

Improving alcohol and mental health treatment for lesbian, bisexual and queer women: Identity matters

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National population and community survey studies consistently demonstrate that lesbian, bisexual and queer (LBQ) women consume alcohol at higher levels and experience higher rates of alcohol dependence than heterosexual women.¹⁻⁶ However, a growing body of research suggests that the picture is more complex, with rates of drinking and alcohol dependence among LBQ women varying by sexual identity.^{1,2,7,8} For example, a national US study found that bisexual women reported higher rates of past-year heavy drinking and alcohol dependence compared with lesbian women.⁷ On the other hand, an Australian study found that lesbian women reported higher rates of at-risk and binge drinking than bisexual or 'mainly heterosexual' women.¹⁰

Alcohol and mental health problems are commonly co-occurring morbidities¹¹ and LBQ women also experience higher rates of mental health problems than heterosexual women. The causal relationship is not definitive but stress and discrimination have been implicated as important predictors of alcohol use among LBQ women¹⁰ and, in one of the few longitudinal studies of LBQ women's health, anxiety was prospectively associated with hazardous alcohol use, and hazardous drinking was prospectively associated with depression.¹² A meta-analysis conducted by King et al.¹³ concluded that the risk of lifetime mood disorders, anxiety

Abstract

Objective: Lesbian, bisexual and queer (LBQ) women experience substantial unmet alcohol and mental health treatment needs. This paper explores the way in which sexual identity shapes experience, and needs, in relation to alcohol and mental health treatment, and presents key messages for improving treatment.

Methods: Twenty-five in-depth interviews were undertaken with same-sex attracted Australian women, aged 19–71. Interview transcripts were analysed thematically.

Results: Key messages offered by participants focused on language, disclosure and practitioner training. Variation in sexual identity did not alter treatment expectations or needs; however, we noted an important difference with respect to identity salience, with high LBQ identity salience linked with preference for disclosure and acknowledgement of sexual identity in treatment interactions, and low identity salience linked with a preference not to disclose and for sexual identity not to require acknowledgement in treatment.

Conclusions: Treatment providers may find it useful to gather information about the centrality of sexual identity to LBQ women as a means of overcoming treatment barriers related to heteronormative conventions and discrimination, language and disclosure.

Implications for public health: Treatment providers should adopt more inclusive language, seek information about identity salience and the importance of sexual identity to the current treatment, and regularly pursue LBQ-related professional development upskilling.

Key words: alcohol, mental health, treatment, lesbian, bisexual, queer

disorders and substance use disorders were at least 1.5 times higher among LBQ populations compared with heterosexual populations.^{3,14} Research suggests that bisexual women experience greater rates of mental health problems compared with lesbian women.^{15,16} In Australian research, bisexual women reported the highest levels of perceived stress, depression and anxiety symptoms, and

the lowest scores on the mental health index and social support scales.¹⁰

Higher rates of alcohol and mental health problems among LBQ women may account for their greater likelihood of seeking and receiving treatment for alcohol and mental health problems.^{3,14,18} However, population surveys, as well as convenience samples of treatment populations, suggest that LBQ

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women experience greater treatment barriers and are less satisfied with treatment than their heterosexual counterparts.^{19,22} For example, McNair et al.²¹ found that Australian LBQ women reported lower continuity and lower satisfaction with general practitioner (GP) care than heterosexual women. In a US study, LBQ people expressed less satisfaction with inpatient and outpatient mental health services and lower levels of connection, support and satisfaction with substance use treatment programs, than heterosexual people.^{20,22}

Major concerns relating to health services for LBQ individuals include heterosexism (prejudiced attitudes or discriminatory practices against sexual minorities), poor provider knowledge and communication skills, and lack of LBQ-specific resources and referral networks.^{23,24} GP services are the most frequently accessed form of alcohol or mental health treatment.^{25,26} Recently, McNair et al.²⁴ identified three barriers that can lead to a silencing or lack of acknowledgement of sexual identity in GP services: 1) an assumption that women preferred to disclose, rather than be asked about, their sexual identity (reflecting, in part, lack of understanding of the many barriers women face in relation to disclosure, such as fear of negative reactions); 2) reduced confidence felt by women about disclosure after experiencing heterosexism; and 3) deliberate silencing, whereby the provider was aware of the person's sexual identity but did not acknowledge this information in subsequent interactions. Similar levels of discomfort related to disclosure, alienation and discrimination have been identified in alcohol treatment programs.^{22,27}

There is some evidence to suggest that bisexual women experience higher rates of alcohol and mental health problems than lesbian women, and greater treatment barriers in healthcare,³ which results in bisexual women being even less likely than lesbian women to disclose their sexual identity to healthcare providers.²⁸ Experiences of bisexual clients in healthcare include: invalidation of bisexuality; equating bisexuality with promiscuity or having multiple partners; and lack of provider knowledge about bisexual issues.^{29,30} In another study, McNair and Bush³¹ found that queer (defined by the authors in this context as indicating a fluid sexual and/or gender identity), pansexual (sexual attraction and behaviour not limited by biological sex, gender or gender identity), and gender-

diverse people were even more likely than bisexual women to experience barriers to mental healthcare.

Although previous work has documented the barriers that LBQ women experience in alcohol and mental health treatment, there has been little progress in reducing these barriers, resulting in substantial unmet alcohol and mental health treatment needs among LBQ populations.^{3,32,33} There has been insufficient attention paid to understanding how variations in sexual identity shape needs in relation to – and experiences of – alcohol and mental health treatment.²⁸ Instead of treating LBQ women as a homogenous sub-population, it has been suggested that LBQ sub-groups should be considered separately in the context of their healthcare needs.¹⁷ This paper aims to address this gap by focusing on how differences in sexual identity among LBQ women shaped treatment experience and needs. We explored this issue through thematic analysis of key messages for improving alcohol and mental health treatment offered by a community sample of Australian LBQ women. Our qualitative approach emphasised the importance of understanding sexual identity and its significance in the lives of individual LBQ women and how this influenced their experiences of treatment and self-perceived needs of treatment.

Methods

Participants and Procedure

Data for this study were from the qualitative component of the ALICE (Alcohol and Lesbian/bisexual women: Insights into Culture and Emotions) study. Between November 2012 and April 2013, a convenience sample of 521 Australian women completed an online survey that was advertised as exploring experiences of alcohol, mental health and treatment among same-sex attracted women. The study was advertised through Facebook, LBQ websites, print media and emails to LBQ social groups. Inclusion criteria included being aged 18 years or more and identifying as same-sex attracted. Women were invited to participate regardless of their alcohol or mental health history. Participants were invited to provide contact details for inclusion in the qualitative component of the study. Almost half ($n=232$; 44.5%) agreed to the follow-up, with 102 participants located in Victoria and therefore accessible for face-to-face interviews.

A random sample of these 102 women was generated, stratified by age, location (metropolitan, regional and rural) and sexual identity, to ensure we interviewed a range of women based on sociodemographic and individual influences. After 10 interviews, we noted that heavy drinkers were under-represented, and we therefore stratified the sample further to include more heavy drinkers. After 10 additional interviews, we observed that women born outside Australia were under-represented and we adjusted the final sampling frame accordingly. After 25 interviews, it was agreed by the interviewers (AP and RM) that saturation had been reached, both in relation to commonality of themes among participants, as well as theoretical saturation of themes consistent with the literature.^{34,35} Thirty-seven women were contacted to achieve the final sample of 25 interviewees. The twelve women who did not participate either could not be contacted ($n=7$) or declined further involvement in the study ($n=5$). Women were interviewed between December 2012 and October 2013.

Interviews were conducted by two experienced researchers. AP, PhD, is a sociologist and qualitative alcohol researcher who has more than ten years' experience conducting interviews related to alcohol, drug use and mental health. AP identifies as heterosexual. RM, PhD, is a practising general practitioner and public health researcher whose research has focused on health inequality and LBQ health. RM identifies as lesbian. Interviewers described their work history to participants prior to beginning the interview and while they did not directly disclose their sexual identities, it was often enquired about and subsequently disclosed. Interviews took place either in a private room at the interviewers' university, the home of the interviewee, or a neutral location such as a café, as preferred by participants. Two interviews with women in rural areas were conducted by phone. Interviews lasted between 30 and 190 minutes and participants were offered a \$50 shopping voucher as reimbursement for their time and travel. The interview was semi-structured and guided by an interview schedule that focused on sexual identity, alcohol use, mental health, and treatment seeking. At the beginning of the interview participants were asked, "Do you mind telling me a bit about your sexual orientation and what terms you use for yourself?" We also asked women, "How out or open are you about your sexual orientation?"

with prompts for “with everyone/most people/close friends/family/few people/no-one”. This paper uses data from these questions and draws on the findings relating to previous treatment experiences and expectations relating to alcohol and mental health treatment. In particular, we asked the following question at the end of the interview: “We are intending to develop training for healthcare providers on how best to help LBQ women with their alcohol use and mental health issues. What is the one key message you would like these health providers to understand?” Interviews were audio-recorded and transcribed verbatim, with pseudonyms used to ensure participants remained anonymous. Participants signed a consent form prior to participation and were provided the option to review and amend their transcripts. Ethics approval was granted by the University of Melbourne Health Sciences Human Ethics Committee (ID: 1237539).

Analysis

Thematic analysis of interview transcripts was undertaken using NVivo version 9.³⁶ We adopted a grounded theory approach, with thematic construction of categories emerging from the data, and no a priori establishment of themes. Two researchers (AP and RM) coded the first three interviews and compared and contrasted thematic categories, before reaching agreement on a coding framework. When these themes were presented to the broader research team for discussion it was agreed that the themes had face validity in relation to the team members' expertise as clinicians, LBQ women's health specialists, consumers, LBQ researchers and alcohol researchers. One researcher (AP) then thematically coded the remainder of the interviews. For the purpose of this paper, we undertook a second layer of analysis to identify whether women who identified in a certain way, for example, as lesbian or bisexual, reported different treatment needs or expectations. For this comparison, we grouped the women into three categories: lesbian ($n=11$); bisexual ($n=5$); and 'other' ($n=8$; more details on the 'other' group below). Quotations are presented that represent the views of a majority of the sample, except in circumstances where participants held opposing or conflicting views. In these cases, examples of contrasting views are presented.³⁷

Findings

Participants

The 25 participants ranged in age from 19–71 years ($mean=40.1$ years). Eighteen women were born in Australia, with one identifying as Aboriginal; three women were born in the UK; and one each in New Zealand, the US, Russia and Singapore. Eleven women lived in metropolitan Melbourne, 11 lived in regional areas (outer urban areas in Melbourne or regional towns in Victoria) and three lived in rural areas. The majority of participants identified as female; one participant identified as transgender, one as intersex and one as gender queer. In terms of sexual identity, 11 participants identified as lesbian, five as bisexual, two as gay, two as queer, and two as pansexual. Three participants preferred not to be labelled. Nine participants were in relationships: six with women and three with men; and five participants had children. Women varied in their drinking patterns, with a mix of light, moderate and heavy drinkers.

Experiences of treatment

Of the 25 interviewees, only four reported having accessed treatment specifically for alcohol use, which included alcohol counselling, 12-Step programs and residential rehabilitation. In contrast, the majority ($n=17$) reported receiving treatment for mental health problems from counsellors, psychologists or psychiatrists. All participants reported having previously attended GPs, with some having discussed alcohol and mental health issues with GPs. Some participants had discussed alcohol use with mental health providers, while others had discussed mental health with alcohol treatment providers, reflecting the complex and overlapping nature of healthcare, and the need for services to address multiple issues. Participants reported both positive and negative experiences in all three services. Although reports of negative experiences ($n=49$) outweighed reports of positive experiences ($n=15$), this may, in part, reflect the manner in which the questions were asked and our goal of learning how we might improve experiences of healthcare for LBQ women.

Negative experiences of treatment reported by participants reflected themes reported in the research literature. These included insufficient management of issues (particularly in relation to GPs and

mental health providers not acknowledging problematic drinking); insufficient provider training in LBQ issues; inadequate attention to the complex inter-relationship between alcohol and mental health; heteronormative assumptions; experience of discrimination and negative attitudes; and discomfort disclosing sexual identity.^{2,3,19-24,27,31-33}

Key messages for the development of more appropriate healthcare

We asked participants to share their key messages for improving alcohol and mental health treatment for LBQ women. Three main themes emerged, including the need for: 1) inclusive language; 2) acknowledgement of sexual identity; and 3) LBQ training. These themes were not unanimously reported by all participants and participants often held opposing views. These contradictory views highlight the complex nature of treatment provision for LBQ women. Participants acknowledged the existence and complexity of multiple and conflicting views, but also provided suggestions about how these conflicts could be resolved.

Key message 1 – The need for more inclusive language, especially around disclosure

The most common suggestion focused on the need for service providers to use more inclusive language. This arose from experiences that most services overwhelming make heteronormative assumptions both verbally and in the written language used on intake and other forms. Many of these assumptions occurred at first treatment contact, leaving participants feeling alienated, silenced or misunderstood from the outset. Even if providers were apologetic and accepting of sexual identity, a barrier had been established that was either insurmountable or took time to overcome. In terms of improving service provision, participants reported that it was simple: make sure intake forms do not use heteronormative language in regard to sexuality and gender (e.g. by including more options than 'married' and 'single' or 'male' and 'female'). With regards to verbal communication, participants suggested that asking about relationship status and sexual history without making assumptions about heterosexuality would go a long way in facilitating rapport. For example:

The language is very what is known as heteronormative and I see it across the board

... It starts with the intake form ... and also be careful how you ask the questions, because you can shove the person off from as soon as they sit down ... they might ask you along the lines of "are you married, have you got family?" ... [Instead of] asking them what their preferred name is and asking them whether they are in a relationship, what is the gender of their partner, if it is appropriate. But not just this standard question that you don't think about, are you married? That's a conversation close. (Female, 37 years, identifies as gay)

While most participants reported feeling alienated by heteronormative practices, some also reported preferring not to disclose their sexual identity unless they felt it was specifically relevant to the treatment. For example:

Interviewee: I actually haven't disclosed my sexual orientation to any of my treatment providers.

Interviewer: Why have you chosen not to disclose?

Interviewee: Doesn't seem relevant.

Interviewer: Okay. It's not something you're doing deliberately?

Interviewee: No it's not. I'm not deliberately hiding it away but when I think about disclosure I think "would a straight person come out and say oh by the way I'm straight?" If they wouldn't then why should I go oh by the way I'm bisexual? (Female, 28 years, identifies as bisexual)

The fact that some women reported a preference for disclosure, while others preferred not to disclose, was sympathetically acknowledged by participants as a complex task for treatment providers:

I wouldn't volunteer any of that information [sexual identity] to a standard GP unless it was relevant ... but if it was going to help, yes. That's a bit of a tricky, sort of - what the doctor thinks might help might not be essentially what I might think will be helping. (Female, 42 years, prefers not to self-identify with any particular label)

Participants offered suggestions of ways to deal with diverse disclosure preferences. For example, that intake forms could have an option about preferring not to disclose such information. Another suggestion was that providers discuss the perceived relevance of sexual identity to treatment:

You could have boxes [on forms] and you could say do you identify as gay, lesbian, whatever and down the bottom it could be 'prefer not to disclose' ... Then you could

disclose if you want to and you don't have to if it's not relevant or you just don't want to. (Female, 25 years, identifies as lesbian)

Even asking the question, "Do you think that this [sexual identity] is relevant?" might be one way of moving forward. If the client is saying, no, then that's fine. (Female, 30 years, identifies as pansexual)

Key message 2 – The need to acknowledge sexual identity as an important component of identity while also not assuming it is the cause of all mental health and alcohol problems

Participants discussed the importance of having their sexual identity acknowledged in treatment interactions but differed in their views about how much attention should be placed on it. It was suggested by some participants that LBQ women can be invisible in services and that acknowledging sexual identity is important. However, others suggested treatment providers should not treat LBQ women differently to heterosexual women:

Generally, the lesbian community doesn't want to be treated any differently. It's equality we're after. (Female, 47 years, identifies as lesbian)

On the other hand, some believed this ignored the reality that different groups have fundamentally different treatment needs, for example:

Treating everybody the same makes LBQ people invisible ... "Oh, we don't discriminate because we treat everybody the same"; and there's actually discrimination within that because you're not actually considering various groups. (Female, 71 years, identifies as lesbian)

Some participants felt as though not enough focus was placed on exploring the complex inter-relationship between sexual identity, alcohol and mental health problems, with alcohol treatment providers focusing only on alcohol use (not sexual identity or mental health) and mental health providers not focusing enough on alcohol. On the other hand, a number of participants reported that they felt too much focus was placed on sexual identity as the cause of the problem, particularly in mental health treatment, even if the primary reasons for seeking treatment were related to work or other unrelated issues. For example:

Often if someone goes to a mainstream service and comes out as gay, there's sometimes a tendency to think that that's

what the issue is. But it actually might not be the issue. It just happens to be who you are, and the issue can be around anything. So - although it's important, I guess, to look at that relationship between sexuality and mental health - it doesn't mean that there's a direct relationship all the time. (Female, 56 years, identifies as lesbian)

Two participants reported on the complex topic of sexual identity and motherhood. One participant lamented a tendency for her practitioner to focus on her sexuality or age, rather than her occupational concerns:

Are you listening to me? I'm saying that my boss is driving me insane and everything like that and you're trying to tie it back to my orientation? The other thing I get is are you sure you don't want to be a mum? Just because I've got ovaries and a womb doesn't mean I need to use it, you know what I mean? ... I'm always having to justify that. That's a bit frustrating. (Female, 36 years, identifies as pansexual)

Alternatively, a woman of a similar age reported that she felt not enough attention was paid to these issues for LBQ women and how it influenced drinking:

Women who are gay and they aren't sure as to whether or not they want to have kids, and they're not in a partnership, that stress of having to make that decision on your own and being gay, how it affects gay women, in terms of mental health and depression and drinking, and how it affects how they live and what their choices are ... [It would help] if there was a culture that was more accepting and willing to say, you know ... it's quite normal and we want to help you make those choices or offer you assistance. (Female, 35 years, identifies as gay)

Key message 3 – The need for improved training in LBQ issues and LBQ specialist services

Most participants expressed the view that although GPs were the most commonly accessed providers for alcohol and mental healthcare, they were the least educated about LBQ issues. Some participants reported experiencing discriminatory attitudes from GPs, which could be both overt and subtle. For example, "men [male GPs] of a certain age will kind of be baffled by it almost to the point of they don't get it", resulting in feeling that it's not "deeply hurtful, but it's kind of like you have to come out five times a day, essentially" (Female, 35 years, identifies as gay). Some participants reported experiencing negative attitudes from mental health practitioners,

but the most common complaint about mental health providers was in relation to lack of knowledge about LBQ issues, which led to a feeling of being misunderstood.

Given their previous experience of discriminatory attitudes and/or experience of providers lacking knowledge about LBQ issues, some participants suggested that there was a compelling need for specialist services. Many identified particular services in the Melbourne metropolitan area that specialised in LBQ health, which they felt made treatment easier to access and led to better health outcomes. For example:

Interviewee: Your local GP down the road is no good – they're just no good. They might mean well, but they don't live in that sort of world. They don't see the problems. But take the model of [LBQ-specific health service name].

Interviewer: So, in your mind, there is a real need for LBQ-specific organisations?

Interviewee: It's not just a need, it's an essential thing. (Female, 42 years, prefers not to self-identify with any particular label)

The alternative view to this was that every provider should be adequately trained in LBQ issues, so that women could feel comfortable accessing any service that they may need. This was a particularly strong view in regional and rural areas, where the availability of specialist services was low. For participants from these areas, there was a view that providers should be able to understand the different needs of minority populations. For example:

There's a very well-known gay clinic or practice that lots of gay people go to, because it's comfortable and there's acceptance ... they're experts in gay health ... But shouldn't every clinic be? ... A proactive approach to gay services not being gay services at all, but just services for everybody. You don't know who you're going to treat so you [should] be able to treat anyone with the same level of service that you would treat a straight person or a man or an elderly person. (Female, 35 years, identifies as gay)

The main suggestion for improving the knowledge of providers was for LBQ education to be embedded into the training of health professionals, both at the university level and in ongoing training. However, it was also pointed out that receptionists and other peripheral staff in services need to receive training so as not to unknowingly facilitate a hostile or unfriendly environment for LBQ

women.

Participants almost unanimously reported on the importance of having a rainbow flag sticker visible, either on the window or in the waiting room of services, to immediately make them feel welcome. However, it was suggested that the presence of such stickers was not enough and that services had to be LBQ-competent before they could promote themselves to LBQ clients:

It's lovely if you accept and are willing to work with sexual minorities. But if you haven't got the training for this minority group, then get it first ... You can always display the rainbow flag ... but it's more important that you've got the skills to be working in this field. (Female, 37 years, identifies as gay)

Views on healthcare according to sexual identity salience

Given the complexity of the findings in relation to treatment, particularly with regard to opposing views about disclosure, focus on sexual identity and the desire for specialist services, we conducted additional analyses to explore potential differences in responses based on sexual identity. We found very few differences between how participants identified and their views of treatment. This might be a consequence of our small sample and the variation in which women identified – with the 'other' category comprising women who identified as queer, pansexual, gay and preferred not to be labelled. The exception was that bisexual and 'other' participants were more likely than lesbian participants to report having experienced treatment providers making incorrect assumptions about their sexual identity. For bisexual and 'other' participants, assumptions about heterosexuality or homosexuality were often made based on the gender of their current partner, which compounded misunderstanding, distrust or feelings of alienation. However, across all sexual identities participants reported a preference for disclosure, and others for non-disclosure. Participants in each identity group reported wanting their sexual identity to be better acknowledged, while others believed too much emphasis was already placed on it. In addition, participants in each group reported mixed views about the need for specialist treatment services versus a desire for all services to adequately address LBQ issues.

While few patterns in treatment needs could be recognised between participants who identified as lesbian, bisexual or in other ways,

we did note while searching for patterns in the data that LBQ 'identity salience'³⁸ was an important indication of participants' experiences and views about treatment. That is, the importance that participants attached to their LBQ identity, and how open or 'out' they were in other aspects of their lives, was a strong indication of the differences we have identified in treatment views. Generally speaking, we found that participants with high LBQ identity salience, that is, those who placed strong emphasis on their sexual identity as an important marker of their self-concept, indicated preferences for: disclosure; having their sexual identity acknowledged in subsequent treatment interactions; and all services to be better equipped to work with LBQ clients. Participants with low identity salience, that is, those who placed less emphasis on LBQ status as central to their identity, were: more reluctant to disclose; more likely to suggest that their sexual identity was irrelevant to treatment; and more likely to want to access specialist services where they felt safer and better understood. An example of varying levels of identity salience, and subsequent treatment views, are presented in two opposing examples below:

Interviewee: I identify as bisexual. People are always trying to convince me that I shouldn't use bi and I usually just ignore them.

Interviewer: Why do they say that?

Interviewee: I hang out in a lot of very, very radical, queer spaces and generally it's sort of seen as upholding the gender binary and only means two, but look, I agree with all of that but I've just adopted that as part of my explanation of that label so I can still use the same one.

Interviewer: So how open or out are you about your sexual orientation?

Interviewee: More or less completely.

Interviewer: What about the doctor you went to, have you been able to talk about your sexuality openly with him or her?

Interviewee: Yes. I gave her the simplified version which I use for people I don't care about, which is dude: lesbian. It's not strictly accurate, but it gets the point across. (Gender queer, 20 years, identifies as bisexual)

Interviewee: I work at [employment name]. I sing in a choir. I became a vegan a bit more than a year ago, so that's probably the thing that takes up the most amount of my headspace at the moment, I suppose; not headspace, but in terms of identity maybe. I'm a lesbian as well. That's probably lower on the list in terms of my identity.

Interviewer: How open are you about your sexuality with friends and family?

Interviewee: I've still got friends, actually, who don't know, which is sometimes a bit of an issue ... It feels mostly – it's a fairly abstract kind of thing ... I mean, I've always thought with people at work and whatever, I just want them to accept me as me and just treat me like a normal person. I don't want it to be a big thing.

Interviewer: What about with your healthcare providers?

Interviewee: No ... it's quite weird in a way, the whole thing of – I do define as a lesbian, but there's a shitload of things [with lesbians] I have nothing in common with ... there's a lot more I have in common with other people than that ... I don't want to be treated any differently about it ... and not made a big deal of either way ... There's other things that are more important or that say more about me, I suppose. (Female, 47 years, identifies as lesbian)

As is evident from these experiences, the concept of identity salience is complex and we do not intend to suggest that it is a straightforward exercise to compartmentalise LBQ women as having either a high or low sexual identity salience. There is some ambivalence in these reflections, which demonstrates this complexity. For example, the first person identifies strongly as bisexual but tells doctors she is lesbian, assuming, perhaps, that they understand lesbian better than bisexual identity. However, these representations demonstrate a relationship between identity salience and disclosure among LBQ women, with participants who expressed a stronger investment in their LBQ identity more likely to disclose than those who expressed a lower investment. Some participants reported that they would never hide their sexual identity from treatment providers (as in the case of the first participant, above), while others reported that they had never come out to their GPs or mental health providers (as in the case of the second participant). Others were selective, disclosing to some providers but not others. In these circumstances, the degree of openness about sexual identity with treatment providers matched participants' openness about their sexual identity with friends, families and co-workers, as well as how strong an emphasis they placed on their LBQ identity salience.

Discussion

In recognition of the continuing barriers that LBQ women face accessing and receiving alcohol and mental health treatment, this study explored key messages for improving treatment offered by a sample of same-sex attracted women. Participants held conflicting views about the need for disclosure and importance of acknowledging sexual identity in treatment, and the need for specialist services. We identified that these differing opinions were largely influenced by differences in, and the importance attached to, participants' LBQ identity salience. The primary areas of consensus in participants' accounts were around the need for services to overcome heteronormative conventions, to provide better training regarding LBQ issues, and to make fewer assumptions.

In Australia, alcohol and mental health issues are commonly discussed with GPs and, even where specific treatment for substance use or mental health is accessed, discussing mental health issues in alcohol treatment, or vice versa, is common practice. This multifaceted and overlapping system of healthcare emphasises the need for service providers across the treatment spectrum to be knowledgeable about and willing to deal with the possible intersections between alcohol and mental health concerns among LBQ women.

Previous research has identified that alcohol treatment providers receive limited or no training on LBQ issues and rarely discuss sexual identity with their clients, although they believe that these issues are important.^{39,40} McNair and colleagues²⁴ highlighted that inappropriate handling of sexual identity disclosure in healthcare can damage the person-provider relationship. However, gathering information about sexual identity and paying adequate attention to issues related to sexual identity is complex; there is no one-size-fits-all approach. Irrespective of their identity, participants in the current study had mixed views about the need for disclosure, emphasis and attention to sexual identity, and the need for specialist LBQ services.

We suggest that health providers can navigate this complex area and provide more tailored services for LBQ women by paying more attention to sexual identity salience. According to Morris, identity salience "refers to the likelihood that a given

identity will be active across situations ... [In general] identities that are higher on the salience hierarchy are more likely to be enacted"^{38(p24)} Morris further suggests that greater commitment to identity results in greater identity salience. In previous work, McNair et al. have used the term 'identity salience' to describe the significance that LBQ participants assigned to their LBQ identity relative to other identity categories.⁴¹ They found that LBQ identity salience influenced preferences for, and intensity of, social connections (LBQ and/or mainstream); disclosure (from very open to very closeted); and the need for public identity recognition (from full recognition to none). Women with high LBQ identity salience were more likely to publicly identify as LBQ.⁴¹

In the current study, women whose sexual identity appeared to be central to their sense of self, that is, those with high LBQ identity salience, were more likely to indicate a preference for disclosure of sexual identity in treatment and for acknowledgment of sexual identity in subsequent treatment interactions. On the other hand, participants with low LBQ identity salience or, to put it a better way, those whose identity was more powerfully shaped by factors other than their sexual identity, were less likely to report a preference for disclosure and for discussion of sexual identity in treatment. Sexual identity and disclosure is a complex issue, and the concept of identity salience is not straightforward. However, health providers can become adept at facilitating identity disclosure, and part of this must be a commitment to understanding how strongly sexual identity is part of a person's self-concept, which can then be used to guide more in-depth exploration of the relevance of sexual identity to their alcohol use and mental health issues.

The concept of identity salience can also be extended to gender identity salience. Our data includes some people with non-binary gender identities. Indeed, gender diversity is rapidly becoming more visible in society and in healthcare,^{42,43} with a recent Australian study of same-sex attracted women including 5% who identified as trans female and 10% who identified as other gender identities including gender diverse, gender queer, non-binary gender and agender.³¹ The gender diverse people in that study were most likely to report depression, and also most likely to fear discrimination in healthcare. Other emerging work is showing that trans and

gender diverse people have higher levels of unmet need and untreated depression than bisexual people⁴⁴ and service providers are even less educated about gender identity issues than LBQ issues.⁴⁵ Raising awareness of treatment providers to this emerging disadvantaged group is timely.

Implications for public health

Our findings highlight the need for treatment providers to seek information about, and reflect on, the importance of identity salience to LBQ women. If practitioners are more sensitive to identity salience, they may be better able to understand women's preferences for disclosure and acknowledgement of sexuality in ongoing treatment interactions. We acknowledge that seeking information about identity is not a straightforward process and may be difficult for busy treatment providers. However, the LBQ participants interviewed in this study provided some suggestions for relatively simple ways of eliciting this information, through: 1) changing intake forms to include inclusive language, with a written or oral preference for non-disclosure; 2) seeking information about whether the person thinks her sexual identity is important or necessary to the treatment being sought; and 3) regularly seeking professional development training and upskilling around the needs of LBQ women with regards to alcohol and mental health. Participants emphasised the importance of being able to trust services that advertise themselves as being LBQ friendly, and this goes beyond simply displaying a rainbow sticker. It is also important to note the existence of a 'Rainbow Tick' guideline for Australian health service accreditation for lesbian, gay, bisexual, transgender and intersex inclusive practice.⁴⁶ 'Rainbow Tick' provides criteria against which an official accreditation agency can assess whether six standards (organisational capacity, cultural safety, professional development, consumer consultation, disclosure and documentation, and access and intake processes) are met by the service. Similar programs could be established elsewhere to improve service delivery for LBQ women. In addition to gathering information about identity salience, GPs and mental health and alcohol services can undertake Rainbow Tick accreditation to ensure they are using inclusive language and not making assumptions about sexuality.

Limitations

Our data are from a non-representative convenience sample of LBQ women who reside in the state of Victoria and, in this regard, the findings may not apply to all Australian LBQ women. Participants were recruited for the initial survey online, which means the sample is limited to women who access computers and are responsive to research engagement. The small and heterogeneous sample made it difficult to group women into meaningful categories for the purpose of analysis, with those identifying in various ways being subsumed into an 'other' category. However, this reflects a growing literature highlighting the many and varied non-binary sexual identities of same-sex attracted women, and an increasing tendency toward resistance to labelling.⁴⁷ It should also be considered that women who have engaged in same-sex sexual behaviour but who identify as exclusively heterosexual may have been less likely to participate in the research. However, our sample did include women who identified as mainly/mostly heterosexual and previous research suggests only 2% of women who identify as exclusively heterosexual have engaged in same-sex behaviour.⁹ Due to our sample size, we were not able to explore the influence of age and cultural background, and even though our sample included seven women born outside of Australia, most were from Anglophone countries and only one identified as Aboriginal. We encourage more quantitative and further qualitative research that investigates the importance of identity salience as an indicator of treatment needs, while also acknowledging the importance of cultural background and age, as they are likely to influence aspects of identity salience and treatment experience.

Conclusion

We have highlighted the value of understanding the importance of identity salience for LBQ women seeking treatment for alcohol and mental health. This is in addition to the need for inclusive practices and ensuring all staff have sufficient training with respect to the treatment needs of LBQ women. As with any person seeking health services, it is important to respect LBQ women's desires to disclose information in the way and time that is right for them. The initial service contact, even with reception staff, can damage a therapeutic relationship

and a bad experience may not only dissuade LBQ women from returning to that provider, but from seeking treatment at all. As such, in addition to inclusive language, upskilling healthcare providers and ensuring their services are responsive to the needs of LBQ women, treatment providers should sensitively approach the issue of discussing sexual identity by considering the importance of identity salience to the individual.

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