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The Social and Cultural Significance of Women's Sexual Identities Should Guide Health Promotion: An Analysis of the Sydney Women and Sexual Health (SWASH) Survey

Rada Germanos,[1] Rachel Deacon,[2,3] and Julie Mooney-Somers[4]

Abstract

Our analysis aimed to identify the major risk behaviors and health issues for young lesbian, bisexual and queer women, and combine this with lifestyle and community engagement data to guide targeted health promotion for these groups. We conducted statistical analysis of 379 self-complete surveys from women aged 17–30 years attending lesbian, gay, bisexual, trans, and queer (LGBTQ) community events during the Sydney Gay and Lesbian Mardi Gras Festival period in February 2010 and 2012. We found concerning rates of tobacco, alcohol, and illicit drug use across all groups; a mental illness diagnosis and formal psychological support access were common. Queer women had the highest rates of illicit drug use, experiences of sexual coercion, and anti-LGBTQ discrimination. They were also the most proactive with their health. Bisexual women had low STI testing despite having high rates of sexual activity with both men and women. Lesbian women had the poorest uptake of Pap smears and STI testing. Findings demonstrate that meaningful sexual behavior is irrelevant for the majority of health disparities affecting sexual minority women. Meaningful engagement with contemporary sexual identities and their local social and cultural significance is essential for the development of appropriate and effective targeted public health interventions.

Key words: bisexual, health, health promotion, lesbian, queer, sexual identity, sexual minority, women.

Introduction

THERE ARE A VARIETY OF WAYS of capturing information on women's sexuality. One review reported 100 different methods.[1] Large epidemiological studies often rely on behavior indicators to categorize ''women who have sex with women'' (WSW). An alternative approach focuses on orientation, such as inviting women to pick a point on the scale: ''Exclusively lesbian, mostly lesbian, bisexual, mostly heterosexual, and exclusively heterosexual.''[2] Yet another approach relies on self-selected identity, as in our study: ''Do you think of yourself primarily as: Lesbian/dyke/gay/homosexual, bisexual, queer, heterosexual/straight, other identity.''[3] A more complex option involves researchers developing a composite indicator based on attraction and behavior, or behavior and identity.

Different measures produce different findings. An analysis of the 2002 U.S. National Survey of Family Growth (6,493 women aged 20–44 years) revealed striking differences when women were categorized by identity (i.e., homosexual vs. heterosexual, bisexual vs. heterosexual, sexual minority vs. heterosexual, homosexual vs. non-homosexual) versus behavior (WSW vs. not).[1] The authors concluded: ''Results from studies based on behavior should not be generalized to identity groups and vice versa.''

The choice to use a particular measure should reflect an underlying theory about the nature of the relationship being investigated. For example, the behavioral category ''men who have sex with men'' (MSM), reflects a theoretical perspective that behavior and not identity is the source of HIV risk.[4] The problem with ignoring or not making explicit a theoretical basis becomes clear when an identity category is used where a behavior

[1]Sydney School of Medicine, University of Sydney, Sydney, NSW, Australia.
[2]Discipline of Addiction Medicine, University of Sydney, Sydney, NSW, Australia.
[3]South Eastern Sydney Local Health District, Sydney, NSW, Australia.
[4]Centre for Values, Ethics and the Law in Medicine, University of Sydney, Sydney, NSW, Australia.

category is more relevant.[5] In the context of HIV research and women, the term ''lesbian'' obscured the more relevant risk behavior: sex with men. So WSW, with its focus on behavior, was preferable. Equally problematic—and more common—is when a behavioral category is used with no conceptual link made between the measured sexual behavior and the health outcome. Sex between women is very rarely a health risk in and of itself. For the vast majority of health disparities affecting sexual minority women, from smoking to experiences of violence to psychological distress, their sexual behavior is not directly relevant.

In this paper we take the theoretical perspective that the ''complex social and cultural connotations''[4] of sexual minority identities are relevant to health. Sexual identity is unlikely to be the only, or perhaps most, relevant identity for women. But we assume it plays some role in how the lesbian, gay, bisexual, trans, and queer (LGBTQ) identifying women responding to our survey organize their lives. We use the term ''trans'' as both a self-ascribed gender identity and as inclusive shorthand to refer to transgender, transsexual, and other non-normatively gendered people.[6] We assume that sexual identity groups have some shared culture, ideas, or norms around, for example, smoking or drinking and that these influence behavior. This is the perspective taken in recent smoking intervention studies to address smoking within minority groups,[7,8] including LGBT communities (see http://socrush.com/). These programs attend to the values, interests, and social dynamics of ''peer crowds.'' It was assumed that young people relate to particular social groupings within which particular ''health behaviors can be normative…and have symbolic meanings that make them socially valuable''.[7] Thus, effectively addressing risky health behaviors requires understanding and engagement with these social identities. The exploratory work we present in this paper uses these ideas to think about addressing lesbian, bisexual, and queer (LBQ) women's health disparities. We do this by using an existing dataset of demographic, lifestyle, and health information from a sample of young LBQ women.

The Sydney Women and Sexual Health (SWASH) survey has run biennially since 1996 as a collaboration of ACON Health, a leading health promotion organization specializing in HIV and lesbian, gay, bisexual, transgender, and intersex (LGBTI) health and researchers at local universities. SWASH provides a comprehensive dataset on the health and wellbeing of women engaged with LGBTQ communities in Sydney (Mooney-Somers, 2015). The collaboration conducts analyses that are practically useful for those delivering health services to this community and has shaped ACON Health's Health Outcome Strategies on Smoking[9] and Alcohol and Other Drugs.[10]

Our desire to inform health promotion, and our perspective that sexual identity is important for health, made us consider whether we could use our data set for more than documenting rates of risk behaviors. We conducted an analysis to identify the major risk behaviors and health issues for young lesbian, bisexual and queer identified women, and to combine lifestyle and community engagement data to guide targeted health promotion for these groups.

Methods

Participants

We used data from self-complete surveys from a convenience sample of young women attending community events during the Sydney Gay and Lesbian Mardi Gras Festival period in February 2010 and 2012. Only the two most recent datasets were analyzed to ensure a snapshot of contemporary populations and dynamics.

Measures

Several measures from the SWASH survey were used. Demographics: age, education, employment, residential location, sexual identity (lesbian/gay, bisexual or queer), trans status. Sexual practices and relationships: male and female sexual partners, regular partner, casual partners. AOD use: alcohol consumption, smoking status, illicit drug use. Mental health: psychological distress (K6),[11] diagnosis of mental illness, mental health service access. Discrimination and violence: experiences of anti-LGBTQ behavior, sexual coercion since age 16, domestic violence. Health care engagement: Pap smear, STI screening, regular general practitioner/medical clinic, if out to practitioner. Lifestyle and LGBTQ community engagement: sense of community connection, proportion of LGBTQ friends; engagement with LGBTQ community.

Data analysis

The 2010 and 2012 datasets were pooled to maximize the sample size. Women who indicated they completed the 2010 survey were removed from the 2012 cohort. Women identifying as heterosexual or ''other'' were excluded, the latter because ''other'' does not represent a sexual identity position. Sexual identity was used as the independent variable for subsequent analyses.

Table 1. Demographic Characteristics by Stated Sexual Identity

	Sample %	*Lesbian/Gay (n = 244)%*	*Bisexual (n = 72)%*	*Queer (n = 63)%*	χ^2 *(df)*
Location					45.36 (4)***
Inner Suburbs	*59.1*	*55.3*	*44.4*	*90.5*	
Outer Suburbs	*31.7*	*32.4*	*52.8*	*4.8*	
Outside Sydney	*9.2*	*12.3*	*2.8*	*4.8*	
University Education	69.7	65.6	70.8	84.1	8.21 (2)*
Full-Time Employment	49.6	53.7	43.1	41.3	4.61 (2)
Transgender/Transsexual	4.0	2.5	4.2	9.5	6.59 (2)*
Anglo/British Identity	63.6	67.2	54.2	60.3	10.59 (6)

*$P < .05$; **$P < .01$; ***$P < .001$.
df, degrees of freedom.

Table 2. Relationships and Sexual Practices, by Sexual Identity

	Sample %	*Lesbian/Gay (n = 244)%*	*Bisexual (n = 72) %*	*Queer (n = 63) %*	χ^2 *(df)*
Regular Partner(s) for > 6 Months	46.4	49.2	36.1	47.6	8.23 (2)
Ever Had Sex with a Woman	95.3	96.3	90.3	96.8	4.89 (2)
Ever Had Sex with a Man	64.4	55.7	80.6	79.4	22.33 (2)***
Casual Sex in the Last 6 Months	42.5	37.3	50.0	54.0	7.75 (2)*
With Women	*26.6*	*30.7*	*6.9*	*33.3*	65.48 (6)***
With Men	*5.5*	*1.6*	*15.3*	*9.5*	
With Both	*10.3*	*4.9*	*27.8*	*11.1*	

*$P < .05$; **$P < .01$; ***$P < .001$.

We restricted our analysis to women aged 30 years and under as they are the prime targets of the health promotion activities we want to inform. They also had the highest proportion of bisexual and queer-identified women. We used descriptive statistics with cross tabs and chi squares to examine differences between the three sexual identity groups for all measure listed above. Analyses were completed using SPSS Version 21.0 (SPSS, Chicago, IL, USA).

Research ethics

Ethics approvals were given by the Human Ethics Research Committees at the University of Sydney (2012 survey) and University of New South Wales (2002–2010 surveys) and by the ACON Health Research Ethics Review Committee.

Results

The final dataset comprised 379 questionnaires from lesbian, bisexual, or queer identifying women residents of New South Wales aged 17–30 years.

Demographics

Of the 379 respondents, 64% identified as lesbian, 19% as bisexual, and 17% as queer. The mean age was 24.5 years. Queer women were significantly more likely to also identify with transgender/transsexual gender identities when compared to lesbian or bisexual women ($P < .05$).

This is a highly educated, economically active, and urbanized sample, with 90% living in the Sydney metropolitan region (Table 1). Queer women overwhelmingly lived in inner city suburbs ($P < .001$), and bisexual women were the most

Table 3. Smoking, Alcohol, and Other Drug Use, by Sexual Identity

	Sample %	*Lesbian/Gay (n = 244)%*	*Bisexual (n = 72)%*	*Queer (n = 63)%*	χ^2 *(df)*
Lifetime Risk (> 2 Standard Drinks)	72.8	72.1	76.4	71.4	0.58 (2)
Binge (> 4 Standard Drinks)	88.7	88.5	90.3	87.3	0.31 (2)
Current Smoker	39.3	40.6	37.5	36.5	3.35 (2)
Illicit Drug Use Last 6 Months	69.6‡	52.9	62.5	82.5	18.62 (2)***
Marijuana	45.4	38.9	50.0	65.1	14.57 (2)**
Cocaine	19.5	15.6	20.8	33.3	10.15 (2)**
Ecstasy	31.0	28.5	31.9	39.7	2.95 (2)

*$P < .05$; **$P < .01$; ***$P < .001$.

‡The calculation of ''any illicit drug use'' requires participants to respond to 11 individual questions. Participants can choose ''never,'' but many simply leave the item blank. For the purposes of this analysis, we have interpreted a non-response to individual items as indicative of non-relevance, that is, the participant has not used that drug.

Table 4. Self-Rated Distress and Engagement with Mental Health Care Services, by Sexual Identity

	Sample %	*Lesbian/Gay (n = 244)%*	*Bisexual (n = 72)%*	*Queer (n = 63)%*	χ^2 *(df)*
Current Distress#					7.86 (4)
Low	*65.4*	*67.2*	*70.8*	*52.4*	
Moderate	*22.7*	*22.1*	*15.3*	*33.3*	
High	*11.9*	*10.7*	*13.9*	*14.3*	
Lifetime Diagnosed Mental Illness	47.2	46.7	43.1	54.0	1.68 (2)
Lifetime Counselor/Psychiatrist Access	65.7	62.7	62.5	81.0	7.20 (2)*

*$P < .05$; **$P < .01$; ***$P < .001$.

#Cut off scores: Low = 0–7, Medium = 8–12, High = 13–24.[19]

Table 5. Experiences of Discrimination and Violence, by Sexual Identity

	Sample %	*Lesbian/Gay (n = 244)%*	*Bisexual (n = 72)%*	*Queer (n = 63)%*	χ^2 *(df)*
Domestic Violence as Adult	29.3	28.7	25.0	36.5	2.27 (2)
Sexual Coercion Since 16 Years	29.0	24.6	30.6	44.4	9.68 (2)**
Anti-LGBTQ Behavior Last 12 Months	40.4	38.1	27.8	63.5	19.25 (2)***

*$P < .05$; **$P < .01$; ***$P < .001$.
LGBTQ, lesbian, gay, bisexual, transgender, and queer.

likely to live in outer suburbs. Lesbian women were the most geographically dispersed, with the highest regional representation. Queer women were significantly more likely to report engagement in higher education ($P < .05$).

Sexual practices and relationships

The vast majority had had sex with a woman in their lifetime (Table 2). A majority had had sex with a man in their lifetime: lowest among lesbian women ($P < .001$). Bisexual and queer women were significantly more likely to report casual sex in the preceding six months compared to lesbian women ($P < .05$). Patterns of casual sex differed significantly across the three groups: Bisexual women were twice as likely to report recent casual sex with a man compared to queer women, and six times more likely than lesbian women ($P < .001$); rates of casual sex with women showed little variation.

Alcohol and other drug use

The Australian National Health and Medical Research Council (NHMRC) recommends drinking no more than two standard drinks on any day to reduce the *lifetime risk* of harm from alcohol-related disease or injury.[12] Almost three-quarters of respondents exceed these guidelines, with little variation across groups (Table 3). The same guidelines recommend people drink no more than four standard drinks on a single occasion (binge drinking) to reduce the risk of *short-term* alcohol-related harm.[12] Most women had exceeded these guidelines in the last six months, with little variation across groups.

Just under half of women were current smokers. There was little variation across groups.

Seventy percent of respondents reported using an illicit drug in the last six months: marijuana the most common, followed by ecstasy and cocaine. Queer women were significantly more likely to report any illicit drug use ($P < .001$) and more likely to report use of marijuana ($P < .01$) and/or cocaine ($P < .01$).

Mental health

A minority of women reported experiencing high levels of non-specific psychological distress in the preceding four weeks (Table 4). There was no significant variation across groups.

Table 6. Healthcare Disclosure and Utilization of Screening Tests, by Sexual Identity

	Sample %	*Lesbian/Gay (n = 244)%*	*Bisexual (n = 72)%*	*Queer (n = 63)%*	χ^2 *(df)*
Regular GP/Clinic	64.9	63.9	68.1	65.1	0.42 (2)
Regular GP with Disclosure	45.9	46.7	38.9	50.8	2.10 (2)
Lifetime STI Screening	58.0	52.9	58.3	77.8	12.76 (2)**
Lifetime Pap Smear Screening	68.6	65.2	70.8	79.4	4.90 (2)

*$P < .05$; **$P < .01$; ***$P < .001$.

Table 7. Engagement with LGBTQ Communities, by Sexual Identity

	Sample %	*Lesbian (n = 244)%*	*Bisexual (n = 72)%*	*Queer (n = 63)%*	χ^2 *(df)*
''Very''/''Mostly'' Connected to LGBTQ Communities	48.8	48.0	29.2	74.6	27.97 (2)***
''Most''/''All'' Friends Are LGBTQ	43.8	44.7	25.0	61.9	18.80 (2)***
LGBTQ Events Attended, Last 6 Months					
Lesbian Bars	76.5	77.9	68.1	81.0	3.81 (2)
Gay Bars	68.9	70.9	62.5	68.3	1.84 (2)
Dance Parties	39.8	38.1	33.3	54.0	6.82 (2)*
Community Events	47.5	47.1	30.6	68.3	19.19 (2)***
Group Meetings	23.0	22.5	12.5	36.5	11.02 (2)**
Sporting Groups	15.6	17.2	13.9	11.1	1.61 (2)

*$P < .05$; **$P < .01$; ***$P < .001$.

Nearly half of respondents reported receiving a diagnosis of depression, anxiety disorder, or other mental health disorder in their lifetime. Two thirds reported accessing counseling or psychological services in their lifetime. This was significantly more likely among queer women ($P < .05$).

Discrimination and violence

Experiences of discrimination and violence were common (Table 5). Queer women were significantly more likely to report sexual coercion since the age of 16 ($P < .01$), and more than twice as likely to report recent anti-LGBTQ behavior ($P < .001$) than bisexual women.

Health-care engagement

Just under half of respondents reported they had a regular General Practitioner or attended the same clinic *and* that they were ''out'' to their GP about their sexuality (Table 6). There was no significant variation across groups.

A majority of women had accessed Pap smear and STI screening on at least one occasion. Queer women were significantly more likely to report STI testing; 79% compared to 53% of lesbian women ($P < .01$).

Lifestyle and LGBTQ community engagement

Just under half the sample reported strong LGBTQ community or friendship connections. Queer women were most likely to report a strong feeling of community connection ($P < .001$) and a high proportion of LGBTQ friends ($P < .001$), in sharp contrast to bisexual women (Table 7).

Licensed venues were the most common avenue for engagement with LGBTQ communities. Queer women were highly engaged across all LGBTQ activities and reported the highest engagement with community events. Lesbian women were moderately engaged across all activities and venues. Bisexual women were primarily engaged through commercial venues with the lowest attendance at community events.

Discussion

It is clear that some risk behaviors were common to all groups, namely hazardous alcohol consumption, illicit drug use, and tobacco use. Below we review the major risk behaviors and health issues for queer, bisexual, and lesbian women in turn and consider how lifestyle and community engagement findings could help guide targeted health promotion.

Queer women

Queer women represented the most localized and highly educated group. They were most likely to have many LGBTQ friends and to feel strongly connected to LGBTQ communities. The prevalence of potentially risky behaviors (illicit drug use, tobacco use, hazardous alcohol consumption, casual sex) is of concern. High rates of reported anti-LGBTQ behavior suggest these women are highly visible, perhaps because of personal appearance or attendance at visible LGBTQ activities. The pattern of high-risk behaviors, high rates of recent psychological distress, and experiences of discrimination and sexual coercion evoke a picture of a highly vulnerable group. However, rates of STI screening and counselor access were high and women reported having a regular GP, indeed many were out to their GP about their sexuality. This suggests a sense of autonomy over their health and may reflect exposure to proactive health messages as well as the availability of accessible and appropriate health services in the inner suburbs where they primarily reside.

Engaging queer women for health promotion likely needs to consider the presence of a localized and highly educated community, and the high representation of trans individuals. Campaigns should be directed to a wide range of issues, from mental health to illicit drug use, smoking, and risky drinking. They may be more successful if they draw on non-binary notions of gender, and adopt a politicized, critical, and edgy approach in their language and visual media. Delivery of health promotion materials through a range of licensed inner city venues, community and university groups would be appropriate.

Young women's adoption of ''queer'' is not uncommon in Australia, North America, or Europe.[13–16] This reflects a desire for more inclusive, open, and unstable sexuality and gender categories.[15,17] The non-gender specific nature of queer appears to have particular appeal;[15,18] an appeal not restricted to trans individuals and their partners. We would argue, health promotion efforts need to reflect both the openness of ''queer''' and engage with local meanings.

Bisexual women

Bisexual women were geographically dispersed, although the majority lived in the inner and outer suburbs of Sydney. Only one quarter reported having many LGBTQ friends, and they were much less likely to feel strongly connected with LGBTQ communities. Community engagement was overwhelmingly via commercial events, not community organized activities. This may reflect a lack of interest, a sense of exclusion from LGBTQ spaces, or geographical distance. Lower rates of anti-LGBTQ harassment suggest bisexual women may not be a visible sexual minority. This has implications for targeted health promotion and physician-initiated disclosure and risk assessment. Materials or programs with an explicit LGBTQ focus may not resonate with these women. Campaigns encouraging STI screening and addressing smoking and alcohol consumption would need to be nuanced and speak to women who have sex with both men and women, possibly without drawing upon conventional LGBTQ imagery. STI risk is the health issue that stands out for the bisexual women in our sample. They were the most likely to report recent casual sex with a man but STI testing was lower in queer women.

Recent work from the UK and Canada demonstrates mental health disparities between self-identified lesbian and bisexual women. This is a pattern not demonstrated by our results.[18,20] There are a number of possible explanations for this: We have sampled young women who attend events celebrating LGBTQ identity and community, rather than a representative sample of bisexual women. There is also an issue of categorization. The aforementioned studies, and many others, require women to identify as heterosexual, lesbian, or bisexual. Our inclusion of ''queer'' as a standalone identity, therefore, troubles a comparison. It is not clear how queer-identified women respond to a narrower range of identities. They may assimilate under an existing category

(we suspect largely ''bisexual''), self-exclude, or be excluded from analysis if they select ''other.'' That is, the mental health findings for bisexual women in other studies may encompass queer women's experiences. For these reasons, we hesitate to make direct comparisons with bisexual cohorts in other studies.

Lesbian women

Lesbian women reported the lowest rates of Pap smear and STI screening in the sample. This echoes a well-established finding and suggests persistent problems with the perception of relevance and access issues.[21–26] Health promotion campaigns need to highlight the importance of STI and Pap screening, even for women who exclusively have sex with women, and empower women to seek screening. Lesbian women are highly community-attached, so an effective campaign may be identity-based and delivered through licensed venues, community groups, and events. The high proportion of lesbian women from regional areas demands the use of online and regional women's groups for health promotion activities.

Broader implications

After demonstrating persistent differences between lesbian and bisexual, and between bisexual and heterosexual women, Bauer and Jairam conclude, ''Women of different orientation identities…should not be grouped together for analysis, even when frequencies are low.''[1] Our analysis extends this: Differences between bisexual and queer women in our study were striking, and locate queer women (in one metropolitan setting at least) as a group characterized by engagement in behaviors that pose health risks. In many ways, bisexual and queer women appeared more unlike each other than they were unlike lesbian women.

Women who self-identify as queer tend to be excluded or collapsed into the categories of lesbian or bisexual in research studies. Indeed, heterosexual, bisexual, and gay/lesbian ''have become so culturally and politically entrenched in contemporary societies that they have achieved the status of 'natural kinds,' that is, naturally occurring rather than socially constructed distinctions.''[27] Recent discussions about the adequacy of these categories reflects a concern around the relationship between these identity labels and attraction and behavior.[5,27] We take a different perspective: The standard categories do not reflect the identities that have social and personal meaning for women. This presents a methodological problem: It reduces the validity of comparing findings such as ours with other studies that utilize different approaches to sexual identity categorization. Perhaps more importantly, it has the potential to misdirect health promotion efforts, and misses opportunities for more nuanced and relevant work.

Echoing Bauer and Jairam,[1] we note our findings are time and culture bound. We do not claim a representative sample with findings generalizable to all LBQ women. Instead, we are interested in the idea of engaging with the social and cultural significance of contemporary, local sexual identities to shape effective and relevant local health promotion. Our results reflect the features of young women drawn to the activities and events during the Sydney Mardi Gras festival period: community-attached and highly urban. We are unlikely to sample sexual minority women who are uneasy about their sexual desires, are socially isolated, or not enticed to such events. Of those that are sampled, however, we have a clear picture of both the issues and avenues for intervention.

Conclusion

We were motivated by a desire to provide useful knowledge for our health promotion colleagues on whether there were differences within sexual minority women. While some health issues are relevant for all sexual minority women—smoking is a good example—other issues are more or less pertinent. Despite increasing evidence that sexual minority groups do not face the same set of health issues,[18,20] we find few examples of what this means practically for health promotion or intervention. For example, a Canadian study on sexual orientation and health stated, ''Bisexual women, in particular, reported poorer health outcomes than lesbian or heterosexual women, indicating that this group may be an appropriate target for specific health promotion interventions.''[20] The authors did not suggest specific interventions. We suspect this means health promotion for sexual minority women rarely engages with the diversity that our analysis, along with many others, has shown.

Our second aim was to use demographic and lifestyle data to guide health promotion efforts. We identified modes of socializing that may be more or less relevant, and raised questions about the extent to which health promotion to sexual minorities should always be branded as the all-encompassing ''LGBT'' or ''LGBTQ.'' This is our key message for those engaging in health promotion for this population. We are not aware of research exploring whether LBQ women respond to the same imagery, language, or branding in health promotion. We are advocating here for health promotion to be crafted to appeal to specific identity groups. This is in line with recent intervention work using the concept of ''peer crowds,''[7,8] but is a position advocated by many working in LGBT health.[2,28]

The vast majority of health disparities affecting sexual minority women, from smoking to experiences of violence to psychological distress, are not explained by their sexual practice. Nor does knowledge of sexual practice provide a means for intervention. Attending to self-selected sexual identity allows us to engage with the effects of social and cultural factors in shaping young women's health practices. Understanding the relationships between these factors and health for different sexual minority groups is paramount to developing appropriate and effective targeted public health interventions. This work, in turn, is dependent upon ongoing thoughtful engagement with contemporary, localized social identities.

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Address correspondence to:
Julie Mooney-Somers, PhD
Centre for Values, Ethics and the Law in Medicine
University of Sydney
Medical Foundation Building
Camperdown, NSW 2006
Australia

E-mail: julie.mooneysomers@sydney.edu.au