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## The Role of Healthcare Stereotype Threat and Social Identity Threat in LGB Health Disparities

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*Health disparities exist between lesbian, gay, and bisexual (LGB) individuals and heterosexuals and can be explained by differential access to healthcare, unique experiences with discrimination, and higher prevalence of HIV/AIDS. This article will examine another possible explanation, namely healthcare stereotype threat and social identity threat in the healthcare experiences of sexual minority individuals. In doing so, this article integrates previous research on stereotypes and discrimination with regard to LGB individuals as well as research concerning LGB individuals' experiences with healthcare providers. The article concludes with a discussion about future research and potential interventions to ameliorate identity threats for LGB individuals in healthcare contexts. From a social justice perspective, identity threats serve as an important contextual variable feeding health disparities among sexual minorities. If better understood, such threats and resultant disparities may be reduced via cost-effective changes in environmental cues and educational strategies.*

Health disparities exist between lesbian, gay, and bisexual (LGB) individuals and heterosexuals (The Institutes of Medicine, 2011) with LGB individuals showing elevated risks for mental health problems (King et al., 2008); physical health problems (Lick, Durso, & Johnson, 2013); and substance abuse problems (McCabe, Hughes, Bostwick, West, & Boyd, 2009) (for a review see Williams & Mann, 2017). These differences can be explained, in part, by differential access to healthcare and the continued higher impact of HIV/AIDS, particularly among

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gay men. Furthermore, minority stressors related to sexual orientation have been linked with LGB health disparities (Frost, 2017; Meyer, 2003; Williams & Mann, 2017). Meyer (2003, 2013) characterizes these minority stressors as existing on a continuum from those that are distal to the individual (emanating from outside the individual) such as experiences of discrimination to those that are more proximal (emanating from inside the individual) such as perceptions of stigma and internalized homophobia.

The central purpose of this article is to expand upon this minority stress work, examining two types of stigma, namely healthcare stereotype threat and social identity threat, as potentially important, yet underexplored, factors contributing to LGB health disparities. Though the general phenomena of stereotype and social identity threats have been linked directly with poor health outcomes (Blascovich, Spencer, Quinn, & Steele, 2001), we are interested in this article in examining how these threats *indirectly* affect health by negatively impacting encounters in healthcare contexts. We explore healthcare stereotype threat and social identity threat, investigating key prerequisites for and potential consequences of these threats as they apply to LGB health. We conclude with suggestions for future research and interventions. We limit discussion to LGB health only (rather than expand to transgender or other gender identities), as the research support thus far is based on samples of sexual minorities.

### **Stigma: Stereotype and Social Identity Threats**

In his formulation of minority stress, Meyer (2003) points to distinct forms of stigma that serve as stressors in the lives of sexual minority individuals. On one hand, he points to stereotype threat as a type of stigma, citing Claude Steele's early work with the construct. According to stereotype threat theory (Steele, 1997; Steele & Aronson, 1995), individuals who belong to groups about which there are negative stereotypes can fear either being judged through the lens of these stereotypes or confirming the stereotypes. Such fear leads to a cascade of cognitive and physiological consequences, ultimately interfering with the task at hand. Since its inception, hundreds of papers have been published documenting that the presence of stereotypes in the environment can have deleterious consequences for those to whom the stereotypes apply (Shapiro, Aronson, & McGlone, 2016). Many of these studies follow a similar paradigm: Individuals in the stereotyped group and individuals not in the stereotyped group perform some task in contexts where the stereotype is either made salient or not. Across a variety of outcomes, results typically show that when the stereotype is made salient, stereotyped individuals underperform in comparison to those who are not stereotyped. Importantly, however, when the stereotypes are not salient, no performance differences emerge. As an example of a classic stereotype threat study, Spencer, Steele, and Quinn (1999) had men and women take a difficult math test after being told that

previous administrations of the test produced gender differences (threat condition) or not (no threat condition). As predicted by the theory, women underperformed in comparison to men only when threat was present.

In addition to immediate consequences, stereotype threat can have downstream effects. For example, rather than contend with negative stereotypes, stereotyped individuals may ultimately opt out of, or disengage from, domains where the stereotypes are applicable (Meyer, 2003; Steele, 1997). This idea has been put forth, for example, to explain why women are absent from STEM fields: Rather than deal with the anxiety, cognitive burden, and performance decrements associated with stereotype threat, women simply leave fields where they are believed to be inferior. Davies and colleagues examined women's desire to pursue stereotypically male versus female domains (Davies, Spencer, Quinn, & Gerhardstein, 2002) as well as their leadership aspirations (Davies, Spencer, & Steele, 2005) in contexts where stereotypes about women were either made salient or not. When primed with stereotypes about women via television commercials, women expressed less interest in pursuing quantitative educational and vocational domains (i.e., stereotypically male domains) than verbal domains (i.e., stereotypically female domains) and also indicated less interest in taking on a leadership role in a subsequent group problem-solving task. Once again, it is critical to emphasize that when the threat was removed, women did not show these effects.

Beyond presenting stereotype threat as a specific form of stigma, Meyer (2003) also characterizes stigma as a fear of being discriminated against due to a marginalized identity. Others have conceptualized this type of stigma and the hypervigilance that arises from it as social identity threat (Steele, Spencer, & Aronson, 2002). The two forms of stigma—stereotype threat and social identity threat—are distinguishable in a couple important ways. First, whereas stereotype threat involves concerns of being judged through the lens of specific negative stereotypes and of potentially confirming those stereotypes, social identity threat involves broader concerns of being discriminated against because of a devalued identity. Second, and perhaps related, stereotype threat requires specific stereotypes to be activated and relevant in a particular setting; social identity threat, in contrast, is more diffuse and does not require that stereotypes be salient. In their presentation of social identity threat, Murphy and Taylor (2011) suggested a variety of cues, separate from the presence of stereotypes that elicit identity threat. For example, cues can elicit threat by signifying whether or not a person is welcome in a particular setting. For example, objects in a room, such as posters or leaflets, can trigger social identity threat in an individual to the extent that they do not contain images reflecting that individual's identity. Prior discrimination in a context, whether experienced directly or by similar others, can also trigger identity threat and lead to hypervigilance for cues that such marginalization will occur again.

### **Stereotype and Social Identity Threats in Healthcare Contexts**

To date, the overwhelming majority of studies examining stereotype and social identity threats have occurred in performance-related domains, with most of the studies focusing on academic performance. Yet, the theories are quite generalizable and could apply to any contexts in which negative perceptions of one's identities might be relevant. Scholars have begun thinking about ways in which stereotype threat might be pervasive in the context of health and healthcare. In the first experiment of its kind, Abdou and Fingerhut (2014) applied the traditional stereotype threat paradigm to examine whether African American women experience healthcare stereotype threat, or stereotype threat specific to healthcare contexts. African American and Caucasian women participating in an online study consisting of a virtual healthcare setting completed measures of anxiety, a well-established mediator in the stereotype threat process, after waiting in a virtual waiting room, which either contained or did not contain images that conveyed negative stereotypes about African American women's sexuality. In the threat condition, the walls of the waiting room contained health-related posters which made salient the stereotypes of African American women as hypersexual and irresponsible. One poster, for example, contained an image of a pregnant African American teen. Results showed that African American women high in ethnic identity under threat reported more state anxiety while in the "waiting room" than similarly identified Caucasian women or African American women not under threat.

Abdou, Fingerhut, Jackson, and Wheaton (2016) examined social identity threats in healthcare across a variety of social identities, not just race/ethnicity. Approximately 1,500 older adults participating in the Health and Retirement Study were asked whether they feared being judged by the doctor or other medical staff based on a variety of identities including race/ethnicity, gender, age, weight and socioeconomic status. In this sample, 17% of participants reported threat based on at least one identity. Importantly, those who reported social identity threat were more likely to be hypertensive and depressed and to report poorer self-rated health and higher levels of physician distrust.

In addition to limited empirical work, others have theorized about potential consequences of stereotype and social identity threats for minority individuals (mostly conceptualized as ethnic minorities) on health behaviors and health outcomes. Because of the anxiety that stereotype threat produces, Burgess, Warren, Phelan, Dovidio, and van Ryn (2010) suggested that within healthcare contexts, stereotyped individuals may feel uncomfortable communicating with their providers for fear that they will be judged or that they will do something to confirm a stereotype. Furthermore, as Schmader and Johns (2003) show that identity-related threats can place demands on cognition, we hypothesize that this could in turn affect patients' ability to take in a doctor's recommendations potentially affecting adherence to treatment. Ultimately, as a way to avoid these uncomfortable

situations, Burgess and colleagues (Aronson, Burgess, Phelan, & Juarez, 2013; Burgess, Warren, Phelan, Dovidio, & van Ryn, 2010) hypothesized that minority individuals stop seeking care or delay seeking care, negatively impacting health outcomes.

### **Prerequisites for Healthcare Stereotype and Social Identity Threats in LGB Individuals**

No data currently exist directly testing stereotype threat theory in the context of LGB health. It is clear, however, that the theory holds great relevance for understanding LGB health disparities. The fundamental prerequisite of stereotype threat theory—that negative stereotypes about a group exist and are relevant in the context—is clearly met in the case of sexual minorities. Research on perceptions of gay and lesbian individuals consistently supports gender inversion theory (Kite & Deaux, 1987). In other words, gay men are stereotyped as feminine and lesbian women as masculine. Even as attitudes toward LGB individuals have changed over time, this stereotype has persisted (Blashill & Powlishta, 2009; Mitchell & Ellis, 2013). Other negative stereotypes have also emerged in research over the years. Gay men, for example, have been stereotyped as hypersexual (Levitt & Klassen, 1976), perverted (Simmons, 1965), possessing political agendas (Anderson & Kanner, 2011), closeted and (paradoxically) flamboyant (Clausell & Fiske, 2005), and as possessing symptoms of mental illness (Boysen, Vogel, Madon, & Wester, 2006). Lesbian women have been stereotyped as sexually deviant, confused, and angry (Geiger, Harwood, & Hummert, 2006). Research on stereotypes of bisexuals is much more limited. An unpublished dissertation (Parent, 2012) suggests the stereotypes for bisexuals are similarly negative and involve beliefs about immorality and gender inversion. Zivony and Lobel (2014) further demonstrated the existence of stereotypes of bisexual men in particular, showing that a fictitious bisexual male target was rated as more confused and indecisive, more likely to have had many previous relationships, less likely to be able to maintain a long term relationship, and less trustworthy than a heterosexual or gay male target.

Given the existence of these stereotypes in the broader culture, it is likely that these representations appear in healthcare contexts as well—and, importantly, these stereotypes have direct relevance for health and healthcare. In line with this, Mohr, Chopp, and Wong (2013) suggested that assumptions that gay men are effeminate can affect the way a clinician treats a client and that such treatment may vary depending on whether the clinician holds traditional or nontraditional views about gender roles. Furthermore, to the extent that a lesbian patient is assumed to be more masculine, healthcare providers may assume this means she is less communicative and less emotional and thus treat her accordingly. If gay and bisexual men are viewed as hypersexual, treatment may be guided by and perhaps narrowly focused on this assumption, though it may not be relevant in a particular

case. Highlighting the relevance of sexual orientations for healthcare settings, and in particular within the context of therapy, Mohr et al. (2013) concluded the following:

... stereotyping based on sexual orientation... may lead therapists to overlook idiosyncratic characteristics of individual clients, perceive stereotype-consistent characteristics when they are not present in clients, and reach incorrect conclusions about clients' presenting problems and overall level of functioning (pp. 40–41).

Prerequisites related to the broader concept of social identity threat also are apparent in the case of LGB health. Most central are data demonstrating: (1) that the medical community possesses negative attitudes toward sexual minority patients and (2) that LGB individuals often report being discriminated against in healthcare contexts and receiving subpar care. These conditions set the stage for LGB individuals entering healthcare contexts to worry that they may be marginalized due to their minority sexual orientation. In an older study of doctors in the San Diego area (Mathews, Booth, Turner, & Kessler, 1986), almost 33% of respondents indicated feeling “sometimes uncomfortable” when treating a homosexual patient, and another 7% reported feeling “often uncomfortable.” In a more recent follow-up study with individuals from the same San Diego association of doctors (Smith & Mathews, 2007), attitudes proved to be less negative. In this round, 16% indicated feeling “sometimes uncomfortable” when treating a homosexual patient and 1.6% reported feeling “often uncomfortable” (D. Smith, personal communication, May 18, 2015). Thus, as with general societal attitudes toward LGB persons (Hicks & Lee, 2006), attitudes within healthcare have improved over time; however, a significant percentage still seem to feel negatively toward their sexual minority patients.

Despite potentially positive changes in attitudes across time, LGB people themselves continue to report discrimination and dissatisfaction with healthcare providers. In a study conducted by Lambda Legal (2010) concerning healthcare fairness for LGBT people and those living with HIV, 28.5% of the LGB participants indicated concern that they would be treated differently by medical personnel because of their sexual orientation, with 9.1% fearing that they would be refused service because of being LGB. Clift and Kirby (2012) found that individuals in same-sex couples were significantly less likely than individuals in different-sex couples to feel that doctors spent enough time with them or showed them respect.

Studies examining sexual minority men and women separately also reveal continued perceptions of discrimination. Beehler (2001) used in-depth interviews with gay men to ascertain their experiences with healthcare workers. Though the men reported attempting to build open relationships with primary care physicians, they also reported that the healthcare system was largely homophobic and heterosexist. Additionally, the men reported that healthcare providers remained largely ignorant of the special healthcare needs of the gay population. Paralleling the

existing work with gay men, Mosack, Brower, and Petroll (2013) found that sexual minority women reported less satisfaction with their healthcare providers than heterosexual women. In a sample of Canadian sexual minority women, Geddes (1994) reported that 19% had a negative experience when disclosing their sexual orientation to doctors

The disconnect between reports of doctors' accepting attitudes and patients' reports of discrimination and pervasive heterosexism may reflect the existence of subtle, nonconscious homophobia among healthcare workers and in healthcare settings. In the context of race, this form of subtle prejudice, whereby one claims to not be racist but subtly treats individuals differently based on their race, is referred to as aversive racism (Dovidio & Gaertner, 2004; Major, Mendes, & Dovidio, 2013). Penner et al. (2010) examined aversive racism in medical contexts involving African American patients and non-African American providers. Physicians completed measures of both explicit and implicit racism, while patients completed measures assessing their reaction to the provider, including constructs such as satisfaction with care and perceptions of the doctor's warmth and friendliness. Patients responded particularly negatively to doctors who were aversive racists, or those who scored low in explicit prejudice but high in implicit prejudice (i.e., those who see themselves as egalitarian, but who, in fact, harbor prejudicial attitudes). In fact, patients responded more negatively to these individuals than to those who reported prejudice at both the explicit and implicit levels. The aversive racists likely behave in distinct, yet subtle ways as a means to express their underlying prejudice that the stigmatized patients can "feel" and respond to in a negative manner. Although this study was done in the context of race, a similar phenomenon may occur with sexual minorities and explain why doctors self-report positive attitudes yet patients perceive them as homophobic. Finally, to the extent LGB individuals report experiencing poorer healthcare on account of their sexual orientation and beliefs that doctors marginalize sexual minorities, social identity threats become likely in future encounters within healthcare.

### **Consequences of Healthcare Stereotype and Social Identity Threats in LGB Individuals**

Data on stereotypes about and attitudes toward LGB individuals suggest that the prerequisites for stereotype and social identity threat to occur are apparent in healthcare contexts. Additional research suggests that consequences of these threats in general are also present specifically in the context of LGB health (e.g., impaired communication with providers due to anxiety, cognitive load, and, ultimately, disengagement with the healthcare domain).

Central to effective communication between sexual minority patients and their providers is the disclosure of one's minority sexual identity. Yet, many LGB individuals report that they have not "come out" to their healthcare providers and



that they fear doing so. In a diverse sample of LGB adults gathered in New York (Durso & Meyer, 2013), 10% of gay men and 12.9% of lesbian women reported that they had not disclosed their sexual orientation to their doctors. The numbers were significantly higher for bisexual men (39.3%) and bisexual women (32.6%), suggesting that these subpopulations may be at even greater risk for healthcare stereotype threat. In a study of gay and bisexual men in the United Kingdom (Guasp, 2011), 34% of the men were not out to their healthcare providers, a higher portion than those not out to coworkers or managers.

Also in line with the outcomes proposed by stereotype threat theory, research consistently shows that LGB individuals are more likely than heterosexuals to delay seeking healthcare or to avoid it altogether—clear signs of disengagement. Data, for example, show that lesbian and bisexual women are less likely to receive preventative care than heterosexual women. In data pooled across studies of lesbian health and then compared with general population data, Cochran et al. (2001) found that lesbian women were significantly less likely than heterosexual women to have received a pelvic exam or a mammogram. Similarly, Matthews, Brandenburg, Johnson, and Hughes (2004) found that while there were not sexual orientation differences in whether a woman had ever received a Pap test, lesbians were significantly less likely than heterosexual women to have routine annual Pap testing. In comparisons of men who have sex with men (MSM) and general population data, Alvy et al. (2011) found that MSM were over two times less likely to have visited the doctor in the past two years. This could be because these men were healthier, though the larger literature on health disparities suggests that this is not likely to be the case. It is more probable that these men did not seek out care either because of a lack of insurance and/or because of fears of being stigmatized, again potentially indicating disidentification with healthcare.

In terms of delaying care, data reveal a very similar story. For example, in data collected from lesbian and heterosexual women between 1996 and 1997, 36.8% of lesbian women reported delaying healthcare in the year prior because of sexual identity concerns (van Dam, Koh, & Dibble, 2001). In contrast, only 2.7% of heterosexual women reported such a concern. In addition, 30.4% of the lesbian women reported that fear of discrimination based on sexual identity always or most of the time contributed to incidents of delaying healthcare. Less than 1% of heterosexual women reported similar fears.

More recent data corroborate these findings. In analyses of the 2007 California Health Interview Survey (Krehely, 2009), 29% of LGB adults had delayed receiving healthcare in comparison to only 17% of heterosexual adults. In a Harris Interactive Poll commissioned by the Mautner Project (Harris Interactive, 2005), separate samples of LGB individuals, lesbian women, and heterosexuals were queried as to whether they had ever delayed obtaining healthcare and, if so, whether a variety of reasons accounted for the delay. Whereas 54% of the heterosexuals had delayed receiving healthcare, 63% of the LGB and 75% of the



lesbian samples reported delaying care. For all the samples, the leading causes for delaying care concerned economics (i.e., concerns about healthcare costs, lack of insurance). However, stigma-related issues appeared more prominently in the sexual minority than the heterosexual samples. For example, whereas only 12% of heterosexuals reported delaying care due to previous bad experiences with healthcare providers, 22% of the LGB and 27% of the lesbian sample reported this reason. Similarly, whereas only 3% of the heterosexuals reported delaying care for fear of being discriminated against, 15% of the LGB and 16% of the lesbian samples reported this reason.

### **Future Research and Interventions**

This article represents a new line of thinking among scholars linking stereotype and social identity threats to nonperformance domains and, more specifically, to healthcare contexts and to population-level health disparities. Given the nascent stage of this work, research is needed to establish the existence and effects of healthcare stereotype threat and social identity threat in the healthcare experiences of LGB people. Although the research reviewed in this article suggests that these threats are likely to be present in the healthcare experiences of LGB persons, direct tests of healthcare stereotype threat and social identity threat need to be conducted with the LGB population. Such studies should include lab experiments that mimic traditional stereotype threat studies. Following Abdou and Fingerhut (2014), for example, LGB participants could be randomly assigned to conditions where LGB stereotypes are present or not in a simulated healthcare context to see how this affects a variety of outcomes. Of course, unlike traditional stereotype threat work in which performance (usually academic performance) is measured as the outcome, performance is not likely a relevant outcome in healthcare contexts. Instead, researchers might measure the extent to which salient stereotypes affect outcomes such as perceptions of stigma, trust of the healthcare provider, anxiety and cognitive load. Researchers would also be wise to extend beyond the lab to examine how identity threats manifest in actual healthcare settings. Such research will need to sample widely from the LGB population and not rely solely on participants seeking healthcare as many individuals may have already disengaged from the healthcare domain on account of the very threats we are suggesting occur.

Future research will need to pay attention to the fact that the LGB community and the experiences of LGB individuals are not monolithic. At the most basic level, experiences of threat as experienced by gay men, as opposed to lesbian women and bisexual men and women, must be disentangled. This becomes particularly important as the stereotypes, and therefore the threat of stereotypes, vary between groups. For example, though gay men may fear being judged through a stereotype that suggests that they are promiscuous and carriers of HIV/AIDS, lesbian women

likely do not worry about being seen through such a lens, and may instead worry about being seen as too “butch” or angry or perhaps seen as not sexual at all given stereotypes about lesbian bed death. Furthermore, LGB individuals exist within a multitude of other communities, and the intersection of these social environments and identities likely affects how identity threats are experienced and embodied. How, for example, a Latina lesbian contends with stereotypes about her minority ethnic identity, her sexual orientation, and her gender individually, let alone stereotypes that may arise as a result of the confluence of these identities, is unknown.

Context may be an important moderating variable. For example, geographic location may ultimately determine the extent to which identity threat becomes a relevant construct. Stigma and marginalization based on sexual orientation vary from place to place, and this affects mental health directly and indirectly. Hatzenbuehler, Keyes, and Hasin (2009) made this point clearly in investigating how statewide variations in policies supporting LGB rights are associated with mental health outcomes for LGB individuals. Similar analyses need to be done at more of a micro level (e.g., regions within a state to compare more versus less populated areas) and at a larger macro level (e.g., across countries and cultures), as geography likely dictates the degree to which stereotypes are salient, whether prior discrimination in healthcare has occurred, and whether LGB people are represented in the medical environment. Internationally, for example, there are countries, many of which are located in Africa or Asia, where same-sex sexual behavior is still criminalized (Carroll & Itaborahy, 2015). Identity threats for LGB individuals are likely most present and impactful in these countries as an encounter with a physician that calls one’s LGB sexual orientation or sexual behavior into question has potentially dire consequences.

In addition to documenting healthcare stereotype threat and effects in LGB patients, future work could focus on reducing threat. Extrapolating from work on stereotype threat reduction in academic settings (e.g., Murphy, Steele, & Gross, 2007), Abdou and Fingerhut (2014) suggested that one possible and probable way to reduce stereotype threat in medical settings is to provide cues that the environment is open and accepting and that stereotypes are not relevant in the context. Healthcare facilities could create environments where inclusiveness is reflected. For example, healthcare centers could post mission statements where clearly articulated commitments to diversity are made (Burgess et al., 2010). Instead of having posters that only include heterosexual families, for example, an office waiting room could include images of same-sex couples or other nontraditional family groups. Steele, Tinmouth, and Lu (2006) suggested that one way to signify that a medical provider is accepting of sexual minorities is to include demographic questions regarding sexual orientation on intake forms. Similarly, they suggested that a provider’s willingness to directly ask about a patient’s sexual orientation positively influences disclosure, ultimately benefitting health outcomes.

Such suggestions, however, highlight the complexities inherent in healthcare stereotype threat, and stereotype threat in general, as well as in harm reduction strategies. On one hand, including sexual orientation on forms demonstrates that the doctor or other healthcare provider does not presume heterosexuality and is, therefore, open to a variety of sexualities. On the other hand, it highlights the identity and makes it salient within an environment that may already be assumed to be homophobic, potentially exacerbating the experience of threat. Research is needed specifically within medical contexts to better understand how situational cues, especially those directly related to social identities, serve to protect or exacerbate healthcare stereotype threat and broader identity threats.

Research on intergroup relations more generally may offer possible solutions. For example, Penner et al. (2013) utilized the theory of Common Ingroup Identity (CII; Gaertner & Dovidio, 2000) to ameliorate tensions in African American patient/non-African American provider healthcare situations. CII suggests that intergroup tensions can be decreased by reframing who is in the ingroup and by casting a wider net so that previously considered outgroups are now part of the ingroup. To the extent that individuals recast others as part of the ingroup as opposed to the outgroup, they should treat these “others” better and interactions should proceed more smoothly. To create a sense of oneness between patient and provider, researchers told their participants that they would need to work as a team to come up with a solution for the patient’s healthcare issue. Additionally, both patients and providers were told that their team was designated with a team color and were given buttons signifying the team name and color, further substantiating a shared identity. Other participants were not given such information. Though this intervention did not result in any immediate effects, it did produce longer-term effects. Specifically those in the CII condition demonstrated greater trust of their physician and physicians in general four and 16 weeks later and greater adherence to the physician’s recommendations 16 weeks later. Such an intervention is interesting in that it does not require highlighting any single identity and still succeeds in reducing identity threat.

### **Summary and Conclusion**

Health disparities among LGB individuals exist for a variety of health outcomes. The Institutes of Medicine (2011) called for heightened research on understanding sexual minorities’ health, health experiences, and factors that ameliorate and exacerbate disparities. Central to this research agenda should be examinations of LGB healthcare stereotype threat and social identity threat as prior research in different domains and among different populations makes clear that such threats are associated with a cascade of adverse outcomes. Ultimately such research will aid in both explaining and reducing disparities via cost-effective mechanisms.

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