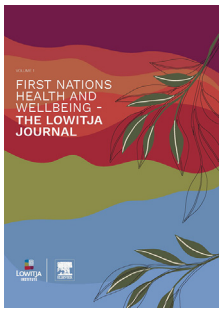

Original Research

Considering First Nations LGBTIQ+ identity in anti-racist healthcare: Relations between comfort in healthcare, microaggressions and wellbeing

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Abstract

First Nations scholars and practitioners have increasingly called for anti-racist healthcare to address disparate health outcomes between First Nations and non-First Nations Australians. However, these arguments largely miss the significant negative impact that colonial heterosexism and cisgenderism (i.e. discrimination and marginalisation of queer and transgender peoples) have on LGBTIQ+ (lesbian, gay, bisexual, transgender, intersex, queer/questioning) First Nations peoples' wellbeing. To address this gap, survey data from 63 First Nations LGBTIQ+ adults in Western Australia were utilised to illustrate the impact of racism, heterosexism and cisgenderism in healthcare settings on First Nations LGBTIQ+ peoples' wellbeing. This study examined relations between participant wellbeing and 1) their comfort in being asked about their LGBTIQ+ and First Nations identity by a health provider, and 2) their experiences of race-based and LGBTIQ+-based discrimination (microaggressions) in broader community settings. Higher comfort in being asked about LGBTIQ+ identity was associated with higher wellbeing, whereas experiencing LGBTIQ+-based microaggressions within First Nations communities was associated with lower wellbeing. These findings add to the literature by showing that First Nations LGBTIQ+ patients experience additional

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discrimination. This paper also discusses findings with reference to settler-colonial racism (i.e. the racism enacted against First Nations LGBTIQ+ peoples to maintain settler norms and control) and offers suggestions for updating anti-racist healthcare.

Keywords: Anti-racist; Settler-colonial racism; LGBTQ+; Microaggressions; Intersectional

Highlights

- Anti-racism healthcare discourse has overlooked intersectional identities, including First Nations LGBTIQ+ identities.
- Heterosexism and cissexism enforce rigid Eurocentric notions of sexuality and gender onto First Nations peoples.
- Comfort in discussing LGBTIQ+ identity is associated with higher well-being among First Nations LGBTIQ+ adults.
- Cissexism and heterosexism from First Nations communities, in the form of microaggressions, are associated with lower wellbeing.
- To be effective for First Nations LGBTIQ+ patients, anti-racist healthcare practices must address hetero- and cis-normativity, as well as anti-Indigenous racism, which is implicit within settler healthcare systems.

Introduction

In Australia, First Nations[1] discourse on health inequalities has focused on the role of racism in maintaining inequalities, with associated calls for decolonised healthcare and anti-racist practice (Bond & Singh, 2020; Gatwiri et al., 2021). However, these discussions have often overlooked the concept of intersectionality (i.e. the idea that the forms of discrimination and prejudice faced by people with more than one marginalised identity are unique) (Crenshaw, 1991). In turn, anti-racist healthcare discourse has largely overlooked the needs of First Nations peoples who identify on the LGBTIQ+ (lesbian, gay, bisexual, trans, intersex, queer) spectrum. This omission is despite arguments from First Nations LGBTIQ+ community members and academics that colonisation in Australia brought a Christian dogma that demonised sexuality and gender diversity and reinforced a rigid, man/woman gender binary wherein heterosexual monogamy is the societal ideal and universal cultural norm (Day, 2021; O'Sullivan, 2021). The dual beliefs that heterosexual and cisgender identities are the 'norm' (i.e. heterosexism and cisgenderism; Riggs et al., 2015) are thus inextricably connected in the settler-colonial nation and infiltrate settler systems such as healthcare.

The omission of LGBTIQ+ identities in current anti-racist healthcare risks anti-racism initiatives falling short of meeting the healthcare needs of First Nations LGBTIQ+ patients. Research that unpacks the ways in which heterosexism, cisgenderism and racism are linked within settler healthcare systems is therefore needed. To address this gap in the literature, this study analysed survey data collected as part of a more extensive study focused on understanding First Nations LGBTIQ+ adults' experiences in Western

[1]First Nations is used here to include Aboriginal and Torres Strait Islander peoples. This is the preferred term among the authorship group. The authors acknowledge the diversity of Aboriginal and Torres Strait Islander peoples and respect individuals' rights to identity in ways that are meaningful to them.

Australian healthcare and community settings. It assessed associations between participants' wellbeing and comfort in discussing their LGBTIQ+ and First Nations identity with their healthcare provider. In addition, it assessed relations between participants' experiences of daily cisgenderism, heterosexism and racism, and their wellbeing. These findings interpreted through the emerging construct of *settler-colonial racism* are presented to highlight approaches to anti-racist healthcare that are inclusive of First Nations LGBTIQ+ patient needs.

Anti-racist healthcare

In recent years, Australian representative healthcare bodies have signalled an increased commitment to reducing and preventing racism within their practices (e.g. Royal Australian College of General Practitioners, 2018). This shift is attempting to address significant inequities in health outcomes experienced by racialised people. One such effort, most recently highlighted by the global Black Lives Matter (BLM) movement, is anti-racism. Anti-racism is 'praxis [which] seeks to achieve equity, social justice and peace and move toward a world where racism either is non-existent, or its health effects are negligible' (Griffith & Semlow, 2020, p. 374). A more advanced understanding of anti-racism views racism as a 'wicked problem' that requires a multi-pronged and sustained critical approach. Came and Griffiths (2018) detail anti-racist practice requiring five core elements: reflexive relational praxis, structural power analysis, sociopolitical education, monitoring and evaluation and systems change approaches. In Australia, First Nations communities have been at the forefront of anti-racism activism for decades, with First Nations LGBTIQ+ peoples playing a crucial role in these efforts (Kerry, 2014). The global relevance of the United States-based BLM movement has provided an additional platform for these communities to amplify their ongoing discussions and campaigns around anti-First Nations racism. Contextualised through the terminology specific to Australian First Nations peoples' collective identity, the *Blak Lives Matter* and *#AboriginalLivesMatter* movements have aired several high-profile cases where First Nations people were denied adequate healthcare and subsequently died (Gatwiri et al., 2021; Krakouer & Georgatos, 2020). These deaths, and countless others, occurred within the backdrop of the Australian Federal Government policy to 'Close the Gap' between First Nations and non-First Nations health outcomes (Dawson et al., 2021).

In healthcare literature, anti-racism has been interpreted through various lenses, including policies combatting anti-Black and anti-First Nations racism and equity and inclusion training (Hassen et al., 2021; Lee Bishop et al., 2022). Regarding primary healthcare, Hassen et al., (2021) describe interventions at multiple levels of the ecosystem: the individual level (e.g. cultural safety and anti-bias training with a focus on critical self-reflection), interpersonal (e.g. interventions that address healthcare provider power and privilege, development of practitioner guidelines), community level (e.g. strategic partnerships with First Nations peoples, reorganising power by forming groups dedicated to anti-racism, involving racialised communities in decision-making) and organisational level (e.g. incorporating anti-racism into key performance indicators, implantation of anti-racist organisational policy). The highest level of anti-racist healthcare, the policy level, involves policies to retain and recruit racialised staff and infrastructure to enhance accountability (Hassen et al., 2021). Hence, anti-racist practice can occur across all healthcare system levels.

Racism, settler-colonialism and First Nations LGBTIQ+ identities

Racism and settler-colonialism are tightly linked but distinct constructs. Where racism is a form of

prejudice and discrimination to assert racial superiority, settler-colonialism is focused on the acquisition and continued control/ownership of sovereign land (Paradies, 2016; Wolfe, 2006). The acquisition and settlement of territory owned by First Nations peoples necessarily involves the imposition of racist ideologies and practices to delegitimise First Nations claims to sovereignty. Thus, racism is used to support settler-colonialism, but it can also exist independently. Although the rise in anti-racism discourse in healthcare is promising, there is often an assumption that racism is a uniform experience across and within racialised communities, and that the experiences of racism for First Nations peoples in settler-colonial states mimics that of non-First Nations peoples (Brayboy, 2005; Sylvestre et al., 2019). Unique to the settler-colonial context, anti-First Nations racism and settler ignorance are core organising features of health systems, and they work in tandem to perpetuate health inequalities (Sylvestre et al., 2019). Further, anti-First Nations racism substantially differs from racism against other ethnic minority groups with its features of continued erasure and denial of First Nations sovereignty and peoplehood (Brayboy, 2005). Critical to this study, erasure of First Nations identities includes attempts to homogenise First Nations peoples via the denial and sidelining of diverse identities, including sexuality and gender diversity.

The ongoing legacy of settle-colonialism has created a system in which First Nations LGBTIQ+ individuals face the direct impacts of colonisation but also systemic racism that permeates societal institutions and everyday interactions. First Nations LGBTIQ+ scholars have argued that settler-colonial processes present First Nations peoples as a homogenous group through an Imperialist-Christian lens that enforces heterosexuality and binary gender roles (Day, n.d.; O'Sullivan, 2021). This homogenisation aims to control First Nations identity to maintain the supremacy of colonial value systems by rendering intersectional aspects of First Nations identities invisible. Thus, although all forms of anti-First Nations racism are leveraged by settler-colonialism, denial and erasure of queer identities is a unique form experienced by First Nations LGBTIQ+ peoples. This denial and erasure is enacted via heterosexism and cisgenderism. The racial hierarchy imposed on First Nations peoples, and used to justify settler-colonialism, is thus bolstered via non-Indigenous settlers continuing to define what it is to be First Nations.

Heterosexism and cisgenderism are present within healthcare discourse in settler-colonial nations. For example, Sylvestre and colleagues (2019) found that Canadian medical educators understood that First Nations groups are not homogenous. Nevertheless, although one participant likened working with First Nations patients to working with LGBTIQ+ communities, none of the study participants acknowledged that First Nations patients *might also be* LGBTIQ+; thus, an intersectional approach to patient care might be required. Their findings led Sylvestre and colleagues to conclude that settler-colonialism has become embedded in the structures of Canadian healthcare systems, with those training future generations of healthcare workers struggling to identify the impact of ongoing forces of settler-colonialism on First Nations patients. While their study provides a pointer to the relevance of intersectionality, it stopped short of explicitly engaging with this manifestation of contemporary First Nations LGBTIQ+ experience.

First Nations LGBTIQ+ experiences

Within Australia, First Nations LGBTIQ+ peoples experience discrimination, incarceration, trauma,

family violence, community exclusion and distrust in health services (Day et al., 2023). Issues faced by non-LGBTIQ+ First Nations peoples are also compounded among LGBTIQ+ community members. For example, food insecurity in remote communities manifests as LGBTIQ+ family members being prioritised last for scarce resources (Bonson, 2023). Heterosexism and cisgenderism are also present within First Nations communities. In 2015, during Australia's debate on the legalisation of marriage equality, several First Nations community members issued the *Uluru Bark Petition* (Yumina, 2015), which stated that marriage was a 'traditional and spiritual bond between a man and a woman' and that it was '...an affront to the Aboriginal People of Australia to suggest another definition of marriage'. Signatories to the Petition argued that generations of mothers and fathers had passed down traditions governing family structures that viewed marriage as between a man and a woman. The Petition further called upon the Australian Government to reject any attempts to 'redefine the institution of marriage', thus implying that same-sex marriage was not a culturally endorsed practice. First Nations LGBTIQ+ scholars and activists robustly critiqued the Petition and the associated view that First Nations peoples were inherently heterosexual and cisgender (e.g. Bonson, 2015). Additionally, Day (n.d.) has critiqued the act of asking for evidence of pre-colonial queerness in First Nations communities, challenging who, in fact, benefits from this question and reframing the answer around evidence of European-developed heterosexuality and gendered violence. Regardless of evidence as to inclusivity within pre-colonial First Nations communities, or perhaps due to the difficulties in accessing pre-colonial ontological and epistemological positionings that are uncontaminated by colonial value systems, there is a conflation of traditional cultural practices and values with hetero- and cis-normativity within some contemporary First Nations communities. This questioning of queer identities within and by some First Nations communities further serves the settler-colonial mission of otherising, homogenising and delegitimising queer First Nationhood.

Settler-colonial healthcare and First Nations LGBTIQ+ peoples

Previous research has documented the inability of setter colonial healthcare systems to cater to First Nations LGBTIQ+ patients. First Nations LGBTIQ+ patients experience racism, heterosexism and cisgenderism in mainstream services (Day et al., 2023; Johnson-Jennings et al., 2014). Further, 23.3% of First Nations LGBTQA+ young peoples reported overhearing 'rude, hurtful or ignorant comments about their (LGBTQA+) identity' when accessing an Aboriginal Community Controlled Health Service and 43.3% had heard hurtful comments about their First Nations identity when accessing an LGBTQA+ health service (Liddelow-Hunt et al., 2023). The decision to discuss one's sexual identity with a healthcare provider involves a multitude of factors, including health provider characteristics, patient demographics and whether there are signs of inclusion in the facility (Eliason & Schope, 2001; Seelman et al., 2020). Previous research has found that lesbian, gay and bisexual (LGB) patients are often *not* 'out' to their healthcare provider, and many patients actively avoid questions about their sexuality (Eliason & Schope, 2001). Likewise, trans men who are 'out' to healthcare providers are more likely to report mistreatment in healthcare than trans men who are not 'out' (Seelman et al., 2020). These findings suggest that LGBTIQ+ patients can risk discrimination or the stress of self-censoring by hiding one or more aspects that make up their identity when accessing healthcare. Conversely, patients who feel safe presenting their whole identity

within healthcare settings likely experience higher inclusion and wellbeing.

Furthermore, because health settings are extensions of the community, particularly in terms of targeted First Nations and LGBTIQ+ services, experiences of discrimination in broader community settings can impact perceptions of safety in healthcare. In a recent report with > 600 First Nations LGBTQA+ young peoples, most participants reported experiencing at least one LGBTQA+-based microaggression (i.e. the frequent, oftentimes subtle acts of discrimination toward people with marginalised identities; Nadal et al., 2015) and at least one race-based microaggression (e.g. hearing non-First Nations LGBTQA+ people saying things that are racist) within the last 12 months (Liddelow-Hunt et al., 2023). Furthermore, participants experienced *intersectional* microaggressions in healthcare settings including not being seen by a service due to their First Nations LGBTIQ+ identity. Racial microaggressions, including those encountered within settler health systems, are a tool used by settler-colonial processes to reinforce notions of white superiority by devaluing First Nations worldviews, cultures and sovereignty through exclusion, omission, stereotyping and exceptionalism (Seet & Paradies, 2018). Likewise, LGBTIQ+ microaggressions reinforce colonial notions of hetero- and cis-normativity. When combined, race and LGBTIQ+-based microaggressions send potent messages of erasure and exclusion to First Nations LGBTIQ+ peoples, arguably impacting their wellbeing.

Current study

Current anti-racist dialogue has overlooked opportunities for critique of heterosexism and cisgenderism (Douglas et al., 2011). Understanding the experiences of First Nations LGBTIQ+ peoples in settler healthcare systems therefore requires an updated framing of anti-First Nations racism, one that dually acknowledges the unique forms of racism experienced by First Nations peoples *and* the ways in which heterosexism and cisgenderism are leveraged by settler healthcare systems to achieve the ongoing goals of settler-colonialism. As such, to inform the current analyses, the term *settler-colonial racism* (Uink et al., 2022) was leveraged: racism that benefits the settler-colonial mission via erasure of diverse First Nations identities. This definition pulls from descriptions of settler-colonialism that highlight the 'elimination of the native' as central to the settler mission (Wolfe, 2006) but expands the term to situate LGBTIQ+ oppression *within* racism. Given the growing popularity of anti-racism in healthcare it is critical that heterosexism and cisgenderism be incorporated into anti-racist dialogue.

Importantly, the current study was not designed to validate settler-colonial racism as a construct; rather, it provided a conceptual framework with which to understand the unique healthcare and community experiences of First Nations LGBTIQ+ peoples. It analysed survey data from a larger study exploring Australian First Nations LGBTIQ+ peoples' experiences in healthcare and the community to isolate the specific role that comfort in discussing one's LGBTIQ+ and First Nations identity with health providers plays in First Nations LGBTIQ+ peoples' wellbeing. It was hypothesised that greater comfort in discussing LGBTIQ+ and First Nations identity would be associated with higher levels of wellbeing. Additionally, relations between experiences of racial and LGBTIQ+ microaggressions and participant wellbeing were assessed. Given the role of microaggressions in maintaining the erasure of First Nations and LGBTIQ+ identities, it was hypothesised that higher racial and LGBTIQ+ microaggressions would be associated with poorer wellbeing.

Methods

Positionality statement

Authors S.B., D.B, and B.H. are First Nations LGBTIQ+ scholars who have spent several years advocating for improved monitoring and health outcomes for First Nations LGBTIQ+ peoples in Australia. First Author Uink is a heterosexual, cisgender Aboriginal woman who advocates for LGBTIQ+ informed anti-racist practice within First Nations healthcare. Author Bennett is a queer, non-Indigenous woman who has led several institutional initiatives improving LGBTIQ+ student and staff experiences in higher education. Their viewpoints offer a rich understanding of the findings presented in this paper via understanding First Nations Australian LGBTIQ+ patient experiences at interpersonal, communal, institutional and systemic levels, inside and outside healthcare settings, as well as viewpoints of those who support an intersectional approach to anti-racist health practices.

Adherence to principles of Indigenous data sovereignty

This study was conceptualised as part of a larger research study (see Figure 1) led by First Nations LGBTIQ+ researchers and advocates who had witnessed the continual absence of health research with First Nations LGBTIQ+ community members. To ensure that the questions reflected communities' experiences and trends in the international literature it took a ground-up approach to building the survey that was used. The authors were also informed by a community advisory group of First Nations Elders and leaders, one of whom identified as gay. Initial study findings were presented at two community forums, where service providers and community members provided feedback and further contextualised study findings. The project has a high level of Indigenous data ownership, as defined by the Maiam nayri Wingara Indigenous Data Sovereignty Communique (naryi Wingara, 2018).

This research being led by First Nations LGBTIQ+ researchers meant that members of the First Nations LGBTIQ+ community have ownership of project data. Specifically, First Nations LGBTIQ+ project investigators have final approval of how data from the project are used, interpreted, stored, re-used and shared.

Participants

Participants were First Nations LGBTIQ+ adults living in Western Australia who completed an online survey about their experiences in healthcare and within the broader community. The survey was open between September and December 2019 and advertised via popular First Nations LGBTIQ+, First Nations and LGBTIQ+ social media pages. All participants provided informed consent. Ethics approval was provided by the Murdoch University, University Human Research Ethics Committee (#2018/006), and all procedures followed the Australian National Health and Medical Research Council ethical guidelines for research with

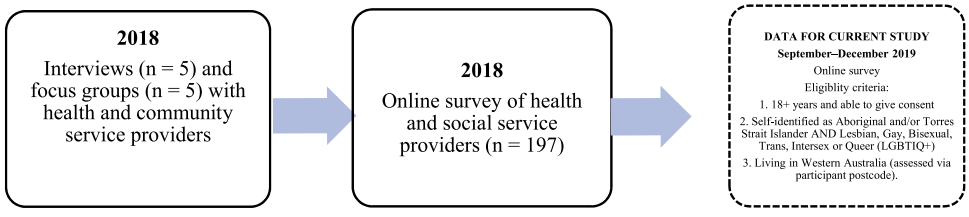

Figure 1: Project methods and participant recruitment.

Aboriginal and Torres Strait Islander peoples (NHMRC, 2018).

Forty-two survey responses were removed due to invalid data (e.g. not First Nations or LGBTIQ+, deliberately homophobic remarks entered; Supplementary Figure 1). The final sample consisted of 63 First Nations LGBTIQ+ adults (18–25 years = 41.4%; 26–30 years = 22.2%; 31–35 years = 17.5%; 36–40 years = 11.1%; 41–45 years = 3.2%; 46–50 = 1.6%; 51–55+ = 3.2%). The average number of completed questions was 98.8%, representing a strong completion rate. Table 1 outlines participants' sexuality and gender. Participants were asked two questions 'Which of the following best reflects how you would describe your sexual orientation/your gender?'. Sexuality and gender options were selected based on common categories used by First Nations LGBTQA+ peoples including Brotherboy and Sistergirl, which are culturally specific terms for trans men and trans women, respectively. Participants also had an option to select 'other' for their gender and sexuality, after which they were given an open-text response box. This option enabled participants to define their gender/sexuality in their own terms, especially if there were unfamiliar or uncomfortable with frequently used terms in Western gender/sexuality discourse (e.g. gay, lesbian). Notably, participants were able to select *multiple* gender and sexuality indicators, meaning that percentages in Table 1 represent every time an option was selected; therefore, totals were > 100%, 16 (39.3%) participants selected multiple sexuality identifiers and six (9.52%) participants selected multiple gender options.

	N (%)
Sexuality	
Lesbian	16 (25.40)
Gay	15 (23.81)
Bisexual	25 (39.68)
Pansexual	10 (15.87)
Queer	9 (14.29)
Asexual	2 (3.17)
Questioning	5 (7.94)
Heterosexual	0 (0.00)
Don't label myself	7 (11.11)
Prefer not to say	1 (1.59)
Other (e.g. old world queer, metrosexual)	3 (4.76)
Gender	
Man	20 (31.75)
Woman	29 (46.03)
Sistergirl	3 (4.76)
Brotherboy	1 (1.59)
Trans	2 (3.17)
Trans man	0 (0.00)
Trans woman	0 (0.00)
Trans masc	1 (1.59)
Female-male	0 (0.00)
Male-female	0 (0.00)
Trans femme	0 (0.00)
Gender diverse	2 (3.17)
Gender queer	2 (3.17)
Non-binary	6 (9.52)
Agender	1 (1.59)
Prefer not to have a label	3 (4.76)
Prefer not to answer	0 (0.00)
Other (e.g. pangender, bigender)	4 (6.35)
Born with a variation in sex characteristics	
Yes	1 (1.59)
No	62 (98.41)
Current gender different to how it was described on birth certificate	
Yes	12 (19.04)
No	51 (80.95)

Table 1: Survey participants' sexuality and gender (*n* = 63)

Measures

Comfort in discussing LGBTIQ+ identity and First Nations identity

Participants responded to two questions explicitly developed for the project. Q1: 'How comfortable do you feel about staff from health and community organisations asking you about your LGBTIQ+ identity?' Q2: 'How comfortable do you feel about staff from health and community organisations asking you about your Aboriginal and/or Torres Strait Islander Identity?' (1 = Extremely comfortable; 5 = Extremely uncomfortable). Scores on each item were reversed so that higher scores indicated greater comfort.

Intersectional microaggressions

Participants' experiences of racism, heterosexism and cisgenderism were measured via the LGBTIQ+ People of Color Microaggression Scale (Balsam et al., 2011). The scale measures subtle forms of discrimination that occur in interpersonal contexts, on a day-to-day basis, that are based on racial and LGBTIQ+ identity. Items were adapted to reflect the local context and to include microaggressions based on sexuality *and* gender diversity (see Supplementary Table 1). Participants responded in a yes/no format to whether they had experienced racism within LGBTIQ+ relationships (relationship racism: 2 items), racism by LGBTIQ+ communities (LGBTIQ+ racism: 7 items) and LGBTIQ+ discrimination within First Nations communities (First Nations heterosexism/cisgenderism: 7 items). Total scores for each of these subscales were calculated; higher scores indicated a greater number of microaggressions. Importantly, the assessment of LGBTIQ+ racism was focused on the racialised experience of First Nations LGBTIQ+ participants by the wider LGBTIQ+ community, rather than a broader focus on all forms of setter colonialism (e.g. Brayboy, 2005), while the measure of First Nations heterosexism and cisgenderism focused on the policing and exclusion of LGBTIQ+ identities by First Nations community members.

Wellbeing

Participants completed a six-item culturally specific measure of wellbeing: the Inner Peace subscale of the Growth Empowerment Measure (Haswell et al., 2010). Example items included: 'Reflecting on your sense of general, every-day sense of wellbeing, how much do you... feel very happy with self and life?' (1 = Strongly agree; 5 = Strongly disagree). Items were reverse scored so that higher scores indicated higher levels of wellbeing. The scale demonstrated excellent internal reliability (α = .946).

Data analysis

All analyses were conducted with SPSS V28 (IBM Corp, 2021). Descriptive statistics (mean, SD) and bivariate correlations between each variable were assessed (Table 2). Separate linear regression models with robust standard errors assessed relations between wellbeing and i) comfort in discussing LGBTIQ+ identity, ii) comfort in discussing First Nations identity, iii) relationship racism, iv) LGBTIQ+ racism, and v) First Nations heterosexism/cisgenderism. A regression approach was selected, as it provided estimates on the extent to which individual (i.e. between-person) differences in comfort in discussing identities and experiences of microaggressions were related to individual differences in wellbeing. Hence, the analysis established whether an individual who was relatively high on comfort in discussing LGBTIQ+ identity, for

	Wellbeing	Comfort LGBTIQ+	Comfort First Nations	First Nations heterosexism/ cisgenderism	LGBTIQ+ racism	Relationship racism
Wellbeing	1.00	–	–	–	–	–
Comfort LGBTIQ+	.336**	1.00	–	–	–	–
Comfort First Nations	.255*	.551*	1.00	–	–	–
First Nations heterosexism/ cisgenderism	-.309*	-.100	-.330**	1.00	–	–
LGBTIQ+ racism	-.141	.193	-.028	.367*	1.00	–
Relationship racism	-.071	.172	-.045	.244	.492**	1.00

Note. N = 62. *P < .05. **P < .001.

Table 2: Correlations between study variables

example, also had higher wellbeing compared with individuals who felt less comfort in discussing their identity. The sample size of 63 was also deemed appropriate for regression analysis (Jenkins & Quintana-Ascencio, 2020). Separate univariate models were used, as the authors were interested in establishing a unique relation between each predictor and wellbeing, rather than estimating the relation between one predictor and an outcome net of the impact of other predictors (which a multiple regression approach would have provided). This choice meant that five models were run, resulting in multiple tests of the outcome (wellbeing). This analytical approach also meant that multiple hypotheses were tested, which can increase the chance of finding a significant result by chance (i.e. type 1 error; Streiner, 2015). As such, a Benjamin-Hochberg correction with a 25% false discovery rate (i.e. expected proportion of 'false positives' set at 25% of all results) was applied, which reduced the risk of type 1 error. This adjustment resulted in an adjusted *p* value of .055.

Results

Participants reported moderate comfort in discussing their LGBTIQ+ identity with a health or community organisation (mean = 3.45, SD = 1.21). Likewise, participants had moderate comfort when asked about their First Nations identity by a health or community organisation (mean = 3.81, SD = 1.24). Participants also reported moderate levels of wellbeing (mean = 3.65, SD = 1.06). Fifty (80.65%) participants reported experiencing at least one form of racial microaggression within the LGBTIQ+ community in their lifetime (mean = 3.03, SD = 2.18), and 51 (82.36%) reported experiencing at least one LGBTIQ+ based microaggression from within a First Nations community (mean = 2.53, SD = 2.15). Just under half (43.5%) of participants reported at least one instance of relationship-based racism (mean = 0.61, SD = 0.78).

Pairwise correlations between study variables ranged between -.071 and .949 (Table 2). Notably, comfort in discussing LGBTIQ+ identity and First Nations identity were moderately and positively correlated (.551), suggesting that some participants may have an overall high level of comfort in sharing aspects of their identity, whether queer or First Nations, with their healthcare provider. Alternatively, participants who feel comfortable sharing one aspect of their identity (e.g. First Nations) may feel that they are able to share additional aspects (e.g. queer identity).

Being asked about identity and wellbeing

Comfort in being asked about LGBTIQ+ identity was significantly and positively related to wellbeing, accounting for 12% of the variance in wellbeing scores (Table 3). This finding suggests that individuals who felt more comfortable being asked about their LGBTIQ+ identity by health or community organisations also had higher levels of wellbeing. Comfort in being asked by care providers about First Nations identity was also positively associated with wellbeing; however, this relation only reached trend-level significance (Table 3).

	B (SE)	95% CI (lower–upper)	*p*	Adjusted R^2
Comfort LGBTIQ+	.330 (.093)	.143–.517	.001*	.120
Comfort First Nations	.218 (.11)	-.055–.441	.055	.049
First Nations Heterosexism/ cisgenderism	-.152 (.060)	-.272– -.032	.014*	.080
LGBTIQ+ racism	-.069 (.238)	-.194–.057	.278	.003
Relationship racism	-.098 (.173)	-.444–.249	.576	-.012

Notes. N = 60. *B*(SE) = unstandardised regression coefficient (standard error) *P < .055.

Table 3: Unstandardised regression coefficients for relations between comfort, microaggressions and wellbeing

Intersectional microaggressions and wellbeing

LGBTIQ+-based microaggressions were the only form of microaggression that were significantly associated with wellbeing scores (Table 3). Experiencing more LGBTIQ+-based microaggressions was associated with lower wellbeing, suggesting that homophobia and cisgenderism in First Nations communities are detrimental to overall wellbeing. Race-based microaggressions within LGBTIQ+ communities and race-based microaggressions within romantic relationships were not significantly associated with participant wellbeing.

Discussion

This study aimed to examine whether comfort in discussing LGBTIQ+ identity and First Nations identity with health providers and experiences of microaggressions are associated with wellbeing among First Nations LGBTIQ+ adults. This analysis was situated within a framework of settler-colonial racism, to acknowledge the concerted efforts to erase First Nations peoples' gender and sexual diversity within current examinations of anti-racist healthcare. The findings suggest that discussing First Nations *and* LGBTIQ+ identities is a source of discomfort for many patients with these identities. However, participants who felt more comfortable being asked about their LGBTIQ+ identity reported higher wellbeing. Additionally, cisgenderism and heterosexism enacted via microaggressions within First Nations communities contributed to lower wellbeing. These findings also highlight the diversity of First Nations LGBTQA+ sexualities and genders. Many participants opted to use multiple identifiers to describe their identity (i.e. there were 21 combinations of sexuality such as 'queer, gay, bisexual, asexual' provided in an open-ended text response, and 14 combinations of gender such as man and trans). Moreover, the Australian First Nations' specific terms of Sistergirl (trans woman) and Brotherboy (trans man) were rarely endorsed by participants. This may have been due to participants being from Western Australia, where Sistergirl and Brotherboy are less frequently used to describe trans identities. Nevertheless, these findings highlight that participants should be given options on how to identity their sexuality and gender, as one identifier may not necessarily represent them.

Below is a brief discussion of the current findings given previous research. Due to the focus of anti-racism on *praxis*, the remainder of the Discussion highlights how settler-colonial racism can be addressed in healthcare systems.

Impact of discussing LGBTIQ+ and First Nations identity with health providers

The finding that feeling comfortable discussing LGBTIQ+ identity with a health provider was associated with higher wellbeing aligns with previous findings, which suggest that LGBTIQ+ patients fear negative consequences (e.g. misunderstanding, discrimination) of being 'out' to a healthcare provider (e.g. Eliason & Schope, 2001; Seelman et al., 2020). Participants who reported feeling more comfortable discussing their LGBTIQ+ identity may have had less fear about being discriminated against, thus leading to their higher levels of wellbeing. Being asked about sexual or gender identity could also signal to patients that they are in an LGBTIQ+ inclusive space, which could explain the link to higher wellbeing. Alternatively, participants who reported feeling more comfortable being asked about their LGBTIQ+ identity may have been attending healthcare services that they deemed inclusive, enabling them to experience higher wellbeing. When First Nations LGBTIQ+ patients need to hide one of their identities, healthcare professionals are not provided with information that could be important to diagnosis and care (Uink et al., 2023).

Likewise, efforts to hide aspects of identity take a cognitive and emotional toll on First Nations LGBTIQ+ peoples (Eastman, 2023). Conversely, when First Nations patients feel comfortable discussing their LGBTIQ+ identity, they can access effective and tailored healthcare.

When asked about First Nations identity, the finding of moderate comfort levels could reflect broader anti-First Nations narratives in Australian healthcare systems. These narratives blame First Nations patients for poor health outcomes rather than system failures (Bond & Singh, 2020). Further, given the failure of settler healthcare systems to recognise First Nations groups as diverse and contemporary (Sylvestre et al., 2019), participants may have felt uncomfortable discussing their First Nations identity out of fear of receiving a stereotyped, homogenised response to care. Although the relation between comfort in discussing First Nations identity and wellbeing did not reach a level of statistical significance in the current study, the direction of this relation was positive, suggesting that greater comfort in discussing First Nations identity could link to higher wellbeing. Further studies are needed to study this relationship.

The impact of microaggressions on wellbeing

The high levels of intersectional microaggressions found in this study are consistent with previous research on ethnically diverse and First Nations LGBTIQ+ peoples (Giwa & Greensmith, 2012; Liddelow-Hunt et al., 2023; Rosenberg, 2021; Weber et al., 2018). LGBTIQ+-based microaggressions within First Nations communities may stem from beliefs among community members that sexuality and gender diversity did not exist before colonisation (e.g. Yumina, 2015). Cisgenderism and heterosexism in First Nations communities were also significantly associated with participant wellbeing. Previous research suggests that participation in First Nations communities and support from First Nations peers provides a respite from racism and provides wellbeing for First Nations peoples (Jaramillo et al., 2016; Salmon et al., 2018). However, the protective effects of being connected to community and culture may be diminished when First Nations LGBTIQ+ peoples face rejection from cultural spaces through heterosexist or anti-trans microaggressions, particularly those that act to render such identities invisible.

Documenting the experiences of cisgenderism and heterosexism within First Nations communities has important implications for healthcare provision. Previous research suggests that awareness of gender and sexuality biases within First Nations communities among Aboriginal Community Controlled Health Organisation staff prevents them from discussing LGBTIQ+ inclusive care, particularly with their boards, out of fear of disrespecting or contradicting the views of Elders (Uink et al., 2023). In addition, it would be incorrect to assume that First Nations spaces, including Aboriginal Community Controlled Health Organisations, are necessarily safe spaces for LGBTIQ+ peoples. Although community-controlled healthcare services are known for providing culturally safe care, through their respect of First Nations healthcare practices, the current findings suggest that this level of cultural safety does not necessarily translate to cultural safety for LGBTIQ+ patients. Given that Aboriginal community-controlled organisations are largely funded based on Federal Government strategy, it is vital that such funding agreements include specific LGBTIQ+ funding.

Surprisingly, race-based microaggressions were not associated with wellbeing in the current study. Research with non-LGBTIQ+ First Nations adults shows that everyday racial discrimination accounts for

27.1% of the gap in psychological distress between First Nations and non-First Nations (Thurber et al., 2022). Race-based microaggressions in romantic relationships (i.e. relationships racism) are also a salient concern for First Nations LGBTIQ+ adults (Carlson, 2020; Hill et al., 2021). The current study focused on wellbeing as the outcome of interest, which is a distinct concept from psychological distress. Indeed, recent work suggests that relationship racism is paradoxically linked to *higher* wellbeing (i.e. connection to culture) among First Nations LGBTIQ+ young peoples (Amos et al., 2023). These findings suggest that there may be distinct relationships between race-based microaggressions and distress versus wellbeing, and this distinction warrants further investigation.

Implications for anti-racist healthcare in settler-colonial nations

The current findings suggest that healthcare providers cannot view racism as a one-dimensional phenomenon but as nuanced and intersecting with the goals of settler-colonialism. Here, definitions of First Nations identity that centre on cisgenderism and heterosexism are leveraged, in this case by some First Nations community members, to erase diverse identities, thus reinforcing the colonial mission of 'elimination of the native' (Wolfe, 2006). It has been argued that this is intimately tied to the policing and delegitimising of First Nations racial identities to uphold a racial hierarchy, enacted by settler-colonial systems. Aboriginal community-controlled organisations, who purport to provide culturally safe care to First Nations patients, must therefore adopt an expansive form of anti-racist practice, to avoid reinscribing settler notions of gender and sexuality into culturally endorsed spaces. Suppose that anti-racist healthcare caters to all members of a racial minority group; in that case, it is crucial to create a space that is explicitly safe for diverse genders and sexualities. Safety and visibility are core competencies for supporting First Nations LGBTQA+ young peoples (Uink et al., 2023a). Healthcare organisations can develop these competencies by ensuring that staff have First Nations cultural safety training, infusing First Nations content into LGBTIQ+ inclusivity training (and vice versa), having specific organisational policies about First Nations LGBITQ+ clients in place, having visible signs of inclusion in health promotion materials, and having policies and training around use of inclusive language (Uink et al., 2023b).

Second, viewing anti-racist healthcare through the lens of First Nations LGBTIQ+ patients requires intentional change at all system levels. While there is often temporary value in developing anti-racism resources or workshops for frontline health workers (i.e. the interpersonal level; Hassen et al., 2021), this level of learning addresses symptoms of settler-colonial racism in terms of patient care while ignoring structural discrimination that renders First Nations' LGBTIQ+ patients vulnerable. In settler-colonial nations, healthcare systems are founded on, and maintained by, colonial epistemology, positioning First Nations peoples as objects to be known regarding homogenous cultural and healthcare needs (Short, 2016). Therefore, current health systems must adopt policies that challenge the normalisation of cisgender and heterosexual identities to be able to effectively support the wellbeing of First Nations LGBTIQ+ patients. This effort to decolonise sexuality and gender in healthcare must be replicated in federal health funding and policy that drive practice within critical health services (Day & Bonson, 2023).

Third, given the potentially inadvertent yet significant harm that First Nations healthcare providers can

cause when treating LGBTIQ+ patients by replicating cisgenderism and heterosexism that plays out in First Nations communities, it is essential that such services adopt explicit, intentional efforts to counter community-based discrimination by adopting LGBTIQ+ inclusive practice. The current findings suggest that services must insist on quality care for LGBTQA+ First Nations patients, necessitating negotiation with community members and Elders. Promisingly, First Nations health services in Australia are increasingly embracing gender and sexuality diverse patients into their remit (Uink et al., 2023). The current findings may also have utility for informing healthcare in other settler-colonial nations. While the experiences of First Nations LGBTQA+ individuals may not directly translate to other countries (Pihama et al., 2020), the impact of settler-colonialism on First Nations LGBTQA+ communities share similarities across contexts. In Canada and the USA, for example, scholars such as Morgensen (2011) and Anderson (2016) have explored the interconnected processes of colonial violence, erasure of First Nations sovereignty, and imposition of heterosexual and patriarchal norms on Two-Spirit and First Nations LGBTQA+ individuals. These works emphasise the importance of reclaiming traditional knowledge and practices as a means of resistance and healing.

Limitations

A strength of this study was that it leveraged pre-existing data to illustrate the need for anti-racism discourse in healthcare to include settler-colonial racism considerations. However, this meant that the data came from adults living in Western Australia, restricting the generalisation of findings to healthcare systems in other parts of Australia. Likewise, individuals born with a sex variation were underrepresented in this sample, as were heterosexual individuals (who could have been gender diverse). Second, the assessment of LGBTIQ+ racism was limited to the racialised experiences of First Nations LGBTIQ+ participants (e.g. being the token Aboriginal and/or Torres Strait Islander person in groups or organisations). Future studies would benefit from examining the impact of a wider range of settler-colonial processes on First Nations LGBTIQ+ wellbeing, such as forced assimilation and geographical displacement. Third, the data are cross-sectional; thus, causal relations between First Nations LGBTIQ+ patient experiences and wellbeing cannot be concluded. Longitudinal studies of First Nations LGBTIQ+ patients' healthcare experiences and wellbeing are needed to establish pathways to health and illness among First Nations LGBTIQ+ peoples. Longitudinal analysis would also enable future research to assess the alternative hypothesis that patients with lower wellbeing are less comfortable discussing their identities with health providers, which is a concerning finding if true. Lastly, while the current findings provide insight into relations between comfort in discussing First Nations and LGBTIQ+ identities will health providers and wellbeing, further research that unpacks the specific barriers within settler health systems that prevent First Nations LGBTIQ+ patients accessing healthcare is needed. Beyond this tract of inquiry, future research should also highlight the celebration and joy that comes with First Nations LGBTIQ+ identities, which itself can be an antidote to setter colonialism (Hill et al., 2021).

Conclusion

These findings illustrate that racism that manifests in discrimination of LGBTIQ+ identities within First Nations communities is pervasive both inside and outside of healthcare settings. Indeed, the delegitimising and erasure of First Nations LGBTIQ+ identities appears particularly insidious to wellbeing when it emerges through the experience of

heterosexism and cissexism in First Nations communities. These empirical findings support the argument that genuine anti-racist practice in Australia – and globally – will be ineffective unless it expands to include cisgenderism and heterosexism, with an overall aim to dismantle the systems working to exclude, deny and suppress First Nations peoples' sovereignty, agency, intersectionality and heterogeneity. This new version of anti-racist practice is starkly at odds with settler-colonialism and its reliance on reductionist conceptualisations of First Nations identity. Such broad focus on the mechanisms by which settler-colonial systems erase queer First Nations identities will result in anti-racist initiatives that meet the healthcare needs of First Nations LGBTIQ+ patients.

Author contributions

BU, RB, SB, DB and BH conceptualised the study. BU performed data analysis, and BU, RB, DB and BH interpreted it. BU, RB, SB, DB and BH performed writing - original draft preparation. SB, DB and BH performed writing - reviewing and editing, funding acquisition. DB and BH undertook funding acquisition.

Data statement

Data from this project are not currently publicly available. All requests for data should be directed to the last author.

Declarations of interest

None.

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Sian Bennett (she/her) is a cisgender lesbian Gamilaroi living on Noongar Country in Western Australia and lecturing at Kurongkurl Katitjin, Edith Cowan University in Perth, Western Australia. Her current role involves teaching Aboriginal and Torres Strait Islander perspectives across several disciplines, including paramedicine and biomedicine. Ms Bennett's research interests include Aboriginal higher education, equity and diversity in higher education, Aboriginal and Torres Strait Islander LGBTQA+ mental health, Aboriginal and Torres Strait Islander children's health, and Indigenous futurism.

Dameyon Bonson (he/him) is a cisgender, gay Aboriginal and Torres Strait Islander male from the Northern Territory (NT). He is a private practitioner of FN LGBTIQA+SB Cultural Competency and in Suicidology. Dameyon is also the Founder of Black Rainbow. Dameyon's advocacy and that of Black Rainbow have catalysed much of the recent research and activity in FN LGBTIQA+SB suicide prevention, social and emotional wellbeing, and mental health. For the past decade, his practice and fieldwork have been

in regional and remote communities, most recently in the Northern Territory. Dameyon's work as an FN LGBTIQA+SB Cultural Competency Practitioner throughout the NT has been consistently supported by the Commonwealth's National Suicide Prevention Trial since 2019. He has a postgraduate qualification in Suicidology and is currently completing his Master of Suicidology.

Professor Braden Hill (he/him) is a cisgender gay Nyungar (Wardandi) man and Deputy Vice-Chancellor (Students, Equity and Indigenous) at Edith Cowan University, Australia. His research focused on First Nations LGBTIQ+ wellbeing and he led the Breaking the Silence: Identifying as Aboriginal and LGBTIQ+ project.

Supplementary material

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