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# Heteronormativity and practitioner–patient interaction

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**ABSTRACT**

Heteronormativity is the presumption of heterosexuality as the default sexual orientation and can result in discrimination against the lesbian, gay, and bisexual (LGB) population. This study serves as one of the first experimental studies to examine heteronormative perceptions in communication and their effects on practitioner–patient relationships. LGB participants were randomly assigned to read either heteronormative or non-heteronormative vignettes of a doctor–patient interaction. They then indicated how much health-relevant information they would disclose to the doctor in the vignette and their level of trust in the doctor. In the heteronormative condition, participants were less likely to disclose health-relevant information to the doctor in the vignette and were less trustful of the doctor as compared to those in the non-heteronormative condition. These results have important health implications, as lack of disclosure and trust may prevent people from getting needed care and prevent doctors from giving the best health advice possible. The results of this study provide further evidence that there is a need for more education for all health care professionals to feel comfortable while respectfully communicating with and treating patients who do not identify as heterosexual in order to ensure the best health care experience.

Although doctors are responsible for contributing to a patient's well-being, many members of stigmatized groups such as lesbian, gay, and bisexual (LGB)[1] feel discriminated against by their own doctors. Evidence suggests that the subtle ways in which doctors communicate disapproval may negatively affect the interaction with and health outcomes of LGB patients. One way in which doctors communicate disapproval is through heteronormativity, or the assumption that everything is normally and naturally heterosexual (Kitzinger, 2005). Common examples include assuming that one's partner is always of the opposite sex, asserting that identifying one's orientation as gay or lesbian is immoral, and disregarding bisexuality as a sexual orientation (Habarth, 2011).

Heteronormative assumptions by physicians may stem in part from inadequate training on sexual and gender diversity. More than one-third of medical schools in the United States and Canada spend little, if any, time discussing lesbian, gay, bisexual, and transgender (LGBT) health-related issues during clinical training (Obedin-Maliver et al., 2011). In the United States, during preclinical years, medical students spend a median of only 5 hours discussing LGBT issues with regard to health care (Obedin-Maliver et al., 2011). With minimal preparation, many doctors graduating from medical school do not feel comfortable treating a patient who does not identify as heterosexual; as a result, barriers are created that hinder a trust-filled relationship and the provision of appropriate care (Wallick, Cambre, & Townsend, 1992).

With an identity that is already widely stigmatized by society, this type of disapproval and heteronormative communication may increase one's stigma consciousness about one's sexuality. Stigma consciousness, the extent to which targets of stereotypes are aware of them and expect to be stereotyped, has important influences on how people experience and behave in stereotype-relevant situations (Pinel, 1999). Higher levels of stigma consciousness with regard to one's sexual orientation are related to depressive symptoms and mental health well-being in general (Berghe, Dewaele, Cox, & Vincke, 2010; Lewis, Derlega, Griffin, & Krowinski, 2003). Moreover, people high in stigma consciousness have been shown to avoid stereotype-relevant situations in which there are opportunities to confirm the stereotype (Pinel, 1999), which may be particularly relevant for medical encounters.

Most of the research in the field of heteronormativity follows critical traditions of communication theory, with heteronormativity being examined and critiqued in varying circumstances with the intent that this analysis will produce awareness and insight into how to combat heteronormativity (Chevrette, 2013; Craig, 1999; Kincheloe & McLaren, 2002). For example, Goins and Pye (2013) examined intake forms and determined how the wording affected lesbian, gay, bisexual, transgender, and queer (LGBTQ) patients. Based on these qualitative data, Goins and Pye (2013) offered insight as to how to change the wording on intake forms to be more inclusive.

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[1]The acronyms LGB, LGBT, and LGBTQ are used variably in the article based on the terminology that was used in each of the cited references.

While our study follows many aspects of the critical tradition in that it serves to analyze and examine heteronormativity, it also takes on practices that relate to the sociopsychological approach, focusing on how these heteronormative attitudes affect an interpersonal interaction in an experimental setting. This experimental study does not serve to adjudicate between two competing traditions of communication theory (Myers, 2001). However, it does serve to contribute to a dialogue between traditions, in which we follow the critical tradition to examine heteronormativity's occurrence in both nonverbal and verbal communication and its societal implications, and we follow the sociopsychological tradition to examine how a doctor's communication style can influence a patient's decisions, beliefs, and feelings during a doctor–patient interaction and how this may impact those reading about this interaction. We strive to analyze what has been and is considered heteronormative in communication, and we also aim to understand heteronormativity's implications in a common interaction in a manner that is experimentally observable.

To our knowledge, this research is the first experimental study to examine the extent to which exposure to heteronormativity (the assumption that everyone is heterosexual) affects lesbian, gay, bisexual, pansexual, and asexual patients' willingness to disclose health-relevant information and trust in their physician. We created vignettes that were used to create the experimental and control conditions.[2] Participants read vignettes that described heteronormative or non-heteronormative communication throughout a doctor–patient interaction. We note that although the most inclusive acronym to use for the study's participants is LGBPA, most participants identified as LGB, and LGB is the most commonly used acronym in research. Thus, when referencing the lesbian, gay, bisexual, pansexual, and asexual participants of the study, we henceforth utilize the acronym LGB.[3]

## Heteronormative communication and health disparities In the LGB community and their effect on the practitioner–patient interaction

Although doctors do not have individual control over the structural barriers that exist in the health care system, they do have control over their own doctor–patient interactions. Evidence suggests that heteronormativity exhibited in health care professionals' communication contributes to these health disparities (Röndahl, Innala, & Carlsson, 2006). The greatest health risk for people who identify as LGB is that they avoid health care in the first place. This lack of regular health care leads to less opportunities to conduct screening, act upon preventative care, and educate one's patients (Harrison & Silenzio, 1996; Heck, Sell, & Gorin, 2006; Krehely, 2009). Heteronormative communication in the practitioner–patient setting can lead to an avoidance of health care and thus some of the health disparities that are present.

Members of the LGB community are at a greater risk of developing cancer, having higher rates of substance abuse, contracting HIV, and developing mental health problems that can lead to suicide (Bränström & van der Star, 2013; Dean et al., 2000; Fredriksen-Goldsen, Kim, Barkan, Muraco, & Hoy-Ellis, 2013; Hart & Flowers, 2001; Palefsky, Holly, Ralston, & Jay, 1998; Robertson, 1998; Stall, Greenwood, Acree, Paul, & Coates, 1999). Structural barriers that impede a high quality of care include denial of health insurance to partners and limitations of partner decision making (Mayer et al., 2008).

One way in which heteronormativity is conveyed is through the communication style a doctor utilizes. Appropriate doctor–patient communication is important for positive health outcomes and positive doctor–patient interactions (Evans, Stanley, & Burrows, 1992). When a person feels respected, he or she is more likely to comply with medical recommendations, report higher satisfaction with provided services, and achieve health-related behavior changes (Beck, Daughtridge, & Sloane, 2002), whereas poor communication leads to lower trust in one's provider (Bohnert, Zivin, Welsh, & Kilbourne, 2011). Heterosexual assumptions communicated by a health care professional have been reported to lead to a feeling of invisibility, fear of mistreatment postdisclosure, lack of trust and confidence in the physician, and lack of disclosing sexual orientation (Röndahl et al., 2006). Barriers to access and quality health care include a reluctance to disclose sexual orientation due to the insufficient number of competent providers and lack of culturally sensitive prevention services. These phenomena can in turn lead to inaccurate diagnoses and inaccurate patient history (Cegala, Street, & Clinch, 2007). Additionally, Durso and Meyer (2013) found that nondisclosure was related to poorer psychological well-being at a 1-year follow-up. Whether or not one discloses one's sexual orientation is influenced by whether or not the doctor is gay-friendly, and the doctor's communication style is the primary predictor of sexual orientation disclosure even above one's level of "outness" (Klitzman & Greenberg, 2002; White & Dull, 1998).

Heteronormativity can be communicated both verbally and nonverbally. Verbally, physicians may assume a patient is cohabiting with the opposite sex, asking whether a person is "single, divorced, or married" instead of being inclusive of those cohabiting or in civil unions. Use of the general term "intercourse" interchangeably with "vaginal intercourse" assumes heterosexual intercourse and can confuse those answering the question who are engaging in anal intercourse (Goins & Pye, 2013; Röndahl et al., 2006; Wilton, 2000). Additionally, heteronormativity can be expressed when a physician implies that behaviors relating to same-sex intercourse are deviant, such as the phrase "objects during sex" instead of "sexual toys" (Goins & Pye, 2013). Nonverbal heteronormative cues also have detrimental effects on the quality of the doctor–patient interaction. Röndahl et al.

[2]For access to vignettes, please contact the corresponding author.

[3]Opinions vary as to whether asexuality is considered a sexual orientation. We chose to include it as a sexual orientation based on research suggesting that sexual orientation is most closely related to one's erotic fantasy desire (Storms, 1980). Because people who identify themselves as asexual are often not attracted to anyone in an erotic fashion, we feel that, for this study, asexuality can be considered a sexual orientation (Bogaert, 2012).

(2006) found that when health care professionals found out that their patient identified as LGB, they avoided eye contact with the patient and the patient's partner (if he or she was in the room), and turned their backs to the patient.

## Research objectives

The objective of the current research was to examine the extent to which exposure to heteronormative communication affects LGB participants' willingness to disclose health-relevant information and their perceived trust in the physician. We also examined how stigma consciousness and level of outness affect disclosure and trust, and how these constructs interact with heteronormativity to influence disclosure and trust.

## Research hypotheses

The research hypotheses are as follows:

1. Participants who read a heteronormative vignette will report less overall disclosure when compared to those who are assigned to read the non-heteronormative vignette. Given that heteronormativity in medical settings leads to reports of feelings of invisibility and fear of mistreatment postdisclosure among LGB individuals (Röndahl et al., 2006), we reasoned that heteronormativity would also be related to reduced willingness to disclose information for lack of confidence in being heard and lack of confidence in consequences of disclosure.
2. Participants assigned to the heteronormative vignette will report less overall trust in their physician when compared to those assigned to the non-heteronormative vignette. Reduced trust in one's physician is also associated with the physician's heteronormativity (Röndahl et al., 2006), which has important consequences even independent of disclosure.

We also examined the effects of two moderators that we expected to have an influence on how heteronormativity would be experienced: the extent to which people were aware of the stigma about sexual orientation (stigma consciousness; Pinel, 1999) and the degree to which people have disclosed their sexual orientation to others (level of outness).

3. Stigma consciousness will moderate heteronormativity's effect on overall disclosure and overall trust. Stigma consciousness has been found to strengthen the perception and negative experience of stigma surrounding particular identities (Pinel, 1999.) We predicted that participants high in stigma consciousness would be more attuned to discriminatory cues and thus report a lower willingness to disclose information and less trust.
4. Level of outness will also moderate the effect of condition on trust and disclosure. Those who have revealed their sexual orientation to some people are more likely to have had experiences with disapproval. We therefore expected that participants higher in outness would be less affected by the heteronormativity and more likely to disclose information and trust the doctor.
5. Stigma consciousness and outness will have an interactive effect on disclosure and trust. Those who were low in stigma consciousness and high in outness were predicted to be more likely to disclose information and to have more trust in their practitioner as compared to people who were high in stigma consciousness and low in outness. Being more aware of the stigma that surrounds their identity should be associated with less openness about their sexual identity for fear of being stigmatized.

## Overview of research

Participants were recruited using Amazon's Mechanical Turk (MTurk). MTurk is an online crowdsourcing tool that allows "workers" to complete online tasks or "human intelligence tasks" (HITS) for relatively small amounts of remuneration. MTurk has become an increasingly popular tool for social science research, with multiple experimental and survey studies consistently replicating findings from prior research (e.g., Boynton & Richman, 2014). To test our hypotheses, heteronormativity was manipulated in an experimental design by use of vignettes that we created that portrayed a heteronormative or non-heteronormative doctor–patient interaction. LGB participants read one of the two scenarios and then indicated their responses to several questionnaires.

## Methods

### Participants

Participants were screened for sexual orientation. Those who identified as lesbian/gay, bisexual, pansexual, or other, but not heterosexual, were recruited to participate in the main study ($N$ = 133) and received $0.60 in Amazon credit for their participation. Participants who took the prescreen but did not qualify for the main study received $0.10 in Amazon credit. After being transferred to the main study, participants were randomly assigned to read either the heteronormative vignette or the non-heteronormative vignette.

The final sample size was 133 people: 73 who identified as bisexual, 39 who identified as gay or lesbian, 10 who identified as pansexual, five who identified as asexual, one who identified as gray asexual, one who identified as queer, one who identified as mostly heterosexual, one who identified as heteroflexible, and one who identified as transgender; one identified as other but chose not to write in what "other" stood for. While those participants who identified themselves as queer and transgender could be heterosexual by orientation, we chose to include them in the LGB group because they had the option to choose heterosexual to indicate their orientation, but did not.

Of the 133 participants, 52 participants were male and 81 were female (ages 18–75 years). Most participants were Caucasian ($n$ = 96), however, participants of multiple different ethnicities participated as well (African-American = 10; Asian = 11; Hispanic = 8; Other = 9).

### Procedure

Participants were randomly assigned to read either the heteronormative or non-heteronormative vignette. Both types of

vignette that we created were based on descriptions of heteronormativity in past research (Goins & Pye, 2013; Röndahl et al., 2006; Wilton, 2000) and questions that are normally asked in first-visit primary care interviews (A. Punwani & D. Utamsingh, personal communication, August 10, 2013) and in some intake forms (Goins & Pye, 2013). Researchers in the field of LGB research read the vignettes to ensure realism. In the vignette, Dr. Smith, whose entire identity is ambiguous, has an interaction with a patient who reveals that he or she is bisexual. Bisexuality was chosen because it was the most prominent non-heterosexual orientation in the United States (Gates, 2011). Based on the condition of the vignette, the doctor's communication during the interaction was either heteronormative or non-heteronormative. There were four vignettes in total, a heteronormative and non-heteronormative vignette for male and female.[4] Participants who indicated female on their prescreen as their gender were randomly assigned to read either the heteronormative or non-heteronormative vignette for females, and the same was done for those who identified their gender as male.

After reading the vignette, participants completed the disclosure questionnaire, followed by the Wake Forest Physician Trust Scale, the Stigma Consciousness Scale, the Outness Inventory, and demographic information. After completing the measures, the participants were given the opportunity to write how they felt about Dr. Smith.

### Disclosure questionnaire

The disclosure questionnaire was derived from disclosure questions that commonly appear on intake forms at the doctor's office and that doctors commonly ask during a first visit obtained through an interview with two physicians. One of the physicians is a primary care physician for the Miami VA Health System and the other physician is a primary care physician in private practice to obtain a balanced set of questions (A. Punwani & D. Utamsingh, personal communication, August 10, 2013). Participants were asked how comfortable they felt disclosing health-relevant information to Dr. Smith (the doctor in the vignette). Items included physical health history, sexual orientation, substance use, eating habits, sexual activity history, alcohol consumption habits, employment status, mental health history, and family structure (Cronbach's $\alpha$ of .98). Overall disclosure was calculated by averaging all of the answers to the disclosure questions.

### Wake Forest Physician Trust Scale (Hall et al., 2002a)

This scale was used to assess level of trust in one's physician. The scale is strongly correlated with desire to stay with a physician, satisfaction with that physician, willingness to recommend the physician to friends (desire to switch physicians: r = −0.69, satisfaction: r = 0.76, recommend to friends: r = 0.74). Hall et al., (2002b) also found that general trust in physicians is, on average, lower than trust in a specific physician.

### Stigma consciousness scale for LGB

Pinel's Stigma Consciousness Scale for Gay Men and Lesbians (Pinel, 1999) measures the extent to which those who identify as gay or lesbian are aware of the stigma that surrounds their sexual orientation (Cronbach's $\alpha$ of .81).

### Outness inventory

Mohr and Fassinger's Outness Inventory (Mohr & Fassinger, 2000) measures the extent to which people are open about their sexual orientation. The test measures degree of outness in general (4 items; $\alpha$ = .79), outness to the family (4 items; $\alpha$ = .74), and outness to one's religious community (2 items; $\alpha$ = .97). Assessing these multiple levels of outness is comprehensive and representative of the ongoing process of how disclosure of sexual orientation occurs in everyday experiences (Chevrette, 2013).

## Results

### Overall disclosure

In the first model (referred to as Model 1) of our hierarchical linear regression, we tested the variables of Condition, Outness, and Stigma Consciousness and their effect on overall disclosure. The Omnibus test was significant, $R^2_{adj}$ = 0.323, $F(3, 124) = 21.234$, $p < .01$. In this model, both Condition and Stigma Consciousness were significant predictors of overall disclosure.

However, these results were further qualified by significant interaction effects shown by the next model (Model 2). Model 2 contained the variables of Stigma Consciousness, Condition, Outness, Stigma Consciousness × Condition, Outness × Condition, and Stigma Consciousness × Outness in order for us to examine moderation effects on overall disclosure. The Omnibus test for the regression looking at interaction effects was significant, $R^2_{adj}$ = 0.36, $F(6, 121) = 12.83$, $p < .01$. Stigma Consciousness, Condition, and the interaction between Outness and Condition were significant predictors of overall disclosure.

Condition had a statistically significant effect on overall disclosure, $\beta = 0.54$, $p < .01$. Those in the heteronormative condition had significantly lower levels of overall disclosure ($n = 64$, $M = 2.94$, $SD = 0.96$) when compared to those in the non-heteronormative group ($n = 66$, $M = 3.94$, $SD = 0.77$; Figure 1).

Stigma Consciousness also had a significant main effect on overall disclosure that was independent of the effects that the interaction terms and other variables had on overall disclosure, $\beta = -0.44$, $p < .01$. Those who were higher in Stigma Consciousness were less willing to disclose information than those lower in Stigma Consciousness (Figure 2).

The interaction between level of Outness and Condition was significant, $F(6, 121) = 12.83$, $p = .02$. We used the pick-a-point approach, in which three points are picked: one standard deviation below the average, the average, and one standard deviation above the average for the moderator

[4]While we recognize that gender is not solely binary, we created one vignette for male and one for female to eliminate the confounding variable that heteronormativity may also have an effect on gender identity since the focus of the study was in examining sexual orientation.

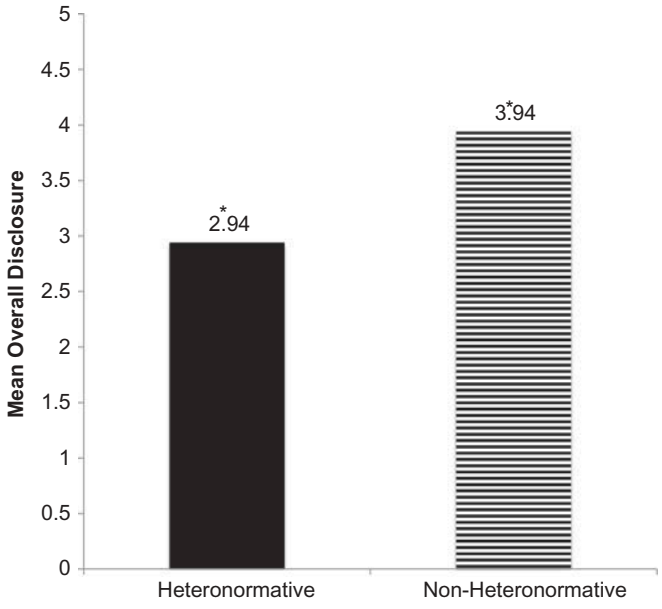


**Figure 1.** Condition and its effect on overall disclosure. Significance: *$p < .01$.

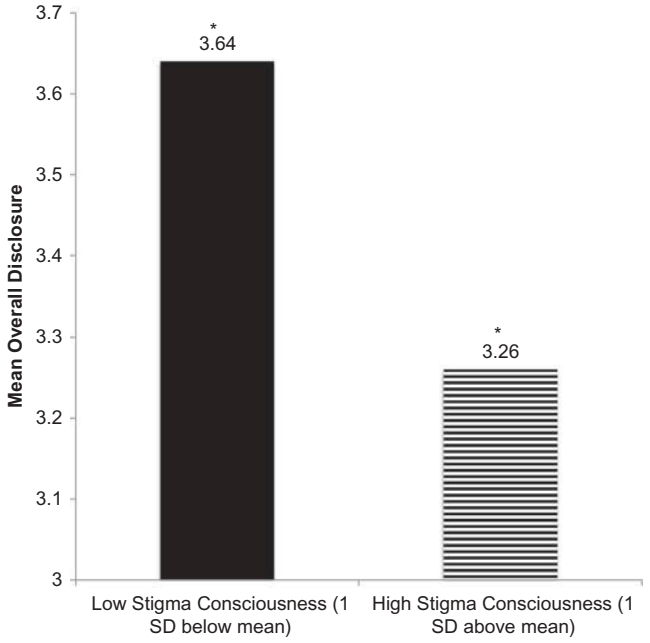


**Figure 2.** Stigma consciousness and its effect on overall disclosure. Significance: *$p < .01$.

variable (the variable that may modify the effect of the independent variable). Then the focal predictor (the independent variable) is analyzed at all three levels of the moderator. With Condition as the focal predictor and level of Outness as the moderator, we found that Condition had a significant main effect on overall disclosure that is independent from the effect that level of Outness had at one standard deviation below the mean for Outness ($b = 0.73$), the mean of Outness ($b = 1.08$), and for one standard deviation above for Outness ($b = 1.42$; in all cases, $p < .05$). As can be seen, those who are more open about their sexual identity are reportedly more affected by

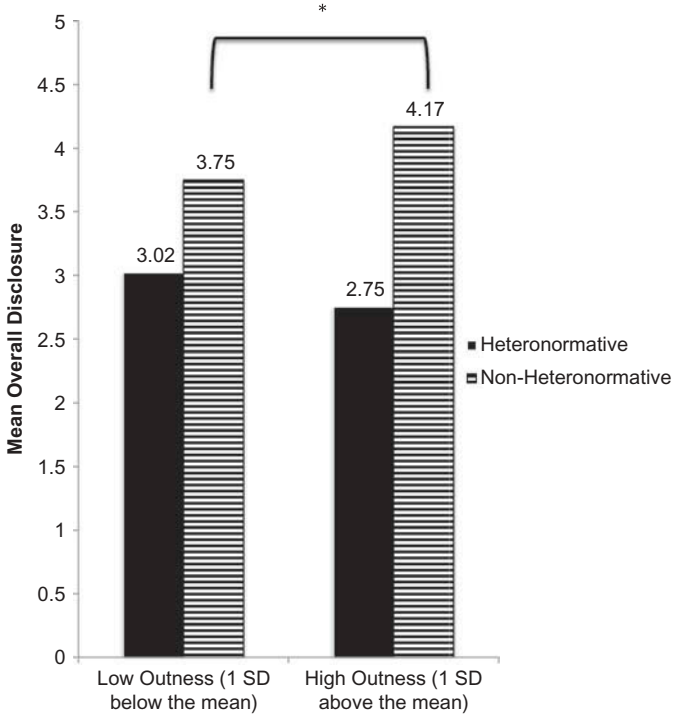


**Figure 3.** Outness and its moderation on disclosure. Level of outness only had a significant effect on disclosure in the non-heteronormative condition. Disclosure in the heteronormative condition was equally low regardless of outness.

condition. However, there were only significant differences between those with high Outness and those with low Outness, $F(6, 121) = 12.83$, $b = 0.13$, $p = .05$, in the non-heteronormative group. This demonstrates that what is causing the moderation is an effect in the non-heteronormative condition, not in the heteronormative condition (Figure 3).

### *Overall trust*

In the first model (referred to as Model 1) of our regression, we incorporated the variables of Condition, Outness, and Stigma Consciousness in order to examine their effect on overall trust. The Omnibus test was significant, $R^2_{adj} = 0.41$, $F(3, 126) = 30.52$, $p < .01$. Condition and Stigma Consciousness again were significant predictors of overall trust.

In order to examine the moderation effects, we included the interaction variables of Stigma Consciousness, Condition, Outness, Stigma Consciousness × Condition, Outness × Condition, and Stigma Consciousness × Outness. The Omnibus test for the regression looking at interaction effects was significant, $R^2_{adj} = 0.42$, $F(6, 123) = 16.55$, $p < .01$. Here, Stigma Consciousness and Condition were significant predictors of overall trust and the interaction term of Stigma Consciousness × Condition was marginally significant ($p = .08$).

According to Model 2, Condition had a significant main effect on overall trust, $\beta = 0.57$, $p < .01$. Those in the heteronormative condition had significantly lower levels of trust ($n = 65$, $M = 26.05$, $SD = 7.86$) when compared to those in the non-heteronormative group ($n = 67$, $M = 30.81$, $SD = 8.78$; Figure 4).

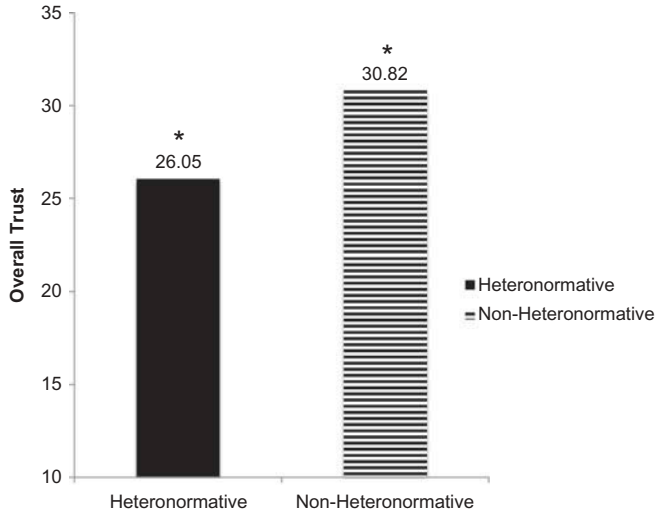


**Figure 4.** Condition and its effect on overall trust. Significance: *$p < .01$.

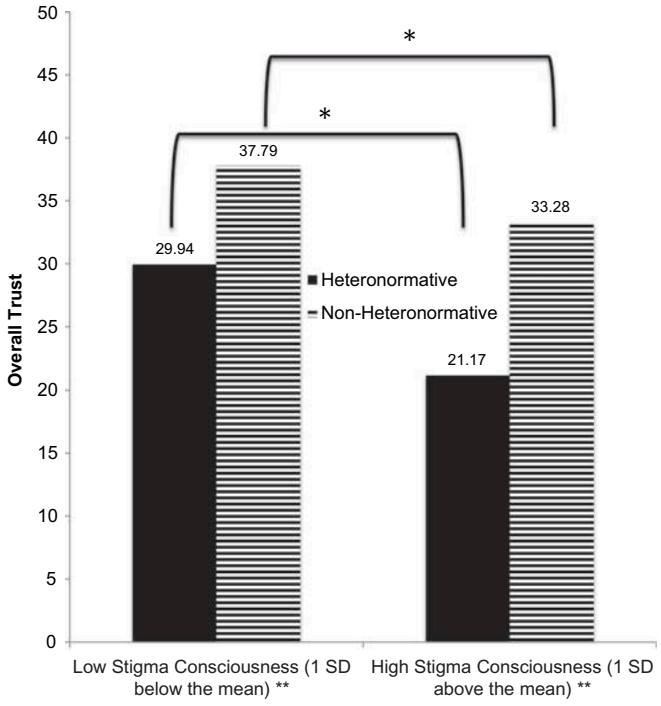


**Figure 5.** Stigma consciousness and overall trust. There was an effect both within and between groups, once again showing the main effects of both condition and stigma consciousness on overall trust. Significance: *$p < 0.1$, **$p < .01$.

Stigma Consciousness also had a significant effect on overall trust that is independent of that of all other interaction terms and main variables used in the study, $\beta = -0.500$, $p < .01$. This indicates that those higher in stigma consciousness reported less overall trust in the doctor.

The interaction effect between Stigma Consciousness and Condition on overall trust was marginally significant, $F(6, 123) = 16.55$, $p = .08$, so we examined whether Stigma Consciousness moderated the effect of Condition on overall trust.

Using the pick-a-point approach again, we found that Condition had a significant main effect that was independent of the effects of Stigma Consciousness on disclosure at one standard deviation below the mean of Stigma Consciousness ($b = 0.79$), the mean of Stigma Consciousness ($b = 9.98$), and one standard deviation above the mean of Stigma Consciousness ($b = 12.12$; in all cases, $p < .01$. Participants in both conditions who were more aware of the stigmatization that surrounds their sexual identity had less overall trust in their doctor (Figure 5). Furthermore, as the regression coefficients illustrate, the effect of condition on trust increases as stigma consciousness increases.

## Discussion

### *Heteronormativity and the practitioner–patient interaction*

As predicted, participants who read the heteronormative vignette were less likely to feel comfortable disclosing health information to the doctor and had less trust in the doctor compared to those who received the non-heteronormative vignette. These results have important implications for the future of health communication between doctors and patients. Doctors may unintentionally be acting disrespectfully and insensitively toward their LGB patients when they exhibit forms of heteronormative communication. As a result, patients may feel as though they cannot trust their doctor and feel less willing to disclose health-relevant information.

If heteronormative communication can contribute to low trust and lack of willingness to disclose information in doctor visits, patients are unlikely to get what they need from their doctors. If patients are not able to feel confident in discussing health concerns with their doctor, they cannot get the help or medical aid they require. Additionally, the doctor is often not able to properly diagnose the patient because the doctor does not have all relevant health-information. This may lead to fewer behavior-related health changes and, potentially, poorer mental health. The measure of trust we used would also tend to underestimate the general trust in physicians (Hall, et al. 2002b). Thus, not only could patients faced with heteronormative communication not trust the doctor, but they may not trust the medical profession as a whole. Patients may then lack compliance with regard to medical recommendations and have poorer health, which will only increase health disparities among the LGB community.

### *Level of outness and the practitioner-patient interaction*

Those participants higher in level of outness were more affected by the type of vignette they received when examining overall disclosure. Participants in the non-heteronormative group had differences in overall disclosure between levels of outness: those higher in outness were significantly more likely to disclose information than those lower in outness. This could be because those who are more open about their sexual orientation are more willing to share with a doctor in the first place, especially if the doctor seems accepting.

There was no statistically significant difference in overall disclosure in the heteronormative group between levels of outness, which may suggest that when a person feels disrespected, no matter how open the person is with sexual

identity, that person will choose not to disclose information. However, level of outness did not have an interaction effect or main effect on overall trust. It is possible that there are differences in how much a participant trusts the doctor as a person versus how much the participant trusts the doctor as a professional. Since the doctor does have a professional degree, the participant may not judge the doctor's ability to diagnose, but will feel offended in disclosing information.

### Stigma consciousness and the doctor–patient interaction

While stigma consciousness did not moderate the effect of condition on overall disclosure, those participants higher in stigma consciousness were more affected by the vignette they received when examining overall trust. This could be because when people are more aware of the stigma that surrounds their sexual orientation, they could be more attuned to the cues and more able to articulate heteronormativity present in a doctor's manner of communication. Being more attuned to such cues would then lead to people ruminating about more of the mannerisms and thus being less likely to then trust the doctor as a person and professional because the doctor's personal and professional communication skills are poor.

It is important to recognize that stigma consciousness had a main effect on overall disclosure and overall trust that is independent of the effect of a doctor's manner of communication. Because stigma consciousness has a main effect, this evinces that people in general who are higher in stigma consciousness will be less likely to disclose health-relevant information to a doctor and will have less overall trust in a doctor. Hence, if one is already higher in stigma consciousness and thus is increasingly less likely to disclose information and trust a doctor, once heteronormative communication is brought into the picture, the person is even less likely to disclose-health relevant information and will have even less trust in the doctor than those not exposed to heteronormative communication. Stigma consciousness and openness about one's sexual orientation did not have a significant interaction effect on disclosure or trust. This could be due to the strength of stigma consciousness and its main effect on overall disclosure and trust.

### Communication theory and the doctor–patient interaction

A subject such as heteronormativity is often presented in an analytical perspective or simply observed because it is difficult to put boundaries on what can be considered heteronormative, as it is an interpretive construct. However, utilizing past research and consulting experts in the field, we were able to show the experimentally observed effects of heteronormativity and raise awareness of the detrimental effects of heteronormativity in a localized setting experienced by many individuals. The success of this experiment creates further room for dialogue among other traditions of communication theory in this field, perhaps following the sociocultural tradition along with the critical tradition and understanding how heteronormative communication came to be and how it has remained in communication (Craig, 1999). Conclusively, this study serves as a prime example of dialogue between two very different traditions in communication theory overcoming the weaknesses that the traditions separately hold (Craig, 1999), raising consciousness and awareness of heteronormativity's negative effects.

### Limitations and future directions

One limitation is that most participants identified as bisexual, Caucasian, and female, which is not representative of demographics of the United States. A 2012 Gallup report found that racial minorities are more likely to identify as LGBT and slightly more women than men identify as LGBT (Gallup, 2012). In addition, a 2011 study found that slightly more people identify as bisexual than gay or lesbian; however, in our sample, bisexual participants comprised a majority of the sample (Gates, 2011). Of note is that although the person in the vignette identified as bisexual, we found no significant differences between individual's sexuality (bisexual, gay or lesbian, etc.) and disclosure or trust. Future research may seek to obtain a more nationally representative sample.

Another limitation of this study is that the vignettes were created using evidence from qualitative interviews. Researchers in this field as well as people who identify as LGB verified them for validity, but actual realism is difficult to ascertain since doctors' visits do not follow a specified script. We therefore cannot fully extrapolate what would happen in person with a doctor who exhibits heteronormative communication. Because participants were exposed to heteronormative communication in the form of reading the vignette and then reacting to the doctor in that vignette, we cannot be conclusive about how participants would feel about their own doctor if this study were done in person. Nevertheless, if indirect heteronormative communication can lead to such a strong effect, we predict that direct heteronormative communication would have a stronger effect. We hypothesize that ways to overcome this limitation would be to use a videotaped scenario instead of written vignettes, have participants act out a written script so that they are physically involved in this interaction, or even to have a research assistant act as a doctor in a real scenario that could be advertised as a practice session for medical school students or residents.

We encourage future research that investigates the features of doctor–patient communication that are considered LGB friendly in order to better understand how to train physicians to better serve the LGB population. One participant who received the heteronormative vignette wrote, "I wouldn't have a doctor like Dr. Smith. The first appointment would be cut short and there would never be a second." Many participants who received the heteronormative vignette referred to the doctor as being "rude" or "unprofessional." Another participant who received the heteronormative vignette stated that this exact situation had happened to him or her. Some ways that physicians may decrease heteronormative assumptions include more inclusive language, such as asking about one's significant other instead of referencing an opposite-sex relationship, not assuming the patient is in an opposite-sex relationship with regard to intercourse, and maintaining respect and composure

regardless of one's personal opinions if a person chooses to disclose a sexual orientation. Making eye contact while talking and sitting at eye level with the patient are also ways to signal respect. Increasing the number of hours in medical school during which doctors are required to learn about how to appropriately and respectfully treat LGB individuals and increasing the amount of clinical exposure to LGB populations are two suggestions toward achieving this goal.

## Conclusion

This study, which serves as an example that successfully follows both the critical tradition and the sociopsychological tradition of communication theory, suggests that when LGB people are exposed to heteronormative communication, they are less likely to disclose health-relevant information and less likely to trust a doctor as compared to those who are exposed to non-heteronormative communication. The experience of or even the expectation of experiencing these kinds of interactions at the doctor's office may be one factor contributing to health disparities among sexual minorities.

One implication of this research is that medical education should incorporate training about heteronormative communication. Heteronormativity negatively impacts LGB patients, so by improving medical education and training to emphasize non-heteronormative communication, we might be able to improve the practitioner–patient interaction for these patients, improving trust, disclosure and, potentially, patient health in this population.

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