
Additionally, much can be learned from the online format of this survey, its introduction to
developing measures adapted specifically for use among Latinx and non-heterosexual women
– particularly the reliable measure of experiences communicating with healthcare providers,
and the reliability estimates found for Antonovsky’s Sense of Coherence Questionnaire,
which had not been previously used, in the current population.

The present study provides a useful introduction to variables influencing sense of
coherence, communication with providers, and (sexual) health among LBQ Latinx women,
while highlighting multiple gaps in the current literature regarding LGBTQ and Latino/a/x
health. Future research should continue to explore unique variables that might influence the health experiences and needs of LBQ Latinx women in unthought-of ways based upon prior research with cisgender, heterosexual, or non-Latinx populations. Future studies should also focus on characteristics such as religious affiliation or Latino/a/x cultural values, particularly as related to perceptions of gender and sexuality which shape health; factors highlighted as potential latent variables in the current study. Additional research should also explore the current study’s findings according to differences in sexual orientation and gender identity, particularly the relationship between gender typicality, communication, and health.

In addition to these factors, future research should consider the healthcare experiences and needs of LBQ Latinx women within broader ecological contexts. On a macro-level, the political and sociocultural climate surrounding LGBTQ and Latinx populations could greatly impact access to culturally sensitive healthcare and the healthcare experiences of LBQ Latinx women. Geographic location, for example, is one factor shown to tremendously impact healthcare and health outcomes for LGBTQ+ populations, with persons in the Midwest or rural areas faring significantly worse than those in urban or Northern/Western parts of the United States (Fisher, Erwin, & Coleman, 2014). Changing policies surrounding marriage equality, workplace discrimination, bullying in schools, and ‘bathroom bills’ serve to further impact healthcare and health among LGBTQ persons, both directly (e.g. healthcare access) and indirectly (e.g. heightened stress impacting health). Similarly, media depiction and public opinion about LGBTQ persons – although improving with recent years – continues to shape the lived experiences and health of persons who identify as LGBTQ. Although perhaps less explicit, factors such as geographic location, policies and legislation, media depiction,
and public opinion also impact Latinx persons through avenues such as institutionalized racism and the historical oppression of persons of color and immigrants.

On a community level, additional factors directly and indirectly influencing the lived experiences and health of Latinx LGBTQ persons come from discrimination within the LGBTQ community itself. Multiple bodies of research highlight the ‘whitewashing’ and male privilege which occurs within the broader LGBTQ community, with persons of color and women often describing experiences of discrimination and oppression (e.g. Fox & Ore, 2010; Ghabrial, 2017). Religious beliefs also serve to uniquely impact Latinx LGBTQ persons, with the large prevalence of Catholicism within Latino/a communities standing in often sharp contrast with the lifestyles of LGBTQ-identified persons (Pew Research Center, 2015). As one participant in the study described, factors such as geographic location and religion can also interact to shape experiences: “My current geographic location (Utah) has exposed me to more judgment surrounding sexual health than my state of origin (Wisconsin) ever has; the religious culture plays a big part in that, especially with divulging my sexual orientation.” Given research documenting the importance of social support and sense of community as a protective factor for marginalized populations, understanding how these factors promote inclusion and exclusion of certain members of Latinx and LGBTQ communities – likely having an impact on the health of such persons – is worthy of further exploration.

Thinking more at the micro-level, individual characteristics such as education, health insurance, and socioeconomic status compound with meso and macro-level factors to shape privilege and oppression among LGBTQ Latinx persons. Again, future research should seek to examine how factors across the social ecological model interact with one another to shape
the lived experiences and ultimately the health of LBQ Latinx women and LGBTQ Latinx persons more broadly. In particular, it is the researchers hope that such intersecting constructs can be informed by the current study’s findings regarding the role of communication and sense of coherence in shaping health for LBQ Latinx women.

While the current study is not without its areas of potential improvement, the findings resulting from its exploratory nature demonstrate the importance of conducting further research with this population. This study’s findings—both significant and non-significant—are potentially useful in emphasizing the role of sense of coherence, communication comfort, and communication experiences with providers in shaping health, as well as the need for continued research on how these constructs are related. Additionally, the findings exemplify multiple gaps in the current literature regarding Latinx health, LGBTQ health, and the ways these two identities might intersect with other identities to differently shape sense of coherence and health for the current study’s population of LBQ Latinx women.

Additional data collected in the current study but not utilized in the analyses described prior also suggests a number of important future directions for research with this population. Outness to healthcare providers has been shown to increase trust between healthcare providers and patients, while opening the door for conversations about the unique (sexual) healthcare needs of non-heterosexual persons (Neville & Henrikson, 2006). Thirty percent of participants in the current study were out to none of their healthcare providers, 40% were out to less than half of their providers, and only 30% were out to more than half (14% of whom were out to all their providers). Although not a focus within the current study, research should continue to explore factors influencing an individual’s likelihood of ‘coming out’ to providers, and the additional factors which shape how outness influences health.
The current study also asked participants a series of questions about their healthcare experiences as a non-heterosexual woman and Latinx woman, specifically. Frequency distributions for these items revealed additional information about the experiences of LBQ Latinx women in healthcare settings. When asked how often healthcare providers asked participants about their sexual orientation, 52% said they had never been asked, and 32% said providers only sometimes asked them. Thirty-four (34%) of participants said healthcare providers had always assumed they were heterosexual, 19% said they were usually assumed to be heterosexual, 25% said they were sometimes assumed, and 18% said they were never assumed to be heterosexual. Participants were also asked how often healthcare providers asked them about the sex of their sexual partner(s), with 56% saying they’d never been asked, 28% saying they were sometimes asked, and only 13% saying they were usually or always asked. 38% of participants said their healthcare providers always assumed their sexual partner(s) to be male, 26% said this was usually assumed, 17% said this was sometimes assumed, and 15% said this was never assumed. As one participant in the current study explained when asked if there was anything else she’d like to share about her healthcare experiences: “Healthcare providers never offered information or asked about sexual identity. I always had to offer the information about my identity in order to receive advice”. As another participant described: “I am a light skinned femme Latina that is often mistaken for a heterosexual white female.” These themes, that participants were rarely asked about their sexual orientation or sexual partners and often assumed to be heterosexually-identified with male partners, present a problem in terms of sexual health.

Existing literature shows multiple disparities regarding sexual health among non-heterosexual women. Although these disparities are certainly not tied exclusively to whether
or not an individual discloses their sexual orientation or information about sexual partners, literature does suggest a lack of awareness among non-heterosexual women about their sexual health risks (e.g. O’Hanlan et al., 2004; Marrazzo, Coffey, & Bingham, 2005). Paired with provider discomfort communicating topics of sexual health with non-heterosexual patients (e.g. Hinchcliff, Gott, & Galena, 2005; Stott, 2013), this lack of awareness can be devastating for ensuring open communication and conversations about prevention for non-heterosexual women. As found by Neville and Henrickson (2006), women who reported that healthcare providers frequently assumed they were heterosexual were less likely to seek preventative care in the future. Taken in combination, these findings highlight the importance of increasing knowledge of sexual minority women’s needs and developing cultural competence in communication and care – areas on which future research should continue to focus.

Participants in the current study were also asked a series of questions accessing their experiences of discrimination in healthcare settings. For the most part, participant responses to these items were positive. When asked how often participants had thought about how their experiences might be improved if they identified as heterosexual, 45% said they’d never felt that way, 29% only sometimes felt that way, and only about 20% felt that way usually (11%) or always (10%). Fifty-five percent (55%) of participants said they’d never felt judged by a healthcare provider for their sexual orientation, with 31% saying they sometimes felt judged, and only 11% saying they usually or always felt judged. Sixty-three percent (63%) of participants said they’d never had a healthcare provider make an inappropriate or discriminatory comment toward them for their sexual orientation, 25% said this happened sometimes, and 8% said it happened usually. No participants responded that they felt like
healthcare providers always made unfair or discriminatory comments toward them. At a surface level, these findings seem relatively positive, suggesting that perhaps the role of healthcare providers in contributing to LGBTQ health disparities isn’t a direct one – such as might occur through blatantly discriminatory experiences – but an indirect one due to lack of competency training when working with LGBTQ patients.

However, when participants were given the opportunity to describe any experiences not captured by survey items, a different picture emerged. As one participant described: “After disclosing that I was a queer woman to a male gynecologist in his 60s, I felt that the pelvic exam he gave me was rough and lacked any warning of what he would be doing to me. He only said what he would do after he'd already done them. I felt violated and assaulted and never went back to him or any other male gynecologist”. Another mentioned the following: I think health care providers need more training in working with non-binary folks. I find that when I have brought up non-binary issues (dysphoria associated with certain body parts), they have been mostly unprepared. My worst experience was with a gynecologist which made my experience incredibly distressing to the point that I took the day off work to go home and process with my partner”. Perhaps the explanation behind these types of more blatantly discriminatory experiences is captured by another participant, who wrote: I think I've experienced incredible privileges due to my cisgender identity, femme appearance, and citizenship status. I am also outwardly 'healthy' appearing, based on Eurocentric standards, which have protected me from a lot of the healthcare discrimination + disparities that I see among my friends who are not cis and/or without health insurance”. While the current finding’s quantitative data yielded that the experiences of LBQ Latinx women were relatively positive in terms of discrimination, qualitative responses suggest there is certainly progress to
be made toward health equity for all. Future research – particularly using qualitative methodologies – should continue to explore the lived experiences of LGBTQ and other minority persons within healthcare settings, gaining a better understanding of the unique challenges they face and applying this understanding to health equity promotion.

Participants were also asked a series of questions related to the depiction of diverse persons in materials available at healthcare clinics. Twenty-five percent (25%) of participants reported having never seen materials in healthcare clinics which depict ethnically diverse persons, with only 55% reporting they’d seen these materials sometimes. Forty-seven percent (47%) reported never seeing materials which specifically address the health needs of ethnically diverse persons, with 40% saying they’d only seen these materials sometimes. When asked these same questions about the depiction of non-heterosexual persons or families in healthcare clinic materials, 66% said they’d never seen such materials and 27% said they’d only sometimes seen materials which depicted non-heterosexual persons or families. In terms of materials, 56% of participants had never seen materials in healthcare clinics which specifically addressed the health needs of non-heterosexual persons, and 32% had only seen these materials sometimes. While the lack of diverse representation is likely not a direct factor adversely impacting health, research has shown that the lack of inclusion of LBQ women in dominant sexual scripts has negatively influenced awareness of sexual health risks for this population (Power, McNair, & Carr, 2009). Research on social representation more broadly, such as the impact of diverse representation on the likelihood of paying attention to tobacco graphic health warnings (Bigman, Nagler, & Viswanath, 2016), supports the need for greater inclusion of LGBTQ and ethnic minority persons on health communication materials.
Taken in combination, the current findings and those implicated by additional data from the current study highlight the importance of continued research with this understudied population given the emphasis on LGBTQ persons, ethnic minority persons, and women within current national health initiatives and research. Understanding the unique needs of populations at the intersections of these identities – such as LBQ Latinx women – paves the way for more representative health research and more equitable healthcare for all. It is the researcher’s hope that the present study serves as merely a starting point to raise awareness for the healthcare needs of LBQ Latinx women.
REFERENCES


Lindstrom, D. (2014). Incorporating salutogenesis and sense of coherence into home and community health occupational therapy intervention. *Home & Community Health*


http://orwh.od.nih.gov/research/strategicplan/index.asp


Stott, D. (2013). The training needs of general practitioners in the exploration of sexual health matters and providing sexual healthcare to lesbian, gay, and bisexual patients. *Medical Teacher, 35*, 752-759.


Tate, C., Bettergarcia, J., & Brent, L. (2015). Re-assessing the role of gender-related


Appendix A: Consent Form and Screening Questionnaire

This survey is available in both English and Spanish. Please select which language you prefer. Esta encuesta está disponible en inglés y español. Por favor, seleccione su preferencia.

Introduction
The purpose of this study is to investigate how healthcare experiences and individual strengths shape sexual health beliefs and behaviors. This study will better help us understand the importance of healthcare experiences and may be useful for interventions, policies, and programs aimed at supporting healthcare needs of non-heterosexual and Latina/x women.

Procedures and Confidentiality
You are being asked to participate in this study by completing the following survey. This survey will help us understand how healthcare experiences and individual strengths shape sexual health beliefs and behaviors. It should take approximately 10-15 minutes to complete. Participants may develop a greater awareness of their previous healthcare experiences, they ways they cope following a stressful event, and their own beliefs and behaviors as related to sexual health beliefs and behaviors. You will not be asked to provide your name, address, or any personal identification information that will be directly connected to you. In addition, all data obtained will be kept confidential and will only be reported in an aggregate format (by reporting only combined results and never reporting individual ones). All surveys will be concealed and kept confidential to the extent allowed by law.

Participation
Completion of this survey is completely voluntary. You have the right to withdraw at any time or refuse to participate entirely. Participants who opt to complete this survey will have the opportunity to enter a drawing for one of ten $20 Visa gift cards. You will be directed to a new page to provide your email address if you choose to be entered into the drawing. Note your email address will not in any way be connected to your responses on this survey. Winners will be notified by April 15th, 2017.

Questions about the Survey
If you have questions regarding this survey, you may contact the primary investigator at mtguerra@ncsu.edu. If you feel you have not been treated according to the descriptions in this form, or your rights as a survey respondent have been violated during the course of this project, you may contact Deb Paxton, Regulatory Compliance Administrator, Box 7514, NCSU Campus.

I have read the above consent and understand the above information. I am at least 18 years of age and agree to participate in this study with the understanding that I may choose not to participate or stop participating at any time without penalty.
☐ Agree
☐ Disagree

Please select which of the following best represents your sexual orientation:
- Heterosexual
- Lesbian
- Queer
- Bisexual
- Other (please specify) ____________________

Which of the following best represents your gender identity?
- Male
- Female
- Gender queer or non-binary
- Other (please specify) ____________________

Which of the following best represents your sex at birth?
- Male
- Female

Do you identify as Latina/Latinx?
- Yes, I identify as Latina/Latinx.
- No, I do not identify as Latina/Latinx.
Appendix B: Demographics Questionnaire

Are you or have you ever been sexually active?
☑ Yes, I am or have been sexually active.
☑ No, I have not ever been sexually active.

With partners of which biological sex have you engaged in sexual behaviors? Select all that apply.
☑ Male (at birth)
☑ Female (at birth)
☑ Other, such as intersex (please specify) ____________________

Which of the following best represents how you'd describe your own gender presentation?
☑ Very masculine/"butch"
☑ Somewhat masculine/"butch"
☑ Neither masculine nor feminine (e.g. androgynous)
☑ Somewhat feminine/"femme"
☑ Very feminine/"femme"
☑ Other (please specify) ____________________

Do you currently have health insurance?
☑ Yes
☑ No

Why do you currently not have health insurance? Please select all reasons that apply.
☑ Employer does not pay for health insurance
☑ Insurance company refused coverage for health reasons
☑ Not eligible for employer-paid health insurance
☑ Cannot afford insurance
☑ Do not believe in insurance or do not need
☑ Dissatisfied with previous insurance plan or provider
☑ Other (please specify) ____________________

Were you without health insurance for any period of time in the last 12 months?
☑ Yes
☑ No
How would you describe your level of English proficiency?

<table>
<thead>
<tr>
<th></th>
<th>Very weak</th>
<th>Somewhat weak</th>
<th>Fair</th>
<th>Somewhat strong</th>
<th>Very strong</th>
</tr>
</thead>
<tbody>
<tr>
<td>Writing in English</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reading in English</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speaking in English</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Which of the following best matches your immigration status?
- First generation immigrant - I was not born in the United States or Puerto Rico.
- Second generation immigrant - I was born in the United States or Puerto Rico, but at least one of my parents was not born in the United States or Puerto Rico.
- I was born in the United States or Puerto Rico and am not an immigrant.

Which of the following best represents your highest level of education?
- Less than high school
- High school graduate
- Some college
- 2 year degree (for example - AA, AS)
- 4 year degree (for example - BA, BS)
- Master's degree (for example - MA, MEd, MS)
- Doctorate degree (for example - MD, JD, PhD)

Which of the following best represents your age?
- 18 - 24
- 25 - 34
- 35 - 44
- 45 - 54
- 55 - 64
- 65 - 74
- 75 - 84
- 85 or older

In which state or geographic region of the United States do you live?

Is there anything else you'd like to share about your experiences related to sexual health or the healthcare system more broadly?
Appendix C: Healthcare Experiences Questionnaire

The following questions address the topic of communication with healthcare providers. Please answer these questions based on your past experiences.
<table>
<thead>
<tr>
<th>Question</th>
<th>Never</th>
<th>Sometimes</th>
<th>Usually</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often do healthcare providers encourage you to ask questions?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>How often do healthcare providers listen to your reason for the visit?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>How often have healthcare providers given you an easy to understand explanation in response to your questions?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>How often do providers use medical words you do not understand?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>How often do providers talk too fast when talking with you?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>How often do providers ignore what you told them?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>How often do healthcare providers interrupt you when you were talking?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>How often have healthcare providers shown interest in your questions and concerns?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>How often have healthcare providers answered all your questions to your satisfaction?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How often have providers used a condescending, sarcastic, or rude tone or manner with you?</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How often have providers talked about specific things you could do to prevent illness?</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>-----</td>
<td>----</td>
<td></td>
</tr>
<tr>
<td>How often do you feel you can tell your provider anything, even things you might not tell anyone else?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often do you feel you can trust your provider with your medical care?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often do you feel healthcare providers have always told you the truth about your health, even if there was bad news?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often do you feel your providers care as much as you do about your health?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often do you feel your providers have really cared about you as a person?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Have you ever needed an interpreter (someone who helps you talk with others who do not speak your language) at a healthcare provider's office?

- Yes
- No
The next two questions address your interactions with an interpreter. Please answer these questions based on your past experiences.

<table>
<thead>
<tr>
<th></th>
<th>Always</th>
<th>Most of the time</th>
<th>About half the time</th>
<th>Sometimes</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often have you used an interpreter to help you talk with a provider?</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>How often have interpreters treated you with courtesy and respect?</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

The next few questions address preventative health suggestions from healthcare providers. Please answer these questions based on your past experiences.
<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Sometimes</th>
<th>Usually</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often do healthcare providers talk to you about healthy eating habits?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>How often do healthcare providers talk to you about the exercise or physical activity you get?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>How often do healthcare providers talk to you about things in your life that worry you or cause you stress?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>How often have providers talked to you about mammograms?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>How often have providers talked to you about breast self-exams?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>How often have providers talked to you about pap smears?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>How often have providers talked to you about safe sex practices?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>How often have providers talked to you about your risk of being diagnosed with a sexually transmitted infection (STI)?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
How often have providers talked to you about your risk of being diagnosed with HIV/AIDS?

The following set of questions addresses your experiences with healthcare providers as a non-heterosexual woman, specifically. Please answer these questions based on your past experiences.
<table>
<thead>
<tr>
<th>Question</th>
<th>Never</th>
<th>Sometimes</th>
<th>Usually</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often have healthcare providers asked you about your sexual orientation?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often have healthcare providers asked you about your gender identity?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often have healthcare providers assumed you were heterosexual?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often have healthcare providers used the wrong pronoun when referring to you (e.g. called you a 'he' when you identify as a 'she')?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often have healthcare providers asked about the sex of your sexual partner(s)?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often have healthcare providers assumed your sexual partner(s) to be male?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often have you felt uncomfortable openly identifying as a non-heterosexual woman in any healthcare setting?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>No</td>
<td>Yes</td>
<td>Maybe</td>
<td>Don't Know</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>----</td>
<td>-----</td>
<td>-------</td>
<td>------------</td>
</tr>
<tr>
<td>How often have you felt uncomfortable openly identifying as a non-heterosexual woman with a healthcare provider about sexual health, specifically?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often have you felt providers communicated with you differently because of your gender presentation?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often have you felt providers communicated with you differently because of your sexual orientation?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often have providers been able to address your questions about sexual health as a non-heterosexual person?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often have you thought that your experiences with healthcare providers might be improved if you identified as heterosexual?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often have you felt judged by a healthcare provider for your sexual orientation?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
How often have healthcare providers made inappropriate or unfair comments toward you because of your sexual orientation and/or gender identity?

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
</table>

The following questions talk about your experiences in healthcare environments EXCLUDING your interactions with healthcare providers. Please answer these questions based on your past experiences.
<table>
<thead>
<tr>
<th>Question</th>
<th>Never</th>
<th>Sometimes</th>
<th>Usually</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often do you see materials in health care clinics which represent ethnically diverse persons?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often do you see materials in health care clinics about the health needs of ethnically diverse persons, specifically?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often do you see materials in health care clinics which represent non-heterosexual persons or families?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often do you see materials in health care clinics about the health needs of LGBTQ persons, specifically?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often have you felt welcomed by clinic front desk staff?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often have you felt you've been treated differently by front desk staff because of your racial or ethnic identity?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often have you felt you've been treated differently by front desk staff because of your gender identity or gender presentation?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix D: Sense of Coherence — Orientation to Life Questionnaire (Antonovsky, 1987)

These next few questions will discuss questions about how you view yourself and the world. Please select the answer which best fits your feelings.

When you talk to people, do you have the feeling that they don't understand you?
- 1 - never
- 2
- 3
- 4
- 5
- 6
- 7 - always have this feeling

In the past, when you had to do something which depended upon cooperation with others, did you have the feeling that it:
- 1 - surely wouldn't get done
- 2
- 3
- 4
- 5
- 6
- 7 - surely would get done

Think of the people with whom you come into contact daily, aside from the ones to whom you feel closest. How well do you know most of them?
- 1 - you feel that they're strangers
- 2
- 3
- 4
- 5
- 6
- 7 - you know them very well
Do you have feelings that you don't really care about what goes on around you?
- 1 - very seldom or never
- 2
- 3
- 4
- 5
- 6
- 7 - very often

Has it happened in the past that you were surprised by the behavior of people whom you thought you knew well?
- 1 - never happened
- 2
- 3
- 4
- 5
- 6
- 7 - always happened

Has it happened that people whom you counted on disappointed you?
- 1 - never happened
- 2
- 3
- 4
- 5
- 6
- 7 - always happened

Life is:
- 1 - full of interest
- 2
- 3
- 4
- 5
- 6
- 7 - completely routine
Until now your life has had:
- 1 - no clear goals or purpose at all
- 2
- 3
- 4
- 5
- 6
- 7 - very clear goals and purpose

Do you have the feeling that you're being treated unfairly?
- 1 - very often
- 2
- 3
- 4
- 5
- 6
- 7 - very seldom or never

In the past ten years, your life has been:
- 1 - full of changes without your knowing what will happen next
- 2
- 3
- 4
- 5
- 6
- 7 - completely consistent and clear

Most of the things you do in the future will probably be:
- 1 - completely fascinating
- 2
- 3
- 4
- 5
- 6
- 7 - deadly boring
Do you have the feeling that you are in an unfamiliar situation and don't know what to do?

- 1 - very often
- 2
- 3
- 4
- 5
- 6
- 7 - very seldom or never

What best describes how you see life:

- 1 - one can always find a solution to painful things in life
- 2
- 3
- 4
- 5
- 6
- 7 - there is no solution to painful things in life

When you think about your life, you very often:

- 1 - feel how good it is to be alive
- 2
- 3
- 4
- 5
- 6
- 7 - ask yourself why you exist at all

When you face a difficult problem, the choice of a solution is:

- 1 - always confusing and hard to find
- 2
- 3
- 4
- 5
- 6
- 7 - always completely clear
Doing the things you do every day is:
1 - a source of deep pleasure and satisfaction
2
3
4
5
6
7 - a source of pain and boredom

Your life in the future will probably be:
1 - full of changes without knowing what will happen next
2
3
4
5
6
7 - completely consistent and clear

When something unpleasant happened in the past your tendency was:
1 - "to eat yourself up about it"
2
3
4
5
6
7 - to say "ok that's it, I have to live with it" and go on

Do you have very mixed up feelings and ideas?
1 - very often
2
3
4
5
6
7 - very seldom or never

When you do something that gives you a good feeling:
1 - it's certain that you'll go on feeling good
2
3
4
5
6
7 - it's certain that something will happen to spoil the feeling

Does it happen that you have feelings inside you would rather not feel?
1 - very often
2
3
4
5
6
7 - very seldom or never

You anticipate that your personal life in the future will be:
1 - totally without meaning or purpose
2
3
4
5
6
7 - full of meaning and purpose

Do you think that there will always be people whom you'll be able to count on in the future?
1 - you're certain there will be
2
3
4
5
6
7 - you doubt there will be
Does it happen that you have the feeling that you don't know exactly what's about to happen?

- 1 - very often
- 2
- 3
- 4
- 5
- 6
- 7 - very seldom or never

Many people - even those with a strong character - sometimes feel like sad sacks (losers) in certain situations. How often have you felt this way in the past?

- 1 - never
- 2
- 3
- 4
- 5
- 6
- 7 - very often

When something happened, have you generally found that:

- 1 - you overestimated or underestimated its importance
- 2
- 3
- 4
- 5
- 6
- 7 - you saw things in the right proportion

When you think of the difficulties you are likely to face in important aspects of your life, do you have the feeling that:

- 1 - you will always succeed in overcoming difficulties
- 2
- 3
- 4
- 5
- 6
- 7 - you won't succeed in overcoming the difficulties
How often do you have the feeling that there's little meaning in the things you do in your daily life?
☐ 1 - very often
☐ 2
☐ 3
☐ 4
☐ 5
☐ 6
☐ 7 - very seldom or never

How often do you have feelings that you're not sure you can keep under control?
☐ 1 - very often
☐ 2
☐ 3
☐ 4
☐ 5
☐ 6
☐ 7 - very seldom or never
Appendix E: Sexual Health Beliefs and Behaviors Items

Please answer the following questions to the best of your ability.
<table>
<thead>
<tr>
<th>I feel knowledgeable about my risks of being diagnosed with a sexually transmitted infection, excluding HIV/AIDS.</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Somewhat agree</th>
<th>Neither agree nor disagree</th>
<th>Somewhat disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>I feel knowledgeable about my risks of being diagnosed with HIV/AIDS.</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Somewhat agree</th>
<th>Neither agree nor disagree</th>
<th>Somewhat disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>I feel knowledgeable about my risks of being diagnosed with breast cancer.</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Somewhat agree</th>
<th>Neither agree nor disagree</th>
<th>Somewhat disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>I feel knowledgeable about my risks of being diagnosed with gynecological cancers (e.g. uterine, cervical, ovarian).</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Somewhat agree</th>
<th>Neither agree nor disagree</th>
<th>Somewhat disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>I feel comfortable communicating with my healthcare provider(s) about my overall health needs.</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Somewhat agree</th>
<th>Neither agree nor disagree</th>
<th>Somewhat disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I feel comfortable communicating with my healthcare provider(s) about my sexual health needs.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

I am likely to disclose my sexual orientation to a healthcare provider.

| Women who only have sex with other women are less likely to be diagnosed with a sexually transmitted infection (excluding HIV/AIDS). |
|---|---|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

Women who only have sex with other women are less likely to be diagnosed with HIV/AIDS.

| Women who have sex with both men and women are at an increased risk of being diagnosed with a sexually transmitted infection (excluding HIV/AIDS). |
|---|---|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
Women who have sex with both men and women are at an increased risk of being diagnosed with HIV/AIDS.

<table>
<thead>
<tr>
<th>Have any of your family members...</th>
<th>Have any of your close friends...</th>
<th>Have you...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Yes, not to my knowledge</td>
<td>Yes</td>
</tr>
<tr>
<td>No, not to my knowledge</td>
<td>No, not to my knowledge</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have any of your family members...</td>
<td>Have any of your close friends...</td>
<td>Have you...</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>----------------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Have any of your close friends...</td>
<td>Have you...</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you...</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>...been diagnosed with breast cancer?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>...been diagnosed with any form of gynecological cancer (e.g. cervical cancer, uterine cancer, ovarian cancer)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>...been diagnosed with HIV/AIDS?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>...been diagnosed with a sexually transmitted infection (STI) other than HIV/AIDS?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Since "coming out" as a non-heterosexual person, what percentage of your healthcare providers have you told about your sexual orientation?

- None
- Less than 25%
- Between 25-50%
- Between 50-75%
- Between 75-100%

When was the last time you...

<table>
<thead>
<tr>
<th>Activity</th>
<th>Within the last six months</th>
<th>Within the last year</th>
<th>Within the last two years</th>
<th>Between 2-5 years ago</th>
<th>More than 5 years ago</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>...had a mammogram?</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>...did a breast self-exam?</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>...had a pap smear?</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>...took an HIV test?</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>...visited any healthcare provider for any reason?</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>...visited any healthcare provider for a reason related to women's health or sexual health?</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>...visited a gynecologist?</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>
Please answer the following questions.

<table>
<thead>
<tr>
<th></th>
<th>Very bad</th>
<th>Bad</th>
<th>Fair</th>
<th>Good</th>
<th>Very good</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overall, I would rate my current health</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>as:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Overall, I would rate my current sexual</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>health as:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
</tr>
<tr>
<td></td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
</tr>
</tbody>
</table>
Appendix F: Participant Recruitment Message

Hi, my name is Mary Guerrant and I am a graduate student at North Carolina State University collecting data for my dissertation. I’m sending this message to find LGBQ+ Latina/x women interested in participating in a survey about their healthcare experiences, individual strengths, and beliefs about sexual health. This study will help us understand the role of healthcare experiences in shaping minority health disparities, and may be useful in interventions, policies, and programs aimed at promoting health for LGBTQ+ and Latino/a/x populations in the United States.

The survey is available in both English and Spanish, and takes about 15-20 minutes to complete. Participants who opt to complete this survey will have the opportunity to enter a drawing for one of ten $20 Visa gift cards. You will be directed to a new page to provide your email address if you choose to be entered into the drawing. Note your email address will not in any way be connected to your responses on this survey. This study has been approved by North Carolina State University’s IRB (#11634).

Please click the link below to access the web-based survey. Thank you in advance for consideration – feel free to share this message with others!

https://ncsu.qualtrics.com//SE/?SID=SV_1S5k8sbW6hnoHfD

All the best,

Mary T. Guerrant, M.S.
PhD Candidate, North Carolina State University
Dept. of Psychology; Applied Social and Community Psychology
mtguerra@ncsu.edu / 580-209-2028