Health Seeking Behaviors of LGBTQ+ Community Members: Access to Affirming Physical and Mental Healthcare

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Access to Affirming Physical and Mental Healthcare

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Abstract

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The current literature states the percentage of adults in the United States (US) who identify as lesbian, gay, and bisexual is approximately 9.3%, and this percentage has nearly tripled from 3.5% in 2012 (Jones, 2025). An increase in adults identifying as lesbian, gay, bisexual, trans, and queer (LGBTQ+) has resulted in greater representation as recipients and consumers of healthcare (Mitchell et al., 2023). LGBTQ+ adults experience significant disparities in access to physical and mental healthcare, yet the current literature fails to examine the combined influence of overlapping social identities. Using an intersectional framework (Crenshaw, 1991), the current study examined how sexual orientation, gender identity, and race/ethnicity predicted access to physical and mental healthcare among LGBTQ+ adults living in Washington, D.C., Maryland, and Virginia. Using data from Rainbow Families' LGBTQ+ Community Needs Assessment (N = 441), logistic regression analyses determined that White LGBTQ+ participants, more specifically White lesbian cis women, White bisexual cis women, and White gay cis men, reported reduced access to physical and mental healthcare compared to LGBTQ+ people of color. Although unexpected, increased access to physical and mental healthcare for LGBTQ+ people of color potentially influenced by access to Whitman Walker-Health, a LGBTQ+-focused federally qualified health center, and mandated LGBTQ+ cultural competency training for all healthcare providers in Washington, D.C. Study limitations included convenience sampling in addition to an overrepresentation of

White participants and small subsamples of trans and BIPOC participants, limiting generalizability of findings. Findings underscore the importance of intersectional analyses in LGBTQ+ health research and highlight the need for expanded provider training, systemic policy changes, and targeted interventions to ensure equitable access to affirming physical and mental healthcare services for LGBTQ+ adults.

Keywords: lesbian, gay, bisexual, trans, LGBTQ+, healthcare disparities, healthcare access, physical healthcare, mental healthcare, federally qualified health center, social determinants of health, structural determinants of health, minority stress theory, theory of intersectionality

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Chapter 1: Overview

Introduction

Statement of the Problem

Despite legal advances such as the Marriage Equality Act (Obergefell v. Hodges, 2015), LGBTQ+ adults continue to experience pervasive discrimination, including rising rates of hate crimes in Washington, D.C. (Levin & Nakashima, 2019). This sustained exposure to violence and stigma has well-documented consequences for physical and mental health of LGBTQ+ adults (Flores et al., 2022), making access to affirming healthcare a critical public health concern. While existing research has established that LGBTQ+ adults experience healthcare disparities, much of the literature examines sexual orientation, gender identity, or race/ethnicity in isolation. As a result, prior research fails to adequately assess how these identities intersect to shape access to affirming physical and mental healthcare. Without an intersectional approach, the mechanisms through which discrimination translates into unmet healthcare needs remain insufficiently understood. This study addresses this gap by examining how participants' intersecting identities influence access to affirming physical and mental healthcare among LGBTQ+ adults in a region with both heightened visibility and persistent structural inequities.

Health Disparities in the LGBTQ+ Community

The inclusion of sexual orientation and gender identity (SOGI) questions in major health surveys has improved the visibility of LGBTQ+ populations and advanced understanding of health disparities that were previously difficult to document. However, the Behavioral Risk Factor Surveillance System (BRFSS), a primary source of population health data, did not include SOGI measures until 2014, and initial adoption was limited to a small number of states (Centers for Disease Control and Prevention [CDC], 2014). Although participation has expanded over the

years, with 32 states including these measures by 2021 (CDC, 2021), substantial gaps in data collection remain, limiting comprehensive assessment of healthcare needs for LGBTQ+ adults.

Historically, the absence of SOGI data in statewide surveillance systems restricted researchers' ability to examine health outcomes, healthcare access, and service utilization among LGBTQ+ adults. The National Institutes of Health (NIH, 2011) identified this lack of inclusive data as a significant barrier to improving LGBTQ+ health equity. Despite recent progress, nearly one-third of states still do not collect SOGI data through the BRFSS, limiting national understanding of health disparities affecting LGBTQ+ populations. Where such data is available, findings consistently indicate poorer mental health outcomes, elevated chronic stress, and higher rates of depression among LGBTQ+ adults (Gonzales & Henning-Smith, 2017). Longitudinal research further suggests that these disparities reflect not only individual aging processes, but also broader cohort differences shaped by social, economic, and cultural conditions (Caruana et al., 2015).

Research examining generational differences underscores the complexity of LGBTQ+ health disparities. Studies found that lesbian, gay, and bisexual adults experience higher levels of psychological distress and poorer physical health across cohorts, with bisexual adults reporting the most severe economic and health-related disadvantages (Liu & Reczek, 2021; Russell et al., 2022). Younger LGBTQ+ adults reported comparatively better physical health yet significantly worse mental health, again with bisexual adults experiencing disproportionate disparities (Russell et al., 2022). These patterns suggest that LGBTQ+ health disparities are rooted in structural conditions rather than individual behaviors alone, with discrimination remaining a central and persistent factor (Kassing et al., 2021; Russell et al., 2022).

Although public attitudes toward LGBTQ+ identities have shifted, discrimination within healthcare and employment remains widespread. National survey data indicated that a substantial proportion of the public continues to endorse discriminatory practices in both healthcare and employment settings (Flores et al., 2020b). As a result, understanding LGBTQ+ health disparities requires not only improved data collection but also attention to the structural and contextual factors that shape access to physical and mental healthcare. Given healthcare systems, policies, and community resources vary by region, it is essential to examine how healthcare disparities manifest within specific local contexts. Washington, D.C., where LGBTQ+ community members represent a sizable proportion of the population, provides a critical setting for examining how structural inequities influence access to affirming physical and mental healthcare.

Gaps in data collection and the persistence of documented health disparities highlight a central problem addressed by the present study. Existing studies frequently examined sexual orientation, gender identity, or race/ethnicity in isolation, limiting understanding of how these identities operate jointly within specific healthcare contexts. Given that healthcare access is shaped by local systems, provider practices, and structural conditions, examining these disparities within Washington, D.C., Maryland, and Virginia is particularly important. The current study responded to this gap by using an intersectional framework to examine how sexual orientation, gender identity, and race/ethnicity both independently and in combination predict access to healthcare among LGBTQ+ adults in this region. By situating individual experiences within a broader structural and geographic context, this study aims to clarify mechanisms of unmet care and contribute empirical evidence to inform more equitable healthcare practices.

Health Disparities in Washington D.C.

LGBTQ+ adults living in Washington, D.C. face a range of interconnected health concerns including elevated rates of chronic stress, depression, substance use, and high-risk sexual behaviors, as highlighted in the DC LGBTQ+ Health Report (2017). The Health Equity Report (2018), commissioned by the DC Department of Health, identified nine social determinants of health: education, employment, income, housing, medical care, transportation, access to healthy food, the outdoor environment, and community safety. Together, these social determinants reflect the multiple pathways through which structural inequality affects health outcomes for LGBTQ+ adults. Health disparities research in Washington, D.C. highlighted the role of structural racism and limited access to affordable healthcare in maintaining inequities (King et al., 2022) but the existing literature tends to examine disparities for White and Black adults separately from disparities between LGBTQ+ and non-LGBTQ+ adults. To date, no researcher has explored how the intersection of social identities collectively shapes healthcare access within the LGBTQ+ community. This gap in research underscores the importance of the present study and sets the stage for exploring how intersecting identities influence access to physical and mental healthcare across Washington D.C., Maryland, and Virginia.

Purpose of the Study

The purpose of this study was to explore the needs of LGBTQ+ adults using data collected during Rainbow Families' LGBTQ+ Community Needs Assessment (see Appendix B). Specifically, I used logistic regression analysis to examine how the participants intersecting social identities (i.e., sexual orientation, gender identity, and race/ethnicity) meaningfully shaped access to physical and mental healthcare within Washington D.C., Maryland, and Virginia. Quantitative research is grounded in positivist philosophy, or positivism, which asserts that objective, measurable knowledge about reality can be obtained through empirical observation,

experimentation, and statistical analysis (Gamage, 2025). Positivism emphasizes systematic inquiry and deductive reasoning, with the goal of identifying, generalizing, or predicting patterns within large representative samples (Omodan, 2022; Junjie & Yingxin, 2022). My role as the researcher was to observe, measure, and analyze while minimizing the influence of personal beliefs (Bryman, 2016). I answered research questions using descriptive and inferential statistics consistent with quantitative research practices (Creswell & Creswell, 2017).

Research Questions

1. Can access to physical and mental healthcare be predicted from sexual orientation for LGBTQ+ adults in the current study?
2. Can access to physical and mental healthcare be predicted from gender identity for LGBTQ+ adults in the current study?
3. Can access to physical and mental healthcare be predicted from race/ethnicity for LGBTQ+ adults in the current study?
4. Can access to physical and mental healthcare be predicted from sexual orientation, gender identity, and race/ethnicity for LGBTQ+ adults in the current study?

Methodology

This study was an analysis of data collected in Rainbow Families' LGBTQ+ Community Needs Assessment (see Appendix B). I examined the relationship between three demographic variables (a) sexual orientation, (b) gender identity, (c) race/ethnicity and access to physical healthcare in addition to mental healthcare for LGBTQ+ adults who live in Washington D.C., Maryland, and Virginia. I used logistic regression analysis to examine how healthcare access can

be predicted by participants' social identities including sexual orientation, gender identity, and race/ethnicity.

Research Design

Rainbow Families, an LGBTQ+ nonprofit organization, commissioned a comprehensive needs assessment to better understand the experiences of LGBTQ+ adults across Washington, D.C., Maryland, and Virginia. I assisted Rainbow Families in the development of a needs assessment survey questionnaire (see Appendix A). While the LGBTQ+ Community Needs Assessment is not a formal assessment, I modeled Rainbow Families' LGBTQ+ Community Needs Assessment after the San Francisco LGBTQ+ Community Needs Assessment (Horizon Foundation, 2018). Rainbow Families is part of a coalition of LGBTQ+ organizations dedicated to serving the LGBTQ+ community, including Whitman-Walker Health, Capital Pride Alliance, The DC Center, SMYAL, Casa Ruby, and Capital Stonewall Democrats. Although Rainbow Families commissioned the comprehensive needs assessment survey, LGBTQ+ Coalition Members provided input on survey development during a focus group meeting prior to survey administration. Rainbow Families launched an extensive survey designed to capture the multidimensional needs of LGBTQ+ community members.

Data Collection

Data collection for the LGBTQ+ Community Needs Assessment occurred online via Qualtrics from March 2021 to May 2021 in a single sitting with no follow-up. Rainbow Families' LGBTQ+ Community Needs Assessment gathered demographic information including sexual orientation, gender identity, age, race/ethnicity, relationship status, education, income, and employment status. Rainbow Families' LGBTQ+ Community Needs Assessment gathered information regarding social and community events, parenthood and childcare, physical

healthcare, mental healthcare, legal assistance, recovery support, housing assistance, and civic engagement. Participants were asked about access to these services, barriers to accessing services, the importance of LGBTQ+-specific services and any experiences of discrimination.

Data Analysis

To address the research questions outlined in this dissertation, I conducted an analysis of data collected through Rainbow Families' LGBTQ+ Community Needs Assessment. This assessment provided a rich dataset that captured demographic information and healthcare experiences with a wide range of services in Washington D.C., Maryland, and Virginia. Given the purpose of this study is to understand how intersecting identities influence healthcare access, the analysis centered on three key demographic variables: sexual orientation, gender identity, and race/ethnicity. These variables were derived from participants' self-reported responses within the survey and were used to examine patterns in access to both physical and mental healthcare. To evaluate these relationships, I used logistic regression. This analytic approach allowed for the examination of dichotomous outcomes regarding participants' access to healthcare. By modeling both main effects and the combined influence of intersecting identities, the analysis provided a framework for understanding how overlapping social identities shape experiences in healthcare for LGBTQ+ community members. The following section expands on the potential significance of dissertation findings and their implications for researchers, clinicians, policymakers, and community organizations.

Statement of Potential Significance

This study examined how intersecting identities including sexual orientation, gender identity, and race/ethnicity shape access to physical and mental healthcare among LGBTQ+ adults in Washington, D.C., Maryland, and Virginia. By addressing gaps in the literature, the

findings inform clinical practice, service delivery, and organizational planning. The results also provide empirical support for policy advocacy and strategic decision-making aimed at expanding equitable access to affirming healthcare. This dissertation is among the first quantitative intersectional analyses of physical and mental healthcare access in a regional LGBTQ+ sample. The findings challenge assumptions that LGBTQ+ people of color uniformly experience poorer access, highlighting instead context-dependent disparities. Patterns of unmet care among White cis lesbian and bisexual women and White cis gay men underscore the influence of structural factors such as federally qualified health centers and mandated healthcare provider training.

Theoretical Foundations

The theoretical framework for the study included minority stress theory (Meyer, 2003) and the theory of intersectionality (Crenshaw, 1991). Minority stress theory addresses the unique stressors experienced by minoritized individuals, including LGBTQ+ community members, as a function of their social identities. Meyer (2003) argued in minority stress theory that the health disparities experienced by LGBTQ+ adults stem from stressors created by a hostile, homophobic culture. These stressors including lifelong harassment, maltreatment, violence, discrimination, and victimization place a disproportionate burden on LGBTQ+ community members, contributing to adverse physical and mental health outcomes (Meyer et al., 2021).

The theory of intersectionality examined how multiple social identities and group membership impact an individual's lived experiences as well as access to resources such as healthcare (Crenshaw, 1989). The theory of intersectionality emphasized how multiple forms of inequality or disadvantage converge and create obstacles that cannot be understood by dichotomous thinking. The theory of intersectionality moves beyond individual experiences of discrimination and focuses on how broader systems of power and oppression create systemic

inequalities including healthcare disparities (Crenshaw, 1989). Although Crenshaw (1991) focused exclusively on the intersection of racism and sexism, the theory of intersectionality can be applied to the LGBTQ+ community as LGBTQ+ community members are marginalized at the intersection of their social identities. LGBTQ+ adults face combined adversity such as racism, sexism, heterosexism, biphobia, and transphobia. In this study, I integrated intersectionality into a quantitative research design by using logistic regression to examine how overlapping social identities influence healthcare access for LGBTQ+ adults. In the next section, I will outline limitations. My methodological choices such as relying on self-report data could introduce potential limitations that shape how the dissertation findings should be interpreted. Therefore, it is important to acknowledge the limitations associated with the current study.

Limitations

Although the present study offers important contributions, study limitations warrant consideration when interpreting the findings. First, Rainbow Families' LGBTQ+ Community Needs Assessment relied on voluntary participation and administration online. These features introduce self-selection and technology access constraints that may reduce representativeness, as not all potential participants have reliable internet access or feel comfortable navigating a web-based survey (Andrade, 2020b). Second, recruitment occurred primarily through email outreach from LGBTQ+ nonprofit organizations, resulting in a convenience sample (Andrade, 2020a; Bornstein et al., 2013). LGBTQ+ adults without affiliation to LGBTQ+ nonprofit organizations, or those with weaker ties to LGBTQ+ community, may be underrepresented. This sampling approach can bias estimates of access and experiences toward those who are already engaged with community services. As a result, generalizability beyond the sample may be limited.

Third, Rainbow Families' LGBTQ+ Community Needs Assessment relied on self-report measures. Self-report measures are vulnerable to multiple sources of bias, including social desirability, recall inaccuracies, and underreporting of sensitive experiences (Althubaiti, 2016; Edwards, 1953; Howard & Dailey, 1979; Kormos & Gifford, 2014; Paulhus, 1991). Given the topics involve stigmatized identities and mistreatment, survey respondents may have been reluctant to fully disclose, which could attenuate or distort measured associations. While sexual minority (lesbian, gay, bisexual) survey non-response rates can be comparable to non-minorities (Lee et al., 2018), trans adults experience unique stressors, discrimination, and marginalization that hinder engagement and result in lower participation due to safety concerns (Pho et al., 2023).

Fourth, survey length and survey burden may have contributed to fatigue and participant attrition (Spires et al., 2018). Long surveys increase the likelihood of skipped items or early termination, which can introduce nonresponse patterns that are not random. These patterns may affect both the completeness of the dataset and the stability of regression estimates. Finally, the current analysis drew a subset of variables from a larger dataset then focused on two survey measures: physical healthcare and mental healthcare. By focusing exclusively on two specific measures, the analysis may have omitted potentially relevant confounding variables (Chowdhury & Turin, 2020), limiting a more holistic interpretation of healthcare access among LGBTQ+ adults surveyed. While this scope aligns with the study's aims, it potentially constrains the breadth of inferences by excluding other relevant domains such as housing or civic engagement that may interact with access to healthcare. Future research should incorporate a wider set of measures to clarify how multi-domain needs shape healthcare access. Limitations underscore the importance of cautious interpretation and highlight avenues for future research, including probability-based sampling, mixed method data collection to reduce technology barriers,

strategies to minimize survey burden, and the use of multi-informant or administrative data to triangulate self-report.

Key Terms

For the purposes of the current study, the following are key terms to support understanding. *Healthcare access* was the dependent variable measured as access to *physical healthcare* and *mental healthcare*. *Sexual orientation, gender identity,* and *race/ethnicity* were all predictor variables. In the current study, healthcare access is operationalized as perceived adequacy of care (i.e., I get what I need out of the provider), not simply utilization or availability of healthcare services. Perceived adequacy is consistent with patient centered care by focusing on the patient's subjective experience, needs, and values rather than purely structural metrics like appointment availability or service utilization (Chen, 2025; Hoseini-Esfidarjani et al., 2021; Youssef et al., 2020); this approach prioritizes the quality of the interaction and the extent to which care feels tailored to the individual, which are core tenets of patient-centeredness.

Bisexual a term used to refer to a person who is emotionally, romantically, and/or sexually attracted to more than one sex, gender, or gender identity (District of Columbia Department of Health, 2017)

Cis refers to a person whose gender identity aligns with the sex assigned at birth (District of Columbia Department of Health, 2017)

Ethnicity refers to cultural traits such as language, religion, and traditions that specific communities share (Haozous et al., 2014)

Gay a term used to refer to a person who is emotionally, romantically, or sexually attracted to members of the same gender (District of Columbia Department of Health, 2017)

Gender is a term used to refer to social construction and meaning a culture associates with a person's attitudes, behaviors, feelings, and their assigned biological sex (Argüello, 2020)

Gender dysphoria refers to clinically significant distress caused when a person's sex assigned at birth is not the same as the one with which they identify (American Psychological Association, 2013)

Gender identity a term used to refer to a person's sense of being a woman, a man, trans, cis, or other gender identification (Argüello, 2020); gender can be the same or different than the sex assigned at birth (District of Columbia Department of Health, 2017)

Healthcare Access refers to "timely use of personal health services to achieve the best possible health outcomes" (Institute of Medicine Committee on Monitoring Access to Personal Health Care Services, 1993)

Heterosexism refers to a system of cultural beliefs, norms, and practices that advantages heterosexuals and disadvantages those not identifying as heterosexual (Argüello, 2020)

Homophobia refers to fear and hatred of people who are attracted to members of the same sex (District of Columbia Department of Health, 2017)

Interpersonal discrimination refers to discrimination based on an individual's beliefs, words, and behaviors (Pincus, 1996)

Intersectionality The theory of intersectionality suggests individuals have social and cultural identities (i.e., race, gender identity, sexual orientation) which shape reality; the intersection of identities (i.e., race and gender) generates unique challenges (Crenshaw, 1989)

Lesbian is a term used to refer to a woman who is emotionally, romantically, and/or

sexually attracted to other women (District of Columbia Department of Health, 2017)

LGBTQ+ is an acronym which refers to the following sexual orientations and gender identities "Lesbian, gay, bisexual, trans, queer;" the plus sign represents other identities that are not specified in this acronym such as non-binary and gender non-conforming and recognizes the limitless sexual orientations and gender identities within the LGBTQ+ community (District of Columbia Department of Health, 2017)

Mental Healthcare refers to short term counseling, crisis intervention, long term counseling or therapy, and supportive groups (see Appendix B)

Minority Stress Theory refers to theoretical framework designed to better understand the lived experiences of minority groups and the impact of stress (i.e., stigma, discrimination) on physical and mental health of minoritized individuals (Meyer, 2003)

Non-binary or gender non-confirming is an umbrella term used to describe a person whose gender identity does not fall within the traditional binary of "man" or "woman" (District of Columbia Department of Health, 2017)

Physical Healthcare refers to visiting a hospital, doctor's office, or other healthcare provider to address and heal physical health issues or injuries (see Appendix B)

Queer is an umbrella term used to describe a spectrum of gender identities and sexual orientations that are counterculture to the mainstream including gay, lesbian, bisexual, pan-sexual, trans, and queer (District of Columbia Department of Health, 2017)

Race refers to a socially constructed category based on physical characteristics such as skin color to create social hierarchy (Haozous et al., 2014)

Rainbow Family refers to a same-sex or household with LGBTQ+ parent(s).

According to Rainbow Families, non-profit organization, a ***Rainbow family*** refers to any lesbian, gay, bisexual, trans or queer person who has a child or children or is planning to have a child or children by way of donor insemination, surrogacy, foster care, fostering to adoption, adoption, co-parenting, or other means.

Sexual orientation is a term used to refer to an inherent physical, emotional, and/or sexual attraction to other people; sexual orientation is independent of gender identity (District of Columbia Department of Health, 2017)

Sexual identity is a term used to refer to how an individual describes their own sexuality and how it is expressed (Argüello, 2020)

Structural discrimination refers to discrimination based on laws, policies, institutions, and the related behavior of individuals who work in or control these laws, policies, or institutions that are "race/ethnic/gender neutral in intent but have a differential and/or harmful effect on minority race/ethnic/gender groups" (Pincus, 1996, p. 186)

Trans is a term used to refer to an individual whose gender identity is different from cultural expectations based upon the sex assigned at birth (District of Columbia Department of Health, 2017)

Chapter 2: Literature Review

Discrimination within the LGBTQ+ Community

The LGBTQ+ community continues to face discrimination across the United States (US) despite ongoing social and political efforts to promote inclusion. Legal protections vary widely by state, leaving many LGBTQ+ adults without safeguards in employment and healthcare. For instance, 27 states do not prohibit employment discrimination based on sexual orientation, and 19 states fail to protect LGBTQ+ adults from housing discrimination (Human Rights Campaign, 2022). Recently, multiple states have enacted restrictions on gender-affirming care (Conron et al., 2022; Redfield et al., 2023), further limiting civil rights and healthcare access. LGBTQ+ children are disproportionately exposed to childhood trauma (Anderson & Blosnich, 2013; Austin et al., 2016), which contributes to long-term physical and mental health challenges (Schnarr et al., 2019; Suarez et al., 2021). When combined with restrictive laws and persistent discrimination across the lifespan, these early adversities intensify existing disparities in healthcare access and health outcomes within the LGBTQ+ community.

Historical Discrimination within the LGBTQ+ Community

Historically, physical and mental health providers pathologized non-heterosexual identities, reinforcing discriminatory beliefs and practices that alienated LGBTQ+ community members from appropriate healthcare. Early editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) classified non-heterosexual orientation as a sociopathic personality disturbance (APA, 1952) and later as a sexual deviation (APA, 1968). These designations

reinforced the perception of LGBTQ+ identities as "deviant" and contributed to systemic discrimination within healthcare settings (Drescher, 2015; Spitzer, 1981). Although major diagnostic criteria related to sexual orientation were not fully removed until 2013, the legacy of pathologization continues to influence trust in healthcare providers (Arnold & Dhingra, 2020).

Historical discrimination contributed to delays in seeking healthcare, poor health outcomes, and increased mortality among LGBTQ+ adults (Zeeman et al., 2019). Despite progress in political and professional environments, discrimination remains common and has measurable effects on both physical and mental health for LGBTQ+ adults. Experiences of discrimination also influence broader social determinants of health, including access to housing, employment, and necessary healthcare (Downing & Rosenthal, 2020). For LGBTQ+ adults, discrimination begins early in life. LGBTQ+ children report elevated rates of adverse childhood experiences (ACEs), including emotional abuse, physical abuse, neglect, and exposure to household dysfunction. These adversities shape long-term physical and mental health outcomes and influence opportunities for healthy social development. The systemic and institutionalized discrimination faced by LGBTQ+ adults across the lifespan underscores the need for continued efforts to dismantle harmful practices and create equitable access to healthcare.

Theory of Intersectionality

Crenshaw (1991) developed the theory of intersectionality to explain how multiple social identities shape individuals' experiences of discrimination and access to social resources. The Theory of Intersectionality emphasizes that people hold simultaneous memberships in interconnected social groups, and these identities interact within systems of power, such as laws, policies, and governmental structures, to produce both disadvantage and privilege. The Theory of Intersectionality highlights how overlapping forms of oppression, including racism and sexism,

often converge to create compounded social injustice (Crenshaw, 1991). Given the LGBTQ+ community encompasses diverse social identities, the intersection of these identities directly influences lived experiences and opportunities. LGBTQ+ adults, particularly those holding multiple marginalized identities, face heightened levels of discrimination and reduced access to equitable healthcare resources. Intersectionality argues that individuals do not experience discrimination in isolation, but rather the way society is organized creates conditions where certain groups are more likely to face discrimination and disadvantages. The Theory of Intersectionality provides a critical lens for understanding how overlapping identities affect the experiences of LGBTQ+ adults in healthcare, community settings, and broader social systems.

Minority Stress Theory

Meyer (2003) identified unique stressors experienced by minoritized individuals and demonstrated their negative influence on health outcomes. Within Minority Stress Theory, discrimination-related and internal stigma-related stressors, such as internalized homophobia, internalized transphobia, and identity concealment, contribute significantly to adverse health outcomes among LGBTQ+ adults (Frost et al., 2015; Griffin et al., 2019). Minority Stress Theory provides a valuable framework for understanding the impact of societal discrimination on the LGBTQ+ community (Meyer, 2015). This model highlights the unique stressors experienced by LGBTQ+ adults because of their marginalized status within society. Adverse health outcomes are heightened for LGBTQ+ adults who hold multiple marginalized identities (McConnell et al., 2018). Minority stress is associated with increased risk for psychological distress, mental health disorders, and suicidality among LGBTQ+ people, particularly LGBTQ+ people of color (Hatzenbuehler & Pachankis, 2016; Meyer & Frost, 2013). Given LGBTQ+ adults' interactions with healthcare providers are shaped by the intersection of their identities, understanding

minority stress is essential for delivering culturally competent healthcare. Recognizing minority stress as an etiological factor helps explain the disproportionate burden of physical and mental health challenges in the LGBTQ+ community. Importantly, these experiences of discrimination are not limited to adulthood. LGBTQ+ children and adolescents are also more likely to experience discrimination and elevated rates of adverse childhood experiences.

Addressing discrimination against women, racial/ethnic minorities, and LGBTQ+ adults requires both policy-level and community-based strategies (Bleich et al., 2019; Casey et al., 2019; Schulson et al., 2019; SteelFisher et al., 2019). Chronic minority stress, disproportionate health inequalities, and substantial childhood adversity affect LGBTQ+ adults. Challenges such as identity-based discrimination, humiliation and rejection, presumed heterosexuality, and internalized homophobia within healthcare influence healthcare access (Dawson et al., 2025). Researchers consistently document multilayered discrimination within the LGBTQ+ community, highlighting the value of an intersectional lens to illuminate nuanced experiences in healthcare.

Healthcare Access and Current Discrimination within the LGBTQ+ Community

Existing literature identifies four overlapping demographics, gender, sexual orientation, race/ethnicity, and income, as central to understanding health outcomes among LGBTQ+ adults. Barriers arise at both individual and systemic levels and reduce the likelihood that individuals will seek, reach, obtain, and receive services appropriate to their needs (Levesque et al., 2013). These access barriers disproportionately affect women, LGBTQ+ people, and people of color and operate across multiple systems. An intersectional approach is therefore essential to recognize how overlapping identities shape healthcare experiences and access to healthcare.

Social Determinants of Health within the LGBTQ+ Community

Social determinants of health, including access to food, housing, financial resources, and neighborhood safety, influence physical and mental health outcomes (Hatzenbuehler & Pachankis, 2016). Adverse conditions such as housing instability or lack of health insurance negatively affect health (Alderwick & Gottlieb, 2019), yet lesbian, gay, and bisexual adults experience pronounced disparities in social determinants of health (Schuler et al., 2021). Limited protection from discrimination in housing, education, and employment restricts LGBTQ+ adults' ability to access and utilize essential social resources such as physical and mental healthcare.

State-level policies also shape health determinants. Researchers have demonstrated that structural discrimination influences education, employment, voting rights, real estate access, incarceration, healthcare, and tax policy (Homan et al., 2021). LGBTQ+ people of color and trans adults frequently report concealing their identities, encountering discrimination, and experiencing harassment or bullying in educational, healthcare, and workplace settings. These experiences of discrimination contribute to poor mental health (Conron et al., 2022; Conron et al., 2023; Feldman et al., 2021; Mallory et al., 2022) and exacerbate barriers to safe, stable, and affordable housing (Conron et al., 2018; Henderson et al., 2019; Romero et al., 2020).

Marginalized social identities within the LGBTQ+ community further limit access to resources (Parmenter, 2021). Adults identifying as lesbian, gay, or bisexual experience higher rates of adverse social determinants of health, including lower educational attainment (Wilson et al., 2021), increased poverty, unemployment, and limited access to healthcare (Schuler et al., 2021). These disparities parallel those faced by other minoritized groups, such as racial and ethnic minorities and individuals living below the federal poverty line. When these identities overlap, healthcare access and quality decline (Alegria et al., 2010). Thus, the combined effects of sexual orientation, gender identity, and race/ethnicity shape access to care and healthcare

experiences (Choi et al., 2021; Wilson, Gordon, et al., 2021; Wilson, Mallory, et al., 2021). LGBTQ+ adults with multiple marginalized identities experience higher rates of discrimination, which further restricts healthcare access and worsens health outcomes (Smart et al., 2022). Current research sought to understand how overlapping social identities influence access to physical and mental healthcare. Without understanding the ways in which access to physical and mental healthcare services is influenced by the intersection of identities, researchers, practitioners, and policy makers will lack the ability to fully understand healthcare disparities within the LGBTQ+ community.

Healthcare Access within the LGBTQ+ Community

An individual's social identities influence both experiences of discrimination and access to healthcare across adulthood. Previously, researchers identified common individual-level barriers for LGBTQ+ adults, including difficulty finding inclusive providers (Owens et al., 2007), discomfort discussing sexual orientation or gender identity (Skerven & de St. Aubin, 2015), and fear, shame, or anticipated stigma (Shipherd et al., 2010). Systemic barriers documented for trans adults include denial of services, disrespectful treatment, insensitive providers, unwelcoming environments, limited availability and appropriateness of services, and insufficient provider competence (Stotzer et al., 2013). Among lesbian, gay, and bisexual adults, cost and provider availability remained prominent obstacles (Dahlhamer et al., 2016). More broadly, many LGBTQ+ adults cited a lack of competent providers and past experiences of insensitivity or discrimination; nearly half report fear of being refused treatment as a key deterrent to seeking care (Holt et al., 2022; Keating et al., 2021; Romanelli & Hudson, 2017).

Providers identified additional access barriers such as discrimination, co-morbid physical and mental health concerns, transportation, finances, legal issues, and lack of insurance (Moe &

Sparkman, 2015). Community needs assessments echoed these patterns. In Chicago, 10% of LGBTQ+ respondents reported rarely or never safely accessing health insurance or physical healthcare, and 15% reported rarely or never safely accessing mental healthcare (Morton Group, 2019). In San Francisco, trans respondents were three times more likely to lack access to physical and mental healthcare (Horizons Foundation, 2018). In Chicago, 20% rated health insurance/physical healthcare as fair or poor, rising to 29% for mental healthcare (Morton Group, 2019). In Connecticut, 16% reported refusal of physical healthcare and 15% reported refusal of mental healthcare due to sexual orientation and/or gender identity (Consultation Center, 2021).

Findings from Pennsylvania mirror these trends. Although most respondents identified a healthcare provider (80.8%), nearly one-fifth lacked a primary provider (19.2%), and a similar share reported negative reactions from providers, a rate that doubled for trans respondents (PHMC, 2020). While medical forms typically contain questions about gender identity, limiting gender to a binary option on forms can contribute to inadequate or discriminatory care. In Pennsylvania, respondents noted provider shortcomings in LGBTQ+ cultural competence (PHMC, 2020). Similarly, researchers also reported providers lacked competence to work with LGBTQ+ adults, specifically regarding sexual health concerns (Mizock et al., 2021). Structural access barriers, such as physician scarcity and distance to clinics, can disproportionately affect trans adults, especially in locations where inclusive providers are scarce (Polizopoulos-Wilson et al., 2021). Interpersonal barriers, including low trust and insufficient provider knowledge of trans health, further undermine quality of healthcare (Polizopoulos-Wilson et al., 2021).

Physical Healthcare. Over the past two decades, researchers have documented substantial physical health disparities between LGBTQ+ and heterosexual adults. The theory of fundamental cause posits that health inequalities persist because higher-status groups retain

greater access to protective resources such as knowledge, prestige, power, and social connections (Phelan et al., 2004). Analyses from the Stockholm Public Health Cohort supported this theory; lesbian, gay, and bisexual adults faced higher risk of highly preventable disease morbidity compared with heterosexual adults (Bränström et al., 2016b). Additional findings show age and gender differences as lesbian, gay, and bisexual adults reported poorer general health, more physical symptoms (i.e., pain, insomnia, dermatitis, tinnitus, intestinal problems), and chronic conditions (i.e., diabetes, asthma, hypertension). Furthermore, these disparities persisted into adulthood for women but diminished in young adulthood for men (Bränström et al., 2016a).

A New Jersey survey highlighted frequent concerns in physical and mental healthcare, including HIV, STIs, hypertension, mental health services, and interpersonal violence services (Qureshi et al., 2018). Eighty percent of respondents did not seek routine or necessary physical healthcare, and trans respondents more often lacked insurance (Qureshi et al., 2018). Half of trans patients reported provider discrimination, including refusal of care (Qureshi et al., 2018). Across three cohort studies, LGBTQ+ adults reported delaying physical healthcare due to cost, lack of insurance, and provider discrimination, with greater reliance on community clinics than primary care (Tabaac et al., 2020). More than half of LGBTQ+ adults identified lack of provider knowledge and competency as major barriers to healthcare (Zajac & Godshall, 2020).

Mental Healthcare. Two models frame mental health disparities among LGBTQ+ adults. Minority Stress Theory attributes disparities to stressors from hostile or stigmatizing environments that generate discrimination (Meyer, 2003). Bronfenbrenner's Ecological Systems Theory emphasizes that outcomes reflect interactions between individuals and layered social environments over time (Bronfenbrenner, 2005). Together, these models suggest that interpersonal and environmental stress exposure drives disparities and healthcare requires

understanding community-specific stressors. Empirical studies show elevated anxiety and stress among LGBTQ+ adults and a twofold risk of major depressive disorder (Hawks et al., 2019; Pachankis, 2018). Trauma exposure further increases risk for anxiety, depression, and suicidality (Kassing et al., 2021). Electronic medical record analyses indicated higher rates of depression, anxiety, and trauma histories for LGBTQ+ adults, with particularly poor outcomes among bisexual adults (Batchelder et al., 2021). LGBTQ+ adults face increased risk for depression across the lifespan, with susceptibility remaining significant into older age, alongside persistent exposure to discrimination and social isolation (Bränström et al., 2023).

LGBTQ+ adults may be reluctant to seek healthcare for a myriad of reasons including provider discrimination. LGBTQ+ adults may also struggle to trust providers given the healthcare system has historically caused harm through experimentation including conversion therapy (Salway et al., 2023), lobotomies, electroconvulsive therapy, castration, testicle transplants (Blakemore, 2019), and labeling LGBTQ+ adults with personality disorders (Goldhammer et al., 2018). A disproportionate number of LGBTQ+ adults may be diagnosed with mental health disorders due to cumulative LGBTQ+-related stressors, including the internalization of negative societal messages; these external and internal stressors contribute to adverse physical and mental health outcomes (Meyer et al., 2021; Veltman & La Rose, 2019). Physical and mental health challenges are further complicated when LGBTQ+ adults experience provider discrimination (Rees et al., 2020). Literature review by Rees et al. (2020) discussed how LGBTQ+ adults felt ignored, mistreated, or pathologized by providers because of their sexual orientation or gender identity. As healthcare providers, it is vital to understand that variations in sexual orientation and/or gender identity are not mental health disorders.

Provider discrimination contributed to mistrust of the mental healthcare system, delays in care, and poorer outcomes (Arnold & Dhingra, 2020; Pachankis et al., 2021; Scott, Gaska, et al., 2023; Zeeman et al., 2019). Researchers should explore health outcomes of bisexual adults to better understand how to improve existing healthcare services given bisexual adults demonstrate the poorest outcomes (Batchelder et al., 2020, Dilley et al., 2010; Gonzales & Henning-Smith, 2017; Liu & Reczek, 2021; McCabe et al., 2020; Russell et al., 2022; White et al., 2022). Cohort analyses found generational differences in mental health challenges as older LGBTQ+ adults reported more physical violence, while younger LGBTQ+ adults reported higher distress, daily discrimination, and greater likelihood of suicide attempts (Meyer et al., 2021). During childhood and adolescence, LGBTQ+ youth are three times more likely to self-harm and four times more likely to attempt suicide (Gorse, 2022), yet all it takes is one accepting adult to reduce the risk of suicide by 40% (Price & Green, 2023). Yet only one-third of LGBTQ+ youth are accepted by their families while one-third face active parental rejection and the final one-third hide their identities until much later in life (Katz-Wise et al., 2016).

Research on LGBTQ+ health outcomes has expanded with increased inclusion of LGBTQ+-only samples and greater racial/ethnic diversity within samples, which improves visibility of intersecting identities (Walch et al., 2020). Even so, community-based clinics remain under-resourced as many maintain large caseloads with limited staff, and only a minority report competence in LGBTQ+ mental health, especially for trans adults and LGBTQ+ people of color (Pachankis et al., 2021). Providers should create visibly inclusive environments, including inclusive materials and artwork reflecting racial, gender, and cultural diversity, to signal safety and reduce fear of discrimination (Jones-Schenk, 2018; Lawlis et al., 2019). Nonetheless, progress requires both education and sustained funding for LGBTQ+-focused healthcare.

Provider Education and Training. Targeted education can improve clinical preparedness and attitudes. A yearlong pediatric curriculum addressing LGBTQ+ health increased comfort with history-taking, guideline application, and knowledge of topics like homelessness, environmental risk, gender dysphoria, and local resources (Roth et al., 2021). Programs that teach terminology, review discrimination and its health impacts, cover trans healthcare, and include skills practice (i.e., taking sexual histories) improved provider knowledge and confidence (Morris et al., 2019). Attitude change is supported by interactive learning such as presentations by LGBTQ+ speakers and patient videos describing discrimination in healthcare (Morris et al., 2019). Systematic reviews found significant improvements in providers' knowledge and attitudes after training including more inclusive attitudes toward LGBTQ+ clients (Strong & Folse, 2015), decreases in transphobia (Bauer et al., 2017), improvements in trans healthcare (Eriksson & Safer, 2016), and overall reductions in discrimination (Jacobs et al., 2000; Lindsay et al., 2019). Training should focus on promoting compassion, naming biases, and learning to use effective communication such as gender-neutral language and proper terminology (Moe & Sparkman, 2015). Training should also emphasize appropriate clinical interview questions and importance of addressing provider bias (Matsuzaka et al., 2021).

While the average time dedicated to LGBTQ+ health content has increased from five hours to 11 hours (Streed Jr. et al., 2024), graduate students' lack of comfort caring for LGBTQ+ adults persists (Jurček et al., 2021; Zelin et al., 2018). Gaps in provider knowledge about LGBTQ+ healthcare and the need for more practice providing direct care suggests that 11 hours of education and training is insufficient for providers (Streed Jr. et al., 2024). Researchers emphasized the need for more training and professional development for faculty, staff, and field instructors on LGBTQ+ specific concerns within social work education (Mehrotra et al., 2024)

and medical education (Fu et al., 2024; Goldhammer et al., 2018). Researchers suggested teaching the concepts of intersectionality, minority stress theory, and health disparities for sexual and gender minorities to graduate students (Bi et al., 2020) in addition to recruiting faculty willing to teach and conduct evidenced based research focused on LGBTQ+ health and health disparities (Streed Jr. et al., 2024). Considering educational shortcomings, healthcare providers should pro-actively seek training that focuses on LGBTQ+ healthcare needs to increase cultural competence. Researchers emphasized that a positive attitude towards LGBTQ+ adults is associated with an increased number of curriculum hours and specific training on the physical and mental healthcare needs of LGBTQ+ adults (Boekeloo et al., 2024; Cruciani et al., 2024).

Providers' Attitudes, Knowledge, and Skills. Improving LGBTQ+ healthcare requires structural changes (i.e., standardized sexual orientation and gender identity data collection) and interpersonal improvements (i.e., provider education and training). The primary barrier to inclusive healthcare is inadequate training (Aisner et al., 2020; Hughes et al., 2017). Providers reported discomfort working with LGBTQ+ patients when they lack education on LGBTQ+ health, which can manifest as unwillingness to provide care (Dorsen & Van Devanter, 2016; Stewart & O'Reilly, 2017;). Many providers avoid or rarely discuss sexual orientation (55.4%) or gender identity (71.9%) to avoid making patients uncomfortable (Goldhammer et al., 2018). While 95.3% of oncologists report comfort treating LGBTQ+ patients, only 53.1% feel confident in their knowledge of LGBTQ+ health needs (Schabath et al., 2019). Common themes include systemic barriers to culturally competent care, knowledge gaps, and a desire for improvement (Usshera et al., 2022). Encouragingly, providers express strong interest in further education, especially on trans health (Schabath et al., 2019; Usshera et al., 2022). Education must also address provider bias to mitigate discriminatory behavior and improve patient experiences.

Drug and Alcohol Recovery Services. According to data from the National Survey on Drug Use and Health (NSDUH, 2020), 5.5 million LGBTQ+ adults currently meet diagnostic criteria for a substance use disorder, and 3.9 million LGBTQ+ adults experience both substance use and co-occurring mental health conditions. More than half of LGBTQ+ adults reported alcohol use within the past month, and approximately one quarter met criteria for alcohol use disorder. Marijuana remains the most frequently used substance, followed by the misuse of prescription stimulants, sedatives, and opioid pain relievers (NSDUH, 2020). Among those with co-occurring disorders, an estimated 94% did not receive any form of treatment (NSDUH, 2020).

Substance use within LGBTQ+ populations is frequently conceptualized as a coping mechanism in response to minority stress, discrimination, and trauma (Felner et al., 2020; Rojas et al., 2019). Experiences of victimization are strongly associated with illicit drug and alcohol use, and LGBTQ+ adults who participate in community spaces report disproportionately higher victimization rates (Philips et al., 2020). Although such community environments may help reduce social isolation (Wedell et al., 2022), research on culturally competent addiction treatment specifically designed for LGBTQ+ adults remains limited (Green & Feinstein, 2012).

Despite the elevated prevalence of substance use and co-occurring mental health conditions, LGBTQ+ adults are significantly less likely to seek treatment (NSDUH, 2020). Stigma, the complexity of co-occurring disorders and trauma histories, and prior negative experiences in care settings contribute to reduced engagement. Nationally, only 12% of mental health facilities and 18% of substance use treatment programs offer LGBTQ+ specific services (Williams & Fish, 2020). Publicly funded facilities, which are often the primary option for individuals without private insurance, are the least likely to provide LGBTQ+ inclusive programming, thereby exacerbating existing inequities in access to care (Williams & Fish, 2020).

Supportive Housing Services. LGBTQ+ adults experience disproportionately elevated levels of housing unaffordability, lower homeownership rates, and an increased risk of being homeless (Romaero et al., 2020). Structural barriers, including discrimination in education, employment, renting, home buying, and mortgage lending, significantly limit access to stable and affordable housing (Badgett et al., 2019; Friedman et al., 2013; Meyer et al., 2021; Sun & Gao, 2019). Housing instability is further associated with heightened interpersonal violence, mental health concerns, and substance use, with lesbian, gay, and bisexual adults reporting higher prevalence of each of these challenges (Cusack et al., 2023). Strengthening federal and state anti-discrimination protections related to sexual orientation and gender identity, alongside mandatory training for civil servants, would enhance awareness, reduce discriminatory practices, and improve service provision. Additionally, improving data collection is essential to identify barriers within housing programs. Researchers found that lesbian, gay, and bisexual adults are twice as likely as heterosexual adults to be denied rental or home purchase opportunities, while trans adults experience denial rates approximately double those of lesbian, gay, and bisexual adults and are twice as likely to report homelessness (Badgett et al., 2019; Meyer et al., 2021).

An intersectional framework is critical for understanding housing access barriers, particularly for trans adults and LGBTQ+ people of color. Homelessness among LGBTQ+ adults arises from intersecting structural, systemic, interpersonal, and intrapersonal factors. Research on LGBTQ+ adults experiencing homelessness highlighted substantial needs related to mood disorders, internalized homophobia, and high rates of substance use (Ecker et al., 2019; Mayfield, 2001; Reback et al., 2007). Social network dynamics vary, with trans women frequently developing mutual support systems that serve as chosen family structures, while lower income LGBTQ+ adults often experience pronounced social isolation (Porter et al., 2003;

Sakamoto et al., 2009). Studies of trans adults experiencing homelessness document frequent interpersonal conflict, trauma, substance use, and mental health symptoms, as well as pervasive barriers and discrimination within shelter and housing systems (McCann & Brown, 2021; Shelton & Bond, 2017). Successful exits from homelessness require stable employment, financial security, and sustained service support (Johns et al., 2017). Provider education remains vital to reducing discriminatory barriers that hinder access to housing and supportive services.

Current Discrimination within the LGBTQ+ Community

While the Marriage Equality Act (*Obergefell v. Hodges*, 2015) legalized same-sex marriage, LGBTQ+ adults continue to experience minority stress arising from persistent stigma and discrimination. In Washington, D.C., reported hate crimes targeting LGBTQ+ adults increased from 107 incidents in 2016 to 209 in 2018, representing the largest two-year increase among U.S. cities examined (Levin & Nakashima, 2019). During this period, hate crimes based on sexual orientation rose from 40 to 60 incidents, while those based on gender identity increased from 19 to 36. These patterns are concerning given 14.3% of adults in Washington, D.C. identify as lesbian, gay, or bisexual, more than double the national average (Flores & Conron, 2023), positioning the city as a critical context for examining minority stress exposure.

Minority Stress Theory distinguishes between distal stressors, such as discrimination, violence, and institutional stigma, and proximal stressors, including vigilance, concealment, and internalized stigma, which contribute to health disparities among sexual and gender minority populations (Meyer, 2003, Meyer et al., 2021). Consistent with this framework, LGBTQ+ community members are nine times more likely than heterosexual adults to be victims of violent hate crimes (Flores et al., 2022), and trans adults are more than four times more likely than cis adults to experience violence (Flores et al., 2020a). Chronic exposure to distal stressors heightens

proximal stress responses, which together contribute to adverse physical and mental health outcomes. These dynamics underscore the need for healthcare research and interventions that address both structural sources of stigma and their internalized consequences, particularly when examined through an intersectional lens (Crenshaw, 1991).

Sexual Orientation and Gender Identity. A "double stigma" can affect lesbian/gay or bisexual adults with a co-occurring mental illness, and this dual marginalization is often overlooked in treatment planning (Holley et al., 2016). LGBTQ+ people face both interpersonal and structural discrimination, as well as differential access to healthcare (Holt et al., 2022). The result is not only a shortage of providers but a lack of safe and accessible healthcare services.

Race and Ethnicity. Researchers determined that both sexual orientation and racial identity predict harassment risk (Whitfield et al., 2019). While White LGBTQ+ adults were more likely to be harassed in the community, LGBTQ+ people of color experienced increased rates of harassment at home by family (Whitfield et al., 2019). Furthermore, LGBTQ+ people of color face discrimination, rejection, and invalidation from white LGBTQ+ community members, suggesting a hierarchy privileging white cis men (Parmenter et al., 2021). While White cis men may be minoritized from the larger heterosexual community, they still carry the privileges associated with their race and gender as evidence by segregation within the LGBTQ+ community (Surace et al., 2024). Safety concerns are common with more than one-third of LGBTQ+ people of color reporting uncertainty about their safety in public or whether bystanders would intervene (Horizons Foundation, 2018). Researchers emphasized how LGBTQ+ people of color report poorer general health due to more experiences of discrimination, less frequent access to healthcare, and lower feelings of social cohesion (Kannot & Du Bois, 2023). These relationships may be explained by a hierarchy within the LGBTQ+ community, which situates

White LGBTQ+ community members at the top of the social structure, as evidenced by rejection and discrimination towards LGBTQ+ people of color (Parmenter et al., 2021).

Women of Color. LGBTQ+ women of color experience "triple jeopardy," navigating oppression linked to race/ethnicity, gender, and sexual orientation (SteelFisher et al., 2019). LGBTQ+ women of color reported higher rates of discrimination, greater physical and emotional impairment, and delays in seeking care, leading to poorer outcomes (Scott, Knopp, et al., 2023). Specifically, women of color experienced discrimination within healthcare as providers often minimize severity of symptoms and do not provide care that addresses healthcare needs (Okoro et al., 2020). Findings align with broader research connecting discrimination to reduced health seeking behaviors (Fredriksen-Goldsen et al., 2014; Zeeman et al., 2019). Structural racism, sexism, and income inequality intersect with identity to influence health (Homan et al., 2021).

Socioeconomic Status. Cost is a leading barrier to healthcare (Zajac & Godshall, 2020; Horizons Foundation, 2018). The theory of Intersectionality emphasizes that differential access to power and resources produces unique social problems (Crenshaw, 1989). Researchers have identified the ability to access resources as the most significant challenge for LGBTQ+ people of color (Harris et al., 2020), highlighting differential access to healthcare (Waters et al., 2024) and the existence of structural discrimination (Holt et al., 2022). Poverty and resource constraints disproportionately affect trans adults and LGBTQ+ people of color, reflecting structural intersectionality and the compounding effects of racism and discrimination (Crenshaw, 1991; Harris et al., 2020;). These dynamics limit access to safe, culturally competent healthcare.

Implications. Mistrust of healthcare systems and discrimination within healthcare settings demands action at both institutional and interpersonal levels. Healthcare providers should adopt strategies that improve quality, safety, and inclusivity (Lawlis et al., 2019; Lund &

Burgess, 2021; McKinnish et al., 2019). Perceived safety strongly influences whether LGBTQ+ adults pursue physical and mental healthcare services. This study responded to gaps in the literature by assessing how access to healthcare is influenced by social identities. Researchers consistently documented inequities in healthcare access and experiences of discrimination, with LGBTQ+ people of color reporting particularly high levels of harassment in families, communities, and healthcare (Harris et al., 2020; Holt et al., 2022; Mizock et al., 2021; Parmenter et al., 2021; Polizopoulos-Wilson et al., 2021; Qureshi et al., 2018; Sadika et al., 2020; Stepleman et al., 2019; Whitfield et al., 2019); these inequities directly affect health (Meyer et al., 2021). Expanding affordable, accessible healthcare services and prioritizing diversity, equity, and inclusion in physical and mental health training programs are necessary steps for improvement. Healthcare providers should consider LGBTQ+-specific programming, proactive primary care engagement, and visible signals of inclusion to improve access.

Summary and Future Direction

Research on LGBTQ+ adults consistently linked marginalized social statuses to poorer health and well-being. Nevertheless, outcomes can improve over time with targeted provider training and systems that recognize how overlapping identities shape risk. There is a continued need for education on the healthcare needs of LGBTQ+ adults, with explicit attention to individuals who hold more than one minoritized identity. Increased public funding can expand provider education and ongoing training focused on LGBTQ+ health, which in turn improves experiences with healthcare providers and the availability of culturally competent care within community-based agencies. Strengthening provider education about LGBTQ+ community needs is therefore a direct path to improving access to inclusive physical and mental healthcare.

Researchers have also observed that LGBTQ+ adults report greater satisfaction and psychological well-being when their communities experience collective autonomy (Kachanoff et al., 2020). Comprehensive needs assessments create opportunities for LGBTQ+ adults to share feedback that enhances existing services and supports LGBTQ+ community autonomy through data-driven improvement. The present study used data from Rainbow Families' LGBTQ+ Community Needs Assessment to examine healthcare experiences of LGBTQ+ adults and identify areas for improvement. Findings are intended to enhance ownership of physical and mental healthcare providers' responsibility to improve cultural competence through training. Recommended steps for improvement include identifying an internal change agent responsible for implementation, assessing readiness at multiple levels (individual, group, structural, cultural) (Ricca et al., 2018). Providers should also recruit community advocates to deliver cultural competency training to reduce discrimination in healthcare settings (Ricca et al., 2018).

Nowaskie (2021) offered a model for developing inclusive healthcare through OutCare Health, an online platform, that curates national LGBTQ+ resources and maintains a public directory of culturally competent healthcare providers. The platform lists thousands of providers across specialties and offers education to close gaps in clinical preparedness, attitudinal awareness, and foundational knowledge (Nowaskie, 2021). Rainbow Families has developed a similar directory. Results from Rainbow Families' LGBTQ+ Community Needs Assessment expanded this vetted resource list, making it accessible to a broader segment of the community. To achieve sustained improvements, the field must continue to conduct comprehensive needs assessments that center LGBTQ+ voices and translate findings into concrete service changes.

Comprehensive Needs Assessments

Gahagan and Colpitts (2017) applied strength-based frameworks, including community based participatory research (CBPR) and intersectionality, to reframe LGBTQ+ health. CBPR engages those most affected by research as partners in design, data collection, analysis, and dissemination. Social problems exist at multiple levels and, as a result, interventions are needed at the community, state, and national policy levels. Given the LGBTQ+ community is comprised of unique and diverse individuals, it is vital to explore within-group differences. Crenshaw (1991) asserts that one-dimensional research "ignores intragroup differences" which … "contributes to tension among group members" (p. 1242). When within group differences are understood, interventions can be tailored to meet the specific needs of LGBTQ+ community members. Incorporating sexual orientation and gender identity (SOGI) as standard demographics in comprehensive needs assessments increases visibility and improves needs identification.

Comprehensive needs assessments benefit entire communities by promoting equity in access to resources (Zajac & Godshall, 2020). Assessment data can improve health outcomes and encourage greater provider investment in effective healthcare services (Carlton & Singh, 2018). Comprehensive needs assessments that highlight concrete programming options increase the likelihood that findings will be incorporated into policy and practice (Whitaker, 2018). Key benefits of comprehensive needs assessments include (a) increased visibility of LGBTQ+ people through standard SOGI data collection; (b) a clearer understanding of access to physical and mental healthcare services and barriers to physical and mental healthcare; and (c) a roadmap for enhancing culturally competent healthcare. In short, comprehensive needs assessments can improve services by clarifying healthcare needs among LGBTQ+ community members.

Washington, DC has a large and diverse LGBTQ+ population across race, ethnicity, gender, sexual orientation, and income. Within Washington D.C., 14.3% of adults identified as

lesbian, gay, or bisexual, more than twice the national average (Flores & Conron, 2023), and approximately 1% identified as trans (Herman et al., 2022). Washington, DC's racial and ethnic composition included African American (41%), White (36%), Hispanic or Latino/a (13%), and multiracial residents (5%) (US Census Bureau, 2024). The median household income was $109,707, with 17.3% of residents living in poverty and 4.1% uninsured (US Census Bureau, 2024). Despite demographic diversity and visibility, LGBTQ+ adults in DC continued to report elevated levels of harassment (Levin & Nakashima, 2019), underscoring the need for a comprehensive needs assessment to assess healthcare access and discriminatory experiences.

The present study used data from Rainbow Families' LGBTQ+ Community Needs Assessment to examine the needs of LGBTQ+ adults in Washington D.C., Maryland, and Virginia. Within this dissertation, I conducted data analysis using logistic regression to examine how intersecting social identities, including sexual orientation, gender identity, race/ethnicity, shaped access to physical and mental healthcare. The study analyzed how these identities predicted access to healthcare. Specifically, I evaluated the relationships among sexual orientation, gender identity, and race/ethnicity, and assessed whether intersectional combinations of participants' identities were associated with differences in access to healthcare services. Correlation analyses were used to evaluate how intersections among sexual orientation, gender identity, and race/ethnicity related to disparities in access to physical and mental healthcare for LGBTQ+ community members residing in Washington D.C., Maryland, and Virginia.

Chapter 3: Methods

The present study employed a quantitative research design to analyze data obtained from Rainbow Families' LGBTQ+ Community Needs Assessment (see Appendix B). Logistic regression analysis was selected as the primary analytic strategy to examine the relationship between demographic predictors, sexual orientation, gender identity, and race/ethnicity, and access to healthcare among LGBTQ+ community members. Logistic regression was used to determine whether sexual orientation, gender identity, and race/ethnicity significantly predicted disparities in physical and mental healthcare access within the sampled LGBTQ+ population.

Logistic regression is an appropriate method for this analysis because the outcome variables, access to physical healthcare and access to mental healthcare, were operationalized as dichotomous indicators of perceived access to care, and the predictors were categorical (Hosmer & Lemeshow, 2000; Lomax & Hahs-Vaughn, 2012). This approach allowed for the estimation of the likelihood that participants' healthcare needs were not consistently met as a function of their social identities, while simultaneously accounting for the independent and combined effects of multiple categorical predictors. Additionally, logistic regression also facilitated intersectional analysis by enabling the simultaneous examination of multiple social identities and their combined influence on healthcare access, thereby aligning with the theory's emphasis on the joint effects of overlapping systems of privilege and marginalization (Crenshaw, 1991).

Research Questions

1. Can access to physical and mental healthcare be predicted from sexual orientation for LGBTQ+ adults in the current study?
2. Can access to physical and mental healthcare be predicted from gender identity for LGBTQ+ adults in the current study?

3. Can access to physical and mental healthcare be predicted from race/ethnicity for LGBTQ+ adults in the current study?
4. Can access to physical and mental healthcare be predicted from sexual orientation, gender identity, and race/ethnicity for LGBTQ+ adults in the current study?

Participants

The current study used the sample of LGBTQ+ adults who participated in Rainbow Families' LGBTQ+ Community Needs Assessment (N=441). Participants were self-selected and recruited through email messages from LGBTQ+ nonprofit organizations. Participants received a brief description of the survey and the expected completion time in minutes. After volunteering to complete the survey, participants were routed to Qualtrics, where survey data was collected. Purposeful and convenience sampling was used to recruit LGBTQ+ adults living in Washington, D.C., Maryland, and Virginia. All participants were recruited by email messages and completed the Qualtrics-based survey at a single time point. Participants could stop at any time.

Population and Sample

Rainbow Families' LGBTQ+ Community Needs Assessment is a cross-sectional survey of 441 adults living in Washington, D.C., Maryland, and Virginia. The goal was to gather information to inform the work of community-based organizations serving LGBTQ+ adults. Researchers used convenience sampling via email messages to recruit participants. During recruitment, the researchers also leveraged connections with the LGBTQ+ Coalition in Washington, D.C. to circulate the survey among additional organizations, including Whitman-Walker Health, Capital Pride Alliance, The DC Center, SMYAL, Casa Ruby, and Capital Stonewall Democrats. This approach sampled minority populations that are traditionally underrepresented in research. The present study used this sample to examine how access to

physical and mental healthcare is shaped by sexual orientation, gender identity, and race/ethnicity. By focusing on LGBTQ+ adults, the study strengthens the knowledge base regarding the understanding of access to affirming physical and mental healthcare for this population.

Demographics

Four hundred forty-one participants completed Rainbow Families' Community Needs Assessment. Demographics information about participants within the LGBTQ+ Community Needs Assessment are included below in Table 1. Participants reported living in District of Columbia (n=170, 40.18%), Maryland (n=159, 37.58%), and Virginia (n=92, 21.75%). Many participants identified as middle-aged between 31-44 (n=186, 47.09%) and 45-64 (n=92, 23.29%) while most participants identified as either Gay (n=124, 30.02%) or Lesbian (n=123, 29.78%) with a smaller percentage identifying as bisexual (n=76, 18.4%), Queer (n=27, 6.53%), and Pansexual (n=12, 2.9%). The most popular gender labels used by participants included Cis Woman (n=209, 50.61%) and Cis Man (n=125, 30.27%) followed by non-binary (n=27, 6.54%), Gender-Queer (n=19, 4.6%), Trans Man (n=17, 4.12%), and Trans Woman (n=5, 1.21%). Regarding race/ethnicity, a majority of participants self-identified as White (n=319, 78.77%), with a significantly smaller percentage of participants identifying as People of Color including African American/Black (n=33, 8.15%), Latino/Latina (n=20, 4.94%), Asian (n=16, 3.95%), Bi-racial (n=12, 2.96%), and Middle Eastern (n=3, 0.74%).

Table 1
Demographic Variables of Rainbow Families' LGBTQ+ Community Needs Assessment Sample

Variables	*N*	Percentage
Age	395	
Under 18	21	5.32
18-21	13	3.29
22-24	16	4.05
25-30	57	14.43
31-44	186	47.09

45-64	92	23.29
65+	10	2.53
Sexual Orientation	413	
Gay	124	30.02
Lesbian	123	29.78
Bisexual	76	18.4
Straight	40	9.69
Queer	27	6.53
Pansexual	12	2.9
Gender Identity	413	
Cis Woman	209	50.61
Cis Man	125	30.27
Non-binary	27	6.54
Gender Queer	19	4.6
Trans Man	17	4.12
Trans Woman	5	1.21
Race/Ethnicity	405	
White	319	78.77
African American/Black	33	8.15
Latina/Latino	20	4.94
Asian	16	3.95
Bi-racial	12	2.96
Middle Eastern	3	0.74
Location	423	
District of Columbia	170	40.18
Maryland	159	37.58
Virginia	92	21.75
Relationship Status	405	
Single	90	22.22
Committed Relationship	50	12.35
Domestic Partnership	14	3.46
Married/Civil Union	239	59.01
Separated	2	0.49
Divorced	8	1.98
Widowed	2	0.49
Highest Degree in School	405	
Elementary or Middle	7	1.73
Some High School	16	3.95
High School/GED	9	2.22
Some College	21	5.19
Vocational Certificate	2	0.49
Associate’s Degree	11	2.72
Bachelor’s Degree	120	29.63
Master’s Degree	139	34.31
Doctoral Degree	28	6.91
Professional Degree	50	12.35

Employment Status	404	
Employed, full-time	318	78.71
Employed, part-time	23	5.96
Not employed, looking	22	5.45
Not employed, not looking	34	8.42
Retired	5	1.24
Disabled, unable to work	2	0.5
Household Income	382	
No income	8	2.09
Less than $10,000	3	0.79
$10,000 - $19,999	4	1.05
$20,00-0 - $29,999	4	1.05
$30,000 - $39,999	8	2.09
$40,000 - $49,999	9	2.36
$50,000 - $59,999	9	2.36
$60,000 - $69,999	11	2.88
$70,000 - $79,999	21	5.5
$80,000 - $89,999	14	3.66
$90,000 - $99,999	14	3.66
$100,000 - $149,999	90	23.56
$150,000 - $199,999	58	15.18
$200,000 or more	129	33.77

Procedures

A community needs assessment can be used to identify the needs of a target population within a specific context (Berberet, 2006). Research by Craig (2011) recommended community needs assessments include the evaluation of existing health and mental health services as well as the impact of these services on the target population. In addition, implementation of a needs assessment requires collaboration between stakeholders (Craig, 2011). Rainbow Families and LGBTQ+ Coalition Members collaborated on the development of a LGBTQ+ need assessment. Rainbow Families and LGBTQ+ Coalition Members guided research design and data collection.

Research Design

I assisted Rainbow Families in the development of a comprehensive needs assessment survey (see Appendix A). While the LGBTQ+ Community Needs Assessment (see Appendix B) is not a formal assessment, I modeled Rainbow Families' LGBTQ+ Community Needs

Assessment after the San Francisco LGBTQ+ Community Needs Assessment (Horizon Foundation, 2018). Following Craig (2011), Rainbow Families' LGBTQ+ Community Needs Assessment was developed in four phases: (1) key-informant interviews; (2) focus groups; (3) a quantitative survey; and (4) community feedback on the results. First, I conducted one-on-one interviews with key informants including Rainbow Families' Executive Director and members of Rainbow Families' Board of Directors to shape survey content. Second, I conducted a focus group meeting with LGBTQ+ Coalition members to obtain feedback about the survey instrument. Third, I administered the need assessment survey via Qualtrics to gather data from LGBTQ+ adults in Washington, D.C., Maryland, and Virginia. Finally, I presented the results at Rainbow Families' annual conference for feedback from LGBTQ+ community members.

Validity

Validity of Rainbow Families' LGBTQ+ Community Needs Assessment was established through expert review and pilot testing (Magee et al., 2013). Content validity was supported by grounding survey development in the existing literature and aligning items with clearly defined assessment objectives (Rickards et al., 2012). Prior to administration, the instrument was reviewed by subject-matter experts including LGBTQ+ Coalition members. Evidence of content validity includes adaptation of previously developed community needs assessments (Consultation Center, 2021; Horizons Foundation, 2018; Morton Group, 2019; PHMC, 2020), in addition to incorporation of focus group feedback and review by subject-matter experts. In addition, evidence of face validity was established through pilot testing with the target population (Hill et al., 2022).

Data Collection

Participants were recruited via email messages from Rainbow Families and other LGBTQ+ non-profit organizations (i.e., Whitman-Walker Health, Capital Pride Alliance, The DC Center, SMYAL, Casa Ruby, and Capital Stonewall Democrats) and participants completed the survey electronically via Qualtrics. To participate in this survey, individuals did not complete a screener. Data collection occurred online via Qualtrics from March 2021 to May 2021 in a single sitting with no follow-up. Rainbow Families' LGBTQ+ Community Needs Assessment collected demographic information including sexual orientation, gender identity, age, race/ethnicity, relationship status, education, employment, and income. Survey domains included community events, childcare, physical and mental healthcare, legal assistance, recovery support, housing assistance, and civic engagement. Participants reported experiences of provider discrimination and barriers to accessing services, as well as the importance of LGBTQ+-specific services. The purpose of the quantitative inquiry was to identify the existence access barriers and the subsequent influence of sexual orientation, gender identity, and race/ethnicity on access to physical and mental healthcare for LGBTQ+ community members.

Data Analysis

Statistical Package for the Social Sciences (SPSS) was used to analyze dependent variables derived from the physical and mental healthcare measures in the LGBTQ+ Community Needs Assessment. Prior to modeling, I transformed and coded variables. For sexual orientation predictor variable, gay coded as 0 (reference category), lesbian coded as 1, and bisexual coded as 2. For gender identity predictor variable, cis man coded as 0 (reference category), cis woman coded as 1, and trans and gender non-conforming adults coded as 2. Due to small subsample sizes among participants identifying as trans men, trans women, non-binary, and gender-queer, these gender identities were aggregated into a single trans and gender non-conforming category

to ensure sufficient cell sizes for reliable statistical estimation. For race and ethnicity predictor variable, White coded as 0 (reference category) and People of Color coded as 1. Due to limited representation across specific racial and ethnic minority groups, these racial/ethnic groups were collapsed to preserve statistical power and reduce the risk of unstable parameter estimates (Peduzzi et al., 1996). Collapsing categories under such conditions is an appropriate practice in quantitative research involving LGBTQ+ populations with small subgroup sizes and is consistent with prior empirical studies (Meyer & Wilson, 2009).

For both physical and mental healthcare access outcomes, a binary dependent variable was constructed using the survey item, "I get what I need out of the provider." This item was selected from the physical and mental healthcare sections of Rainbow Families' LGBTQ+ Community Needs Assessment to capture a critical dimension of healthcare access, perceived adequacy of care, which reflects whether individuals' healthcare needs are consistently met to measure a critical gap in services (Dey et al., 2025). Responses of always were coded as 0 (reference category), indicating healthcare needs were consistently met, whereas responses of never or almost never, sometimes, or most of the time were coded as 1, indicating that healthcare needs were not consistently met. Response categories collapsed into a dichotomous variable to preserve statistical power and ensure stable parameter estimation, particularly given uneven cell sizes across response options, a practice that is common and appropriate in logistic regression analyses with limited subgroup representation (Dai et al., 2011; Peduzzi et al., 1996). Assumption testing included noncollinearity, linearity, and independence of errors (Lomax & Hahs-Vaughn, 2012). I used likelihood-ratio tests to evaluate each variable's contribution to the model and estimated odds ratios via maximum likelihood estimation (Hosmer & Lemeshow, 2000; O'Connell & Rivet Amico, 2019).

Power Analysis

Statistical power is the probability of rejecting the null hypothesis when it is false (Lomax & Hahs-Vaughn, 2012) or the probability of obtaining a statistically significant result (Cohen, 1992). An a priori power analysis was conducted in G*Power to determine the minimum sample size required for logistic regression with three predictor variables. Consistent with conventional standards, the analysis specified an alpha level of .05, desired statistical power of .80, and a large effect size (Cohen's $f^2 = .35$; Cohen, 1988). Using the multiple-predictor regression framework implemented in G*Power, which is commonly applied to logistic regression planning when predictors are categorical and outcomes are dichotomous (Statistics Solution, 2013), the minimum required sample size is 27 participants. Given Rainbow Families' LGBTQ+ Community Needs Assessment included 441 participants, the final sample size substantially exceeded the minimum requirement, indicating that the study was sufficiently powered to detect large effects in the logistic regression analyses. Although overall statistical power was adequate, it is important to note that power constraints remained at the subgroup level, particularly for intersectional analyses involving smaller identity-based subsamples including participants who identified as trans and People of Color.

Human Participants and Ethical Concerns

The George Washington University Institutional Review Board (IRB) reviewed the current study's proposal and determined the study to be exempt. According to George Washington University's IRB policies, the current study was exempt from review given the nature of the publicly available data. This study involved analysis of data from a public dataset and did not present ethical concerns associated with new data collection. The dataset contained no identifiers that could be used to connect participants' personal identities to their responses.

Missing Data

Participants could skip questions, refuse to answer, respond with "I don't know/I prefer not to answer," or not be asked certain questions. For the purposes of this study, I used pairwise deletion to include cases with missing data in the current analysis. With pairwise deletion, cases with missing data on a particular variable were excluded only from analyses that included that variable, but pairwise deletion included the case when analyzing other variables with non-missing data. Pairwise deletion was chosen to use all information available and minimize the loss associated with listwise deletion, which deletes a case with any missing data (Kang, 2013). Consequently, the sample size for analyses differs slightly across models. Pairwise deletion can lead to information loss, which is a limitation. However, pairwise deletion was chosen over listwise deletion to maximize available data, maintain statistical power, and avoid the risks of introducing bias or patterns from estimated values (Kang, 2013).

Measures

Rainbow Families' LGBTQ+ Community Needs Assessment (see Appendix B) examined nine domains including safety, social and community events, parenthood and childcare, physical healthcare, mental healthcare, legal assistance, recovery support, housing assistance, and civic engagement. Within each domain, the survey explored barriers to accessing services, experiences of provider discrimination, and the importance of LGBTQ+-specific services. The present study used the physical and mental healthcare domains to examine how access barriers are shaped participants' overlapping social identities including sexual orientation, gender identity, and race/ethnicity. All measures included in this study were self-report and were administered via Qualtrics. I gained permission from Rainbow Families to use these measures in my dissertation research.

Physical Healthcare

The Physical Healthcare section included 13 questions about access to services in the past three years (i.e., hospital, doctor's office, or other provider for physical issues or injuries). These items are included in Table 2. Participants first reported whether they had access to physical healthcare and specified the county where they received services. Participants then rated how true several statements were about their typical physical healthcare experiences on a four-point scale from 1 (never or almost never) to 4 (always). Example items included: "I get what I need out of the provider"; and whether the provider was sensitive to needs related to gender identity or expression, LGBTQ+ identity, race/ethnicity, age, and disability status. Two questions asked if participants heard of Rainbow Families' directory of affirming healthcare providers and whether they would use this resource (yes/no). Participants identified the type of organization where they received care (LGBTQ+-focused, a general organization with an LGBTQ+-specific provider, or a general organization with a general provider). Participants also rated physical healthcare providers' knowledge of LGBTQ+ concerns and terminology on the same four-point scale from 1 (never or almost never) to 4 (always).

Participants indicated whether they had experienced situations such as denial of care, refusal to provide basic services, incorrect pronoun use or failure to acknowledge gender identity, and verbal or physical harassment. Insurance items asked about coverage type (i.e., no coverage, private insurance through employer or someone else's employer, student plan, Medicaid, Medicare, military) and if health insurance met current needs (1 = very well to 4 = I don't have insurance). Finally, participants evaluated the importance of LGBTQ+-specific services and selected significant medical needs (i.e., STI testing and prevention, inclusion training for providers, affordable care and insurance, education, mental health counseling, trans

health, partner benefits, women's health, and LGBTQ+-identified providers). Participants also selected access barriers (i.e., not knowing how or where to access services, affordability, transportation, caregiving responsibilities, accessibility, privacy concerns, trans-friendliness, LGBTQ+ friendliness, cultural sensitivity, and pandemic restrictions).

Table 2

Items Included in the Physical Health section of Rainbow Families' LGBTQ+ Community Needs Assessment

1. Did you visit any kind of clinic, doctor, nurse practitioner, or other medical care provider in the past three years? (i.e., telehealth appointments and/or in-person appointments)

Please tell us more about your typical experience getting health care. How often are the following statements true for your typical health care experience?

2. I get what I need out of it
3. The provider(s) is/are sensitive to my needs and perspective based on my gender identity/expression.
4. The provider(s) is/are sensitive to my needs and perspective as a LGBTQ+ identified person
5. The provider(s) is/are sensitive to my needs and perspective as a person of color
6. The provider(s) is/are sensitive to my needs and perspectives based on my age.
7. The provider(s) is/are sensitive to my needs based on my disability-related needs.
8. Where do you usually get your health care?
9. Is your medical provider knowledgeable about LGBTQ concerns and terminology?
10. Are you aware of Rainbow Families' directory of vetted health care and other service providers, available to members?
11. How long does it usually take you to get to a place where you get health care services?
12. How do you usually get to your health care appointments?
13. Whether or not you have personally needed this service, how important is it that LGBTQ+-specific healthcare providers and services are available?

Mental Healthcare

The Mental Healthcare section included 10 questions about access to services in the past three years (i.e., crisis intervention, long-term counseling or therapy, and support groups).These items are included in Table 3. Participants first reported whether they had access to mental

healthcare and specified the county where they received services. Participants then rated how true several statements were about mental healthcare experiences on a four-point scale from 1 (never or almost never) to 4 (always). Items in the mental healthcare section paralleled those in the physical healthcare section (i.e., provider sensitivity to gender identity or expression, LGBTQ+ identity, race, ethnicity, age, and disability status). Participants rated the importance of LGBTQ+-specific mental healthcare and selected access barriers from the same list used in the physical healthcare section of Rainbow Families' LGBTQ+ Community Needs Assessment.

Table 3

Items included in the Mental Health section of Rainbow Families' LGBTQ+ Community Needs Assessment

1. Did you go to therapy or counseling, or use any kind of support group, drop-in group, teletherapy or other kind of emotional or mental health support in the past three years?

Please tell us more about your typical experience getting health care. How often are the following statements true for your typical health care experience?

2. I get what I need out of it
3. The provider(s) is/are sensitive to my needs and perspective based on my gender identity/expression.
4. The provider(s) is/are sensitive to my needs and perspective as a LGBTQ+ identified person
5. The provider(s) is/are sensitive to my needs and perspective as a person of color
6. The provider(s) is/are sensitive to my needs and perspectives based on my age.
7. The provider(s) is/are sensitive to my needs based on my disability-related needs.
8. Where do you usually get emotional support services?
9. How do you usually get emotional support services?
10. Whether or not you have personally needed this service, how important is it that LGBTQ+-specific providers and services are available for emotional support?

Chapter 4: Results

Logistic Regression

The LGBTQ+ community is vastly understudied, particularly the intersecting identities within the LGBTQ community. Logistic regression was conducted to determine whether sexual orientation, gender identity, and race/ethnicity could predict access to healthcare for LGBTQ+ adults. Descriptive statistics for predictor and outcomes variables included in Table 4 and Table 5. The results of the logistic regression included in Table 6, Table 7, Table 8, and Table 9. The assumptions for logistic regression were assessed including noncollinearity, linearity, and independence of errors.

Assumption testing

Noncollinearity. Although it is not possible to request multicollinearity statistics, such as tolerance and VIF, using logistic regression in SPSS (Lomax & Hahs Vaugh, 2012), researcher estimated values by running the same predictor variables (e.g., sexual orientation, gender identity, race/ethnicity) in a multiple regression model. I ran multiple regression models and requested the collinearity statistics with the following parameters: tolerance values less than .10 and VIF values greater than 10 indicate multicollinearity (Menard, 1995). Regarding physical health output, sexual orientation (tolerance = .558, VIF = 1.793), gender identity (tolerance = .558, VIF = 1.793), and race/ethnicity (tolerance = .999, VIF = 1.001) statistics provide evidence

that multicollinearity does not exist within this model. Regarding mental healthcare output, sexual orientation (tolerance = .492, VIF = 2.033), gender identity (tolerance = .490, VIF = 2.041), and race/ethnicity (tolerance = .994, VIF = 1.006) statistics provide evidence that multicollinearity does not exist within this model. In summary, both models have met the assumption of non-collinearity according to tolerance and VIF values.

Linearity. The linearity assumption is only applicable to continuous variables (Lomax & Hahs Vaugh, 2012); therefore, this assumption does not apply to categorical variables (e.g., sexual orientation, gender identity, race/ethnicity) within physical or mental healthcare models.

Independence of errors. I assessed independence by examining a scatterplot of the standardized residuals against values of each independent variable. According to Lomax & Hahs Vaugh (2012), all cases should fall randomly within -2.0 to +2.0 to satisfy this assumption. Regarding physical and mental healthcare models, all data points were within an absolute value of 2.0. In summary, the assumption of independence has been met for both models.

Table 4
Descriptive Statistics of Predictor and Outcome Variables for Physical Healthcare Access

Predictor Variables	*N*	Outcome Variables	*N*
Sexual Orientation	204	**Sexual Orientation**	204
Gay	76	Access to Healthcare	
Lesbian	83	Always	67
Bisexual	45	Not Always	137
Gender Identity	246	**Gender Identity**	246
Cis Man	75	Access to Healthcare	
Cis Woman	134	Always	80
Trans/Gender Non-conforming	37	Not Always	166
Race/Ethnicity	251	**Race/Ethnicity**	251
White	169	Access to Healthcare	
Person of Color	31	Always	82
		Not Always	169

Note. Sample size for variables differs across models due to missing data

Table 5
Descriptive Statistics of Predictor and Outcome Variables for Mental Healthcare Access

Predictor Variables	*N*	Outcome Variables	*N*
Sexual Orientation	103	**Sexual Orientation**	103
Gay	32	Access to Healthcare	
Lesbian	43	Always	30
Bisexual	28	Not Always	73
Gender Identity	134	**Gender Identity**	134
Cis Man	32	Access to Healthcare	
Cis Woman	77	Always	39
Trans/Gender Non-conforming	25	Not Always	95
Race/Ethnicity	137	**Race/Ethnicity**	137
White	110	Access to Healthcare	
Person of Color	27	Always	39
		Not Always	98

Note. Sample size for variables differs across models due missing data

Research Question 1: Can access to physical and mental healthcare be predicted from sexual orientation for LGBTQ+ adults in the current study?

Sexual orientation. Logistic regression analysis was conducted to determine whether healthcare access (physical healthcare and mental healthcare) could be predicted from sexual orientation (gay, lesbian, bisexual). When interpreted using Cohen (1988), small effect size is observed for both physical and mental healthcare (physical healthcare: Cox and Snell $R^2 = .162$, Nagelkerke $R^2 = .216$; mental healthcare: Cox and Snell $R^2 = .185$; Nagelkerke $R^2 = .247$). For physical healthcare, the final model is a significant improvement in fit over null model [x^2 (3) = 36.090, p = <.001]. For mental healthcare, the final model is a significant improvement in fit over null model [x^2 (3) = 21.062, p = <.001]. These results suggest that the predictors reliably distinguished between LGBTQ+ adults who always have their healthcare needs met and LGBTQ+ adults who do not always have their healthcare needs met by physical and mental healthcare providers.

Of the three predictor variables in the model, lesbian (Wald = 18.386, df = 1, p = <.001) and bisexual (Wald = 12.207, df = 1, p = <.001) sexual orientation categories were statistically significant predictors of not always having physical healthcare needs met by healthcare providers. Lesbian (Wald = 5.007, df = 1, p = .025) and bisexual (Wald = 9.565, df = 1, p = .002) sexual orientation categories were also statistically significant predictors of not always having mental healthcare needs met by healthcare providers. The odds ratio for sexual orientation suggests that participants who identify as lesbian or bisexual were three to three and one-half times more likely to not always have their physical healthcare needs met while participants who

identify as lesbian or bisexual were two to four times more likely to not always have their mental healthcare needs met.

Research Question 2: Can access to physical and mental healthcare be predicted from gender identity for LGBTQ+ adults in the current study?

Gender Identity. Logistic regression analysis was conducted to determine whether healthcare access (physical healthcare and mental healthcare) could be predicted from gender identity (cis man, cis woman, trans and gender non-conforming). When interpreted using Cohen (1988), small effect size is observed for both physical and mental healthcare (physical healthcare: Cox and Snell R^2 = .165, Nagelkerke R^2 = .219; mental healthcare: Cox and Snell R^2 = .188, Nagelkerke R^2 = .251). For physical healthcare, the final model is a significant improvement in fit over null model [x^2 (3) = 44.221, p = <.001]. For mental healthcare, the final model is a significant improvement in fit over null model [x^2 (3) = 27.974, p = <.001]. These results suggest that the predictors reliably distinguished between LGBTQ+ adults who always have their healthcare needs met and LGBTQ+ adults who do not always have their healthcare needs met.

Of the three predictor variables in the model, cis woman (Wald = 29.530, df = 1, p = <.001), trans and gender non-conforming (Wald = 8.774, df = 1, p = .003) gender identity categories were statistically significant predictors of not always having physical healthcare needs met by providers. Cis man (Wald = 4.274, df = 1, p = .039) and cis woman (Wald = 19.438, df = 1, p = <.001) gender identity categories were statistically significant predictors of not always having mental healthcare needs met by providers. The odds ratios for gender identity suggest that LGBTQ+ participants who identify as cis women as well as trans and gender non-conforming were three times more likely to not always have their physical healthcare needs met by providers

whereas LGBTQ+ participants who identify as cis men and cis women were two to three times more likely to not always have their mental healthcare needs met by providers.

Research Question 3: Can access to physical and mental healthcare be predicted from race/ethnicity for LGBTQ+ adults in the current study?

Race/ethnicity. Logistic regression analysis was conducted to determine whether healthcare access (physical healthcare and mental healthcare) could be predicted from race/ethnicity (white and person of color). When interpreted using Cohen (1988), small effect size is observed for physical and mental healthcare (physical healthcare: Cox and Snell R^2 = .116, Nagelkerke R^2 = .155; mental healthcare: Cox and Snell R^2 = .181, Nagelkerke R^2 = .242). For physical healthcare, the final model is a significant improvement in fit over null model [$x^2(2)$ = 30.996, p = <.001]. For mental healthcare, the final model is a significant improvement in fit over null model [$x^2(2)$ = 27.426, p = <.001]. These results suggest that the predictors reliably distinguished between LGBTQ+ adults who always have their healthcare needs met and LGBTQ+ adults who do not always have their healthcare needs met by physical and mental healthcare providers.

Of the two predictor variables in the model, only White (Wald = 25.364, df = 1, p = <.001) race/ethnicity category was a statistically significant predictor of not always having physical healthcare needs met by providers. Similarly, only White (Wald = 22.530, df = 1, p = <.001) race/ethnicity category was a statistically significant predictor of not always having mental healthcare needs met by providers. The odds ratios for race/ethnicity suggests that LGBTQ+ participants who identify as White were two times more likely to not always have their physical and mental healthcare needs met by healthcare providers. The following tables present

the results for the models including the regression coefficients, Wald statistics, odds ratios, and 95% CIs for the odds ratios.

Table 6

Summary of Logistic Regression Analysis for Variables Predicting Access to Physical Healthcare

Effect	ß	*SE*	95% CI		*p*	OR	Wald
			LL	*UL*			
			Physical Healthcare				
Sexual Orientation[a]							
Gay	.11	.23	.71	1.74	.65	1.11	.21
Lesbian	1.08	.25	1.80	4.84	.00	2.95	18.39
Bisexual	1.25	.36	1.73	7.07	.00	3.50	12.21
Gender Identity[b]							
Cis Man	.03	.23	.65	1.62	.91	1.03	.01
Cis Woman	1.08	.2	1.99	4.34	.00	2.94	29.53
Trans/GNC	1.14	.38	1.47	6.59	.00	3.11	8.77
Race/ Ethnicity[c]							
White	.75	.15	1.58	2.84	.00	2.12	25.36
People of Color	.59	.31	.98	3.34	.06	1.81	3.65

Note. CI = confidence interval; *LL* = lower limit; *UL* = upper limit; *OR* = odds ratio

[a] 0 = gay, 1 = lesbian, 2 = bisexual.

[b] 0 = cis man, 1 = cis woman, 2 = trans and gender non-conforming.

[c] 0 = White, 1 = People of Color.

Table 7

Summary of Logistic Regression Analysis for Variables Predicting Access to Mental Healthcare

Effect	ß	*SE*	95% CI		*p*	OR	Wald
			LL	*UL*			
			Mental Healthcare				
Sexual Orientation[a]							
Gay	.65	.37	.92	3.96	.08	1.91	3.02
Lesbian	.73	5.01	1.1	3.92	.03	2.07	5.01
Bisexual	1.53	9.57	1.75	12.10	.00	4.60	9.57
Gender Identity[b]							
Cis Man	.79	.38	1.04	4.65	.04	2.20	4.27
Cis Woman	1.19	.27	1.93	5.56	.00	3.28	19.44
Trans/GNC	.24	.40	.58	2.80	.55	1.27	.36
Race/ Ethnicity[c]							
White	1.03	.22	1.83	4.27	.00	2.79	22.53
People of Color	.53	.4	.78	3.71	.18	1.70	1.77

Note. CI = confidence interval; *LL* = lower limit; *UL* = upper limit; *OR* = odds ratio

[a] 0 = gay, 1 = lesbian, 2 = bisexual.

[b] 0 = cis man, 1 = cis woman, 2 = trans and gender non-conforming.

[c] 0 = White, 1 = People of Color.

Research Question 4: Can access to physical and mental healthcare be predicted from sexual orientation, gender identity, and race/ethnicity for LGBTQ+ adults in the current study?

Physical healthcare. Logistic regression analysis was conducted to determine whether healthcare access could be predicted from interaction of sexual orientation, gender identity, and race/ethnicity. When interpreted using Cohen (1988), small effect size is observed (Cox and Snell R^2 = .184; Nagelkerke R^2 = .245) for physical healthcare. The final model is a significant improvement in fit over null model [x^2 (14) = 40.600, p = <.001]. These results suggest that the predictors reliably distinguished between LGBTQ+ adults who always have their physical healthcare needs met and LGBTQ+ adults who do not always have their physical healthcare needs met. Of the fourteen predictor variables in the model, white lesbian cis woman (Wald = 11.397, df = 1, p = <.001) and white bisexual cis woman (Wald = 8.592, df = 1, p = .003) were statistically significant predictors of not always having physical healthcare needs met by providers. The odds ratios suggests white lesbian cis women were two and a half times more likely to not always have their physical healthcare needs met and white bisexual cis women were almost four times more likely to not always have their physical healthcare needs met.

Mental healthcare. Logistic regression analysis was conducted to determine whether healthcare access could be predicted from interaction of sexual orientation, gender identity, and race/ethnicity. When interpreted using Cohen (1988), small effect size is observed (Cox and Snell R^2 = .260; Nagelkerke R^2 = .347) for mental healthcare. The final model is a significant improvement in fit over null model [x^2(11) = 30.754, p = .001]. These results suggest that the predictors reliably distinguished between LGBTQ+ adults who always have their mental healthcare needs met and LGBTQ+ adults who do not always have their mental healthcare needs met. Of the eleven predictor variables in the model, white gay cis man (Wald = 5.431, df = 1, p = .020), white lesbian cis woman (Wald = 5.997, df = 1, p = .014), and white bisexual cis woman (Wald = 4.249, df = 1, p = .039) were statistically significant predictors of not always having

mental healthcare needs met. The odds ratios suggests that white gay cis men were three times more likely to not always have their mental healthcare needs met. In addition, odds ratios suggests that white lesbian cis women were two and a half times more likely and white bisexual cis women were three and one-quarter times more likely to not always have their mental healthcare needs met. The following tables present the results for the models including the regression coefficients, Wald statistics, odds ratios, and 95% CIs for the odds ratios.

Table 8

Summary of Logistic Regression Analysis for Variables Predicting Access to Physical Healthcare

Effect	ß	*SE*	95% CI		*p*	OR	Wald
			LL	*UL*			
Gay cis man white	.03	.26	.62	1.72	.9	1.03	.02
Gay cis man POC	-.41	.65	.19	2.36	.53	.67	.4
Gay trans/GNC white	1.1	1.16	.31	28.84	.34	3.00	.91
Lesbian cis woman white	.99	.29	1.51	4.77	.00	2.69	11.4
Lesbian cis woman POC	1.01	.58	.88	8.64	.08	2.75	3.00
Lesbian trans/GNC white	1.61	1.1	.58	42.8	.14	5.00	2.16
Bisexual cis man white	.00	1.41	.06	15.99	1.0	1.00	.000
Bisexual cis woman white	1.34	.46	1.56	9.41	.00	3.83	8.59
Bisexual cis woman POC	.69	1.23	.18	22.06	.57	2.00	.32
Bisexual trans/GNC white	1.1	.82	.61	14.86	.18	3.00	1.81

Note. CI = confidence interval; *LL* = lower limit; *UL* = upper limit; *OR* = odds ratio

Table 9

Summary of Logistic Regression Analysis for Variables Predicting Access to Mental Healthcare

Effect	ß	*SE*	95% CI		*p*	OR	Wald
			LL	*UL*			
Gay cis man white	1.1	.47	1.19	7.56	.02	3.00	5.43
Gay cis man POC	-.41	.91	.11	3.99	.66	.67	.2
Gay trans/GNC white	------	------	--------	-------	-----	-------	-------
Lesbian cis woman white	.92	.37	1.20	5.21	.01	2.50	6.00
Lesbian cis woman POC	.00	.82	.20	4.96	1.00	1.00	.00
Lesbian trans/GNC white	.00	1.41	.06	15.99	1.00	1.00	.00
Bisexual cis man white	------	------	--------	-------	-----	-------	-------
Bisexual cis woman white	1.18	.57	1.06	9.97	.04	3.25	4.25
Bisexual cis woman POC	------	------	--------	-------	------	-------	-------
Bisexual trans/GNC white	1.61	1.1	.58	42.8	.14	5.00	2.16

Note. CI = confidence interval; *LL* = lower limit; *UL* = upper limit; *OR* = odds ratio

Chapter 5: Interpretations, Conclusions, and Recommendations

Introduction – Overview of Study

The purpose of this study was to examine how sexual orientation, gender identity, and race/ethnicity both independently and intersectionally predicted access to healthcare among LGBTQ+ adults living in Washington, D.C., Maryland, and Virginia. Guided by Minority Stress Theory (Meyer, 2003) and the Theory of Intersectionality (Crenshaw, 1991), this study sought to extend prior research by moving beyond single-axis analyses to examine how overlapping social identities shape healthcare access within a specific regional and structural context. Findings indicate that sexual orientation, gender identity, and race/ethnicity were significant predictors of access to both physical and mental healthcare, though the patterns observed were not consistent with national trends. White LGBTQ+ participants, specifically White cis lesbian women, White cis bisexual women, and White cis gay men, were more likely to report unmet healthcare needs than LGBTQ+ people of color. This finding diverges from much of the existing literature and underscores the importance of considering regional context and structural factors when interpreting healthcare disparities. Intersectional analyses further revealed that specific combinations of social identities were associated with access barriers, reinforcing the value of multidimensional analytic approaches in LGBTQ+ health research.

Findings demonstrated that privilege in one domain (race) does not eliminate marginalization in another (sexual orientation or gender). Minority Stress Theory (Meyer, 2003) provides a unifying framework for understanding the patterns of healthcare access observed in the present study. The theory posits that sexual and gender minority individuals experience unique, chronic, and socially based stressors that exist in addition to general life stress. These stressors are structured at multiple levels, including distal stressors (i.e., discrimination,

structural exclusion, policy-level inequities) and proximal stress processes (i.e., internalized stigma, anticipated rejection, concealment, and vigilance). Over time, these stress processes accumulate and exert deleterious effects on both physical and mental health, as well as on health-seeking behaviors and engagement with healthcare systems (Meyer et al., 2021). In the context of the current findings, Minority Stress Theory helps explain why healthcare access is not solely determined by insurance status or geographic proximity to services, but is also shaped by individuals' anticipation of stigma, prior experiences of discrimination, and the structural organization of healthcare systems that remain fundamentally heteronormative and cis-normative.

This chapter situates findings within the broader empirical literature and interprets findings through Minority Stress Theory and The Theory of Intersectionality to clarify the mechanisms through which discrimination, structural barriers, and anticipated stigma influence access to physical and mental healthcare. Particular attention is given to the role of distal stressors and proximal stress processes in shaping access to healthcare. The discussion also considers how regional factors, including the presence of LGBTQ+ focused healthcare organizations and mandated cultural competency training, influence the observed patterns of access. The chapter concludes with an examination of study limitations, recommendations for future research, and implications for clinical practice aimed at improving access to affirming healthcare for LGBTQ+ adults. Next, I will outline unique dissertation results then I will interpret findings in the preceding section.

Several factors may explain why the findings of this dissertation differ from prior studies, including the demographic composition of Rainbow Families' LGBTQ+ Community Needs Assessment. First, the small number of participants identifying as trans or people of color may

have limited the statistical power of the logistic regression analyses. Logistic regression models with small subgroup sizes can yield unstable estimates, particularly when the number of cases per predictor is low (Long, 1997). Although no absolute sample size requirement exists, methodological guidelines recommend a minimum of 15–20 cases per predictor variable to ensure reliable estimation (Austin & Steyerberg, 2017), as smaller samples reduce power and limit the detection of statistically significant effects (Ali et al., 2019). Alas, the underrepresentation of trans participants and LGBTQ+ people of color may have impacted the observed results. While the findings remain internally valid, they are not generalizable and may inadequately capture the healthcare experiences of LGBTQ+ people of color.

Second, the sample is not representative of the racial and ethnic composition of Washington, D.C., Maryland, and Virginia, nor of the broader LGBTQ+ population. Census data indicated that the Washington, D.C., Maryland, Virginia metropolitan area is comprised of approximately 46% White, 24% Black, 15% Hispanic, and 9% Asian adults (U.S. Census Bureau, 2024). Nationally, 58% of LGBTQ+ adults identify as White, while 42% identify as people of color, including 21% Hispanic, 12% Black, and 2% Asian adults (Choi et al., 2021). In contrast, participants in Rainbow Families' LGBTQ+ Community Needs Assessment were disproportionately White (79%), with only 21% identifying as people of color, including 8% Black, 5% Hispanic, and 4% Asian adults. Overrepresentation of White LGBTQ+ adults and underrepresentation of LGBTQ+ adults from minoritized racial and ethnic groups limits the generalizability of the findings. The predominance of White participants limited the ability to examine how intersections of sexual orientation, gender identity, and race or ethnicity shape healthcare access.

Another potential explanation for the findings of the current dissertation is the presence of healthcare services specifically designed to address the needs of LGBTQ+ people of color within the study region. The comparatively greater access to physical and mental healthcare reported by LGBTQ+ people of color may reflect the sustained efforts of LGBTQ+ nonprofit organizations and federally qualified health centers (FQHCs), which have been shown to reduce structural barriers and improve access to affirming healthcare services (Furness et al., 2020; Matsuzaka et al., 2021; Romanelli & Hudson, 2017). As discussed in the sampling limitations section, the current sample was recruited from an urban region with a robust network of LGBTQ+-focused organizations and healthcare resources. Consequently, the findings must be interpreted within the broader healthcare context of Washington, D.C., Maryland, and Virginia, where affirming healthcare services are more readily available than in many other geographic regions.

Whitman-Walker Health, an LGBTQ+-focused FQHC, provides comprehensive physical and mental healthcare to LGBTQ+ adults and people of color in Washington, D.C., Maryland, and Virginia (Hudson, 2018). Approximately 9% of patients at Whitman Walker-Health identify as trans, 20% as Hispanic or Latina, and 30% as African American (Goldstein et al., 2019). Although most nontrans patients reside in Washington, D.C., many trans patients travel from surrounding states, including West Virginia, New York, Pennsylvania, North Carolina, Georgia, and Florida, and over 90% receive gender-affirming hormone therapy at Whitman Walker-Health (Goldstein et al., 2019). Prior research indicated that LGBTQ+ people of color are more likely to seek care from LGBTQ+-focused FQHCs due to their culturally responsive, integrated service models (Hudson, 2018). Consistent with available literature (Hudson, 2018; Macapagal et al., 2016), 21 participants in the current study reported receiving healthcare from Whitman-Walker

Health, suggesting that access to affirming healthcare services may have contributed to higher reported healthcare access among LGBTQ+ people of color. However, because LGBTQ+-focused FQHCs are not uniformly available across regions and the sample was drawn from an area with extensive LGBTQ+-specific healthcare infrastructure, the current findings should be interpreted cautiously and understood as context-specific rather than representative of national patterns.

An additional explanation for the study's findings may be the influence of legislative mandates governing provider education. The LGBTQ Cultural Competency Continuing Education Amendment Act (2016) requires all licensed healthcare providers in Washington D.C. to complete LGBTQ+–specific continuing education as a condition of license renewal. The comparatively greater access to physical and mental healthcare reported by LGBTQ+ people of color in the present study may reflect the effectiveness of this policy in reducing provider-related barriers to care. This pattern contrasts with national trends, which consistently document poorer access and worse physical and mental health outcomes among LGBTQ+ people of color (Daher et al., 2021; Homan et al., 2021; Robertson et al., 2021; Walubita et al., 2022). Together with the presence of LGBTQ+-focused organizations such as Whitman-Walker Health, mandated cultural competency training may have contributed to increased access to affirming healthcare for LGBTQ+ people of color within the current study. The following section examines each research question in relation to the existing literature, highlighting areas of convergence and divergence.

Interpretation - Discussion of Findings

Sexual Orientation as a Predictor of Healthcare Access

The first research question in this study examined whether access to physical and mental healthcare could be predicted by participants' sexual orientation. Results of regression analysis

indicated lesbian and bisexual sexual identities predicted reduced access to physical and mental healthcare. The results of this analysis align with previous research regarding the influence of sexual orientation on access to physical and mental healthcare (Batchelder et al., 2021; Dahlhamer et al., 2016; Dawson et al., 2025; Dilley et al., 2010; Downing & Rosenthal, 2020; Hirsch et al., 2016; Macapagal et al., 2016; Lindley et al., 2025; Liu & Reczek, 2021; Russell et al., 2022; Schuler et al., 2021; Tabaac et al., 2020). Compared to heterosexual women, lesbian and bisexual women experience a unique barrier to healthcare due to perceived or experienced discrimination (Barefoot et al., 2017; Elliot et al., 2015). There are multiple reasons why lesbian and bisexual adults reported barriers for physical and mental healthcare including provider discrimination, unemployment, health insurance limitations, and cost of care.

Sexual Orientation and Physical Healthcare

The results of this study indicated lesbian and bisexual identities predicted reduced access to physical healthcare in alignment with available literature. Historically, bisexual, and lesbian adults reported increased barriers to physical healthcare (Buchmueller & Carpenter, 2010; Damaskos et al., 2018; Dawes et al., 2025; Downing & Rosenthal, 2020; Hsieh et al., 2016; Schuler et al., 2021; Turpin et al., 2021). While there are no identified physiological differences between lesbian or bisexual women and heterosexual women, there are differences in health risk behaviors. Researchers found lesbian and bisexual women reported higher prevalence of obesity, tobacco use, and alcohol use, as well as increased rates of diabetes, heart disease, and cancer (Hsieh et al., 2016; Mravcak, 2006; O'Hanlan & Isner, 2007; Trinh et al., 2017; Wolstein et al., 2018). Despite these increased health risks, lesbian and bisexual women often lack access to physical healthcare. Researchers discussed how lesbian and bisexual women are more likely to experience unemployment (Charlton et al., 2018), financial instability (Downing & Rosenthal,

2020), rely on public health insurance (Alnabulsi & Talbert, 2024; Tabaac et al., 2021), and report difficulty obtaining healthcare (Bolibol et al., 2023; Hsieh et al., 2016; Jennings et al., 2019; Lindley et al., 2025) highlighting interconnected structural barriers for physical healthcare.

Given employment remains the primary pathway to health insurance for adults, higher rates of unemployment among lesbian and bisexual women significantly restrict access to employer-sponsored coverage and increase reliance on public insurance (Alnabulsi & Talbert, 2024; Charlton et al., 2018; Schuler et al., 2021). While public insurance mitigates some cost barriers, persistent financial constraints, coverage limitations, and cost-sharing requirements contribute to ongoing unmet healthcare needs among lesbian and bisexual women (Downing & Rosenthal, 2020; Russell et al., 2022). Workplace discrimination further undermines employment stability and access to affordable private insurance (Fish et al., 2021; Tabaac et al., 2021; Tolbert et al., 2024; Waters et al., 2024), reinforcing structural barriers to physical healthcare despite recent policy gains. Consistent with Minority Stress Theory (Meyer, 2003), these employment and insurance related barriers function as distal stressors, while ongoing financial strain and anticipated discrimination in healthcare settings may operate as proximal stress processes that collectively constrain access to care among lesbian and bisexual women.

Financial stability among lesbian and bisexual women may be linked to employment and insurance access. Prior researchers indicated that lesbian and bisexual women experience higher rates of employment and financial insecurity than heterosexual women (Schuler et al., 2021), a disparity that may be exacerbated by the gender wage gap, given women's lower average earnings relative to men (Iceland & Redstone, 2021). Lesbian and bisexual women may therefore experience greater economic disadvantage than heterosexual women or gay men. Additionally, partnered lesbian and bisexual women have historically faced barriers to accessing spousal health

insurance (Ponce et al., 2010), a challenge not encountered by heterosexual couples. Although policy reforms, including the Affordable Care Act and marriage equality, have expanded healthcare access for sexual minority populations (Bolibol et al., 2023), the present findings indicate that lesbian and bisexual women continue to experience substantial barriers to care.

Current findings can be interpreted through Minority Stress Theory (Meyer, 2003), which conceptualizes health disparities among sexual minority populations as the cumulative result of chronic exposure to both distal and proximal stressors. Distal stressors, including structural discrimination, workplace marginalization, and economic exclusion, may contribute to higher rates of unemployment, financial instability, and reliance on public insurance among lesbian and bisexual women, thereby limiting access to physical healthcare. Proximal stressors such as anticipated stigma, hypervigilance, and prior negative healthcare experiences may further discourage engagement with healthcare systems, particularly for preventive and routine healthcare. Over time, the accumulation of these stress processes may exacerbate health risk behaviors and physical health conditions while simultaneously limiting access to affirming physical healthcare. Thus, disparities in access to physical healthcare among lesbian and bisexual women reflect not only socioeconomic disadvantage but also the embodied consequences of sustained minority stress operating across structural and interpersonal domains.

The findings of this dissertation align with existing literature regarding the existence access barriers among lesbian and bisexual adults. Prior research indicated lesbian and bisexual participants reported barriers to physical healthcare including unemployment, affordability of healthcare, and experiences of provider discrimination. Moreover, prior research suggested both the financial burdens associated with healthcare and the significant impact of discrimination within physical healthcare for lesbian and bisexual women. Dissertation findings highlight the

interconnected structural barriers that continue to impede healthcare access for lesbian and bisexual adults.

Sexual Orientation and Mental Healthcare

The results of this study indicated lesbian and bisexual identities predicted reduced access to mental healthcare which is in alignment with available literature. Unique experiences of discrimination may have a deleterious effect on lesbian and bisexual women's mental health which function as distal minority stressors embedded in healthcare systems (Meyer, 2003). Researchers found lesbian and bisexual women reported higher instances of isolation, and lack of support from family or friends (O'Hanlon & Isler, 2007; Martinez et al., 2024). Researchers also found lesbian and bisexual women struggled with alcohol and drug use (Rosario, 2008). Compared to heterosexual women, lesbian and bisexual women are more likely to experience a major depressive episode, suicidal thoughts, and attempt suicide (Kerr et al., 2013; Wilson et al., 2021). Despite the increased risks, lesbian and bisexual women often lack access to mental healthcare (Moagi et al., 2021; Trinh et al., 2017; Williams et al., 2021). Among lesbian and bisexual women without access to care, cost was the most cited barrier followed by not knowing where to go for care, and fear of involuntary commitment (Dahlhamer et al., 2016). Furthermore, lesbian, and bisexual women may avoid mental healthcare due to provider discrimination (Hempleler et al., 2024). This avoidance reflects proximal minority stress processes, like anticipated stigma and hypervigilance, which discourage engagement with mental healthcare.

Given lesbian and bisexual women report a higher number of adverse childhood experiences compared to heterosexual women (Blosnich & Andersen, 2015), these accumulated stressors may contribute to their elevated risk for adverse mental health outcomes. Within a minority stress framework, elevated exposure to adverse childhood experiences may compound

later distal and proximal stressors, amplifying vulnerability to mental health disparities. Researchers discussed how lesbian and bisexual women faced an earlier mortality compared to heterosexual women due to high-risk behaviors such as tobacco and alcohol use and unmet mental health needs (McKetta et al., 2024). Viewed through Minority Stress Theory (Meyer, 2003), structural barriers, and discrimination operate as distal stressors, while fear of mistreatment, internalized stigma, and avoidance of care function as proximal stress processes, jointly limiting access to mental healthcare among lesbian and bisexual women.

Lesbian and bisexual participants in this study affirmed previous research findings on healthcare disparities for physical and mental healthcare. Structural determinants of health including financial instability, unemployment, and reliance on public health insurance create and/or maintain systemic barriers to both physical and mental healthcare for lesbian and bisexual women. Yet LGBTQ+ adults experienced a myriad of stressors including racial discrimination (Choi et al., 2021; McConnell et al., 2018) and gender discrimination (Scott, Knopp, et al., 2023; Smart et al., 2022), highlighting multiple dimensions of discrimination in healthcare.

Gender Identity as a Predictor of Healthcare Access

The second research question in this study examined whether access to physical and mental healthcare could be predicted by participants' gender identity. Results of regression analysis indicated trans and cis woman gender identities predicted reduced access to physical healthcare while cis woman and cis man gender identities predicted reduced access to mental healthcare. The results of this analysis align with previous research regarding the impact of gender identity on access to healthcare. Previously, researchers found participants who identify as trans are more likely to report barriers to physical healthcare (Berrian et al., 2025; Clark et al., 2023; Feldman et al., 2021; Gonzales & Henning-Smith, 2017; Pachankis et al., 2021;

Polizopoulos-Wilson et al., 2021; Stepleman et al., 2019; Tordoff et al., 2023). There are multiple reasons why trans adults and cis women may experience access barriers for physical healthcare such as provider discrimination and health insurance limitations. Fear of provider discrimination and challenges with insurance are identified as barriers to physical healthcare for trans adults. Also, cis women's caregiving responsibilities can impact other identified barriers to care including employment and access to health insurance (Vohra-Gupta et al., 2022).

These findings can be further understood through Minority Stress Theory (Meyer, 2003), which posits that health disparities among marginalized populations arise from chronic exposure to both distal stressors, such as structural discrimination and institutional barriers, and proximal stress processes, including fear of mistreatment, hypervigilance, and healthcare avoidance. From this perspective, gender identity shapes access to healthcare not only through material constraints (i.e., insurance coverage, provider availability), but also through cumulative stress processes that influence if adults feel safe seeking care and if care is experienced as accessible or affirming.

Gender Identity and Physical Healthcare

The results of this study indicated trans and cis woman gender identities predicted reduced access to physical healthcare which is in alignment with available literature. A potential explanation for dissertation results could be the caregiving role cis women hold within society (Stall et al., 2023). Caregiving responsibilities hinders women's ability to access healthcare by creating financial and logistical constraints including unemployment or underemployment hindering their ability to access full-time employment, health insurance, and healthcare services (Cardoso et al., 2021). Caregiving often leads to reduced work hours or job loss for cis women, which contributes to financial instability and the influences affordability of healthcare. Lack of supportive workplace policies such as paid leave or affordable daycare forces cis women to

choose between work and caregiving responsibilities limiting career advancement and personal health management (Son Hing et al., 2023). Caregiving responsibilities can also lead to chronic stress, burnout, and physical health issues for cis women. Women caregivers are more likely to suffer from anxiety, depression, sleep disorders, and chronic health conditions like hypertension and diabetes (Li et al., 2021). Due to caregiving responsibilities, cis women may leave the work force and then must rely on public health insurance to access healthcare (Damaske, 2023).

The role of caregiver can have a unique impact on cis women and their ability to access healthcare (Stall et al., 2023) with single women more likely to report barriers to care (Vohra-Gupta et al., 2022). Caregiving responsibilities can lead to a delay in healthcare or cis women may forgo their healthcare due to lack of alternative care for children or elderly parents (Arbaugh et al., 2024; Finneran et al., 2023; Gaur et al., 2020). Researchers emphasized lack of alternative care often delayed preventative care with cis women missing an average of 3 to 4 visits per year (Arbaugh et al., 2024; Ganguly et al., 2025; Gaur et al., 2024). Researchers discussed strategies to increase attendance such as providing childcare at healthcare facilities (Arbaugh et al., 2024; Gaur et al., 2024) and employer-based childcare subsidies (Sano et al., 2020). Until structural supports including paid leave and affordable childcare are expanded, cis women will continue to forgo their own physical healthcare needs making it harder to manage their own personal health. Perhaps it could be that cis women felt they could not access healthcare due to employment limitations such as working part-time with no access to health insurance benefits, provider limitations due to reliance on public health insurance associated with unemployment and underemployment, or time limitations due to caregiving responsibilities. While dissertation results were surprising, other researchers also found cis women experienced access barriers for physical healthcare.

Within a minority stress framework, caregiving responsibilities can be conceptualized as a gendered distal stressor embedded in broader systems of sexism and labor inequity. Cis women's disproportionate responsibility for caregiving reflects structural gender norms that limit access to stable employment, employer-sponsored insurance, and flexible scheduling, thereby constraining healthcare access. Over time, these structural pressures contribute to chronic stress, financial strain, and healthcare postponement, which function as pathways through which gender-based inequality translates into unmet physical healthcare needs.

Finneran et al. (2023) found cis women and trans adults are more likely to delay seeking physical healthcare but for distinct reasons. Cis women were more likely to delay care due to lack of childcare whereas trans adults were more likely to delay care due to "nervousness associated with visiting a healthcare provider" (Finneran et al., 2023, p. 1158); this nervousness includes fear of discrimination such as negative words of actions during healthcare appointments (Samulowitz et al., 2018). Consequently, it is not surprising that trans participants within the current study reported a lack of access to physical healthcare. There are multiple explanations for access barriers like fear of discrimination (Cascalheira & Choi, 2023; Meyer et al., 2021; James et al., 2024), health insurance limitations (Berrian et al., 2024; Alnabulsi & Talbert, 2024; Ramsey et al., 2022), and gender bias (Samulowitz et al., 2018). Gender bias in healthcare has a negative effect on those who providers identify as feminine, including trans adults, due to less knowledge of female and trans health than male health (Samulowitz et al., 2018; Villines, 2022).

A potential explanation for dissertation results could be the impact of discrimination. While trans adults experience stressors that all people experience in day-to-day life, trans adults also experience a chronic level of stress related to ongoing occurrences of discrimination (Cascalheira & Choi, 2023; Meyer et al., 2021). Trans adults are more likely to experience

discrimination from healthcare providers including refusal of care, use of incorrect pronouns, use of abusive language, or use of physical force during examination in addition to verbal, physical, or sexual assault (Berrian et al., 2024; Feldman et al., 2021; Holt et al., 2022; James et al., 2024; Jennings et al., 2019; Macapagal et al., 2016; Nowaskie & Menez, 2024; Stepleman et al., 2019) which contributed to future delays in seeking care (Babey et al., 2022; Casey et al., 2019; Tabaac et al., 2021; Zeeman et al., 2019). Fear of mistreatment deterred one-quarter (24%) of trans adults from seeking necessary care (James et al., 2024), a pattern also observed in James et al. (2016), indicating that healthcare experiences have not improved over time.

Another potential explanation for findings is the role of health insurance, as trans adults are more likely to rely on public coverage (Alnabulsi & Talbert, 2024; Ramsey et al., 2022). Even when gender-affirming care is covered, access barriers such as coverage denials and limited availability of in-network providers remain substantial (Bakko & Kattari, 2020; Berrian et al., 2024). Some insurers required a diagnosis of gender dysphoria to authorize care (Bhatt et al., 2022; Schulz et al., 2018), while failing to cover the mental health evaluations necessary to obtain the diagnosis (Shelton & Lester, 2020). These gaps in coverage for gender affirming care often shift costs to patients, forcing trans adults to pay out of pocket, further restricting access to physical healthcare. For trans adults, delayed or avoided physical healthcare reflects both distal and proximal minority stress processes. Distal stressors include documented experiences of provider discrimination, denial of care, and insurance exclusions, while proximal stress processes manifest as anticipatory stigma, fear of mistreatment, and heightened anxiety surrounding healthcare encounters. The “nervousness” described by trans participants is consistent with minority stress theory’s emphasis on hypervigilance and avoidance as adaptive responses to

repeated exposure to discrimination, responses that nonetheless reduce access to care over time (Meyer, 2003).

From a minority stress perspective, insurance barriers to gender-affirming care constitute structural stressors that systematically undermine access to healthcare for trans adults. Coverage denials and limited in-network provider availability not only create financial barriers but also reinforce expectations of mistreatment within healthcare systems. These structural conditions exacerbate minority stress by signaling institutional non-affirmation, increasing healthcare avoidance and contributing to unmet physical healthcare needs. Collectively, these findings illustrate how gender identity shapes access to physical healthcare through interconnected structural and psychological pathways, consistent with Minority Stress Theory. While cis women and trans adults encounter distinct barriers, both groups experience chronic, identity-related stressors that accumulate over time and restrict access to affirming physical healthcare.

Gender Identity and Mental Healthcare

The results of this study indicated cis woman and cis man gender identities predicted reduced access to mental healthcare. This result is noteworthy given cis men, and cis women are more likely to have employer-based insurance or public insurance (Alnabulsi & Talbert, 2024). Despite insurance coverage for physical healthcare, cis women and cis men cited lack of insurance coverage for mental healthcare then costs of care as barriers to mental healthcare (Daher et al., 2022; Dahlhamer et al., 2016). Due to potential systemic barriers to care including affordability of mental healthcare services and health insurance limitations, participants within the current study provided a novel finding indicating access barriers for mental healthcare among cis women and cis men. While these results were surprising, other researchers within the field also found cis women as well as cis men had trouble accessing mental healthcare.

Previous research examining the impact of gender identity on access to mental healthcare found cis men are more likely to report a delay in mental healthcare whereas cis women are more likely to report a shortage of mental healthcare providers (Lindley et al., 2025; Rapp et al., 2021). Delays in care and lack of access can be indicative of underlying barriers. Researchers identified negative healthcare experiences, lack of insurance coverage, and costs of care (Cardoso et al., 2021; Daher et al., 2021; Vohra-Gupta, et al., 2023) as additional structural barriers to mental healthcare for cis women. Yet cis men are more likely to postpone mental healthcare due to discrimination (Macapagal et al., 2016) and report difficulty finding a new mental healthcare provider (Dahlhamer et al., 2016). Literature review by Rees et al. (2020) emphasized lesbian, gay and bisexual (LGB) adults often reported stigma, discrimination, lack of provider knowledge surrounding LGBTQ+ community needs, and lack of competence in working with LGB community members as shared barriers to accessing mental healthcare.

Gender norms and cultural expectations may discourage cis men from seeking mental healthcare. Researchers discussed how cis men experience mental health challenges due to societal expectations to avoid vulnerability (Gough & Novikova, 2020). Researchers suggested that cis men were least likely to seek mental healthcare (Prasath et al., 2023) which may be attributed to shame and stigma thereby reducing cis men's use of mental healthcare (Seehuus et al., 2021). Moreover, researchers found identification with a masculine gender role led to avoidance of mental healthcare despite need for care (Abshire et al., 2021; Christiansen & Hansen, 2015; Williams et al., 2021). An avoidance of mental healthcare may be attributed to the stigma surrounding mental health and masculinity, which is alarming given cis men are more likely to die by suicide than cis women (Ahmad et al., 2024). Furthermore, cis gay men have higher rates of domestic violence, substance abuse, and depression compared to heterosexual cis

men (Bass & Nagy, 2023). These factors contribute to unique mental health challenges for cis gay men and can increase their vulnerability to mental health and substance use disorders as well as suicide highlighting the need for access to care. LGBTQ+ adults' marginalized identity can increase exposure to stressors and increase the risk for health disparities (Meyer et al., 2021), which are further exacerbated by inability to access mental healthcare.

These findings can be understood through Minority Stress Theory (Meyer, 2003), which posits that sexual minority individuals experience chronic, identity-related stressors that extend beyond general life stress and directly shape health behaviors and access to care. Although cis women and cis men are more likely to hold employer-based or public insurance, insurance coverage alone does not protect against minority stress processes that uniquely affect LGBTQ+ adults, particularly in mental healthcare settings. Structural barriers such as limited mental health coverage, high out-of-pocket costs, and shortages of affirming providers function as distal stressors, while prior negative healthcare experiences, anticipated stigma, and fears of invalidation operate as proximal stress processes that discourage help-seeking. For cis LGB adults, mental healthcare may represent a particularly vulnerable context in which sexual orientation is more likely to be disclosed. Prior research indicates that cis men are more likely to delay mental healthcare due to discrimination and difficulty locating affirming providers, whereas cis women more frequently encounter provider shortages and cost-related barriers.

Within a minority stress framework, healthcare delays and avoidance behaviors can be understood not as individual reluctance, but as adaptive responses to anticipated stigma and repeated exposure to non-affirming systems. Over time, such avoidance exacerbates mental health disparities by limiting early intervention and continuity of care. Gender norms further interact with minority stress processes, particularly for cis men. Societal expectations which

emphasize emotional restraint and self-reliance contribute to internalized stigma surrounding mental health help-seeking, intensifying proximal stress processes such as shame and concealment. For cis gay men, these dynamics are compounded by elevated exposure to sexual orientation based discrimination and higher prevalence of depression, substance use, and interpersonal violence. Consistent with Minority Stress Theory (Meyer 2003. Meyer et al., 2021), the cumulative impact of distal structural barriers and proximal stress responses helps explain why cis LGB adults, despite insurance coverage, continue to experience significant barriers to accessing affirming mental healthcare. These patterns underscore that privilege in gender identity does not negate exposure to sexual orientation based minority stress.

Race/Ethnicity as a Predictor of Healthcare Access

The third research question in this study examined whether access to physical and mental healthcare could be predicted by participants' race/ethnicity. Results of regression analysis indicated that White race/ethnicity predicted reduced access to physical and mental healthcare. The results of this analysis were unexpected given racial and ethnic healthcare disparities are well-documented, with minority groups often experiencing barriers such as differences in insurance coverage, access to primary care, and quality of healthcare (Apodaca et al., 2022; Waters et al., 2024). Historically, Black, Indigenous, and People of Color (BIPOC) reported decreased access to healthcare (Apodaca et al., 2022; Bleich et al., 2019; Harris et al., 2020; Parmenter et al., 2021; Waters et al., 2024). Within the current study, however, White LGBTQ+ adults reported decreased access to physical and mental healthcare. Dissertation results contrast

with the available literature but there may be an explanation for results including provider discrimination towards LGBTQ+ identities and the location of healthcare services.

A potential explanation for dissertation results is the location of healthcare. One question in Rainbow Families' LGBTQ+ Community Needs Assessment asked participants to identify location of healthcare services. For physical healthcare, most participants reported they receive physical healthcare from a general (non-LGBTQ+) organization or clinic (65%) with nearly half as many participants receiving physical healthcare from a general (non-LGBTQ+) organization or clinic but with an LGBTQ+ specific program or provider (28%) and even fewer participants receiving physical healthcare from an LGBTQ+ focused organization or clinic (7%). For mental healthcare, most participants reported they receive mental healthcare from a general (non-LGBTQ+) organization or clinic (53%) with nearly half as many participants receiving mental healthcare from a general (non-LGBTQ+) organization or clinic but with an LGBTQ+ specific program or provider (31%) and even fewer participants receiving mental healthcare from an LGBTQ+ focused organization or clinic (16%).

Dissertation results align with previous researchers (Hudson, 2018; Macapagal et al., 2016; Wilson et al., 2022) who found White LGBTQ+ adults are more likely to receive healthcare at non-LGBTQ+ organizations compared to LGBTQ+ people of color who rely on LGBTQ+ organizations or public clinics for access to care. These patterns can be understood through Minority Stress Theory (Meyer, 2003) framework, which posits that healthcare environments structured around cis-heteronormative assumptions function as distal stressors for LGBTQ+ community members. Receiving healthcare services in general, non-LGBTQ+ healthcare settings may increase exposure to invalidation, microaggressions, and institutional

non-affirmation, thereby elevating stress and undermining perceptions of care adequacy for LGBTQ+ adults.

LGBTQ+ focused FQHCs provide increased access to physical and mental healthcare for all LGBTQ+ adults, especially LGBTQ+ people of color, by addressing systemic barriers such as lack of insurance, cost of care, as well as stigma and shame through specific programs dedicated to LGBTQ+ health (Hudson, 2018). Whitman-Walker Health, a LGBTQ+ focused FQHC, could be a potential explanation for dissertation results due to three social justice-oriented features (HRSA, 2023). First, FQHCs are required to provide healthcare services to everyone within an underserved area regardless of ability to pay for healthcare services. Second, FQHCs conduct detailed needs assessments every three years to ensure that healthcare meets the needs of the community by addressing barriers to care. Third, FQHCs are required to provide "enabling services", defined as "non-clinical services that do not include direct patient care that enable the individual to access healthcare and improve health outcomes" (HRSA, 2023, p. 2) including case management, transportation and childcare. LGBTQ+ focused FQHCs provide more mental healthcare and enabling services compared to the national average (Hudson, 2018) suggesting potential for expanded access to healthcare for LGBTQ+ adults in the current study.

From a minority stress perspective, LGBTQ+-focused FQHC may serve as protective environments that reduce exposure to distal stressors and buffer proximal stress processes by offering affirming care, enabling services, and institutional validation of LGBTQ+ identities (Meyer et al., 2021). These features may mitigate anticipated stigma and reduce the need for vigilance during healthcare encounters. However, dissertation results suggest White LGBTQ+ adults are less likely to receive healthcare from a LGBTQ+ focused FQHC in alignment with available literature (Hudson, 2018; Macapagal et al., 2016; Wilson et al., 2022) suggesting White

LGBTQ+ adults within the current do not benefit from increased access to healthcare and enabling services provided by Whitman-Walker Health. The lower likelihood that White LGBTQ+ adults receive care from LGBTQ+-focused FQHCs suggests reduced access to these stress buffering resources. In the absence of affirming institutional contexts, White LGBTQ+ adults may experience greater cumulative minority stress despite racial privilege, particularly when navigating general healthcare systems that remain heteronormative and cis-normative.

Dissertation results could also be indicative of dominant institutional paradigms and broader societal norms that frame health in white cis-heteronormative terms which influences conceptualization of health and healthcare. Researchers discussed how BIPOC conceptualize health as survival whereas white people conceptualize health as access to care (Cosse et al., 2024). Given White people equate access to care with the experience of being treated fairly (Fish et al., 2021), White LGBTQ+ adults may be shocked by discrimination. Minority Stress Theory explains why White LGBTQ+ adults may report heightened distress in response to provider discrimination. While racial privilege may reduce prior exposure to systemic mistreatment, encounters with healthcare discrimination related to sexual orientation or gender identity can activate proximal stress processes, including anticipated stigma, hypervigilance, and mistrust of providers (Meyer, 2003). Therefore, provider discrimination towards LGBTQ+ adults regardless of race/ethnicity is another potential explanation for dissertation results with barriers such as provider discrimination universal within the LGBTQ+ community (Montero et al., 2024).

In the absence of consistent access to affirming healthcare, LGBTQ+ adults, including White LGBTQ+ adults, continue to encounter substantial barriers to care rooted in discrimination and structural inequities (Sileo et al., 2023). Prior research indicates that many White LGBTQ+ adults report discriminatory experiences in healthcare settings, with fear of providers widely

endorsed across the LGBTQ+ population (Casey et al., 2019). In addition to provider-related barriers, White LGBTQ+ adults face significant financial constraints, including higher rates of uninsurance, reduced access to employer-sponsored coverage, and increased medical debt relative to White non-LGBTQ+ adults (Wilson et al., 2022). These disparities are compounded by higher rates of unemployment and uninsurance, which force greater reliance on out-of-pocket payment and contribute to delayed care, financial strain, and unmet healthcare needs (Park et al., 2021; Roberts, 2021; Shih et al., 2022). White LGBTQ+ adults also report higher prevalence of anxiety, depression, chronic health conditions, and health-risk behaviors compared to their non-LGBTQ+ counterparts (Montero et al., 2024; Wilson et al., 2022). Consistent with Minority Stress Theory, fear of discrimination, insurance instability, and financial strain likely function as interrelated distal stressors that cumulatively discourage healthcare engagement, contributing to delayed care and worsening health outcomes over time (Meyer, 2003; Meyer et al., 2021).

Rethinking Privilege and Access in Regional LGBTQ+ Healthcare Contexts

Although White LGBTQ+ adults do not experience race-based barriers to care, White LGBTQ+ adults remain exposed to chronic, identity-based stressors embedded within healthcare systems structured around cis-heteronormative norms; these findings are well explained by Minority Stress Theory (Meyer, 2003; Meyer et al., 2021). Reliance on general healthcare settings may increase exposure to distal stressors such as institutional non-affirmation and provider discrimination, while financial instability and insurance gaps further intensify stress. In the absence of affirming environments such as LGBTQ+-focused FQHCs, these distal stressors may activate proximal stress processes including fear, vigilance, and mistrust that undermine access to both physical and mental healthcare. Current results underscore that racial privilege

does not insulate LGBTQ+ adults from minority stress and highlight the importance of affirming healthcare environments as critical buffers against cumulative stress exposure.

Given the disparities in access to healthcare observed in this study, more research on LGBTQ+ adults' access to healthcare is needed. Results of this dissertation suggest access to healthcare is limited among a population already disproportionately affected by negative physical and mental health outcomes. These findings underscore the importance of moving past cis-heteronormative institutional paradigms and reconceptualizing healthcare by understanding healthcare disparities and addressing social hierarchies responsible for inequalities. Structural systems of oppression such as racism, sexism, biphobia, and transphobia influence access to healthcare with adults who occupy positions at the top of each social hierarchy experiencing the best health (Homan et al., 2021). Furthermore, The combined influence of social identities increased the likelihood of discrimination for LGBTQ+ adults (Cyrus, 2017; McConnell et al., 2018) and the collective influence on access to healthcare warrants further exploration.

Intersection of Identities as a Predictor of Healthcare Access

The fourth research question in this study whether access to physical and mental healthcare could be predicted by the intersection of participants' social identities. Regression analysis indicated that White cis lesbian, and White cis bisexual identities predicted reduced access to physical healthcare, while White cis lesbian, White cis bisexual, and White cis gay identities predicted reduced access to mental healthcare. This pattern contrasts with prior research, which consistently demonstrates that LGBTQ+ people of color experience greater healthcare barriers due to compounded discrimination related to racism, sexism, biphobia, and transphobia (Apodaca et al., 2022; Harris et al., 2020; Huang et al., 2024; Scott, Gaska, et al., 2023; Scott, Knopp, et al., 2023; Mathur et al., 2024). Discrimination has been linked

underutilization of healthcare (Loeb et al., 2024; Whitehead et al., 2016), healthcare delays (Apodaca et al., 2022; Haviland et al., 2020; Glick et al., 2018), and avoidance of healthcare services (Casey et al., 2019; Okoro et al., 2020), disproportionately affecting LGBTQ+ people of color (Drabish & Theeke, 2022; Smith, 2020; Williams et al. 2019).

In contrast, findings indicate that White cis lesbian, gay, and bisexual adults experience barriers to healthcare. While reduced access among White cis lesbian and bisexual women aligns with existing literature, the identification of mental healthcare barriers among White cis gay men represents a novel contribution. Prior studies documented that White cis LGB adults experience poorer physical and mental health, higher engagement in health-risk behaviors, and greater likelihood of being uninsured or unemployed compared to White heterosexual adults (Montero et al., 2024; Trinh et al., 2017; Wilson et al., 2021; Wilson et al., 2022). Despite racial privilege, White LGBTQ+ adults reported higher rates of discrimination than White non-LGBTQ+ adults, underscoring that Whiteness does not negate sexual minority stress (Montero et al., 2024; Wilson et al., 2022). Although Whiteness confers certain societal privileges, identifying as LGBTQ+ introduces distinct forms of marginalization which shape healthcare experiences and demonstrate the effects of intersecting social identities for LGBTQ+ adults within the current study.

Findings illustrate how intersecting identities produce distinct patterns of healthcare access and demonstrate that LGBTQ+ status remains a salient axis of marginalization shaping healthcare experiences. Although White LGBTQ+ adults benefit from racial privilege relative to LGBTQ+ people of color, Minority Stress Theory (Meyer et al., 2021) suggests that sexual minority stressors may independently and cumulatively shape healthcare access. Chronic exposure to stigma, discrimination, and heteronormativity within healthcare systems can undermine trust in providers, increase healthcare avoidance, and reduce engagement with both

physical and mental healthcare, even among White cis adults. Minority Stress Theory provides a useful framework for understanding the current findings. Minority Stress Theory (Meyer, 2003) posits that sexual and gender minority individuals experience chronic stress arising from stigmatization, discrimination, and social marginalization, which operates at both structural (i.e., institutional barriers, policy exclusions) and interpersonal levels (i.e., discrimination, provider bias). These stressors accumulate over time and negatively affect health outcomes and access to healthcare, even among individuals who otherwise hold socially privileged identities.

Within Minority Stress Theory, barriers such as provider discrimination, insurance exclusions, and heteronormative healthcare practices function as distal stressors, or external, objective stressors imposed on sexual minority individuals. Minority Stress Theory further emphasizes proximal stress processes, including expectations of rejection, vigilance, and internalized stigma. Avoidance of healthcare, delays in seeking care, and dissatisfaction with providers observed among White cis LGB participants may reflect anticipatory stress resulting from prior discriminatory experiences or fears of future stigmatization within healthcare settings.

Intersection of Identities and Physical Healthcare

The results of this study indicated White cis lesbian, and White cis bisexual identities reduced access to physical healthcare, consistent with prior literature. Researchers found White cis lesbian and bisexual women have lower rates of private insurance coverage and higher rates of uninsurance than their heterosexual counterparts (Charlton et al., 2018; Gonzales & Blewett, 2014; Lunn et al., 2017; Montero et al., 2024; Wilson et al., 2022), suggesting insurance instability as a key mechanism underlying these results. Moreover, reliance on public insurance is itself associated with additional barriers, including service denial at non-accepting facilities and stigmatizing treatment at accepting facilities (Okoro et al., 2020; Vohra-Gupta et al., 2023),

indicating that stigma surrounding public coverage further constrains access to healthcare. From a Minority Stress Theory perspective, insurance instability and stigma surrounding public coverage function as distal stressors embedded within healthcare systems, disproportionately limiting healthcare access for sexual minority women despite formal coverage eligibility.

Although public insurance may be more accessible (Sears et al., 2025), LGBTQ+ adults are more likely to experience restricted coverage of services under public plans (Alnabulsi & Talbert, 2024). Notably, lesbian and bisexual women report out-of-pocket costs for preventive services ostensibly covered under the Affordable Care Act, including Pap smears, mammograms, and colonoscopies (Biddell et al., 2021), contributing to medical debt among approximately 40% of this population (Lupez et al., 2025). Medical debt reflects the cumulative effects of structural sexism, including gender-based wage inequities and disproportionate caregiving demands that limit full-time employment and access to employer-sponsored insurance (Arbaugh et al., 2024; Daher et al., 2021; Ganguly et al., 2025; Gaur et al., 2024; Jain et al., 2024; Stall et al., 2023). Within Minority Stress Theory, medical debt represents an embodied consequence of intersecting structural stressors, including sexism, sexual minority stigma, and labor inequities, that systematically undermine access to stable healthcare coverage. Consequently, lesbian and bisexual women utilized routine physical healthcare services less frequently (Ganguly et al., 2025; Kelly-Brown et al., 2022; Tabaac et al., 2021) and reported higher levels of unmet need due to cost (Biddell et al., 2021; Daher et al., 2021; Hsieh et al., 2016; Nguyen et al., 2018; Rapp et al., 2021) identifying affordability as a salient pathway explaining the present findings.

Beyond structural barriers, fear of discrimination further limits access to preventive care. Anticipated or prior negative provider interactions deter lesbian and bisexual women from seeking routine physical healthcare services (Gillani et al., 2024; Tracy et al., 2010). Minority

Stress Theory conceptualizes these processes as proximal stressors, or anticipated stigma, fear of mistreatment, and hypervigilance, which discourages engagement even when services are available. Consistent with this framework, lesbian and bisexual women lacking a trusted provider are significantly less likely to utilize preventive services such as mammography, colonoscopy, and Pap smears (Kim et al., 2022; Nelson et al., 2023). Access to trusted providers may mitigate minority stress by reducing anticipatory stigma and facilitating sustained engagement in preventive care, thereby improving early detection and treatment outcomes (McKay et al., 2023). Current findings align with Minority Stress Theory by demonstrating that intersecting structural and interpersonal stressors, rather than individual health behaviors alone, contribute to persistent barriers to physical healthcare access among White cis lesbian and bisexual women. Therefore, reduced access to physical healthcare reflects the cumulative impact of structural and interpersonal stressors associated with sexual minority status, rather than isolated economic or logistical barriers.

Intersection of Identities and Mental Healthcare

The results of this study indicated White cis lesbian, White cis bisexual, White cis gay identities predicted reduced access to mental healthcare. Although unexpected, these results may be understood in the context of elevated mental health needs within LGBTQ+ populations, including higher prevalence of mood and anxiety disorders, substance use disorders, and suicidality (Bostwick et., 2010; Kates et al., 2018; Lu et al., 2025; Medina-Martinez et al., 2021; McCabe et al., 2009; McCarthy et al., 2014; Lee et al., 2017). Limited access to mental healthcare may exacerbate these disparities by constraining opportunities for early intervention and treatment (Lee et al., 2017), particularly among bisexual adults, who consistently report higher rates of psychological distress and unmet mental health needs (Bostwick et., 2010;

Dawson et al., 2025; Medina-Martinez et al., 2021; Steele et al., 2017). Notably, although LGBTQ+ adults utilize mental healthcare at higher rates than heterosexual adults, they are also more likely to report disparities in access and quality of care (Platt et al., 2018; Williams, 2022).

Mental healthcare access among LGBTQ+ adults is shaped not only by availability but also by provider competence. Prior research indicates that clinicians' limited knowledge of LGBTQ+ identities and health concerns contributes to dissatisfaction and disengagement from care (Rees et al., 2020). While cis men are more likely than cis women to report access to affirming mental healthcare (McKay et al., 2023), Minority Stress Theory (Meyer et al., 2021) provides a critical explanatory pathway linking elevated rates of mood disorders, substance use, and suicidality among LGBTQ+ adults to barriers in mental healthcare. Minority Stress Theory offers a unifying framework for understanding how chronic exposure to stigma related stressors increases vulnerability to mental health conditions while simultaneously discouraging engagement with mental healthcare due to anticipated judgment, invalidation, or discrimination.

Despite racial privilege, White cis lesbian and bisexual women may face multiple structural barriers to mental healthcare, including insurance limitations, affordability, and restricted provider choice. Reliance on in network providers combined with the high cost of out of network care may further limit access, particularly for those with caregiving responsibilities and limited flexibility, contributing to appointment nonadherence. These findings underscore the role of structural conditions, rather than individual preferences, in shaping mental healthcare access and highlight the need for systemic interventions, including expanded insurance coverage, affordable childcare, and flexible paid leave. White cis gay men similarly encounter barriers to mental healthcare, particularly those rooted in stigma and provider bias. Dissatisfaction with care often arises when clinicians display judgment toward same sex relationships, rely on

heteronormative assumptions, or demonstrate limited knowledge of gay men's health concerns (Frye et al., 2015; Glick et al., 2012; Griffin et al., 2019). Such negative experiences may activate minority stress processes, including vigilance and avoidance, leading to reduced utilization of mental healthcare despite elevated need (Clark et al., 2025; Macapagal et al., 2016; Martos et al., 2018). Structural barriers, including insurance limitations, cost of care, and provider discrimination, further compound these challenges (Dawes et al., 2023).

An intersectional application of Minority Stress Theory clarifies how sexual minority stressors persist across racial identities, albeit with variation in form and intensity. While LGBTQ+ people of color may experience compounded stress due to racism and heterosexism, White LGBTQ+ adults remain subject to discrimination, and heteronormativity that meaningfully shape mental healthcare access. Collectively, these findings demonstrate that racial privilege does not eliminate minority stress but instead intersects with sexual identity to produce distinct patterns of healthcare inequity. Structural barriers, provider bias, and anticipatory stress contribute to both physical and mental healthcare disparities, underscoring the need for systemic interventions that address minority stress within healthcare environments. From a Minority Stress Theory perspective, healthcare providers and healthcare systems play a critical role in either perpetuating or mitigating minority stress, positioning affirming, inclusive care as a necessary intervention to reduce healthcare disparities among LGBTQ+ adults.

Summary of Findings

The results of this study suggest that White lesbian cis women and White bisexual cis women experience reduced access to physical healthcare whereas White lesbian cis women, White bisexual cis women, and White gay cis men experience reduced access to mental healthcare. These findings can be most coherently interpreted through Minority Stress Theory

(Meyer, 2003), which distinguishes between distal stressors (i.e., discrimination, structural exclusion) and proximal stress processes (i.e., anticipated stigma, vigilance, and avoidance) that jointly shape health outcomes and healthcare engagement for these LGBTQ+ community members. From a Minority Stress Theory perspective, provider discrimination, insurance exclusions, affordability limitations, and caregiving-related time scarcity function as distal stressors, or external, objective conditions that systematically limit access to affirming healthcare for White cis lesbian, bisexual, and gay adults. Current findings suggest wealthy, white, cis lesbian, gay, and bisexual adults in Washington D.C., Maryland, and Virgina often experience healthcare disparities potentially due to discrimination and lack of provider competency.

Minority Stress Theory helps explain why racial privilege does not offset sexual minority stress. Although White LGBTQ+ adults may be buffered from race-based discrimination, they remain fully exposed to sexual orientation–based stigma embedded within healthcare systems structured around cis-heteronormativity (Mezzalira et al., 2025; Quinlan, 2025; Ravi et al., 2024). From a Minority Stress Theory perspective, healthcare functions as either stress-amplifying or stress-buffering environments. Non-affirming systems reproduce minority stress through heteronormativity and provider bias, whereas affirming, inclusive care environments have the potential to interrupt minority stress pathways and improve healthcare access for LGBTQ+ adults. Furthermore, navigating the healthcare system requires identifying providers who offer affirming care to mitigate the health effects of chronic minority stress. This chapter demonstrated the influence of sexual orientation, gender identity, and race/ethnicity on access to physical and mental healthcare for LGBTQ+ adults in the current study. In the next section, I will review study limitations, suggest recommendations for future research, and then discuss why providers must help address healthcare disparities within the LGBTQ+ community.

Study Limitations

Convenience Sample and Sample Size

This study is limited by use of convenience sampling. This study is an analysis of Rainbow Families' LGBTQ+ Community Needs Assessment, which is a self-selection study administered via the internet. Not only are self-selection studies limited in terms of the types of participants they attract, but administration online further limits generalizability (Khazaal et al., 2014). These variables impacted the generalizability of findings as not everyone has access to a computer, the internet, or the ability to navigate a web-based survey. Also, Rainbow Families' LGBTQ+ Community Needs Assessment recruited participants via email messages from LGBTQ+ non-profit organizations. Due to convenience sampling, LGBTQ+ adults without affiliation to LGBTQ+ organizations or those with weaker ties to the LGBTQ+ community may be underrepresented (Meyer & Wilson, 2009). The experiences of LGBTQ+ adults who do not actively engage in the LGBTQ+ community may not be represented in the current findings.

To address these limitations, future research should collect data from participants in-person before, during, or after physical and mental healthcare appointments. Collecting data from participants in-person may allow for a larger sample size and increased representation of various demographics within the LGBTQ+ community. The current sample was recruited from an urban location with a large and visible LGBTQ+ community as well as the existence of multiple LGBTQ+ focused community-based organizations and LGBTQ+ specific healthcare services. As a result, this study should be replicated in rural and suburban locations to collect data to identify disparities in access to physical and mental healthcare throughout the United States.

This study is also limited by small sample size. Due to the limited number of participants who identified as BIPOC, I collapsed racial and ethnic identities into a dichotomous variable to maintain adequate statistical power for analysis (Dai et al., 2011). While this approach was necessary, it limited the ability to examine within-group differences and obscured the unique healthcare experiences of specific racial and ethnic groups, thereby constraining generalizability. Similarly, the small number of participants who identified as trans men, trans women, nonbinary, and gender-queer required consolidation of these gender identities into a broader category (i.e., trans and gender nonconforming), precluding more nuanced analyses of healthcare access across gender-diverse groups. Therefore, current findings may not fully capture variation in healthcare access across distinct racial, ethnic, and gender identities. While category aggregation limits within-group analysis, aggregation ensured analytic stability and ethical inclusion of marginalized identities. Researchers should avoid excluding small groups from analyses (Grijseels et al., 2025), as doing so would further marginalize an already underrepresented population and disregard the Belmont Report's principle of Justice (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979).

Future research should prioritize larger and more diverse samples, including intentional oversampling of LGBTQ+ people of color and trans populations (Steele et al., 2017), to examine within-group and between-group differences to better understand how intersecting marginalization shapes healthcare access for LGBTQ+ adults. Trans and gender non-conforming adults experience barriers to participation in research due to mistrust, fear of safety, and potential for harassment leading to lower data collection rates (Alpert et al., 2023; Pho et al., 2023; Seelman et al., 2107). These factors require researchers to build trust, guarantee privacy, and ensure data collection is safe (Andreassen et al., 2024). Future researchers should strive to meet

sample size requirements of 50 cases per predictor variable to determine significance (Aldrick & Nelson, 1984; Concato et al., 1995; Peduzzi et al., 1995; Peduzzi et al., 1996; Wright, 1995). Within the current study, external validity is limited due to the non-random sample (Andrade, 2018). Conversely, internal validity is high due to combination of convenience sampling and logistic regression (Andrade, 2021) which yielded insight on LGBTQ+ adults' access to healthcare within Washington D.C., Maryland, and Virigina.

Self-Report Survey and Time of Completion

This study is limited by use of self-report measures. Rainbow Families' LGBTQ+ Community Needs Assessment used self-report measures, which have limitations including response bias (Howard & Dailey, 1979; Paulhus, 1991) and social desirability bias (Edwards, 1953). Given that the topics on the survey are sensitive in nature, participants may not have felt comfortable fully or accurately disclosing relevant information. Using only self-report measures also left the survey open to interpretation errors (Kormos & Gifford, 2014). The most notable limitation is the amount of time required to complete the survey. Due to the length of the survey, there may have been a loss of interest and participant attrition (Spires et al., 2018). Furthermore, the survey identified if barriers to care existed but did not explore specific barriers. To address limitations, future researchers should include a semi-structured interview to obtain qualitative data to complement quantitative data collected from the self-report survey. In the following section, I will further explore recommendations for future research.

Recommendations for Future Research

The present study contributes to the growing body of LGBTQ+ health disparities research by applying an intersectional framework to examine access to affirming physical and mental healthcare services among LGBTQ+ adults in Washington, D.C., Maryland, and Virginia. While

the findings offer important insights, findings also highlight several directions for future research that are necessary to deepen understanding, improve methodological rigor, and enhance the generalizability and practical utility of intersectional LGBTQ+ health research. SAMHSA (2025) recommended expanding data collection efforts to capture the distinct healthcare experiences of LGBTQ+ adults. However, the nation's largest health survey, the BRFSS, removed demographics questions related to gender identity in 2023 (CDC, 2023). Without vital BRFSS data, researchers will not be able to delineate the health status of trans adults across the US. Future researchers should strive to increase representation of LGBTQ+ adults, especially trans adults, to better understand healthcare disparities. An increase in data collection can contribute to greater representation of LGBTQ+ community needs. Therefore, gathering data on health disparities among LGBTQ+ adults is a fruitful area for future research.

Expanding Sample Diversity and Representation

Future research should prioritize recruiting larger and more diverse samples of LGBTQ+ adults, particularly trans and gender non-conforming adults in addition to LGBTQ+ people of color. In the current study, small subgroup sizes required the consolidation of gender identity and race/ethnicity categories, which limited the ability to examine within-group differences and obscured nuanced healthcare experiences. Intentional oversampling strategies, community-based recruitment, and partnerships with organizations serving trans communities and LGBTQ+ people of color are critical to addressing this gap. Increasing representation would allow researchers to examine heterogeneity within racial/ethnic groups and among diverse gender identities, thereby strengthening the application of intersectionality in quantitative research.

Mixed Methods and Qualitative Inquiry

Given the complexity of healthcare access and the unexpected findings observed in this study, future research would benefit from mixed methods designs that integrate quantitative and qualitative approaches. The key assumption of a mixed methods approach is that the combination of quantitative and qualitative data provides a more in-depth understanding than possible through the collection and analysis of quantitative or qualitative data alone (Creswell & Plano Clark, 2018). Qualitative methods, such as semi-structured interviews or focus groups, could provide deeper contextual understanding of how LGBTQ+ adults interpret and navigate healthcare systems, particularly regarding perceived adequacy of care, provider discrimination, and trust. Qualitative data may help explain why certain groups such as White cis lesbian, bisexual, and gay participants reported unmet healthcare needs despite presumed structural privilege. Future researchers could use a convergent mixed methods design (Creswell & Plano Clark, 2018) combining a survey with semi-structured interviews to further understand LGBTQ+ adults' healthcare experiences. Incorporating participants' narratives would allow researchers to capture lived experiences that cannot be fully explained through regression models alone. Another potential area for exploration in future research is the collection of longitudinal data to better assess changes over time regarding healthcare disparities among LGBTQ+ adults.

Longitudinal and Developmental Approaches

Future studies should employ longitudinal designs to examine changes in healthcare access over time within the LGBTQ+ community. Cross-sectional data limits the ability to assess causal relationships or the cumulative effects of discrimination, policy changes, and provider training initiatives on healthcare access. Longitudinal research could clarify how life course factors, such as aging, shifts in employment or insurance status, and evolving gender identity or sexual orientation disclosure, influence access to physical and mental healthcare. Longitudinal

research designs would also allow researchers to assess whether structural interventions such as mandated LGBTQ+ cultural competency training or expansion of federally qualified health centers produce sustained improvements in access over time. Future researchers could use an explanatory mixed methods design (Creswell & Plano Clark, 2018) to combine comprehensive needs assessments and semi-structured follow-up interviews. Longitudinal research using an explanatory sequential design highlights change over time regarding healthcare disparities, including healthcare access, then allows LGBTQ+ adults to elaborate on change. The rationale for this approach is that quantitative data and subsequent analysis provide an understanding of the research questions while qualitative data and subsequent analysis explain the statistical results by exploring participants' perspectives in more detail (Tashakkori & Teddlie, 1998).

Refining Measurement of Healthcare Access

Future research should continue to refine how healthcare access is operationalized and measured in LGBTQ+ populations. The current study focused on perceived adequacy of care ("I get what I need out of the provider"), which aligns with patient-centered care models but does not capture other dimensions of access such as availability, utilization, affordability, or continuity of care. Future studies could examine multiple access indicators simultaneously to distinguish between structural access (i.e., insurance coverage, provider availability) and experiential access (i.e., provider sensitivity, perceived discrimination). Developing and validating multidimensional measures of healthcare access specific to LGBTQ+ populations would strengthen both clinical and policy-relevant research. Future researchers could use an exploratory mixed methods design (Creswell & Plano Clark, 2018) to develop a standardized measure of healthcare access for LGBTQ+ community members; this design is particularly useful when the researchers need to develop an instrument (Creswell, 1999; Creswell et al.,

2004). An exploratory mixed methods design will allow future researchers to develop a survey instrument grounded in the perspectives of LGBTQ+ community members.

Factor Analysis

Future research should focus on the empirical validation of Rainbow Families' LGBTQ+ Community Needs Assessment by employing exploratory factor analysis to determine the underlying dimensional structure (Knekta et al., 2019). I identified factor analysis as a recommended next step to evaluate construct validity and internal structure. Future research should employ factor analysis to assess construct validity by examining whether survey items load onto theoretically defined domains of need. Factor analysis provides evidence of internal structure by reducing item sets into latent dimensions, facilitating construct-level interpretation (Tavakol & Wetzel, 2020). Following initial content validation by subject matter experts, confirmatory factor analysis will verify that the observed data fits the theoretical model, ensuring that each factor accurately represents its intended content domain (Atkinson et al., 2011). Factor analysis will improve questionnaire design by evaluating construct validity, reducing redundant items, and grouping related survey items into meaningful underlying dimensions (Inu et al., 2025). Applying factor analysis to Rainbow Families' LGBTQ+ Community Needs Assessment will rigorously assess the construct and content validity of the newly developed survey (Indu et al., 2025). Factor analysis can mathematically confirm if these themes truly represent the community's lived experience (Priya, 2025).

Intersectional Analytic Strategies

While this study applied intersectionality through interaction terms in logistic regression, future research should explore alternative analytic strategies that more fully capture intersectional complexity. Multilevel modeling, latent class analysis, or person-centered

approaches may allow researchers to identify distinct profiles of healthcare access based on intersecting identities and social positions. Also, future research should consider incorporating other salient identities and structural factors such as socioeconomic status, disability status, immigration status, and geographic location to better reflect the multidimensional realities of LGBTQ+ community members' lives.

Geographic and Policy Contexts

Replication of this study in other geographic regions is essential. The Washington, D.C., metropolitan area has a relatively robust network of LGBTQ+-focused physical and mental healthcare resources and protective policies, which may have influenced the observed findings. Future research should examine access to physical and mental healthcare in rural, suburban, and politically restrictive regions where affirming services are less available. Comparative studies across states or regions could clarify how policy environments, provider training mandates, and healthcare infrastructure shape access to affirming care for LGBTQ+ community members.

Implications for Intervention and Implementation Research

Finally, future research should move beyond documenting disparities to testing interventions designed to improve healthcare access for LGBTQ+ populations. Implementation science approaches could evaluate the effectiveness of provider training programs, organizational policy changes, and community-based healthcare models in reducing unmet physical and mental healthcare needs. Research that links intersectional disparities to actionable system-level interventions will be critical for translating findings into meaningful clinical and policy change. Beyond implementation and policy reform, it is necessary to examine how clinical practices as well as diagnostic standards that shape everyday practice and may create barriers to affirming care for LGBTQ+ adults.

Implications for Practice

Findings from the current study suggest that the most urgent priorities for improving equitable access to physical and mental healthcare among LGBTQ+ adults involve addressing provider-level discrimination and strengthening affirming healthcare organizations. First, mandated LGBTQ+ cultural competency training for healthcare providers represents the highest-impact and most feasible intervention. Provider discrimination emerged as a consistent barrier across sexual orientation, gender identity, and race/ethnicity, including among White cis LGB adults who are often presumed to experience fewer access barriers. Training that addresses heteronormativity, implicit bias, and culturally responsive care has the potential to improve both physical and mental healthcare experiences across identity groups and reduce unmet healthcare needs. Second, sustained funding and expansion of LGBTQ+-focused federally qualified health centers (FQHCs) is a critical structural intervention. The comparatively greater access reported by LGBTQ+ people of color in this study may reflect the presence of affirming, community-based healthcare organizations that reduce financial, logistical, and discriminatory barriers to care. Expanding such models can promote intersectional equity by addressing multiple barriers simultaneously, including insurance limitations, affordability, and stigma.

Additional priorities include standardized collection of sexual orientation and gender identity data within healthcare systems and community needs assessments to ensure visibility and inform resource allocation, as well as policy efforts to expand insurance coverage and affordability for mental healthcare services. While these initiatives are essential for long-term equity, their effects are more indirect and dependent on broader systemic change. Secondary structural supports, such as childcare and caregiving accommodations, may further reduce access barriers for cis women, though these interventions require cross-sector coordination. Finally,

continued provider self-reflection, supervision, and implicit bias training remain ethically necessary but insufficient in isolation, underscoring the need for policy-level mandates and organizational accountability. Together, these prioritized recommendations emphasize that improving LGBTQ+ healthcare access requires structural, enforceable, and intersectionally informed interventions rather than reliance on individual-level change.

Counselors are ethically bound to uphold the principles of autonomy, beneficence, nonmaleficence, justice, fidelity, and veracity (ACA, 2014), which form the foundation of professional counseling identity and ethical practice (CACREP: Professional Counseling Orientation and Ethical Practice). In line with these standards, counselor education programs are responsible for preparing students to competently serve diverse populations through training grounded in multiculturalism, social justice, and ethical decision-making (CACREP: Social and Cultural Diversity). Heteronormative assumptions in healthcare contribute to inadequate treatment, and fear of discrimination among LGBTQ+ adults (Mezzalira et al., 2025; Quinlan, 2025; Ravi et al., 2024), underscoring the need for culturally responsive and affirmative counseling relationships (CACREP: Counseling and Helping Relationships). Ethical counseling practice requires that LGBTQ+ clients receive care equivalent in quality to that provided to heterosexual and cis clients, along with counselor advocacy to address systemic barriers to access (CACREP: Social and Cultural Diversity; Professional Counseling Orientation).

Consistent with CACREP standards, counselor training programs must intentionally integrate LGBTQ+ affirming competencies across coursework, skills development, and supervised clinical experiences rather than limiting such content to isolated instruction (CACREP: Professional Counseling Orientation; Practicum and Internship). Preparation should include counselor self-awareness of bias, understanding of minority stress and systemic

oppression, ethical and legal considerations, and the application of culturally responsive assessment and intervention strategies (CACREP: Social and Cultural Diversity; Assessment and Diagnosis; Counseling and Helping Relationships). Given persistent barriers to LGBTQ+ affirming healthcare and documented mental health disparities, comprehensive training and supervision are essential to reduce counselor unpreparedness, strengthen client engagement and outcomes, and foster safe, affirming therapeutic environments (CACREP: Supervision; Practicum and Internship). Training is essential because many counselors report feeling unprepared to provide affirmative care, leading to reduced client satisfaction, early termination, and unmet mental health needs (Fish et al., 2021). Counselor training programs must incorporate LGBTQ+ competencies to ensure counselors can effectively serve this community by reducing trauma and creating safe therapeutic environments (Euser & Chamberlin, 2024).

Acknowledging Clinical Influences

Although homosexuality was removed from DSM in the early 1970s, gender-related diagnoses have continued to evolve in ways that influence counseling practice. Earlier editions of the DSM classified incongruence between assigned sex at birth and gender identity as gender identity disorder, a diagnosis that framed gender diversity as pathological. In the DSM-5-TR, this diagnosis was replaced with gender dysphoria, which refers to the psychological distress that may accompany gender incongruence and treatment can include gender-affirming care. The use of gender dysphoria as a diagnostic category remains contested, as some clinicians argue that it reinforces stigma and pathologization (Winter et al., 2009). Requiring a diagnosis of gender dysphoria to access gender-affirming care is problematic, as not all adults seeking care experience distress, potentially creating barriers that conflict with principles of client autonomy

and justice. Within counselor education, these diagnostic tensions underscore the importance of training counselors to critically evaluate diagnostic frameworks, recognize the limits of pathology-based models, and engage in ongoing self-reflection to address implicit bias. Failure to do so can contribute to discriminatory practice (Gopal et al., 2021). These diagnostic and ethical considerations point to the influence of provider bias within healthcare, underscoring the need to examine how implicit assumptions shape clinical interactions and access to care.

Acknowledging Bias in the Healthcare System

Implicit biases are unconscious feelings, attitudes, or beliefs about a person based on a group membership (Vela et al., 2022). Researchers have concluded that providers have the same levels of implicit bias as the general population and these implicit biases influence diagnoses, treatment decisions, and recommendations about levels of care (FitzGerald & Hurst, 2017). Providers may work under the assumption that clients identify as heterosexual and cis, placing the burden to disclose on the client (Ramsey et al., 2022). While implicit biases are involuntary and can unintentionally affect decisions, managing bias is a learned skill that must be practiced regularly over time for change to occur (Sabin, 2022). Without examining implicit bias through training and supervision, providers have the potential to negatively impact care by allowing bias to change the approach to treatment. Supervision can further support critical self-reflection related to sexual orientation and gender identity. By acknowledging and addressing systemic barriers like provider bias, providers can work towards creating a more equitable healthcare system that provides LGBTQ+ adults with access to affirming healthcare.

Acknowledging Scope of Practice

Many graduate mental health programs including clinical mental health counseling, school counseling, school psychology, and social work have historically provided limited

training in sexual and gender minority health (Gay, Lesbian & Straight Education Network, 2019). Clinicians who completed their training more than a decade ago may have received little to no formal education specific to LGBTQ+ adults, contributing to reported gaps in preparedness among mental health providers (Fish et al., 2022; Rees et al., 2021; Stryker et al., 2022). Given the continued growth of the LGBTQ+ population in the US (Jones, 2025), these gaps underscore a critical need to expand training for the mental health providers to better serve this population.

Training gaps extend to medical education, where graduate students receive an average of only 11 hours of LGBTQ+-related instruction (Streed Jr. et al., 2024). Although this represents modest progress, medical students continue to demonstrate limited proficiency in providing care to LGBTQ+ patients (Jewell & Petty, 2024; Jurček et al., 2021; Zelin et al., 2018). To address these gaps, graduate programs must integrate LGBTQ+ content longitudinally across curricula, emphasizing practices such as inclusive clinical interviewing (Bass & Nagy, 2023; Deutsch, 2016; Moe & Sparkman, 2015) as well as strategies to identify and mitigate provider bias, a barrier to equitable healthcare (Matsuzaka et al., 2021). Attention must be given to the adequacy of professional training programs responsible for preparing healthcare providers to serve LGBTQ+ populations. The most urgent priorities are mandated LGBTQ+ cultural competency training, as these interventions directly address provider discrimination and demonstrate the greatest potential to improve equitable access to both physical and mental healthcare.

Summary and Conclusion

Summary of Findings

The purpose of this study was to examine how sexual orientation, gender identity, and race/ethnicity both independently and intersectionally predict access to physical and mental healthcare among LGBTQ+ adults living in Washington, D.C., Maryland, and Virginia. Using an

intersectional framework and logistic regression analyses of data from Rainbow Families' LGBTQ+ Community Needs Assessment, several key findings emerged. First, sexual orientation was a significant predictor of healthcare access. Participants who identified as lesbian or bisexual were more likely than gay participants to report that their physical and mental healthcare needs were not consistently met. These findings indicate that sexual minority women, particularly lesbian and bisexual women, continue to experience substantial barriers to both physical and mental healthcare. This pattern is consistent with prior research documenting heightened exposure to provider discrimination, insurance instability, and cost-related barriers among lesbian and bisexual adults. Second, gender identity significantly predicted access to healthcare, though the patterns differed by type of care. Cis women and trans and gender non-conforming participants were more likely to report unmet physical healthcare needs compared to cis men. In contrast, cis men and cis women were more likely to report unmet mental healthcare needs compared to trans adults. These findings suggest that caregiving responsibilities, employment and insurance constraints, gender bias in healthcare, and stigma surrounding mental health help-seeking may operate differently across gender identities and care domains.

Third, race/ethnicity emerged as a significant predictor of healthcare access in an unexpected direction. White LGBTQ+ participants were more likely than LGBTQ+ people of color to report unmet physical and mental healthcare needs. This finding contrasts with national trends that consistently document poorer healthcare access among people of color. The result may reflect the regional context of the study, including the presence of LGBTQ+-focused federally qualified health centers and mandated LGBTQ+ cultural competency training for healthcare providers in Washington, D.C., which may have increased access for LGBTQ+ people

of color in this sample. However, the overrepresentation of White participants and the small number of participants who identify as people of color limit the generalizability of this finding. Fourth, intersectional analyses revealed that specific combinations of social identities were associated with heightened risk for unmet healthcare needs. White lesbian cis women and White bisexual cis women were significantly more likely to report unmet physical healthcare needs, while White lesbian cis women, White bisexual cis women, and White gay cis men were more likely to report unmet mental healthcare needs. These findings challenge assumptions that racial privilege uniformly protects LGBTQ+ individuals from healthcare disparities and demonstrate that privilege in one social domain does not negate marginalization in others.

Furthermore, even participants with identities often associated with structural privilege (i.e., White, cis, employed) reported difficulty accessing affirming care, underscoring the pervasive influence of heteronormativity and stigma within physical and mental healthcare systems. In sum, the findings demonstrate that access to affirming physical and mental healthcare among LGBTQ+ adults is shaped by the complex and intersecting influences of sexual orientation, gender identity, and race/ethnicity. The results underscore the necessity of intersectional approaches in LGBTQ+ health research and highlight the need for systemic interventions particularly mandated provider training and expansion of LGBTQ+-affirming healthcare models to reduce persistent disparities and improve equitable access to healthcare.

Conclusion

Based on data from the latest Gallup poll (Jones, 2025), the percentage of adults who identify as LGBTQ+ (9.3%) has doubled since 2020. Survey data from the Gallup poll revealed that the LGBTQ+ population is growing as more Americans self-identify as lesbian (1.4%), gay (2%), bisexual (5.2%), and trans (1.3%). LGBTQ+ adults are more likely to experience health

disparities throughout the lifespan (Bränström et al., 2016a; Bränström et al., 2016b) such as external stressors related to discrimination and internal stigma stressors related to identity concealment (Frost et al., 2015; Griffin et al., 2019; Meyer et al., 2021). Psychological stressors can contribute to physical health problems such as HIV, obesity, cardiovascular disease, cancer, and disability (Cronholm et al., 2015; Felitti et al., 1998; Merrick et al., 2018). Psychological stressors can also contribute to mental health problems such as depressive disorders, anxiety disorders, substance use disorders, decreased self-care, decreased engagement in healthcare, and suicidality (Hatzenbuehler & Pachankis, 2016; Meyer & Frost, 2013; Meyer et al., 2021).

While structural determinants of health including sexism, biphobia, and transphobia influence access to care, social determinants of health including employment and health insurance also have a profound effect on LGBTQ+ adults' ability to access and afford healthcare. Although results suggest that White cis men and women who were employed, insured, and financially secure lacked access to affirming healthcare, findings of this study demonstrate how clinical practice and public policies can address structural and political barriers that perpetuate systemic inequalities. As evidenced by results, Washington D.C. serves as an example on how to increase access to healthcare for LGBTQ+ adults specifically LGBTQ+ people of color. Access to Whitman-Walker Health combined with mandated LGBTQ+ cultural competence training for all healthcare providers serves as a blueprint for improvements in the current healthcare system. Mandated training to renew licenses will motivate providers to access LGBTQ+ related health content. Providers should be ready to attend trainings to increase knowledge of the healthcare needs of LGBTQ+ adults. Healthcare providers should also be ready to examine their own personal biases and seek consultation or supervision as needed.

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Appendix A

Positionality Statement

Positionality refers to the stance a researcher adopts within a study (Savin-Baden & Major, 2013). Positionality requires intentional consideration of the researcher's identity to allow readers to evaluate how personal characteristics and perspectives may influence the study population, the phenomenon under investigation, and the research process (Wilson et al., 2022). Catherine Theresa Kelly (she/her) was born and raised in the Uni-ted States. She identifies as a white 34-year-old bisexual cis woman with Irish, Italian, and German heritage. As a bisexual cis woman who identifies as a member of the LGBTQ+ community, she recognizes her 'insider' status which facilitated immediate rapport and trust with participants. To mitigate insider bias, she utilized member-checking to ensure participants' voices were represented accurately and not through the lens of her own personal history. She also identifies as a Philadelphian from a middle-class household with two parents who identify as practicing Roman Catholics. She

attended 12 years of Catholic school then received a bachelor's degree in psychology from Temple University and a master's degree in Community and Trauma Counseling from Thomas Jefferson University in Philadelphia, Pennsylvania. Now, I will give you context for this research project as well as an understanding of my journey at George Washington University.

In the summer of 2019, I took 'Advanced Leadership and Advocacy in Counseling' where I was instructed to reach out to a local non-profit organization; this is where my partnership with Rainbow Families began. As a professional counselor, I facilitated an adoption support group for Rainbow Families for 3 years from 2019 until 2021. Regarding my area of specialization, I took 'Community Psychology I' in Fall 2020 and 'Community Psychology II' in Spring 2021. During 'Community Psychology II,' I was again instructed to reach out to a local non-profit organization and collaborate on a project. During this time, I partnered with Rainbow Families to construct a needs assessment questionnaire based on feedback from Rainbow Families and members of the LGBTQ+ Coalition. I assisted Rainbow Families in development of the questions used for their LGBTQ+ Community Needs Assessment. I modeled Rainbow Families' LGBTQ+ Community Needs Assessment after the San Francisco LGBTQ+ Community Needs Assessment (Horizon Foundation, 2018). LGBTQ+ Coalition members used the results from Rainbow Families' LGBTQ+ Community Needs Assessment to gather support for a new LGBTQ+ community center. In April 2025, the new DC LGBTQ+ Community Center opened its doors. Research, to me, is scholarship in action.

During creation of Rainbow Families' LGBTQ+ Community Needs Assessment, I adhered to Community Psychology principles for research including promoting social justice, adopting an ecological perspective, respecting diversity, in addition to prioritizing empowerment through community inclusion and partnership. I was the primary investigator for this study as

part of the research endeavor necessary to fulfil requirements for PhD in Counselor Education and Supervision. Many of my research ideas stemmed from subjective experiences and observations as a volunteer who facilitated a support group with LGBTQ+ community members interested in adoption through Rainbow Families, the same LGBTQ+ non-profit organization responsible for administering the LGBTQ+ Community Needs Assessment.

Appendix B

Rainbow Families' LGBTQ+ Community Needs Assessment

Your Connection to the DMV Area LGBTQ+ Community

1. What is the zip code where you currently live or stay most of the time?
2. There are a variety of terms people in the LGBTQ+ community use to describe their sexual orientation, including queer, pansexual, two-spirit, or same gender loving. Of the following sexual orientation identities, which fits you best?
3. How do you currently describe your gender identity? Please select the one you most identify with at this time. By 'gender identity' we mean your internal understanding of your own gender, or the gender(s) with which you identify.
4. How old are you?
5. How do you describe your race/ethnicity? Please select the race/ethnicity that you identify most with and if you would like to provide more detail about your race/ethnicity, please do so in the box provided.
6. Which of the following best describes your current relationship status?
7. Which of the following categories best describes your employment status?
8. What is the highest degree or level of school you have completed? If currently enrolled, mark the previous grade or highest degree received.
9. Are you in school now?
10. What is your total household income?

Rainbow Families

11. Have you heard of Rainbow Families before this?
12. If Yes, have you attended/participated in Rainbow Families programs or events?
13. When thinking of a non-profit in service of LGBTQ+ families (including LGBTQ+ headed families, prospective parents, families with LGBTQ+ children), what services would be of interest to you?
14. If you do not have access to support, classes, or other activities, would Rainbow Families' virtual programs be of interest to you?
15. If Yes, what type of virtual programs are you interested in?
16. Provided there were sufficient membership benefits, what do you view as a reasonable annual membership fee?
17. How do you prefer to receive information about programs, support groups, and classes from Rainbow Families?
18. Would you like to be added to Rainbow Families email distribution list? If yes, please enter your first and last name as well as your email address here:

Your Feelings of Safety as a Person in the LGBTQ+ Community:

19. How safe do you feel in your neighborhood?
20. How safe do you feel with the person or people you date or are in a relationship with?
21. How safe do you feel where you work?
22. How safe do you feel at your school?
23. How safe do you feel on public transit? (i.e., Metro or bus)
24. How safe do you feel interacting with police or other law enforcement officials?
25. Concerns about my own physical and emotional safety limit where I can live.
26. Concerns about my own physical and emotional safety limit where I can sleep.
27. Concerns about my own physical and emotional safety limit where I can work.
28. Concerns about my own physical and emotional safety limit where I can get health care
29. Concerns about my own physical and emotional safety limit where I can get other services, such as help with legal or housing matters.

In the past 12 months, how often have your experienced the following?

30. Not had a place to sleep for the night, and stayed in a car or on the street?
31. Not had a place to sleep for the night, and stayed with friends or family?
32. Not had enough food to eat or money to buy food for you or your family?
33. Not had money to buy medicine you or your family needed?
34. Had power (gas and electric) or water shut off because you didn't have enough money to pay the bills?

For each one, please mark whether you needed help with it in the past, need that kind of help now, or might need it in the future.

35. Paying for school for myself
36. Paying for school for my children or other family members
37. Planning for retirement
38. Staying in my home as I get older
39. Getting immigration-related services, such as help with legal matters

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Medical/Physical Healthcare: Visiting a hospital, doctor's office, or other healthcare provider to address and heal physical health issues or injuries. This does not include behavioral/mental health, which you will be asked about later in the survey.

40. Did you visit any kind of clinic, doctor, nurse practitioner, or other medical care provider in the past three years? (i.e., telehealth appointments and/or in-person appointments)
41. If yes, in what zip code do you usually receive health care?

    Please tell us more about your typical experience getting health care. How often are the following statements true for your typical health care experience?

42. I get what I need out of it
43. The provider(s) is/are sensitive to my needs and perspective based on my gender identity/expression.
44. The provider(s) is/are sensitive to my needs and perspective as a LGBTQ+ identified person
45. The provider(s) is/are sensitive to my needs and perspective as a person of color
46. The provider(s) is/are sensitive to my needs and perspectives based on my age
47. The provider(s) is/are sensitive to my needs based on my disability-related needs
48. Where do you usually get your health care?
49. Is your medical provider knowledgeable about LGBTQ concerns and terminology?
50. Are you aware of Rainbow Families' directory of vetted health care and other service providers, available to members?
51. If not, would you envision yourself utilizing this resource in the future?
52. Are there any issues that prevent you from accessing care?
53. How long does it usually take you to get to a place where you get health care services?
54. How do you usually get to your health care appointments?
55. Whether or not you have personally needed this service, how important is it that LGBTQ+-specific healthcare providers and services are available?
56. Do any of the following concerns or situations keep you from seeking health care services?
57. Is there anything else you'd like to share about your experiences or concerns getting health care?

Emotional Support, Mental Health Counseling, and/or Therapy: Includes short term / crisis intervention counseling, long term/regular counseling or therapy, and supportive groups.

58. Did you go to therapy or counseling, or use any kind of support group, drop-in group, teletherapy or other kind of emotional or mental health support in the past three years?
59. If Yes, in what zip code do you usually receive emotional support services, counseling, and/or therapy?

    Please tell us more about your typical experience getting emotional support, counseling, and/or therapy. How often are the following statements true for you?
60. I get what I need out of it
61. The provider(s) is/are sensitive to my needs and perspective based on my gender identity/expression.
62. The provider(s) is/are sensitive to my needs and perspective as a LGBTQ+ identified person
63. The provider(s) is/are sensitive to my needs and perspective as a person of color
64. The provider(s) is/are sensitive to my needs and perspectives based on my age
65. The provider(s) is/are sensitive to my needs based on my disability-related needs
66. Where do you usually get emotional support services?
67. How do you usually get emotional support services?
68. How long does it usually take you to get to a place where you get emotional support services?
69. How do you usually get to your emotional support services?
70. Whether or not you have personally needed this service, how important is it that LGBTQ+-specific providers and services are available for emotional support?
71. Do any of the following concerns or situations keep you from seeking emotional support services?
72. Rainbow Families provides resources/services on emotional support, do you envision yourself participating in these services?
73. Is there anything else you'd like to share about your experiences or concerns getting emotional support, counseling or therapy?

Drug and Alcohol Recovery Services: Treatment and support services that help people manage substance use. Includes, but is not limited to, outpatient and residential treatment centers or programs as well as 12 step and other peer led support groups.

74. Did you use any kind of services or support related to drug or alcohol recovery in the past three years? (i.e., telehealth, teletherapy, and/or in person appointments)
75. If Yes, in what zip code do you usually receive recovery support services?

    Please tell us more about your typical experience recovery support. How often are the following statements true for you?
76. I get what I need out of it
77. The provider(s) is/are sensitive to my needs and perspective based on my gender identity/expression.
78. The provider(s) is/are sensitive to my needs and perspective as a LGBTQ+ identified person
79. The provider(s) is/are sensitive to my needs and perspective as a person of color
80. The provider(s) is/are sensitive to my needs and perspectives based on my age
81. The provider(s) is/are sensitive to my needs based on my disability-related needs
82. Where do you usually get recovery support services?
83. How do you usually get recovery support services?
84. How long does it usually take you to get to a place where you get recovery support services?
85. How do you usually get to your recovery support services?
86. Whether or not you have personally needed this service, how important is it that LGBTQ+-specific providers and services are available for recovery support?
87. Do any of the following concerns or situations keep you from seeking recovery support services?
88. Is there anything else you'd like to share about your experiences or concerns getting recovery support?

Legal Services, Information, and Advocacy: Getting information about or assistance with legal issues related to any aspect of your life including, but not limited to, housing, family, employment, name and/or gender marker change, and immigrations.

89. Did you use any kind of legal assistance -in the past three years?

90. If yes, in what zip code do you usually receive legal assistance?

    Please tell us more about your typical experience getting legal assistance. How often are the following statements true for you?
91. I get what I need out of it
92. The provider(s) is/are sensitive to my needs and perspective based on my gender identity/expression.
93. The provider(s) is/are sensitive to my needs and perspective as a LGBTQ+ identified person
94. The provider(s) is/are sensitive to my needs and perspective as a person of color
95. The provider(s) is/are sensitive to my needs and perspectives based on my age
96. The provider(s) is/are sensitive to my needs based on my disability-related needs
97. Where do you usually get legal services?
98. How do you usually get legal services?
99. How long does it usually take you to get to a place where you get legal services?
100. How do you usually get to your legal services?
101. Whether or not you have personally needed this service, how important is it that LGBTQ+-specific lawyers or other legal services are available?
102. Are you aware of Rainbow Families' directory of vetted health care and other service providers including legal professionals, available to members?
103. If not, would you envision yourself utilizing this resource in the future?
104. Do any of the following concerns or situations keep you from seeking legal assistance?
105. Rainbow Families facilitates services related to getting legal assistance, do you envision yourself participating in these services?
106. Is there anything else you'd like to share about your experiences or concerns getting legal assistance?

Housing Support: Assistance with securing a place to stay or live, or keeping your current housing. Includes, but is not limited to, getting tenant counseling, housing assistance, and/or using shelters.

107. Did you use any kind of housing support or assistance in the past three years?
108. If Yes, in what zip code do you usually receive housing support services

    Please tell us more about your typical experience getting help with housing issues. How often are the following statements true for you?
109. I get what I need out of it
110. The provider(s) is/are sensitive to my needs and perspective based on my gender identity/expression.
111. The provider(s) is/are sensitive to my needs and perspective as a LGBTQ+ identified person
112. The provider(s) is/are sensitive to my needs and perspective as a person of color
113. The provider(s) is/are sensitive to my needs and perspectives based on my age
114. The provider(s) is/are sensitive to my needs based on my disability-related needs
115. Where do you usually get housing support services?
116. How do you usually get housing support services?
117. How long does it usually take you to get to a place where you get housing support services?
118. How do you usually get to your housing support services?
119. Whether or not you have personally needed this service, how important is it that LGBTQ+-specific housing services, such as tenant counseling, housing assistance, and/or using shelters, are available?
120. Do any of the following concerns or situations keep you from seeking help with housing issues?
121. Is there anything else you'd like to share about your experiences or concerns getting support for housing issues?

LGBTQ+ Social and Community Events: Ways that you connect to the LGBTQ+ community through events, gatherings, and other social activities. These events could include going to LGBTQ+-specific social events, celebrations, religious services, talks, concerns, or other organized events in public spaces.

122. Did you participate in any kind of organized social or community activities or events for LGBTQ+ community members in the past three years?

    Please tell us more about your typical experience participating in LGBTQ+ specific social or community events. How often are the following statements true for you?
123. I get what I need out of it
124. The provider(s) is/are sensitive to my needs and perspective based on my gender identity/expression.

125. The provider(s) is/are sensitive to my needs and perspective as a LGBTQ+ identified person
126. The provider(s) is/are sensitive to my needs and perspective as a person of color
127. The provider(s) is/are sensitive to my needs and perspectives based on my age
128. The provider(s) is/are sensitive to my needs based on my disability-related needs
129. How long does it usually take you to get to LGBTQ+-specific social or community events?
130. How do you usually get to LGBTQ+-specific social or community events?
131. Even if you haven't participated in LGBTQ+-specific social or community events, how important is it to you that these events are available?
132. Rainbow Families offers a variety of social events and gathering each year to celebrate LGBTQ+ families, build community, and allow children the opportunity to be around other families like theirs. Would you envision yourself participating in these programs?
133. Do any of the following concerns or situations keep you from participating in LGBTQ+-specific social or community events?
134. Rainbow Families facilitates LGBTQ+ social events in the community, do you envision yourself participating in these services?
135. Is there anything else you'd like to share about your experiences or concerns participating in social or community events?

Civic Engagement

The following questions are about the options you have for making your voice heard in our society. To what extent do you agree/disagree with the following statements about your options for making your voice heard?

136. I believe at least one of my local elected officials has my best interest at heart.
137. I know of ways to provide my own input into local laws, policies, and decisions.
138. There is at least one LGBTQ+ organization or group of advocates in my neighborhood who speaks up for the issues that personally affect me.
139. In general, I feel that the laws and policies in the city where I live support LGBTQ+ people.
140. What is one important thing local government can do to improve the community/environment?

More About You!

141. What is your current housing situation? Please select only one. If your housing situation changes frequently, please check the option that describes where you have stayed most often in the past six months.
142. Are you receiving any housing subsidy? Examples of subsidies include Section 8, LINC, FEPS, public housing and subsidized housing developments in which you pay a percentage (such as 30%) of your income for rent.
143. In your childhood/youth, did you ever live in foster care (group home, foster family, etc.)?
144. Do you have any children?
145. If Yes, do your children attend daycare or early childhood education services?
146. How important is it for your child to attend an inclusive daycare or school?
147. Do you identify as a person with a disability?
148. Have you ever served in the armed forces?
149. How hard is it for you to pay for the very basics like food, housing, medical care, and heating?
150. Have you ever been homeless?
151. Are you currently homeless?
152. How many times have you experienced homelessness in your lifetime?
153. If you have been in a shelter, have you ever experienced physical, verbal, or sexual assault/harassment by residents or shelter staff because of your actual or perceived sexual orientation, gender identity, or gender expression?
154. Have you ever been incarcerated?
155. What type of health insurance coverage do you currently have?
156. If you have health insurance do you think that it meets your needs
157. Have you ever experienced any of the following while attempting or receiving medical care?
158. What is the biggest LGBTQ+-related medical need for people in our community?
159. Which type of queer designated space would you personally take advantage of?
160. Is there anything else you want non-profit organizations or funders supporting the LGBTQ+ community to know?