

**BISEXUAL WOMEN'S MENTAL HEALTH RESEARCH: A COMMUNITY-BASED,  
SOCIAL JUSTICE APPROACH**

by

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The goals of this paper were to review the public health literature on bisexual women's mental health, discuss the strengths and limitations of the research and propose a social justice framework for a future research agenda. The social justice framework includes Community-Based Participatory Research and the use of an intersectional approach. The literature has found bisexual women to have higher rates of depression, anxiety and suicidality than heterosexual and lesbian women, indicating the public health significance of this topic. Reported protective factors of mental health for bisexual women were social support and connectedness to the lesbian gay bisexual transgender community. Risk factors were discrimination, lack of community and social support, poverty, substance use, self-harm and eating Disorders. Limitations of the research include but are not limited to inconsistent categorization of sex category and gender expression, lack of population-based random samples, and lack of longitudinal data. Current research falsely approaches bisexual women as an unstratified and monolithic community, defaulting to unmarked privileged categories. The small body of research on this topic is lacking but warrants further investigation through longitudinal and qualitative community-driven studies.

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## 1.0 INTRODUCTION

Women who identify as bisexual are found to have a prevalence of 58.7% lifetime history of a mood disorder, as compared to lesbian women (44.4%) heterosexual women (30.5%) and the general population (21%) nationwide, illustrating elevated rates in bisexual women (Bostwick et al., 2010). Despite being a clear public health problem, research addressing the health and well-being of bisexual women is limited. Bisexual women are commonly collapsed together with lesbian women; little work specifically addresses bisexual women separately from other groups (Koh et al., 2000; Tao, 2008; Fredriksen-Goldsen et al., 2010; Jorm et al., 2002; Steele et al., 2009; McCabe et al., 2009). Studies that do include bisexual women, while few in number, suggest a high prevalence of mental health problems such as depression, anxiety, mood disorders, and suicidality. Depression and anxiety to are found to be of particular concern for this group (Fredriksen-Goldsen et al., 2010; Cochran et al., 2000; Meyer, 2003; Ross et al., 2010).

I argue herein that it is critical for future research to look at bisexual and lesbian women separately, and to proceed with a community-driven participatory research (CBPR) approach which is embedded in an intersectional social justice framework. A CBPR approach is one in which community members define the problems and solutions to a health problem and are partners in all phases of research including design, implementation, analysis and dissemination

of information. Researchers relinquish their role as “expert” and recognize that the community is best at understanding and defining its health problems and its strengths. A social-justice approach keeps anti-oppression, anti-racism teachings at its core. It is deliberate about calling out and mitigating social hierarchies and power dynamics in the research process, in the community, and on a national level. This necessitates an intersectional approach that functions based on the idea that each person has many identities which interact with and affect each other in non-additive ways.

The specific goals of this position paper are to illustrate the importance of the above issues, review the literature about bisexual women’s mental health and recommend a social justice approach for moving research forward in this area. The paper will begin with a discussion of how bisexuality has been defined, measured, and categorized in the literature. My perspective is fed by my experience as a bisexual woman who has been diagnosed with major depression and anxiety.

To conduct my review of the existing scientific literature, I used the following search terms in the PubMed online database and reviewed reports from national and local organizations working in LGBT Health Research. Key search terms in PubMed included: “(Bisexual OR Pansexual OR Queer) AND (Woman OR Women OR Female OR Gender) AND (Mental Health OR Depression OR Anxiety OR Suicide OR Suicidality OR Suicidal Ideation OR Dysthymia). Results from the search yielded 412 articles. Reading through titles and abstracts, I eliminated articles that did not specifically measure mental health in bisexual women separately from other groups. I expanded my search by using citations from key articles. I gathered supporting community resources by reaching into online community networks and synthesized the information by listing the key themes, methods and recommendations.



## **2.0 HOW ARE BISEXUAL WOMEN CATEGORIZED IN PUBLIC HEALTH RESEARCH?**

Most research on women who have sex with women (WSW) focuses on lesbians or merges lesbians and bisexuals into one group (Hughes et al., 2006, Fredriksen-Goldsen et al., 2010). It is now recommended that lesbians and bisexual women be considered separate groups in research due to emerging evidence that these two groups have different health needs (Koh et al., 2006; Fredriksen-Goldsen et al., 2010). While bisexuality has long been considered a behavioral phase or transition period from straight to gay, it is a valid identity, whether it is short term or long term. Bisexuals exist and should be respected as having a legitimate sexual orientation, regardless of whether they identify as bisexual for one week or their whole lives. Thus, bisexuals need to be viewed as a separate group which experiences the world differently from gay, lesbian, and straight people (Koh et al., 2000, 2006; Tao, 2008; Fredriksen-Goldsen et al., 2010; Jorm et al., 2002; Steele et al., 2009).

The rhetoric in most research to date oversimplifies the Lesbian Gay Bisexual Transgender Queer (LGBTQ) community as monolithic. Race, socio-economic status, sex category and gender stratifications are often not specifically addressed, nor are these categories theorized within the context of public health. Theoretical frameworks of complex social identities such as race, class and gender must be addressed to develop better vocabulary and

discussion in these areas. Public health research commonly defines these categories as naturalized binaries (man/woman; heterosexual/homosexual) without discussion about how their meanings are socially constructed, change over time, depend on context, are not exhaustive or mutually exclusive, and are culturally relative. A lack of theorizing of gender, sex category and sex has led to misuse of these terms. A common misclassification is the use of *gender* instead of *sex category*. Gender is the display of masculinity and femininity and sex category is the affiliation of a person with terms such as “woman” and “man”. I will use *sex category* and *gender* in this way, except when I am respecting another author’s use of it in their own work. There is an unexamined assumption that these categories are natural binaries. This is problematic because gender is not dichotomous (West et al. 1987). Social identities are in flux and are individually defined. Imposing sex category polarization and the homo/hetero binary may fail to capture relevant aspects of identity, attraction/affect, and behavior (Broido, 2000; Rust, 1993).

This same gap reappears in bisexual research (Eady et al., 2011; Morris, 2002; Koh et al., 2006; Wilsnack et al., 2008; Rust, 1993; Ross et al., 2010). Rates and experiences with depression and anxiety are underexplored in bisexual people of color and bisexual transgender people, with no acknowledgement of bisexual transgender people of color (Ross et al., 2010; Wilsnack et al., 2008).

Estimates of the LGBTQ population are inconsistent due to the use of multiple definitions, varying sample methodologies and the stigma of being LGBTQ in the U.S. An unknown number of individuals are not open about their LGBTQ identity publicly, or sometimes even to themselves. This makes it difficult to estimate the number of bisexual women in the U.S., let alone develop a sampling frame representative of the population. However, attempts have been made. In a recent study on sexual behavior in the U.S., Herbenick et al. (2010) found 3.6%

of the female population identified as bisexual. When measuring by attraction and identity, Tao (2008) found bisexual women to make up 3.1%-4.8% of women. Bisexuals of any gender or sex were found to make up half of the LGB population (Egan et al., 2007). Regardless of how many bisexual women there are, this is an important population to serve.

A lack of a standard way of defining bisexual women in research makes it difficult to estimate the number of bisexual women in the U.S. Most commonly, researchers define bisexual women by 1) identification as bisexual (*identity*), 2) attraction to men and women (*attraction*) or 3) report of men and women as sexual partners (*behavior*). Also, studies differ with respect to the time period being assessed. Time periods vary, including *past 6 months*, *past 12 months*, *past 5 years* and *lifetime*. Sell et al. (1996) found that self-reported identity was the most common way of categorizing the LGBT population in public health research. Self-identification is an effective way to define bisexual women because it is most relevant to social affiliation, discrimination, and community (Wilsnack et al., 2008). More importantly, letting participants choose their own category is the most respectful of their self-concept. Further, Bostwick et al. (2010) found that when categorizing by *attraction*, by *behavior* and by *identity*, the *identity* category had the highest rates of mood disorders and anxiety. Analyzing all three categories by giving study participants the option to select how they identify their sexuality, who they are attracted to and who they have engaged in sexual activity with is the most thorough approach. Using all three methods allows the researcher to compare rates and find how the categories are similar or different. This provides insight into which aspects of sexuality are most relevant to each health issue experienced by bisexual women. It is also important to look at these three components over time: past 6 months, past 12 months, past 5 years and lifetime to prevent recall bias. It may also make a small step toward the public health field's understanding sexual fluidity and change over

time. While it is not always possible to use all three measures due to survey space or financial limitations, understanding the different dimensions of sexuality and how these are associated with mental health issues may help elucidate mechanisms to explain notable mental health disparities. All three dimensions should be used when possible.

However, many times resources are limited and one dimension must be chosen. The most appropriate dimension to choose varies by health topic. For example, when looking at sexually transmitted infections (STI), sexual orientation should be defined by *behavior* because sexual behavior is more relevant to risk of contracting an STI. Alternatively, in mental health research, sexual orientation is best measured by participant self-identification. Self-identification reflects an individual's self-concept and risk of internalized or externalized oppression and the subsequent mental health effects. Additionally it has excellent specificity, and will accurately capture those who strongly identify but can miss individuals who do not identify as strongly with given sexual orientation categories (Steele et al., 2009; Dean et al., 2004; Smith et al., 2003; Tjepkema et al., 2008; 2008; Broido, 2000). Categorizing participants by sexual behavior results in a larger sample size than categorizing by identity, but may include people who consider themselves heterosexual. When looking at mental health in particular, self-identification should be used to define participants to better evaluate how bisexual identity affects women as compared to other sexual identities, and sex categories.

### **3.0 BISEXUAL WOMEN AND MENTAL HEALTH: WHAT DO WE KNOW?**

A small body of literature shows that bisexual women have alarmingly high rates of mental health problems (Wilsnack et al., 2008; Rothblum et al., 2001; Steele et al., 2009; Tjepkema et al., 2008; McLaughlin et al., 2010; Kertzner et al., 2009; Ross et al., 2010; Bostwick et al., 2010; Koh et al., 2006; Lehavot et al., 2011; Fredriksen-Goldsen et al., 2010). Mental health issues include depression, mood disorders, anxiety, mental distress and suicidality. While it is known that bisexual and lesbian women experience depression and anxiety more than heterosexual women, and that women are more likely to report mental health problems than men, it is not common knowledge that bisexual women have been found to have higher rates than lesbians. Whether rates are different or similar, it is important to recognize that lesbians and bisexual women are separate groups and need to be treated as such in research. Both groups endure multiple forms of oppression and deal with mental health issues at rates higher than the national average. There is fluidity and community overlap between lesbians and bisexual women and both similarities and differences should be taken into account in research and intervention design. Additionally, it should be common practice to compare bisexual women's mental health to that of bisexual men's. Bisexual men serve as an important comparison group, as referenced in Table 1 (Bostwick, et al., 2010; Warner et al., 2004; Page, 2004; Tjepkema et al., 2008).

**Table 1: Comparing Bisexual Men and Bisexual Women**

	Author	Bisexual men	<b>Bisexual Women</b>	Lesbian Women	Gay Men	Heterosexual Women	Heterosexual Men
Mood Disorder	Bostwick (2010)	36.9%	58.7%	44.4%	42.3%	30.5%	19.8%
	Tjepkema (2008)	11.4%	25.2%	11.4%	11.1%	7.7%	4.0%
Depression	Bostwick (2010)	35.8%	52.3%	41.8%	37.8%	27.3%	15.4%
Anxiety Disorder	Bostwick (2010)	38.7%	57.8%	40.8%	41.2%	31.3%	18.6%
	Tjepkema (2008)	10.1%	17.7%	8.7%	8.5%	5.8%	3.0%
Suicidality	Warner (2004)	55%	57%	56%	47%	Not Available	Not Available

These data suggest that bisexual men and women have different factors affecting their mental health and experiences with mental health services, signifying that sex categories should be separated in research.

There is a dearth of generalizable research on bisexual women’s mental health. Only five of the nine studies discussed in this section are representative, two of which were conducted in the U.S., and only one of which was done on a U.S. national level. Other representative studies were conducted in Canada and Australia, and Washington State. Two studies are convenience samples with comparison groups. Convenience samples are not representative and cannot be used to determine prevalence estimates. However, they are useful when they come from community knowledge and are used to justify funding for larger population-based random samples. Given limited community resources, convenience samples are the most feasible sample design. Population-based random samples require thousands of dollars and hours of labor and are

out of the scope of possibility for most community-based organizations. The state of this research points to a need for questions about sexual orientation to be included in all ongoing representative surveys.

Prevalence estimates of mood disorders, depression and anxiety for bisexual women range from 24.3% to 91.5% (Fredriksen-Goldsen et al., 2010; Steele et al., 2009; Bostwick et al., 2010). Lifetime prevalence of mental health issues among bisexual women is higher than among lesbian and heterosexual women as referenced in Table 2.

**Table 2: Lifetime Prevalence**

		Bisexual Women	Lesbian Women	Heterosexual Women
Depression	Bostwick (2010)	52.3%	41.8%	27.3%
Mood Disorder	Bostwick (2010)	58.70%	44.40%	30.50%
	Steele (2009)	31.40%	13.40%	9.90%
	Tjepkema (2008)	25.20%	11.40%	7.70%
Anxiety	Bostwick (2010)	57.80%	40.80%	31.30%
	Tjepkema (2008)	17.70%	8.70%	5.80%
Suicidality	Steele (2009)	45.4%	29.5%	9.6%
	Koh (2006)	21.30%	16.70%	10.20%
Frequent Mental Distress	Fredriksen-Goldsen (2010)	32.30%	18.80%	Not Available

Bostwick et al., (2010) conducted a secondary analysis of wave two of the 2004-2005 National Epidemiologic Survey on Alcohol and Related Conditions, a nationally representative sample. The authors assess lifetime and past-12 months prevalence of *DSM-IV* defined mood and anxiety disorders by sexual orientation for women and men. Unfortunately, wave one did not include questions about sexual orientation so data cannot be compared between wave one and wave two. This highlights the importance of consistency in asking for sexual orientation demographics so rates can be compared over time. This is one of few studies that carefully

compares identity, attraction and sexual behavior among lesbians, bisexuals, heterosexuals, and individuals who are unsure, for women and for men. Self-identified bisexual women had the highest lifetime prevalence of any mood disorder (58.7%) and any anxiety disorder (57.8%) as compared to those attracted to men and women (32.3% and 36.8%, respectively), those with lifetime sexual behavior with men and women (55.8% and 50.7%, respectively), self-identified lesbians (44.4% and 40.8%, respectively), self-identified heterosexuals (30.5% and 31.3%, respectively), and those who were unsure (36.5% and 37.6%, respectively). Of the three categories of identity, attraction, and behavior, sexual attraction was the only category in which mostly female attraction (41.1%) had a higher prevalence than women equally attracted to women and men (39.2%). Women who identified as bisexual had much higher rates of any lifetime mood and anxiety disorder (58.7% and 57.8%, respectively) versus men who identified as bisexual (36.9% and 38.7%, respectively).

Fredriksen-Goldsen et al., (2010) used data from the (2003-2007) Washington State Behavioral Risk Factor Surveillance System, a telephone interview survey. They found that bisexual women had lower levels of Health-Related Quality of Life (HRQOL) than both lesbians and heterosexual women. HRQOL is a well validated measure of perceived physical and mental health over time. Frequent mental distress is defined as 14 or more days of poor mental health, a common way for clinicians to define depression and anxiety disorders. Bisexual women experienced significantly higher rates of frequent mental distress and poor general health (32.3%) than lesbians (18.8%). Income below 200% of the federal poverty level and lack of exercise were independently associated with frequent mental distress and poor general health for both lesbians and bisexual women. Living in an urban core and tobacco use were associated with frequent mental distress for bisexual women only. Health-related factors associated with poor



general health for bisexual women were health insurance coverage, financial barrier to health care services, obesity and frequent mental distress. For future telephone surveys, it will be important to identify whether bisexual women and lesbian women are as likely to have a landline phone as heterosexual women in order to avoid bias.

Steele et al., (2009) did a cross-sectional analysis of the data from the Canadian Community Health Survey (CCHS): cycle 2.1. CCHS is a representative national population-based survey. Cycle 2.1 was the first Canadian population-based survey to include questions on sexual orientation. Women who identified as bisexual were most likely to report poor or fair mental and physical health, mood or anxiety disorders, lifetime STD diagnosis, and lifetime suicidality. After adjustment, rates for self-reported mood or anxiety disorder were 3.6 times higher for bisexual women when compared to heterosexual women. Rates were 31.4% for bisexual women, 13.4% for lesbians and 9.9% for heterosexual women. Self-reported poor or fair mental health was 3.7 times higher for bisexual women than for heterosexual women after adjustment. Unadjusted rates were 19.6% for bisexual women, 6.2% for lesbians and 5.2% for heterosexual women. Lifetime suicidal ideation was most disparate for bisexual women. 45% of bisexual women had seriously considered suicide as compared to a similarly disturbing 29.5% of lesbians and 9.6% of heterosexual women. Bisexual women were 5.9 times more likely than heterosexual women to experience suicidal ideation.

Tjepkema et al., (2008) also used data from the CCHS, but combined cycles 2.1 and 3.1 to increase sample size of LGBT participants. This is one of few reports to compare bisexual women and men. Most studies compare sexual orientation between women or between men, and only compare men and women to each other after combining all sexual orientation categories. This is often due to needing bigger sample sizes to reach statistical significance. In this case,

bisexuals of any sex category were found to have worse mental health than gay and lesbian participants. Bisexual women were found to have the highest rates of fair or poor self-perceived mental health (17.0%), and mood (25.2%) and anxiety (17.7%) disorders followed by bisexual men (9.4%, 11.4% and 10.1% respectively). 6.7% of lesbians, 5.7% of gay men, 5.3% of heterosexual women, and 4.3% of heterosexual men had fair or poor self-perceived mental health. Lesbians had mood and anxiety disorders at rates of 11.4% and 8.7%, gay men had rates of 11.1% and 8.5%, heterosexual women had rates of 7.7% and 5.8% and heterosexual men had rates of 4.0% and 3.0%.

Jorm et al., (2002) used a data sample from the PATH Through Life Project to compare socio-demographic characteristics, anxiety and depression, substance use, cognitive function, well-being, physical health, health habits, use of health services, personality, coping, early-life psychosocial risk factors, and nutrition in a cross-sectional questionnaire. The sampling frame from this study came from the electoral rolls of Canberra and Queanbeyan, Australia, making the results only generalizable to these regions. The questionnaire asked participants to self-identify with one of the four following groups: heterosexual, homosexual, bisexual, or don't know. A weakness of this paper is that it does not analyze the data by sex category or race. The bisexual group had more childhood adversity, adverse life events, less positive support from family, more negative support from friends than the homosexual group. Anxiety, depression and suicidality were highest for the bisexual group, second highest for the homosexual group and lowest for the heterosexual group.

Koh et al., (2006) looked at depression, stress, anxiety, eating disorders, and suicidality in self-identified heterosexual, lesbian, bisexual and unsure women by administering an anonymous written survey to a sample from 33 different health care sites across the U.S., These sites

included private medical offices and lesbian health clinics. Half of the sites were known to serve a constituency that was at least 30% LBQ. The sample was not random and therefore has limited external validity, however disproportionate sampling of LGQ women allowed for comparisons to be made between heterosexual and LGQ groups. The study was approved by the Institutional Review Board of California Pacific Medical Center of San Francisco and was put through two pilot tests. Half of the sample consisted of nonheterosexual women. The study found bisexual women to have significantly higher illicit drug use in the past 12 months (25.5%) compared to lesbian (16.0%) or heterosexual women (13.7%), twice the rate of eating disorders as lesbians and when “out”, and twice the rate of eating disorders as heterosexual women. The study found 24.3% of bisexual women, 11.3% of lesbians and 17.8% of heterosexual women to be currently depressed, while 21.3% of bisexual women, 16.7% of lesbians and 10.2% of heterosexual women ever had thoughts of suicide with 5.6% of bisexual women, 1.0% of lesbians and 0.6% of heterosexual women to have thought about suicide “very often” in the past 12 months. Bisexual women were also found to be younger at first suicide attempt. Within their sample, they found the category “Hispanic nonwhites” to be 2.37 times more likely to have had an eating disorder and American-Indians to be 10 times more likely than whites to have attempted suicide. Extreme racial mental health disparities emphasize the need for an intersectional approach to lesbian and bisexual women’s mental health research.

Wilsnack et al. (2008) conducted face-to-face interviews to look at rates of alcohol consumption and depression among lesbian, bisexual and heterosexual women. They used a wide variety of methods, including organizational and individual social networks, newspaper advertisements and fliers, to recruit a complex convenience sample. Because it is a convenience sample, this study is not representative of the bisexual women population. However, comparison

groups within the sample can be analyzed to indicate similarities and differences between bisexual, lesbian and heterosexual women. Groups typically underrepresented in lesbian and bisexual women's research such as women of color, older lesbians and lesbians of lower socioeconomic status, were deliberately oversampled to increase sample representativeness. Women who have sex with women were divided into 1 of 4 groups that they self-identified with: mostly heterosexual, bisexual, mostly lesbian and only lesbian. Bisexual women were found to have the highest rates of drinking and depression over the past 12 months and throughout their lifetime when compared to all other sexual orientation groups. Rates of depression among bisexuals for the past 12 months (87.2%) and lifetime (91.5%) were especially high as compared to lesbian (56.0% and 56.6%, respectively) and heterosexual women (26.9% and 41.6%, respectively).

Using a convenience sample of self-identified lesbians and their sisters, Rothblum et al., (2001) found significantly higher depression, anxiety, phobic anxiety and psychoticism in bisexual women when compared to lesbians and heterosexual women. Bisexual women also scored lower than lesbians and heterosexual women on the Rosenberg Self-Esteem Scale, which measures self-esteem (Rosenberg, 1965). Researchers recruited their sample by posting advertisements in a national LGBTQ resource book, the *Gayyellow Pages* (1997), and contacting LGBTQ organizations to request they post a flier on an announcement board or in an email or paper newsletter to alert their clientele about the study. When women responded, expressing interest in the study, they were sent two questionnaires, one for themselves and one for their sisters. The expectation was that all of their sisters would be heterosexual, but some were bisexual, creating a bisexual sample. Additionally, some bisexual women answered the ad themselves. Sexual orientation was assessed using the 0-7 point Kinsey Scale (Kinsey et al.,

1948) where 2-5 was considered bisexual, 0-1 was considered heterosexual and 6-7 was considered lesbian or gay. When controlling for age, education, and income, bisexual women were still at greatest risk for mental health problems.

Based on these data, there is a clear need for mental health interventions targeted at bisexual women. Depression, anxiety and suicidality are high in this population, but this problem is not well understood in the health and medical fields. Prevalence estimates only take us so far. For us to really understand what is driving mental health issue among bisexual women, we need to be involving the community to conduct in-depth interviews, surveys and focus groups. Thus far, the literature names biphobia, monosexism, discrimination, lack of social support, and lack of community as risk factors for mental health problems in bisexual women. Explicitly bringing in community voices and utilizing an intersectional framework will add additional depth to this literature, which can be used for intervention creation.

#### **4.0 WHAT PROTECTIVE AND RISK FACTORS ARE ASSOCIATED WITH MENTAL HEALTH AMONG BISEXUAL WOMEN?**

According to existing literature, discrimination, biphobia, monosexism, lack of community, lack of social support, substance use, self-harm, eating disorders and poverty are associated with depression, anxiety and mental health problems among bisexual women (Rothblum et al., 2001; Ross et al., 2010; Eady et al., 2010; Wilsnack et al., 2008; Kertzner et al., 2009; Miller et al.2007; Fredriksen-Goldsen et al., 2010). Protective factors of mental health problems are social support, and LGBTQ community (Hatzenbuehler et al., 2009, Selvidge 2008, Meyer, 2003) as displayed in Table 3.

**Table 3: Protective and Risk Factors for Bisexual Women**

<b>PROTECTIVE FACTORS</b>	<b>RISK FACTORS</b>
<ul style="list-style-type: none"> <li>• Social Support</li> <li>• LGBTQ Community</li> </ul>	<ul style="list-style-type: none"> <li>• Discrimination</li> <li>• Lack of community and social support</li> <li>• Poverty</li> <li>• Substance Use</li> <li>• Self-Harm</li> <li>• Eating Disorders</li> </ul>

Biphobia and monosexism specifically are risk factors for lowered mental health in bisexuals. “Biphobia...is analogous to homophobia in that it describes negativity, prejudice, or discrimination against bisexual people” (Ross et al., 2010). Biphobia is pervasive in both heterosexual and LGBTQ community spaces and can result in social isolation for bisexuals (Rothblum et al., 2001). Monosexism is the pervasive social assumption that people cannot authentically be attracted to people of more than one sex category or gender. “Monosexism is analogous to heterosexism: some people view only single-gender sexual orientations (heterosexuality and homosexuality) to be legitimate, and at the structural level, bisexuality is dismissed or disallowed” (Ross et al., 2010). Monosexism suggests that bisexuals are confused about their sexual orientation, are in transition from straight to gay, in crisis, lying, or in a promiscuous, indulgent phase of life (Miller et al., 2007). Unfortunately, bisexual people often internalize biphobic and monosexist messages “leading to an unconscious acceptance by bisexual people of negative or inaccurate social messages about bisexuality, potentially leading to identity conflict and self-esteem difficulties” (Ross et al., 2010). Biphobia and monosexism are a painful reality for bisexuals and should be critically discussed in all research and intervention design.

Ross et al., (2010) found biphobia and monosexism to contribute to bisexuals’ mental health problems on a macrolevel (social structure), mesolevel (interpersonal), and microlevel (intrapersonal). In an exemplary effort, they utilized community-based participatory research (CBPR) to explore the determinants of mental health problems for bisexual people through qualitative research methods. Their work can be used as a model for future qualitative CBPR projects. They developed a partnership with an LGBTQ health organization, the Sherbourne Health Centre in Toronto, Canada, and hired bisexual activists and community educators onto

the research team. They felt a CBPR approach was necessary given the history of mental health fields' pathologizing LGBT identities. They recruited a convenience sample by advertising in local LGBTQ organizations; community health and social service agencies; online support and discussion groups; and local newspapers. Conducting eight two-hour focus groups and nine one-hour individual interviews, they identified biphobia and monosexism on three levels: macrolevel (social structure), mesolevel (interpersonal), and microlevel (intrapersonal). The findings were presented at a community event and were validated by participants and community members. The following table provides a visualization of biphobia and monosexism working on the micro, meso and macro levels.

**Table 4: Micro, Meso and Macro Levels of Discrimination**

<u>Social Structure</u>	<u>Interpersonal</u>	<u>Intrapersonal</u>
<p><b>Biphobia and monosexism:</b>            -Common social attitudes and beliefs about bisexuality            -Media representation of bisexuality            -Invisibility as a bisexual person</p> <p><b>Homophobia experienced as:</b>            -Violence or Fear of violence            -Discrimination</p>	<p><b>Supportive or unsupportive relationships with:</b>            -Partners            -Family Members            -Friends            -Colleagues            -LGBT Community            -Bisexual Community</p>	<p><b>Internalized biphobia/homophobia experienced as:</b>            -Identity struggles</p> <p><b>Resolved through:</b>            -Self-acceptance            -Self care            -Education/empowerment            -Advocacy/activism</p>

Adapted from Ross et al., 2010

Participants identified community, friends, identity, self-acceptance, self-care, empowerment, education, advocacy, and activism, as having positive effects on their mental health. The sample had relevant experience as 69% reported mental health problems (Ross et al., 2010). Ross et al. suggested that, “These multiple effects of stigmatization may be mutually reinforcing and underlie findings of a greater prevalence of depression, anxiety, alcohol misuse, negative affect,



and suicide attempts and plans in bisexually versus lesbian, gay, and heterosexually identified adults” (Ross et al., 2010).

Biphobia frequently makes bisexuals feel alienated, rejected and pathologized by the gay and lesbian community (Miller et al., 2007; Ka’ahumanu et al., 1996). Bisexuals are often without community, and social support which are known to be protective against mental health problems (Meyer, 2008; Kertzner, 2009; Fredriksen-Goldsen et al., 2010). Additionally, bisexuals lack bisexual friendly resources. (Eady et al., 2010; Miller et al., 2007). More programming directed at this population is urgently needed.

Eady et al., (2010) conducted eight focus groups and one-on-one interviews with male, female, and transgender people who self-identified as bisexual, queer, pansexual, omnisexual, or sexually active with men and women about their experiences with mental health services. They set out to explore how satisfied bisexual people were with mental health services and what they found to be positive or negative about their experiences. Their findings are presented in Table 5.

**Table 5: Key Themes of Negative and Positive Mental Health Experiences**

<b>PRACTICES CONTRIBUTING TO NEGATIVE EXPERIENCES</b>	<b>PRACTICES CONTRIBUTING TO POSITIVE EXPERIENCES</b>
Expressing judgment	Seeking education
Dismissing bisexuality	Asking open-ended questions
Pathologizing bisexuality	Maintaining positive or neutral reactions to disclosure
Asking intrusive or excessive questions	

Adapted from Eady et al., 2010

Positive experiences had to do with supportive or neutral attitudes from mental health providers, whereas negative experiences had to do with biphobic assumptions and pathologizing of clients' bisexuality. Unfortunately, mental health services are not a dependable source of treatment or prevention due to discriminatory providers and practices. The field of psychology has a long history of abuse of LGB and particularly of transgender individuals (Spade, 2003) which has prompted feelings of distrust in the community.

Public health literature shows that discrimination is associated with mental health problems for communities of color and LGBTQ populations (Jorm et al., 2002; Meyer, 2003; O'Donnell, 2011; Koh et al., 2006; McLaughlin et al., (2010). Queer people of color are especially marginalized and neglected by mental health services when little attention is paid to how LGBTQ and people of color identities intersect with each other to produce their own life challenges and resiliency strategies. Provider education and accountability are necessary to making mental health services more accessible to LGBTQ people and QPOC especially. Attention to social justice work within the field is imperative to making prevention and treatment spaces welcoming and nurturing to people of these communities.

Cost and financial expense likely acts as a barrier to mental health treatment, especially for LBQ women, transgender people, and communities of color who are disproportionately low income. A weakness of the Eady et al. paper is that while they did collect sex category-specific data, they did not analyze or report the data by sex category or gender due to small sample sizes. It would have been useful to make qualitative comparisons of focus group and interview data to show patterns of difference and similarity. The results state that there are gaps in the research among bisexual people of color, transgender bisexual people and bisexuals living in rural areas.

Ending therapy as a result of negative experiences was common making mental health services an unreliable source of treatment for bisexuals.

In addition to mental health problems, substance use is influenced by discrimination and lack of social support among bisexual women. Substance use includes drinking alcohol, and illicit drugs.

An association between bisexuality and higher levels of hazardous drinking suggests the need for more research focusing on bisexual women. Possible explanations for the association include cultural factors such as stigma associated with bisexuality, particularly for women (Bostwick et al., 2005; Ochs, 1996), which may operate as a stressor and in turn contribute to alcohol use. Bisexual women may have less access to social support, given the often negative attitudes of both heterosexuals (Herek, 2002) and gays and lesbians (Rust, 1995) toward bisexuality (Wilsnack et al., 2008).

Substance use, including illicit drug use, lifetime and past 12 months hazardous drinking, and risk for substance dependence are all markedly high for bisexual women (Koh et al., 2000, 2006; Wilsnack et al., 2008; King, 2008). McCabe et al., (2009) did a secondary analysis of wave 2 of the National Epidemiologic Survey on Alcohol and Related Conditions and found bisexual identity to be associated with significantly greater odds of past year heavy drinking, past year marijuana use, past year other drug use, and past year alcohol dependence. “Other drugs” include sedative medications, tranquilizer medications, opioid medications, stimulant medications, cocaine, hallucinogens, inhalants, and heroin. This was the same for women who reported a history of men and women as sexual partners, but not for women who reported only female partners. For women and men across all categories of sexual orientation (identity, attraction and behavior), bisexual women reported the highest rate of heavy drinking (25%) with lesbians reporting 20.1% and heterosexual women reporting 8.4%. Previous studies have found that

bisexuals, whether measured by identity, attraction or behavior, have higher rates of substance use than their heterosexual, gay and lesbian counterparts (McCabe et al., 2009).

Self-harm was found to be a risk factor for bisexual women in a cross-sectional survey administered to the younger and mid-aged cohorts of the Australian Longitudinal Study on Women's Health (ALSWH) (McNair et al., 2005). McNair et al., (2005) looked at a variety of mental health factors such as stress, abuse, social support, depression, anxiety, self-harm and suicidality. They found 16% of bisexuals to have reported hurting or attempting to kill themselves in the past six months as compared to 2% of lesbians and 0.8% of heterosexual women. There were only 16 mid-age bisexual women so findings are not generalizable. However, comparison between the three sexual orientation groups is useful to direct further research and indicate that self-harm may be a risk factor for bisexual women.

Public health research is just now beginning to explore risk and protective factors in this area. The best way to find out what is driving depression, anxiety and suicidality among bisexual women is to ask them. CBPR is the way to build trust with the community and generate collective knowledge to inform prevention and treatment efforts.

## **5.0 WHAT ARE THE LIMITATIONS OF CURRENT RESEARCH?**

Bisexual women's mental health research has many methodological flaws. There is little data from representative, random samples, especially within the U.S. Researchers cannot use cross-sectional data to determine the causal relationship between mental health, sex category, sexual identity, and protective and risk factors. Longitudinal designs determine the relationship between these variables including their proximity and temporal asymmetry. They allow for the unique effect of participants to be tracked over time and compared to themselves. More qualitative methods are needed to delve deeper into why bisexual women are experiencing excessive depression, anxiety and suicidality. Social justice and explicit anti-racist approaches should be employed in future research. These include an intersectional approach and a community-based participatory approach. Oversampling of bisexual women of color, transgender bisexuals and transgender bisexuals of color will start to remedy the negligence of these marginalized communities. Interventions and evaluation are much needed for broadening the public health fields' understanding of bisexual women's mental health.

Research on bisexual women's mental health suffers from a lack of longitudinal studies, qualitative methods and interventions. Longitudinal studies are necessary to clarify the sequencing of life events related to development of depression, anxiety, distress and suicidality (Rothblum et al., 2001). Researchers often make speculations about bisexual women that are not

based on data but based on stereotypes and socially held misconceptions about bisexuals. For example, it has been speculated that bisexual women are less likely to be “out” than lesbians, may have an indulgent or erratic personality type that explains the connection between bisexuality and their substance use, or that bisexuals are younger because they have not yet resolved their sexuality (Jorm et al., 2002). It is important that literature not reinforce bisexual stereotypes through unsubstantiated speculation. Additionally only two qualitative studies (Ross et al., 2010; Eady et al., 2010) exist in the literature. Qualitative studies are needed to provide depth to the data and draw themes and meaning from bisexual women themselves, rather than have language shaped by researchers. Definitions of sexuality, sex category, and mental health are often not made clear or standardized which can make comparisons across the literature difficult. Prevalence of depression, anxiety, mood disorders, stress or suicidality among bisexual women is not well established, however existing studies do make clear that rates are high enough to warrant interventions, resources and further research. The common use of nonrandom samples makes findings harder to generalize, though convenience samples are conducted strategically, using comparison groups when possible.

Research on the mental health of sexual minorities has been hampered by methodological limitations, such as nonrandom samples that constrain the generalizability of findings. In addition, many studies contain small samples, which preclude analyses by age, race/ethnicity, and other characteristics that vary with mental health disorders. Lesbian, gay, and bisexual women and men are often combined for analytic reasons, such as the need to increase the overall sample size and corresponding statistical power. This obscured potential differences between lesbians or gays and bisexuals as well as between men and women—and can lead to biased results (Bostwick et al., 2010).

Questions about sexual orientation should always be included in national surveys to obtain reliable generalizable data about bisexual women and other marginalized groups. As there

is no sample frame for bisexual women, researchers can only analyze nation-wide probability sample survey data when sexual identity questions are included in the questionnaire. This method is effective at obtaining generalized findings; however, it means the questions are almost exclusively quantitative and not written with bisexual women in mind. This leaves researchers with limited questions on sexuality, mental health risk factors and resiliency. Comparison groups do not go beyond heterosexual and lesbian women with the exception of a few studies which compare bisexual women and men. Research is primarily in the exploratory stages and more explanatory research is needed to connect poor mental health to other factors such as low income, intersected forms of oppression, education, relationships and how geographic moves interact with mental health (Rothblum et al., 2001).

While better established in disciplines such as Sociology, Critical Race Studies and Feminist theory, an intersectional approach has not been widely used in public health research (Veenstra, 2011). “Intersectionality theory, an influential theoretical tradition inspired by the feminist and antiracist traditions, demands that inequalities by race, gender, and class (and sexuality as well) be considered in tandem rather than distinctly” (Veenstra, 2011). However, as a social science discipline that focuses on population health, public health must continue to integrate intersectionality into its teachings, research and practice. A similar public health model is The Ecological Model. The Ecological Model takes a contextual approach that brings environment and social context to the foreground of populations’, communities’ and individuals’ health (McLeroy, 1988). While useful, this model still views these components as additive instead of intersectional, where identities add to one another, unchanged, rather than complicate and transform each other.

Kertzner et al., (2009) found that an additive analysis of the findings was insufficient and that an intersectional approach was necessary. Their look into comparing the mental health of LGB individuals of different racial backgrounds yielded complex results. They found LGB African Americans to have better mental health than LGB whites, but LGB Latinos to have worse mental health than LGB whites. They hypothesize that this is due to different systems of oppression and resiliency affecting these communities. Given their results, they recommend that communities of color not all be grouped together, but looked at separately as race is not clear cut. This means research cannot assume that all communities of color have the same protective factors and systems of resilience. Therefore, a simple white/of color dichotomy is inadequate and so is an additive assumption that LGBTQ status plus being a person of color automatically means lower mental health.

Furthermore, an additive approach to research keeps dominant identities as the default identities, thereby reinforcing oppressive social hierarchies. In the case of bisexual women's mental health research, dominant categories such as white, cisgender (not transgender) women are kept as the default group. These unmarked categories retain uninvestigated power and privilege as an implicit standard (Choo et al., 2010). Therefore, the little we know about bisexual women's mental health is more accurately about white, cisgender bisexual women rather than bisexual women in general. This leads to more social resources which default to unmarked dominant groups and further marginalize oppressed groups. Rather than focusing on one identity at a time, or at different times, it is necessary to apply analysis of social structural and power dimensions at all times (Choo et al., 2010).

A lack of an intersectional approach leaves bisexual women's mental health research with very little data on bisexual women of color or transgender bisexuals, and no data on



transgender bisexuals of color. Bisexual women are often measured as a monolithic group, rather than a stratified community. There is no body of literature about bisexual women of color or transgender people of color's mental health and therefore, results cannot be generalized to these populations (Koh et al., 2000; Wilsnack et al., 2008; Bostwick et al., 2005; Hughes et al., 2006; Parks et al., 2004; Eady et al., 2010; Morris et al., 2010; Rust, 1993; Ross et al., 2010; Selvidge, 2008). It is well acknowledged that there are many gaps in the literature, but not many suggestions or attempts to change the path of the research. Future research should aim to oversample people of color to better understand the protective and risk factors of mental health in bisexual women and transgender people of color.

Black and Latino lesbian gay and bisexual youth have been shown to be at higher risk for suicide than for white LGB people even in the absence of the usual markers of depression and substance abuse, indicating that they may experience suicidality differently than white LGB people (O'Donnell et al., 2011). This supports the use of an intersectional approach.

African American and Latino LGB individuals face stressors related to alienation from their racial ethnic identity within the LGB community, stigmatization of minority sexual identity within racial/ethnic minority communities, and stressors related to sexual prejudice that affect all LGB persons (Kertzner et al., 2009).

It has been documented that internalized racism is associated with psychological stress, depressive symptoms, substance use and chronic physical health problems (Taylor et al., 1990, 1991; Williams et al., 1999). Internalized racism is the intake of, and belief in, socially held racist messages about oneself. Jones defines it as “acceptance by members of the stigmatized races of negative messages about their own abilities and intrinsic worth” (Jones, 2000). Mental health resources are underutilized by people of color because they are consistently not culturally

competent or racially sensitive (Kohn, 2002). Racism permeates mental healthcare as well, which is why a critical look at racism needs to be taken in all areas of health.

There is not enough data on transgender bisexuals (Ross et al., 2010). Bisexuals are often assumed to be gender conforming and to date straight cisgender people of the opposite sex. While these are nothing more than assumptions, they associate an image of “straightness” with bisexuality (Miller et al., 2007; Ka’ahumanu et al., 1996). Furthermore, it is falsely assumed that all gender nonconforming people are gay (Grant et al., 2011). Gender, sex category, and sexuality are separate constructs and do not determine one another, however, a widely held misconception is that all gay women are masculine and all gay men are feminine, so that if a woman is masculine and a man is feminine, they are gay—too gay to be attracted, or attractive, to people of the opposite sex, and too gay to date straight people. Therefore it is falsely assumed that individuals who fall under the transgender umbrella, including gender nonconforming people, cannot be bisexual. But given that gender, sex category, and sexuality are separate, any transgender person can be bisexual and any bisexual person can be transgender (Bockting et al., 2007). In a study on gay and bisexual identity development among female-to-male (FtM) transgender people, 32% of the sample identified as bisexual (Bockting et al., 2007). In fact, the FtM group was more bisexual than the cisgender control group. Transgender people experience massive amounts of discrimination in daily life and notably in healthcare settings (Lombardi, 2009; Grant et al., 2011), making them at particular risk for mental health problems (Lehavot et al., 2011; Rosario et al., 2009). Given the literature showing that discrimination is associated with past 12 month mood and substance use (McLaughlin et al., 2010), groups such as bisexual people of color and transgender bisexuals need to be recognized in the research. Ideally, they would not just be recognized, but would be driving the research agenda themselves.

Transwomen and transmen are important to include in this research because transwomen are women as cisgender women are women, and transmen are commonly erroneously classified as women when they have female genitalia or have not had any surgical or hormonal body alterations, or if they have unchanged “female” sex category markers on government-issued identification items. In some states such as Ohio, a transgender person cannot ever change the sex category marker on their birth certificate. This can lead to misclassification in a study that relies on these kinds of documents to measure or verify sex category. Instead of using birth sex or government-issued documentation in research, I recommend letting participants self-identify their sex category and gender expression to give better insight into how having a non-normative gender identity is associated with mental health.

We are therefore leaving out an important and vulnerable segment of the bisexual population by restricting sex categories to only “men” and “women”. Transphobia is the fear or hatred of transgender people and is a form of discrimination which is experienced on the institutional, structural and individual levels (Lombardi, 2009; Rosario et al., 2009; Hall et al., 2008). Regardless, treating sex category as dichotomous on a survey is an example of institutionalized transphobia and is an incomplete measurement of gender. Transgender people should be included in all questions about gender and sex category in national and local surveys and all public health data collection (Kertzner et al., 2009; Haas et al., 2011; Ross et al., 2010; Gordon et al., 2007). Most importantly, this would give us data could be used to justify resources tailored specifically for and by this community in an anti-racist CBPR approach.

There is tension between the scarcity of data and the need for support and work in this area. The case has been made that the data is lacking, but is it too insufficient that it is to decide that mental health is a problem for bisexual women on a population level? As a group that

experiences its own unique identity and discrimination, bisexual women need thoughtful studies and CBPR projects to develop the literature on this problem. Moving forward I recommend we are critical about our research practices and tailor our methods to the circumstances specific to this community. A thoughtful research agenda requires building a theoretical social justice framework.

## **6.0 MOVING FORWARD: COMMUNITY BASED PARTICIPATORY RESEARCH AND ANTI-RACISM**

Community Based Participatory Research (CBPR) can only be effectively carried out with an anti-racist framework. Institutionalized racism is rarely addressed in healthcare and public health literature, but is pervasive in United States culture, and persistent in healthcare, resulting in dramatic racial health disparities. Without a deliberate anti-racist approach, CBPR is at risk for repeating racial oppression, as researchers are often white and must examine their whiteness before and while working with communities of color. This is no simple matter, but must be undertaken.

To address institutionalized racism, that is, racism that is embedded in the institutions of medicine and public health, an anti-racist approach to research is necessary (Yonas et al., 2006). Institutionalized racism has real negative health outcomes and leads to widening health disparities between people of color and their white counterparts (Williams, 1999). While health disparities are well documented, institutionalized racism is not well understood. Griffith et al. (2007) defines institutionalized racism as:

a systematic set of patterns, procedures, practices, and policies that operate within institutions so as to consistently penalize, disadvantage, and exploit individuals who are members of non-White groups (Better, 2002; Rodriguez, 1987). Researchers in this area find that institutional racism includes organizational procedures such as hiring, promotion, and evaluation; affects

recruitment and promotion, institutional policies, and organizational climate; and may function at three distinct levels within institutions: attitudes and action of personnel, policies and practices, and structures and foundations (Griffith et al. 2007).

In her discussion of the levels of racism, Jones (2000) describes institutionalized racism as such:

It is structural, having been codified in our institutions of custom, practice, and law, so there need not be an identifiable perpetrator. Indeed, institutionalized racism is often evident as inaction in the face of need. Institutionalized racism manifests itself both in material conditions and in access to power. With regard to material conditions, examples include differential access to quality education, sound housing, gainful employment, appropriate medical facilities, and a clean environment. With regard to access to power, examples include differential access to information (including one's own history), resources (including wealth and organizational infrastructure), and voice (including voting rights, representation in government, and control of the media). It is important to note that the association between socioeconomic status and race in the United States has its origins in discrete historical events but persists because of contemporary structural factors that perpetuate those historical injustices (Jones, 2000).

The Institute of Medicine report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare* sheds light on the disturbing amount of institutionalized racism in healthcare. This report found that substantial racial health disparities exist between white people and people of color due to *quality* of care, regardless of *access* to care (Smedley et al., 2003). African Americans, Hispanic/Latinos, and Native Americans receive lower quality of healthcare and are less likely to get routine medical procedures than whites (Geiger, 2006). These findings are particularly alarming, because they show that even white people and people of color who have the same access to care will get consistently and significantly different levels of care. The level of care delivered to people of color by health professionals is consistently lower than that delivered to white clients, evidence of institutionalized racism.

Operating at the individual level, the intraorganizational level, and the extraorganizational level, institutionalized racism exists in U.S. healthcare organizations and public health departments as it does in the larger sociopolitical U.S. context. It exists in staff attitudes and actions, organizational power dynamics and policies, and through interaction with national, global and cultural structures (Griffith et al., 2007). Additionally, medical professionals stereotype their patients and affect their patients adversely in the following four ways:

- (a) Limiting the treatment options offered to patients of color
- (b) Reinforcing negative attitudes toward patients of color
- (c) Communicating lowered expectations
- (d) Decreasing patients of color's expectations for the future

(van Ryan et al., 2003)

The reality of racism in healthcare and U.S. culture means that a deliberate anti-racism approach is necessary in all CBPR projects. To not implement anti-racist education and teachings and practice them in all research projects is not staying neutral but is in fact perpetuating institutionalized racism (Jones, 2000; Griffith et al., 2007). As Jones (2000) writes, acts of omission maintain racism. A term for an organization's false sense of neutrality towards external and cultural forces of racial oppression is *Administrative Evil*. *Administrative Evil* is the recognition that individuals can act in ways they perceive as neutral, but in fact hurt others (Griffith et al., 2007).

Anti-racist CBPR “requires building trusting relationships that are grounded in a common analysis of power and collective action for social change”. It must acknowledge and mitigate the

power dynamic of researchers as “experts” and community members as passive, ignorant or incapable. Instead the dynamic is deliberately partnered, where co-learning takes place (Yonas et al. 2006). A collaboration between The Partnership Project, the University of North Carolina (UNC) Program on Ethnicity, Culture and Health Outcomes, and The People’s Institute for Survival and Beyond, this CBPR project laid an anti-racist foundation with an 18-month Undoing Racism process (People’s Institute for Survival and Beyond, 2006). This program integrates an understanding of institutional racism into community organizing principles. Four months were dedicated to identifying research partners and six months were committed to the Undoing Racism educational training. This training’s purpose was for participants to build a firm understanding of what institutionalized racism is and how it plays out in healthcare, white organizational culture, and internalized racism (Yonas et al., 2006). This kind of in-depth look into whiteness, structural racism and between-race power dynamics is fundamental to overturning race-related health disparities in the U.S.

CBPR is essential to bisexual women’s mental health research because community formation is important to improving mental health for this group. Lack of social support contributes to poor mental health among bisexual women. CBPR strives to respect communities of people with a shared identity and “to strengthen a sense of community through collective engagement” (Israel et al. 2003). However, community development is not simple for bisexual women. Bisexual women do not represent a geographic location, though a research project might focus solely on one city or location and work with bisexual women within that location. Additionally bisexual women are part of many overlapping communities including but not limited to, the larger LGBT community or queer women and dyke communities, religious, racial or ethnic communities, educational communities such as Universities, family, artistic or



professional communities, or the community they physically live in. Because bisexual women's high rates of mental health problems have been shown to be associated with lack of social support and community connectedness (Kertzner et al., 2009), a community-based approach to research is necessary to avoid contributing to the denial of this group as a community, and to build upon existing established community networks.

## RECOMMENDATIONS

With regards to future research, I recommend that bisexual women be recognized as a category separate from lesbians and be defined through participant self-identification. Additionally, a more nuanced analysis of gender and sex categories is needed in research and public health literature. For studies that focus specifically on bisexual women, “women” as a sex category must be more broadly discussed to include transwomen, transmen and masculine and feminine gender expressions for bisexual women. This will be necessary to capture the effect of sex category and gender experiences on mental health as well as respecting participants’ changing and varied identities.

It is necessary to portray the community as nonmonolithic and diverse by using an intersectional approach, especially with regards to race/ethnicity. Moving beyond the unmarked, white, cisgender, privileged slice of the bisexual women’s community is essential to combating racism in research. It is also necessary for identifying the different and similar ways that bisexual women of color and transgender bisexuals of color experience mental health and risk and protective factors. Research and programming need to be social justice minded and anti-racist at its core.

Research on bisexual women’s mental health should be driven by the community because the community knows its own issues best. Communities need to have a voice in all phases of

research including design, implementation, analysis and dissemination of information. A CBPR approach is essential because it mitigates power dynamics between researchers and community members, builds community, and allows for constant feedback and redefinition within the group. This can empower participants to shape public health literature, research, and programming in their own community.

In this case, CBPR should include a mental health program designed, developed and led by the bisexual women's community. A program is necessary due to the sensitive nature of mental health issues. Community expertise and program evaluation can come together to develop a much needed mental health program as it collects useful data and takes care of women who have immediate mental health needs. Researchers have a responsibility to have supports in place when working with communities who experience discrimination and are possibly depressed, anxious or even suicidal. Interventions in this area are urgent given rates of depression, anxiety and suicidality among bisexual women, in addition to eating disorders, STIs, self-harm, physical health, poverty and further unidentified issues.

As a bisexual woman who continues to deal with depression and anxiety, I am personally close to this issue. As a white cisgender woman, it is vital to me that the research agenda for my community not reproduce racist and transphobic systems of oppression, but rather be active in dismantling them through the approaches I have discussed in this document. I want community-driven research to inform community-driven programs which prevent and treat mental health problems for bisexual people and are deliberately and conscientiously inclusive of our many intersecting identities. I want to engage in research that challenges those involved to grow and learn in the privileged identities we hold, in addition to empowering our marginalized ones.

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