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Racial/ethnic differences in unmet needs for mental health and substance use treatment in a community-based sample of sexual minority women

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Abstract

Aims and objectives—To examine unmet needs for mental health and substance use treatment among a diverse sample of sexual minority women (SMW; lesbian, bisexual).

Background—Sexual minority women are more likely than heterosexual women to report depression and hazardous drinking. However, relatively little is known about SMW's use of mental health or substance use treatment services, particularly about whether use varies by race/ethnicity.

Design—Cross-sectional analysis of existing data.

Methods—Analyses included data from 700 Latina, African American, and white SMW interviewed in wave 3 of the 15-year Chicago Health and Life Experiences of Women (CHLEW) study. Using logistic regression, we examined associations among sexual identity, race/ethnicity, use of mental health and substance use treatment, as well as potential unmet need for treatment.

Results—Overall, lesbian and bisexual women reported high levels of depression and alcohol dependence, and these varied by sexual identity and race/ethnicity. Use of mental health and substance use treatment also varied by race/ethnicity, as did potential unmet need for both mental health and substance use treatment.

Conclusions—Our findings suggest although use of treatment among SMW is high overall, there is a potentially sizable unmet need for mental health and substance use treatment that varies by race/ethnicity with Latina women showing the greatest unmet need for treatment.

Relevance to clinical practice—Nurses and other healthcare providers should be aware of the high rates of depression and hazardous drinking among SMW, understand the factors that may

increase the risk of these conditions among SMW, and be equipped to provide culturally sensitive care or refer to appropriate treatment services as needed.

Key terms

Sexual minority women; lesbian women; bisexual women; depression; alcohol use; mental health treatment; alcohol use treatment; unmet need

Introduction

Sexual minority women (SMW; lesbian and bisexual women) are at heightened risk of problematic or hazardous alcohol use and depression, as compared to heterosexual women (Drabble, Trocki, Hughes, Korcha, & Lown, 2013; Hughes et al., 2006; Hughes, Szalacha, & McNair, 2010b; McCabe, Hughes, Bostwick, West, & Boyd, 2009; Mereish, Lee, Gamarel, Zaller, & Operario, 2015; Wilsnack et al., 2008). Compared to heterosexual women of color, rates of depression and hazardous drinking are higher for SMW of color (Hughes et al., 2006; A. Matthews et al., 2014; Mereish et al., 2015; Mereish & Bradford, 2014). Although use of mental health and substance use treatment is higher among SMW than among heterosexual women (Grella, Cochran, Greenwell, & Mays, 2011; Grella, Karno, Warda, Moore, & Niv, 2009b), because of the substantially elevated rates of both depression and hazardous drinking the possibility of unmet need for treatment may be elevated (McCabe, West, Hughes, & Boyd, 2012; Mereish et al., 2015; Razzano, Matthews, & Hughes, 2008).

Background

Many factors amplify the risk of depression and heavy/hazardous alcohol use among SMW. One of the most critical of these is the excess stress experienced by SMW (Hughes, Haas, Razzano, Cassidy, & Matthews, 2000; A. Matthews et al., 2014; Mereish et al., 2015; Razzano et al., 2008). Compared to heterosexual women, SMW have significantly higher lifetime rates of violence and victimization in both childhood and adulthood (Balsam, 2003; Morris & Balsam, 2008; Hughes, McCabe, Wilsnack, West, & Boyd, 2010a; Hughes, Johnson, Steffen, Wilsnack, & Everett, 2014; Hughes, McCabe, Wilsnack, West, & Boyd, 2010a). Sexual minority women additionally face unique and chronic stressors related to their marginalized status. According to Meyer's Minority Stress Model (Meyer, 1995; 2003), prolonged exposure to stressors such as heterosexism, stigma and discrimination has appreciable effects on sexual minorities' mental and physical health. Among SMW, higher levels of minority stress increase the risk of multiple negative health outcomes such as depression, physical symptomology, and unhealthy behaviors such as alcohol use. (Condit, Kataji, Drabble, & Trocki, 2011; Herek & Garnets, 2007; Hughes, 2011; Keyes, Hatzenbuehler, Grant, & Hasin, 2012; Lewis, Kholodkov, & Derlega, 2012; McCabe et al., 2009).

Given ample evidence that demonstrates high rates of depression and hazardous alcohol use among SMW, it seems obvious that there is also high need for treatment. However, using data from the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), McCabe and colleagues (2012) found that only 30% of bisexual women and 20% of lesbian women with lifetime alcohol disorders have ever sought treatment (McCabe

et al., 2012). Although the rates of treatment are higher among SMW compared to heterosexual women (Grella et al., 2011; 2009b), the need for treatment among SMW is greater due to elevated levels of depression and hazardous drinking (Bostwick, Hughes, & Johnson, 2008; Drabble, Midanik, & Trocki, 2005; Hughes et al., 2010b; 2014; Wilsnack et al., 2008). SMW also have a higher rate of co-occurring depression and hazardous drinking than heterosexual women (Bostwick et al., 2008). Together, these findings suggest that there may be a large unmet need for treatment among SMW (Hughes et al., 2000; Lehavot & Simoni, 2011; McCabe et al., 2012; Mereish et al., 2015; Razzano et al., 2008).

Use of Mental Health and Substance Use Treatment among Women of Color

In general, women of color report lower levels of depression and heavy/hazardous alcohol use compared to white women (Calabrese, Meyer, Overstreet, Haile, & Hansen, 2015). Among SMW, however, rates of depression and hazardous drinking vary much less, if at all, by race/ethnicity (S. D. Cochran, Mays, Alegria, Ortega, & Takeuchi, 2007b; Hughes, Matthews, Razzano, & Aranda, 2003; A. Matthews et al., 2014; Mereish & Bradford, 2014). (Balsam et al., 2015; Bostwick et al., 2014; Grella et al., 2009b), suggesting that the protective effects observed among women of color do not operate in the same way among SMW (Talley, Hughes, Aranda, Birkett, & Marshal, 2013).

Moreover, among SMW of color, rates of treatment use may be lower than for white SMW (Grella, Greenwell, Mays, & Cochran, 2009a; Razzano, Cook, Hamilton, Hughes, & Matthews, 2006; Stanley & Duong, 2015a). In a study of mental health treatment utilization using a sample of lesbian women and a matched sample of heterosexual women, compared to heterosexual women, lesbian women were 3.5 times as likely to use mental health services. Women of color overall were less likely (OR = .25) than white women to have used mental health treatment (Razzano et al., 2006). Further, among people of color with depression or alcohol dependence, the odds of unmet need for treatment were twice that of whites (Grella et al., 2009b). Very little is known, however, about the unmet need for treatment among SMW of color.

The purpose of the current study was to examine mental health and substance use treatment utilization among a diverse sample of SMW. Specifically, we compared lifetime use of mental health and substance use treatment by sexual identity (lesbian and bisexual women) and by race/ethnicity (African-Americans, Latinas, and whites). We then examined the rates of lifetime unmet need for mental health and substance use treatment by race/ethnicity and sexual identity.

Methods

The Chicago Health and Life Experiences of Women (CHLEW) study was designed to replicate and extend the National Study of Health and Life Experiences of Women (NSHLEW), a 20-year longitudinal study of alcohol use among women in the general U.S. population (Wilsnack et al., 1984; Wilsnack et al., 2006). The CHLEW has collected three waves of data between 2000–2014 from women in the greater Chicago metropolitan area (Bostwick, Hughes & Everett, 2015; Hughes, et al., 2006; Hughes, 2011; Talley, Aranda, Hughes et al., 2015). The CHLEW adapted the NSHLEW survey questionnaire to increase

its sensitivity and relevance to SMW's life experiences (e.g., changed the term husband to partner). The CHLEW includes a broad range of questions related to drinking patterns and drinking-related problems, physical and mental health, and a variety of life experiences of women. Each wave of the study has been reviewed and approved by the University of Illinois at Chicago's Institutional Review Board.

Sample

In wave one, 447 women who were English speaking, self-identified as lesbian and 18 years or older were recruited from Chicago and the surrounding suburbs using snowball and social network sampling methods, and were interviewed in 2000–2001. Follow-up interviews were conducted in 2004–2005 with 384 women (response rate = 86%) and in 2010 with 354 women from the original sample (response rate = 79%). Although women who self-identified as heterosexual, bisexual, or transgender in the initial (wave 1) telephone screening interview were excluded, later in the study interview 11 women self-identified as bisexual (21 self-identified as bisexual in wave 2). In 2010–2012 (wave 3) a supplemental sample of younger women (ages 18–25), Black and Latina women, and bisexual women ($N = 373$) were recruited using a modified version of respondent driven sampling (Hughes et al., 2014; Martin, Johnson, & Hughes, 2015). The current study uses data from the most recent follow-up (wave 3). The wave 3 sample includes 354 participants from the original cohort and 373 from the supplemental sample ($N = 727$). For the current analyses, data for participants who identified as heterosexual ($n = 14$), transgender ($n = 4$), or “other” ($n = 7$) as well as missing data ($n = 4$) were excluded from the analyses, for a final N of 700.

Measures

Sexual Identity—Participants were asked if they self-identified as: exclusively lesbian, mostly lesbian, bisexual, mostly heterosexual, exclusively heterosexual, transgender, or some other term. As described above, only women who identified as bisexual, mostly lesbian or exclusively lesbian were included in the current study.

Depression—Depression was assessed using questions from the Diagnostic Interview Schedule (DIS) (Robins et al., 1981). The DIS assesses the presence or absence of symptoms of depression and approximates DSM-IV diagnosis of major depression. A depressive episode was defined as the presence of three or more depressive symptoms for at least 2 weeks, accompanied by “feeling sad, blue, or depressed or by loss of interest or pleasure in things usually cared about.” Participants who met these criteria were asked whether or not they had experienced such an “episode”: 1) during their lifetime; and 2) in the previous 12 months. Both time periods were included in this study.

Alcohol Dependence (12-month and Lifetime)—Consistent with the DSM-IV criteria (American Psychiatric Association, 2000) for alcohol dependence, we created a measure that considered the report of at least 3 symptoms of potential alcohol dependence (of 5 symptoms such as inability to stop drinking before becoming intoxicated, and inability to stop or cut down on drinking over time) to meet criteria for alcohol dependence. We assessed both lifetime and 12-month alcohol dependence.

Mental Health Treatment Use (Lifetime)—Participants were asked if they had ever seen a psychiatrist, social worker, guidance counselor, or any other mental health care provider for an emotional or mental health problem (yes/no).

Alcohol Treatment (Lifetime)—SMW were asked if they had ever gone to anyone – a treatment agency, Alcoholics Anonymous, anyone at all – for help with a drinking problem of her own (yes/no).

Data Analyses

Univariate analyses were used to examine the proportions of women in the sample reporting depression and alcohol dependence by sexual identity and by race/ethnicity. Chi-square tests were used to examine differences by sexual identity and race/ethnicity in depression (lifetime and 12-month), alcohol dependence (lifetime and 12-month), and use of lifetime mental health and substance use treatment services (lifetime). We then calculated potential unmet need for treatment among women who reported either lifetime depression or alcohol dependence, but who had never used relevant treatment services, and used chi square to examine differences by sexual identity and race/ethnicity (white-referent; Latina; African-American). In addition, we fit multivariate logistic regression models to the data while controlling for the effects of demographic characteristics on the healthcare use outcomes. The covariates were dummy coded and each category was compared to the referent group. Covariates included age (30-referent, 31–40, 41–50, 51 years), education (< High School-referent, High School, some College, Bachelors degree, Graduate/Professional degree), health insurance (yes/no), employment (full-time-referent, part-time; unemployed-looking; unemployed-not looking), income (< \$20,000-referent; \$20,000–39,999; \$40,000–74,999; 75,000), relationship status (living with partner-referent; not living with partner; not in a committed relationship), and parental status (has children-yes/no; any children under 18 living at home-yes/no). All analyses were performed using SPSS v. 22 and STATA v. 12 statistical software.

Results

Sample Characteristics

Table 1 summarizes the demographic characteristics of the 517 lesbian and 183 bisexual women included in the sample. Bisexual women reported lower levels of education, lower rates of health insurance, and lower income than lesbian women. Nearly one-fourth (23%) of the sample identified as Latina, 35.8% as African American, and 37.4% as white. Overall, Latina SMW were younger and white SMW were older than the other groups. Health insurance coverage varied significantly by sexual identity and race/ethnicity. Bisexual women (62.3%) were significantly less likely than lesbian women (73.3%) to have health insurance. Latina (63.6%) and African American (61.5%) women were significantly less likely than white women (81.3%) to have insurance coverage. Significant differences were also found among Latina, white, and African American SMW in education, employment, income, relationship status, and parental status.

Depression and Alcohol Dependence

Overall, rates of depression in this study were very high; 59.9% reported lifetime depression and 31.0% reported past year depression. There were no significant differences in either 12-month or lifetime depression by sexual identity, and no effect of race/ethnicity on past year depression. However, there were significant differences in rates of lifetime depression by race/ethnicity. White women had the highest rates of lifetime depression; almost 70% reported lifetime depression, compared to 60.5% of Latinas and 47.0% of African Americans, $X^2(1, N = 671) = 27.12, p < .001$.

There was a statistically significant effect of sexual identity on past-year alcohol dependence, but not on lifetime alcohol dependence. Bisexual women (15.3%) were significantly more likely than lesbian women (3.7%) to report past year alcohol dependence, $X^2(1, N = 684) = 28.04, p < .001$. Bisexual women (6.4%) were also more likely than lesbian women (2.2%) to have co-occurring past year alcohol dependence and depression, $X^2(1, N = 673) = 7.03, p < .01$. There was a significant effect of race/ethnicity on past year alcohol dependence, but not on lifetime dependence. Latina (10.7%) and African American (7.9%) women had higher rates of past-12-month alcohol dependence than white women (3.9%), $X^2(2, N = 661) = 7.61, p < .05$. There were no significant differences by race/ethnicity on lifetime or 12-month co-occurring depression and alcohol dependence. Tables 2–3 summarize rates of alcohol dependence and depression by sexual identity and by race/ethnicity, respectively.

Use of Mental Health and Substance Use Treatment

In bivariate analyses, we found no effects of sexual identity on use of mental health treatment or substance use treatment. Lesbian women were more likely to report use of both mental health and substance use treatment than bisexual women, but this difference was not statistically significant. Race/ethnicity was significantly associated with use of mental health and substance use treatment. Latinas (38.3%) and African Americans (40.1%) used mental health treatment significantly less than whites (59.2%), $X^2(2, N = 676) = 25.35, p < .001$. Latinas (8.1%) used substance use treatment less than African Americans (19.6%) and whites (16.3%), $X^2(1, N = 669) = 10.08, p < .01$ (see Tables 2–3).

We used multivariate logistic regression models to examine the associations between sexual identity and race/ethnicity and use of mental health and substance use treatment, controlling for demographic factors. Results showed that Latina women had lower odds of using mental health treatment compared to white women ($AOR = .51, 95\% CI: .31, .85$). African American women also had lower odds of using mental health treatment than white women, but this was not significant ($AOR = .68, 95\% CI: .41, 1.13$). Lifetime depression was not associated with increased odds of having used mental health treatment; however, lifetime co-occurring depression and alcohol dependence was significantly associated with increased odds of mental health treatment utilization ($AOR = 1.65, 95\% CI: 1.01, 2.71$). There was a significant effect of education on mental health treatment utilization: having attended graduate school doubled the odds of treatment use (Table 4).

As shown in Table 4, Latina women had significantly lower odds of using substance use treatment than white women ($AOR = .43$, 95% CI: .19, .96). Older age was associated with greater odds of substance use treatment

Unmet Need for Mental Health and Substance Use Treatment

To assess potential unmet need for treatment we examined bivariate associations between lifetime rates of non-utilization of treatment among SMW who reported lifetime depression or lifetime alcohol dependence. Table 5 summarizes unmet need for mental health and substance use treatment by sexual identity and race ethnicity. Overall, 39.2% of SMW who reported lifetime depression had never sought mental health treatment, and 57.2% of SMW who reported lifetime alcohol dependence had never accessed substance use treatment. There were no differences by sexual identity for unmet need for either mental health or substance use treatment. However, there was a significant effect of race/ethnicity on unmet need for mental health treatment: 49.0% of Latinas, 42.7% of African Americans and 32.0% of whites had unmet need for mental health treatment, $X^2(2, N = 396) = 8.414, p < .05$. Latina (77.5%) and white (58.7%) women were significantly more likely to have unmet needs for substance use treatment than African American women (43.1%), $X^2(2, N = 162) = 11.52, p < .005$.

Controlling for the potential effects of demographics on unmet need for mental health treatment and substance use treatment, there was no effect of sexual identity on unmet need for either mental health or substance use treatment. Latina women had significantly higher odds of having an unmet need for mental health treatment than white women ($AOR = 2.06$, 95% CI: 1.18, 3.62), but there was no effect of race/ethnicity on unmet need for substance use treatment (Table 6).

Discussion

Lesbian and bisexual women in this study reported high rates of both depression and alcohol dependence, and although use of treatment services was also high, rates of lifetime depression and alcohol dependence far exceeded rates of treatment utilization, and varied by sexual identity and race/ethnicity.

More than one-half of women in the study reported lifetime depression and almost one-fourth reported lifetime alcohol dependence. Overall, these findings support previous research that has found that SMW are at high risk of both depression (Bostwick, Boyd, Hughes, & McCabe, 2010; Conron, Mimiaga, & Landers, 2010; Gilman et al., 2001; Ward, Dahlhamer, Galinsky, & Joestl, 2014) and alcohol dependence (Burgard, Cochran, & Mays, 2005; Conron et al., 2010; Drabble et al., 2013; Gilman et al., 2001; Green & Feinstein, 2012; Hughes et al., 2010b; 2006; McCabe et al., 2009; Mereish et al., 2015; Ridner, Frost, & LaJoie, 2006; Ward et al., 2014; Wilsnack et al., 2008). Further, rates of depression varied by race/ethnicity, but not by sexual identity.

Previous research has linked the higher rates of depression and alcohol dependence among SMW to minority stress, and has demonstrated robust associations between minority stress and risk of depression and heavy drinking (Calabrese et al., 2015; S. D. Cochran et al.,

2007b; Hughes et al., 2003; A. Matthews et al., 2014; Mereish & Bradford, 2014). As noted previously, SMW overall are at risk of poorer mental and physical health outcomes due to their stigmatized identities, and intersections between sexual identity and race/ethnicity may place SMW of color and bisexual women at additional risk due to their multiple marginalized identities (Calabrese et al., 2015; A. Matthews et al., 2014; Mereish & Bradford, 2014). Our finding that bisexual women are at higher risk than lesbian women of co-occurring depression and alcohol dependence may be partially explained by findings from previous research on the additional stress and strain that biphobia and internalized binegativity, experienced by bisexual women both within the heterosexual and LGBT (Lesbian, Gay, Bisexual and Transgender) communities (Bostwick, Everett & Hughes, 2014; Dyar, Feinstein, & London, 2014).

SMW of color's multiply marginalized social status also increases stress and heightens risks (Calabrese et al., 2015; A. Matthews et al., 2014; Molina, Levahot, Beadness, & Simoni, 2014). Our findings of higher rates of past year alcohol dependence among Latina and African American SMW may be explained by the additive effects of sexism, racism, and homophobia (Mereish & Bradford, 2014; Otiniano Verissimo, Grella, Amaro, & Gee, 2014). Higher levels of discrimination have been found to be associated with higher rates of alcohol use among Latina SMW (A. Matthews et al., 2014). Although Latina and African American SMW had lower rates of depression than white SMW, the rates were still quite high. One possible explanation for these elevated levels of depression may be the typically higher levels of homophobia in racial/ethnic minority communities (Balsam, Molina, Beadnell, Simoni, & Walters, 2011; A. Matthews et al., 2014).

In regard to the gap between rates of depression and hazardous drinking and use of treatment, it may be that SMW have greater tolerance for symptoms of depression and experience fewer social sanctions regarding heavy/hazardous drinking. Previous research on unmet needs for treatment has found that depression (Stanley & Duong, 2015b) and alcohol dependence (Grella et al., 2011; 2009b; Hardesty, Cao, Shin, Andrews, & Marsh, 2012) are not statistically associated with treatment utilization. Previous research on substance use treatment utilization in a national sample of people who met criteria for alcohol dependence highlighted that among those who sought substance use treatment drug use alone, or in combination with alcohol use, was a better predictor of treatment utilization than alcohol use alone (Grella et al., 2009b). Further, among those who use substance use treatment, the mental and physical health needs of LGB people may be greater than those of heterosexuals (Flentje, Livingston, Roley, & Sorensen, 2015). In particular, SMW who enter substance abuse treatment have higher rates of mental health diagnoses than heterosexual women (Flentje et al., 2015). Together, these findings suggest that utilization of treatment may partially depend on the severity of symptoms and the perception that those symptoms are severe enough to warrant treatment. Sexual minority women who enter treatment may therefore have poorer overall mental health and more severe substance use, which suggests a need for specialized treatment.

Even if SMW perceive a need and wish to obtain care, they may be hesitant to seek treatment due to potential stigma, discrimination, or lack of culturally sensitive services. One possible explanation for our findings that SMW's, particularly SMW of color's, lower

rates of mental health and substance use treatment may be fear of discrimination in treatment settings (Barefoot, Smalley, & Warren, 2015). In a systematic review of 62 studies on barriers to mental health care, fear of being misunderstood and fear of harassment were the most significant predictors of lower likelihood of utilization among LGBT people with substance use and/or mental health issues (Brown, Rice, Rickwood, & Parker, 2015). Previous negative experiences with healthcare providers and poor quality of care have been found to be associated with early discontinuation of care (Li, Matthews, Aranda, Patel, & Patel, 2015).

Substance use treatment programs may be ill-equipped to address the specific needs of SMW, which may make them feel uncomfortable, unsafe, or as though their needs are not being met in treatment (Dearing & Hequembourg, 2014). Nationally, a low proportion (less than 10%) of substance use treatment programs have specialized services for LGBT people (B. N. Cochran, Peavy, & Robohm, 2007a). Mental health and substance use counselors may further lack training in treatment issues relevant to sexual minorities (Eliason & Hughes, 2004). In a survey of substance use counselors in Iowa, 55% reported that they had received no training on LGBT issues, despite very high levels of education among the counselors surveyed (Eliason, 2001). Further, in the same study, only 40% of the counselors expressed acceptance of LGBT individuals. Training and experience among mental health providers varies widely, and is largely inadequate (Boroughs, Bedoya, O'Cleirigh, & Safren, 2015; King, 2015). For example, there are currently no standards for the training of psychiatric nurses or psychologists who work with sexual minority clients. Cultural competence is essential to the effective provision of therapy and in helping mental health and substance use counselors/therapists know when their own biases and experiences may deleteriously affect therapeutic relationships and outcomes (Boroughs et al., 2015; Sabin, Riskind, & Nosek, 2015).

Thus, one potential way to increase utilization and decrease unmet need for mental health and substance use treatment is to increase the availability of culturally competent treatment providers (Quinn et al., 2015). Interviews with lesbian women and gay men who have used substance use treatment indicate that greater education of counselors; having access to counselors of color and/or who are openly LGBT; and ensuring that LGBT people feel safe, affirmed, and free from homophobia in the treatment setting are needed and would likely increase rates of substance use treatment (C. R. Matthews, Lorah, & Fenton, 2006). Such treatment should also consider additional stressors and risks that women with multiple stigmatized identities may have. Further, treatment should address the larger context faced by those with marginalized identities (e.g., homophobia, racism, biphobia, and sexism) in order to contextualize their distress, normalize their reactions, and destigmatize their identities.

Additional research is needed to understand the barriers to utilization of mental health and substance abuse treatment for SMW, particularly bisexual women and SMW of color. Further, research is needed to better understand SMW's perceptions of counselors and treatment and how those perceptions are associated with utilization, continuation, and outcomes of treatment.

Study Limitations

Several limitations should be considered when evaluating the results of this study. First, the sample of SMW was recruited using non-random methods, which limit generalizability. Women who were less “out” or who were uncomfortable discussing these topics may have been less likely to participate in the CHLEW study. Women who took part in the study were aware that the focus was on sexual orientation and other potentially sensitive topics, such as substance use and depression. Second, because data were cross-sectional, causality and temporality could not be examined. Third, all measures relied on self-report, and thus responses may have been vulnerable to social desirability bias. Fourth, in measuring alcohol dependence, only three of the five DSM-IV (American Psychiatric Association, 2000) alcohol dependence symptoms were assessed in wave 3 of the CHLEW study. Thus, our measurement of alcohol dependence may underrepresent actual alcohol dependence in this sample. Although both lifetime and past year depression and alcohol dependence were assessed, only lifetime treatment utilization was assessed, making it impossible to determine temporality. Finally, we defined unmet need for treatment as the proportion of women with either lifetime depression or alcohol dependence who had never sought treatment. Women’s own perceptions of whether or not they needed treatment were not taken into account. This may overestimate the actual unmet need because women with depression or alcohol dependence may have found other ways to get help, or may have experienced a level of symptoms they perceived as not warranting treatment.

Conclusions

This study is among the few to examine rates of potential unmet need for treatment among SMW by sexual identity and race/ethnicity. Sexual minority women are at heightened risk of depression and alcohol dependence and although use of treatment is high, there is a sizable potential unmet need for both mental health and substance use treatment, particularly among Latina SMW. Our findings suggest the need for treatment that is culturally tailored to the life experiences of SMW, and particularly SMW of color. Recognition of the intersections among sexual identity, race/ethnicity, and minority stress on psychological health and health behaviors is critically important in the effective treatment of SMW.

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Relevance to Clinical Practice

Sexual minority women are at increased risk of depression and hazardous drinking, both of which are implicated in chronic diseases and may negatively impact adherence to medical treatments and treatment efficacy. Asking patients about their sexual identity and sexual relationships provides important information about potential risks. Nurses and other healthcare providers can play a key role in helping SMW, particularly bisexual women and SMW of color, to understand how the multifaceted stressors they face may put them at risk of mental-health or drinking-related problems. Early detection of depression and drinking problems is important to prevent additional physical and mental health problems. Nurses and other healthcare providers can also play an important role in counseling and educating patients about prevention and treatment options. In order to provide culturally sensitive and effective care, healthcare providers need to be educated about the unique stressors and risks faced by sexual minorities.

Table 1

Sample Characteristics for Total Sample and Split by Sexual Identity and Race/Ethnic Group, Chicago Health and Life Experiences of Women (N = 700).

	Sexual Identity (n = 700)						Race/Ethnicity (n = 676)					
	Lesbian (n = 517)			Bisexual (n = 183)			Latina (n = 162)			White (n = 262)		
	n	%		n	%		n	%		n	%	p
Age												.000
30	226	32.3	142	27.5	84	45.9	73	45.1	76	29.0	73	29.0
31–40 years	149	21.3	102	19.7	47	25.7	37	22.8	53	20.2	52	20.6
41–50 years	141	20.1	110	21.3	31	16.9	28	17.3	40	15.3	65	25.8
51 years	184	26.3	163	31.5	21	11.5	24	14.8	93	35.5	62	24.6
Education												.000
< High School	56	8.0	31	6.0	25	13.7	18	11.1	3	1.1	35	13.9
High School Graduate	87	12.4	57	11.0	30	16.4	23	14.2	8	3.1	55	21.8
Some College	217	31.0	161	31.1	56	30.6	57	35.2	61	23.3	93	36.9
Bachelors	147	21.0	113	21.9	34	18.6	30	18.5	75	28.6	38	15.1
Graduate/Professional	192	27.4	154	29.8	38	20.8	34	21.0	115	43.9	30	11.9
Has health insurance	493	70.4	379	73.3	114	62.3	103	63.6	213	81.3	155	61.5
Employment												.000
Full-time	350	50.0	276	53.8	74	40.4	89	54.9	148	56.5	98	38.9
Part-time	123	17.6	91	17.6	32	17.5	30	18.5	48	18.3	41	16.3
Unemployed, looking	108	15.4	62	12.0	46	25.1	28	17.3	20	7.6	59	23.4
Unemployed, not looking	118	16.9	87	16.8	31	16.9	15	9.3	46	17.6	54	21.4
Income												.000
< \$20,000	218	32.6	132	26.7	86	49.4	42	27.6	54	21.3	117	49.0
\$20,000–39,999	129	19.3	89	18.0	40	23.0	24	15.8	54	21.3	50	20.9
\$40,000–74,999	158	23.6	129	26.1	29	16.7	47	30.9	56	22.1	49	20.5
75,000	164	24.5	145	29.3	19	10.9	39	25.7	90	35.4	23	9.6
Relationship Status												.000
Living with partner	268	38.4	226	43.7	42	23.2	57	35.2	131	50.2	73	29.1
Not living with partner	188	26.9	132	25.5	56	30.9	49	30.3	52	20	79	31.6
Not in committed relationship	241	34.5	158	30.6	83	45.9	56	34.6	78	29.9	98	39.2

	Race/Ethnicity (n = 676)									
	Sexual Identity (n = 700)					African American (n = 252)				
	Total (N = 700)	Lesbian (n = 517)	Bisexual (n = 183)	Latina (n = 162)	White (n = 262)					
Parental status	n	%	n	%	n	%	n	%	n	p
Ever had children	269	38.4	191	36.9	78	42.6	49	30.2	136	.000
Children at home	141	20.1	98	19.0	43	23.5	26	16.1	72	.000

Table 2Alcohol Dependence, Depression, and Use of Treatment by Sexual Identity (*N* = 700)

	Lesbian (<i>n</i> = 517)		Bisexual (<i>n</i> = 183)		Total	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Depression						
Depression (12 mo.)	156	30.7	57	31.7	213	31.0
Depression (lifetime)	315	61.3	101	55.8	416	59.9
Alcohol Dependence						
Alcohol Dependence (12 mo.)	19	3.7	27	15.3	46	6.7
Alcohol Dependence (lifetime)	116	22.6	51	27.9	167	24.0
Co-occurring Alcohol Dependence and Depression						
Co-occurring alcohol use and depression (12 mo)	11	2.2	11	6.4	22	3.3
Co-occurring alcohol use and depression (lifetime)	91	17.8	36	19.9	127	18.4
Lifetime Treatment Use						
Mental Health Treatment	249	48.2	84	45.9	333	47.6
Substance Use Treatment	81	15.9	27	14.8	108	15.6

Table 3Alcohol Dependence, Depression, and Use of Treatment by Race/Ethnicity (*N* = 676)

	Latina (<i>n</i> = 162)		White (<i>n</i> = 262)		African American (<i>n</i> = 252)		
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>p</i>
Depression							
Depression (12 mo.)	53	33.1	83	32.4	68	27.3	.342
Depression (lifetime)	98	60.5	181	69.6	117	47.0	.000
Alcohol Dependence							
Alcohol Dependence (12 mo.)	17	10.7	10	3.9	19	7.9	.022
Alcohol Dependence (lifetime)	41	25.3	63	24.2	58	23.1	.875
Co-occurring Alcohol Dependence and Depression							
Co-occurring alcohol use and depression (12 mo)	8	5.1	6	2.4	8	3.4	.483
Co-occurring alcohol use and depression (lifetime)	33	20.4	52	20.2	37	14.9	.524
Lifetime Treatment Use							
Mental Health Treatment	62	38.3	155	59.2	101	40.1	.000
Substance Use Treatment	13	8.1	42	16.3	49	19.6	.006

Table 4

Adjusted odds ratios for logistic regressions of utilization of mental health and substance use treatment.

	Mental health treatment (N = 635)				Substance use treatment (N = 634)			
	AOR	95%CI		p	AOR	95%CI		p
Sexual identity								
Bisexual (ref)	1	-	-	-	-	-	-	-
Lesbian	1.13	0.69	1.84	0.64	1.14	0.59	2.23	0.70
Race								
White (ref)	1	-	-	-	-	-	-	-
Latina	0.51	0.31	0.85	0.01	0.43	0.19	0.96	0.04
African American	0.68	0.41	1.13	0.14	1.10	0.56	2.17	0.78
Depression and Substance Use								
Depression	0.70	0.42	1.16	0.17	-	-	-	-
Alcohol dependence	-	-	-	-	0.15	0.06	0.34	0.00
Co-occurring depression and alcohol dependence	1.65	1.01	2.71	0.05	1.25	0.53	2.94	0.60
Age								
30 (ref)	1	-	-	-	-	-	-	-
31–40 years	1.55	0.85	2.83	0.15	2.92	1.20	7.09	0.02
41–50 years	1.43	0.76	2.67	0.27	3.28	1.31	8.21	0.01
51 years	1.06	0.56	2.03	0.86	4.08	1.59	10.42	0.00
Education								
< High School	1	-	-	-	-	-	-	-
High School Graduate	0.65	0.25	1.68	0.38	0.97	0.31	3.02	0.96
Some College	1.11	0.47	2.59	0.82	0.43	0.15	1.27	0.13
Bachelors	1.82	0.71	4.65	0.21	0.48	0.15	1.57	0.22
Graduate/Professional	2.34	0.89	6.13	0.08	0.36	0.11	1.21	0.10
Insurance	1.02	0.63	1.65	0.93	0.85	0.44	1.64	0.63
Employment								
Full-time (ref)	1	-	-	-	-	-	-	-
Part-time	1.09	0.61	1.95	0.77	0.49	0.20	1.20	0.12

	Mental health treatment (N = 635)				Substance use treatment (N = 634)			
	AOR	Lower	Upper	p	AOR	Lower	Upper	p
Income								
Unemployed (looking)	1.11	0.57	2.16	0.76	0.50	0.19	1.30	0.16
Unemployed (not looking)	1.67	0.88	3.18	0.12	0.93	0.40	2.12	0.85
Relationship Status								
<\$20,000 (ref)	1	-	-	-	-	-	-	-
\$20,000–39,999	1.15	0.62	2.12	0.65	1.02	0.45	2.29	0.96
\$40,000–74,999	0.77	0.41	1.46	0.43	0.48	0.19	1.21	0.12
\$75,000+	0.54	0.26	1.13	0.10	0.66	0.24	1.83	0.42
Parental status								
Ever had children	0.91	0.55	1.52	0.72	0.64	0.34	1.21	0.17
Children at home	1.21	0.67	2.19	0.52	1.30	0.59	2.87	0.52

Notes: OR = odds ratio, CI = confidence interval

Use of mental health treatment: Nagelkerke's Pseudo R^2 : 0.101; Cox & Snell's Pseudo R^2 : 0.074

Use of substance abuse treatment: Nagelkerke's Pseudo R^2 : 0.345; Cox & Snell's Pseudo R^2 : 0.222

Table 5
Percent lifetime unmet need among SMW with either depression or alcohol dependence by sexual identity and race/ethnicity.

	Sexual Identity				Race/Ethnicity		
	Total n (%)	Lesbian n (%)	Bisexual n (%)	p	Latina n (%)	White n (%)	African American n (%)
Mental Health Treatment	163 (39.2)	125 (39.7)	38 (37.6)	.712	48 (49.0)	58 (32.0)	50 (42.7)
Substance use Treatment	95 (57.2)	65 (56.0)	30 (60.0)	.636	31 (77.5)	37 (58.7)	25 (43.1)

NOTE: Unmet need calculated by number of people with either lifetime depression or alcohol dependence and whether or not they had ever had relevant treatment.

Table 6

Adjusted odds ratios for logistic regressions of unmet need for mental health and substance use treatment.

	Unmet need for Mental Health Treatment (N = 371)				Unmet need for Substance Use Treatment (N = 157)			
	AOR	Lower	Upper	p	AOR	Lower	Upper	p
Sexual identity								
Bisexual (ref)	1	-	-	-	-	-	-	-
Lesbian	0.90	0.51	1.59	0.71	1.09	0.39	3.05	0.87
Race								
White (ref)	1	-	-	-	-	-	-	-
Latinas	2.06	1.18	3.62	0.01	2.74	0.81	9.23	0.10
African American	1.47	0.84	2.56	0.18	1.08	0.31	3.79	0.90
Co-occurring depression and alcohol dependence								
	0.63	0.38	1.04	0.07	0.69	0.26	1.86	0.46
Age								
30 (ref)	1	-	-	-	-	-	-	-
31–40 years	0.52	0.26	1.04	0.07	0.29	0.08	1.08	0.06
41–50 years	0.78	0.39	1.60	0.50	0.41	0.10	1.64	0.21
51 years	0.91	0.43	1.92	0.81	0.15	0.04	0.64	0.01
Education								
< High School	1	-	-	-	-	-	-	-
High School Graduate	1.54	0.47	5.05	0.48	1.07	0.17	6.84	0.95
Some College	0.96	0.33	2.80	0.95	1.78	0.30	10.52	0.53
Bachelors	0.59	0.18	1.88	0.37	1.41	0.17	11.41	0.75
Graduate/Professional	0.44	0.13	1.47	0.18	2.93	0.40	21.79	0.29
Insurance	1.10	0.64	1.90	0.73	1.01	0.37	2.76	0.99
Employment								
Full-time (ref)	1	-	-	-	-	-	-	-
Part-time	0.79	0.41	1.55	0.50	3.52	0.84	14.79	0.09
Unemployed (looking)	0.63	0.28	1.39	0.25	2.50	0.57	10.98	0.23
Unemployed (not looking)	0.64	0.31	1.32	0.23	0.49	0.12	2.08	0.33
Income								

	Unmet need for Mental Health Treatment (N = 371)			Unmet need for Substance Use Treatment (N = 157)		
	AOR	95%CI		AOR	95%CI	
		Lower	Upper		Lower	Upper
						p
<\$20,000 (ref)	1	-	-	-	-	-
\$20,000–39,999	0.83	0.41	1.68	0.51	0.13	1.97
\$40,000–74,999	1.44	0.68	3.04	1.98	0.48	8.07
\$75,000+	1.74	0.75	4.00	0.85	0.16	4.49
Relationship Status						
Living with partner (ref)	1	-	-	-	-	-
Not living with partner	0.48	0.17	1.36	0.78	0.18	3.43
Not in committed relationship	0.97	0.58	1.62	1.28	0.46	3.56
Parental status						
Ever had children	1.13	0.63	2.02	4.05	1.48	11.13
Children at home	0.87	0.43	1.77	0.79	0.22	2.79

Notes: OR = odds ratio, CI = confidence interval

Unmet need for mental health treatment: Nagelkerke's Pseudo R²: 0.110; Cox & Snell's Pseudo R²: 0.081

Unmet need for substance abuse treatment: Nagelkerke's Pseudo R²: 0.418; Cox & Snell's Pseudo R²: 0.312