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Satisfaction with access to healthcare and its implications for the psychological well-being of LGBTQ+ people

Dissertação no âmbito do Mestrado em Psicologia Clínica Sistémica e da Saúde orientada pela Professora Doutora Luciana Sotero e pelo Professor Doutor Jorge Gato e apresentada à Faculdade de Psicologia e de Ciências da Educação da Universidade de Coimbra.

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Satisfação no acesso a cuidados de saúde e suas implicações no bem-estar psicológico de pessoas LGBTQ+

Resumo: As pessoas LGBTQ+ encontram-se sujeitas a inúmeros stressores que impactam o seu quotidiano. Deste modo, indivíduos LGBTQ+ podem ter dificuldades no acesso a direitos básicos, como os cuidados de saúde. Neste sentido, a presente investigação procura avaliar a relação entre a satisfação no acesso aos cuidados de saúde e características sociodemográficas dos participantes (i.e., idade, nível educacional, estado relacional, identidade de género, orientação sexual, sexo atribuído à nascença). Além disso, procura analisar a relação entre a satisfação no acesso aos cuidados de saúde e indicadores de mal-estar psicológico, stress proximal e suporte social em pessoas LGBTQ+. A amostra recolhida *online* envolveu 116 pessoas LGBTQ+, das quais 87 cisgénero e 29 trans ou não-binárias, com idades compreendidas entre os 18 e os 71 anos. Os resultados obtidos não permitiram identificar correlações estatisticamente significativas entre a satisfação no acesso a cuidados de saúde e as características sociodemográficas. Por sua vez, identificaram-se correlações estatisticamente significativas entre a satisfação no acesso aos cuidados de saúde e o stresse proximal (homofobia internalizada) e o suporte social proveniente da família. Verificou-se, assim, que (1) menores níveis de satisfação com o acesso aos cuidados de saúde se associam a níveis mais elevados de homofobia internalizada e (2) maiores níveis de satisfação no acesso aos serviços de saúde se associam a níveis mais elevados de suporte social. Em suma, este estudo permite concluir que persistem barreiras no acesso a cuidados de saúde inclusivos e espera com este estudo contribuir para a melhoria no acesso de pessoas LGBTQ+ aos cuidados de saúde em Portugal, colmatando assim a escassez de investigações nesta área.

Palavras-chave: LGBTQ+; acesso a cuidados de saúde; bem-estar psicológico; homofobia internalizada; suporte social.

Satisfaction with access to healthcare and its implications for the psychological well-being of LGBTQ+ people

Abstract: LGBTQ+ people are subject to numerous stressors that impact their daily lives. Thus, LGBTQ+ individuals may have difficulties in accessing basic rights, such as healthcare. In this sense, the present research seeks to assess the relationship between satisfaction in accessing healthcare and participants' sociodemographic characteristics (i.e., age, educational level, relational status, gender identity, sexual orientation, sex assigned at birth). In addition, it seeks to analyze the relationship between satisfaction in access to healthcare and indicators of psychological distress, proximal stress, and social support in LGBTQ+ people. The sample collected online involved 116 LGBTQ+ people, of which 87 cisgender and 29 trans or non-binary, aged between 18 and 71 years. The results obtained did not allow us to identify statistically significant correlations between satisfaction in access to healthcare and sociodemographic characteristics. In turn, statistically significant correlations were identified between satisfaction in access to healthcare and proximal stress (internalized homophobia) and social support from the family. Thus, it was found that (1) lower levels of satisfaction with access to healthcare are associated with higher levels of internalized homophobia and (2) higher levels of satisfaction with access to healthcare are associated with higher levels of social support. In sum, this study allows to conclude that barriers persist in the access to inclusive healthcare and hopes to contribute to improving the access of LGBTQ+ people to healthcare in Portugal, thus filling the scarcity of research in this area.

Key words: LGBTQ+; access to healthcare; psychological well-being; internalized homophobia; social support.

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Index

Introduction ... 6

I – Conceptual framework ... 8

1.1. Emergence of non-normative sexual orientation and gender identity ... 8

1.2. Access to healthcare and discrimination ... 10

1.3. Stress and protective factors for the mental health of LGBTQ+ people ... 11

II – Objectives ... 13

III - Methodology ... 14

3.1. Characterization of the sample ... 14

3.2. Variables and instruments ... 15

3.2.1 Sociodemographic questionnaire ... 15

3.2.3 Satisfaction with access to healthcare ... 15

3.2.2 Mental health ... 15

3.2.5 Proximal minority stress ... 16

3.2.4 Social support ... 17

3.3. Sample selection and data collection procedures ... 17

3.4. Statistical analyses ... 19

IV – Results ... 19

4.1. Descriptive statistics ... 20

4.2. Differences in satisfaction with access to healthcare as a function of sociodemographic and sexual and gender identity characteristics ... 20

4.3. Association between satisfaction with access to healthcare and indicators of mental distress ... 22

4.4. Association between satisfaction with access to healthcare and internalized homophobia ... 22

4.5. Association between satisfaction with access to healthcare and social support ... 23

V – Discussion ... 23

5.1. Limitations and future research ... 25

Conclusion ... 26

Bibliography ... 28

Introduction

Historically, lesbian, gay, bisexual, trans, and other sexual and gender minority people (LGBTQ+) have faced several challenges associated with their sexual orientation and gender identity (Clarke et al., 2010). In this sense, Psychology has emerged as a prominent area in creating useful and inclusive scientific content that promotes the well-being of LGBTQ+ people. In this research, the acronym LGBTQ+ will be used as a representative term that includes diverse sexual and gender orientations other than cisgender and heteronormative ones (Clarke et al., 2010).

Portugal shows good indicators when it comes to respecting and fulfilling the legal rights of the LGBTQ+ community, ranking fourth out of 49 European countries in terms of legal equality (Rainbow Europe, 2021). However, 71% of the Portuguese population considers that discrimination towards people with LBG orientations still exists (Eurobarometer, 2019). At the same time, 59% of the Portuguese population consider that there is a lot of discrimination towards trans people (Eurobarometer, 2019). In this context, discrimination is considered to be any differential treatment, usually negative, of a certain group or set of people in relation to others (Plous, 2003). In this sense, 65% of LGBTQ+ people in Portugal never or rarely assume, in an explicit way, their sexual orientation or gender identity (Fundamental Rights Agency - FRA, 2020a, 2020b). Furthermore, 40% of LGBTQ+ people in Portugal felt discriminated in at least one area of their lives (FRA, 2020a). Discrimination is thus experienced both generally and in specific sectors of work, justice, education, social security and health (FRA - European Union Agency for Fundamental Rights, 2020a; Gato, 2022; Moleiro & Pinto, 2009; Oliveira et al., 2010). Also, sexual orientation (19%) and gender identity (16%) are among the main motivations for hate crimes and discriminatory violence in Portugal (Barómetro APAV-INTERCAMPUS, 2019).

The LGBTQ+ community shows concern about several issues associated with access to health services and discrimination by health professionals (Gato, 2022; Macedo, 2018; Sousa & Moleiro, 2015). Congruently, there is a lack of training of health professionals regarding the specific health needs of the LGBTQ+ population (Lopes et al., 2016; Stotzer et al., 2013). In this way, the perceived or expected discrimination and consequent distrust of health services (Lusa, 2018) results in lower access to the healthcare system, with 30% of LGBTQ+ people stating that they "think twice" before going to a health service (ILGA Portugal, 2015).

Minority Stress Theory has provided a basic framework for understanding sexual and gender minorities mental health disparities (Meyer, 1995, 2003, 2015). This model posits that sexual and gender minorities experience distinct chronic stressors that are related to their stigmatized identities, including victimization, prejudice, and discrimination (Bialer & McIntosh, 2016; Hendricks & Testa, 2012; Meyer, 1995, 2003). Minority stress varies along a *continuum*, including distal stress-producing situations, such as discrimination (Meyer, 2003), and proximal stress-producing situations, such as internalized homophobia and anticipation of stigma (Huynh et al., 2020; Meyer, 2003, 2015). Among LGBTQ+ individuals, diverse studies reveal high rates of depression and mood disorders (Bostwick et al., 2010; Cochran et al., 2007), anxiety disorders (Cochran et al., 2003; Gilman et al., 2001), suicide ideation and attempts, as well as psychiatric comorbidities (Cochran et al., 2003; Gilman et al., 2001) when compared to their heterosexual and cisgender peers. In turn, there may be factors that may have a positive impact in these mental health indicators, such as perceived social support by individuals in the LGBTQ+ community (Ryan et al., 2020).

Therefore, within sexual and/or gender minorities, this study aims to understand the relationship between the satisfaction in the

access to healthcare and sociodemographic characteristics of the participants. Simultaneously, it intends to understand the association between access to healthcare and indicators of mental distress (i.e., depression, anxiety, and stress), proximal stress (internalized homophobia) and one protective factor (social support).

I – Conceptual framework

1.1. Emergence of non-normative sexual orientation and gender identity

Sexual orientation regards romantic, sexual, intellectual and emotional attraction to another person (American Psychological Association - APA, 2015a; Gato, 2022; Rice, 2015). Heterosexual orientation is the attraction to individuals of a different gender, while homosexual orientations encompass lesbian individuals (attraction between two women), gay male individuals (attraction between two men), bisexual individuals (attraction to same and different gender), pansexual people (attraction to another person regardless of their gender expression, gender identity, and biological sex), among others (APA, 2015a; Rice, 2015).

Gender identity refers to personal self-recognition as male or female, as both, or as a trans person (APA, 2015b; Ordem dos Psicólogos Portugueses - OPP, 2020). People whose gender identity coincides with the sex assigned at their birth are called cisgender (Gato, 2022). Trans people, in turn, are those whose gender identity does not coincide with the sex assigned at birth (APA, 2015b, 2021; OPP, 2020). Trans people may or may not choose to use medical treatments to make their bodies and gender expressions more congruent with their gender identity (OPP, 2020). However, it should be noted that not all individuals who do not identify with their sex assigned at birth consider themselves trans (APA, 2021).

LGBTQ+ people have always been targets of discrimination, with homosexuality being considered a mental pathology and integrated in the second edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-II) in 1973 (Clarke et al., 2010). Although a study conducted by Kinsey (1948) sought to normalize homosexuality, the way its results were interpreted by mental health professionals caused homosexuality to be viewed as an "abnormal" practice and therefore a mental illness (Clarke et al., 2010). Following this, the scientific community began to conduct studies focused on the differences in psychological adjustment between homosexuals and heterosexuals and on ascertaining the causes of homosexuality (Moleiro et al., 2017). It is noteworthy that most of these research were conducted with individuals diagnosed with mental illness and who were in prisons or psychiatric treatment facilities (Bohan, 1996). In a pioneering study, using a community sample of homosexual men, Hooker (1957) concluded that there were no differences in psychological adjustment between homosexuals and heterosexuals, discrediting the hypothesis that homosexuality was a mental illness (Clarke et al., 2010). After the path of depathologization (Robles et al., 2021), homosexuality was no longer considered a mental illness, being removed in 1993 from the DSM (APA, 1973) and the World Health Organization's International Classification Diseases (ICD) (Clarke et al., 2010). Actually, there is no scientific evidence to claim that LGBTQ+ identities constitute a mental illness (APA, 2021; OPP, 2020) and that LGBTQ+ people show an intrinsic predisposition to psychopathology (Gonsiorek & Weinrich, 1991).

More recently, research began to view sexuality as more fluid over time (Diamond, 2006; Diamond et al., 2017), that is, sexual identity is not constant and can change throughout one’s life (APA, 2015a; Arrieta & Palladino, 2015; Clarke et al., 2010; Henrickson, 2008). In this sense, some people reject the labeling of lesbian, gay, or

bisexual, even though they are attracted to and have same-sex sexual practices (Cohler & Hammack, 2007).

1.2. Access to healthcare and discrimination

Access to healthcare is guaranteed in the Constitution of the Portuguese Republic, specifically in article 64, which states that "everyone has the right to health protection and the duty to defend and promote it" (Assembleia da República, 2005, p.49). Simultaneously, the World Health Organization (WHO) states that health is "a state of complete physical, mental and social well-being and does not consist merely of the absence of disease or infirmity" (WHO, 1946, p.1). Thus, it is understood that healthcare should not be denied to any individual, regardless of their social, legal and institutional perimeters, extending to racial, gender, and marital issues (WHO, 1946).

Discrimination and prejudice are present in several components of LGBTQ+ people's lives, including their access to healthcare services (FRA, 2020a; Gato, 2022; Moleiro et al., 2017; Moleiro & Pinto, 2009; Oliveira et al., 2010; Saleiro et al., 2022). In fact, a study conducted by ILGA Portugal (2015) revealed that 17% of enquired LGBTQ+ people had experienced discrimination in health services, including derogatory comments made by the health professionals, discomfort in physical contact with the user after he or she indicated that he or she was LGBTQ+, barriers in blood donation by gay or bisexual men, or difficulty in accompanying same-sex partners in consultations or hospitalizations. In parallel, it was suggested to 11% of the study sample that homosexuality could "cured" (ILGA Portugal, 2015).

Recurrent episodes of invisibility combined with perceived or expected discrimination (Lusa, 2018) result in lower access to healthcare services, as well as a gatekeeping process (ILGA Portugal, 2015). Therefore, 40% of LGBTQ+ people seek prior information

about health professionals or services in order to minimize the risk of discrimination (ILGA Portugal, 2015).

Poor training of healthcare professionals is undoubtedly one of the biggest obstacles that LGBTQ+ people experience in accessing healthcare (Lopes et al., 2016; Macedo, 2018; Sousa & Moleiro, 2015). For example, many healthcare professionals lack basic clinical knowledge and skills to deal with issues related to trans identities (Bradford et al., 2013). Although in Portugal the right to health is constitutionally guaranteed for all people, studies indicate that both internationally and in Portugal there are still many barriers and situations of discrimination faced by LGBTQ+ people (Gato, 2022).

1.3. Stress and protective factors for the mental health of LGBTQ+ people

Minority stress varies along a *continuum*, which may include situations generating distal stress or proximal stress (Gato, 2022). Distal stress stems from episodes of interpersonal discrimination, victimization, hate crimes, attempts to change sexual orientation and/ or gender identity, microaggressions, and other situations of discrimination that may occur in a LGBTQ+ person daily life (Meyer, 2003). Accordingly, it is understood that distal stress is associated with observable events, corresponding to the classical concept of discrimination (Gato, 2022). Proximal stress refers to the internalization of stigma via cognitive and affective processes, including internalized homophobia, anticipation of stigma (for example, through processes such as anxiety and worry), and concealment of one's sexual orientation and/or gender identity (Meyer, 2003, 2015).

Considering that stigma and discrimination can significantly increase stress levels (Bialer & McIntosh, 2016), LGBTQ+ people are found to be at higher risk for mental health problems at all stages of

their development (Meyer, 2003; Russell & Fish, 2016). Congruently, a study conducted by Russell and Fish (2016) with young members of the LGBTQ+ community found that 18% met criteria for major depression and 31% reported suicidal behaviors at some point in their lives. These rates are concerning, especially when compared to the national rates, where 8.2% of youth would have diagnosed major depression and 4.1% would have reported any type of suicidal behavior (Kessler et al., 2012; Nock et al., 2013).

Given the fact that the poor indicators of mental health and well-being among the LGBTQ+ community are attributable to the effects of discrimination (Feinstein, 2020; Hsieh & Ruther, 2016; Katz-Wise et al., 2017; Meyer, 2003; Moleiro & Pinto, 2015; Pachankis & Bränström, 2018; Russell & Fish, 2016), there is a wide possibility that specific aspects such as internalized homophobia may also play a role in the LGBTQ+ community health outcome (Huynh et al., 2020; Meyer, 2003; Pereira & Silva, 2021). Internalized homophobia corresponds to personal acceptance that the stigma is legitimate, involving the value system and self-concept of an LGBTQ+ individual (Gato, 2022; Saleiro et al., 2022; Weinberg, 1972).

Although minority stress occurs in a variety of contexts, social support and certain individual coping mechanisms act as buffers against its effects, helping to reduce or prevent situations of psychological and physical illness (Meyer, 2015; Ryan et al., 2020). In turn, Pereira and Silva (2021) found that higher levels of loneliness were associated with lower levels of social support, mental health problems, difficulties in maintaining romantic relationships, discrimination, low use of coping strategies, and non-disclosure of sexual orientation. Congruently, lower levels of loneliness were associated with the presence of social support and the maintenance of positive relationships (Pereira & Silva, 2021). Thus, social support, positive identity and resilience stand out as protective factors for the mental health of the LGBTQ+ population

(Pereira & Silva, 2021). In this sense, it is worth emphasizing the need to study not only the negative aspects associated with LGBTQ+ people, but also the impact of protective factors on psychological processes in sexual and gender minorities.

II – Objectives

This study aims to understand what accounts for LGBTQ+ individuals' satisfaction with their access to healthcare. First, we explore differences in satisfaction with access to healthcare as a function of participant's sociodemographic characteristics (age, educational level, and relationship status) and their sexual and gender identity characteristics, such as gender identity (trans and gender diverse vs. cisgender individuals), sexual orientation (plurisexual vs. monosexual individuals), and gender x sexual orientation (sexual minority women vs sexual minority men). We hypothesize that participants who are (H1a) younger, (H1b) who have a higher educational level, and (H1c) who are in a relationship will report higher levels of satisfaction with access to healthcare. Concomitantly, we postulate that (H2a) cisgender, (H2b) monosexual, and (H2c) women will report higher satisfaction with access to healthcare. Finally, this study aims to explore the association between access to healthcare and indicators of mental distress (i.e., depression, anxiety, and stress), proximal stress (internalized homophobia) and social support, as protective factor. We conjecture that there is a positive and significant correlation between satisfaction in access to healthcare and indicators of mental distress, namely (H3a) depression, (H3b) anxiety, and (H3c) stress. In parallel, we hypothesize that (H4) internalized homophobia will correlate positively on a significantly level with satisfaction with access to healthcare. Finally, we postulate that (H5a) social support, including from (H5b) from family, (H5c) friends, and (H5d) significant other will present an inverse correlation with satisfaction with access to healthcare.

III - Methodology

In this section the sociodemographic characteristics of the sample will be described, as well as the variables and instruments used in this study. Next, the sample selection and data collection procedure will be presented. Finally, the statistical analyses performed in this research are described.

3.1. Characterization of the sample

The sample consisted of 116 participants ranging in age from 18 to 71 (M = 33.23; SD = 12.21), with just over half of the participants being between the ages of 18 and 30 years. Considering the educational level of the participants, most participants attended higher education. In terms of relationship status, the sample was evenly distributed among people who are in a relationship and those who are not. Regarding sex assigned at birth, sexual orientation, and gender identity, most participants were male, gay, and cis, respectively.

Table 1. Characterization of the sample: Sociodemographic variables

		n	Percentage %
Level of education	Less than high school	23	19.8
	High school	6	5.2
	Professional program	6	5.2
	Some college	5	4.3
	Undergraduate degree	47	40.5
	Graduate degree	29	25
Relationship	Yes	54	46.6
	No	62	53.4
Gender identity	Cis	87	75
	Trans and non-binary	29	25
Sexual orientation	Gay	50	43.1
	Bisexual	26	22.4
	Pansexual	16	13.8
	Lesbian	13	11.2
	Queer	8	6.9
	Heterosexual	2	1.7
	Other	1	0.9
Sex assigned at birth (only cis)	Male	55	63.2
	Female	32	36.8

3.2. Variables and instruments

The protocol of the present study consists of the Sociodemographic Questionnaire and four self-report instruments.

3.2.1 Sociodemographic questionnaire

This questionnaire was designed for the present study and allowed us to collect the necessary information for the characterization of the sample, namely regarding participants age, level of education, relationship status, gender identity, sexual orientation, and sex assigned at birth.

3.2.3 Satisfaction with access to healthcare

To evaluate the satisfaction with access to healthcare, we used the Access to Healthcare Measure (AHM), which was created by the international research team responsible for the project SGM. The AHM was built with reference to the guidelines of the Centers for Disease Control and Prevention and The County Health Rankings and Roadmaps (2015). With these guidelines in mind, the AHM is a brief self-report instrument that consists of three items (e.g., "I was treated unfairly when seeking health services due to my identity as a sexual/gender minority person."). Items are rated on a Likert scale from 1 (*Strongly disagree*) to 5 (*Strongly agree*). Higher scores on the AHM scale translate into greater dissatisfaction with health services and professionals. In the present study, the AHM scale showed good internal consistency ($\alpha = .79$).

3.2.2 Mental health

To assess mental health indicators, we used the Portuguese version of the Depression, Anxiety, Stress Scales-21 (DASS-21) (Lovibond & Lovibond, 1993; Pais-Ribeiro et al., 2004). The total scale comprises 21 items equally distributed across three dimensions: depression, anxiety, and stress (Lovibond & Lovibond, 1995; Pais-

Ribeiro et al., 2004). Items are answered according to a 4-point Likert self-response scale ranging from 0 (*Did not apply to me at all*) to 3 (*Applied to me completely or most of the time*) according to the degree to which statement applied to the subject during the past week (Pais-Ribeiro et al., 2004). The score for each subscale is obtained by adding up the scores of its respective items (Lovibond & Lovibond, 1995; Pais-Ribeiro et al., 2004). The highest scores on each subscale correspond to more negative affective states (Pais-Ribeiro et al., 2004). Regarding internal consistency, the original studies of the DASS-21 indicate that the scale obtained a very good internal consistency (α = .91), as did the dimensions: (1) Depression (α = .91), (2) Anxiety (α = .84) and (3) Stress (α = .90) (Lovibond & Lovibond, 1995). The Portuguese version of the DASS-21 showed in the original validation studies very good internal consistency (α = .95), including in the subscales (1) depression (α = .90), (2) anxiety (α = .86) and (3) stress (α = .88) (Apóstolo et al., 2006). In the present study the scale also showed very good internal consistency (as measured by Cronbach's alpha) for the total score (α = .91), as well as for depression (α = .92), anxiety (α = .89), and stress (α = .91).

3.2.5 Proximal minority stress

The chosen proximal minority stress process in this study was internalized homophobia. We used the Internalized Homophobia scale (IHP) (Martin & Dean, 1987). This instrument is composed of nine items, ranging from 1 (*Strongly Disagree*) to 5 (*Strongly Agree*). As for the interpretation of this scale, higher scores mean higher levels of internalized stigma (Martin & Dean, 1987). Regarding its reliability, the IHP shows high Cronbach's alpha values (α= .85) (Martin & Dean, 1987). In the present study, the IHP showed reasonable internal consistency (α= .76).

3.2.4 Social support

To assess social support, we used the Portuguese version of the Multidimensional Scale of Perceived Social Support (MSPSS; Portuguese version of Carvalho et al., 2011; original version of Zimet et al., 1988, 1990, 2011). The MSPSS makes a subjective assessment of social support, collecting information about the social support perceived by participants in three areas: family, friends, and significant other (Carvalho et al., 2011; Zimet et al., 1988, 1990, 2011). The instrument comprises 12 items rated on a Likert scale from 1 (*I completely disagree*) to 7 (*I completely agree*) (Carvalho et al., 2011). The score for each of the three subscales is obtained by averaging each subscale items, and the total score is obtained by averaging the 12 items (Zimet et al., 1988). The maximum score for each subscale as well as the total of the scale is seven and higher scores mean greater social support (Zimet et al., 1988).

According to the original studies, this instrument shows good internal consistency both for the total scale (α = .88) and for their dimensions: family (α = .87), friends (α = .85) and significant other (α = .91) (Zimet et al., 1988). In the Portuguese validation studies, a very good internal consistency was also found for the total scale (α = .94) and for the subscales of family (α = .87), friends (α = .93) and significant other (α = .92) (Carvalho et al., 2011). In the present study, the total MSPSS score had a very good internal consistency coefficient (α = .91.), as did the subscales of family (α = .93), friends (α = .95), and significant other (α = .93).

3.3. Sample selection and data collection procedures

The present research is a cross-cultural project led by Professor Ashley Randall (Arizona State University, USA), whose main objective is to analyze relational dynamics in same-sex couples. The project involves 18 countries and in Portugal is led by Professor Ana Paula

Relvas (University of Coimbra). Professor Luciana Sotero (University of Coimbra), Professor Jorge Gato (University of Porto), and Professor Alda Portugal (University of Madeira) are also members of the Portuguese research team. Therefore, there was a predefined protocol in advance, with the following inclusion criteria: (1) being at least 18 years old, inclusive; (2) identifying as a sexual or gender minority (LGBTQ+ person); and (3) being a resident in Portugal. To comply with the usual requirements of a research study, an Informed Consent was prepared with the objective of elucidating the participants about the general objective of the study, the anonymity and confidentiality of their answers and the voluntary nature of their participation.

Prior to the application of the research protocol, a pilot study was conducted with five participants. In this initial study, an oral reflection interview was conducted with each participant, with the purpose of ascertaining any lapses that have might existed. Throughout the pilot study, the following aspects were recorded: (1) the average response time; (2) observations on the introduction to the protocol, specifically on the clarification of the objective and instructions; (3) observations on the items of the questionnaire regarding their clarity, adequacy, and redundancy; and (4) suggestions for reformulation. Once this phase was concluded, the online research protocol was devised, using the Qualtrics software.

The data collection process occurred between June and November 2021 through a convenience sampling and snowballing method, based on the dissemination of the study in several online social network platforms (e.g., Facebook and Instagram) and with the support of non-profit associations focused on LGBTQ+ rights.

3.4. Statistical analyses

After sample collection, data were input from Qualtrics, processed, and statistically treated using *the Statistical Package for the Social Sciences* (SPSS, version 25).

First, the total values of the scales and respective dimensions used in this study were calculated. Then, the internal consistency of each dimension and scale was analyzed through Cronbach's alpha, according to the guidelines outlined by Pestana and Gageiro (2008). Subsequently, the normality of the distribution of the collected data was assessed using the asymmetry and kurtosis indicators (Bryman & Cramer, 1992) and descriptive statistics were presented.

T-tests were used to detect differences in the satisfaction in the access to healthcare as a function of sociodemographic characteristics (age, educational level, and relationship status), as well as a function of sexual and gender identity characteristics such as gender identity (trans and gender diverse vs. cisgender individuals), sexual orientation (plurisexual vs. monosexual), and gender x sexual orientation (sexual minority women vs sexual minority men).

To understand the relationships between access to healthcare and indicators of mental distress (i.e., depression, anxiety, and stress), proximal stress (internalized homophobia) and social support, Pearson's correlations were performed. In the present study, the magnitude of the Pearson's correlation values were interpreted according to Pallant's (2005) guidelines.

IV – Results

In this subsection the results of the statistical analyses will be described and interpreted. The results will follow the same order of presentation in which they appeared previously.

4.1. Descriptive statistics

As can be seen in Table 2, the asymmetry and kurtosis indicators suggest that the variables and instruments have a symmetric distribution, and a mesokurtic curve, except for the dimension social support of friends, which presents a slightly leptokurtic curve.

Table 2. Descriptive statistics of all variables and instruments

Variables and instruments	Sk	Ku	Min	Max	M	SD
Depression	0.82	0.06	0.00	18.00	5.15	4.63
Anxiety	1.62	2.85	0.00	21.00	4.09	4.58
Stress	0.62	-0.06	0.00	21.00	7.11	5.20
Satisfaction with access to healthcare	0.10	-0.97	1.00	4.33	2.46	0.98
Social support (Global)	-1.02	0.79	2.00	7.33	5.79	1.16
Social Support (Family)	-0.89	-0.49	0.25	7.00	4.82	1.74
Social Support (Friends)	-2.12	5.86	0.25	7.00	6.06	1.21
Social Support (Significant others)	-1.78	3.24	1.00	8.00	6.64	1.53
Internalized homophobia	0.88	0.07	1.00	4.00	1.71	0.69

4.2. Differences in satisfaction with access to healthcare as a function of sociodemographic and sexual and gender identity characteristics

To understand the differences in satisfaction in access to healthcare according to sociodemographic characteristics, some variables were treated to create categories, namely age groups, level of education, and sexual orientation (Table 3). Thus, age groups allow us to make a distinction between young adults (i.e., individuals between 18 and 30 years) and adults (i.e., individuals between 31 and 71 years, according to the sample limits). Considering the educational level of the participants, two groups were created to distinguish between those who have attained higher education (i.e., individuals who attended some college, undergraduate degree, and graduate degree) ant those who have not (i.e., individuals who attended less than high school, high school, and professional program). Regarding sexual orientation, individuals were divided according to mono or pluri orientations. Monosexual orientation is thus understood as people who are attracted

to one sex or gender (gays men, lesbians women, and heterosexual individuals) (APA, 2021). In turn, plurisexual people are those whose sexual orientation leaves open the potential for attraction to more than one sex or gender (bisexual, pansexual, queer, and others) (APA, 2021).

Table 3. Sociodemographic and sexual and gender identity groups

		n	Percentage %
Age groups	Young adults	60	52.2
	Adults	55	47.8
Level of education	Less than higher education	35	30.2
	Higher education	81	69.8
Sexual orientation	Monosexual	51	44
	Plurisexual	65	56

As can be seen in Table 4, no statistically significant differences were found in satisfaction in access to healthcare, neither as a function of participants' sociodemographic nor their sexual and gender identity characteristics. In this sense, it was evident that the hypotheses associated with sociodemographic, sexual and gender identity characteristics were not corroborated by the statistical analyses. In other words, individuals who are (H1a) younger, (H1b) with a higher level of education and (H1c) who are in a relationship did not report higher values of satisfaction with access to healthcare than the other participants. Likewise, we understood that (H2a) cisgender, (H2b) monosexuals, and (H2c) women did not report higher levels of satisfaction with access to healthcare, contrary to what was predicted.

Table 4. Satisfaction in access to healthcare according to sociodemographic and sexual and gender identity characteristics

	M	SD	*t*	*df*	*p*
Age groups					
Young adults	2.72	0.95	2.807	98	.614
Adults	2.18	0.97			
Level of education					
Less than higher education	2.42	0.89	-0.286	99	.154
Higher education	2.48	1.02			
Relationship					
Yes	2.48	1.01	0.166	99	.728
No	2.45	0.97			
Gender identity					
Cis	2.23	0.87	-4.915	99	.986
Trans and non-binary	3.26	0.93			
Sexual orientation					
Monosexual	2.69	0.98	1.997	99	.954
Plurisexual	2.30	0.96			
Sex assigned at birth (only cis)					
Male	2.14	0.90	-1.101	76	.232
Female	2.36	0.82			

4.3. Association between satisfaction with access to healthcare and indicators of mental distress

No statistically significant correlations were observed between access to healthcare and indicators of mental distress, namely depression (r = .18, p = .08), anxiety (r = .12, p = .24), and stress (r = .19, p = .06). In this sense, hypotheses 3a, 3b, and 3c were rejected.

4.4. Association between satisfaction with access to healthcare and internalized homophobia

Internalized homophobia correlated significantly with satisfaction with access to healthcare (r = .24, p = .05), i.e., the higher the internalized homophobia experienced by LGBTQ+ participants, the lower the satisfaction with healthcare. Therefore, the hypothesis 4 was not rejected.

4.5. Association between satisfaction with access to healthcare and social support

Access to healthcare was found to correlate significantly with social support (r = -.32*, p* = .01). In this sense, higher scores on the AHM scale, were associated with lower values of social support. Regarding the social support subscales, only the family dimension correlated significantly with access to healthcare (r = -.35*, p* = .01). No statistically significant correlation was observed between access to healthcare and social support from friends (r = -.13*, p* = .20) or significant other (r = -.20*, p* = .06). Therefore, the hypotheses 5a, and 5b were confirmed, while the hypotheses 5c, and 5d were not confirmed.

V – Discussion

Sexual and gender minorities are exposed to numerous stressors that impact their daily lives, mostly associated with stigma regarding their gender identity and/or sexual orientation. Few studies have explored the association between LGBTQ+ individuals' satisfaction with access to healthcare and mental distress or minority stress variables. This way, we aimed to understand the association between participants' sociodemographic and sexual and gender characteristics, indicators of mental distress, internalized homophobia, and social support and their satisfaction with access to healthcare. Our results showed that satisfaction with access to healthcare was only associated with internalized homophobia, overall social support, and social support from the family, highlighting the role of proximal minority stress processes and protective factors.

Contrary to our predictions (Bradford et al., 2013; Carstensen et al., 1999; Galambos et al., 2006; Gove et al., 1989; ILGA Portugal, 2015; Lopes et al., 2016), participants' sociodemographic and sexual and gender identity characteristics were not associated with satisfaction

with access to healthcare. We attribute this absence of significant associations to a self-selection bias. In other words, it is possible to speculate that participation in an online survey presupposes a certain social capital and that our sample is not representative of the wider LGBTQ+ community. While observing the sample characterization, we verify that we are dealing with a relatively small sample, with higher educational level and with easy access to generalized healthcare. Therefore, this collection method fails to reach more diverse samples in terms of sociodemographic composition.

Regarding the association between satisfaction with access to healthcare and indicators of mental distress, again no significant correlations were found. The non-existence of a correlation between access to healthcare and indicators of mental distress, namely depression, stress, and anxiety, can be much better understood by again considering the cultural context of the study and the characteristics of the participants.

Concerning the relationship between access to healthcare and internalized homophobia, it was found that individuals with lower satisfaction with healthcare have higher levels of internalized homophobia. This premise is consistent with the minority stress model (Meyer, 1995, 2003, 2015), which explains that LGBTQ+ people are exposed to discrimination that consequently affects their subjective well-being and mental health, in various domains of their lives, namely health (FRA, 2020a; Gato, 2022; Moleiro et al., 2017; Moleiro & Pinto, 2009; Oliveira et al., 2010; Saleiro et al., 2022). Thus, internalized homophobia is consistent with worse affective health (Huynh et al., 2020; Meyer, 2003; Pereira & Silva, 2021) and worse behavioral health, namely worse adherence to medical treatment and care (Earnshaw et al., 2013; Earnshaw & Chaudoir, 2009; ILGA Portugal, 2015).

Respecting the relationship between access to healthcare and social support, a negative correlation was found. That is, LGBTQ+ individuals who have higher levels of social support report higher levels of satisfaction with their access to healthcare. In fact, social support is a coping mechanism and a buffer against the effect of discrimination (Meyer, 2015; Pereira & Silva, 2021; Ryan et al., 2020). Some research also suggests that individuals with higher social support show lower cortisol reactivity in response to a stressful event, when compared to people with lower social support (Balsam & Mohr, 2007; Burton et al., 2014). Only the subscale of family showed a significant correlation with satisfaction with access to healthcare in this study. Cultural specificities in Portugal place a strong focus on the role of the family and the social support provided to its members (Gato et al., 2020; Steinbach et al., 2016), as it was possible to observe in the present study. In this sense, our results suggest that the family holds a fundamental role as a source of support for LGBTQ+ people, helping to mitigate the effects of discrimination experienced in their daily lives (FRA, 2020b). Thus, it is evident that individuals who perceive themselves in a strong family network develop a set of positive beliefs and select more appropriate coping strategies, namely regarding their access to health resources (Fontaine & Matias, 2003; Gato, 2022).

5.1. Limitations and future research

One of the limitations of the present research relates to the small size and homogeneity of the sample, as well as the occurrence of a self-selection bias. This way, the data collection procedure used in this study itself implies some segregation, since we were only able to access LGBTQ+ individuals who have some social status and economic comfort that allows them easy access to the questionnaire through the internet. Another limitation of the present study is the generalization of LGBTQ+ people as a single uniform group.

As for future research, we suggest continuing to study the impact of access to healthcare in the LGBTQ+ community, in comparison to a sample of heterosexual individuals in order to highlight possible differences. It could also be useful to incorporate other variables that enhance the understanding of the LGBTQ+ population, namely, ethnicity, social class, and family composition. At the same time, future studies could focus on the differences that the LGBTQ+ population feels about the social support coming from family, friends or significant others and the impact on their daily lives. Finally, complementary qualitative methodologies could be used in the future, to gain a better understanding of the influence of access to healthcare on indicators of mental distress, internalized homophobia, and social support.

Despite the limitations described above, the present study corroborated that there are factors associated with minority stress, such as internalized homophobia, that influence satisfaction in access to healthcare in LGBTQ+ people. In parallel, this research also allowed us to understand that social support, as a protective factor for LGBTQ+ people, exerts a buffering effect.

Conclusion

This research aimed to further understand the issue of access to healthcare for LGBTQ+ people in Portugal. In parallel, the study aimed to underline the importance of studying not only the stress factors, but also the protective factors associated with LGBTQ+ people mental health.

Our results revealed that despite the right to access to healthcare being enshrined in the Constitution of the Republic, there are still barriers imposed on LGBTQ+ people, namely related to proximal stress factors. Protective factors associated with a higher satisfaction with access to healthcare were also identified, such as social support.

Overall, present research raised awareness about the impact that minority stress can have on LGBTQ+ people, namely in the access to basic rights such as access to healthcare.

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