Who I Am

A Study of Bisexuality and Mental Health

Submitted by

Julia Taylor

Bachelor of Nursing, Master of Health Science (Sexual Health)

This thesis is submitted in total fulfilment of

the requirements for the degree of

Doctor of Philosophy

Australian Research Centre in Sex, Health and Society

School of Psychology and Public Health

College of Science, Health and Engineering

La Trobe University

Victoria, Australia

December, 2018

Table of Contents

Table of Contents ..... **i**

Abstract ..... **iii**

Statement of Authorship ..... **iv**

Acknowledgements ..... **v**

Chapter 1: Introduction **1**

Who I Am 2

Personal Motivation 3

Conceptual Underpinnings and Assumptions 6

Thesis Overview 9

Relevance to the Field 11

References 13

Chapter 2: Background **16**

Introduction to Paper 1 16

Out of the Darkness and Into the Shadows: The Evolution of Contemporary Bisexuality 17

Chapter 3: Literature Review **35**

Introduction to Paper 2 35

Bisexual Mental Health: A Call to Action 36

Chapter 4: Methodology **68**

Introduction to Paper 3 68

Who I Am: Reflections on a Successful Bisexual Research Methodology 69

Chapter 5: Cisgender Mental Health **108**

Introduction to Paper 4 108

Bisexual Mental Health: Findings from the *Who I Am* Study 109

Chapter 6: Transgender and Gender Diverse Mental Health **125**

Introduction to Paper 5 125

The Mental Health of Transgender and Gender Diverse Bisexuals: Findings from the *Who I Am* Study 126

Chapter 7: The Three Dimensions of Bisexuality **160**

Introduction to Paper 6 160

Experiences of Bisexual Identity, Attraction and Behaviour and their relationship with Mental Health: Findings from the *Who I Am* Study 161

Chapter 8: Service Access **188**

Introduction to Paper 7 188

Bisexuals' Experiences of Mental Health Services: Findings from the *Who I Am* Study 189
Chapter 9: Conclusions 216
Major Findings 217
Limitations of the Research 223
Implications and Future Research 224
Bi+ Australia 226
Concluding Remarks 227
References 227
Supplementary Material 231
Media Article 1 231
Media Article 2 234
Media Article 3 238

Abstract

Bisexual people have consistently been found to experience poorer mental health than their lesbian, gay and heterosexual counterparts; however the reasons behind this remain under-researched and largely unknown. The *Who I Am* study was developed in direct response to this phenomenon. The study recruited 2,651 bisexual participants, an unprecedented number in bisexually focussed research. Respondents were included in the study if they reported bisexual identity and/or attraction and /or behaviour. The *Who I Am* study was a cross-sectional online survey of Australian adults. Data were analysed using a range of statistical techniques including univariate analyses (frequency counts & calculations of distribution), bivariate analyses (chi square tests & correlations) and multivariate analyses (regression modelling). This thesis presents a series of papers that provide details of the study from its inception to its completion with the addition of a beginning introductory chapter and a final concluding chapter.

Major findings suggest that internalised biphobia is predictive of poor mental health in bisexual people regardless of their gender. For cisgender (gender congruent with biological sex) respondents, poor mental health was associated with being in a heterosexual relationship and having an unsupportive partner, while for transgender and gender diverse participants not participating in LGBTI (lesbian, gay, bisexual, transgender and intersex) community events predicted poorer mental health. Respondents with a bisexual identity were more likely to experience psychological distress than those who experienced bisexual attraction and/or behaviour without identity. Although participants reported high levels of engagement with mental health services, there were barriers to disclosing their bisexuality to health professionals. The majority of participants wanted increased access to services specialised in working with bisexual people. These findings will work to better inform mental health service provision, policy development and future research.

Statement of Authorship

Except where reference is made in the text of the thesis, this thesis contains no material published elsewhere or extracted in whole or in part from a thesis submitted for the award of any other degree or diploma.

No other person's work has been used without due acknowledgment in the main text of the thesis.

This thesis has not been submitted for the award of any degree or diploma in any other tertiary institution.

All research procedures reported in this thesis were approved by the La Trobe University Human Ethics Committee.

Signed:

Date: 31st December, 2018

Acknowledgements

First, I would like to acknowledge the commitment of the two people who have provided wisdom, guidance and expertise to every particular of the *Who I Am* study from its beginning to its end, my supervisors, Jennifer Power and Elizabeth Smith. I am sincerely grateful for your genuine interest and enthusiasm for the project, your expert academic input and your commitment to supporting me to bring my vision to fruition. You have allowed me the freedom to develop this research in the way that I felt was needed and have enabled me to be myself throughout the process. You have inspired me, pushed me beyond my intellectual boundaries and provided the expertise required to ensure this project is the best it could have been. I would also like to extend my sincere gratitude to the other members of my Research Progress Panel, Anthony Lyons, Steven Angelides and Christopher Fisher. Your insights and expertise have been invaluable in the development, implementation and write up of this study.

I am very grateful to La Trobe University for supporting me to conduct this research with a post-graduate scholarship without which my time to spend on this study would have been substantially less. To the La Trobe University Human Ethics Committee and, in particular, Sara Paradowski, thank you for always being available to provide advice to ensure a high ethical standard was maintained throughout this study. In addition, I am grateful to both La Trobe University's Marketing and Recruitment team and the La Trobe University Media Unit for providing assistance in recruiting participants for this research – without your support, the real success story of this study (the sheer size of the sample) which has been the driver for it becoming a valuable contribution to the field, would not have been achieved.

To the organisations who work tirelessly to support the bisexual community, thank you for your ongoing support and for maintaining your excitement for the *Who I Am* study throughout this rather long process. The Victorian Bisexual Alliance,

beyondblue, Working It Out, Kentish Regional Clinic, Melbourne Bisexual Network, North West Tasmania's LGBTI Suicide Prevention Network and ACON your support and eagerness to see this research completed has inspired and motivated me. In addition, I would like to thank the numerous academics and service providers who have contacted me during the project to offer their support and inform me of their interest. I would especially like to acknowledge the ongoing support and wisdom of LGBTI leader/guru/activist/educator Sharon Jones who has been, and continues to be, my inspiration, my mentor and my friend.

To my family, to quote Brian Molko, 'without you I'm nothing'. To my husband, you have held my hand through every step of this journey. Your belief in me, your commitment to my happiness and your love for me just the way I am means that I can pursue my dreams, be myself and reach my potential. Without you the *Who I Am* study would not exist, thank you so much for your unwavering support. To my son, thank you for being my constant inspiration, for teaching me how to be my best self, for never taking without giving and for your super-brain that got me out of trouble more than once when statistics proved out of my reach. To my daughter, your little gifts of love that litter my desk have kept me going when the days have been long. You love me without conditions, you support me without reasons and you genuinely want me to pursue whatever it is that makes me happy (including this PhD) – thank you.

I am very grateful to my father who has shown a keen interest in this research from the outset. Thank you Dad for your eagerness to support me throughout my doctoral journey by reading every letter of this thesis more times than anyone, by providing valuable feedback that has meant that the standard of my work is higher, by sharing your clinical expertise and insights and by always being willing to be a sounding board for my ideas which has helped to shape this research into something I am proud of. You never make me feel like anything is out of my reach and for that I am truly grateful. To my

Mum, the best advice I've ever been given was to 'do what you find interesting because it will lead you somewhere you want to be'. Thank you for always knowing what to say to me to make me brave enough to jump headfirst into the things I want to do. (Also, thank you for giving me a desk, office chair and computer set up for a present – it has made the final leg of my doctoral journey so much easier!)

Finally, but most importantly, to the fantastic inspiring bisexual people who took the time to participate in this study – thank you! So many of you wrote to me to thank me for doing this research and your voices, both in the form of gracious emails and on the pages of the survey, have spurred me on and reminded me why this research is needed. Without your willingness to share, the state of bisexual mental health may never change. Through your collective voices I have found a connection with a group of people who have suffered, who have had to fight to be who they are, but who ultimately have triumphed by persisting in the face of opposition and who are acutely aware of the need for change. This research is dedicated to you and I hope that it can be at least a small step along the road towards a better future for you all.

Chapter 1

Introduction

"Bisexuality and pansexuality should not be such difficult concepts to wrap your brain around."

– *Who I Am* participant

In 2016, one of the most iconic female characters of all time, Wonder Woman, was officially declared bisexual by her creators, DC Comics (Pesce, 2016). Finally bisexuality had a face; a woman "as lovely as Aphrodite – as wise as Athena – with the speed of Mercury and the strength of Hercules" (DC Comics, 2016, p.10). Here was a confirmed 'bisexual' who was mentally sound, confident, the epitome of strength and resilience and in no way confused; and the world embraced it (McMillan, 2016; Pesce, 2016; Shepherd, 2017). The only downside of this good news story: Wonder Woman isn't real.

This particular depiction of a bisexual person and the acceptance of them within mainstream culture paints a very different picture to that of the current state of bisexuality presented in academic research, scholarly literature and through the stories of bisexual people themselves. While healthy and happy bisexual people certainly exist, the literature would suggest that they are in the minority. What we know is that, unlike Wonder Woman, bisexual people are likely to experience high levels of psychological distress, mental disorders, self-harm and suicidality (Bostwick et al., 2007; Brennan, Ross,

Dobinson, Veldhuizen, & Steele, 2010; Conron, Mimiaga, & Landers, 2010; Hughes, Szalacha, & McNair, 2010; Jorm, Korten, Rodgers, Jacomb, & Christensen, 2002; Koh & Ross, 2006; Leonard, Lyons, & Bariola, 2015; McNair, Kavanagh, Agius, & Tong, 2005; Persson, Pfaus, & Ryder, 2015; Steele, Ross, Dobinson, Veldhuizen, & Tinmouth, 2009). Indeed, despite wide variation in study designs, sample sizes, geographic locations and recruitment techniques, one clear consensus exists in the literature; bisexual people experience poorer mental health than lesbians, gay men and heterosexuals (Bostwick, Boyd, Hughes, & McCabe, 2010; Bostwick et al., 2007; Conron et al., 2010; Eisner, 2013; Hughes et al., 2010; Jorm et al., 2002; Koh & Ross, 2006; Leonard et al., 2012; Li, Dobinson, Scheim, & Ross, 2013; Persson et al., 2015; Pompili et al., 2014; Steele et al., 2009). So, why is this the case? Despite well-established evidence of a high prevalence of poor mental health in the bisexual population, the reasons behind it remain under-researched and largely unknown. It is this that provides the premise of the research project that was undertaken for this thesis – the *Who I Am* study.

Who I Am

The *Who I Am* study aims to answer the question: why do bisexual people experience poor mental health? This research seeks to work towards the improvement of bisexual mental health by generating new knowledge that sheds light on the factors associated with poor mental health in this population. It is intended that this knowledge will be shared broadly to inform better service provision, policy development and future research. This study was conducted in Australia and utilised a cross-sectional survey design and recruited an unprecedented 2,651 participants making it the largest study of Australian bisexuals to date and one of the largest conducted in the world.

Defining ‘bisexuality’ for the purposes of recruitment for this study involved extensive consideration. There is significant scholarly debate relating to the definition of

the term ‘bisexual’ and this will be examined closely in Chapters 2 and 3. For research purposes, definitions of this diverse and complex sexual orientation must be determined by each study’s aims and as such this study’s definition was drawn from the current literature relating to the mental health of this population. Higher incidences of poor mental health have been found among people who identify as bisexual, as well as those who are attracted to more than one gender regardless of their identity and those who have had intimate experiences with more than one gender (Bostwick et al., 2010). For this reason an adaptation of Yoshino’s (2000) inclusive three axes approach to defining bisexuality has been employed in this study to include people who report bisexual attraction and/or identity and/or sexual experience and this has been broadened to include people who define themselves under any of these three categories regardless of if their bisexual desire could be classified as occasional or incidental. The nuances relating to these three dimensions and their relationship to mental health, has been examined in detail in this thesis and is presented in Chapter 7.

The survey instrument included questions relating to basic demographics, common bisexual life experiences (gleaned from the literature and consultation with bisexual people and relevant organisations), mental health and service access. Data were analysed using a range of univariate, bivariate and multivariate techniques to examine the life experiences of the sample and to explore associations between mental health and experiences of bisexuality. This study was a significant undertaking and would not have progressed as smoothly as it did without years of planning and a high level of personal commitment.

Personal Motivation

I have found through my journey as a human that outside of the universal laws of nature, nothing happens without someone wanting it to happen and setting about making

it happen. It was this understanding alongside three distinct experiences in my life that led me to undertaking the *Who I Am* study. This journey started the better part of a decade ago (or possibly longer).

In 2010 I commenced study of a Master of Health Science degree at the University of Sydney, specialising in sexual health. It took only a couple of weeks of studying for me to realise that this was an area I was more passionate about than any other I had been exposed to and I knew very quickly that this would be my future direction. The most intriguing new piece of information I came across in the early stages of this degree was that people of sexual and gender minority groups experience poorer mental health. I had not been exposed to this phenomenon before, though it was no great surprise to me as I was aware of the stigmatisation and discrimination faced by this population in our society. What was surprising was that when I delved deeper into this research I found that bisexual people experienced poorer mental health than gay, lesbian and heterosexual people. I struggled to understand this. My limited grasp of bisexuality at that time was based loosely on the trickling down of concepts such as the Kinsey Scale (Kinsey, Pomeroy, & Martin, 1948) into mainstream culture which depicted bisexuals as existing somewhere between homosexuality and heterosexuality. I had assumed, based on this, that bisexual people would fall somewhere between these two groups for mental health outcomes as well. At that point I wanted to understand why this was not the case and began searching the literature for answers. I was unable to find any comprehensive studies answering this question as at that time they simply did not exist. I concluded that this research badly needed doing and maybe I should be the one to do it. However, at the same time as I was considering this I was offered a job in youth health that was too good an opportunity to turn down and so I left this research idea, assuming others would be noticing this glaring gap and wanting to address it also, and headed into my next endeavour.

In my job as a nurse specialist in youth health, I spent my years travelling around high schools delivering sexual education and, more often, engaging one on one with young people providing sexual health and mental health counselling. I was privileged to work with some young lesbian, gay and bisexual people. As time wore on, I started noticing trends in my conversations with them. Young lesbian and gay students would tell me about their experiences and the struggles they were facing - they all had similar stories and were easily able to articulate their concerns. They presented either formally for counselling or at lunch times for informal chats and were most often seeking support around coming out to their families and broader school communities or trying to cope with the fallout from their recent coming out. These young people were generally happy to be referred to LGBTI (lesbian, gay, bisexual, transgender and intersex) specialist services. When I searched through the literature and online resources I was able to find ample information to inform my practice with them. In contrast, when I worked with young bisexual people, their stories were vastly different from one another, they had difficulty explaining to me why they were struggling - except to say they knew it was something to do with their sexuality and they refused referral to specialist LGBTI services which they saw as only for gay, lesbian and gender diverse people. When I sought out literary insights to assist me to support them to my surprise, though years had elapsed since my Masters degree, there was still very little available for me to base my practice on. Again, I was faced with wanting to, in fact this time *needing* to, know more about this topic that remained relatively unexamined.

Throughout these years of study and work, my own experiences of questioning my sexuality and having non-monosexual attraction further fuelled my desire to understand bisexuality and, in particular, to understand why bisexual people seemed to be struggling in substantial numbers. I personally was struggling with bisexuality in a way that I was unable to articulate or understand, my youth health clients were struggling with

bisexuality and were equally unable to articulate it or understand why and the literature was struggling to present an understanding of why bisexual people were suffering. At this point in my life it became undeniable – this research needed to be done, and I needed to do it.

Conceptual Underpinnings and Assumptions

The *Who I Am* study was developed within a context of overlapping theories and concepts that created a multi-faceted and multi-disciplinary lens through which the study was conceptualised. This lens provided a foundation upon which assumptions were developed that guided the creation of the research plan, the development and delivery of the survey, the analysis of the data and the interpretation and reporting of results. Due to the overlapping between theories in social and health science research, drawing upon multiple theories to develop and interpret research in these fields is a common practice (Ngulube, 2015; Portney, 2009).

There were a number of social theories that were useful for exploring the relationship between bisexuality and deleterious mental health for this research. The theory of social determinants of health posits that belonging to specific social groups can determine health and well-being and that this is related to the social environment in which people live rather than innate individual attributes (Braveman & Gottlieb 2014).. It has been argued (Horner & Roberts 2014) that sexual orientation *is* a social determinant of health in and of itself with clear differences in health outcomes, and particularly mental health outcomes, between different sexual orientation groups. This notion that the health and wellbeing of individuals is shaped by social groupings and social contexts was a key assumption that guided the *Who I Am* study. Driven by this assumption, the current study examined mental health by exploring relationships between participants' mental wellbeing and common bisexual life experiences that emerge from existing as a 'bisexual'

within a broader Australian social context. This allowed for an exploration of mental health in relation to community connectedness, being 'out' about sexual orientation, relationships, experiences of stigma and discrimination and experiences of feeling invisible within immediate social contexts and society more broadly.

In order to delve deeper into the understanding of the stigmatisation of bisexual people and their common life experiences that have been linked to poor mental health (W. Bostwick, 2012; W. B. Bostwick, Boyd, Hughes, West, & McCabe, 2014; Dobinson et al., 2005; Dodge et al., 2012; Leonard et al., 2015; Molina et al., 2015; Paul, Smith, Mohr, & Ross, 2014; Ross, Dobinson, & Eady, 2010), the theory of heteronormativity that pertains to society more broadly has been useful in framing this research. Heteronormativity is a theory presented by American social theorist Michael Warner (1991) and is based on an extension of the concept of 'compulsory heterosexuality' earlier postulated by acclaimed writer Adrienne Rich (2003) to explain society's pervasive stance that heterosexuality is the only acceptable orientation with all those not fitting into it as being pushed into the margins. This theory provides a valuable perspective for the understanding of the social derivation of stress for gay, lesbian and bisexual people but it fails to make distinctions between these groups.

It is now well established that mental health is significantly poorer in the bisexual community than it is among gay and lesbian populations (Bostwick, Boyd, Hughes, & McCabe, 2010; Bostwick et al., 2007; Conron et al., 2010; Eisner, 2013; Hughes et al., 2010; Jorm et al., 2002; Koh & Ross, 2006; Leonard et al., 2012; Li, Dobinson, Scheim, & Ross, 2013; Persson et al., 2015; Pompili et al., 2014; Steele et al., 2009). Extending beyond the concept of heteronormativity to 'compulsory monosexuality' has been useful in making sense of the mental health disparities that exist specifically for bisexual people as opposed to all sexual minority groups. Compulsory monosexuality posits heterosexuality and homosexuality as the only acceptable sexual orientation groups or,

perhaps more accurately, the only narrative most people have access to, thus further illustrating the marginalisation of bisexual people (Germon, 2008). Applying this theory to the development of the current study allowed for a more nuanced lens through which bisexuality and the challenges bisexual people face could be examined.

Compulsory monosexuality does not only provide a lens through which to view stigma at a societal level, it also has an impact on the fundamental ways in which people think about their sexuality. In line with this, Macalister's (2011) application of Piaget's cognitive schema theory to explain various challenges faced by bisexual people both resulting from the way they view themselves and the way they are viewed by others has provided an additional valuable framework for the *Who I Am* study. Macalister (2011) posits that humans' innate drive to categorise the world in an effort to better cognitively manage the significant variety of external stimuli to which they are exposed, results in a subconscious motivation to slot bisexuality into existing mental schemas of more commonly understood and accepted sexual orientations such as homosexual and heterosexual, thereby rendering the bisexual as invisible and erased. While, in this study, I did not aim to examine the psychological processes by which humans seek to find categories in the social world, it was useful to understand that the social world does tend to operate according to categories, often in binary distinctions between gender (woman/man) and sexuality (homosexual/heterosexual). Such categorisation may be psychological or social in its origin, or a combination of both. Either way, this concept reminds us that bisexual people do not fit neatly into the categories by which people come to make sense of gender and sexuality and that this is the basis from which bisexual people navigate their world.

Viewing the challenges faced by bisexuals through a multifaceted lens both in the social and individual spheres has influenced the way the *Who I Am* study was constructed and interpreted and allows the study to fit within a real world *and* academic context.

Thesis Overview

This thesis consists of nine chapters: this introductory chapter, background and literature review chapters, a chapter detailing the methodological approach of the study, four chapters dedicated to the findings of the study and a final chapter which draws together overall conclusions. Chapters 2 to 8 are completed papers prepared for academic journals. When this thesis was submitted, these were at varying stages of publication (submitted, under review, in press or published). The decision to present the thesis as a series of papers relates directly to the research aim to improve bisexual mental health by generating new knowledge and sharing it broadly; a range of papers published in varying academic journals was determined to be the most effective way to disseminate this information in the academic space. As each paper is an entity in and of itself, references are presented at the end of each. For ease of navigation and consistency, reference lists for sections not presented as papers (chapters 1 and 9) will appear at the end of the chapter and not at the end of the entire dissertation.

Immediately following this introductory chapter, Chapter 2 presents the paper *'Out of the Darkness and into the Shadows: The Evolution of Contemporary Bisexuality'* as published in the Canadian Journal of Human Sexuality. This paper chronicles the development of the concept of bisexuality over the past 150 years and provides essential background to the topic without which many of the concepts discussed throughout the thesis would lack context. It demonstrates the persistent invisibility and erasure of bisexuality and bisexual people throughout history both in academic and social contexts, a phenomenon that many argue still exists today (Angelides, 2001; Eisner, 2013). In Chapter 3 the literature review is presented as the paper *'Bisexual Mental Health: A Call to Action'* as published in Issues in Mental Health Nursing. This paper draws on the current literature and calls sexuality researchers to 'action' to examine the reasons behind the poor mental health of bisexual people in an effort to improve the future for bisexual

people. The current statistics relating to the mental health of this population are presented as well as a definition of bisexuality and an exploration of key themes identified from the literature that may be associated with mental health: invisibility and erasure; stereotypes and biphobia; identity and labels; intimate relationships and sexual behaviour; coming out and community and belonging. Chapter 4 presents a paper that details the methodological approach used in the *Who I Am* study and consists of a reflection on methodological successes and challenges experienced throughout the research process. In this paper, insights gleaned during the study are shared in order to better inform future research in this area. This paper is currently under review with the Journal of Sex Research.

Four chapters of this thesis (Chapters 5-8) comprise papers reporting the study's findings and are co-authored by my supervisors, Dr Jennifer Power and Dr Elizabeth Smith. In Chapter 5, the first data based paper details the mental health findings of the cisgender cohort of the sample. An additional co-author, Dr Mark Rathbone, was invited to join the authorship team to assist in ensuring the findings had clinical relevance to a General Practice audience. This paper (Paper 3) is titled *'Bisexual Mental Health: Findings from the Who I Am Study'* and has been accepted for publication in the Australian Journal of General Practice where it is currently in press. The major findings of this paper were that internalised biphobia, being in a heterosexual relationship, and not having a supportive partner were predictive of higher psychological distress in this bisexual cohort. Chapter 6 presents findings relating to transgender and gender diverse participants and reports that, for this sub-group, internalised biphobia and a lack of engagement in LGBTI community events were significant predictors of higher psychological distress. This paper is currently under review with the Journal of Bisexuality. The thesis then moves to exploring the mental health differences of those experiencing different dimensions of bisexuality (identity, attraction and behaviour) as discussed above, with Chapter 7 illustrating that bisexual identity is more strongly

associated with poor mental health than are experiences of bisexual attraction and/or bisexual behaviour without their coexisting with a bisexual identity. This paper is currently under review with Archives of Sexual Behaviour. Finally, Chapter 8 presents how mental health services are experienced by participants, finding that the majority of respondents would like more access to specialised bisexual services and that there are significant associations between gender and service access, and mental health and service access. This paper is currently under review with the International Journal of Mental Health.

The thesis concludes with Chapter 9. This chapter draws together the final conclusions of the *Who I Am* study by presenting a brief overview of the project and revisiting the research aims and guiding question, reiterating the major findings, discussing the study's limitations, presenting the overall implications for service provision, policy development and future research and finally drawing the thesis to a close with some brief concluding remarks.

Relevance to the Field

The research detailed in this thesis presents a significant contribution to the field of sexuality studies, and bisexual studies in particular. In the first instance, the sheer size of the study's sample is important and novel considering the characteristically dispersed and hidden nature of the target group. In addition, although the focus of this thesis is the mental health of participants, this survey examined a number of other areas that will be of interest across disciplines including demographic trends, drug and alcohol use, relationships, common bisexual life experiences and the positive and negative aspects of being bisexual in 21st Century Australia. The findings presented in this thesis are based on the data most relevant to the research aims of this study. Due to the large amounts of data

as yet unanalysed, there will be numerous opportunities for further analysis and publication post-doctorally.

The significant interest, enthusiasm and gratitude from bisexual people, service providers, scholars and the media during this study has been unexpected and encouraging and has provided further evidence of the need for this research. Since preliminary findings were released I have had numerous invitations to speak at meetings and events including the national Better Together Conference 2019, the Rainbow Network's LGBTIQ+ Youth Mental Health Forum, Tasmania's LGBTI Suicide Prevention Annual Collaborative Meeting, Melbourne Bisexual Network's Annual General Meeting and a meeting of the Chief Executive Officers of the Australian Federation of AIDS Councils from across Australia. In addition, numerous media organisations have published articles on the study's preliminary findings and translational outcomes (see Supplementary Material at the end of the thesis for a sample of these) and I have been invited for radio interviews including on Joy FM and RTRFM. In addition, the findings of this study and the knowledge I have gleaned throughout the process of conducting it have translated directly into the development of a new national organisation Bi+ Australia. This organisation has recently launched and aims to improve the mental health of bisexual Australians through support, education and research (www.biplusaustralia.org).

The findings of this study will provide a substantial contribution to the currently limited literature on the reasons behind poor mental health in bisexual people and will work to inform service provision, policy development and future research with the ultimate aim of improving the mental health of bisexual people. Every step toward generating a greater understanding of bisexuality and improving support and acceptance for bisexual people within society, is a positive step toward happy healthy bisexuals not being confined to fictional characters such as Wonder Woman but instead being a common example of a group of people who are understood, valued and celebrated.

References

Angelides, S. (2001). *A history of bisexuality*. Chicaco, IL: The University of Chicago Press.

Bostwick, W. (2012). Assessing bisexual stigma and mental health status: A brief report. *Journal of bisexuality, 12*(2), 214-222. doi: 10.1080/15299716.2012.674860

Bostwick, W. B., Boyd, C. J., Hughes, T. L., & McCabe, S. E. (2010). Dimensions of sexual orientation and the prevalence of mood and anxiety disorders in the United States. *American journal of public health, 100*(3), 468. doi: 10.2105/AJPH.2008.152942

Bostwick, W. B., Boyd, C. J., Hughes, T. L., West, B. T., & McCabe, S. E. (2014). Discrimination and mental health among lesbian, gay, and bisexual adults in the United States. *American Journal of Orthopsychiatry, 84*(1), 35.

Bostwick, W. B., McCabe, S. E., Horn, S., Hughes, T., Johnson, T., & Valles, J. R. (2007). Drinking patterns, problems, and motivations among collegiate bisexual women. *Journal of American College Health, 56*(3), 285-292. doi: 10.3200/JACH.56.3.285-292

Braveman, P. & Gottlieb, L.. (2014). The social determinants of health: It's time to consider the causes of the causes. *Public Health Reports, 129*(1), 19-31.

Brennan, D. J., Ross, L. E., Dobinson, C., Veldhuizen, S., & Steele, L. S. (2010). Men's sexual orientation and health in Canada. *Canadian Journal of Public Health / Revue Canadienne de Sante'e Publique, 101*(3), 255-258.

Comics, D. (2016) Wonder Woman: A Celebration of 75 Years. Burbank: DC Comics.

Conron, K. J., Mimiaga, M. J., & Landers, S. J. (2010). A population-based study of sexual orientation identity and gender differences in adult health. *The American Journal of Public Health, 100*(10), 1953-1960.

Dearholt, S. L. D., D. (2012). *Johns Hopkins Nursing Evidence-Based Practice: Model and Guidelines* (2nd ed.). Indeanapolis: Sigma Theta Tau International.

Dobinson, C., Macdonnell, J., Hampson, E., Clipsham, J., & Chow, K. (2005). Improving the access and quality of public health services for bisexuals. *Journal of bisexuality, 5*(1), 39-77. doi: 10.1300/J159v05n01_05

Dodge, B., Schnarrs, P., Reece, M., Martinez, O., Goncalves, G., Malebranche, D., . . . Fortenberry, J. D. (2012). Individual and social factors related to mental health concerns among bisexual men in the midwestern United States. *Journal of bisexuality, 12*(2), 223-245. doi: 10.1080/15299716.2012.674862

Eisner, S. (2013). *Bi: Notes for a bisexual revolution*. California: Seal Press.

Germon, J. E. (2008). Kinsey and the politics of bisexual authenticity. *Journal of bisexuality, 8*(3-4), 243-258.

Horner, J. & Roberts, N. J. (2014). Time to recognise sexual orientation as a social determinant of health. *Medical Journal of Australia, 200*(3), 137.

Hughes, T., Szalacha, L. A., & McNair, R. (2010). Substance abuse and mental health disparities: Comparisons across sexual identity groups in a national sample of

young Australian women. *Social Science & Medicine, 71*(4), 824-831. doi: 10.1016/j.socscimed.2010.05.009

Jorm, A. F., Korten, A. E., Rodgers, B., Jacomb, P. A., & Christensen, H. (2002). Sexual orientation and mental health: results from a community survey of young and middle-aged adults. *The British journal of psychiatry : the journal of mental science, 180*, 423.

Kessler, R. C., Andrews, G., Colpe, L. J., Hiripi, E., Mroczek, D. K., Normand, S. L. T., . . . Zaslavsky, A. M. (2002). Short screening scales to monitor population prevalences and trends in non-specific psychological distress. *Psychol. Med., 32*(6), 959-976. doi: 10.1017/S0033291702006074

Kinsey, A. C., Pomeroy, W. B., & Martin, C. E. (1948). *Sexual behavior in the human male*. USA: W. B. Saunders Company.

Koh, A. S., & Ross, L. K. (2006). Mental health issues: a comparison of lesbian, bisexual and heterosexual women. *Journal of Homosexuality, 51*(1), 33.

Leonard, W., Lyons, A., & Bariola, E. (2015). A closer look at private lives 2. Melbourne, Australia: Australian Research Centre in Sex, Health and Society, La Trobe University

Leonard, W., Pitts, M., Mitchell, A., Lyons, A., Smith, A., Patel, S., . . . Barrett, A. (2012). Private Lives 2: The second national survey of the health and wellbeing of GLBT Australians. Melbourne, Australia: Australian Research Centre in Sex, Health and Society, La Trobe University.

Li, T., Dobinson, C., Scheim, A., & Ross, L. (2013). Unique issues bisexual people face in intimate relationships: A descriptive exploration of lived experience. *Journal of Gay & Lesbian Mental Health, 17*(1), 21-39. doi: 10.1080/19359705.2012.723607

Macalister, H. E. (2011). In defense of ambiguity: Understanding bisexuality's invisibility through cognitive psychology. In S. Anderlini-D'Onofrio (Ed.), *Women and bisexualtiy: A global perspective*. USA: Routledge.

McLaughlin, C. P. K., A. D. (2004). *Continuous Quality Improvement in Health Care: Theory, Implementation and Applications* (2nd ed.). Canada: Jones and Bartlett Publishers.

McMillan, G. (2016, September 29). 'Wonder Woman' comic writer confirms hero is bisexual. *The Hollywood Reporter*. Retrieved from https://www.hollywoodreporter.com/heat-vision/wonder-woman-is-bisexual-writer-933809

McNair, R., Kavanagh, A., Agius, P., & Tong, B. (2005). The mental health status of young adult and midlife nonheterosexual Australian women. *Australian and New Zealand Journal of Public Health, 29*(3), 265.

Molina, Y., Marquez, J., Logan, D., Leeson, C., Balsam, K., & Kaysen, D. (2015). Current Intimate Relationship Status, Depression, and Alcohol Use Among Bisexual Women: The Mediating Roles of Bisexual-Specific Minority Stressors. *A Journal of Research, 73*(1), 43-57. doi: 10.1007/s11199-015-0483-z

Ngulube, P., Mathipa, E. R. & Gumbo, M. T. (2015). Theoretical and conceptual framework in the social sciences. In E. R. G. Mathipa, M. T. (Ed.), *Addressing research challneges: Making headway in developing researchers* (pp. 43-66). Noordywk: Mosala-MASEDI Publishers & Booksellers.

Paul, R., Smith, N. G., Mohr, J. J., & Ross, L. E. (2014). Measuring dimensions of bisexual identity: Initial development of the bisexual identity inventory. *Psychology of Sexual Orientation and Gender Diversity, 1*(4), 452-460.

Persson, T. J., Pfaus, J. G., & Ryder, A. G. (2015). Explaining mental health disparities for non-monosexual women: Abuse history and risky sex, or the burdens of non-disclosure? *Social Science & Medicine, 128*, 366-373. doi: 10.1016/j.socscimed.2014.08.038

Pesce, N. L. (2016). Wonder Woman is bisexual - 'obviously' says DC Comics. *NY Daily News*. Retrieved from http://www.nydailynews.com/life-style/woman-bisexual-dc-comics-article-1.2813018

Pompili, M., Lester, D., Forte, A., Seretti, M. E., Erbuto, D., Lamis, D. A., . . . Girardi, P. (2014). Bisexuality and suicide: A systematic review of the current literature. *11*(8), 1903-1913.

Portney, L. G. W., M. P. (2009). *Foundations of Clinical Research: Applications to Practice* (3rd ed.). New Jersey: Pearson Education.

Rich, A. C. (2003). Compulsory heterosexuality and lesbian existence (1980). *Journal of Women's History, 15*(3), 11-48.

Ross, L. E., Dobinson, C., & Eady, A. (2010). Perceived determinants of mental health for bisexual people: a qualitative examination. *American journal of public health, 100*(3), 496. doi: 10.2105/AJPH.2008.156307

Shepherd, J. (2017, 27 September). Wonder Woman 2: Thousands of fans sign petition to make superhero bisexula in sequel. *The Independent*. Retrieved from https://www.independent.co.uk/arts-entertainment/films/news/wonder-woman-2-bisexual-fans-superhero-petition-gal-gadot-patty-jenkins-a7969376.html

Smith, B., Dalen, J., Wiggins, K., Tooley, E., Christopher, P., & Bernard, J. (2008). The brief resilience scale: Assessing the ability to bounce back. *International Journal of Behavioral Medicine, 15*(3), 194-200. doi: 10.1080/10705500802222972

Steele, L., Ross, L., Dobinson, C., Veldhuizen, S., & Tinmouth, J. (2009). Women's sexual orientation and health: Results from a Canadian population-based survey. *Women & Health, 49*(5), 353-367. doi: 10.1080/03630240903238685

Walshe, K. R., T. G. . (2001). Evidence-based management: From theory to practice in health care. *The Milbank Quaterly, 79*(3), 429-457.

Warner, M. (1991). Introduction: Fear of a queer planet. *Social Text, 9*(4), 3-17.

Yoshino, K. (2000). The epistemic contract of bisexual erasure. *Stanford Law Review, 52*(2), 353-461.

Chapter 2

Background

"Gay men tell me my sexuality isn't real, lesbians tell me I'm really a lesbian, straight people tell me I was just experimenting."

– *Who I Am* participant

This chapter presents the paper *'Out of the Darkness and into the Shadows: The Evolution of Contemporary Bisexuality'* as published in the Canadian Journal of Human Sexuality, Volume 27, Issue 2, 2018. The initial literature review highlighted the need for a paper that preceded the review. While it remains somewhat removed from the central topics of the *Who I Am* study, the concepts it presents are fundamental to understanding bisexuality as it currently exists. The bisexual life experiences identified as key themes in the literature review, and therefore explored in the *Who I Am* study, have their roots in the academic theorising and social happenings of the past century. Without a clear understanding of their development over-time their depictions in the review lack the depth required to fully engage with their existence and persisting potential relationship to mental health. Though some of the upcoming accounts occurred many years ago, their impacts are still evident in the 21st Century. This first paper will provide the background information necessary to contextualise the complex journey of oppression that bisexuality has taken over time and will allow the reader to connect with the resulting deleterious effects still experienced by bisexual people today.

Citation: Taylor, J. (2018). Out of the darkness and into the shadows: The evolution of contemporary bisexuality. *The Canadian Journal of Human Sexuality, 27*(2), 103-109.

Out of the Darkness and Into the Shadows:

The Evolution of Contemporary Bisexuality

Julia Taylor

Abstract

Bisexuality, as we currently understand it, has evolved over the past 150 years both shaped by and shaping cultural change, scholarly endeavour and individual experience. In order to understand bisexuality in contemporary Western society it is essential to understand its past. This article explores the history of bisexuality within scholarly literature and social conversation by examining its progression from a largely silent past to a contemporary topic of scholarly investigation, a socio-political concept and a lived experience. With the growing awareness of poor mental health and suicidality among bisexual people in Western society, there has never been a more pressing time to examine bisexuality from its roots to its current existence with the aim of building a foundation from which academics, activists, health professionals and bisexual individuals can work together towards a more positive future where bisexuality can emerge from the shadows and be explored, understood, accepted and celebrated.

Key Words: *Bisexuality, bisexual history, bisexual theory, LGBTI, sexuality*

Bisexuality is a complex and little understood sexual orientation that, despite its persistent presence in Western society, has often been omitted from the pages of history and, perhaps to a lesser extent, contemporary literature. The aim of this paper is to provide the reader with an understanding of bisexuality in a contemporary context by exploring its development as a scholarly topic of investigation, a socio-political concept and a lived experience. This exploration of the emergence of contemporary bisexuality will be presented as an overview of the relevant theorists and theories over the past century followed by a chronological discussion of the theorising of bisexuality within scholarly literature and broader Western culture from the 1970's to the present day. With the recent and consistent findings of high rates of poor mental health in the Western bisexual population (Bostwick, Boyd, Hughes, & McCabe, 2010; Bostwick et al., 2007; Conron, Mimiaga, & Landers, 2010; Eisner, 2013; Hughes, Szalacha, & McNair, 2010; Jorm, Korten, Rodgers, Jacomb, & Christensen, 2002; Koh & Ross, 2006; Leonard et al., 2012; Li, Dobinson, Scheim, & Ross, 2013; Persson, Pfaus, & Ryder, 2015; Pompili et al., 2014; Steele, Ross, Dobinson, Veldhuizen, & Tinmouth, 2009), there has never before been such urgency to gain a deeper understanding of bisexuality. It is essential now to acknowledge bisexuality's largely silent past, understand its emergence into the shadows and finally afford it its rightful place in the 'light' within scholarly literature and broader Western culture.

In the latter half of the 19th century the disciplines of biology and psychiatry were foremost in attempting to explain 'normal' human sexuality, often by describing 'abnormal' sexuality. This focus on deviance in the early theorising of sexuality centred on homosexuality and often entirely neglected to make mention of those individuals who held sexual desire for more than one gender. This invisibility, of what we now term bisexuality, has become a mainstay of the theoretical literature on the topic. Despite the relative absence in historical, and some would argue contemporary (Angelides, 2001),

literature, bisexuality as we currently understand it emerged at the turn of the 20th Century (MacDowell, 2009). At this point the term bisexual began to be used to describe a person who held sexual attraction for members of both sexes, in essence breaking away from the word's previous usage, most commonly in the fields of anatomy and physiology, where it referred to the beginning state of each human as neither male nor female but undifferentiated or bisexed (MacDowell, 2009). At this time, early theorists ignited the beginnings of a quiet conversation on bisexuality that would take the better part of a century to grow in the face of a silencing majority.

This emerging discourse was accompanied by, or perhaps the product of, the psychomedical fraternity's early exploration into the characteristics and causes of those individuals curiously presenting with sexual attraction to both males and females. In 1915 Havelock Ellis identified this seemingly rare conundrum with, in his words, the "somewhat awkward name" of "psychosexual hermaphroditism" (1999, p17). Ellis described this phenomenon using his theory of inversion, suggesting that psychosexual hermaphraditism developed due to an interruption in the normal process of each person maturing into either the male or female form with attraction to the opposite sex. Ellis was amongst the earlier physicians to address bisexuality in their writing. Although Ellis did not remove himself greatly from the psychiatric theories of the day or the established heterosexual/homosexual binary embedded in early 20th Century literature, he aimed to shed light on the invisible bisexual, not as a confused invert (homosexual), but as a peculiarity of their own.

Sigmund Freud (1920) extended this theory of normal development occurring out of a state of anatomical hermaphraditism, citing Von Krafft-Ebing's notion that this hermaphraditism also exists in the realm of the psyche, and presented this context as the potential basis for bisexual attraction. Freud struggled to elaborate on this within his writing, finding the existence of such dual attraction, in the absence of consistent

feminine and masculine psychological traits, perplexing (Freud, 1999) . He could only attribute this to the individuals' inability to move beyond the infantile stage of psychic hermaphraditism (Freud, 1920; 1999). In Angelides' (2001) valuable contribution to the historicising of bisexuality, he presents a critical summation of Freud's early theorising on the topic positing that Freud's preoccupation with the determination of sexual desire resting solely on gender of object choice, operates to erase the possibility of attraction to more than one gender. Shiri Eisner, a celebrated writer and bisexual activist, extends this sentiment suggesting that a number of negative stereotypes relating to bisexuality in 21st Century Western society such as bisexuality being a passing phase, an unfinished process and a sign of immaturity, can be attributed to Freud (Eisner, 2013).

Freud's estranged pupil and psychoanalyst in his own right Wilhelm Stekel's publication on bisexuality offered a contrasting opinion to that of Freud's and, in fact, to that of most academics writing on the topic of bisexuality in the early 1900's (Bos, 2007; Stekel, 1999). Stekel's (1999) theory, published in 1920, was similarly based on the assumption of anatomical and psychological hermaphraditism, however Stekel diverges from the beliefs of his contemporaries by postulating that this bisexual basis is not an early phase of development, but rather the constant and continuous state of all humans. Thus, all those who hold monosexual attraction, that is attraction to only one gender, are repressing their natural state of bisexual attraction and therefore are expressing a form of neurosis (Stekel, 1999).

This early era of bisexual theorising was plagued with the troublesome task of fitting a seemingly awkward contradiction into theories that were rooted in the established sexual binaries of both male and female, and heterosexual and homosexual, a task some would argue is still faced in academia and in Western social culture today. Alfred Kinsey's (1948) significant and lasting contribution of the Kinsey Scale in the 1940's marked a shift in the way bisexuality was understood. The Kinsey Scale presents sexual

orientation as existing on a continuum with 0 assigned to those with exclusive opposite sex behaviour and/or attraction and 6 to those with exclusive same-sex behaviour and/or attraction (Kinsey et al., 1948). With this scale Kinsey and his colleagues (1948) were able to illustrate not only that a large proportion of the population occupied the 'bisexual' space between 1 and 5 of the scale, but further, the significant diversity in attraction and experience of those people. Although many criticisms have ensued, adaptations of the Kinsey Scale are still widely used in research on sexuality as a basic measure of sexual orientation, and this step forward in the theorising of bisexuality functioned to broaden discourse and pave the way for more meaningful explorations of this diverse and complex orientation.

Following Kinsey's veritable breakthrough in the way bisexuality was conceptualised, there was somewhat of a silence on the topic that remained relatively unbroken until, in the 1970's, bisexuality found its place as an area of scholarly interest, a lifestyle choice and an identity (Udis-Kessler, 2013). The social climate of the 1960's and 70's saw increasing sexual freedom and an emergence of alternative lifestyles and living arrangements that provided the foundation for the gay and lesbian movement, gaining momentum at that time, and the ever-growing and highly political feminist movement (Angelides, 2001; Udis-Kessler, 2013). These movements, characterised by the push toward greater sexual liberation, afforded an ideal environment for the cultivation of another social agitation at the time in its infancy; the bisexual movement. The bisexual movement has continued to progress over the decades since, often in the face of significant opposition. This progress is detailed in the upcoming passages presented chronologically by decade.

1970's

Although the theorising of bisexuality has its roots in the late 19th and early 20th Centuries, it wasn't until the 1970's that bisexuality burst out of the shadows of sexuality literature and became a topic of academic endeavour in its own right. Not surprisingly, this significant expansion in the academic theorising of bisexuality occurred alongside a broader cultural shift discussed above, that illuminated this apparently 'new' sexual identity, as encapsulated by the 1974 Newsweek article announcing "bisexuality is in bloom" (as cited in Rust, 2000, p554). During an era that saw the sexual revolution at its peak, 'bisexual chic' presented a sexuality that defied society's sexual repression and afforded true sexual liberation (Brennan & Hegarty, 2012; Rust, 2000c).

During this time theorists sought to break the silence on bisexuality in scholarship by confirming its existence and attempting to make sense of its complexities. Blumstein and Schwartz's (1999) groundbreaking research, published in 1977, expressed their key finding, after exploring the lives of bisexuals, as a consistent lack of consistency. They concluded that bisexuals, by their very nature, defied categorisation and, as a population, were characterised by diversity and fluidity (Blumstein & Schwartz, 1999). The theoretical and social grappling with this lack of consistency described by Blumstein and Schwartz (1999) persists today.

In the following year, 1978, American psychiatrist Fritz Klein published what remains a core text on bisexuality; The Bisexual Option. Klein was determined that society needed to move away from the common held misconception of the bisexual as a 'disguised homosexual' and presented bisexuality as a sexual orientation in and of itself (Klein, 1999). He attempted to address the issues of inconsistency and diversity associated with bisexuals by identifying four disparate categories of bisexuality: transitional; historical; sequential and concurrent (Rust, 2000b). In addition to this

contribution Klein illuminated shortcomings of Kinsey's sexuality continuum, developing a new measure of sexual orientation that aimed to address these, by separating sexual experiences from sexual desires (Klein, 1993).

Michael Storms (1980) echoed Klein's views on the deficiencies of the Kinsey Scale in the same year publishing his own model of sexuality. He believed that Kinsey's continuum presented bisexuals as existing either as half homosexual and half heterosexual, or as made up of finite combinations of the two, essentially decreasing in the degree of either extreme as an individual moves closer to one end of the continuum or the other (Storms, 1980). Storms' two-dimensional model plots bisexual orientation along two axes of homo-eroticism and hetero-eroticism, allowing a clearer expression of orientation that appreciates desire for and experience with both genders, without minimising desire for or experience with one or the other (Storms, 1980).

In addition to this flourish of bisexual theory in the 1970's there emerged recognition, by some, of the lack of acceptance bisexuals experienced within Western society. Klein (1999) propounded that this lack of acceptance, and further, the negative attitudes towards bisexuals, resulted from the challenge bisexuality presented to homosexuals and heterosexuals by raising uncertainties as to their own ambiguity, and in doing so, generating inner conflict. Charlotte Wolff suggested in 1977 that Western culture had imposed a 'straight jacket' on bisexuality and pointed out that bisexuals are accepted by neither heterosexuals nor homosexuals (as cited in Brennan, 2012). Wolff believed that Western culture had been so successful in what she termed 'brainwashing' the bisexual that bisexuals found themselves not knowing what they were or who they were (Brennan & Hegarty, 2012). Klein commented on this internalisation of societal attitudes in The Bisexual Option stating that reducing bisexuality to a better known dichotomous sexuality in disguise, can be adopted by an individual in search of their self-

identity due to the lack of a suitable alternative; a situation he referred to as “tragic” (Klein, 1999, p40).

1980’s

The 1980’s was a difficult period for bisexuals, and for the better part of this decade the boom in theorising bisexuality that had occurred in the preceding ten years, was seemingly on hiatus while the AIDS crisis took centre stage. This crisis was the result of the rapidly spreading sexually transmitted Human Immunodeficiency Virus (HIV) that led to the deadly Acquired Immune Deficiency Syndrome (AIDS) in infected individuals, for which treatment options at the time were scarce and largely ineffective. In response to the knowledge that this virus was usually contracted in the context of homosexual male sex, initially this epidemic was ignored by the heterosexual community who were later accused of writing it off as the ‘gay disease’ (Rust, 2000c). The realisation that there was one group of people who engaged in sexual behaviour with both camps was propelled by mainstream media who vilified bisexuals, and in particular male bisexuals, as lying cheating vectors of disease (Rust, 2000c). Alongside this demonization by some heterosexuals, bisexuals were ostracised by gay and lesbian communities as their blurring of homosexual and heterosexual distinctions threatened to undermine the gay and lesbian’s highly political fight for rights, in the desperate climate of AIDS (Rust, 2000c; Udis-Kessler, 2013).

The scholarly literature on bisexuality at this time was similarly deleterious. In 1984, Altshuler published the results of a study, which involved interviewing just thirteen self-identified bisexuals, reporting that only one participant, whom he described as psychotic, met the criteria for bisexuality, which he defined as equal pleasure and equal frequency with relatively random gender choice of sexual partners. From this he deduced that bisexuality was merely a label one might use to save face, maintain status or deny

internal conflict and that true 'bisexuals' did not exist (Altshuler, 1984; Rust, 2000a). The following year Valverde's book Sex, Power and Pleasure positioned bisexuality away from the notion of it being a 'third' sexual orientation and instead described it as a choice to combine homosexual and heterosexual lifestyles (Valverde, 1999). These publications dealt a blow to the pioneering efforts of theorists of the 1970's who had worked hard to present bisexuality as a separate and unique sexual orientation, that not only existed, but deserved attention and exploration despite its previous absence from the literature. In addition, they further fuelled negative attitudes that bisexuals were illegitimate and untrustworthy.

Ironically, Udis-Kessler (2013) later argued, this 'bad press' relating to bisexuality in the early and mid-1980's inadvertently raised the profile of bisexual groups who were gaining in solidarity at the time in the face of opposition. She marks the 1987 Lesbian and Gay March in Washington as a pivotal point in the emerging bisexual movement, as it proved to its members their community's ability and eagerness to collect in one place with a shared purpose, later leading to the development of the first bisexual conference and other organised bisexual pride events (Udis-Kessler, 2013).

1990's

The 1990's saw the reinvigoration of bisexuality both in popular culture and academia. This re-emergence had a distinctly political tone with bisexual activists and academics uniting in an effort to strengthen their political pull (Rust, 2000c). The mainstream media again fuelled the shift by presenting bisexuality in a favourable light as a 'new' sexuality to try (Rust, 2000c).

In 1994, Weinberg, Williams and Pryor co-authored a key text on bisexuality; Dual Attraction. This book reports on research conducted on bisexuals in San Francisco in the 1980's and builds on these findings to inform bisexual theory. They offered the first

model of bisexual identity formation and from the findings of their research, ‘types’ of bisexuals were identified with the aim of better articulating differing points along the Kinsey Scale labelling them as the pure type, the mid type, the heterosexual-leaning type, the homosexual-leaning type and the varied type (Weinberg, Williams, & Pryor, 1994). Furthermore, within Dual Attraction, Weinberg and colleagues outlined their theory of sexual preference presenting the development of an ‘open gender schema’ as a way of conceptualising bisexual attraction at the individual level (Weinberg et al., 1994).

Scholars engaged enthusiastically in literary conversation on bisexuality during the 1990’s, with a common thread of viewing bisexuality as significantly complex and therefore hard to quantify, study, define or even comprehend, while also agreeing that the thwarted attempts to do so thus far had been too simplistic and failed to appreciate the inherently diverse nature of bisexuals and bisexuality (Däumer, 1999; Du Plessis, 1996; Garber, 1995; Hemmings, 1999). However, the agreements ended there, with this inherent diversity not just a trait of the bisexual population but likewise implicit in the literature published at the time with clear divisions, disagreements and contradictions between theorists.

In the early 1990’s Däumer (1999) refuted earlier theorising on bisexuality as a third sexual orientation, positing the simplicity of this failed to acknowledge the social and political implications for bisexuals stuck between two dominant cultures. In 1995, Hemmings (1999) described the paradox of bisexual theorising as the bisexual community attempting to label what they wished to remain unlabelled and expressed that theorising on the topic was fraught from the outset as it could only be done under existing structures that were built around more easily definable and categorised orientations. In the same year Hemmings offered these insights, Harvard Professor Marjorie Garber (1995) published her seminal work Vice Versa, a book that presented bisexuality as the epitome of sexual fluidity and not just another sexual orientation but the undoing of orientations.

The following year Du Plessis (1996) criticised Garber's attempts to provide one all encompassing explanation of bisexuality, warning against defining the undefinable and urging his fellow theorists to avoid aiming to have the 'last word' on bisexuality and instead to join forces to allow bisexuality to be defined by its connectedness and strength of alliances, not by its fluidity.

2000 - 2010

As the new millennium broke, two opposing positions had emerged from the preceding decades' of bisexuality literature. On one hand was the affirming, acknowledging and accepting stance which viewed bisexuals as liberated, healthy and aware. On the other was the erasing, disputing and undermining position that presented bisexuals as not really existing, conflicted and even traitorous. At the turn of the new Century, American psychologist Gary Zinik (2000) paid homage to these oppositions by developing two opposing models of bisexuality. The 'flexibility model' describes bisexuals as flexible beings who are able to act as "chameleons" (Zinik, 2000, p57) moving with ease between the homosexual and heterosexual worlds (Zinik, 2000). The opposing 'conflict model' portrays bisexuals as confused 'fence-sitters' whose inability to make a decision with regard to their sexuality provokes internal turmoil (Zinik, 2000).

In the same year as Zinik's contribution to bisexual theory, Kenji Yoshino published a work focussing on the social and theoretical erasure of bisexuals that Shiri Eisner would later refer to as groundbreaking (Eisner, 2013). According to Yoshino (2000), bisexuals are invisible in Western society not because they are nonexistent or few in number, but because they have been systematically, and at times deliberately, erased. Yoshino (2000) goes on to introduce the concept of an 'epistemic contract' relating to bisexual erasure that monosexuals, knowingly or unknowingly, hold investment in, which

has come about as the result of bisexuality's ability to destabilize monosexual identities and behaviour, and threaten the social norm of monogamy.

Despite Yoshino's efforts to illuminate the issues associated with bisexual erasure, in 2005 a study was published that gained widespread attention and threatened to erase bisexuality from the consciousness of Western culture by apparently providing, once and for all, 'scientific evidence' that bisexuality did not exist, at least not in males (Carey, 2005; Rieger, Chivers, & Bailey, 2005). This study conducted by Rieger and colleagues (2005), that was famously reported on in the New York Times under the provocative title 'Gay, Straight or Lying', examined bisexual males' genital arousal in response to both male and female sexual stimuli concluding that true bisexuals, that is those aroused by both genders, did not exist (Carey, 2005). This was a development bisexual men could ill afford after a history of invisibility and erasure in academic literature and Western society, an invisibility only interrupted by the AIDS crisis which saw the media launching a scathing attack on them. Hemming's (2002) makes note of this invisibility in her highly critical review of much of the bisexuality writing to date, in which one of her many criticisms is that the focus of scholarly literature on bisexuality has been devoted to bisexual females, often to the exclusion of bisexual males. Notwithstanding these developments, the end of the decade showed promise with regard to the erasure and invisibility of bisexuality, at least amongst Australian youth, with research reporting trends toward an increasing visibility of bisexuality and an increase in the blurring of binary lines amongst young people (Pallotta-Chiarolli & Martin, 2009).

2010 – present

Consistent with the ebbing and flowing of bisexuality as a focus of scholarly endeavour and societal interest, in recent years there has again been significant expansion in these domains. A broadening discourse of identity terminology for those attracted to

more than one gender has emerged to include pansexual, polysexual, homoflexible, heteroflexible, biromantic, bisensual and bi-curious, to name a but a few (Eisner, 2013; Sunfrog, 2013). Alongside this a large representative study of Australian adults, conducted in 2013, indicated that identifying as bisexual is increasing (Richters et al., 2014). Moreover, in the same study societal attitudes towards same sex behaviour showed marked improvement from 2002 to 2013 (De Visser et al., 2014) a development that may be partially attributed to the growing social and political awareness and acceptance of gays and lesbians. However, these increasing liberal views were not reflected in the study's measurement of acceptance of non-monogamy, a practice often closely associated with bisexuality regardless of the accuracy of this association, which showed a decline in tolerance towards sex outside of a committed relationship over the same time period (De Visser et al., 2014).

This latest re-emergence of bisexuality has been accompanied by greater visibility of bisexuals in mainstream Western culture and media as exemplified in 2014 when the New York Times seemingly offered a rebuttal for their earlier article that promulgated the non-existence of bisexuality, in The Scientific Quest to Prove Bisexuality Exists (Denizet-Lewis, 2014). This article sought to affirm bisexuality by citing a recent study on arousal patterns which contradicted earlier findings that had suggested patterns of bisexual arousal did not exist (Denizet-Lewis, 2014; Rosenthal, Sylva, Safron, & Bailey, 2011).

There have been a number of theoretical additions to the literature in the years since 2010, with some academics applying theories from other fields to better explain and explore bisexuality. In Callis' 2014 article on non-binary sexualities, the borderland theory, initially developed to describe mixed race, is presented as a lens through which bisexuality can be more clearly understood. She presents bisexuals as existing between the borders of homosexuality and heterosexuality in a borderland space characterised by

identities that can multiply, change and dissolve (Callis, 2014). Another example of this utilisation of older theories to explore aspects of bisexuality is Macalister's (2011) citation of cognitive schema theory. This theory, originally developed by acclaimed psychologist Jean Piaget in the mid 20th Century, is presented by Macalister (2011) to explain both society's lack of acceptance of bisexuals, and bisexuals difficulty in understanding themselves, as the result of each individuals lack of a suitable cognitive schema that would allow them to make sense of such a complex expression of sexuality.

Arguably, one of the most prominent text to have emerged in recent years is Shiri Eisner's (2013) text Bi: Notes for a Bisexual Revolution. This thorough and accessible work posits bisexuality as an all encompassing identity that provides an umbrella under which those attracted to more than one gender can sit regardless of the label they choose to use to describe their sexuality, if they use a label at all (Eisner, 2013). Eisner (2013) is conscious of individual diversity and insists people must be afforded the right to choose their own label, identity and sexual definition. Although Eisner (2013) acknowledges the work that needs to be done and the detrimental impact of negative attitudes, her positive take on the bisexual movement's ability to move forward, is a rare and welcome change of tone to much of the literature on the topic. Her text culminates in a 'call to arms' for bisexuals and bisexual allies to create a revolution in the way bisexuality exists and is understood, characterised by inclusivity and the celebration of diversity, that aims to break down gender and sexuality binaries, fight biphobia and monosexism, acknowledge intersections that impact on the lives of bisexuals and empower bisexual people to take action from the ground up to create a world within which they feel they belong (Eisner, 2013).

This powerful and passionate sentiment is presented at a time when being bisexual is largely accepted in scholarly literature as being associated with poor mental health and high suicide rates (Bostwick et al., 2010; Bostwick et al., 2007; Conron et al., 2010;

Eisner, 2013; Hughes et al., 2010; Jorm et al., 2002; Koh & Ross, 2006; Leonard et al., 2012; Li et al., 2013; Persson et al., 2015; Pompili et al., 2014; Steele et al., 2009), a finding Eisner (2013) directly references in her book as a means to add weight to her urgent call for revolution. This can also be found in Sunfrog's (2013) writing which focuses on male bisexuals calling for them to come out, be visible and stand up to change the future. Both Eisner (2013) and Esterberg (2011) believe the recent progress of the emerging trans movement, that has worked to deconstruct gender binaries in an effort to make a more inclusive society for transgender people, may potentially pave the way for such a revolution. This newfound energy not only acknowledges the omissions of past academic literature and mainstream Western culture, as well as the challenges faced by bisexuals today and the suffering experienced by those whose sexuality falls outside of socially acceptable binaries, it also provides a positive future direction for improvement and a call for all those willing and able to shape a new future where bisexuals are able to be healthy, happy and accepted.

Conclusion

This paper has recounted the development of contemporary bisexuality in the West by presenting an examination of scholarly literature and relevant social developments over the past 150 years. With bisexuality emerging from the shadows of a silent past over recent decades, scholars are now in a position to shed greater light on this little understood sexuality, and in doing so, have the power to go beyond social commentary by moving toward actively shaping a future for bisexuality against a backdrop of acceptance that promotes individual freedom, health and happiness.

References

Altshuler, K. Z. (1984). On the question of bisexuality. *American Journal of Psychotherapy*, *38*(4), 484-493.

Angelides, S. (2001). *A history of bisexuality*. Chicaco, IL: The University of Chicago Press.

Blumstein, P. W., & Schwartz, P. (1999). Bisexuality: Some social psychological issues (1977). In M. Storr (Ed.), *Bisexuality: A critical reader*, pp. 59-74. London: Routledge.

Bos, J. (2007). *The self-marginalization of Wilhelm Stekel freudian circles inside and out*. Dordrecht: Springer.

Bostwick, W. B., Boyd, C. J., Hughes, T. L., & McCabe, S. E. (2010). Dimensions of sexual orientation and the prevalence of mood and anxiety disorders in the United States. *American Journal of Public Health, 100*(3), 468. doi: 10.2105/AJPH.2008.152942

Bostwick, W. B., McCabe, S. E., Horn, S., Hughes, T., Johnson, T., & Valles, J. R. (2007). Drinking patterns, problems, and motivations among collegiate bisexual women. *Journal of American College Health, 56*(3), 285-292. doi: 10.3200/JACH.56.3.285-292

Brennan, T., & Hegarty, P. (2012). Charlotte wolff's contribution to bisexual history and to (sexuality) theory and research: A reappraisal for queer times. *Journal of the History of Sexuality, 21*(1), 141-161.

Callis, A. S. (2014). Bisexual, pansexual, queer: Non-binary identities and the sexual borderlands. *Sexualities, 17*(1-2), 63-80. doi: 10.1177/1363460713511094

Carey, B. (2005, July 5th). Straight, gay or lying? Bisexuality revisited. *New York Times*.

Conron, K. J., Mimiaga, M. J., & Landers, S. J. (2010). A population-based study of sexual orientation identity and gender differences in adult health. *The American Journal of Public Health, 100*(10), 1953-1960.

Däumer, E. D. (1999). Extract from queer ethics; or, the challenge of bisexuality to lesbian ethics (1992). In M. Storr (Ed.), *Bisexuality: A critical reader*, pp. 152-161. London: Routledge.

De Visser, R. O., Badcock, P. B., Simpson, J. M., Grulich, A. E., Smith, A. M. A., Richters, J., & Rissel, C. (2014). Attitudes toward sex and relationships: The second australian study of health and relationships. *Sexual Health, 11*(5), 397-405.

Denizet-Lewis, B. (2014, March 20). The scientific quest to prove bisexuality exists. *The New York Times Magazine*.

Du Plessis, M. (1996). Blatantly bisexual; or, unthinking queer theory. In M. Pramaggiore & D. E. Hall (Eds.), *RePresenting bisexualities: subjects and cultures of fluid desire*, pp. 19-54. London, New York, NY: New York University Press.

Eisner, S. (2013). *Bi: Notes for a bisexual revolution*. Berkeley, CA: Seal Press.

Ellis, H. (1915). *Studies in the psychology of sex: Sexual inversion* (3rd ed. Vol. 2). Philadelphia, PA: F. A. Davis Company.

Esterberg, K. G. (2011). The bisexual menace revisited: or, shaking up social categories is hard to do. In S. Seidman, N. Fischer, & C. Meeks (Eds.), *Introducing the new sexuality studies 2nd edition*. London, New York, NY: Routledge.

Freud, S. (1920) Three contributions to the theory of sex In S. E. Jelliffe & W. A. White (Eds.), *Nervous and mental disease monograph series 2nd edition*. New York, NY, Washington: Nervous and Mental Disease Publishing Co.

Freud, S. (1999). Extract from three essays on the theory of sexuality: 1. The sexual aberrations (1905). In M. Storr (Ed.), *Bisexuality: A critical reader*, pp. 20-28. London: Routledge.

Garber, M. (1995). *Vice versa: Bisexuality and the eroticism of everyday life*. London, New York, NY: Penguin Books.

Hemmings, C. (1999). Extract from locating bisexual identities: Discourses of bisexuality and contemporary feminist theory (1995). In M. Storr (Ed.), *Bisexuality: A critical reader*, pp. 193-201. London: Routledge.

Hemmings, C. (2002). *Bisexual spaces : a geography of sexuality and gender*. New York, NY, London: Routledge.

Hughes, T., Szalacha, L. A., & McNair, R. (2010). Substance abuse and mental health disparities: Comparisons across sexual identity groups in a national sample of young Australian women. *Social Science & Medicine, 71*(4), 824-831. doi: 10.1016/j.socscimed.2010.05.009

Jorm, A. F., Korten, A. E., Rodgers, B., Jacomb, P. A., & Christensen, H. (2002). Sexual orientation and mental health: results from a community survey of young and middle-aged adults. *The British Journal of Psychiatry: The Journal of Mental Science, 180*, 423.

Kinsey, A. C., Pomeroy, W. B., & Martin, C. E. (1948). *Sexual behavior in the human male*. Philladelphia, PA: W. B. Saunders Company.

Klein, F. (1993). *The bisexual option: Second edition* (2nd ed.). New York, NY & London: Routledge.

Klein, F. (1999). Extracts from the bisexual option: A concept of one hundred percent intimacy (1978). In M. Storr (Ed.), *Bisexuality: A critical reader*, pp. 38-49. London: Routledge.

Koh, A. S., & Ross, L. K. (2006). Mental health issues: a comparison of lesbian, bisexual and heterosexual women. *Journal of Homosexuality, 51*(1), 33.

Leonard, W., Pitts, M., Mitchell, A., Lyons, A., Smith, A., Patel, S., . . . Barrett, A. (2012). Private Lives 2: The second national survey of the health and wellbeing of GLBT Australians. Melbourne: Australian Research Centre in Sex, Health and Society, La Trobe University.

Li, T., Dobinson, C., Scheim, A., & Ross, L. (2013). Unique issues bisexual people face in intimate relationships: A descriptive exploration of lived experience. *Journal of Gay & Lesbian Mental Health, 17*(1), 21-39. doi: 10.1080/19359705.2012.723607

Macalister, H. E. (2011). In defense of ambiguity: Understanding bisexuality's invisibility through cognitive psychology. In S. Anderlini-D'Onofrio (Ed.), *Women and bisexualtiy: A global perspective*, pp. 23-33. New York, NY: Routledge.

MacDowell, L. (2009). Historicising contemporary bisexuality. *Journal of Bisexuality, 9*(1), 3-15.

Pallotta-Chiarolli, M., & Martin, E. (2009). "Which sexuality? Which service?": Bisexual young people's experiences with youth, queer and mental health services in Australia. *Journal of LGBT Youth, 6*(2-3), 199-222. doi: 10.1080/19361650902927719

Persson, T. J., Pfaus, J. G., & Ryder, A. G. (2015). Explaining mental health disparities for non-monosexual women: Abuse history and risky sex, or the burdens of non-disclosure? *Social Science & Medicine, 128*, 366-373. doi: 10.1016/j.socscimed.2014.08.038

Pompili, M., Lester, D., Forte, A., Seretti, M. E., Erbuto, D., Lamis, D. A., . . . Girardi, P. (2014). Bisexuality and suicide: A systematic review of the current literature. *Journal of Sexual Medicine, 11*(8), 1903-1913.

Richters, J., Altman, D., Badcock, P. B., Smith, A. M. A., De Visser, R. O., Grulich, A. E., . . . Simpson, J. M. (2014). Sexual identity, sexual attraction and sexual experience: The second australian study of health and relationships. *Sexual Health, 11*(5), 451-460.

Rieger, G., Chivers, M. L., & Bailey, J. M. (2005). Sexual Arousal Patterns of Bisexual Men. *Psychological Science, 16*(8), 579-584.

Rosenthal, A. M., Sylva, D., Safron, A., & Bailey, J. M. (2011). Sexual arousal patterns of bisexual men revisited. *Biological Psychology, 88*(1), 112-115. doi: 10.1016/j.biopsycho.2011.06.015

Rust, P. (2000a). Alternatives to binary sexuality: Modeling bisexuality. In P. Rust (Ed.), *Bisexuality in the United States: A Social Science Reader*, pp. 33-55. New York, NY: Columbia University Press.

Rust, P. (2000b). The biology, psychology, sociology, and sexuality of bisexuality In P. Rust (Ed.), *Bisexuality in the United States: A Social Science Reader*, pp. 403-471. New York: Columbia University Press.
Rust, P. (2000c). Popular images and the growth of bisexual community and visibility. In P. Rust (Ed.), *Bisexuality in the United States: A Social Science Reader*, pp. 537-554. New York: Columbia University Press.
Steele, L., Ross, L., Dobinson, C., Veldhuizen, S., & Tinmouth, J. (2009). Women's sexual orientation and health: Results from a Canadian population-based survey. *Women & Health, 49*(5), 353-367. doi: 10.1080/03630240903238685
Stekel, W. (1999). Extracts from bi-sexual love (1920). In M. Storr (Ed.), *Bisexuality: A critical reader*, pp. 28-31. London: Routledge.
Storms, M. D. (1980). Theories of Sexual Orientation. *Journal of Personality and Social Psychology, 38*(5), 783-792.
Sunfrog. (2013). Pansies against patriarchy: Gender blur, bisexual men, and queer liberation. In N. Tucker (Ed.), *Bisexual politics: Theories, queries and visions*, pp. 319-324. New York, NY & London: Routledge.
Udis-Kessler, A. (2013). Identity/politics: A history of the bisexual movement. In N. Tucker (Ed.), *Bisexual politics: Theories, queries and visions*, pp. 17-30. New York & London: Routledge.
Valverde, M. (1999). Extract from sex power and pleasure (1985). In M. Storr (Ed.), *Bisexuality: A critical reader*, pp. 112-117. London: Routlege.
Weinberg, M. S., Williams, C. J., & Pryor, D. W. (1994). *Dual attraction : understanding bisexuality*. New York, NY: Oxford University Press.
Yoshino, K. (2000). The epistemic contract of bisexual erasure. *Stanford Law Review, 52*(2), 353-461.
Zinik, G. (2000). Identity conflict or adaptive flexibility? Bisexuality reconsidered. In P. Rust (Ed.), *Bisexuality in the United States: A Social Science Reader*, pp. 55-61. New York, NY: Columbia University Press.

Chapter 3

Literature Review

"You have to pretend to be straight in some situations and gay in others and there's nowhere that you really belong so you end up with this fractured self."

– *Who I Am* participant

This chapter presents the paper *'Bisexual Mental Health: A Call to Action'* as published in Issues in Mental Health Nursing, Volume 39, Issue 1, 2018. This review examines the current literature relating to bisexuality broadly and bisexual mental health specifically. The findings provide the fundamental basis upon which the *Who I Am* study is built. In addition to informing the study with an examination of the definitions and prevalence of bisexuality, the mental health of bisexual people is explored in detail and key themes emerging from the literature relating to bisexual life experiences are discussed. It is these themes that are later incorporated as core elements of the study and used to identify correlations between life experiences and the mental health of this group. Furthermore, this review presents recommendations from the existing literature relating to what types of research need to be conducted with this population and how this can best be done. Finally, the paper concludes with a 'call to action' to address these pressing literature gaps so that this research can begin to enable a brighter future for bisexual people.

Citation: Taylor, J. (2018). Bisexual mental health: A call to action. *Issues in Mental Health Nursing*, *39*(1), 83-92.

Bisexual Mental Health: A Call to Action

Julia Taylor

Abstract

Over the past two decades research has consistently found that bisexual people experience poorer mental health than their gay, lesbian or heterosexual counterparts. The reasons behind this high prevalence of poor mental health remain under-researched and largely unknown. In order to improve these outcomes, more research is critically needed with the aim of providing new knowledge upon which health care provision and policy development can be based. This article presents an analysis of the literature to date relating to bisexuality broadly and bisexual mental health specifically, with the aim of providing direction for future research projects.

Recent research across Western countries has consistently reported that bisexual people suffer poorer mental health than other sexual orientation groups (Bostwick et al., 2007; Bostwick, Boyd, Hughes, & McCabe, 2010; Conron, Mimiaga, & Landers, 2010; Eisner, 2013; Hughes, Szalacha, & McNair, 2010; Jorm, Korten, Rodgers, Jacomb, & Christensen, 2002; Koh & Ross, 2006; Leonard et al., 2012; Li, Dobinson, Scheim, & Ross, 2013; Persson, Pfaus, & Ryder, 2015; Pompili et al., 2014; Steele, Ross, Dobinson, Veldhuizen, & Tinmouth, 2009). Though this finding is now well established, the reasons behind this high prevalence of poor mental health in the bisexual population remain largely uninvestigated. The aim of this review is to bring together the sparse and fragmented scholarly knowledge on bisexuality and bisexual mental health and present it as a cohesive whole in order to provide a foundation upon which future research can be constructed. It is intended that this paper will provide the reader with an understanding of bisexuality in a contemporary context as a scholarly topic of investigation, a socio-political concept and a lived experience.

The text has been divided into sections and organised under subheadings for ease of navigation. In the first instance the review method is briefly outlined. The question 'what is a bisexual?' is posed, leading to a brief discussion on the definition and prevalence of bisexuality. The mental health of bisexuals, as evidenced in the literature, is explored, with added discussions on substance use habits and service access followed by an exploration of the prominent themes drawn from the broader bisexuality literature. An examination of the small body of research linking the identified themes to the mental health of bisexual people ensues. This paper concludes by outlining the current research recommendations in this area of study and identifying where gaps in the literature exist, thus providing a clear and cohesive direction for much needed future research.

It is important to note that many of the views and opinions to follow are representative of texts under review and not necessarily the opinion of the author. An example of this is where language that presents gender as binary is used such as ‘opposite sex’ or the presentation of gender as only ‘male’ or ‘female’, which in every case is intended to provide an accurate account of the literature being discussed and is not representative of the author’s viewpoint.

Review method

Searching and reviewing

This review was not conducted under the prescription of a rigid structure or specific stylistic format, as is often the case within health disciplines. Instead it was intended from the outset to be conducted and presented in a format more consistent with the disciplines of social science, by providing a narrative discussion of all relevant literature.

The searching, reviewing and synthesising of literature for this review took several months. At the commencement of the review process, two broad topics relating to the proposed research were identified to guide the literature searching: bisexuality and bisexual mental health. At the outset of the review process, the support of a librarian was enlisted to provide assistance with a review strategy. Initial core texts were identified by academics within the author’s professional networks. Reference lists from each source were read and scanned for further relevant sources. When sources had been identified from previous articles a combination of Google, Bing, various university library websites and Australian state libraries were utilised to gain access to full texts of each source. In addition, relevant journal content lists were searched for articles and databases accessible via university library websites were used to identify relevant texts. Sources were included for review if they were: relevant to the topics bisexuality or bisexual mental health;

written in English and were able to be accessed via the search engines and libraries listed above. Aside from a small number of relevant media articles, the information presented in this review is based on scholarly literature. To ensure the reviewed sources were able to be synthesised in a meaningful way the following areas of focus were identified: history of bisexuality; theorising bisexuality; invisibility and erasure; stereotypes and biphobia; identity and labels; coming out; relationships and sexual behaviour; community and belonging; positives; definition; prevalence; demographics; gender difference; health; substance use and service access. Sources were deemed to fall outside of the scope of this review if they were not relevant to these focus areas.

Synthesising

Due to the large number of sources, and relative complexity of the information being compiled, the author undertook a somewhat unorthodox approach to the process of synthesising the literature. Multiple copies of tables containing summaries of sources were printed along with corresponding notes. Tables were sectioned to allow sources to be separated. Each section included the author's name, year of publication, a unique number that corresponded to the relevant compiled notes and a brief summary of the source which included its relevance to the research topic. Building on the areas of focus outlined above, some new areas were identified and together these were written on sheets of paper which were cut up and stuck onto a large wall. Determining these areas took significant time, and much thought and care was invested in ensuring areas were grouped in a way that was representative of their depictions in the literature, and provided context and meaning to the topic. Tabled source summaries were then stuck under headings relevant to them and colour coded to the relevant sections within the corresponding notes. The end result of this 'visual synthesis' was a large, colourful and orderly, textual montage that allowed grouping and themes to emerge organically.

What is bisexuality?

Definition

The lack of a clear and consistent definition of bisexuality has been a mainstay of the academic literature on the topic since the term first emerged at the turn of the twentieth Century. While this lack of a usable definition can be seen as a perplexing obstacle for researchers, it is a very real issue for bisexual people and in many ways can impact how they perceive themselves, how they relate to others and how they are viewed by society. Some theorists have offered advice to those aiming to articulate what it means to be bisexual, warning against the creation of one all-encompassing definition that might work to oversimplify a characteristically complex and diverse population and encouraging the definition of bisexuality to remain in the hands of each individual bisexual person who may choose to define themselves and their sexuality in any way that is consistent with their individual experience (Du Plessis, 1996; Eisner, 2013).

Numerous scholars have offered definitions of bisexuality. Notable contemporary writer Shiri Eisner (2013) recently defined bisexuality under three distinct but interrelated categories; desire, community and politics. She proposes that being bisexual can be characterised by the desire for more than one sex or gender, or desiring those that are the same sex or gender as oneself as well as those different from oneself (Eisner, 2013). Outside of desire, people may identify as bisexual due to community and/or political alignments that unite them with the bisexual movement both historically and contemporarily (Eisner, 2013). In 1994, Weinberg and colleagues (Weinberg, Williams, & Pryor, 1994) presented their ‘open gender schema’ theory, stating simply that bisexuals were people whose gender schemas were permanently open allowing for the eroticisation of both males and females. Following Diamond’s (2008) unique longitudinal study of bisexual people she posited ‘bisexuality may best be interpreted as a stable pattern of

attraction to both sexes in which the specific balance of same-sex to other-sex desires necessarily varies according to interpersonal and situational factors' (Diamond, 2008, p. 12). Bradford (2004) asked participants to offer their own definition of bisexuality, finding the most consistent explanation related to what bisexuality was not rather than what it was; it was not homosexual nor was it heterosexual. For the purposes of research Yoshino (2000) perhaps offers the most concise definition that can be utilised when designing studies of this population which is simply that bisexuality can exist along three axes, identity, attraction and behaviour, and that researchers might recruit people as bisexuals who incorporate any one, any combination or all of these elements into their lives.

Prevalence

Attempting to accurately quantify sexual orientation, and in particular bisexuality with its inconsistent definitions and broad range of expression, is particularly difficult, and an accurate numerical value to represent this prevalence may well be impossible to obtain (Rust, 2000). However, with the ever increasing availability of representative data on sexuality, the current knowledge on prevalence of bisexuality is better than it has ever been.

A number of large representative studies both in the United States and in Australia have aimed to quantify sexual orientation by asking participants how they self-identify, reporting a range of 0.9–2.6% of males and 1.4–3.6% of females identify as bisexual (Herbenick et al., 2010; Richters et al., 2014; Smith, Rissel, Richters, Grulich, & De Visser, 2003). McNair, Kavanagh, Agius, and Tong (2005) analysed data from the Australian Longitudinal Study on Women's Health finding that non-monosexuality in women was reported with greater frequency by women in their 20s than those in their 50s with 7.9% of younger women and 1.6% of older women selecting 'mainly heterosexual',

'bisexual' or 'mainly homosexual' to describe themselves, with 'mainly heterosexual' being the most commonly selected option in this group. In addition, the Australian Study of Health and Relationships found that identifying as bisexual had increased in Australia between 2002 and 2013 (Richters et al., 2014; Smith et al., 2003). The second implementation of this national study, which recruited over 20,000 participants, reported on bisexuality using the three axes approach separating identity, attraction and experience, finding that while only 1.3% of men and 2.2% of women identify as bisexual, 5.8% of males and 14.2% of females report non-monosexual attraction and 5.6% of men and 13.2% of women have had sexual experiences with more than one gender (Richters et al., 2014).

Mental health

The available data on the mental health of bisexual people offers one clear consensus: bisexual people have poorer mental health than other sexual orientation groups (Bostwick et al., 2007, 2010; Conron et al., 2010; Eisner, 2013; Hughes et al., 2010; Jorm et al., 2002; Koh & Ross, 2006; Leonard et al., 2012; Li et al., 2013; Persson et al., 2015; Pompili et al., 2014; Steele et al., 2009). While minor variations outside of this 'rule' exist, in general not one study was identified for this review that presented an alternative overall position despite broad variations in the design, methodology, size and scope of studies. In Conron and colleagues' (2010) secondary analysis of the Massachusetts Behavioral Risk Factor Surveillance Survey that recruited 67,359 respondents via random-digit-dialling, bisexual people were found to be more likely to report frequent tension or worry, sadness and past year suicidal ideation than their heterosexual counterparts. Another secondary analysis of a large American based survey (Bostwick et al., 2010) examined mental health across the three axes of sexual orientation, finding higher rates of mood disorders not only for bisexually identified individuals but also for those who reported attraction to, or sexual behaviour with, more than one gender

independent of their identity. Two Australian studies, one targeting LGBT participants and the other a broader community based survey, similarly found that poorer mental health was reported with greater frequency by bisexual Australians than other sexual identity groups (Jorm et al., 2002; Leonard et al., 2012). Jorm and colleagues' (2002) study reported that while the existence of poor mental health in homosexual participants was able to be accounted for by increased risk across a range of measures including socio-demographic characteristics and early-life psychosocial experiences, this was not the case for bisexual participants, a finding that led the authors to suggest that bisexuality may be a risk factor in and of itself.

Several studies have explored mental health and sexual orientation in all female populations. Two waves of data from the Australian Longitudinal Study on Women's Health have been analysed for this purpose, both reporting similar results finding that bisexual women, and women with other identities that fall outside of monosexual attraction, have significantly higher rates of depressive symptoms, stress, symptoms of anxiety and previous self-harm (Hughes et al., 2010; McNair et al., 2005). The most recent of these analyses found that bisexual women were nearly twice as likely as lesbian women and four times as likely as heterosexual women to report feeling that life was not worth living, with 16.2% of bisexual respondents reportedly feeling this way (Hughes et al., 2010). A recent Canadian study (Persson et al., 2015) similarly found higher rates of depression and anxiety in non-monosexual women. In addition, a larger Canadian population based study of 61,715 females found that mood and anxiety disorders, as well as poor or fair self-reported mental health, were much more frequently reported by bisexual women than heterosexuals or lesbians and an alarming 45.4% of bisexual participants reported suicidal ideation in their lifetime compared with 29.5% of lesbians and 9.6% of heterosexuals (Steele et al., 2009). Smaller samples of particular sub-populations of women concur with these findings with Bostwick's and colleagues'

(Bostwick et al., 2007) exploration of drinking patterns by sexual orientation reporting that bisexual females were significantly more likely to contemplate suicide after alcohol consumption than heterosexual women, and Koh's & Ross's (2006) study of mental health outpatients finding bisexual women were more likely to report frequently feeling stressed, current depression and having ever attempted suicide than lesbian or heterosexual women.

There is a persistent silence surrounding male bisexuality in scholarly literature, and in keeping with this, only one study was found when searching the literature for this review that primarily focussed on the mental health of men by sexual orientation and included bisexuality. When Brennan and his colleagues (Brennan, Ross, Dobinson, Veldhuizen, & Steele, 2010) conducted an analysis of male participants' responses to the Canadian Community Health Survey they found that, after adjusting for potential confounders, bisexual men were more likely than gay or heterosexual men to report lifetime suicidality, with 34.8% of male bisexual respondents reporting ever having seriously considered suicide compared with 25.2% of gay men and 7.4% of heterosexual men. In addition, bisexual men reported poor or fair mental health with greater frequency than gay or heterosexual men (Brennan et al., 2010).

While the aforementioned studies have focussed solely on one gender or another, there exists a small body of research that examines mental health and sexual orientation, separating male and female datasets that report differences in the experience of mental health between male and female bisexuals (Bostwick, Boyd, Hughes, West, & McCabe, 2014; Leonard et al., 2012; Leonard, Lyons, & Bariola, 2015; Page, 2004). In Page's (2004) study of bisexual Americans' experiences of mental health services, more women reported stress or difficulty as a result of their sexual orientation than men. In the second Private Lives study exploring LGBT health and wellbeing in Australia, bisexual women were found to report higher levels of psychological distress, more frequent anxiety and

higher rates of diagnosis or treatment of a mental disorder than bisexual men (Leonard et al., 2012, 2015). Other studies have shown similar findings with bisexual women more likely to report mental health problems than bisexual men (Bostwick et al., 2014).

Substance use

Limited and conflicting data exist around bisexuals' patterns of substance use. While two studies have reported similar findings related to cannabis, suggesting use is higher for bisexual females than other sexual identity groups, data on alcohol and smoking rates share less consensus (Hughes et al., 2010; Leonard et al., 2015). The Private Lives 2 study (Leonard et al., 2012) found only minor variations in alcohol consumption and smoking rates between sexual identity groups. An analysis of data collected in a large Canadian population based study (Steele et al., 2009) reported higher rates of daily smoking and risky drinking by lesbian and bisexual women than their heterosexual counterparts, while a secondary analysis of the same survey data (Brennan et al., 2010), this time focussing on gay, bisexual and heterosexual men, found differences between drinking patterns and smoking rates became statistically insignificant after adjusting for potential confounding factors. Furthermore, two studies that compared drinking rates of bisexual and heterosexual women reported contrasting findings with one suggesting bisexual women drank significantly less alcohol than heterosexual women while the other reported the opposite (Bostwick et al., 2007; Conron et al., 2010). Similarly, Koh's & Ross's (2006) finding that bisexual women have higher illicit drug use than heterosexual or lesbian women is limited in its reliability by the study's recruitment technique which included only those visiting outpatient mental health clinics. This lack of consensus and significant differences in sampling makes determining substance use trends in this population problematic with no clear indication as to whether bisexual people are more or less at risk of drug and alcohol use than those of other sexual orientations.

Service access

Although service access is an issue that has the potential to have an impact on the mental health of bisexuals, the relationship between service accessibility and mental wellbeing has received little academic attention. Some researchers have suggested that negative attitudes from service providers, or the perceived risk of negative attitudes, may present a barrier to help-seeking among bisexual people (Li et al., 2013). The Private Lives 2 study found that bisexual men and women were substantially less likely than gay or lesbian participants to report being 'out' to their General Practitioner (GP) (Leonard et al., 2012). In Dobinson's and colleagues' (Dobinson, Macdonnell, Hampson, Clipsham, & Chow, 2005) community consultative research exploring a range of issues faced by bisexuals in relation to their health and well-being, the majority of participants felt service providers were neither knowledgeable nor inclusive of bisexual clients, with participants who had disclosed their sexual orientation to service providers reporting a range of responses to their disclosure from being accepted to being subjected to inappropriate sexual comments, biphobic attitudes and inappropriate or inapplicable care (Dobinson et al., 2005). Similarly Page's study, focussing on self-identified bisexuals' experiences of mental health services, found that issues such as clinicians' lack of knowledge about bisexuality, their view that bisexual behaviour or attraction is unhealthy, the lack of validation of bisexuality as a legitimate orientation and their limited skill in working with bisexuals were the most prominent issues for bisexual people seeking mental health treatment (Page, 2004).

Themes

Several themes emerged from the broader literature on bisexuality during the review process. These themes, briefly detailed below, represent only part of the complex tapestry that makes up the unique experiences of bisexual people in Western culture.

They depict some of the most prominent aspects of the bisexual life portrayed in the literature to date and are discussed within the context of their gradual evolution over time. Each emerging theme has the potential to have an impact on the mental health of bisexuals in contemporary society.

Invisibility and erasure

Many scholars, writers, activists and bisexual community members have described the invisibility of bisexuality, both in literature and in broader Western society. Yoshino (2000) describes this invisibility as encompassing the almost total omission of bisexuality in many areas including literature relating to sexuality. In Foucault's (1978) influential work, exploring and theorising sexuality from an historical standpoint, bisexuality is entirely neglected. This observation is not intended to point fault at Foucault himself for failing to make mention of this under represented sexuality, but instead serves to affirm accusations of bisexual invisibility by drawing attention to the fact that within Foucault's recount of the history of sexuality, bisexuality simply does not appear. Similarly, in Weeks' (1989) examination of the regulation of sexuality over the past 200 years, bisexuality is nowhere to be found. Klein (1993) describes this invisibility of bisexuality in scholarly endeavour as a 'profound silence' (Klein, 1993, p. 12), a silence Angelides (2001) believes has persisted into the twenty-first century. The invisibility of bisexuality is not only evident within academic writing; it is a social phenomenon within Western culture. Ochs (2011) describes this existence of social invisibility as being physical in nature, with 'bisexuality' rarely being physically visible, pointing out the rarity of seeing a person with a male lover on one arm and a female lover on the other. Participants in a study examining bisexual mental health in Canada (Ross, Dobinson, & Eady, 2010) described this very situation, with many expressing their frustration at having their sexual identity wrongly assumed based on the gender of their partner.

Some scholars have theorised that the invisibility associated with bisexuality is not simply the result of an inadvertent omission or the lack of a physically visible presence, but instead can be, at least in part, attributed to erasure. Eisner defines bisexual erasure as 'the widespread social phenomenon of erasing bisexuality from any discussion in which it is relevant or is otherwise invoked (with or without being named)' (Eisner, 2013, p. 59). Angelides (2001) postulates, and MacDowell (2009) concurs, that this erasure, evident in the writings of some of the best known theorists of sexuality including Freud and Kinsey, is undertaken in an effort to preserve the existing heterosexual/homosexual binary. This bisexual erasure, like invisibility more generally, occurs not only on the pages of academic texts, but in cultural attitudes and in the experiences of bisexual people (Ault, 1994; Eisner, 2013).

Stereotypes and biphobia

Stereotypes relating to bisexuality are extensive in number, cover a range of differing aspects of the bisexual existence and are most commonly derogatory in nature. Over time they have been promulgated by varying influential opponents across both heterosexual and gay and lesbian communities (Eadie, 1999; McLean, 2004). Stereotypes exist that attack individual character traits of bisexuals, paint bisexuals as a danger to society, undermine the bisexual's ability to find happy and healthy relationships, deny the existence of bisexuality and portray the identity as a political cop-out (Angelides, 2001; Däumer, 1999; Dobinson et al., 2005; Du Plessis, 1996; Eadie, 1999; Esterberg, 2011; Garber, 1995; Herek, 2002; McLean, 2004, 2007).

These negative attitudes towards bisexuality can fuel a specific form of discrimination directed at bisexual people commonly termed biphobia. Biphobia, also referred to as bi-negativity, can emerge from within both the heterosexual and homosexual communities (Blumstein & Schwartz, 1999; Paul, Smith, Mohr, & Ross,

2014; Weinberg et al., 1994). In Herek's (2002) research exploring North Americans' attitudes towards bisexuality, for which participants were randomly selected, he reported respondents' attitudes to bisexuals were more negative than for all other groups including those relating to religion, race, ethnicity and politics, with the only exception being injecting drug users. Several studies have identified biphobic discrimination as a problem particularly associated with lesbian and gay communities, with research reporting both significant experiences of biphobia from bisexuals within these communities and a high incidence of negative attitudes towards bisexuality from homosexually identified individuals (Ault, 1994; Brennan & Hegarty, 2012; Dobinson et al., 2005; Feinstein, Dyar, Bhatia, Latack, & Davil, 2014; Li et al., 2013). In addition, biphobia can be internalised by bisexual people causing significant distress (Paul et al., 2014). In a recent study (Chard, Finneran, Sullivan, & Stephenson, 2015) examining men's experiences of homophobia across Western and non-Western countries, bisexual men reported significantly higher levels of internalised homophobia than gay men, regardless of their nationality. This combination of society's negative attitudes towards bisexuality and experiences of biphobia can have a significant impact on bisexual people, an issue that will be further explored in latter sections of this review (Bostwick, 2012; Dobinson et al., 2005).

Despite the plethora of negative stereotypes, some assumptions surrounding bisexuals have taken a decidedly more positive tone depicting bisexuality as a pure and natural state that has not been tainted by society's efforts to manipulate people into monosexual identities, a post-modern, chic and trendy identity that allows individuals to enjoy the best of both the heterosexual and homosexual worlds (Däumer, 1999; Esterberg, 2011).

Identity and labels

Incorporating bisexuality as a core aspect of individual identity is a relatively new phenomenon not documented prior to the sexual revolution of the 1970's (Esterberg, 2011; George, 1999; Udis-Kessler, 2013). In addition, despite bisexual behaviour being observed cross-culturally, bisexuality as an identity appears largely isolated to Western societies (Carrier, 1999; Esterberg, 2011; Sittitrai, Brown, & Virulrak, 1999). A bisexual identity can be self-applied for a variety of reasons that include individual attraction and behaviour as well as political alignments and socio-cultural contexts (Bradford, 2004; Dollimore, 1996). In the twenty-first century, a broadening discourse of identity terminology for those attracted to more than one gender has emerged to include pansexual, polysexual, homoflexible, heteroflexible, biromantic, bisensual and bi-curious, among others (Eisner, 2013; Sunfrog, 2013).

There exists one resounding point of agreement in the literature on the topic of bisexual identity: developing and maintaining such an identity is a complex task. The difficulty of determining an applicable sexual identity for individuals whose attraction and/or behaviours fall outside of socially acceptable monosexual experiences has been reported by numerous researchers (Balsam & Mohr, 2007; Bradford, 2004; Clausen, 1999; Dodge et al., 2012; Ross et al., 2010; Weinberg et al., 1994). This struggle with sexual identity has been found to be more onerous for bisexuals than for homosexuals, an issue personally reflected on by Jan Clausen in her article My Interesting Condition within which she expressed that her identity dilemma 'takes up a ridiculous amount of energy, both my own and other people's' (Clausen, 1999, p. 108). A bisexual identity is often referred to as an ongoing process characterised by continued uncertainty and persistent confusion (Bradford, 2004; Weinberg et al., 1994).

While the consensus is that the process of self-identifying as bisexual is complex, the act of labelling others as bisexual is immensely problematic (Angelides, 2001; Ellis, 1999). Due to the fluidity of sexual self-identification and the potential incongruence

between self-identity, attraction and behaviour, relying on the reporting of identity by research participants would act to significantly narrow the categories incorporated in studies of non-monosexual sexuality. To address this issue several scales and measures have been developed for the purpose of creating objective categories of sexual orientation based on a range of factors, the most notable and broadly used of which have been the Kinsey Scale (Kinsey, Pomeroy, & Martin, 1948) and the Klein Sexual Orientation Grid (KSOG) (Klein, 1993). More recently there has been a shift to the three axes approach to sexual orientation which asks participants about their identity, attraction and behaviour (Bostwick et al., 2010; Drucker, 2010).

Intimate relationships and sexual behaviour

Bisexuals' intimate relationships are characterised by complexity, diversity and often, challenges (Bradford, 2004; McLean, 2004; Ross et al., 2010; Weinberg et al., 1994). Some challenges represent internal conflicts within bisexuals themselves and can include making difficult decisions regarding disclosure of their sexuality within relationships and, as one study (Li et al., 2013) reported, the fear of entering a monogamous relationship with one gender and not being sexually satisfied (Li et al., 2013). Other difficulties can arise as a result of partners, or potential partners, holding negative attitudes towards bisexuality including the assumption that bisexual people are destined to cheat, causing jealousy and insecurity (Bradford, 2004; Dobinson et al., 2005; Li et al., 2013; McLean, 2004). The complexity of bisexuals' intimate relationships often relates to the significant diversity in relationship structures existing among this population and the intricacies of negotiating monogamy or non-monogamy within these relationships (Dobinson et al., 2005; Weinberg et al., 1994). The invisibility associated with being in a relationship, particularly a monogamous relationship, can make simply maintaining a bisexual identity in these circumstances a challenge in and of itself (Dobinson et al., 2005; Ross et al., 2010).

The literature on bisexual sexual behaviour highlights patterns of multiple partners (Badcock et al., 2014). This multiplicity can impact positively on sexual wellbeing. One study of bisexual women (Schick, Rosenberger, Herbenick, Calabrese, & Reece, 2012) found those who engaged in sexual behaviour with both men and women in the recent past reported greater arousal, less pain, higher rates of orgasm and better overall sexual wellbeing than bisexual women with only one sexual partner. Other studies have found that bisexual participants have more sexual partners than heterosexuals over a 12 month period, bisexual women are more likely to have sexual intercourse before the age of 16 than their straight or gay peers and bisexual men are significantly more likely to have paid for sex than heterosexuals or homosexuals (Koh & Ross, 2006; Rissel et al., 2014; Rissel, Richters, Grulich, De Visser, & Smith, 2003a, 2003b). In addition, a number of large studies have reported correlations between bisexuality in women and a past history of sexual abuse, with female bisexuals substantially more likely than women of other sexual orientation groups to report ever having experienced abuse or sexual coercion (De Visser et al., 2014; McNair et al., 2005; Persson et al., 2015).

Coming out

The term 'coming out' is commonly used to describe the act of a person who identifies with a minority sexual identity disclosing this identity to another. For same-sex attracted people this is often seen as a positive and necessary step towards greater self-acceptance and living fully in congruence with their sexual identity (McLean, 2007). Although bisexual people are usually same-sex attracted, the process of coming out has been described as more complicated than for other same-sex attracted people, with added layers of complexity that are unique to the bisexual's experience (Dobinson et al., 2005; McLean, 2007). The contention in defining bisexuality along with the prevalence of negative stereotypes, the continued uncertainty of those identifying as bisexual and the complexities of bisexual relationships, can impact on a bisexual person's comfort in

disclosing their sexual identity to others (Dobinson et al., 2005; McLean, 2007; Ross et al., 2010).

Perhaps as a consequence of the significant complexity of the coming out process for bisexual people, bisexuals have been found to be less out than their gay and lesbian counterparts with bisexual males the least likely to have disclosed their identity (Balsam & Mohr, 2007; Dobinson et al., 2005; Eisner, 2013; Koh & Ross, 2006; Leonard et al., 2012; Persson et al., 2015; Weinberg et al., 1994). In McLean's research of Australian bisexuals she found that over half of her sample had not disclosed to at least one parent while Weinberg and colleagues reported that just one third of participants in their study had disclosed to their partner (McLean, 2007; Weinberg et al., 1994). As a way of avoiding questions related to their sexuality and allowing for greater selectivity in to whom they chose to disclose, those who identify as bisexual report presenting as heterosexual or homosexual depending on the context at the time (McLean, 2007, 2008; Weinberg et al., 1994). The act of altering their identity dependent on the company they are in has been found to be a significant issue for bisexual people with the challenge of having to present a different persona in different situations reportedly leading to anger and frustration (McLean, 2008; Weinberg et al., 1994).

Community and belonging

Bisexual people have been found to have lower levels of social support than their gay and lesbian counterparts (Bradford, 2004; Hughes et al., 2010; McNair et al., 2005; Ross et al., 2010). A number of studies have reported that bisexual people often feel unsupported and unacknowledged by their family, friends and the broader society due to their sexual identity (Bradford, 2004; Ross et al., 2010). Community groups that specifically cater for bisexuals are few and far between, and when they do exist, barriers such as geographic location and the fear of stigma from the broader community can limit

membership. However, for those bisexuals who are able to access these groups, the ability to mingle with others who share their sexual identity has been described in a positive light (Dodge et al., 2012; Ross et al., 2010).

Bisexuals report varying degrees of involvement in, and experiences of, lesbian, gay and LGBT (lesbian, gay, bisexual and transgender) community groups, as well as within the heterosexual community. Several studies have reported similar results where this is concerned, finding that some bisexuals feel accepted within the homosexual community and some within the heterosexual community, while many report not feeling accepted anywhere (Bradford, 2004; Dobinson et al., 2005; Dodge et al., 2012; Ross et al., 2010). An interviewee in Bradford's (2004) study summed up this feeling of belonging nowhere by stating 'bi's are too straight for the gay community and they're too queer for the straight community' (Bradford, 2004, p. 15).

This social isolation and lack of community involvement has been found to lead to feelings of loneliness and isolation for bisexual people, with bisexual men being particularly vulnerable (Bradford, 2004; Dodge et al., 2012; Eisner, 2013; Leonard et al., 2012; McLean, 2008). Klein (1999) discusses this issue for bisexuals as early as the 1970s highlighting the need for bisexuals, as human beings, to feel they belong to a group: 'they need to sit around the communal fire not only in warmth but in dignity' (Klein, 1999, p. 40). Not only has research shown that being part of a community which views bisexuality in a positive light reduces feelings of isolation for bisexual people, this increased social connection has also been associated with a feeling of validation with regard to their identity, a significant sense of relief, decreased internalised homophobia, greater ease with managing the public aspect of a bisexual identity and a greater ability to deflect social negativity (Bradford, 2004; Chard et al., 2015; Knous, 2006; McLean, 2008; Weinberg et al., 1994).

Positive aspects

Despite the vast majority of literature on bisexuality, focussing on the difficulties of being bisexual, some studies have reported briefly on the positive aspects of living as a bisexual person. Although it is recognised that there are positive aspects to all of the aforementioned themes, this section is presented separately in the review as this is a more accurate representation of its occurrence in the literature. In Rostosky et al.'s (2010) sample, respondents expressed a sense of freedom from social rules and labels, the feeling that they were able to live as their authentic and honest selves, a greater understanding of those oppressed by society and freedom within relationships to express themselves and love without gender boundaries (Rostosky, Riggle, Pascale-Hague, & McCants, 2010). Bradford's study (Bradford, 2004) of self-identified bisexuals reported similar findings with many participants feeling they had gained a sense of strength, independence and self-reliance in coming to terms with a sexuality that is largely unaccepted in Western culture, describing their journey as an ultimately enriching experience allowing them to look beyond gender within relationships and empathise with underprivileged society members.

Linking themes to mental health

Each identified literature 'theme', as presented in this review, has the potential to play a part in the unique mental health experiences of bisexual individuals and to date there has been only small pockets of research exploring these associations. This research field is in its infancy and is at present characterised by small studies focussed on drawing links between one or two specific aspects of bisexuality and mental health, alongside larger studies aimed at exploring mental health across sexual orientation groups which offer some preliminary findings that may begin to provide some insight into why these high rates of poor mental health exist.

A number of studies have reported that experiences of biphobia and bi-negativity as well as negative stereotyping and social attitudes towards bisexual people are associated with higher rates of depression and lowered levels of self-esteem (Bostwick, 2012; Dodge et al., 2012; Molina et al., 2015; Ross et al., 2010). Although these associations reportedly exist, studies in both the United States and Australia have found that discrimination and abuse on the basis of sexual orientation is more commonly experienced by lesbians and gay men (Bostwick et al., 2014; Leonard et al., 2015). As bisexual people have repeatedly been found to have poorer mental health than their lesbian and gay counterparts, these findings would suggest that while experiences of biphobia are likely to play a role in the mental health of bisexual people, they do not alone appear to offer an explanation for the existing mental health disparities between sexual orientation groups.

Relationships between the mental health of bisexuals and identity, labels, and coming out, are complex and research in this area has been limited and inconsistent. Dodge's and colleagues' (2012) study of bisexually behaving men in the United States found that participants' feelings of insecurity in the way they label their sexual identity as well as pressure to assume a monosexual identity had a negative impact on their mental health. In a similar vein, participants in a Canadian based study reported the positive mental health benefits associated with the self-acceptance of their bisexual identity (Ross et al., 2010). While coming out has been associated with positive mental health benefits for lesbians and gay men, for bisexual people this association appears to be less clear (Koh & Ross, 2006; McLean, 2007). McLean's (McLean, 2007) research into the lives of bisexual Australians suggests that 'being out', at least in some capacity, may have positive mental health implications. These findings are mirrored by Ross's and colleagues' (Ross et al., 2010) study reporting that bisexual participants noted the mental health benefits of their being out in the workplace. In contrast, Koh's & Ross's (2006)

comparative study of the mental health of bisexual, lesbian and heterosexual women found that bisexual women reported recent suicidal ideation with greater frequency if they were out than if they were not. By comparison a recent study of 470 bisexually identified women in the United States reported no correlation between outness and mental health (Molina et al., 2015).

As previously discussed, bisexual people's relationships are often characterised by significant complexity and this complexity can have implications for sexual behaviour. Li and colleagues (Li et al., 2013) recently reported on the findings of their Canadian research relaying that bisexual participants discussed the positive mental health benefits associated with relationships where partners were supportive of their bisexual orientation. Although Koh's & Ross's (2006) research found that being in a relationship was associated with decreased stress regardless of one's sexual orientation, other studies have reported that different relationship types can have different mental health implications for bisexual people (Dyar, Feinstein, & London, 2014; Molina et al., 2015). Two studies were identified for this review that explored mental health and varying types of relationships in bisexual populations, both of which focussed solely on women (Dyar et al., 2014; Molina et al., 2015). Findings suggest that bisexual women in same-sex relationships fare best, while bisexual women with one male partner and those with concurrent multiple female and male partners have higher incidences of depressive symptoms (Dyar et al., 2014; Molina et al., 2015). In addition, sexual behaviour has been found to be associated with mental health outcomes, with one international survey finding that bisexual women who had engaged in sexual behaviour with only women or with both women and men in the preceding 30 days had had fewer mentally unhealthy days than those with only one male sexual partner (Schick et al., 2012).

Feeling part of a community and having a sense of belonging within social groups is intertwined with mental health and wellbeing. As community and belonging can be

complex and at times problematic for bisexual people it is not surprising that the limited research conducted in this area has found an association with mental health (Dodge et al., 2012; Ross et al., 2010; Sheets & Mohr, 2009). Support from friends and family has been found to be closely associated with bisexuals' mental wellbeing with greater support equating to better mental health as illustrated by one study reporting that bisexually identified friends can have an especially positive impact on mental wellbeing (Ross et al., 2010; Sheets & Mohr, 2009). Dodge and colleagues (Dodge et al., 2012) report that bisexual men are particularly vulnerable to social isolation stemming from a lack of social acceptance and unavailability of a bisexual community. Furthermore, the Private Lives 2 study reported gender differences among bisexuals in relation to community participation and bisexual mental health, with participation in mainstream community events being associated with increased resilience for both bisexual males and bisexual females, while participation in LGBT specific community events was associated with increased resilience for bisexual women but not bisexual men (Leonard et al., 2015).

Research recommendations

Many researchers and theorists of bisexuality have included in their publications recommendations for future research. There is clear urging by the academic community to conduct research that focuses solely on bisexuals (Balsam & Mohr, 2007; Dodge & Sandfort, 2007; MacDonald, 2000). In addition there is a recurring recommendation within the literature that this future research needs to focus on the health, and specifically the mental health, of bisexual people (Dobinson et al., 2005; McNair et al., 2005; Ochs, 2011). Many scholars take this further by calling specifically for studies that aim to offer greater understanding of why bisexual people have been found to have poorer mental health than those of other sexual orientations, an area of investigation in which current knowledge is extremely limited (McNair et al., 2005; Ochs, 2011).

Several recommendations have been put forward within the literature on *how* bisexuality should be researched and these relate to the recruitment of participants, measures of sexual orientation and the gender of participants. Some have identified the importance of recruiting from a broad range of settings, particularly when exploring health related issues of bisexual people, to ensure inclusion of participants in both clinical and community settings (Paul et al., 2014). Others have focussed on the use of measures of sexual orientation with the general consensus within current literature being that recruiting via just one dimension of sexual orientation is inferior and that instead, for broad studies exploring issues that exist across dimensions, a three axes approach to include attraction, behaviour and identity is optimal (Bostwick et al., 2010; Laumann, Gagnon, Michael, & Michaels, 1994; Mathy, Lehmann, & Kerr, 2004; McNair et al., 2005; Yoshino, 2000). Finally, bisexual men and women have been found to have different experiences of bisexuality and different mental health outcomes and there is minimal data exploring bisexuality in the context of broader categorisations of gender that move beyond male and female binaries, thus there is a need to study gender groups in isolation from one another to gain further insights into the variations in mental health of bisexuals of different gender identities (Dobinson et al., 2005; Leonard et al., 2012).

Review conclusion

This review was conducted for the purpose of informing the development of future research in the area of bisexuality and specifically bisexual mental health. The term bisexuality has been briefly defined and the results of scholarly endeavour to understand the mental health of bisexual people were explored. Major themes emerging from the literature have been presented that relate to the lived experiences of bisexuals in contemporary society and the small pockets of research that have examined these themes alongside mental health outcomes have been summarised. Recommendations from

scholars in the field as to how best to conduct research of bisexual populations have been outlined.

Several gaps in the literature on bisexuality exist. Perhaps the most pressing of these is the currently extremely limited knowledge of why bisexual people experience poorer mental health than the lesbian, gay or heterosexual counterparts. Larger-scale studies exploring this issue with a specific focus on bisexual people are urgently needed in order to equip those in the academic, political, health and social services spheres, including and as well as bisexuals themselves, with knowledge that can better inform future research, policy development, mental health interventions, social support programs and self-care. The insights this research would provide will play an integral role in building a future where bisexuals can be happy, healthy, accepted and celebrated.

Declaration of interest

The author reports no conflicts of interest. The author alone is responsible for the content and writing of the article.

References

Angelides, S. (2001). *A history of bisexuality*. Chicago, IL: The University of Chicago Press.

Ault, A. (1994). Hegemonic discourse in an oppositional community: Lesbian feminists and bisexuality. *Critical Sociology, 20*(3), 107–122.

Badcock, P. B., Smith, A. M. A., Richters, J., Rissel, C., De Visser, R. O., Simpson, J. M., … Grulich, A. E. (2014). Characteristics of heterosexual regular relationships among a representative sample of adults: The second Australian study of health and relationships. *Sexual Health, 11*(5), 427– 438.

Balsam, K. F., & Mohr, J. J. (2007). Adaptation to sexual orientation stigma: A comparison of bisexual and lesbian/gay adults. *Journal of Counseling Psychology, 54*(3), 306.

Blumstein, P. W., & Schwartz, P. (1999). Bisexuality: Some social psychological issues

(1977). In M. Storr (Ed.), *Bisexuality: A critical reader*, pp. 59–74. London: Routledge.

Bostwick, W. B. (2012). Assessing bisexual stigma and mental health status: A brief report. *Journal of Bisexuality*, *12*(2), 214–222. doi: 10.1080/15299716.2012.674860

Bostwick, W. B., Boyd, C. J., Hughes, T. L., & McCabe, S. E. (2010). Dimensions of sexual orientation and the prevalence of mood and anxiety disorders in the United States. *American Journal of Public Health*, *100*(3), 468. doi: 10.2105/AJPH.2008.152942

Bostwick, W. B., Boyd, C. J., Hughes, T. L., West, B. T., & McCabe, S. E. (2014). Discrimination and mental health among lesbian, gay, and bisexual adults in the United States. *American Journal of Orthopsychiatry*, *84*(1), 35.

Bostwick, W. B., McCabe, S. E., Horn, S., Hughes, T., Johnson, T., & Valles, J. R. (2007). Drinking patterns, problems, and motivations among collegiate bisexual women. *Journal of American College Health*, *56*(3), 285– 292. doi: 10.3200/JACH.56.3.285-292

Bradford, M. (2004). The bisexual experience: Living in a dichotomous culture. In R. C. Fox (Ed.), *Current research on bisexuality*, pp. 7–23. New York, NY: Harrington Park Press.

Brennan, D. J., Ross, L. E., Dobinson, C., Veldhuizen, S., & Steele, L. S. (2010). Men's sexual orientation and health in Canada. *Canadian Journal of Public Health / Revue Canadienne de Sante'e Publique*, *101*(3), 255–258.

Brennan, T., & Hegarty, P. (2012). Charlotte Wolff 's contribution to bisexual history and to (sexuality) theory and research: A reappraisal for queer times. *Journal of the History of Sexuality*, *21*(1), 141–161.

Carrier, J. M. (1999). Mexican male bisexuality (1985). In M. Storr (Ed.), *Bisexuality: A critical reader*, pp. 75–86. London: Routledge.

Chard, A. N., Finneran, C., Sullivan, P. S., & Stephenson, R. (2015). Experiences of homophobia among gay and bisexual men: Results from a cross-sectional study in seven countries. *Culture, Health & Sexuality*, *17*(10), 1174–1189. doi: 10.1080/13691058.2015.1042917

Clausen, J. (1999). Extract from my interesting condition (1990). In M. Storr (Ed.), *Bisexuality: A critical reader*, pp. 107–111. London: Routledge.

Conron, K. J., Mimiaga, M. J., & Landers, S. J. (2010). A population-based study of

sexual orientation identity and gender differences in adult health. *The American Journal of Public Health*, *100*(10), 1953–1960.

Däumer, E. D. (1999). Extract from queer ethics; or, the challenge of bisexuality to lesbian ethics (1992). In M. Storr (Ed.), *Bisexuality: A critical reader*, pp. 152–161. London: Routledge.

De Visser, R. O., Badcock, P. B., Rissel, C., Richters, J., Smith, A. M. A., Grulich, A. E., … Simpson, J. M. (2014). Experiences of sexual coercion in a representative sample of adults: The second Australian study of health and relationships. *Sexual Health*, *11*(5), 472–480.

Diamond, L. M. (2008). Female bisexuality from adolescence to adulthood: Results from a 10-year longitudinal study. *Developmental Psychology*, *44*(1), 5–14.

Dobinson, C., Macdonnell, J., Hampson, E., Clipsham, J., & Chow, K. (2005). Improving the access and quality of public health services for bisexuals. *Journal of Bisexuality*, *5*(1), 39–77. doi:10.1300/J159v05n01_05

Dodge, B., & Sandfort, T. G. M. (2007). A review of mental health research on bisexual individuals when compared to homosexual and heterosexual individuals. In B. A. Firestein (Ed.), *Becoming visible: Counseling bisexuals across the lifespan*, pp. 28–51. New York, NY: Columbia University Press.

Dodge, B., Schnarrs, P., Reece, M., Martinez, O., Goncalves, G., Malebranche, D., … Fortenberry, J. D. (2012). Individual and social factors related to mental health concerns among bisexual men in the Midwestern United States. *Journal of Bisexuality*, *12*(2), 223–245. doi: 10.1080/15299716.2012.674862

Dollimore, J. (1996). Bisexuality, heterosexuality, and wishful theory. *Textual Practice*, *10*(3), 523–539. doi: 10.1080/09502369608582258

Drucker, D. J. (2010). Male sexuality and Alfred Kinsey's 0–6 scale: Toward "a sound understanding of the realities of sex". *Journal of Homosexuality*, *57*(9), 1105–1123. doi: 10.1080/00918369.2010.508314

Du Plessis, M. (1996). Blatantly bisexual; or, unthinking queer theory. In M. Pramaggiore & D. E. Hall (Eds.), *RePresenting bisexualities: Subjects and cultures of fluid desire*, pp. 19–54. London, New York, NY: New York University Press.

Dyar, C., Feinstein, B. A., & London, B. (2014). Dimensions of sexual identity and minority stress among bisexual women: The role of partner gender. *Psychology of Sexual Orientation and Gender Diversity*, *1*(4), 441–451.

Eadie, J. (1999). Extracts from activating bisexuality: Towards a bi/sexual politics (1993). In M. Storr (Ed.), *Bisexuality: A critical reader*, pp. 119–137. London: Routledge.

Eisner, S. (2013). *Bi: Notes for a bisexual revolution*. Berkeley, CA: Seal Press.

Ellis, H. (1999). Extracts from studies in the psychology of sex, Volume I:Sexual inversion (1897) and from studies in the psychology of sex, Volume II: Sexual inversion (1915). In M. Storr (Ed.), *Bisexuality: A critical reader*. London: Routledge.

Esterberg, K. G. (2011). The bisexual menace revisited: Or, shaking up social categories is hard to do. In S. Seidman, N. Fischer, & C. Meeks (Eds.), *Introducing the new sexuality studies 2nd edition*. London, New York: Routledge.

Feinstein, B. A., Dyar, C., Bhatia, V., Latack, J. A., & Davil, J. (2014). Willingness to engage in romantic and sexual activities with bisexual partners: Gender and sexual orientation differences. *Psychology of Sexual Orientation and Gender Diversity*, *1*(3), 255–262.

Foucault, M. (1978). *The history of sexuality* (Vol. 1). New York, NY: Pantheon Books.

Garber, M. (1995). *Vice versa: Bisexuality and the eroticism of everyday life*. London, New York: Penguin Books.

George, S. (1999). Extracts from women and bisexuality (1993). In M. Storr (Ed.), *Bisexuality: A critical reader*. London: Routledge.

Herbenick, D., Reece, M., Schick, V., Sanders, S. A., Dodge, B., & Fortenberry, J. D. (2010). Sexual behavior in the United States: Results from a national probability sample of men and women ages 14–94. *Journal of Sexual Medicine*, *7*, 255–265.

Herek, G. M. (2002). Heterosexuals' attitudes toward bisexual men and women in the United States. *The Journal of Sex Research*, *39*(4), 264– 275.

Hughes, T., Szalacha, L. A., & McNair, R. (2010). Substance abuse and mental health disparities: Comparisons across sexual identity groups in a national sample of young Australian women. *Social Science & Medicine*, *71*(4), 824–831. doi: 10.1016/j.socscimed.2010.05.009

Jorm, A. F., Korten, A. E., Rodgers, B., Jacomb, P. A., & Christensen, H. (2002). Sexual orientation and mental health: Results from a community survey of young and middle-aged adults. *The British Journal of Psychiatry: The Journal of Mental Science*, *180*, 423.

Kinsey, A. C., Pomeroy, W. B., & Martin, C. E. (1948). *Sexual behavior in the human male*. Bloomington, IN: W. B. Saunders Company.

Klein, F. (1993). *The bisexual option: Second edition* (2nd ed.). New York & London: Routledge Ltd.

Klein, F. (1999). Extracts from the bisexual option: A concept of one hundred percent intimacy (1978). In M. Storr (Ed.), *Bisexuality: A critical reader*, pp. 38–48. London: Routledge.

Knous, H. M. (2006). The coming out experience for bisexuals: Identity formation and stigma management. *Journal of Bisexuality*, *5*(4), 37–59. doi: 10.1300/J159v05n04_05

Koh, A. S., & Ross, L. K. (2006). Mental health issues: A comparison of lesbian, bisexual and heterosexual women. *Journal of Homosexuality*, *51*(1), 33.

Laumann, E. O., Gagnon, J. H., Michael, R. T., & Michaels, S. (1994). *The social organization of sexuality: Sexual practices in the United States*. Chicago, IL: University of Chicago Press.

Leonard, W., Lyons, A., & Bariola, E. (2015). *A closer look at Private Lives 2*. Melbourne: Australian Research Centre in Sex, Health and Society, La Trobe University.

Leonard, W., Pitts, M., Mitchell, A., Lyons, A., Smith, A., Patel, S., … Barrett, A. (2012). *Private Lives 2: The second national survey of the health and wellbeing of GLBT Australians*. Melbourne: Australian Research Centre in Sex, Health and Society, La Trobe University.

Li, T., Dobinson, C., Scheim, A., & Ross, L. (2013). Unique issues bisexual people face in intimate relationships: A descriptive exploration of lived experience. *Journal of Gay & Lesbian Mental Health*, *17*(1), 21–39. doi: 10.1080/19359705.2012.723607

MacDonald, A. P. (2000). A little bit of lavender goes a long way: A critique of research on sexual orientation. In P. Rust (Ed.), *Bisexuality in the United States: A social science reader*, pp. 24–30. New York, NY: Columbia University Press.

MacDowell, L. (2009). Historicising contemporary bisexuality. *Journal of Bisexuality*, *9*(1), 3–15.

Mathy, R., Lehmann, B., & Kerr, D. (2004). Bisexual and transgender identities in a nonclinical sample of north Americans: Suicidal intent, behavioral difficulties, and mental health treatment. *Journal of Bisexuality*, *3*(3,4), 93–109. doi: 10.1300/J159v03n03_07

McLean, K. (2004). Negotiating (non)monogamy: Bisexuality and intimate relationships. *Journal of Bisexuality*, *4*(1-2), 83–97.

McLean, K. (2007). Hiding in the closet? Bisexuals, coming out and the disclosure imperitive. *Journal of Sociology*, *43*(2), 151–166.

McLean, K. (2008). Inside, outside, nowhere: Bisexual men and women in the gay and lesbian community. *Journal of Bisexuality*, *8*(1,2), 63–80. doi: 10.1080/15299710802143174

McNair, R., Kavanagh, A., Agius, P., & Tong, B. (2005). The mental health status of young adult and midlife nonheterosexual Australian women. *Australian and New Zealand Journal of Public Health*, *29*(3), 265.

Molina, Y., Marquez, J., Logan, D., Leeson, C., Balsam, K., & Kaysen, D. (2015). Current intimate relationship status, depression, and alcohol use among bisexual women: The mediating roles of bisexual-specific minority stressors. *Sex Roles*, *73*(1), 43–57. doi:10.1007/s11199-015-0483-z

Ochs, R. (2011). Why we need to "get bi". *Journal of Bisexuality*, *11*(2,3), 171–175. doi: 10.1080/15299716.2011.571983

Page, E. H. (2004). Mental health services experiences of bisexual women and bisexual men: An empirical study. In R. C. Fox (Ed.), *Current research on bisexuality*, pp. 137–160. New York, NY: Harrington Park Press.

Paul, R., Smith, N. G., Mohr, J. J., & Ross, L. E. (2014). Measuring dimensions of bisexual identity: Initial development of the bisexual identity inventory. *Psychology of Sexual Orientation and Gender Diversity*, *1*(4), 452–460.

Persson, T. J., Pfaus, J. G., & Ryder, A. G. (2015). Explaining mental health disparities for non-monosexual women: Abuse history and risky sex, or the burdens of non-disclosure? *Social Science & Medicine*, *128*, 366– 373. doi: 10.1016/j.socscimed.2014.08.038

Pompili, M., Lester, D., Forte, A., Seretti, M. E., Erbuto, D., Lamis, D. A., … Girardi, P. (2014). Bisexuality and suicide: A systematic review of the current literature. *Journal of sexual medicine*, *11*(8), 1903–1913.

Richters, J., Altman, D., Badcock, P. B., Smith, A. M. A., De Visser, R. O., Grulich, A. E., … Simpson, J. M. (2014). Sexual identity, sexual attraction and sexual experience: The second Australian study of health and relationships. *Sexual Health*, *11*(5), 451–460.

Rissel, C. E., Heywood, W., De Visser, R. O., Simpson, J. M., Grulich, A. E., Badcock, P.

B., … Richters, J. (2014). First vaginal intercourse and oral sex among a representative sample of Australian adults: The second Australian study of health and relationships. *Sexual Health*, *11*(5), 406–415.

Rissel, C. E., Richters, J., Grulich, A. E., De Visser, R. O., & Smith, A. M. A. (2003a). Experiences of commercial sex in a representative sample of adults. *Australian and New Zealand Journal of Public Health*, *27*(2), 191–197.

Rissel, C. E., Richters, J., Grulich, A. E., De Visser, R. O., & Smith, A. M. A. (2003b). First experiences of vaginal intercourse and oral sex among a representative sample of adults. *Australian and New Zealand Journal of Public Health*, *27*(2), 131–137.

Ross, L. E., Dobinson, C., & Eady, A. (2010). Perceived determinants of mental health for bisexual people: A qualitative examination. *American Journal of Public Health*, *100*(3), 496. doi: 10.2105/AJPH.2008.156307

Rostosky, S. S., Riggle, B. E., Pascale-Hague, D., & McCants, L. (2010). The positive aspects of a bisexual self-identification. *Psychology & Sexuality*,*1*(2), 131–144. doi: 10.1080/19419899.2010.484595

Rust, P. (2000). Review of statistical findings about bisexual behaviour, feelings, and identities In P. Rust (Ed.), *Bisexuality in the United States: A social science reader*, pp. 129–184. New York, NY: Columbia University Press.

Schick, V., Rosenberger, J., Herbenick, D., Calabrese, S., & Reece, M. (2012). Bidentity: Sexual behavior/identity congruence and women's sexual, physical and mental well-being. *Journal of Bisexuality*, *12*(2), 178–197. doi: 10.1080/15299716.2012.674855

Sheets, R. L., , & Mohr, J. J. (2009). Perceived social support from friends and family and psychosocial functioning in bisexual young adult col lege students. *Journal of Counseling Psychology*, *56*(1), 152–163. doi:10.1037/0022-0167.56.1.152

Sittitrai, W., Brown, T., & Virulrak, S. (1999). Extracts from patterns of bisexuality in Thailand (1991). In M. Storr (Ed.), *Bisexuality: A critical reader*, pp. 87–99. London: Routledge.

Smith, A. M. A., Rissel, C. E., Richters, J., Grulich, A. E., & De Visser, R. O. (2003). Sexual identity, sexual attraction and sexual experience among a representative sample of adults. *Australian and New Zealand Journal of Public Health*, *27*(2), 138–145.

Steele, L., Ross, L., Dobinson, C., Veldhuizen, S., & Tinmouth, J. (2009). Women's

sexual orientation and health: Results from a Canadian population-based survey. *Women & Health*, *49*(5), 353–367. doi: 10.1080/03630240903238685

Sunfrog. (2013). Pansies against patriarchy: Gender blur, bisexual men, and queer liberation. In Tucker N., (Ed.), *Bisexual politics: Theories, queries and visions* (pp. 319–324). New York & London: Routledge.

Udis-Kessler, A. (2013). Identity/politics: A history of the bisexual movement. In N. Tucker (Ed.), *Bisexual politics: Theories, queries and visions* (pp. 17–30). New York & London: Routledge.

Weeks, J. (1989). *Sex, politics, and society: The regulation of sexuality since 1800* (2nd ed.). London: Longman.

Weinberg, M. S., Williams, C. J., & Pryor, D. W. (1994). *Dual attraction: Understanding bisexuality*. New York, NY: Oxford University Press.

Yoshino, K. (2000). The epistemic contract of bisexual erasure. *Stanford Law Review*, *52*(2), 353–461.

Chapter 4

Methodology

"It's just so refreshing to be able to open up about stuff that normally has to be concealed"

– *Who I Am* participant

This chapter presents the paper *'Who I Am: Reflections on a Successful Bisexual Research Methodology'* as submitted to the Journal of Sex Research where it is currently under review. This article details the research methodology used in the *Who I Am* study and explores both its successes and challenges. It is not a common practice in PhD theses to present the methodology chapter as a publishable paper. However, the significant insights gleaned from conducting research in an area that has received limited scholarly attention was deemed by the research team (myself and my supervisors) as of interest and relevance to academics and researchers. Further, the uniqueness of using a nation-wide quantitative methodology for this population, coupled with a large sample size, potentially made it of interest to a wider audience. It is intended that the sharing/publishing of these experiences will help to inform future research focusing on bisexuality and, more specifically, bisexual mental health, and will reduce the continued need for 'reinventing the wheel'.

Under Review: Taylor, J., Power, J. & Smith, E. (2018). Who I Am: Reflections on a successful bisexual research methodology. Submitted to *Journal of Sex Research*.

Who I Am: Reflections on a Successful Bisexual Research Methodology

Julia Taylor, Jennifer Power & Elizabeth Smith

Abstract

Bisexual people have consistently been found to experience poorer mental health than their lesbian, gay and heterosexual counterparts and more research is urgently needed to shed greater light on the reasons behind this phenomenon. However, due to the paucity of such research, there is a severe limitation of methodological insights to inform future research. A significant challenge for researchers in this area is the difficulties encountered in recruiting from a characteristically diverse and hidden population. This paper presents the methodological approach of the recent *Who I Am* study with a particular focus on the effective recruitment strategies that allowed the research team to overcome common barriers to recruitment. The study utilised a cross-sectional survey method and, through the incorporation of an extensive recruitment strategy and comprehensive survey instrument, successfully recruited one of the largest samples of bisexual people to date (*n* = 2,651). Paid Facebook advertising and the publication of media articles were found to be the most effective recruitment techniques. Feedback showed that participants especially welcomed the inclusivity of the survey. Sharing methodological successes and challenges in this field will prove valuable in informing much needed future research.

Keywords: Bisexual research; LGBT research methodologies; Bisexuality; Bisexual mental health

Introduction

Both historically and contemporarily, bisexuality has received comparatively little attention in academic research, often overshadowed by, or absorbed within, studies of other sexual minority groups (Balsam & Mohr, 2007; Dodge & Sandfort, 2007; MacDonald, 2000). With the now well established finding that bisexual people experience significantly poorer mental health than their lesbian, gay and heterosexual counterparts (Bostwick, Boyd, Hughes, & McCabe, 2010; Bostwick et al., 2007; Conron, Mimiaga, & Landers, 2010; Eisner, 2013; Hughes, Szalacha, & McNair, 2010; Jorm, Korten, Rodgers, Jacomb, & Christensen, 2002; Koh & Ross, 2006; Leonard, Lyons, & Bariola, 2015; Leonard et al., 2012; Li, Dobinson, Scheim, & Ross, 2013; Persson, Pfaus, & Ryder, 2015; Pompili et al., 2014; Steele, Ross, Dobinson, Veldhuizen, & Tinmouth, 2009), a clear consensus is emerging within current literature on the topic: more research is needed to understand why the experience of bisexuality differs substantially enough from other minority sexualities to be evident in health differentials (Balsam & Mohr, 2007; Dobinson, Macdonnell, Hampson, Clipsham, & Chow, 2005; Dodge & Sandfort, 2007; MacDonald, 2000; McNair, Kavanagh, Agius, & Tong, 2005; Ochs, 2011). To date, research with bisexuals has largely consisted of studies with small sample sizes of bisexual people or broader studies that either fail to separate bisexuals from other sexual minority participants or fall short of providing any in depth analysis of the unique life experiences of the bisexual population. It is for these reasons that there are increasing calls from scholars and health care clinicians to conduct bisexually focussed research, particularly research on bisexual mental health, with larger samples of bisexual people (Dobinson et al., 2005; McNair et al., 2005; Ochs, 2011).

There are numerous challenges associated with studies of bisexual people. The dispersed and invisible nature of bisexuals within society can make recruitment a significant challenge and researchers have long made recommendations that inclusion

criteria for bisexually focussed research needs to be as broad as possible in an effort to increase participation (Blumstein & Schwartz, 1999). However, broadening the recruitment criteria to include people who identify their sexuality in different ways and/or who may be in either heterosexual or same-sex relationships can make recruitment complex and criteria unclear. Yoshino (2000) suggests that bisexuality can be conceptualised as existing across three dimensions - identity, attraction and behaviour - and that 'bisexual' people can experience all or any combination of these dimensions. The general consensus within the current literature is that recruiting bisexual people based on one dimension is insufficient and, where it is applicable to the research aims, a three dimensional approach to identifying participants as 'bisexual' should be taken (Bostwick et al., 2010; Laumann, Gagnon, Michael, & Michaels, 1994; Mathy, Lehmann, & Kerr, 2004; McNair et al., 2005; Yoshino, 2000).

In this paper, we outline the method utilised in the *Who I Am* study, a large Australian-based survey of bisexual adults, which utilised the three axes of bisexuality as the criteria for participant recruitment. The aim of this paper is to identify successes and challenges associated with recruitment to a study utilising a criteria that are more complex than sexual identity and recruitment of bisexual people who are not connected to LGBT communities utilising a broad-reaching advertising and engagement strategy. How this study overcame bisexual recruitment challenges to engage an unprecedented number of participants and generate an extensive and valuable dataset that will provide much needed evidence relating to bisexual mental health will be demonstrated clearly in the hope that these new insights and successes may inform the development of future research in this field.

Method

Study Design

The *Who I Am* study was a cross sectional survey of Australian adults that utilised a self-report questionnaire to collect data. The questionnaire was completed online using Qualtrics survey software and was open from September 2016 to March 2017. Participants were invited to enter a prize draw upon completion of the survey to win an Apple iPad mini and this opportunity was presented in the recruitment advertisements.

Sample

Participants were included in the survey if they were over the age of eighteen, living in Australia and reported experience of all or any combination of bisexual identity, bisexual attraction and/or bisexual behaviour. The inclusive definition has been driven by the aims of the research and is an adaptation of Yoshino's three dimensional approach which has been expanded to include those with incidental and occasional bisexual experience as previous research has reported that poor mental health among bisexual people is not only confined to those with a bisexual identity but also those with any experience of bisexuality across these three dimensions (Bostwick et. al, 2014). Due to the characteristically diverse, dispersed and hidden nature of the target population convenience sampling was identified as the only available method by which to recruit participants and a detailed recruitment strategy was employed to include four recruitment arms: online; media; networks and direct engagement (detailed below).

Branding/Advertising

A range of advertising material was created using Canva online design software with a common branding (the *Who I Am* title with consistent colour and font) superimposed on images of people of different genders, using varying colours and themes. Wording on the advertisements varied with some including the words 'bisexual' and 'pansexual' and others simply calling for people 'attracted to more than one gender'.

The domain name ‘whoiamsurvey.com’ was purchased to ensure ease of finding the online survey and this web address was included in all advertisements. In addition, a QR code was created using Qualtrics software and included in print advertising. This advertising material was utilised across all four recruitment arms.

Timing

The time period during which the survey was to be open was strategically planned to optimise recruitment with the survey to be launched during the week of International Bisexual Visibility Day (September 23rd) to foster media interest and to increase potential for sharing across social media platforms; the survey remained open during late spring, summer and early autumn (Australian seasonal time) to facilitate the circulation of print advertising during pride festivals which are most commonly held in this period and other events such as university orientation weeks.

Online

The majority of recruitment was conducted online via Facebook. A Facebook page was created and was monitored and updated regularly during the recruitment period. A total of approximately $1,700AUD was spent on paid Facebook advertising campaigns. All campaigns were targeted at people over the age of eighteen and living in Australia and each campaign involved slightly different ‘interests’ targeting. For example, in one campaign people who liked Facebook pages relating to bisexuality and pansexuality were targeted. In other campaigns information relating to common demographics of bisexuals (for example those who were younger, female and non-religious) (Fredriksen-Goldsen, Kim, Barkan, Balsam, & Mincer, 2010; Herbenick et al., 2010; Koh & Ross, 2006; Persson et al., 2015; Richters et al., 2014; A. M. A. Smith, Rissel, Richters, Grulich, & De Visser, 2003) were used to promote the study to people who liked mainstream pages commonly associated with people in those demographic groups. In addition to formal

Facebook advertising, relevant Facebook pages (such as student unions, LGBTI [lesbian, gay, bisexual, transgender and intersex] organisation pages and the pages of prominent LGBTI Australians) were directly messaged and asked to share the study's advertisement. A disadvantage of Facebook advertising that was experienced on a minor scale during this recruitment process was that other Facebook users were able to comment and share our advertisements and on some occasions these comments were negative and discriminatory. When such comments were added to advertisement posts the research team were able to delete them. However, on one occasion, a Facebook user shared an advertisement to their own page accompanied by discriminatory language and this was unable to be easily deleted. The research team was supported by the La Trobe University's Human Research Ethics Committee to ameliorate this situation and ultimately contacted Facebook who removed the post. This derogatory engagement by Facebook users made up only a small fraction of the responses received, however it did mean that the research team had to monitor the advertising campaign closely and consistently in order to ensure any discriminatory comments were deleted immediately and thus the impact on other users was avoided or minimised.

Media

With the support of the La Trobe University's Media and Communications Department, relevant media outlets were contacted and asked to promote the study. Sydney's Star Observer and Joy FM were included in a small and targeted media strategy supported by La Trobe University's Media Team and were sent a media release detailing information about the study and how to access the survey. This resulted in publicity in both outlets. In addition, the lead researcher promoted the study on an interview for Australia's national LGBTI radio station Joy FM (JoyFM, 2017). The lead researcher also wrote an article for Rabelais student magazine and successfully approached them for publishing. A Huffington Post Australia Blog occurred after the author heard about the

study through professional networks and then approached the research team requesting information in order to write an article.

Networks

The 'networks' arm of the *Who I Am* recruitment strategy involved promoting the study through the researchers' professional networks, usually via email. Furthermore, relevant organisations were approached and asked to promote the study via their professional networks.

Direct Engagement

Direct engagement involved the researchers' promotion of the study in person when appropriate opportunities arose during the recruitment period including at professional meetings and relevant events such as Pride events across Australia. In addition, print advertising was distributed to sexual health centres, university student associations and other relevant organisations to directly engage participants who might be present within these spaces. A total of approximately $800AUD was spent on print advertising and postage across Australia to relevant organisations.

Survey Instrument

The survey instrument consisted of a total of ninety-one questions and was designed to take the average respondent approximately 20-30 minutes to complete. The instrument included five initial screening questions based on inclusion and exclusion criteria, thirteen basic demographic questions, two standardised mental health measures (which, combined, comprised sixteen questions), sixteen further questions on mental health and service use and forty-one questions relating to life experiences as a bisexual person. The majority of survey questions were closed in nature including simple dichotomous response options such as yes or no or Likert-type scaling systems (Allen & Seaman, 2007). Some open questions were included to allow respondents to share more

detailed accounts of their experiences as bisexual people. With the exception of the screening questions, respondents were able to answer or skip questions at their discretion. Questions deemed by the researchers to be of an emotionally sensitive nature were accompanied by warnings and phone numbers for mental health helplines. The order of questions was extensively considered to improve engagement and enhance the smooth journey of the participants through the survey by asking less personal questions first, allowing participants to share their bisexual life experiences throughout the bulk and middle of the survey and presenting mental health questions towards the end. The final three questions were qualitative and participants were able to write as much or as little as they wished. The survey ended on a positive note with the final question asking about the positive aspects associated with being a bisexual person. Please see Supplement 1 to view the full survey instrument.

The two standardised measures included in the survey instrument were the Kessler Psychological Distress Scale (K10) (Kessler et al., 2002) and the Brief Resilience Scale (BRS) (B. Smith et al., 2008). The K10 is a ten question inventory that measures psychological distress over the preceding four weeks and is commonly used in research both in Australia and internationally and also in clinical settings (ABS, 2012). The BRS is a six question inventory also commonly used in research and measures participants' ability to bounce back from stressful events (B. Smith et al., 2008). All other questions in the survey instrument were devised by the researchers following an extensive review of the literature, consultation with LGBTI, bisexual specific and mental health organisations and piloting the instrument with a small sample of potential respondents. Particular attention was paid to wording and the use of language within the survey instrument to ensure questions were inclusive across broad definitions and experiences of gender and sexuality.

Ethics

Ethics approval for the study was granted by both the La Trobe University's Human Research Ethics Committee and the community based ACON (formally AIDS Council of New South Wales) Research Ethics Review Committee.

Data Analysis

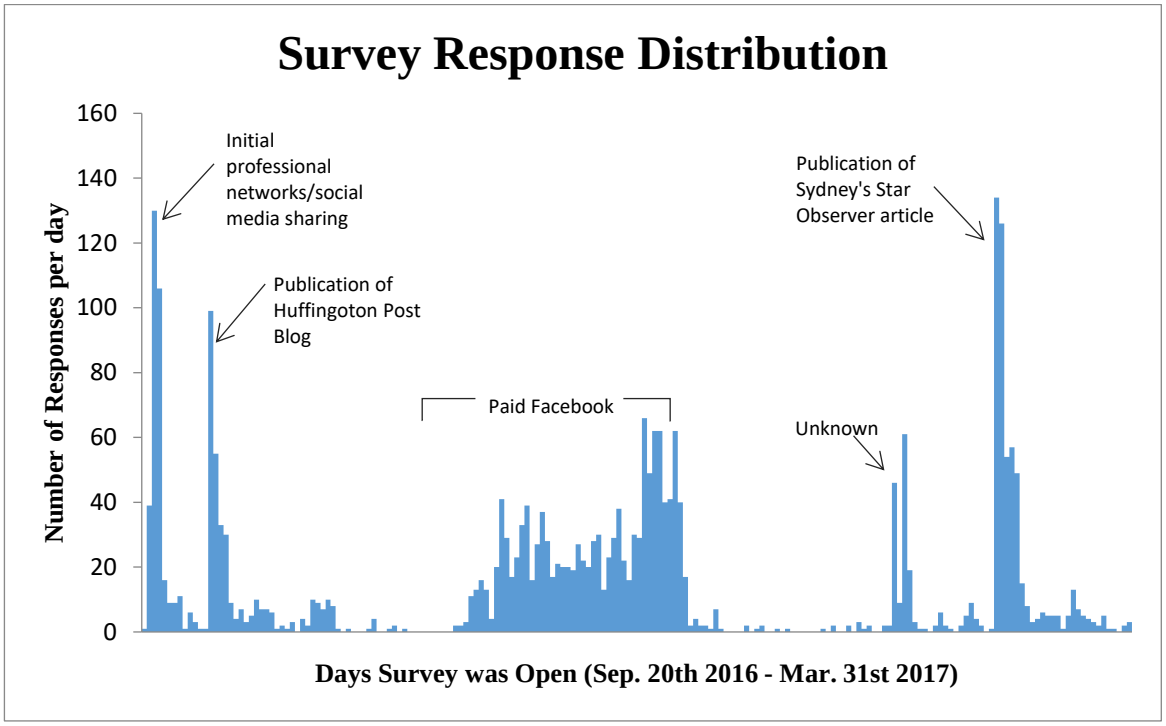
Results reported in this paper relate specifically to the methodological approach taken to the *Who I Am* study. IBM SPSS Version 25 software was used to conduct a frequency analysis of survey responses day by day and a histogram of the distribution of survey responses was generated using Microsoft Office software. This was then visually analysed to identify whether noticeable 'spikes' in participation were able to be attributed to recruitment activities. Automated Facebook and Qualtrics analytics were examined and findings relevant to the paper's aims are presented. Frequency analyses of the sample's demographic characteristics was conducted to demonstrate the broad spread of participants resulting from the extensive recruitment strategy. Finally, informal data received during the data collection period was compiled and thematically analysed.

Results

The survey was open for 192 days and was completed by 2,651 respondents. The mean number of responses per day was 13.6. As observed in the Survey Response Distribution histogram (Figure 1), there were five key areas of increased response activity. These resulted from initial advertising via sharing on social media and through professional email networks, publication of articles in both Sydney's Star Observer and the Huffington Post Australia Blog, paid Facebook advertising and one increase that cannot be accounted for (Figure 1). The researchers spent the recruitment period contacting relevant organisations to ask them to share the survey link and/or print advertising through their networks, on their social media pages and in person at relevant events; the unexplained spike in activity may have been due to a particular instance of

this. The opportunity to enter a prize draw to win an Apple iPad mini proved popular with 988 participants entering this draw. The distribution of print advertising was not found to be associated with noticeable increases in participant numbers and only one participant used the QR code to access the survey.

Figure 1



The comprehensive recruitment strategy employed for the *Who I Am* study and the online nature of the study resulted in a large sample that was broadly spread across demographic characteristics. Participants were recruited from every state and territory in Australia, with 57.4% of the sample from New South Wales or Victoria (Table 1) which is reflective of the general population, 57.7% of whom live in one of these two states (ABS, 2017b). The majority of respondents (79.5%) lived in capital cities or inner or outer suburbia (Table 1). The *Who I Am* sample was found to be ethnically similar to that of the general Australian population with 84.3% defining their ethnicity as Anglo/Australian which is comparable to 89% of Australians identifying having Anglo/Australian ancestry (ABS, 2013) and 2.7% of participants reporting Aboriginal and/or Torres Strait Islander origins which compares closely to the 2.8% of people

reporting this within the broader population (ABS, 2017a). The majority of participants (64.4%) were cisgender women and there was, as anticipated, an overrepresentation of younger respondents with almost half the sample (46.6%) in the 18-24 age group (Table 1). There were participants from all income brackets, all education levels, all employment statuses and all listed religions (Table 1). In addition, the sample included a diverse spread of participants with varying degrees of bisexual attraction, identity and behaviour.

Table 1 - Sample Characteristics

Characteristic	***n***	**Frequency**	**Percent (%)**
Age group (in years)	2,651	-	-
18-24	-	1,236	46.6
25-44	-	1,144	43.2
45+	-	271	10.2
Gender	2,484	-	-
Cisgender Man	-	410	16.5
Cisgender Woman	-	1,600	64.4
Transgender or gender diverse	-	474	19.1
Aboriginal and/or Torres Strait Islander origin	2,581	-	-
Yes	-	70	2.7
No	-	2,511	97.3
Ethnicity	2,585	-	-
Anglo/Australian	-	2,178	84.3
Other	-	407	15.7
English as first language	2,615	-	-
Yes	-	2,509	95.9
No	-	106	4.1
State or territory currently residing	2,620	-	-
VIC	-	891	34.0
NSW	-	612	23.4
WA	-	260	9.9
QLD	-	280	10.7
TAS	-	216	8.2

ACT	-	189	7.2
SA	-	150	5.7
NT	-	22	0.8
Local area description	2,619	-	-
Capital city/inner suburban	-	1,395	53.3
Outer suburban	-	685	26.2
Regional centre	-	340	13.0
Rural or remote	-	199	7.6
Religion	2,614	-	-
No religion	-	2,025	77.5
Roman Catholic	-	140	5.4
Anglican	-	49	1.9
Other Christian	-	139	5.3
Buddhism	-	43	1.6
Islam	-	5	0.2
Hinduism	-	12	0.5
Judaism	-	25	1.0
Other	-	176	6.7
Highest level of education achieved	2,499	-	-
Year 10 or below	-	61	2.4
Year 11	-	65	2.6
Year 12	-	711	28.5
Apprenticeship/trade certificate/TAFE certificate/Tertiary diploma	-	498	19.9
Undergraduate university degree	-	745	29.8
Postgraduate university degree	-	419	16.8
Employment/activities (multiple answer question)	2,651	-	-
Student	-	927	35.0
Full-time employment	-	751	28.3
Part-time employment	-	391	14.7
Casual employment	-	515	19.4
Self-employed	-	153	5.8
Not in paid employment (including volunteer work)	-	258	9.7
Home duties/home with children	-	107	4.0
Carer	-	33	1.2

Retired	-	40	1.5
Other	-	70	2.6
Total pre-tax income per year	2,569	-	-
$0	-	91	3.5
$1 - $29,999	-	1,062	41.3
$30,000 - $49,999	-	413	16.1
$50,000 - $79,999	-	440	17.1
$80,000 - $99,999	-	147	5.7
$100,000 - $124,999	-	111	4.3
$125,000 - $149,999	-	43	1.7
$150,000 - $199,999	-	28	1.1
$200,000 or more	-	25	1.0
Prefer not to answer	-	209	8.1

Although the largest spikes in participation coincided with the publication of media articles (Figure 1), the data suggest that paid Facebook advertising was the single most effective recruitment strategy used in the *Who I Am* study with 1,237 respondents completing the survey during the Facebook advertising campaigns. Automated Facebook analytics show that these campaigns resulted in a total of 2,122 people clicking on the advertisement link (link clicks) equating to an average cost of $0.68AUD per click. The most successful targeting strategies (the campaigns that achieved the most link clicks for the least cost) were those that targeted people who 'followed' pages related to bisexuality and/or pansexuality. Due to targeting Facebook users who were 'followers' of pages known to be popular with demographic groups found to have a high prevalence of bisexuality (such as pages of music festivals, women's magazines etc.), 65% of those the advertisements reached were women, 31% were men and 4% had uncategorised gender and younger people were much more likely to see these advertisements than older people.

It was understood by the research team from the outset that having a comprehensive and inclusive survey instrument was an essential component of this

research. Unexpectedly, throughout the data collection period respondents frequently contacted the research team via email to express their thoughts on the study. With the exception of one participant who requested more of a focus on sexual behaviours and sexual activity in future research, this feedback was entirely positive and could be classified under two categories: feedback on the survey instrument and participants' experiences of completing it; and appreciation for the study as a whole.

Feedback that related specifically to the survey instrument included respondents' comments on the inclusivity of the instrument:

"I just completed your Who I Am survey, and was really pleased with how inclusive it was"

"such a thorough survey respectful of all identities"

While others thanked the researchers for the opportunity to share their experiences of bisexuality with one respondent emailing their gratitude in being able to share what they usually hide:

"It's just so refreshing to be able to open up about stuff that normally has to be concealed."

The most common type of feedback researchers received was gratitude for the study being conducted. The researchers received numerous emails from participants simply thanking them for conducting the survey. Others wanted to explicitly express their gratitude for the study being in the area of bisexuality:

"I'd like to thank you for taking an interest in the B of the LGBTI"

"More recognition for bisexual/pansexual people is a great idea."

"Thank you so much for studying this often over-looked area."

"Thank you for conducting it! Means a lot to me as a queer person."

In addition to the feedback relating to the survey instrument and the *Who I Am* study as a whole there was a high level of enthusiasm for, and interest in, the study and its findings from academics and service providers. It appears that such little research has been conducted examining reasons for the high prevalence of poor mental health in bisexual people that there is a veritable hunger for it. Academics from across the globe have contacted the researchers showing their eagerness to learn of the study's findings and to better understand how the research was conducted and how large numbers of participants were able to be recruited. Service providers have expressed their urgent need for a concise compilation of the study's findings as they report struggling in their respective fields when working with bisexual patients/clients due to the limited knowledge relating to mental health in this population.

Discussion

Selecting an appropriate research methodology can be a complex task (Sogunro, 2002). Exploring the methods utilised by others in the field can assist in identifying a method that will suit the research aims and can alleviate the risk of time wasted by 'reinventing the wheel' (Rubin & Babbie, 2010). In bisexuality research, there exists a significant gap in the literature of studies that include relatively large sample sizes and which focus solely on bisexual people. Thus, the challenge associated with this specific area of academic endeavour is not one of risking wasting time by reinventing the wheel, but, in many respects, one of *spending* time *inventing* the wheel. Ultimately, the time spent developing an extensive recruitment strategy for the current study resulted in a demographically diverse sample of an unprecedented number of bisexual respondents.

Recruiting research participants from hidden, diverse and dispersed populations is a significant challenge in research (de Vaus, 2014; Ellard-Gray, 2015; Iribarren, 2018)

and it is really the success in overcoming this challenge that has allowed the *Who I Am* study to become an important piece of research both in national and international contexts. A key aim from the outset of the study was to recruit a large enough sample to conduct meaningful analyses of the data in order to produce new and meaningful insights into the mental health of bisexual people. It was identified early that this would be the biggest barrier to success for this study. The researchers responded to this challenge by broadening inclusion criteria (whilst still ensuring criteria were appropriate for the aims of the study), developing and implementing an extensive recruitment strategy based on knowledge of known demographic trends of bisexual people and collecting data by means of a high quality online survey. The research team hoped to engage a minimum of 500 respondents which would place the *Who I Am* study among the larger bisexually focussed studies to date. This aim was met and surpassed with a total of 2,651 respondents having completed the survey by the end of the survey period. This success in overcoming the challenges of recruitment resulted in a diverse spread of participants from across geographic and demographic spheres and has ultimately led to a large and valuable dataset the likes of which have not been seen in bisexual research before.

The *Who I Am* study's broad recruitment strategy incorporated some elements that proved more successful than others in recruiting participants. Facebook advertising, though it consumed a large portion ($1,700AUD) of the study's $3,000AUD budget, was the most effective single recruitment strategy used, a finding that is consistent with other recent research (Buckingham, 2017; Whitaker, 2017). In addition, articles published by media organisations, particularly the Huffington Post Australia Blog and Sydney's Star Observer, elicited significant spikes in participant numbers immediately following publication. This proved to be an excellent strategy for recruitment that equated to increased participant numbers, cost nothing and took very little time for the researchers as sending out a press release via email to relevant media organisations was a simple task.

Finally the commonly used method of sharing the survey through the researchers' professional networks and with relevant organisations was effective initially but there was a limit to how far advertising through these paths could reach and so ongoing advertising via this route was not plausible. As is the finding of previous research (Whitaker, 2017), print advertising for the *Who I Am* study was relatively costly, especially when factoring postage costs into the total budget for this, and comparatively ineffective as a recruitment strategy.

Utilising a comprehensive and inclusive survey instrument enhances participation in survey research and increases the likelihood of respondents feeling positive about their experience of participating in research (de Vaus, 2014). With bisexuals rarely being invited to share their life experiences through bisexual specific research it was important to the researchers that their experience of participating in the *Who I Am* study was a good one. Survey design principles that optimise the quality of the instrument were employed in the creation of the *Who I Am* survey, namely: using the current literature to inform question development; employing the opinion of relevant experts through a consultation process; ensuring the survey was long enough to elicit the necessary data but short enough to maintain participant motivation; arranging questions in a logical order; using a variety of question formats; keeping open-ended questions mostly at the end; grouping questions into topic groups for ease of navigation and piloting the instrument prior to the commencement of the data collection period (de Vaus, 2014; Kelley, 2003).

The community appreciation for this survey instrument used for the *Who I Am* study can be observed not just through the high level of participation in the research but through the anecdotal evidence shared with researchers during the study. Participants were grateful for the opportunity to share their experiences of bisexuality and were appreciative that a study on bisexual people was being conducted. Researchers have reported as far back as the 1970's that bisexual people are so rarely given the opportunity

to participate in bisexually focussed research that finding participants eager to share their experiences is not as difficult as one could originally conceive based on the hidden nature of the population (Blumstein & Schwartz, 1999). This is an observation that appears to persist today with respondents from the current study participating in significantly larger numbers than originally anticipated and taking the time to email the researchers after participating in order to express their gratitude.

Limitations

Although the *Who I Am* study's sample size along with the positive feedback received by the researchers during the research process indicates the success of both the study and its methodological approach, the project was not without limitations. As a result of the necessary use of convenience sampling to recruit this diverse and dispersed population and despite the large sample size and demographic diversity of participants, the representativeness of the sample remains unknown and thus the generalisability of findings should be interpreted with appropriate caution. In addition, as the majority of advertising for the study occurred online and the survey was only available electronically, potential participants without internet access were unlikely to know about the study and, if they did, were unable to participate. In addition, as there are so few quantitative studies that focus on bisexual people and those that do recruit comparatively small samples, drawing on the past experiences of other researchers to inform this study was limited and this presented a challenge when designing the study.

Conclusions

This paper has presented the methodological approach of the *Who I Am* study and provided a reflection on the efficacy of the method employed with particular attention to the very successful recruitment strategy that has been pivotal in ensuring the value and novelty of this research. The study was underpinned by theories and concepts relating to

both health research and the existence of health disparities in minority population groups. The study aimed to shed light on the reasons behind the high prevalence of poor mental health in the bisexual population by utilising a cross-sectional survey method. The real success of the *Who I Am* study's methodological approach was that it resulted in a sample size of 2,651 participants, a number unprecedented in bisexually focussed research to date. This was achieved through the combination of a broad recruitment strategy and a comprehensive and inclusive survey instrument. The most successful recruitment techniques were paid Facebook advertising and published media articles, while print advertising proved relatively expensive and largely ineffective. Feedback from participants as well as academics and service providers reiterated the need for this type of research and indicated a genuine appreciation for the *Who I Am* study. In order to inform much needed future research in the field of bisexuality and, more specifically, bisexual mental health, sharing methodological successes and challenges is essential to ensure quality research, optimised recruitment and the minimisation of continued '(re)invention of the wheel' resulting from a lack of shared methodological experiences.

References

ABS, Australian Bureau of Statistics (2012). Information Paper: Use of the Kessler Psychological Distress Scale in ABS Health Surveys, Australia, 2001-08. (4817.0.55.001). Retrieved 2018, from Australian Bureau of Statistics http://www.abs.gov.au/ausstats/abs@.nsf/lookup/4817.0.55.001Chapter92007-08

ABS, Australian Bureau of Statistics (2013). Australian Social Trends, April 2013. (4102.0). Retrieved 2018, from Australian Bureau of Statistics http://www.abs.gov.au/AUSSTATS/abs@.nsf/Previousproducts/4102.0Main%20Features1April%202013

ABS, Australian Buerau of Statistics (2017a). 2016 Census: Multicultural. Retrieved 2018, from Australian Bureau of Statistics http://www.abs.gov.au/ausstats/abs@.nsf/lookup/Media%20Release3

ABS, Australian Bureaur of Statistics (2017b). Australian Demographic Statistics, Jun 2017. (3101.0). Retrieved 12/02/18, from Australian Bureau of Statistics http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3101.0Jun%202017?OpenDocument

Allen, I. E. & Seaman, C. A. (2007). Likert scales and data analyses. *Quality Progress, 2007*(July).

Balsam, K. F. & Mohr, J. J. (2007). Adaptation to sexual orientation stigma: a comparison of bisexual and lesbian/gay adults. *Journal of Counseling Psychology, 54*(3), 306.

Blumstein, P. W., & Schwartz, P. (1999). Bisexuality: Some social psychological issues (1977). In M. Storr (Ed.), *Bisexuality: A critical reader*. London: Routledge.

Bostwick, W. B., Boyd, C. J., Hughes, T. L. & McCabe, S. E. (2010). Dimensions of sexual orientation and the prevalence of mood and anxiety disorders in the United States. *American Journal of Public Health, 100*(3), 468. doi: 10.2105/AJPH.2008.152942

Bostwick, W. B., McCabe, S. E., Horn, S., Hughes, T., Johnson, T. & Valles, J. R. (2007). Drinking patterns, problems, and motivations among collegiate bisexual women. *Journal of American College Health, 56*(3), 285-292. doi: 10.3200/JACH.56.3.285-292

Buckingham, L., Bencher, J., Voytek, C.D., Firore, D., Dunbar, D. Davis-Vogel, A., Metzger, D.S. & Frank, I. (2017). Going social: Success in online recruitment of men who have sex with men for prevention HIV vacccine research. *Vaccine, 35*(27), 3498-3505.

Conron, K. J., Mimiaga, M. J. & Landers, S. J. (2010). A population-based study of sexual orientation identity and gender differences in adult health. *The American Journal of Public Health, 100*(10), 1953-1960.

de Vaus, D. (2014). *Surveys in social research*. NSW: Allen & Unwin.

Dobinson, C., Macdonnell, J., Hampson, E., Clipsham, J. & Chow, K. (2005). Improving the access and quality of public health services for bisexuals. *Journal of Bisexuality, 5*(1), 39-77. doi: 10.1300/J159v05n01_05

Dodge, B. & Sandfort, T. G. M. (2007). A review of mental health research on bisexual individuals when compared to homosexual and heterosexual individuals. In B. A. Firestein (Ed.), *Becoming visible: Counseling bisexuals across the lifespan*. New York: Columbia University Press.

Eisner, S. (2013). *Bi: Notes for a bisexual revolution*. California: Seal Press.

Fredriksen-Goldsen, K. I., Kim, H.-J., Barkan, S. E., Balsam, K. F. & Mincer, S. L. (2010). Disparities in health-related quality of life: A comparison of lesbians and bisexual women. *The American Journal of Public Health, 100*(11), 2255.

Herbenick, D., Reece, M., Schick, V., Sanders, S. A., Dodge, B. & Fortenberry, J. D. (2010). Sexual behavior in the United States: Results from a national probability sample of men and women ages 14-94. *Journal of Sexual Medicine, 7*, 255-265.

Hughes, T., Szalacha, L. A. & McNair, R. (2010). Substance abuse and mental health disparities: Comparisons across sexual identity groups in a national sample of young Australian women. *Social Science & Medicine, 71*(4), 824-831. doi: 10.1016/j.socscimed.2010.05.009

Jorm, A. F., Korten, A. E., Rodgers, B., Jacomb, P. A. & Christensen, H. (2002). Sexual orientation and mental health: results from a community survey of young and middle-aged adults. *The British Journal of Psychiatry : The Journal of Mental Science, 180*, 423.

JoyFM (2017). *Who I Am, Study on Bisexual Mental Health*. Retrieved 2018, from https://joy.org.au/triplebipass/2017/03/22/study-bisexual-mental-health/

Kelley, K., Clark, B., Brown, V. & Sitzia, J. (2003). Good practice in the conduct and reporting of survey research. *International Journal of Quality in Health Care, 15*(3), 261-266.

Kessler, R. C., Andrews, G., Colpe, L. J., Hiripi, E., Mroczek, D. K., Normand, S. L. T., . . . Zaslavsky, A. M. (2002). Short screening scales to monitor population prevalences and trends in non-specific psychological distress. *Psychological Medicine, 32*(6), 959-976. doi: 10.1017/S0033291702006074

Koh, A. S. & Ross, L. K. (2006). Mental health issues: a comparison of lesbian, bisexual and heterosexual women. *Journal of Homosexuality, 51*(1), 33.

Laumann, E. O., Gagnon, J. H., Michael, R. T. & Michaels, S. (1994). *The social organization of sexuality : sexual practices in the United States*. Chicago: University of Chicago Press.

Leonard, W., Lyons, A. & Bariola, E. (2015). A closer look at Private Lives 2. Melbourne, Australia: Australian Research Centre in Sex, Health and Society, La Trobe University

Leonard, W., Pitts, M., Mitchell, A., Lyons, A., Smith, A., Patel, S., . . . Barrett, A. (2012). Private Lives 2: The second national survey of the health and wellbeing of GLBT Australians. Melbourne, Australia: Australian Research Centre in Sex, Health and Society, La Trobe University.

Li, T., Dobinson, C., Scheim, A. & Ross, L. (2013). Unique issues bisexual people face in intimate relationships: A descriptive exploration of lived experience. *Journal of Gay & Lesbian Mental Health, 17*(1), 21-39. doi: 10.1080/19359705.2012.723607

MacDonald, A. P. (2000). A little bit of lavender goes a long way: A critique of research on sexual orientation. In P. Rust (Ed.), *Bisexuality in the United States: A Social Science Reader*. New York: Columbia University Press.

Mathy, R., Lehmann, B. & Kerr, D. (2004). Bisexual and transgender identities in a nonclinical sample of north Americans: Suicidal intent, behavioral difficulties, and mental health treatment. *Journal of Bisexuality, 3*(3-4), 93-109. doi: 10.1300/J159v03n03_07

McNair, R., Kavanagh, A., Agius, P. & Tong, B. (2005). The mental health status of young adult and midlife nonheterosexual Australian women. *Australian and New Zealand Journal of Public Health, 29*(3), 265.

Ochs, R. (2011). Why we need to "get bi". *Journal of Bisexuality, 11*(2-3), 171-175. doi: 10.1080/15299716.2011.571983

Persson, T. J., Pfaus, J. G. & Ryder, A. G. (2015). Explaining mental health disparities for non-monosexual women: Abuse history and risky sex, or the burdens of non-disclosure? *Social Science & Medicine, 128*, 366-373. doi: 10.1016/j.socscimed.2014.08.038

Pompili, M., Lester, D., Forte, A., Seretti, M. E., Erbuto, D., Lamis, D. A., . . . Girardi, P. (2014). Bisexuality and suicide: A systematic review of the current literature. *The Journal of Sexual Medicine, 11*(8), 1903-1913.

Richters, J., Badcock, P. B., Simpson, J. M., Shellard, D., Rissel, C., De Visser, R. O., . . . Smith, A. M. A. (2014). Design and methods of the second australian study of health and relationships *Sexual Health, 11*(5), 383-396.

Rubin, A. & Babbie, E. (2010). *Essential Research Methods for Social Work* (2nd ed.). Belmont: Brooks/Cole CENGAGE Learning.

Smith, A. M. A., Rissel, C. E., Richters, J., Grulich, A. E. & De Visser, R. O. (2003). Sexual identity, sexual attraction and sexual experience among a representative sample of adults. *Australian and New Zealand Journal of Public Health, 27*(2), 138-145.

Smith, B., Dalen, J., Wiggins, K., Tooley, E., Christopher, P. & Bernard, J. (2008). The brief resilience scale: Assessing the ability to bounce back. *International Journal of Behavioral Medicine, 15*(3), 194-200. doi: 10.1080/10705500802222972

Sogunro, O. A. (2002). Selecting a quantitative or qualitative research methodology: An experience. *Educational Research Quarterly, 26*(1), 3.

Steele, L., Ross, L., Dobinson, C., Veldhuizen, S. & Tinmouth, J. (2009). Women's sexual orientation and health: Results from a Canadian population-based survey. *Women & Health, 49*(5), 353-367. doi: 10.1080/03630240903238685

Whitaker, C., Stevelink, S. & Fear, N. (2017). The use of Facebook in recruiting participants for health research purposes: A systemic review. *Journal of Medical Internet Research, 19*(8), 290.

Yoshino, K. (2000). The epistemic contract of bisexual erasure. *Stanford Law Review, 52*(2), 353-461.

Supplement 1 – *Who I Am* Questionnaire

Screening Q1

Do you currently live in Australia?

- ❍ Yes
- ❍ No

Screening Q2

What is your age? (dropdown box)

- ❍ Under 18
- ❍ 18
- ❍ 19
- ❍ 20
- ❍ (etc. up to 99+)

For this survey we are looking for people who answer yes to one or more of the following questions:

Screening Q3

Are you attracted to people of your own gender and at least one other gender?

- ❍ Yes
- ❍ No

Screening Q4

Have you had sexual experiences with people of your own gender and at least one other gender?

- ❍ Yes
- ❍ No

Screening Q5

Do you identify as bisexual or pansexual?

- ❍ Yes
- ❍ No

Firstly, we would like to know some basic information about you.

Q1 Are you of Aboriginal and/or Torres Strait Islander origin?

- ❍ Yes
- ❍ No

Q2 What is your ethnicity?

- ❍ Anglo/Australian
- ❍ Other (please specify) _____

Q3 Is English your first Language?

- ❍ Yes
- ❍ No

Q4 In which state or territory do you currently live?

- ❍ ACT
- ❍ QLD
- ❍ NSW
- ❍ NT
- ❍ SA
- ❍ TAS
- ❍ VIC
- ❍ WA

Q5 Which of the following best describes the area in which you live?

- ❍ Capital city/inner suburban
- ❍ Outer suburban
- ❍ Regional centre (population of 5,000 or more)
- ❍ Rural
- ❍ Remote

Q6 What is your religion?

- ❍ No religion
- ❍ Roman Catholic
- ❍ Anglican
- ❍ Other Christian
- ❍ Buddhism
- ❍ Islam
- ❍ Hinduism
- ❍ Judaism
- ❍ Other religion (please specify) _____

Q7 What is the highest level of education you have completed?

- ❍ Did not go to school
- ❍ Year 10 or below
- ❍ Year 11
- ❍ Year 12
- ❍ Apprenticeship/trade certificate/TAFE certificate/Tertiary Diploma
- ❍ Undergraduate university degree
- ❍ Postgraduate university degree

Q8 How would you describe your current employment/activities? (Select all that apply)

- ❑ Student
- ❑ Full-time employment
- ❑ Part-time employment
- ❑ Casual employment
- ❑ Self-employed
- ❑ Not in paid employment (this includes people engaged in volunteer work)
- ❑ Home duties/home with children
- ❑ Carer
- ❑ Retired
- ❑ Other (please specify) _____

Q9 What is the total of all pre-tax wages/salaries, government benefits, pensions, allowances and other income you usually receive? (Other income can include shared income from partners or family members. Where this is the case please select the amount below that indicates the amount that you have access to.)

- ❍ $0
- ❍ $1-$29,999 per year ($1-$579 per week)
- ❍ $30,000-$49,999 per year ($580-$959 per week)
- ❍ $50,000-$79,999 per year ($960-$1,529 per week)
- ❍ $80,000-$99,999 per year ($1,530-$1,919 per week)
- ❍ $100,000-$124,999 per year ($1,920-$2,399 per week)
- ❍ $125,000-$149,999 per year ($2,400-$2,879 per week)
- ❍ $150,000-$199,999 per year ($2,880-$3,839 per week)
- ❍ $200,000 or more per year ($3,840 or more per week)
- ❍ Prefer not to answer

<u>These questions relate to your sexuality and gender.</u>

Q10 How do you currently describe your gender?

- ❍ Man
- ❍ Woman
- ❍ Trans man
- ❍ Trans woman
- ❍ Non-binary or gender diverse
- ❍ I prefer to refer to myself as... (please specify) _____

Q11 What was your assigned sex at birth?

- ❍ Male
- ❍ Female
- ❍ Assigned another category (please specify) _____

Q12 Do you consider yourself to have a trans and/or non-binary gender identity, history and/or experience?

- ❍ Yes
- ❍ No

Q13 Do you have an intersex variation? (Intersex is a term for people born with atypical physical sex characteristics. There are many different intersex traits or variations.)

- ❍ Yes
- ❍ No
- ❍ Don't know

Q14 What sexual identity do you most identify with?

- ❍ Bisexual
- ❍ Pansexual
- ❍ Heterosexual/straight
- ❍ Gay
- ❍ Lesbian
- ❍ Queer
- ❍ Asexual
- ❍ I do not identify with any sexual identity
- ❍ Other (please specify) _____

Q15 Do you identify as polyamorous? (Note: Polyamory is the practice of maintaining multiple relationships with the knowledge and consent of all those involved.)

- ❍ Yes
- ❍ No

Q16 Over your life, how would you describe your sexual attraction to other people? (For example: mostly attracted to women, only attracted to men, equally attracted to all genders etc.)

The following questions ask about your life experiences as a person whose sexual identity, sexual attraction and/or sexual behaviour incorporates people of your own gender and at least one other gender. In places we have simply referred to this as your 'sexuality'.

	Never	Rarely	Sometimes	Often	Always
Q17 Have you ever been treated badly because of your sexuality?	❍	❍	❍	❍	❍
Q18 Have you ever been treated badly by your family because of your sexuality?	❍	❍	❍	❍	❍
Q19 Have you ever been treated badly by your friends because of you sexuality?	❍	❍	❍	❍	❍
Q20 Do you ever feel that your sexuality is bad or wrong?	❍	❍	❍	❍	❍

	Never	Rarely	Sometimes	Often	Always
Q21 Do you ever feel that those around you refuse to accept your sexuality and/or believe that your sexuality does not exist?	❍	❍	❍	❍	❍
Q22 Do people ever assume you are heterosexual/straight?	❍	❍	❍	❍	❍
Q23 Do people ever assume you are gay or lesbian?	❍	❍	❍	❍	❍
Q24 Do people ever assume you are bisexual?	❍	❍	❍	❍	❍
Q25 Do you ever wish that your sexuality was more visible to those around you?	❍	❍	❍	❍	❍

Q26 If you have been treated badly because of your sexuality, has this occurred more in the company of heterosexual people or LGBTI (lesbian, gay, bisexual, transgender and intersex) people? Please describe.

	Never	Rarely	Sometimes	Often	Always
Q27 How often do you participate in mainstream community events (e.g. sporting, religious, political, cultural etc.)?	❍	❍	❍	❍	❍
Q28 How often do you participate in LGBTI community events (e.g. sporting, cultural, festivals/celebrations etc.)?	❍	❍	❍	❍	❍
Q29 How often do you participate in bisexual or pansexual community events? (e.g. social gatherings, cultural, festivals/celebrations etc.)?	❍	❍	❍	❍	❍

	Never	Rarely	Sometimes	Often	Always
Q30 Are you ever involved in general LGBTI advocacy and/or activism?	❍	❍	❍	❍	❍
Q31Are you ever involved in bisexual or pansexual specific advocacy and/or activism?	❍	❍	❍	❍	❍
Q32 How often do you have contact with heterosexual friends or acquaintances?	❍	❍	❍	❍	❍
Q33 How often do you have contact with LGBTI friends or acquaintances?	❍	❍	❍	❍	❍
Q34 How often do you have contact with bisexual or pansexual friends or acquaintances?	❍	❍	❍	❍	❍

Q35 Are you connected to a bisexual and/or pansexual community? (This question relates to bisexual and/or pansexual specific communities not broader communities such as LGBTI) (Select all that apply)

- ❑ Yes online
- ❑ Yes in person
- ❑ I would like to be but I don't know of any
- ❑ I would like to be but there aren't any in my area
- ❑ No and I don't want to be

Q36 Sexual identity is a term we use to describe our sexuality (e.g. bisexual, pansexual, heterosexual). Has it been difficult or easy for you to find an identity that fits with your attraction and/or experiences?

- ❍ Very difficult
- ❍ Somewhat difficult
- ❍ Neither difficult nor easy
- ❍ Somewhat easy
- ❍ Very easy

Q37 Currently how difficult or easy is it to maintain your sexual identity (e.g. bisexual, pansexual, heterosexual)? (For example, do you find it easy to maintain a consistent sexual identity or does feeling the need to reconsider or change your identity make this difficult for you)

- ❍ Very difficult
- ❍ Somewhat difficult
- ❍ Neither difficult nor easy
- ❍ Somewhat easy
- ❍ Very easy

Q38 Do you feel pressure to identify as...

	Never	Rarely	Sometimes	Often	Always
Heterosexual/straight	❍	❍	❍	❍	❍
Gay or lesbian	❍	❍	❍	❍	❍
Bisexual	❍	❍	❍	❍	❍
Pansexual	❍	❍	❍	❍	❍
Another identity (please specify)	❍	❍	❍	❍	❍
Another identity (please specify)	❍	❍	❍	❍	❍
Another identity (please specify)	❍	❍	❍	❍	❍

<u>In the following questions your 'sexuality' refers to your sexual identity, sexual behaviour and/or sexual attraction that incorporates people of your own gender and at least one other gender.</u>

Q39 Have you ever been stereotyped by others as a result of your sexuality? If so, please briefly describe your experience of this including naming the specific stereotypes you have been exposed to. These stereotypes can be negative (e.g. untrustworthy, going through a phase, promiscuous) or positive (e.g. individual, trendy, free spirited).

Q40 Who in your life is currently aware of your sexuality?

	All	Some	None	Not Applicable
Immediate family	❍	❍	❍	❍
Extended family	❍	❍	❍	❍
Closest friends	❍	❍	❍	❍
Broader friendship group	❍	❍	❍	❍
Work colleagues	❍	❍	❍	❍
Religious/spiritual community	❍	❍	❍	❍
Structured social clubs (e.g. social clubs, sporting clubs etc.)	❍	❍	❍	❍
Health professionals	❍	❍	❍	❍

Q41 Who in your life is currently understanding and supportive of your sexuality?

	All	Some	None	Not Applicable
Immediate family	❍	❍	❍	❍
Extended family	❍	❍	❍	❍
Closest friends	❍	❍	❍	❍
Broader friendship group	❍	❍	❍	❍
Work colleagues	❍	❍	❍	❍
Religious/spiritual community	❍	❍	❍	❍
Structured social clubs (e.g. social clubs, sporting clubs etc.)	❍	❍	❍	❍
Health professionals	❍	❍	❍	❍

Q42 Are you currently in a relationship/s?

- ❍ Yes
- ❍ No

If No Is Selected, Then Skip To Q45

Q43 Is your partner/partners aware that your sexual identity, sexual attraction and/or sexual behaviour incorporates people of your own gender and at least one other gender?

- ❍ Yes
- ❍ No
- ❍ Don't know

If No Or Don't know Is Selected, Then Skip To Q45

Q44 Is your partner/partners understanding and supportive of your sexuality that incorporates people of your own gender and at least one other gender?

- ❍ Very understanding and supportive
- ❍ Somewhat understanding and supportive
- ❍ Neither supportive nor unsupportive
- ❍ Somewhat unsupportive and lacking understanding
- ❍ Very unsupportive and lacking understanding

The following questions are about your current relationship/s. If you are not currently in a relationship please answer these thinking about your most recent relationship. If you have never been in a relationship please leave this section blank and skip to the next page.

Q45 How many partners do you have? (Select the option that best describes your circumstances)

- ❍ One partner only
- ❍ One partner + casual sex with other people
- ❍ One primary partner + one or more other regular partners
- ❍ One primary partner + one or more other regular partners + casual sex with other people
- ❍ Two or more partners whom I see as equal in my life
- ❍ Two or more partners whom I see as equal in my life + casual sex with other people
- ❍ Other (please describe) _____

Q46 What is the gender of your primary partner/s?

- ❍ I have more than one primary partner and they are of different genders
- ❍ Man/men
- ❍ Woman/women
- ❍ Trans man/men
- ❍ Trans woman/women
- ❍ Non-binary or gender diverse
- ❍ Other (please specify) _____

Q47 In your current relationship/s are you monogamous or non-monogamous? Is this something you and your partner/s agreed on? Please tell us about this:

Q48 Are you happy with the level of monogamy in your relationship/s? (Select all that apply)

- ❑ Yes, I am happy with how monogamous I am
- ❑ Yes, I am happy with how monogamous my partner/s is
- ❑ No, I would prefer I was more monogamous
- ❑ No, I would prefer my partner/s was more monogamous
- ❑ No, I would prefer I was less monogamous
- ❑ No, I would prefer my partner/s was less monogamous

The last page asked questions about your current or most recent relationship. On this page we would like to hear about your relationships and sexual partners over your lifetime.

Q49 Who have you been in a relationship with?

	In the past 4 weeks?	In the past year?	In the past 5 years?	In your lifetime?	Never
A man/men	❍	❍	❍	❍	❍
A woman/women	❍	❍	❍	❍	❍
A trans man/men	❍	❍	❍	❍	❍
A trans woman/women	❍	❍	❍	❍	❍
Other (please specify)	❍	❍	❍	❍	❍
Other (please specify)	❍	❍	❍	❍	❍
Other (please specify)	❍	❍	❍	❍	❍

Q50 Who have you been sexually intimate with?

	In the past 4 weeks?	In the past year?	In the past 5 years?	In your lifetime?	Never
A man/men	❍	❍	❍	❍	❍
A woman/women	❍	❍	❍	❍	❍
A trans man/men	❍	❍	❍	❍	❍
A trans woman/women	❍	❍	❍	❍	❍
Other (please specify)	❍	❍	❍	❍	❍
Other (please specify)	❍	❍	❍	❍	❍
Other (please specify)	❍	❍	❍	❍	❍

WARNING: The following question asks about sexual violence. If you have experienced sexual violence and you would like to talk to someone please call Lifeline 13 11 14.

Q51 Have you ever been forced or frightened into doing something sexual that you didn't want to do?

- ❍ No
- ❍ Yes as a child (under 16)
- ❍ Yes as an adult (over 16)
- ❍ Yes as a child and as an adult
- ❍ I don't want to answer this question

REMINDER: If you would like to speak to someone about this call Lifeline on 13 11 14.

Tell us about your mental health.

Q52 This question asks about your mental health in the past as well as your current mental health. Select as many as are relevant to you. If some are not relevant leave them blank. If none are relevant skip this question.

	A health professional has said I have...	In the past I think I have had...	I currently think I have...
Anxiety disorder (e.g. panic attacks, social anxiety)	❑	❑	❑
Depression	❑	❑	❑
Substance use disorder	❑	❑	❑
Bipolar disorder	❑	❑	❑
Schizophrenia	❑	❑	❑
Borderline personality disorder	❑	❑	❑
Eating disorder	❑	❑	❑
Dissociative identity disorder (e.g. multiple personality disorder)	❑	❑	❑
Post-traumatic stress disorder (PTSD)	❑	❑	❑
Other (please specify)	❑	❑	❑
Other (please specify)	❑	❑	❑
Other (please specify)	❑	❑	❑

In the past 4 weeks, about how often did you feel...

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
Q53 tired out for no good reason?	❍	❍	❍	❍	❍
Q54 nervous?	❍	❍	❍	❍	❍
Q55 so nervous that nothing could calm you down?	❍	❍	❍	❍	❍
Q56 hopeless?	❍	❍	❍	❍	❍
Q57 restless or fidgety?	❍	❍	❍	❍	❍
Q58 so restless you could not sit still?	❍	❍	❍	❍	❍
Q59 depressed?	❍	❍	❍	❍	❍
Q60 that everything was an effort?	❍	❍	❍	❍	❍
Q61 so sad that nothing could cheer you up?	❍	❍	❍	❍	❍
Q62 worthless?	❍	❍	❍	❍	❍

WARNING: The following question asks about suicidal thoughts, suicide attempts and self-harm. If you have experienced any of these and would like to talk to someone call Lifeline on 13 11 14. If you do not want to answer this question please leave blank.

Have you ever...

	In the past 2 years	2-5 years ago	More than 5 years ago	Never
Q63 thought about self-harming?	❍	❍	❍	❍
Q64 harmed yourself?	❍	❍	❍	❍
Q65 thought about committing suicide?	❍	❍	❍	❍
Q66 Attempted suicide?	❍	❍	❍	❍

REMINDER: If you would like to speak to someone about this call Lifeline on 13 11 14.

How do you cope with stressful events? Please indicate the extent to which you agree with the following statements:

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
Q67 I tend to bounce back quickly after hard times	❍	❍	❍	❍	❍
Q68 I have a hard time making it through stressful events	❍	❍	❍	❍	❍
Q69 It does not take me long to recover from a stressful event	❍	❍	❍	❍	❍
Q70 It is hard for me to snap back when something bad happens	❍	❍	❍	❍	❍
Q71 I usually come through difficult times with little trouble	❍	❍	❍	❍	❍
Q72 I tend to take a long time to get over set-backs in my life	❍	❍	❍	❍	❍

Q73 Have you ever seen a health professional for mental health concerns?

- ❍ Yes
- ❍ No

Q74 In the past 4 weeks have you seen a health professional for mental health concerns?

- ❍ Yes
- ❍ No

Q75 If you were concerned about your mental health, who would you most likely turn to?

- ❍ Family/friends
- ❍ GP/Doctor
- ❍ Counsellor
- ❍ Psychologist
- ❍ Psychiatrist
- ❍ No-one/would not seek help
- ❍ Other (please specify) _____

Q76 How often do you currently smoke tobacco?

- ❍ Daily
- ❍ At least weekly (but not daily)
- ❍ Less often than weekly
- ❍ Not at all, but I have smoked in the last 12 months
- ❍ Not at all and I have not smoked in the last 12 months

Q77 How often do you drink alcohol?

- ❍ Never
- ❍ Monthly or less
- ❍ 2-4 times a month
- ❍ 2-3 times a week
- ❍ 4 or more times a week

Q78 How often do you have six or more drinks on one occasion?

- ❍ Never
- ❍ Less than monthly
- ❍ Monthly
- ❍ Weekly
- ❍ Daily or almost daily

Q79 Have you used any of these drugs in the past 12 months for non-medical purposes? Select as many as are relevant to you. If none are relevant leave blank.

	Used once or twice	Used occasionally	Used regularly
Pain killers/analsgesics	❍	❍	❍
Tranquilisers/sleeping pills	❍	❍	❍
Steroids	❍	❍	❍
Methamphetamine (e.g. speed, ice, meth)	❍	❍	❍
Marijuana/cannabis	❍	❍	❍
Heroin	❍	❍	❍
Cocaine	❍	❍	❍
Hallucinogens (e.g. acid, magic mushrooms)	❍	❍	❍
MDMA/ecstacy	❍	❍	❍
Ketamine	❍	❍	❍
GHB	❍	❍	❍
Inhalants (e.g. solvents, nitrous, petrol)	❍	❍	❍
Opiates/opioids other than heroin (e.g. morphine, oxycodone)	❍	❍	❍

In the following questions your 'sexuality' refers to your sexual identity, sexual attraction and/or sexual behaviour that incorporates people of your own gender and at least one other gender.

Q80 Would you feel comfortable telling a health professional your sexuality?

Q81 If you have told one or more health professionals about your sexuality please describe briefly your general experience of this. (For example were they supportive or unsupportive.)

Q82 In general, do you think that health professionals are knowledgeable about working with people who have a sexual identity, sexual attraction and/or sexual behaviour that incorporates people of the same gender and at least one other gender?

Q83 Would you like to have more access to services specialised in working with people who have a sexual identity, sexual attraction and/or sexual behaviour that incorporates people of the same gender and at least one other gender?

- ❍ I'm not interested in accessing these services
- ❍ I am happy with the access I have to these services
- ❍ I feel I have some access to these services but would like more
- ❍ I feel I have no access to these services but would like to

In these final three questions we would like to hear about your thoughts and experiences in your own words.

Q84 People who identify as bisexual or pansexual, those who are attracted to their own gender and other genders and people who have sexual experiences with their own gender and other genders have been found to have poorer mental health than other sexuality groups. Why do you think this might be?

Q85 Are there any problems or issues you face as a result of having a sexuality that incorporates people of your own gender and at least one other gender? Can you tell us about these?

Q86 Are there any good things or positives for you that come from having a sexuality that incorporates people of your own gender and at least one other gender? Can you tell us about these?

Chapter 5

Cisgender Mental Health

"Not choosing a side makes me weak. Means there's something not quite right with me. Like I'm unsure of myself. It's very fashionable to be sure of yourself. Know yourself. When the world is judging you like this, it's hard not to be hard on yourself."

– *Who I Am* participant

This chapter presents the paper *'Bisexual Mental Health: Findings from the Who I Am Study'* as submitted to the Australian Journal of General Practice (AJGP) where it has been accepted and is awaiting publication. This paper focuses on the cisgender sub-set of the sample. It was decided during the early stages of analysis that presenting cisgender and transgender/gender diverse participants as one homogeneous group would fail to adequately address the added layer of complexity related to mental health that may be experienced by transgender and gender diverse people and the differences in experiences of bisexuality between these two groups. This first 'findings' paper was submitted to the AJGP as this journal has a broad readership across Australian General Practitioner's (GP's) and would therefore act as an effective conduit to sharing this research directly with those clinicians likely to be in contact with bisexual people experiencing mental health concerns. Dr Mark Rathbone, an experienced General Practitioner, was invited to join the authorship team on this paper to improve the accessibility of the paper to a broader Medical audience and enhance the ease of translation of the findings into practice.

Citation: Taylor, J., Power, J., Smith, L. & Rathbone, M. (2019). Bisexual mental health: Findings from the Who I Am study. *Australian Journal of General Practice*, in press.

Bisexual Mental Health: Findings from the *Who I Am* Study

Julia Taylor, Jennifer Power, Elizabeth Smith & Mark Rathbone

Abstract

Background and objective: Despite consistent evidence that bisexuals have poorer mental health than heterosexuals, gay men or lesbians, the reasons for this remain largely unknown. The *Who I Am* study aims to address this current knowledge gap.

Methods: A cross sectional survey was completed by 2,651 adults living in Australia who had bisexual attraction, identity and/or experience. Ordinal regression identified significant (P <0.05) predictors of poor mental health.

Results: Higher levels of internalised biphobia, being in a heterosexual relationship and having a less supportive partner significantly (P <0.05) predicted higher psychological distress in this sample.

Discussion: While there has been an increased focus on lesbian and gay health in recent years, General Practitioners may be less familiar with the specific health needs of bisexual people. This is the largest study of bisexual Australians to date and provides detailed information about the relationships between bisexual life experiences and poor mental health.

Bisexual people have consistently been found to experience poorer mental health than their gay, lesbian or heterosexual counterparts.[1,2,3,4,5,6,7] They are significantly more likely than those of other sexual orientations to be diagnosed with a mental health disorder,[1] experience symptoms of depression and anxiety,[2] harm themselves[3,4] and report suicidal ideation.[5,6,7] Despite more than one in ten Australians over the age of 16 reporting attraction to more than one gender,[8] the reasons behind poor mental health in bisexual people remain largely unknown.[4,9]

Bisexuality is associated with unique life experiences that may present as challenges for bisexual people. Biphobia, refers to bisexual peoples' experiences of poor treatment and discrimination based on their sexuality and can emanate from both the heterosexual and LGBTI (lesbian, gay, bisexual, transgender and intersex) communities,[10,11] or can emerge internally from a lack of self-acceptance.[12,13] Invisibility and erasure are commonly experienced by bisexual people with their sexuality often being invisible due to assumptions that they are either heterosexual or homosexual based on the presumed gender of their partner[9,13] and the common belief that bisexuality does not exist, leading to an active erasure of their identity by others.[14] Furthermore, literature describes the experience of bisexuals disclosing their sexuality to others, reporting that bisexuals tend to be less 'out' about their sexuality than their gay or lesbian counterparts,[2,11,14] are faced with the unique decision of whether or not to be 'out' to intimate partners[10] and often feel they need to repeatedly come 'out' in order to maintain a state of disclosure as the perceived gender of their partner does not implicitly infer their orientation.[13] Additionally, community and belonging can present significant challenges for bisexual people who frequently report belonging in neither heterosexual nor gay and lesbian communities[15] while access to bisexual specific communities is severely limited.[13] Finally, simply maintaining a bisexual identity within a relationship,[13] finding a supportive partner[11] and negotiating monogamy or non-monogamy in the context of

commonly held stereotypes instantiating bisexuals as promiscuous and unable to commit,[10,11] make navigating intimate relationships complex for bisexual people.[11,13]

Given the uniqueness of these life experiences, it cannot be assumed that what is known about the mental health of lesbian, gay or heterosexual people adequately explains factors affecting bisexual mental health.[16] These life experiences have the potential to detrimentally impact mental health. Despite this, potential relationships between these experiences and mental health have not hitherto been comprehensively explored.

This paper presents findings from the recent *Who I Am* study. This study aimed to address the significant knowledge gap relating to bisexual mental health by improving understanding of the relationship between the social experiences of bisexual people and their mental health by identifying factors that predict poorer mental health in this population.

Methods

Who I Am was a cross-sectional survey of Australian adults conducted between September 2016 and March 2017. Using Yoshino's[17] inclusive definition of bisexuality, this study was open to people who identified as bisexual and/or those who had attraction to more than one gender and/or those who had sexual experience with more than one gender. Convenience sampling was the necessary sampling method for this study due to the characteristically dispersed and hidden nature of the target population. A range of advertising material with consistent *Who I Am* branding was distributed via relevant online platforms including social media sites, online news publications and email networks. Additionally, printed advertising material was distributed to sexual health centres and universities across the country. Wording on the advertisements varied, with some including the word 'bisexual' and others simply calling for people 'attracted to more than one gender'.

The main outcome measure used in this study was the Kessler Psychological Distress Scale (K10).[18] The K10 is widely used in Australian population health research, including national surveys administered by the Australian Bureau of Statistics (ABS).[19] K10 scores range from 10 to 50. For this analysis, K10 scores were grouped into categories with parameters taken from the ABS: low distress (10-15), moderate (16-21), high (22-29) and very high (30-50).[19]

The survey instrument included standard demographic questions relating to age, sex at birth, gender identity, sexual identity, local area description, income and educational attainment. In addition, respondents were asked to report on their past and present mental health. Survey questions related to bisexual life experiences were devised by the researchers in consultation with key mental health, LGBTI and bisexual specific organisations and were further refined following piloting of the instrument with a small sample of potential respondents.

Data were analysed using IBM SPSS Version 25 software. Due to gender diversity presenting an added layer of complexity when examining mental health,[20] the analyses for this paper were conducted on a subset of data containing only cases where gender had been selected as either man or woman and 'sex at birth' was identified as being in congruence with this (cisgender). Analyses included basic frequencies, partial Spearman's rank order correlations, linear-by-linear association chi-square tests and ordinal logistic regression. Independent variables were included in the regression model if they were found to have a significant relationship (set at $P < 0.05$) with K10 categories from the previous Spearman's rho and chi square tests. Twelve variables met this criterion. In addition, 'Do people ever assume you are gay or lesbian?' was included as its relationship with K10 categories was close to significant.

Ethics approval was granted by La Trobe University's Human Ethics Committee (approval number: HEC16-067) and the ACON (formerly the AIDS Council of New South Wales) Research Ethics Review Committee.

Results

The survey was completed by 2,651 Australian adults who identified as bisexual or who had sexual attraction to, or experiences with, more than one gender. The total number of cisgender respondents was 2,010. The majority of these respondents were female (80%). The sample included respondents from all Australian states and territories. Almost 80% lived in inner or outer metropolitan areas. Ages ranged from 18 to 77 years, with a mean of 29 years. Just fewer than 90% of respondents were aged less than 45 years (Table 1). The majority of respondents were in a relationship (60%, *n* = 1,033) with 69.6% (*n* = 991) reporting their current or most recent relationship was heterosexual.

Table 1 – Sample characteristics

Characteristic	***n***	**Frequency**	**Percent (%)**
Gender	2,010	-	-
Man	-	410	20.4
Woman	-	1600	79.6
Age group (in years)	2,010	-	-
18-24	-	915	45.5
25-44	-	889	44.2
45+	-	206	10.2
Aboriginal and/or Torres Strait Islander origin	1,983	-	-
Yes	-	52	2.6
No	-	1,931	97.4
Ethnicity	1,984	-	-
Anglo/Australian	-	1,694	85.4
Other	-	290	14.6
State or territory currently residing	2,010	-	-
VIC	-	686	34.1

NSW	-	471	23.4
QLD	-	221	11.0
WA	-	196	9.8
TAS	-	162	8.1
ACT	-	145	7.2
SA	-	111	5.5
NT	-	18	0.9
Local area description	2,010	-	-
Capital city/inner suburban	-	1,086	54.0
Outer suburban	-	515	25.6
Regional centre	-	256	12.7
Rural or remote	-	153	7.6
Highest level of education achieved	1,959	-	-
Year 10 or below	-	33	1.7
Year 11	-	44	2.2
Year 12	-	544	27.8
Apprenticeship/trade certificate/TAFE certificate/Tertiary diploma	-	380	19.4
Undergraduate university degree	-	603	30.8
Postgraduate university degree	-	355	18.1
Total pre-tax income per year	2,002	-	-
$0	-	63	3.1
$1 - $29,999	-	767	38.3
$30,000 - $49,999	-	335	16.7
$50,000 - $79,999	-	371	18.5
$80,000 - $99,999	-	127	6.3
$100,000 - $124,999	-	94	4.7
$125,000 - $149,999	-	40	2.0
$150,000 - $199,999	-	27	1.3
$200,000 or more	-	21	1.0
Prefer not to answer	-	157	7.8

The mean K10 score was 24.34 (SD=8.89). The majority of the sample (58.5%, *n* = 941) reported high or very high current psychological distress (Table 2). The most

commonly reported mental disorders were depression, anxiety, eating disorders and post-traumatic stress disorder. Within the past two years, close to half of respondents had considered self-harm and/or thought about committing suicide. More than one in four had attempted suicide at some point in their lives (Table 2).

Table 2 – Mental health past and present

Characteristic	***n***	**Frequency**	**Percent (%)**
K10 category	1,609	-	-
Low (10-15)	-	309	19.2
Moderate (16-21)	-	359	22.3
High (22-29)	-	475	29.5
Very high (30-50)	-	466	29.0
In the past I think I have had…	1,667	-	-
Anxiety disorder	-	523	31.4
Depression	-	671	40.3
Bipolar disorder	-	75	4.5
Schizophrenia	-	15	0.9
Borderline personality disorder	-	79	4.7
Eating disorder	-	349	20.9
Dissociative identity disorder	-	21	1.3
Post-traumatic stress disorder	-	196	11.8
Obsessive compulsive disorder	-	10	0.6
Attention deficit hyperactivity disorder	-	6	0.4
Other	-	18	1.1
I currently think I have…	1,667	-	-
Anxiety disorder	-	528	31.7
Depression	-	372	22.3
Bipolar disorder	-	75	4.5
Schizophrenia	-	21	1.3
Borderline personality disorder	-	66	4.0
Eating disorder	-	126	7.6
Dissociative identity disorder	-	26	1.6
Post-traumatic stress disorder	-	151	9.1
Obsessive compulsive disorder	-	13	0.8

Attention deficit hyperactivity disorder	-	10	0.6
Other	-	25	1.5
A health professional has said I have one of the above mental health disorders	1,667	-	-
Yes	-	1,120	67.2
No	-	547	32.8
In the past two years have you…	-	-	-
Thought about self-harming	1,633	814	49.8
Harmed yourself	1,622	417	25.5
Thought about committing suicide	1,633	739	45.3
Attempted suicide	1,617	110	6.8
Have you ever…	-	-	-
Thought about self-harming	1,633	1,268	77.6
Harmed yourself	1,622	952	58.7
Thought about committing suicide	1,633	1,268	77.6
Attempted suicide	1,617	450	27.8

For all ordinal bisexual life experience variables, partial Spearman's rank order tests were conducted to assess potential correlations with K10 categories while controlling for gender, age, local area description, education and income (Table 3). Significant associations were found for all four measures of biphobia, three of the four measures of invisibility and erasure with 'do people ever assume you are gay or lesbian?' close to the set significance ($P = 0.10$), three of the four measures of being 'out' with being 'out' to closest friends not significantly associated ($P = 0.52$) and partner's support and understanding (Table 3). No measure of community and belonging was found to have a significant relationship with K10 categories; participation in LGBTI community events ($P = 0.74$), bisexual community events ($P = 0.39$) contact with LGBTI ($P = 0.82$) or bisexual ($P = 0.85$) friends or acquaintances.

Linear-by-linear chi square association tests were conducted to assess associations between K10 categories and the three categorical life experience variables. Just one was

found to be significantly associated with K10 categories revealing being in a heterosexual relationship was associated with poorer mental health (Table 3). No association was found for 'is your partner aware of your sexuality?' ($P = 0.56$) or 'how many partners do you have?' ($P = 0.28$).

Table 3 – Significant associations between K10 categories and bisexual life experiences

Bisexual life experiences associated with K10 categories	**Chi-square statistic (χ^2)**	**Correlation coefficient**	**Sig. (2-tailed)**
Biphobia	-	-	-
Have you ever been treated badly because of your sexuality?	-	0.17	<0.001
Have you ever been treated badly by your family because of your sexuality?	-	0.16	<0.001
Have you ever been treated badly by your friends because of your sexuality?	-	0.17	<0.001
Do you ever feel that your sexuality is bad or wrong?	-	0.15	<0.001
Invisibility and erasure	-	-	-
Do people ever assume you are heterosexual/straight?	-	0.07	0.01
Do you ever wish that your sexuality was more visible to those around you?	-	0.10	<0.001
Do you ever feel that those around you refuse to accept your sexuality and/or believe that your sexuality does not exist?	-	0.18	<0.001
Being 'out'	-	-	-
Who in your life is aware of your sexuality – immediate family?	-	-0.06	0.03
Who in your life is aware of your sexuality – extended family?	-	-0.10	<0.001
Who in your life is aware of your sexuality – broader friendship group?	-	-0.05	0.04
Intimate relationships	-	-	-
Is your partner/partners understanding and supportive of your sexuality that incorporates people of your own gender and at least one other gender?	-	-0.10	0.01
What is the gender of your primary partner/s?	6.30	-	0.01

A cumulative odds ordinal logistic regression with proportional odds was run to determine the effect of thirteen bisexual life experience variables on K10 categories while adjusting for gender, age, local area description, education and income (Table 4). The final model significantly predicted the dependent variable (K10 category) over and above the intercept-only model (P <0.001). Three of the thirteen independent variables were significant predictors of high or very high levels of psychological distress: 1) participants feeling their sexuality was bad or wrong; 2) being in a heterosexual relationship and 3) lower perceived levels of support or understanding of sexuality from partner/s (Table 4).

Table 4 – Bisexual life experiences as predictors of K10 categories

Bisexual life experiences associated with K10 categories	**OR (95% CI)**	***P***
Biphobia	-	-
Have you ever been treated badly because of your sexuality?	1.13 (0.92-1.38)	0.24
Have you ever been treated badly by your family because of your sexuality?	1.12 (0.96-1.31)	0.15
Have you ever been treated badly by your friends because of your sexuality?	1.05 (0.86-1.29)	0.64
Do you ever feel that your sexuality is bad or wrong?	1.25 (1.07-1.45)	0.004
Invisibility and erasure	-	-
Do people ever assume you are heterosexual/straight?	1.15 (0.93-1.42)	0.19
Do people ever assume you are gay or lesbian?	1.08 (0.93-1.25)	0.34
Do you ever wish that your sexuality was more visible to those around you?	1.00 (0.88-1.13)	0.98
Do you ever feel that those around you refuse to accept your sexuality and/or believe that your sexuality does not exist?	1.15 (0.99-1.33)	0.06
Being 'out'	-	-
Who in your life is aware of your sexuality – immediate family?	1.04 (0.82-1.32)	0.76
Who in your life is aware of your sexuality – extended family?	0.85 (0.66-1.10)	0.21
Who in your life is aware of your sexuality – broader friendship group?	1.01 (0.78-1.30)	0.97
Intimate relationships	-	-
Is your partner/partners understanding and supportive of your sexuality that incorporates people of your own gender and at least one other gender?	0.84 (0.71-0.99)	0.04

What is the gender of your primary partner/s? …	-	-
- Opposite-sex	1.46 (1.03-2.07)	0.03
- Same-sex	1.00 (reference)	-

Discussion

The results of this study support the findings of previous research reporting that bisexual people have poorer mental health than their heterosexual, gay or lesbian counterparts.[1,2,5,7,10,20,21] Levels of psychological distress were considerably higher in this sample than the national average, with 58.5% of participants having high or very high psychological distress compared to 11.7% of the general population.[22] Similarly the K10 mean score of 24.34 for this sample was significantly higher than that found in a recent study of LGBTI Australians' which reported a mean K10 score of 19.6.[20] Suicidality was also substantially more prevalent in this sample than in the broader Australian community with 77.6% of participants having ever thought about committing suicide and 27.8% having attempted suicide compared to the general population of 13.3% and 3.3% respectively.[23]

Biphobia, invisibility, erasure, being 'out' and some aspects of intimate relationships were significantly related to mental health in this sample. However, while the current literature suggests that managing and maintaining monogamy or non-monogamy within relationships presents a significant challenge for bisexual people,[10,11] the present findings suggest that, if these challenges exist, they are not associated with poorer mental health. Additionally, in contrast to the findings of previous research with smaller sample sizes,[13,20] this study found that contact with LGBTI or bisexual people or communities was not related to mental health. In practice, these findings may present useful directions when assessing and supporting the mental health of bisexual people. Asking bisexual patients about the challenges they might face because of their sexual

orientation can be a good starting point to identifying potential issues (see 'Suggested Questions' box at the end of the article for sample questions).

Internalised biphobia refers to a lack of self-acceptance experienced by some bisexuals as a result of their own heteronormative views.[12,13] Bisexual people have been found to experience a greater lack of self-acceptance with regards to their sexuality than homosexuals.[12] Previous qualitative research has indicated a link between participants' mental wellbeing and their level of internal conflict resulting from their sexual and romantic attractions being outside the socially accepted dichotomy of homosexual or heterosexual.[13] The present study supports this, finding that experiencing 'feeling your sexuality is bad or wrong' increases the odds of having higher psychological distress. These findings suggest that self-acceptance of one's sexuality is an important aspect of mental wellbeing for bisexual people.

Participants in the *Who I Am* study who were in heterosexual relationships reported significantly poorer mental health than those in same-sex relationships. This phenomenon has similarly been observed in previous research with bisexual women finding those in same-sex relationships fared best emotionally while those with a male partner were particularly vulnerable to depressive symptoms and bi-negativity.[24] This finding challenges the long promulgated belief that bisexual people in heterosexual relationships are afforded 'heterosexual privilege' because they are less exposed to the stressors associated with being in a same-sex relationship such as having a more visible sexual minority status.[25] The clinical implication of this is that clinicians may see bisexual people in heterosexual relationships as being less vulnerable to social oppression and the stressors associated with it; this finding suggests the reverse.

The mental health benefits afforded to bisexual people whose partners are supportive of their sexual orientation are considerable.[10] A recent qualitative study[10]

revealed that bisexual people report better mental health if they have a partner who is supportive and understanding following disclosure of their bisexual orientation, while negative reactions to disclosure were associated with internal emotional challenges. This study supports this, finding that having a supportive and understanding partner was a significant predictor of better mental health. This is an experience particular to bisexuals as, unlike heterosexual, gay or lesbian people, their sexual orientation is not inferred by the gender of their partner nor is it necessarily obvious to their partners when in a relationship. The 'Suggested Questions' box at the end of this article offers some practical tips for GP's working with bisexual, or potentially bisexual, patients to assist them to start a conversation regarding bisexual relationships and partner support.

There are some limitations to this study. The survey instrument was only available online and the majority of recruiting occurred through online media, thus people not connected to the internet had limited exposure to advertising and could not access the survey. Due to the use of convenience sampling, the findings from this survey may not be representative of the bisexual population in Australia. Additionally, as the survey relied on self-reporting and participants had the ability to skip questions, reporting bias and missing data were limitations. People with transgender or gender diverse experience were not included in these analyses and so the experiences of these participants are not represented in this paper. The complexity that comes from the intersection of gender diversity and bisexuality warrants specific analysis.

This paper presents the findings of one of the largest studies of bisexual people ever conducted and posits a significant contribution to the severely limited knowledge relating to poor mental health in the bisexual population. The results of this study support the previously reported finding that bisexual people have poorer mental health than other sexual orientation groups. Experiences of biphobia, invisibility, erasure and not being 'out' were found to be associated with poorer mental health. Internalised biphobia, being

in a heterosexual relationship and having an unsupportive partner significantly increased the odds of having higher psychological distress. The life experiences associated with poorer mental health in this study are specific to bisexual people and thus, providing mental health care based on existing paradigms developed for those of other sexual orientations is inappropriate. With 10% of the broader population reporting bisexual attraction and GPs the most commonly reported first point of contact for mental health care in Australia,[23] these findings are relevant to all General Practitioners working across Australia.

Implications for General Practice

This paper draws to our attention some very important concepts previously, I'm sure, unappreciated by most of our GP colleagues:

4) the frequency of bisexuality (and therefore the potential number in our patient base who are bisexual);
5) the mental health statistics applying to this cohort of patients and
6) most importantly gives us an insight into the potential psychosocial reasons for these statistics.

This paper demonstrates the importance of identifying bisexuals among our patients and gives us considerable insight into the reasons which predispose them to dramatically worse mental health statistics than other sexual orientation groups.

Suggested Questions for General Practitioners

These questions may be helpful as a starting point for practitioners working with bisexual patients in identifying individuals who might be at risk of poor mental health:

- Do you have a partner/are you sexually active?
  - If yes – what gender is your partner/s?
  - Is your partner supportive of your sexuality?
- Does your sexuality present any challenges for you?

References

1. Loi B, Lea T, Howard J. Substance use, mental health, and service access among bisexual adults in Australia. *J Bisex* 2017; 17(4): 400-17.
2. Persson TJ, Pfaus JG, Ryder AG. Explaining mental health disparities for non-monosexual women: Abuse history and risky sex, or the burdens of non-disclosure?. *Soc Sci Med* 2015; 128: 366-73.
3. Hughes T, Szalacha LA, McNair R. Substance abuse and mental health disparities: Comparisons across sexual identity groups in a national sample of young Australian women. *Soc Sci Med* 2010; 71(4): 824-31.
4. McNair R, Kavanagh A, Agius P, Tong B. The mental health status of young adult and midlife nonheterosexual Australian women. *Aust N Z J Public Health* 2005; 29(3): 265.
5. Steele L, Ross L, Dobinson C, et al. Women's sexual orientation and health: Results from a Canadian population-based survey. *Women Health* 2009; 49(5): 353-367.
6. Brennan DJ, Ross LE, Dobinson C, et al. Men's sexual orientation and health in Canada. *Can J Public Health* 2010; 101(3): 255-258.
7. Bostwick WB, Boyd CJ, Hughes TL, McCabe SE. Dimensions of sexual orientation and the prevalence of mood and anxiety disorders in the United States. *Am J Public Health* 2010; 100(3): 468.
8. Richters J, Altman D, Badcock PB, et al. Sexual identity, sexual attraction and sexual experience: The second australian study of health and relationships. *Sex Health* 2014; 11(5): 451-460.
9. Ochs R. Why we need to “get bi”. *J Bisex*. 2011;11(2-3):171-5.
10. Li T, Dobinson C, Scheim A, Ross L. Unique issues bisexual people face in intimate relationships: A descriptive exploration of lived experience. *J Gay Lesbian Ment Health* 2013; 17(1): 21-39.
11. Weinberg MS, Williams CJ, Pryor DW. Dual attraction : Understanding bisexuality. New York: Oxford University Press, 1994.
12. Chard AN, Finneran C, Sullivan PS, Stephenson R. Experiences of homophobia among gay and bisexual men: Results from a cross-sectional study in seven countries. *Cult Health Sex* 2015; 17(10): 1174-1189.
13. Ross LE, Dobinson C, Eady A. Perceived determinants of mental health for bisexual people: A qualitative examination. *Am J Public Health* 2010; 100(3): 496.
14. Eisner S. Bi: Notes for a bisexual revolution. California: Seal Press, 2013.
15. McLean K. Inside, outside, nowhere: Bisexual men and women in the gay and lesbian community. *J Bisex* 2008; 8(1-2): 63-80.
16. Dodge B, Sandfort TGM. A review of mental health research on bisexual individuals when compared to homosexual and heterosexual individuals. In: Firestein BA, editor. Becoming visible: Counseling bisexuals across the lifespan. New York: Columbia University Press, 2007: 28-51.
17. Yoshino K. The epistemic contract of bisexual erasure. *Stanford Law Rev* 2000; 52(2): 353-461.
18. Kessler RC, Andrews G, Colpe LJ, et al. Short screening scales to monitor population prevalences and trends in non-specific psychological distress. *Psychol Med* 2002; 32(6): 959-976.
19. Australian Bureau of Statistics. Information paper: Use of the Kessler Psychological Distress Scale in ABS health surveys, Australia, 2001-08. Canberra: ABS, 2012. http://www.abs.gov.au/ausstats/abs@.nsf/lookup/4817.0.55.001Chapter92007-08 (accessed Mar 2018).
20. Leonard W, Lyons A, Bariola E. A closer look at Private Lives 2. Melbourne: La Trobe University, 2015.

21. Jorm AF, Korten AE, Rodgers B, et al. Sexual orientation and mental health: Results from a community survey of young and middle-aged adults. *Br J Psychiatry* 2002; 180: 423.
22. Australian Bureau of Statistics. National health survey: Users' guide, 2014-15. Canberra: ABS, 2017. http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4363.0~2014-15~Main%20Features~Users'%20Guide~1 (accessed Mar 2018).
23. Slade T, Johnston, A, Teesson, M, et al. The mental health of Australians 2: Report on the 2007 National Survey of Mental Health and Wellbeing. Canberra: The Department of Health, 2009.
24. Molina Y, Marquez J, Logan D, et al. Current intimate relationship status, depression, and alcohol use among bisexual women: The mediating roles of bisexual-specific minority stressors. *Sex Roles* 2015; 73(1): 43-57.
25. Esterberg KG. The bisexual menace revisited: Or, shaking up social categories is hard to do. In: Seidman S, Fischer N, Meeks C, editors. Introducing the new sexuality studies. 2nd ed. New York: Routledge, 2011: 278-284.

Chapter 6

Transgender and Gender Diverse Mental Health

"I feel like a fake straight or a fake lesbian, and feel cramped in both my gender identity and sexual behaviour."

– *Who I Am* participant

This chapter presents the paper *'The Mental Health of Transgender and Gender Diverse Bisexuals: Findings from the Who I Am Study'* as submitted to the Journal of Bisexuality where it is currently under review. As its name suggests, this paper presents findings of the study related to the mental health of transgender and gender diverse participants. As outlined in the previous chapter introduction, transgender and gender diverse participants' data were separated from cisgender participants for the purposes of performing a more nuanced analysis of their experiences of bisexuality and mental health. It was decided early in the analysis phase of the project that these findings warranted two separate papers to explore these nuances. This article provides a substantial contribution to the currently severely lacking body of literature on transgender and gender diverse bisexuals. It exemplifies the highly prevalent deleterious mental health of this sub-group of the sample and identifies transgender and gender diverse bisexuals as a population group who are particularly vulnerable and in need of greater support.

Under Review: Taylor, J., Power, J. & Smith, E. (2018). The mental health of transgender and gender diverse bisexuals: Findings from the Who I Am study. Submitted to the *Journal of Bisexuality*.

The Mental Health of Transgender and Gender Diverse Bisexuals: Findings from the *Who I Am* Study

Julia Taylor, Jennifer Power & Elizabeth Smith

Abstract

People who identify as bisexual, and people who identify as transgender or gender diverse, report poorer mental health than their cisgender (non-transgender/non-gender diverse) lesbian or gay counterparts. This paper reports on a sub-set of a large survey of bisexual Australian adults (*n*=2,651), examining predictors of poorer mental health among the 19% (*n*=474) of respondents who also identified as transgender or gender diverse. The aim is to better understand how the intersection of bisexuality and gender diversity affects mental health. Very high rates of psychological distress, mental illness and suicidality were reported within the sample. Spearman's rho correlation tests identified biphobia, bisexual erasure and less engagement in LGBTI community events to be significantly associated with psychological distress. Ordinal logistic regression revealed that higher levels of internalised biphobia and less participation in LGBTI community events predicted higher psychological distress.

Key Words: Transgender, gender diverse, bisexuality, mental health, LGBTI mental health

Recent research has consistently found that bisexual people experience higher rates of poor mental health than their gay, lesbian or heterosexual counterparts (Bostwick, Boyd, Hughes, & McCabe, 2010; Bostwick et al., 2007; Conron, Mimiaga, & Landers, 2010; Eisner, 2013; Hughes, Szalacha, & McNair, 2010; Jorm, Korten, Rodgers, Jacomb, & Christensen, 2002; Koh & Ross, 2006; Leonard et al., 2012; Li, Dobinson, Scheim, & Ross, 2013; Persson, Pfaus, & Ryder, 2015; Pompili et al., 2014; Steele, Ross, Dobinson, Veldhuizen, & Tinmouth, 2009). In addition, current literature indicates that transgender and gender diverse individuals experience greater psychological distress and suicidality than those whose affirmed gender meets normative expectations given their sex assigned at birth (also referred to as cisgender) (Herman, 2016; Leonard, Lyons, & Bariola, 2015; Leonard et al., 2012; Mathy, Lehmann, & Kerr, 2004; Smith, et al., 2014). Moreover, people who identify as gender diverse (including non-binary, genderqueer or gender non-conforming) report higher levels of harassment and sexual assault (Harrison, Grant & Herman, 2012) and more anxiety and depression (Thorne, Witcomb, Nieder, Nixon, Yip & Arcelus, 2018) than transgender people who identify with a binary gender.

Research shows there is a strong link between bisexuality and transgender and gender diversity (Kuper, 2012; Leonard et al., 2012; Smith, et al., 2014), however, the experiences of poor mental health in those whose identities traverse both bisexuality and transgender/gender diversity are rarely explored in research. Recent literature has called for the urgent examination of factors relating to high rates of poor mental health in bisexual populations (Dobinson, Macdonnell, Hampson, Clipsham, & Chow, 2005; Leonard et al., 2012; McNair, Kavanagh, Agius, & Tong, 2005; Ochs, 2011; Schick, Rosenberger, Herbenick, Calabrese, & Reece, 2012) as well as among transgender and gender diverse populations (Feldman et. al., 2016; Wanta & Unger, 2017). This paper presents recent findings from one of the largest studies ever conducted exclusively of bisexual people (n = 2,651), the *Who I Am* study, and focuses on the mental health of the

474 transgender and gender diverse participants. This study presents an opportunity to increase understanding of mental health among people at this intersection.

Bisexuality is characterised by diversity. The term 'bisexual' has been used to describe a person who is attracted to both men and women since the turn of the 20th Century (Angelides, 2001; MacDowell, 2009), however, in more recent times, definitions have moved away from defining it as attraction only to the incorporation of aspects such as desire, attraction, behaviour, political and social affiliations and self-applied identity (Diamond, 2008; Eadie, 1999; Eisner, 2013; Weinberg, Williams, & Pryor, 1994). For example, celebrated bisexual writer Shiri Eisner (2013) has acknowledged how the growing discourse around identity labels can be applied to non-monosexual identities, including 'pansexual' and 'queer', and has suggested that all non-monosexual people should be included under an 'umbrella of bisexuality' should they choose to be. Yoshino's (2000) inclusive three axes approach to bisexual orientation includes people who have bisexual identity, attraction and/or experience. Together, Eisner's (2013) 'umbrella of bisexuality' and Yoshino's (2000) three axes include people who are attracted to, or engage in sexual behaviour with, more than one gender or who identify with any of a range of identities that incorporate more than one gender. The authors of the *Who I Am* study have drawn on these definitions in order to capture people within this spectrum of bisexuality.

'Gender diverse' is another umbrella term used to describe persons whose gender identity is not necessarily only man or woman, but may be both or neither. People within the gender diverse umbrella may identify as agender, gender fluid, non-binary, gender non-conforming or something else. The term 'transgender' typically refers to people whose affirmed gender differs from the normative expectations given their sex assigned at birth (Riggs & Bartholomaeus, 2016). Someone who is transgender may be a man or a

woman or they may identify with one or more of the gender diverse terms mentioned above.

Research examining the experiences of transgender and gender diverse people has reported a clear link between identifying as transgender or gender diverse and this broad and inclusive 'umbrella of bisexuality' (Kuper, 2012; Leonard et al., 2012; Smith, et al., 2014). Recent studies of both young people (Smith, et al., 2014) and adults (Kuper, 2012) with diverse genders, including transgender and non-binary identities, report the most common sexual identities within this population to be queer and pansexual. In addition, Private Lives 2 (Leonard et al., 2012), a recent national study of LGBT (lesbian, gay, bisexual and transgender) Australians, reported that over 25% of trans females in their sample identified as bisexual while only 15% whose reported gender was 'female' identified as bisexual.

Transgender and gender diverse people may have different experiences of bisexuality than cisgender people and therefore warrant a specific exploration of their mental health. The ways that the two marginalised identities/experiences intersect may affect experiences of erasure, marginalisation, discrimination, and harassment and may therefore impact mental health and wellbeing in different ways (Bowleg, 2012). One study (Katz-Wise, Mereish & Woulfe, 2017) compared the effects of bisexual-specific minority stress on cisgender and transgender bisexuals and found that bisexual transgender participants showed greater adverse effects on their physical health compared to cisgender women – no associations were found with cisgender men. The intersection of these two minority identities, they argued, meant that their experiences would be different from both cisgender bisexuals and monosexual transgender people.

Transgender/gender diverse identities and bisexuality share deep similarities in their potential to bring current social norms into question. Bisexuality has been credited

as undermining and potentially liberating persistent social beliefs built on the normative concept of sexuality as existing as a gay/straight dichotomy in much the same way as transgender and diverse gender identities work to challenge the long-standing construct of gender as an oppositional man/woman experience (Eisner, 2013). In addition, binary gender norms can be seen currently as working to prescribe sexual desire which, in a heteronormative society, is socially encouraged toward the 'opposite sex'. Where these prescriptions are interrupted by the undoing of man/woman gender conformity, the breadth of potential desire can become removed from gender allowing for a freer experience of attraction and sexual desire that may inherently open doors to bisexuality that were previously closed (Alexander, 2012). However, challenging social codes of both gender and sexuality may also lead bisexual and transgender/gender diverse people to experience further social marginalisation or isolation or may experience this in a different way to their cisgender peers.

Bisexual Life Experiences

A number of life experiences have been identified in the existing literature as particularly challenging for bisexual people. These include: biphobia; invisibility and erasure; being 'out'; community and belonging and intimate relationships. How these experiences relate to gender diverse bisexuals remains unclear and further investigation into this is needed (Angelides, 2001; Ault, 1994; Bostwick, 2012; Bradford, 2004; Dobinson et al., 2005; Eisner, 2013; Hughes et al., 2010; MacDowell, 2009; McNair et al., 2005; Ochs, 2011; Ross, Dobinson, & Eady, 2010; Weinberg et al., 1994). Many of these bisexual life experiences have been suggested to have the potential to impact mental health though current research has tended to examine just one or two of these experiences alongside mental health to the exclusion of others (Bostwick, 2012; Dodge et al., 2012; Dyar, Feinstein, & London, 2014; Koh & Ross, 2006; Leonard et al., 2015; Li et al.,

2013; McLean, 2007; Molina et al., 2015; Ross et al., 2010; Schick et al., 2012; Sheets & Mohr, 2009).

The experience of biphobia is a frequently reported challenge for bisexual people (Bostwick, 2012; Dobinson et al., 2005; Weinberg et al., 1994). The term 'biphobia' refers to discrimination directed specifically at bisexual people as a result of their sexual orientation and can emanate from both the heterosexual and LGBTI (lesbian, gay, bisexual, transgender and intersex) communities (Ault, 1994; Blumstein & Schwartz, 1999; Brennan & Hegarty, 2012; Dobinson et al., 2005; Feinstein, Dyar, Bhatia, Latack, & Davil, 2014; Li et al., 2013; Paul, Smith, Mohr, & Ross, 2014; Weinberg et al., 1994). In addition to biphobia encountered in social settings, bisexual people can also experience internalised biphobia due to their own negative beliefs and attitudes towards bisexuality (Chard, Finneran, Sullivan, & Stephenson, 2015; Paul et al., 2014). Often biphobia stems from the plethora of negative stereotypes that surround bisexuality. These stereotypes can attack the personal character of bisexual people, present the bisexual as dangerous or deviant, inhibit bisexuals from having trusting relationships and deny the very existence of bisexuality as a legitimate and stable sexual orientation (Angelides, 2001; Däumer, 1999; Dobinson et al., 2005; Du Plessis, 1996; Eadie, 1999; Esterberg, 2011; Garber, 1995; Herek, 2002; McLean, 2004, 2007). While transgender people have been found to experience discrimination with greater frequency than their cisgender counterparts (Leonard et al., 2015), transgender/gender diverse bisexual peoples' experiences of biphobia remain largely unknown.

A common theme emerging from the literature on bisexuality is bisexual peoples' experiences of invisibility and erasure. This invisibility exists on the pages of sexuality history books where bisexuality is oddly absent (Angelides, 2001; Foucault, 1978; Klein, 1993; Weeks, 1989) as well as in contemporary scholarly endeavour where the examination and theorising of bisexuality is comparatively silent and largely

overshadowed by examinations of other sexual orientation groups (Angelides, 2001; Yoshino, 2000). This concept of invisibility extends, however, beyond the pages of journal articles and academic books and penetrates the daily lives of bisexual people and Western culture as a whole (Angelides, 2001). Bisexual people report feeling invisible when they are assumed to be either heterosexual or homosexual based on the perceived gender of their partner (Bradford, 2004; Ochs, 2011; Ross et al., 2010). The broader visibility of transgender and gender diverse people has rapidly increased in the past decade with the significant progress of the trans movement (Eisner, 2013). However, whether this increased visibility relating to their gender has had an impact on gender diverse bisexual peoples' experiences of invisibility relating to their sexuality is unknown. In addition to this invisibility which could be described as an inadvertent omission, bisexuals and the concept of bisexuality itself are also actively erased; this erasure is often based on the long promulgated notion that bisexuality does not really exist (Angelides, 2001; Eisner, 2013; MacDowell, 2009). The lack of a visible presence and the active erasure of bisexuality is somewhat perplexing when considered in the context of recent population based studies suggesting that approximately 10% of people fall under Yoshino's (2000) definition of 'bisexual' (Richters et al., 2014; Smith, Rissel, Richters, Grulich, & De Visser, 2003).

The experience of being 'out' about their sexual orientation to those around them can present unique difficulties for bisexual people. Unlike monosexuals, the perceived gender of a bisexual person's partner does not implicitly infer sexual orientation and, as assumptions of sexuality are commonly based on this, bisexuals can feel that they need to repeatedly come out to those around them to maintain a state of disclosure in relation to their identity (Ross et al., 2010). Bisexuals report feeling that disclosure of their sexual identity to others often leads to confronting questions relating to their relationships (McLean, 2007). Furthermore, those in non-monogamous relationships report fearing that

disclosure of their sexual identity would require them to also disclose their non-monogamy (McLean, 2007). Fear is consistently reported as being intertwined with the coming out process for bisexual people (Dobinson et al., 2005; Dodge et al., 2012; Ross et al., 2010).These fears range from fearing that others will not understand or accept their identity to an immense fear of losing their family (Dobinson et al., 2005; Dodge et al., 2012; Ross et al., 2010). The intersection between bisexuality and transgender/gender diversity may add further complexity to the coming out process for transgender and gender diverse bisexuals with the potential need to disclose both their gender and sexuality or either one inferring assumptions or questions related to the other.

Community and belonging have long been reported as problematic for bisexual people with bisexuals more likely to report lower levels of social support than other sexual minority groups (Bradford, 2004; Hughes et al., 2010; McNair et al., 2005; Ross et al., 2010). Although some bisexual people report feeling connected to, and accepted within, LGBTI communities, experiences within these communities vary considerably and can be marred by the presence of negative attitudes and biphobia (Bradford, 2004; Dobinson et al., 2005; Dodge et al., 2012; McLean, 2008; Ross et al., 2010). Bisexual specific community groups exist, though they are very few in number and membership is often limited by geographic location and fears of stigma from the broader community (Dodge et al., 2012; Ross et al., 2010). With the lack of acceptance from both heterosexual and homosexual communities and the minimal existence of a bisexual community, many bisexual people report feeling that they do not belong anywhere (Bradford, 2004; McLean, 2008). Literature relating to community engagement for transgender people reports higher rates of connection to the LGBTI community than that for bisexuals (Leonard et al., 2012) and that connection to transgender communities is linked to mental wellbeing and strength of identity (Barr, Budge & Adelson, 2016).

However how the aforementioned challenges of bisexuality within LGBTI spaces impact on this connection is unclear.

The presence of bisexuality within intimate relationships is characterised by complexity and unique challenges. In the first instance, the decision of whether to disclose their sexual orientation to intimate partners can present a significant dilemma for bisexual people, a dilemma not relevant to monosexual relationships (Dobinson et al., 2005; Li et al., 2013). In the context of commonly held beliefs about bisexuals being promiscuous, untrustworthy and unable to commit (Bradford, 2004; Dobinson et al., 2005; Li et al., 2013; McLean, 2004), bisexual people often report that finding a partner who is understanding and supportive of their sexual orientation can be a difficult task (Dobinson et al., 2005; Weinberg et al., 1994). Furthermore, just maintaining a bisexual identity within the context of an intimate relationship and particularly a monogamous relationship has been reported to be an added challenge for this population (Dobinson et al., 2005; Ross et al., 2010). Finally, bisexual peoples' diverse attractions can lead to increased diversity in relationship structures. As a result, the negotiation of monogamy or non-monogamy within intimate relationships can be a complex and ongoing process for bisexual people (Dobinson et al., 2005; McLean, 2004; Weinberg et al., 1994). Transgender and gender diverse identities within relationships can present a wide range of experiences that may differ from cisgender partnerships, particularly where transgender experience is concerned and transitioning from one gender to another may impact on understandings of sexualities within these partnerships presenting a sometimes complex process of negotiation and individual development for both parties (Hines, 2006).

Current Study

The aim of the *Who I Am* study was to identify the reasons behind the high prevalence of poor mental health in bisexual people. The *Who I Am* study is one of the

largest studies conducted to focus solely on bisexual people and provides a significant contribution to the current limited understanding of poor mental health in this population. This paper posits an important addition to the small body of literature examining the alarmingly high rates of poor mental health among transgender and gender diverse bisexual people and seeks to identify which bisexual life experiences are associated with poor mental health in this cohort and how these experiences differ for cisgender people thereby providing much needed evidence upon which clinical interventions, policy development and future research can be based.

Method

Study Design

The *Who I Am* study was a cross-sectional survey open nationally across Australia from September 2016 to March 2017. The survey was available online via the Qualtrics survey platform.

Survey Instrument

The survey instrument included the Kessler Psychological Distress Scale (K10) (Kessler et al., 2002). This measure provides standardised assessment of current psychological distress using a ten question inventory (ABS, 2012; Kessler et al., 2002). Questions use a five-point Likert Scaling system with a score of 1 to 5 given to each, computing to a final score of between 10 and 50 (ABS, 2012). Lower scores indicate lower levels of current psychological distress while higher scores indicate higher levels (ABS, 2012; Kessler et al., 2002). This measure is commonly used in survey research in Australia and was selected for incorporation into the current study as it data which can be easily compared with those from large representative samples of the broader Australian population and large studies conducted with LGBTI Australians (ABS, 2012, 2017b; Leonard et al., 2015).

In addition to the K10 measure, the survey included a series of basic demographic questions and questions relating to common bisexual life experiences (Table 1). These questions were developed by the researchers following an extensive literature review, community consultation and piloting. Representatives from key Australian LGBTI, bisexual specific and mental health organisations provided feedback on the draft survey with the aim of maximising both user-friendliness of the instrument for participants and usefulness of the findings across disciplines and to interested parties. Only initial questions determining eligibility of participants to complete the survey were compulsory and all other questions were able to be completed or skipped at the discretion of the participant. At the beginning and end of the survey relevant helplines were provided to ensure that risk to participants was minimised. In addition, where questions of a sensitive nature were asked, these helplines were displayed again.

Table 1 - Survey Questions Devised by Researchers

Question	Response options
Mental health past and present	
1. A health professional has said I have… 2. In the past I think I have had… 3. I currently think I have…	- Anxiety disorder - Depression - Bipolar disorder - Schizophrenia - Borderline personality disorder - Eating disorder - Dissociative identity disorder - Post-traumatic stress disorder - Obsessive compulsive disorder - Attention deficit hyperactivity disorder - Other
4. In the past two years have you… 5. Have you ever…	- Thought about self-harming - Harmed yourself - Thought about committing suicide - Attempted suicide
Biphobia*	
6. Have you ever been treated badly because of your sexuality? 7. Have you ever been treated badly by your family because of your sexuality? 8. Have you ever been treated badly by your friends because of your sexuality? 9. Do you ever feel that your sexuality is bad or wrong?	- Never - Rarely - Sometimes - Often - Always
Invisibility and erasure*	

10. Do people ever assume you are heterosexual/straight? 11. Do people ever assume you are gay or lesbian? 12. Do you ever wish that your sexuality was more visible to those around you? 13. Do you ever feel that those around you refuse to accept your sexuality and/or believe that your sexuality does not exist?	- Never - Rarely - Sometimes - Often - Always
Being 'out'*	
Who in your life is aware of your sexuality? 14. immediate family 15. extended family 16. closest friends 17. broader friendship group	- All - Some - None - Not applicable
Community and belonging**	
18. How often do you participate in LGBTI community events (e.g. social gatherings, cultural, festivals/celebrations etc.)? 19. How often do you participate in bisexual or pansexual community events (e.g. social gatherings, cultural, festivals/celebrations etc.)? 20. How often do you have contact with LGBTI friends or acquaintances? 21. How often do you have contact with bisexual or pansexual friends or acquaintances?	- Never - Rarely - Sometimes - Often - Always
Intimate relationships***	
22. Is your partner/partners aware that your sexual identity, sexual attraction and/or sexual behaviour incorporates people of your own gender and at least one other gender?	- Yes - No - Don't know
23. Is your partner/partners understanding and supportive of your sexuality that incorporates people of your own gender and at least one other gender?	- Very understanding and supportive - Somewhat understanding and supportive - Neither supportive nor unsupportive - Somewhat unsupportive and lacking understanding - Very unsupportive and lacking understanding
24. How many partners do you have?	- One partner only - One partner + casual sex with other people - One primary partner + one or more other regular partners - One primary partner + one or more other regular partners + casual sex with other people - Two or more partners whom I see as equal in my life - Two or more partners whom I see as equal in my life + casual sex with other people - Other
25. What is the gender of your primary partner/s?	- I have more than one primary partner and they are of different genders - Man/men

	- Woman/women - Trans man/men - Trans woman/women - Non-binary or gender diverse - Other

*These questions were preceded by the statement: 'The following questions ask about your life experiences as a person whose sexual attraction, sexual behaviour and/or sexual identity incorporates people of your own gender and at least one other gender. In places we have simply referred to this as your 'sexuality'.'

**LGBTI was defined prior to these questions as relating to lesbian, gay, bisexual, transgender and intersex.

***These questions were preceded by the statement: 'The following questions are about your current relationship/s. If you are not currently in a relationship please answer these thinking about your most recent relationship. If you have never been in a relationship please leave this section blank and skip to the next page.'

Sample

The survey was completed by a total of 2,651 adults. Participants were included in the study if they were living in Australia and identified as bisexual and/or were attracted to more than one gender and/or had had sexual experiences with more than one gender. This three dimensional approach to defining bisexuality is an adaptation of Yoshino's three axes definition which, for this study, has been broadened to include those with incidental or occasional bisexual desire as any experiences across these three dimensions has been found to relate to poorer mental health (Bostwick et. al, 2014). This broad and inclusive approach to recruitment resulted from the general consensus within current literature that recruiting via just one dimension (such as identity) excludes people who may have significant same-sex attraction or sexual experiences (Bostwick et al., 2010; Laumann, Gagnon, Michael, & Michaels, 1994; Mathy et al., 2004; McNair et al., 2005; Yoshino, 2000). It was intended that for the *Who I Am* study, this approach would capture the significant diversity that exists amongst bisexuals while simultaneously providing greater opportunity for recruiting a large sample size which can be difficult with a hidden population such as this.

Due to the diverse nature of bisexuality and anticipated challenges recruiting participants from a characteristically invisible, oppressed and dispersed population, convenience sampling was identified as the most effective sampling method for this study. A detailed recruitment strategy was developed to include four recruitment arms:

online advertising using social media; online and print media; promotion through relevant professional networks and print advertising distributed to universities and sexual health centres across the country. A range of advertising material was created with a common branding (the *Who I Am* title with consistent colour and font) alongside a range of images of people of different genders. Wording on the advertisements varied with some including the words 'bisexual' and 'pansexual' and others simply calling for people 'attracted to more than one gender'. The domain name 'whoiamsurvey.com' was purchased to ensure ease of finding the online survey and this web address was included in all advertisements. This advertising material was utilised across all four recruitment arms.

Data Analysis

Data were analysed using IBM SPSS Version 25 software. A sub-set of the data was created which included only those participants who identified their gender to be 'trans man', 'trans woman', 'non-binary or gender diverse' or 'other' and those who identified their gender to be 'man' or 'woman' but indicated a different sex at birth; it was on this subset only that analyses reported in this paper were conducted except in the final analyses where comparisons with cisgender participants have been examined. For the purpose of analysis, and ease of comparison to findings of other studies, K10 scores were computed into four categories (low [10-15], moderate [16-21], high [22-29] and very high [30-50]) with category parameters consistent with those defined by the Australian Bureau of Statistics' K10 score groupings and categorisation for surveys (ABS, 2012). K10 categories were used across analyses as the measure of psychological distress. In addition, the sample mean of K10 scores was calculated for the purpose of comparison with data relating to the mental health of LGBTI Australians. For all analyses significance was set at $p < .05$.

Initial analyses explored frequencies of demographic and past and present mental health variables. A series of bivariate analyses were conducted to assess potential relationships between bisexual life experiences and K10 categories. For ordinal bisexual life experience variables, partial Spearman's rank order correlation tests were run while controlling for covariates: age, gender, local area description, education and income. For the three categorical life experience variables, linear-by-linear association chi square tests were used to assess associations with K10 categories.

Some of the variables found in the previous analyses were found to have a statistically significant relationship to mental health. Ordinal logistic regression was used to determine which were able to predict K10 categories while controlling for the same potential confounders. Before this regression model was run, multicollinearity was assessed by conducting collinearity diagnostics for all independent variables and all Variance Inflation Factor (VIF) values were under 2.0 indicating the multicollinearity assumption had not been violated. In addition, the assumption of proportional odds was met, as assessed by a full likelihood ratio test comparing the fit of the proportional odds model to a model with varying location parameters, $\chi^2(22) = 18.31$, $p = 0.69$.

Finally, a new gender variable was created by assigning each respondent of the *Who I Am* sample (n = 2,651) into one of two categories (transgender/gender diverse and cisgender). K10 categories and bisexual life experiences found in the previous analyses to correlate with K10 categories were further examined using chi square tests and post-hoc analyses to compare experiences of these between these two gender categories.

Ethics Approval

Ethics approval was granted from both the La Trobe University Human Ethics Committee and the community based Research Ethics Review Committee of the former AIDS Council of New South Wales, ACON.

Results

Sample Characteristics

A total of 474 gender diverse or transgender people living in Australia participated in the *Who I Am* study. The majority of participants identified their gender as 'non-binary or gender diverse' (60%), while 14% selected 'other' for their current gender. Identification as trans-man or trans-woman was reported with approximately equal frequency (13%). Ages ranged from 18 to 69 years, with a mean age of 27.91 years. Participants from all states and territories in Australia took part in the study with just over 80% from inner or outer suburban areas. Levels of educational attainment were similar to those of the broader Australian population, with 59% of this sample having completed a trade level certificate or higher compared with 62% of the broader population (ABS, 2017a). Demographic data are summarised in Table 2.

Table 2 - Sample Characteristics

Characteristic	***n***	**Frequency**	**Percentage (%)**
Gender	474	-	-
Trans man	-	63	13.3
Trans woman	-	60	12.7
Non-binary or gender diverse	-	285	60.1
Other	-	66	13.9
Age group (in years)	474	-	-
18-24	-	236	49.8
25-44	-	193	40.7
45+	-	45	9.5
Aboriginal and/or Torres Strait Islander origin	471	-	-
Yes	-	14	3.0
No	-	457	96.4
Ethnicity	470	-	-
Anglo/Australian	-	378	79.7
Other	-	92	19.4

State or territory currently residing	474	-	-
VIC	-	163	34.4
NSW	-	94	19.8
QLD	-	54	11.4
WA	-	49	10.3
TAS	-	44	9.3
ACT	-	38	8.0
SA	-	30	6.3
NT	-	2	0.4
Local area description	474	-	-
Capital city/inner suburban	-	244	51.5
Outer suburban	-	137	28.9
Regional centre	-	62	13.1
Rural or remote	-	31	6.5
Highest level of education achieved	464	-	-
Year 10 or below	-	26	5.5
Year 11	-	16	3.4
Year 12	-	142	30.0
Apprenticeship/trade certificate/Tertiary diploma	-	104	21.9
Undergraduate university degree	-	119	25.1
Postgraduate university degree	-	57	12.0
Total pre-tax income per year	474	-	-
$0	-	25	5.3
$1 - $29,999	-	258	54.4
$30,000 - $49,999	-	63	13.3
$50,000 - $79,999	-	55	11.6
$80,000 - $99,999	-	14	3.0
$100,000 - $124,999	-	12	2.5
$125,000 - $149,999	-	1	0.2
$150,000 - $199,999	-	1	0.2
$200,000 or more	-	4	0.8
Prefer not to answer	-	41	8.6
Relationship status	424	-	-
In a relationship	-	241	56.8

Single	-	183	43.2

Psychological Distress and Mental Health

The mean K10 score for this sample was 27.09 (SD=9.30). K10 categorisation revealed that the vast majority of the sample reported high or very high psychological distress (72%) (Table 3). The most frequently identified mental disorders respondents reported having had in the past, currently or 'had ever' been diagnosed with were depression, anxiety, post-traumatic stress disorder (PTSD), eating disorders and borderline personality disorder (Table 3). Interestingly, for nearly every mental disorder, respondents reported being diagnosed by a health professional with far greater frequency than 'thinking' they actually had these disorders (Table 3).Overall, 79% of the sample had been diagnosed with a mental health disorder at some point in their lives. Rates of suicidality and self-harm were very high with over half the sample reporting having thought about self-harming (64%) or considered committing suicide (55%) in the past two years and nearly half the sample (49%) having ever attempted suicide (Table 3).

Table 3 - Mental Health Past and Present

Characteristic	***n***	**Frequency**	**Percentage (%)**
K10 category	399	-	-
Low (10-15)	-	52	13.0
Moderate (16-21)	-	61	15.3
High (22-29)	-	126	31.6
Very high (30-50)	-	160	40.1
In the past I think I have had…	413	-	-
Anxiety disorder	-	134	28.3
Depression	-	147	31.0
Bipolar disorder	-	20	4.2

Schizophrenia	-	4	0.8
Borderline personality disorder	-	26	5.5
Eating disorder	-	88	18.6
Dissociative identity disorder	-	22	4.6
Post-traumatic stress disorder	-	63	13.3
Obsessive compulsive disorder	-	6	1.3
Attention deficit hyperactivity disorder	-	2	0.4
Other	-	6	1.3
I currently think I have…	413	-	-
Anxiety disorder	-	138	29.1
Depression	-	114	24.1
Bipolar disorder	-	23	4.9
Schizophrenia	-	8	1.7
Borderline personality disorder	-	30	6.3
Eating disorder	-	26	5.5
Dissociative identity disorder	-	24	5.1
Post-traumatic stress disorder	-	56	11.8
Obsessive compulsive disorder	-	7	1.5
Attention deficit hyperactivity disorder	-	4	0.8
Other	-	11	2.3
A health professional has said I have…	413	-	-
Anxiety disorder	-	264	63.9
Depression	-	290	70.2
Bipolar disorder	-	44	10.7
Schizophrenia	-	13	3.1
Borderline personality disorder	-	48	11.6
Eating disorder	-	52	12.6
Dissociative identity disorder	-	16	3.9
Post-traumatic stress disorder	-	73	17.7
Obsessive compulsive disorder	-	10	2.4
Attention deficit hyperactivity disorder	-	11	2.7
Other	-	26	6.3
A health professional has said I have one of the above mental health disorders	413	-	-
Yes	-	325	78.7

No	-	88	21.3
In the past two years have you…	-	-	-
Thought about self-harming	408	260	63.7
Harmed yourself	406	166	35.0
Thought about committing suicide	406	259	54.6
Attempted suicide	406	60	12.7
Have you ever…	-	-	-
Thought about self-harming	408	365	89.5
Harmed yourself	406	305	75.1
Thought about committing suicide	408	372	91.6
Attempted suicide	406	198	48.8

Relationships between Bisexual Life Experiences and Mental Health

Spearman's rank order correlation results indicate that participants who more frequently experienced biphobia had higher levels of psychological distress, with all four measures of biphobia significantly correlating with K10 categories (Table 4).

Although participants who more frequently experienced erasure had higher psychological distress (Table 4), none of the measures of invisibility ('do people ever assume you are heterosexual/straight?' [$p = 0.32$], 'do people ever assume you are gay or lesbian?' [$p = 0.85$] or 'do you ever wish that your sexuality was more visible to those around you?' [$p = 0.47$]) were found to significantly correlate with K10 categories.

Whether or not respondents were 'out' about their sexuality to those around them was not found to be related to mental health with those out to 'immediate family' ($p = 0.56$), 'extended family' ($p = 0.07$), 'closest friends' ($p = 0.11$) or 'broader friendship group' ($p = 0.97$) again not significantly correlating with K10 categories.

Rates of participation in LGBTI community events was found to negatively correlate with K10 categories, with those less frequently participating reporting higher

psychological distress (Table 4). Despite this, no other measure of community and belonging was found to significantly relate to psychological distress ('how often do you participate in bisexual or pansexual community events?' [$p = 0.65$], 'how often do you have contact with LGBTI friends or acquaintances?' [$p = 0.80$] or 'how often do you have contact with bisexual or pansexual friends or acquaintances?' [$p = 0.48$]).

No significant association was found between aspects of intimate relationships and K10 categories ('partner's awareness of your sexuality' [$p = 0.68$], 'partner's support and understanding about sexuality' [$p = 0.06$], 'how many partners do you have?' [$p = 0.20$] and 'what is the gender of your primary partner?' [$p = 0.91$]).

A cumulative odds ordinal logistic regression with proportional odds was run to determine the effect of eight bisexual life experience variables on K10 categories. Bisexual life experience variables were included in this regression model if they were found to have a statistically significant relationship with K10 categories from the previous analyses. Six variables met this criterion (Table 4). Gender, age, local area description, education and income were adjusted for in this model.

The final model statistically significantly predicted the dependent variable (K10 categories) over and above the intercept-only model, $\chi^2(11) = 93.42$, $p = <.001$. Two of the six variables were found to significantly predict the dependent variable. As experiences of participants' feeling their sexuality was bad or wrong increased so too did their odds of being in a higher K10 category and as participation in LGBTI community events decreased, the odds of being in a higher K10 category increased (Table 4).

Table 4 - Relationships between bisexual life experiences and K10 categories

	Spearman's Rho Significant Findings		**Ordinal Logistic Regression Findings**	
Bisexual life experiences significantly correlated with K10	Correlation	Sig.	OR	*p*

categories	coefficient	(2-tailed)	(CI 95%)	
Have you ever been treated badly because of your sexuality?	0.17	0.001	1.20 (0.88-1.64)	0.26
Have you ever been treated badly by your family because of your sexuality?	0.19	<.001	1.20 (0.98-1.47)	0.08
Have you ever been treated badly by your friends because of your sexuality?	0.14	0.01	1.03 (0.78-1.36)	0.85
Do you ever feel that your sexuality is bad or wrong?	0.27	<.001	1.53 (1.23-1.90)	<.001
Do you ever feel that those around you refuse to accept your sexuality and/or believe that your sexuality does not exist?	0.18	<.001	1.17 (0.94-1.45)	0.17
How often do you participate in LGBTI community events?	-0.16	0.002	0.72 (0.59-0.88)	0.001

Comparisons with cisgender participants

A linear-by-linear chi-square test revealed that transgender/gender diverse respondents were significantly more likely to report very high levels of psychological distress than cisgender respondents ($\chi^2(1) = 25.33$, $p = <.001$).

Transgender/gender diverse respondents were significantly more likely than cisgender respondents to experience five of the six 'bisexual life experiences' outlined in Table 4. All of these were associated with poorer mental health. Only one 'life experience' variable, 'do you ever feel that your sexuality is bad or wrong' showed no significant difference between the two groups ($\chi^2(1) = 0.35$, $p = 0.56$).

Transgender/gender diverse respondents were also significantly more likely to have experienced biphobia across all three measures of this: 'have you ever been treated badly because of your sexuality' ($\chi^2(1) = 83.80$, $p = <.001$); 'treated badly by family ($\chi^2(1) = 111.53$, $p = <.001$) and treated badly by friends ($\chi^2(1) = 29.05$, $p = <.001$).

Cisgender participants were significantly more likely to report never feeling that those around them refused to accept their sexuality or believed it did not existed ($\chi^2(1) = 16.92$, $p = <.001$). Despite these indicators of more negative experiences, participation in LGBTI community events was markedly higher for transgender/gender diverse participants than cisgender participants ($\chi^2(1) = 64.79$, $p = <.001$).

Discussion

Previous research has identified both bisexual people and transgender and gender diverse people as being at high risk of experiencing poor mental health (Bostwick et al., 2010; Bostwick et al., 2007; Conron et al., 2010; Eisner, 2013; Herman, 2016; Hughes et al., 2010; Jorm et al., 2002; Koh & Ross, 2006; Leonard et al., 2012; Li et al., 2013; Persson et al., 2015; Pompili et al., 2014; Smith, et al., 2014; Steele et al., 2009). However, there has been limited examination of the mental health of those who identify as both transgender/gender diverse and bisexual. Within this limited literature, the mental health of this group has been found to be particularly poor (Mathy et al., 2004) a finding consistent with the current study. Seventy-two percent of *Who I Am*'s transgender/gender diverse participants reported high or very high psychological distress, a figure that is substantially higher than the Australian national average of 12% (ABS, 2017b). When a comparative analysis with cisgender participants was run it revealed that transgender and gender diverse *Who I Am* participants were significantly more likely to report higher current psychological distress than their cisgender bisexual counterparts. In addition, when compared with the broader Australian LGBT community's K10 mean score of 19.6 (Leonard et al., 2015), this sample was found to have significantly higher psychological distress with a K10 mean score of 27.09.

The most commonly reported mental disorders in this sample (anxiety and depression) are the same as those reported by the Australian general public and broader

LGBT population (ABS, 2017b; Leonard et al., 2015), however, this sample reported these at far greater rates. Interestingly, a significant discrepancy was found between respondents reporting thinking they have had or currently have a mental disorder and having ever been told by a health professional they have a mental disorder. For example, 31% of participants reported thinking they had had depression in the past and 24% thought they had depression at the time the survey was conducted, while over 70% reported having been told they have depression by a health professional. This was the case for every listed mental disorder except eating disorders and dissociative identity disorder. Previous research has found that those in minority groups (such as ethnic minorities) are more likely to experience 'over-diagnosis' and 'misdiagnosis' of mental disorders (Atdjian, 2005; strakowski, 2003; Williams, 2000). It is possible that this finding may be related to the minority status of this sample.

The findings of the current study support previous research reporting that gender diverse and transgender bisexuals are at high risk of suicidal ideation and suicide attempts (Mathy et al., 2004). Reports of the broader Australian population's experiences of suicidality reveals that 13% have thought about committing suicide, while 3% have attempted suicide in their lifetime (Slade, 2009). These figures are substantially lower than the current study's findings revealing that 92% of gender diverse bisexual participants had thought about committing suicide while almost one in two had attempted suicide.

Previous research has linked increased experiences of biphobia to poorer mental health in bisexual people (Bostwick, 2012; Dodge et al., 2012; Molina et al., 2015; Ross et al., 2010). In addition, transgender people have been found to report higher incidences of harassment and abuse than cisgender people (Leonard et al., 2015) a finding that is supported by the findings of the current study with comparative analysis between gender groups revealing transgender and gender diverse people reported experiences of biphobia

with significantly greater frequency than cisgender respondents. Transgender and gender diverse bisexuals' experiences of biphobia and how these relate to their mental health has received little to no previous scholarly attention. Thus the findings of the *Who I Am* study showing that all four measures of biphobia were significantly correlated with mental health and that these experiences were significantly more prevalent among the transgender and gender diverse cohort than for cisgender respondents presents an important first step in creating new knowledge in this area. Internalised biphobia, assessed by asking participants if they ever felt their sexuality was bad or wrong, was found to be of particular importance in the mental health picture of this sample, being one of only two variables that were found to significantly predict psychological distress. This finding can be contextualised by a previous research finding that bisexual people lack self-acceptance of their sexuality at greater levels than gay or lesbian people (Chard et al., 2015). Furthermore, this lack of self-acceptance with regard to sexuality by bisexual people appears to exist with similar frequency regardless of gender, with internalised biphobia being the only form of biphobia reported on in the *Who I Am* study that showed no significant differences between cisgender and transgender/ gender diverse respondents.

Erasure is a commonly discussed phenomenon in the theorising of bisexuality (Angelides, 2001; Eisner, 2013; MacDowell, 2009), however bisexual people's experiences of erasure have rarely been reported in the context of scholarly research. The present study found that transgender and gender diverse respondents who reported more frequent experiences of the perception that those around them refuse to accept their sexuality or believe it does not exist had higher psychological distress. When compared to cisgender respondents, transgender and gender diverse participants were significantly less likely to report never experiencing this erasure. In contrast, although past research has reported a link between bisexual peoples' experiences of invisibility and their mental health (Dobinson et al., 2005), within this transgender and gender diverse sample,

invisibility was not found to correlate with psychological distress. Eisner (2013) points to the recent 'trans movement' that has, in the past decade, significantly increased the visibility of transgender and gender diverse people, as a learning opportunity for the bisexual community in how to raise the profile, and therefore visibility, of a population that falls outside of accepted social dichotomy. It is possible that participants in this sample are experiencing this greater visibility, at least with regard to their gender, and as such are experiencing fewer deleterious psychological ramifications with regard to invisibility. In addition, being 'out' to others about their sexuality is much less common for bisexual people than for other sexual orientation groups (Balsam & Mohr, 2007; Dobinson et al., 2005; Eisner, 2013; Koh & Ross, 2006; Leonard et al., 2012; Persson et al., 2015; Weinberg et al., 1994), however previous research has found that transgender/gender diverse people are more likely to be 'out' than their cisgender counterparts (Pitts, Smith, Mitchell, & Patel, 2006). Interestingly, in this sample of transgender and gender diverse participants, being 'out' or not being 'out' about their sexuality was not related to psychological distress.

In contrast to the findings of previous research (Ross et al., 2010; Sheets & Mohr, 2009), the present study found that contact with LGBTI friends or acquaintances was not associated with mental health. However, being involved in LGBTI community events was certainly important for this sample with lower levels of engagement in the community predictive of higher psychological distress. This may again be intertwined with the diverse gender of this cohort. The Private Lives 2 study (Leonard et al., 2015) reported that participation in LGBT community events was associated with increased resilience for bisexual women but not bisexual men. Meanwhile, a very clear link has previously been found between higher levels of connection to LGBTI communities for gender diverse people and better mental health (Budge, 2014; Leonard et al., 2015; Pflum, 2015). In addition, while transgender and gender diverse *Who I Am* respondents reported

significantly higher rates of participation in LGBTI community events, cisgender men and women were much less likely to be engaged in these communities, a finding that supports previous research (Leonard et al., 2012).

Limitations

Despite a broad recruitment strategy being implemented for this study, the vast majority of participants were recruited online via Facebook and email networks. Therefore people who were not connected via either of these platforms had limited exposure to advertising. In addition, where print advertising and word of mouth reached potential participants, internet access was required to complete the survey. Due to the use of convenience sampling, the findings presented in this paper may not be representative of the transgender/gender diverse bisexual population in Australia. In addition, as a result of the survey relying on self-reporting and participants' ability to choose to skip questions they did not want to answer, reporting bias and missing data could be seen as a limitation. Finally, questions relating to common bisexual life experiences such as levels of 'outness', connection to the LGBTI community and experiences of discrimination were asked of all participants regardless of their gender. For transgender or gender diverse participants, these experiences may relate to their gender and/or their sexuality however this study only examined these in relation to their sexuality which disallowed for a more nuanced analysis of the intersection of gender and sexuality where these experiences were concerned.

Practical Implications

Several clinical implications can be drawn from the findings presented in this paper. Firstly, a clear picture has been presented of very high rates of poor mental health and suicidality among gender diverse/transgender bisexual people. Research has revealed that previous suicide attempts are a significant predictor of death by suicide (Artieda-

Urrutia, 2014; Klonsky, 2016). With one in two of this sample having attempted suicide at some point in their lives, these findings should alert clinicians to the significant risk of suicide in this population and clinical assessment and intervention should be tailored accordingly. In addition, the factors found to be associated with poor mental health in this study, particularly the two predictors of poor mental health experiences of internalised biphobia and less connection to LGBTI communities, provide direction for clinical care in that developing self-acceptance around one's sexuality and facilitating connection to community may be important interventions for this group. Furthermore, the clear differences in experiences between cisgender bisexuals and transgender/gender diverse bisexuals should alert clinicians to the need for different approaches depending on the gender identity of those they are treating.

Policy makers in the health care sector have, until now, had very little evidence upon which policy aimed at improving mental health outcomes for gender diverse bisexual people can be based. The high rates of poor mental health found in this large sample provide justification for the need for policy development in this area. In addition, this research provides new knowledge on the reasons behind this poor mental health which can inform future efforts aimed at addressing this need.

The findings presented in this paper highlight numerous areas for future research. To date, the mental health of transgender/gender diverse bisexuals has received extremely limited scholarly attention and therefore there is much work to be done. One area of interest arising from this study is the significant discrepancy between participants thinking they have a particular mental disorder and a health professional telling them they have a mental disorder. The possibility of 'over-diagnosis', or 'misdiagnosis', of mental disorders in this minority group warrants further investigation. In addition, the identification of certain bisexual life experiences as being found to be associated with poor mental health among these transgender/gender diverse bisexuals, provides direction

for deeper investigation into how these factors relate to mental health in order to further inform service provision and policy development.

Conclusion

The *Who I Am* study is one of the largest studies of bisexual people ever conducted. The study sought to identify the reasons behind the high prevalence of poor mental health in this population. The mental health of gender diverse and transgender bisexuals has received extremely limited attention in the literature to date. This paper aims to address this significant gap by presenting findings of the *Who I Am* study focussing specifically on the experiences of gender diverse and transgender respondents. These findings suggest that gender diverse bisexuals experience very high rates of psychological distress, mental disorders and suicidality. Experiences of biphobia, erasure of their sexuality by others and less engagement in LGBTI community events were associated with poor mental health in this sample. Internalised biphobia and LGBTI community participation were found to significantly predict participants' mental health. Experiences of psychological distress and most associated bisexual life experiences were found to differ significantly between transgender/gender diverse and cisgender participants. The implications of this new knowledge are significant and are relevant to clinicians, policy makers and researchers alike.

Disclosure Statement

The authors have no conflicts of interest to declare.

References

ABS, Australian Bureau of Statistics (2012). Information Paper: Use of the Kessler Psychological Distress Scale in ABS Health Surveys, Australia, 2001-08. (4817.0.55.001). Retrieved 2003/2018, from Australian Bureau of Statistics http://www.abs.gov.au/ausstats/abs@.nsf/lookup/4817.0.55.001Chapter92007-08

ABS, Australian Bureau of Statistics (2017a). Education and Work, Australia, May 2017. (6227.0). Retrieved 07/04/2018, from Australian Bureau of Statistics http://www.abs.gov.au/ausstats/abs@.nsf/mf/6227.0

ABS, Australian Bureau of Statistics (2017b). National Health Survey: Users' Guide, 2014-15. (4363.0). Retrieved 28/03/2018, from Australian Bureau of Statistics http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4363.0~2014-15~Main%20Features~Users'%20Guide~1

Alexander, J. Y. K. (2012). Bisexuality and transgenderism: Intersexions of the others. In F. Klein, Alexander, J. & Yescavage, K. (Ed.), *Bisexuality and transgenderism: Intersextions of the others* (pp. 1-24). New York: Harrington Park Press.

Angelides, S. (2001). *A history of bisexuality*. USA: The University of Chicago Press.

Artieda-Urrutia, P., Parra Uribe, I., Garcia-Pares, G., Palao, D., de Leon, J. & Blasco-Fonecilla, H. (2014). Management of suicidal behaviour: Is the world upside down? *Australian and New Zealand Journal of Psychiatry, 48*(5), 399-401.

Atdjian, S. W. A. (2005). Disparities in mental health treatement in U.S. racial ethnic minority groups: Implications for psychiatrists. *Psychiatric Services, 56*(12), 1600-1602.

Ault, A. (1994). Hegemonic discourse in an oppositional community: Lesbian feminists and bisexuality. *Critical Sociology, 20*(3), 107-122.

Balsam, K. F., & Mohr, J. J. (2007). Adaptation to sexual orientation stigma: a comparison of bisexual and lesbian/gay adults. *Journal of Counseling Psychology, 54*(3), 306.

Barr, S., Budge, S. & Adelson, J. (2016). Transgenderr community belongingness as a mediator between strength of transgender idenitty and well-being. *Journal of Counselling Psychology, 63*(1): 87-97.

Blumstein, P. W., & Schwartz, P. (1999). Bisexuality: Some social psychological issues (1977). In M. Storr (Ed.), *Bisexuality: A critical reader*. London: Routledge.

Bostwick, W. (2012). Assessing bisexual stigma and mental health status: A brief report. *Journal of bisexuality, 12*(2), 214-222. doi: 10.1080/15299716.2012.674860

Bostwick, W. B., Boyd, C. J., Hughes, T. L., & McCabe, S. E. (2010). Dimensions of sexual orientation and the prevalence of mood and anxiety disorders in the United States. *American journal of public health, 100*(3), 468. doi: 10.2105/AJPH.2008.152942

Bostwick, W. B., McCabe, S. E., Horn, S., Hughes, T., Johnson, T., & Valles, J. R. (2007). Drinking patterns, problems, and motivations among collegiate bisexual women. *Journal of American College Health, 56*(3), 285-292. doi: 10.3200/JACH.56.3.285-292.

Bowleg, L. (2012). The problem with the prhase women and minorities: Intersectionality – An important theoretical framework for public health. *American Journal of Public Health, 102*: 1267-1273.

Bradford, M. (2004). The bisexual experience: Living in a dichotomous culture. In R. C. Fox (Ed.), *Current Research on Bisexuality*. New York: Harrington Park Press.

Brennan, T., & Hegarty, P. (2012). Charlotte wolff's contribution to bisexual history and to (sexuality) theory and research: A reappraisal for queer times. *Journal of the History of Sexuality, 21*(1), 141-161.

Budge, S., Kinton Rossman, H. & Howard, K. . (2014). Coping and psychological distress among genderqueer individuals: The moderating effect of social support. *Journal of LGBT Issues in Counselling, 8*(1), 95-117.

Chard, A. N., Finneran, C., Sullivan, P. S., & Stephenson, R. (2015). Experiences of homophobia among gay and bisexual men: results from a cross-sectional study in seven countries. *Culture, Health & Sexuality, 17*(10), 1174-1189. doi: 10.1080/13691058.2015.1042917

Conron, K. J., Mimiaga, M. J., & Landers, S. J. (2010). A population-based study of sexual orientation identity and gender differences in adult health. *The American Journal of Public Health, 100*(10), 1953-1960.

Däumer, E. D. (1999). Extract from queer ethics; or, the challenge of bisexuality to lesbian ethics (1992). In M. Storr (Ed.), *Bisexuality: A critical reader*. London: Routledge.

Diamond, L. M. (2008). Female bisexuality from adolescence to adulthood: Results from a 10-year longitudinal study. *Developmental Psychology, 44*(1), 5-14.

Dobinson, C., Macdonnell, J., Hampson, E., Clipsham, J., & Chow, K. (2005). Improving the access and quality of public health services for bisexuals. *Journal of bisexuality, 5*(1), 39-77. doi: 10.1300/J159v05n01_05

Dodge, B., Schnarrs, P., Reece, M., Martinez, O., Goncalves, G., Malebranche, D., . . . Fortenberry, J. D. (2012). Individual and social factors related to mental health concerns among bisexual men in the midwestern United States. *Journal of bisexuality, 12*(2), 223-245. doi: 10.1080/15299716.2012.674862

Du Plessis, M. (1996). Blatantly bisexual; or, unthinking queer theory. In M. Pramaggiore & D. E. Hall (Eds.), *RePresenting bisexualities: subjects and cultures of fluid desire*. London, New York: New York University Press.

Dyar, C., Feinstein, B. A., & London, B. (2014). Dimensions of sexual identity and minority stress among bisexual women: The role of partner gender. *Psychology of Sexual Orientation and Gender Diversity, 1*(4), 441-451.

Eadie, J. (1999). Extracts from activating bisexuality: Towards a bi/sexual politics (1993). In M. Storr (Ed.), *Bisexuality: A critical reader*. London: Routledge.

Eisner, S. (2013). *Bi: Notes for a bisexual revolution*. California: Seal Press.

Esterberg, K. G. (2011). The bisexual menace revisited: or, shaking up social categories is hard to do. In S. Seidman, N. Fischer, & C. Meeks (Eds.), *Introducing the new sexuality studies 2nd edition*. USA and Canada: Routledge.

Feinstein, B. A., Dyar, C., Bhatia, V., Latack, J. A., & Davil, J. (2014). Willingness to engage in romantic and sexual activities with bisexual partners: Gender and sexual orientation differences. *Psychology of Sexual Orientation and Gender Diversity, 1*(3), 255-262.

Feldman, J., Brown, G. R., Deutsch, M. B., Hembree, W., Meyer, W., Meyer-Bahlburg, H. F. L.,…Safer, J. D. (2016). Priorities for transgender medical and health care research. *Current Opinion in Endocrinology, Diabetes and Obesity, 23*(2), 180-187.

Foucault, M. (1978). *The history of sexuality* (Vol. 1). New York: Pantheon Books.

Garber, M. (1995). *Vice versa: Bisexuality and the eroticism of everyday life*. London, New York: Penguin Books.

Harrison, J., Grant, J. & Herman, J. L. (2012). A gender not listed here: Genderqueers, gender rebels and otherwise in the National transgender Discrimination Survey. *LGBTIQ Policy Journal, 2*: 13-24.

Herek, G. M. (2002). Heterosexuals' attitudes toward bisexual men and women in the United States. *The Journal of Sex Research, 39*(4), 264-275.

Herman, J., Rankin, J., Keisling, S., Mottet, M. & Anafi, M. . (2016). The Report of the 2015 U.S. Transgender Survey. Washington, DC: Ntional Center for Transgender Equality.

Hines, S. (2006). Intimate transitions: Transgender practices of parntering and parenting. *Sociology, 40*(2), 353-371.

Hughes, T., Szalacha, L. A., & McNair, R. (2010). Substance abuse and mental health disparities: Comparisons across sexual identity groups in a national sample of young Australian women. *Social Science & Medicine, 71*(4), 824-831. doi: 10.1016/j.socscimed.2010.05.009

Jorm, A. F., Korten, A. E., Rodgers, B., Jacomb, P. A., & Christensen, H. (2002). Sexual orientation and mental health: results from a community survey of young and

middle-aged adults. *The British journal of psychiatry : the journal of mental science, 180*, 423.
Katz-Wise, S. L., Mereish, E. H. & Woulfe, J. (2017). Associations of bisexual-specific minority stress and healhth among cisgender and transgender adults with bisexual orientation. *The Journal of Sex Research, 54*(7): 899-910.
Kessler, R. C., Andrews, G., Colpe, L. J., Hiripi, E., Mroczek, D. K., Normand, S. L. T., . . . Zaslavsky, A. M. (2002). Short screening scales to monitor population prevalences and trends in non-specific psychological distress. *Psychol. Med., 32*(6), 959-976. doi: 10.1017/S0033291702006074
Klein, F. (1993). *The bisexual option: Second edition* (2nd ed. ed.). New York & London: Routledge Ltd.
Klonsky, E. D., May, A.M. & Saffer, B.Y. (2016). Suicide, suicide attempts, and suicidal ideation. *Annual Review of Clinical Psychology, 12*, 307-330.
Koh, A. S., & Ross, L. K. (2006). Mental health issues: a comparison of lesbian, bisexual and heterosexual women. *Journal of Homosexuality, 51*(1), 33.
Kuper, L., Nussbaum, R. & Mustanski, B. (2012). Exploring the diversity of gender and sexual orientation identities in an online sample of transgender individuals. *The Journal of Sex Research, 49*(2-3), 244-254.
Laumann, E. O., Gagnon, J. H., Michael, R. T., & Michaels, S. (1994). *The social organization of sexuality : sexual practices in the United States*. Chicago: University of Chicago Press.
Leonard, W., Lyons, A., & Bariola, E. (2015). A closer look at private lives 2. Melbourne, Australia: Australian Research Centre in Sex, Health and Society, La Trobe University
Leonard, W., Pitts, M., Mitchell, A., Lyons, A., Smith, A., Patel, S., . . . Barrett, A. (2012). Private Lives 2: The second national survey of the health and wellbeing of GLBT Australians. Melbourne, Australia: Australian Research Centre in Sex, Health and Society, La Trobe University.
Li, T., Dobinson, C., Scheim, A., & Ross, L. (2013). Unique issues bisexual people face in intimate relationships: A descriptive exploration of lived experience. *Journal of Gay & Lesbian Mental Health, 17*(1), 21-39. doi: 10.1080/19359705.2012.723607
MacDowell, L. (2009). Historicising contemporary bisexuality. *Journal of bisexuality, 9*(1), 3-15.
Mathy, R., Lehmann, B., & Kerr, D. (2004). Bisexual and transgender identities in a nonclinical sample of north Americans: Suicidal intent, behavioral difficulties, and mental health treatment. *Journal of bisexuality, 3*(3-4), 93-109. doi: 10.1300/J159v03n03_07
McLean, K. (2004). Negotiating (non)monogamy: bisexuality and intimate relationships. *Journal of bisexuality, 4*(1-2), 83-97.
McLean, K. (2007). Hiding in the closet? Bisexuals, coming out and the disclosure imperitive. *Journal of sociology, 43*(2), 151-166.
McLean, K. (2008). Inside, outside, nowhere: Bisexual men and women in the gay and lesbian community. *Journal of bisexuality, 8*(1-2), 63-80. doi: 10.1080/15299710802143174
McNair, R., Kavanagh, A., Agius, P., & Tong, B. (2005). The mental health status of young adult and midlife nonheterosexual Australian women. *Australian and New Zealand Journal of Public Health, 29*(3), 265.
Molina, Y., Marquez, J., Logan, D., Leeson, C., Balsam, K., & Kaysen, D. (2015). Current Intimate Relationship Status, Depression, and Alcohol Use Among Bisexual Women: The Mediating Roles of Bisexual-Specific Minority Stressors. *A Journal of Research, 73*(1), 43-57. doi: 10.1007/s11199-015-0483-z

Ochs, R. (2011). Why we need to “get bi”. *Journal of bisexuality, 11*(2-3), 171-175. doi: 10.1080/15299716.2011.571983

Paul, R., Smith, N. G., Mohr, J. J., & Ross, L. E. (2014). Measuring dimensions of bisexual identity: Initial development of the bisexual identity inventory. *Psychology of Sexual Orientation and Gender Diversity, 1*(4), 452-460.

Persson, T. J., Pfaus, J. G., & Ryder, A. G. (2015). Explaining mental health disparities for non-monosexual women: Abuse history and risky sex, or the burdens of non-disclosure? *Social Science & Medicine, 128*, 366-373. doi: 10.1016/j.socscimed.2014.08.038

Pflum, S., Testa, R., Balsam, K., Goldblum, P. & Bongar, B. (2015). Social support, trans community connectedness, and mental health symptoms among transgender and gender nonconforming adults. *Psychology of Sexual Orientation and Gender Diversity, 2*(3), 281-286.

Pitts, M., Smith, A., Mitchell, A., & Patel, S. (2006). Private lives: A report on the health and wellbeing of GLBTI Australians. Melbourne: Australian Research Centre in Sex, Health and Society, La Trobe University.

Pompili, M., Lester, D., Forte, A., Seretti, M. E., Erbuto, D., Lamis, D. A., . . . Girardi, P. (2014). Bisexuality and suicide: A systematic review of the current literature. *11*(8), 1903-1913.

Richters, J., Altman, D., Badcock, P. B., Smith, A. M. A., De Visser, R. O., Grulich, A. E., . . . Simpson, J. M. (2014). Sexual identity, sexual attraction and sexual experience: The second australian study of health and relationships. *Sexual Health, 11*(5), 451-460.

Riggs, D. W. & Bartholomaeus, C. (2016). Australian mental health nurses and transgender clients: Attitudes and knowledge. *Journal of Research in Nursing, 21*(3), 212-222.

Ross, L. E., Dobinson, C., & Eady, A. (2010). Perceived determinants of mental health for bisexual people: a qualitative examination. *American journal of public health, 100*(3), 496. doi: 10.2105/AJPH.2008.156307

Schick, V., Rosenberger, J., Herbenick, D., Calabrese, S., & Reece, M. (2012). Bidentity: Sexual behavior/identity congruence and women's sexual, physical and mental well-being. *Journal of bisexuality, 12*(2), 178-197. doi: 10.1080/15299716.2012.674855

Sheets, R. L., Jr., & Mohr, J. J. (2009). Perceived social support from friends and family and psychosocial functioning in bisexual young adult college students. *Journal of Counseling Psychology, 56*(1), 152-163. doi: 10.1037/0022-0167.56.1.152

Slade, T., Johnston, A., Teesson, M., Whiteford, H., Burgess, P., Pirkis, J., Saw, S. . (2009). The Mental Health of Asutralians 2: Report on the 2007 National Survey of Mental Health and Wellbeing. . Canberra.

Smith, A. M. A., Rissel, C. E., Richters, J., Grulich, A. E., & De Visser, R. O. (2003). Sexual identity, sexual attraction and sexual experience among a representative sample of adults. *Australian and New Zealand Journal of Public Health, 27*(2), 138-145.

Smith, E., Jones, T., Ward, R., Dixon, J., Mitchell, A. & Hillier, L. . (2014). From Blues to Rainbows: Menalth Health and Wellbeing of Gender Diverse and Transgender Young People in Australia. Melbourne: The Australian Research Centre in Sex, Health and Society.

Steele, L., Ross, L., Dobinson, C., Veldhuizen, S., & Tinmouth, J. (2009). Women's sexual orientation and health: Results from a Canadian population-based survey. *Women & Health, 49*(5), 353-367. doi: 10.1080/03630240903238685

Strakowski, S., Keck, P., Arnold, L., Collins, J., Wilson, R., Fleck, D., Corey, K., Amicone, J. & Adebimpe, V. (2003). Ethnicity and diagnosis in patients with affective disorders. *Journal of Clinical Psychiatry, 64*(7), 747-754.

Thorne, N., Witcomb, G. L., Nieder, T., Nixon, E., Yip, A. & Arcelus, J. (2018). A comparison of mental health symptomatology and levels of social support in young treatement seeking transgender individuals who identify as binary and non-binary. *International Journal of Transgenderism*, DOI: 10.1080/15532739.2018.1452660.

Wanta, J. W. & Unger, C. A. (2017). Review of the transgender literature: Where do we go from here?. *Transgender Health, 2.1*.

Weeks, J. (1989). *Sex, politics, and society : the regulation of sexuality since 1800* (2nd ed.. ed.). London, England: London, England Longman.

Weinberg, M. S., Williams, C. J., & Pryor, D. W. (1994). *Dual attraction : understanding bisexuality*. New York: Oxford University Press.

Williams, D. W.-M., R. (2000). Racism and mental health: The African American experience. *Ethnicity & Health, 5*(3-4), 243-268.

Yoshino, K. (2000). The epistemic contract of bisexual erasure. *Stanford Law Review, 52*(2), 353-461.

Chapter 7

The Three Dimensions of Bisexuality

"I am constantly using mental energy to assess how queer I am. I kinda feel like an imposter where ever I go. I am always mentally preparing myself to answer and defend questions about my sexuality."

– *Who I Am* participant

This chapter presents the paper *'Experiences of Bisexual Identity, Attraction and Behaviour and their Relationship with Mental Health: Findings from the Who I Am Study'* as submitted to Archives of Sexual Behavior where it is currently under review. This paper presents an examination of the mental health of bisexuals experiencing different dimensions of bisexual orientation (attraction, identity and behaviour). This paper seeks to address a significant gap in the literature where there currently exists very little research exploring the potentially differing experiences of mental health among people who experience bisexuality via different dimensions or through different combinations of these dimensions. This article further extends the answer to the *Who I Am* study's guiding question, 'why do bisexual people experience poor mental health' by providing a practice-focussed identification of the most at risk and vulnerable groups under the broad bisexual umbrella. This new knowledge will assist mental health practitioners in devising mental health assessment and intervention strategies when working with bisexual people and will inform future study in this under-researched area of investigation.

Under review: Taylor, J., Power, J. & Smith, E. (2018). Experiences of bisexual identity, attraction and behaviour and their relationship with mental health: Findings from the Who I Am study. Submitted to *Archives of Sexual Behaviour*.

Experiences of Bisexual Identity, Attraction and Behaviour and their Relationship with Mental Health: Findings from the *Who I Am* Study

Julia Taylor, Jennifer Power & Elizabeth Smith

Abstract

A bisexual orientation can incorporate all or any combination of bisexual identity, attraction or behaviour. With the increasing awareness of poor mental health in the bisexual population, it is essential that the diverse experiences of bisexual orientation are better understood and their potential relationship with mental health is explored. This paper presents findings from one of the largest samples in bisexuality focussed research to date, the *Who I Am* study. The research was a cross-sectional survey conducted in Australia between September 2016 and March 2017. Participants were included in the study if they were over the age of 18, living in Australia and identified as bisexual and/or were attracted to more than one gender and/or had had intimate experiences with more than one gender. Experiences across the three dimensions of bisexual orientation are examined and the results were subjected to chi-square and regression analyses. This demonstrated significant correlations between these dimensions and mental health. Participants reporting a bisexual identity were found to be especially vulnerable to poor mental health. These findings provide a significant contribution to the currently lacking literature on dimensions of bisexual orientation and mental health and will pave the way for more informed research and mental health service provision.

Bisexual people are often defined in uncritical terms as those who are sexually attracted to, or have sex with, people of more than one gender. But in reality, what it means to be bisexual is more complex. There are people who identify as bisexual, who have not had sexual experiences with people of more than one gender. There are also people who have sex with people of the same gender, but who identify as heterosexual. Yoshino (2000) defines bisexuality as a diverse experience that can incorporate bisexual identity, bisexual attraction and/or bisexual behaviour. While this may seem semantic, there is an increasing body of evidence that suggests this more nuanced approach to defining bisexuality may be significant in understanding wellbeing among bisexual people (Bostwick, Boyd, Hughes, & McCabe, 2010; Geary, 2018; Mathy, Lehmann, & Kerr, 2004; McNair, Kavanagh, Agius, & Tong, 2005).

Despite recent research suggesting that the prevalence of those with bisexual attraction is approximately one in ten of the broader population (Richters et al., 2014), research into bisexuality and the lives and experiences of bisexual people has been limited, often overshadowed by the examination of gay and lesbian populations (Angelides, 2001; Klein, 1993). It is now well established that bisexual people experience poorer mental health than their heterosexual, gay or lesbian counterparts (Bostwick et al., 2010; Bostwick et al., 2007; Conron, Mimiaga, & Landers, 2010; Eisner, 2013; Hughes, Szalacha, & McNair, 2010; Jorm, Korten, Rodgers, Jacomb, & Christensen, 2002; Koh & Ross, 2006; Leonard et al., 2012; Li, Dobinson, Scheim, & Ross, 2013; Persson, Pfaus, & Ryder, 2015; Pompili et al., 2014; Steele, Ross, Dobinson, Veldhuizen, & Tinmouth, 2009). Little, however, is known about why bisexuality correlates with poor mental health and whether variations in experiences of bisexual identity, attraction and/or behaviour are associated with differences in mental health outcomes. Examination of experiences of mental health across these three dimensions have rarely been conducted and in research that does explore this, findings have been restricted to comparing bisexuals to other

sexual orientation groups (Bostwick et al., 2010) as opposed to comparing bisexuals to one another. With the increasing acknowledgement that bisexual people have high rates of poor mental health (Bostwick et al., 2010; Bostwick et al., 2007; Conron et al., 2010; Eisner, 2013; Hughes et al., 2010; Jorm et al., 2002; Koh & Ross, 2006; Leonard et al., 2012; Li et al., 2013; Persson et al., 2015; Pompili et al., 2014; Steele et al., 2009), there has never been more urgency to understand which bisexuals are most at risk in order to provide a starting point for intervention and ultimately improvement in outcomes.

Bisexual identity, attraction and behaviour

'Bisexual' is a relatively new self-identity label only emerging in the latter half of the 20th century and, despite the cross-cultural existence of bisexual attraction and behaviour, bisexual identification appears to be largely confined to Western culture (Carrier, 1999; Esterberg, 2011; George, 1999; Sittitrai, Brown, & Virulrak, 1999; Udis-Kessler, 2013). In recent years identity labels for those attracted to more than one gender have broadened beyond 'bisexual', often in an effort to more accurately describe the particular attractions and experiences of those individuals under Eisner's (2013) 'bisexual umbrella', to include pansexual, queer, biromantic, bi-curious, heteroflexible and homoflexible among others (Eisner, 2013; Sunfrog, 2013). In particular, pansexual and queer have increased in usage in recent years and can be seen as more inclusive of gender diversity as they move away from the dichotomous inference of the term 'bi'sexual (Callis, 2014).

There is clear consensus in the literature that finding, applying and maintaining a bisexual identity is complex and often problematic (Balsam & Mohr, 2007; Bradford, 2004; Clausen, 1999; Dodge et al., 2012; Ross, Dobinson, & Eady, 2010; Weinberg, Williams, & Pryor, 1994). In the first instance, finding an identity that adequately reflects the diversity of attraction and experience of bisexual people can be, in itself, a very

difficult task (Bradford, 2004; Dodge et al., 2012; Weinberg et al., 1994). In addition, maintaining an identity that exists outside of the accepted societal dichotomy of heterosexual or homosexual in the face of negative stereotypes, biphobic discrimination, persistent assumptions of sexual orientation based on perceived partner gender, and the invisibility and erasure of bisexuality in broader society, often presents a significant challenge for bisexual people (Balsam & Mohr, 2007; Bradford, 2004; Clausen, 1999; Dodge et al., 2012; Ross et al., 2010; Weinberg et al., 1994). In light of this, it is not surprising that theorists frequently describe bisexual identification as an ongoing process of confusion and uncertainty (Bradford, 2004; Clausen, 1999; Weinberg et al., 1994).

A number of notable sex theorists of the 20th century sought to describe and quantify bisexual attraction (Ellis, 1915; Freud, 1920; Kinsey, Pomeroy, & Martin, 1948; Stekel, 1999). In the 1940's Kinsey and his colleagues (1948) provided a groundbreaking new theory of sexual attraction as existing on a continuum, with exclusive heterosexual attraction at one end and exclusive homosexual attraction at the other. For the first time the existence of, and diversity within, bisexual attraction was able to be clearly conceptualised and the growing discourse around bisexuality that began at this time has paved the way for our contemporary understanding of non-monosexual attraction. In the 21st century, 'bisexual attraction' can be used inclusively to describe sexual and/or romantic attraction to more than one gender (Eisner, 2013). While a number of population based studies have examined bisexual identity, the prevalence of bisexual attraction is rarely reported on. One recent large representative study of Australian adults posited a significant addition to the lacking literature on this topic finding 5.8% of men and 14.2% of women reported attraction to more than one gender (Richters et al., 2014).

Bisexual behaviour refers to a person's intimate and sexual experiences with people of more than one gender. In 1951, a landmark study exploring human sexual behaviour in 191 countries revealed that bisexual behaviour was a common feature of

humans cross-culturally (Ford & Beach, 1951). Additionally, bisexual behaviour has been found to be far more prevalent than bisexual identity and those with heterosexual, gay or lesbian identities can, and do, have sexual experiences with people of more than one gender (Geary, 2018; Richters et al., 2014; Smith, Rissel, Richters, Grulich, & De Visser, 2003). In contrast, bisexual behaviour in the absence of bisexual attraction is very rare (Geary, 2018).

Mental health

Despite vast differences in study design, geographic location, sample sizes and sample characteristics, research examining the mental health of bisexual people offers one clear consensus: bisexual people have higher rates of poor mental health than other sexual orientation groups (Bostwick et al., 2010; Bostwick et al., 2007; Conron et al., 2010; Eisner, 2013; Hughes et al., 2010; Jorm et al., 2002; Koh & Ross, 2006; Leonard et al., 2012; Li et al., 2013; Persson et al., 2015; Pompili et al., 2014; Steele et al., 2009). Bisexual people report a significantly higher incidence of mental disorders (Hughes et al., 2010; Koh & Ross, 2006; McNair et al., 2005; Persson et al., 2015; Steele et al., 2009), self-harm (Hughes et al., 2010), suicidality (Bostwick et al., 2007; Brennan, Ross, Dobinson, Veldhuizen, & Steele, 2010; Conron et al., 2010; Jorm et al., 2002; Koh & Ross, 2006; McNair et al., 2005; Steele et al., 2009) and psychological distress (Leonard, Lyons, & Bariola, 2015) than heterosexuals, lesbians or gay men. Despite these now well established findings and the growing understanding of bisexuality as a characteristically diverse orientation existing across the three dimensions of identity, attraction and behaviour (Bostwick et al., 2010; Drucker, 2010; Yoshino, 2000), few researchers have delved deeper to examine how differences in experiences of these dimensions might relate to mental health.

One valuable contribution to this field of research is Bostwick and colleagues' (2010) examination of data from a population based study in the United States. Although this study does not focus exclusively on the bisexual population, it does provide a rare, nuanced analysis of mental health across the three dimensions comparing sexual identity groups, sexual attraction groups and sexual behaviour groups (Bostwick et al., 2010). This study indicated that women who identify as bisexual were more likely to report poorer mental health than those that identified as lesbian or heterosexual (Bostwick et al., 2010). Similarly, women with bisexual attraction had higher rates of poor mental health than those with only monosexual attraction, and the same was the case for those who had a history of bisexual behaviour as opposed to those who had only had sexual experiences with one gender (Bostwick et al., 2010). These findings were slightly different for men, with bisexually behaving and attracted men having poorer mental health than their monosexually attracted and behaving counterparts. However, while heterosexual identification was associated with the lowest rates of mood disorders, gay identified men had higher rates of mood disorders than men with a bisexual identification (Bostwick et al., 2010). While Bostwick and colleagues (2010) have identified that varying dimensions of sexual orientation have a relationship with mental health (with bisexuals faring worse than other orientation groups in almost every comparison), this study does not provide any information on how bisexual groups compare to one another.

Current Study

The *Who I Am* study aims to address a significant gap in the literature by providing new information about bisexuality and bisexual life experiences and shedding light on how these may be associated with poor mental health in bisexual people. This study is one of the largest studies to date to focus specifically on people who fall under the bisexual umbrella. This paper focuses on bisexual peoples' diverse experiences of bisexual orientation by examining the bisexual identity, attraction and behaviour of *Who I*

Am respondents and exploring whether participants' varying experiences of these three dimensions are related to poor mental health.

Method

Who I Am was a cross-sectional study involving an online survey conducted between September 2016 and March 2017.

Sample

The total sample consisted of 2,651 adults living in Australia. Participants were recruited for the study if they identified as bisexual and/or were attracted to more than one gender and/or had sexual experiences with more than one gender. Recruitment involved online advertising through social media sites, primarily Facebook, print advertising in the form of posters and post cards displayed at sexual health centres and universities across Australia and email and word of mouth advertising through the researchers' professional networks. A range of advertising material was developed using different images, colours and texts while maintaining consistent *Who I Am* branding. Some advertisements asked for 'bisexual or pansexual' people while others simply sought people who were 'attracted to more than one gender'.

Survey Instrument

The *Who I Am* survey included the Kessler Psychological Distress Scale (K10) (Kessler et al., 2002), a standardised measure frequently used in Australian population based surveys as well as other international research (ABS, 2012). For the *Who I Am* study K10 scores were computed into four categories to represent participants' levels of current psychological distress as low (10-15), moderate (16-21), high (22-29) and very high (30-50) (ABS, 2012). The survey instrument also included basic demographic questions. All other *Who I Am* survey questions reported on in this paper were devised by the researchers after a process of literature review, survey drafting, consultation with key

stakeholders, revision of the survey, piloting with a small sample of potential participants and further refinement of the instrument in response to feedback from the pilot. These questions are listed in Table 1. Key stakeholders that were consulted in the development of the instrument included bisexual specific, LGBTI (lesbian, gay, bisexual, transgender and intersex) and mental health organisations in Australia. Mental health helpline phone numbers were provided at the beginning and end of the survey and alongside questions determined by the researchers to be of a sensitive nature.

Table 1 - Survey questions devised by researchers

Question	**Response options**
Bisexual identity	
1. Do you identify as bisexual or pansexual?	- Yes - No
2. What sexual identity do you most identify with?	- Bisexual - Pansexual - Heterosexual/straight - Gay - Lesbian - Queer - Asexual - I do not identify with any sexual identity - Other
3. Has it been difficult or easy for you to find an identity that fits with your attraction and/or experience?	- Very difficult - Somewhat difficult - Neither difficult nor easy - Somewhat easy - Very easy
Do you feel pressure to identify as… 4. Heterosexual? 5. Gay or lesbian?	- Never - Rarely - Sometimes - Often - Always
Bisexual attraction	
6. Are you attracted to people of your own gender and at least one other gender?	- Yes - No
7. How would you describe your sexual attraction?	- Free text response
Bisexual behaviour	
8. Have you had sexual experiences with people of your own gender and at least one other gender?	- Yes - No
Who have you been sexually intimate with… 9. In the past year? 10. In the past 5 years? 11. In your lifetime?	- A man/men - A woman/women - A transgender or gender diverse person/people - Other (please specify)
Mental health	

12. Has a health professional ever said you have…	- Anxiety disorder (e.g. panic attacks, social anxiety) - Depression - Bipolar disorder - Schizophrenia - Borderline personality disorder - Eating disorder - Dissociative identity disorder (e.g. multiple personality disorder) - Post-traumatic stress disorder (PTSD)
13. Have you ever…	- Thought about self-harming - Harmed yourself? - Thought about committing suicide - Attempted suicide

Data Analysis

Data were analysed using IBM SPSS Version 25 software. Frequency counts were conducted on all demographic questions and questions relating to experiences of bisexual identity, attraction and behaviour. An analysis of experiences of same-sex versus different-sex attraction and behaviour was conducted for cisgender (respondents whose biological sex was in-line with their gender identity) respondents only, as the interpretation of same-sex or different-sex has added complexity for transgender and gender diverse people and this could not be meaningfully determined using the available data. Thus transgender/gender diverse participants' sexual attraction and behaviour were analysed by examining whether their experiences incorporated men, women, transgender or gender diverse people, multiple genders or no one. Participants were included in the transgender/gender diverse group for analysis if they identified their gender to be 'trans man', 'trans woman', 'non-binary or gender diverse' or 'other', or identified their gender to be 'man' or 'woman' but indicated a different sex at birth.

Answers to the questions 'do you identify as bisexual or pansexual?', 'are you attracted to people of your own gender and at least one other gender?' and 'have you had sexual experiences with people of your own gender and at least one other gender?', were then used to compute a new variable categorising participants into one of seven groups

based on their experiences across the three dimensions: identity only (n = 1, 0.0%); attraction only (n = 128, 4.8%); behaviour only (n = 95, 3.6%); identity + attraction (n = 419, 15.8%); identity + behaviour (n = 6, 0.2%); attraction + behaviour (n = 358, 13.5%) and identity + attraction + behaviour (n = 1,644, 62.0%). The categories 'identity only' and 'identity + behaviour' were excluded from analyses due to their small frequency counts. The remaining five categories of bisexual orientation were then used in a series of Pearson chi-square tests with post-hoc analyses to examine potential relationships with mental health variables. Significance was set at $p < .05$ and adjusted residuals from post-hoc analyses greater than 2.0 were considered to significantly deviate from expected counts.

Finally, these categories of bisexual orientation were included as an independent variable in a cumulative odds ordinal logistic regression model with proportional odds using K10 categories as the dependent variable and controlling for gender, age, local area description, education and income. Collinearity diagnostics were run and, with the variance inflation factor (VIF) allowance set at <2.0, the assumption of multicollinearity was found not to have been violated. The assumption of proportional odds was met, as assessed by a full likelihood ratio test comparing the fit of the proportional odds model to a model with varying location parameters, $\chi^2(18) = 27.039$, $p = 0.078$. Results were considered significant at $p < .05$.

Ethics

Ethics approval for this study was granted by La Trobe University's Human Ethics Committee and the community based ACON (formerly the AIDS Council of New South Wales) Research Ethics Review Committee.

Results

Sample Characteristics

Who I Am respondents ranged in age from 18 to 77 years. The mean age was 28.8 years (SD = 10.66). The majority of the sample consisted of cisgender women (64.4%). There were respondents from every state and territory in Australia with the majority from inner or outer suburbia (79.5%). All education levels and income brackets were represented. Detailed sample characteristics are presented in Table 2.

Table 2 - Sample characteristics

Characteristic	***n***	**Frequency**	**Percent (%)**
Gender	2,484	-	-
Cisgender Man	-	410	16.5
Cisgender Woman	-	1,600	64.4
Trans man	-	63	2.5
Trans woman	-	60	2.4
Non-binary or gender diverse	-	285	11.5
Other	-	66	2.7
Age group (in years)	2,651	-	-
18-24	-	1,236	46.6
25-44	-	1,144	43.2
45+	-	271	10.2
Aboriginal and/or Torres Strait Islander origin	2,581	-	-
Yes	-	70	2.7
No	-	2,511	97.3
Ethnicity	2,585	-	-
Anglo/Australian	-	2,178	84.3
Other	-	407	15.7
State or territory currently residing	2,620	-	-
VIC	-	891	34.0
NSW	-	612	23.4
WA	-	260	9.9
QLD	-	280	10.7
TAS	-	216	8.2
ACT	-	189	7.2
SA	-	150	5.7

NT	-	22	0.8
Local area description	2,619	-	-
Capital city/inner suburban	-	1,395	53.3
Outer suburban	-	685	26.2
Regional centre	-	340	13.0
Rural or remote	-	199	7.6
Highest level of education achieved	2,499	-	-
Year 10 or below	-	61	2.4
Year 11	-	65	2.6
Year 12	-	711	28.5
Apprenticeship/trade certificate/TAFE certificate/Tertiary diploma	-	498	19.9
Undergraduate university degree	-	745	29.8
Postgraduate university degree	-	419	16.8
Total pre-tax income per year	2,569	-	-
$0	-	91	3.5
$1 - $29,999	-	1,062	41.3
$30,000 - $49,999	-	413	16.1
$50,000 - $79,999	-	440	17.1
$80,000 - $99,999	-	147	5.7
$100,000 - $124,999	-	111	4.3
$125,000 - $149,999	-	43	1.7
$150,000 - $199,999	-	28	1.1
$200,000 or more	-	25	1.0
Prefer not to answer	-	209	8.1
K10 Categories	2,034	-	-
Low psychological distress (10-15)	-	366	18.0
Moderate psychological distress (16-21)	-	428	21.0
High psychological distress (22-29)	-	606	29.8
Very high psychological distress (30-50)	-	634	31.2

Bisexual Identity, Attraction and Behaviour

Seventy-eight per cent of respondents identified as bisexual or pansexual, while 96.2% reported attraction to their own gender and at least one other gender (Table 3) and 79.3% reported having had sexual experiences with more than one gender (Table 4).

Apart from bisexual (42.9%) and pansexual (18.9%), the most common sexual identities were queer (13.0%), heterosexual/straight (7.5%), lesbian (5.7%) and gay (3.9%) respectively (Table 3). The majority of participants (52.7%) reported that it had been difficult or somewhat difficult to find an identity that fitted with their attraction and/or experience (Table 3). In addition, 45.4% of respondents indicated they always or often felt pressure to identify as heterosexual (Table 3).

Having equal attraction to all genders was reported by a similar percentage of cisgender participants (38.7%) and transgender/gender diverse participants (37.0%), however the majority of cisgender participants reported attraction to either mostly same-sex or mostly different-sex people (Table 3). Meanwhile, 29.8% of transgender/gender diverse respondents reported being mostly attracted to women and 15.8% revealed 'other' attractions which mostly included reporting attraction to traits (such as femininity and masculinity) as opposed to gender or not having sexual attraction to anyone (Table 3).

Table 3 - Experiences of bisexual identity and attraction

Characteristic	***n***	**Frequency**	**Percent (%)**
Do you identify as bisexual or pansexual?	2,651	-	-
Yes	-	2,070	78.1
No	-	581	21.9
What sexual identity do you most identify with?	2,520	-	-
Bisexual	-	1,080	42.9
Pansexual	-	476	18.9
Heterosexual/straight	-	189	7.5
Gay	-	99	3.9

Lesbian	-	143	5.7
Queer	-	328	13.0
Asexual	-	60	2.4
I do not identify with any sexual identity	-	93	3.7
Other	-	52	2.1
Has it been difficult or easy for you to find an identity that fits with your attraction and/or experience?	2,255	-	-
Very difficult	-	343	15.2
Somewhat difficult	-	846	37.5
Neither difficult nor easy	-	467	20.7
Somewhat easy	-	373	16.5
Very easy	-	226	10.0
Do you feel pressure to identify as heterosexual?	2,262	-	-
Never	-	-	18.0
Rarely	-	407	12.9
Sometimes	-	292	23.7
Often	-	535	30.8
Always	-	697	14.6
Do you feel pressure to identify as gay or lesbian?	2,247	-	-
Never	-	731	32.5
Rarely	-	470	20.9
Sometimes	-	559	24.9
Often	-	396	17.6
Always	-	91	4.0
Are you attracted to people of your own gender and at least one other gender?	2,651	-	-
Yes	-	2,549	96.2
No	-	102	3.8
How would you describe your sexual attraction? (Cisgender only)	1,884	-	-
Same-sex attracted only	-	44	2.3
Mostly same-sex attracted	-	491	26.1
Equally attracted to all genders	-	730	38.7
Mostly different-sex attracted	-	467	24.8
Only different-sex attracted	-	13	0.7

Fluid/changeable	-	87	4.6
Other	-	52	2.8
How would you describe your sexual attraction? (Transgender or gender diverse only)	449	-	-
Only attracted to men	-	1	0.2
Mostly attracted to men	-	47	10.5
Equally attracted to all genders	-	166	37.0
Mostly attracted to women	-	134	29.8
Only attracted to women	-	3	0.7
Fluid/changeable	-	27	6.0
Other	-	71	15.8

Sexual activity with 'different-sex partners only' was the most commonly reported form of sexual intimacy in the past year for cisgender participants (30.1%), while transgender/gender diverse participants were equally most likely to report having been sexually intimate with multiple genders (31.2%) and no-one (31.2%)(Table 4). Approximately three quarters of the sample, regardless of their gender, reported having had sexual experiences with multiple genders at some point in their lives (Table 4).

Table 4 - Experiences of bisexual behaviour

Characteristic	***n***	**Frequency**	**Percent (%)**
Have you had sexual experiences with people of your own gender and at least one other gender?	2,651	-	-
Yes	-	2,103	79.3
No	-	548	20.7
Who have you been sexually intimate with in the past year? (Cisgender only)	1,654	-	-
Same-sex only	-	281	17.0
Different-sex only	-	498	30.1
Transgender or gender diverse only	-	7	0.4
Multiple genders	-	467	28.2
No-one	-	401	24.2
Who have you been sexually intimate with in the past 5 years? (Cisgender only)	1,654	-	-

Same-sex only	-	201	12.2
Different-sex only	-	365	22.1
Transgender or gender diverse only	-	2	0.1
Multiple genders	-	882	53.3
No-one	-	204	12.3
Who have you been sexually intimate with in your lifetime? (Cisgender only)	1,654	-	-
Same-sex only	-	97	5.9
Different-sex only	-	203	12.3
Transgender or gender diverse only	-	2	0.1
Multiple genders	-	1,257	76.0
No-one	-	95	5.7
Who have you been sexually intimate with in the past year? (Transgender or gender diverse only)	407	-	-
Men only	-	78	19.2
Women only	-	56	13.8
Transgender or gender diverse only	-	19	4.7
Multiple genders	-	127	31.2
No-one	-	127	31.2
Who have you been sexually intimate with in the past 5 years? (Transgender or gender diverse only)	407	-	-
Men only	-	54	13.3
Women only	-	41	10.1
Transgender or gender diverse only	-	13	3.2
Multiple genders	-	218	53.6
No-one	-	81	19.9
Who have you been sexually intimate with in your lifetime? (Transgender or gender diverse only)	407	-	-
Men only	-	33	8.1
Women only	-	21	5.2
Transgender or gender diverse only	-	7	1.7
Multiple genders	-	303	74.4
No-one	-	43	10.6

Bisexual Identity, Attraction and Behaviour and Mental Health

Sixty-one percent of respondents reported high or very high psychological distress (Table 2). A series of Pearson chi-square tests revealed significant associations between bisexual orientation categories and all mental health variables (Table 5). Post-hoc analyses identified that respondents in the 'identity + attraction + behaviour' category had significantly poorer mental health than what would be expected based on the null hypothesis that no association exists. Meanwhile, respondents in the 'attraction only' and the 'attraction + behaviour' categories were found to have significantly fewer experiences of poor mental health (Table 5).

Table 5 - Crosstabulation and Pearson chi-square associations of bisexual orientation categories and mental health

	Mental health variables				
Bisexual orientation categories	**Diagnosed with a mental disorder***	**Thought about self-harming**	**Self-harmed**	**Thought about committing suicide**	**Attempted suicide**
Attraction only	53.2% (-3.2)	64.9% (-3.3)	46.8% (-2.8)	72.4% (-1.8)	19.7% (-2.4)
Behaviour only	72.3% (0.5)	80.3% (0.1)	56.7% (-0.9)	77.0% (-0.6)	32.8% (0.1)
Identity + attraction	67.4% (-0.8)	80.2% (0.2)	57.6% (-1.8)	76.6% (-1.8)	22.5% (-4.1)
Attraction + behaviour	59.4% (-3.7)	73.8% (-2.6)	54.6% (-2.6)	74.0% (-2.7)	27.5% (-1.7)
Identity + attraction + behaviour	72.4% (4.2)	81.8% (2.9)	65.7% (4.6)	83.0% (4.2)	36.0% (5.2)
Chi-square statistic χ^2(df)	28.648 (4)	19.673 (4)	24.375 (4)	18.656 (4)	30.877 (4)

Sig. (*p*)	<0.001	0.001	<0.001	0.001	<0.001
Cramer's V (ϕ_c)	0.117	0.098	0.109	0.095	0.123

Note: Adjusted residuals appear in parentheses below observed percentages

*This question asked only about diagnosis of the following mental disorders: anxiety, depression, bipolar disorder, schizophrenia, borderline personality disorder, eating disorder, dissociative identity disorder, post-traumatic stress disorder, obsessive compulsive disorder and attention deficit hyperactivity disorder.

The cumulative odds ordinal logistic regression model significantly predicted the dependent variable (K10 categories) over and above the intercept-only model, $\chi^2(9) = 282.909$, $p = <0.001$. Respondents in the bisexual 'identity + attraction + behaviour' category (OR 1.455, CI 1.129 – 1.873, $p = 0.004$) and those in the 'identity + attraction' category (OR 1.490, CI 1.096 – 2.045, p = 0.014) had significantly higher odds of high levels of psychological distress than those in the 'attraction only' and 'behaviour only' categories (Table 6). Participants experiencing bisexual attraction only, bisexual behaviour only or bisexual attraction and behaviour were not found to differ significantly from each other in their levels of psychological distress (Table 6). In other words, bisexual identity was associated with higher levels of psychological distress.

Table 6 - Bisexual orientation categories as predictors of high levels of psychological distress (K10)

Bisexual orientation categories	**OR (95% CI)**	**Sig. (*p*)**
Attraction only	1.344 (0.829-2.181)	0.231
Behaviour only	1.314 (0.771-2.239)	0.316
Identity + attraction	1.490 (1.085-2.045)	0.014
Identity + attraction + behaviour	1.455 (1.129-1.873)	0.004
Attraction + behaviour	1.00 (reference)	-

Discussion

There is a large volume of research showing poorer mental health outcomes among people who identify as bisexual (Bostwick et al., 2010; Bostwick et al., 2007; Conron et al., 2010; Hughes et al., 2010; Jorm et al., 2002; Koh & Ross, 2006; Leonard et

al., 2012; Li et al., 2013; Persson et al., 2015; Pompili et al., 2014; Steele et al., 2009). However, the definition of bisexuality is complex and people's experience of bisexual identity may not always align with their sexual experiences and attractions (Blumstein & Schwartz, 1999; Klein, 1993). Similarly, many people who have sexual experience with, and attractions to people of more than one gender do not always identify as bisexual (Richters et al., 2014). This paper is unique in that it examines indicators of mental health according to expressions of bisexual identity, behaviour and attraction. The aim of this is to better understand the nature of bisexuality and its relationship to mental health.

While nearly 80% of *Who I Am* respondents answered yes to the question 'do you identify as bisexual or pansexual?', when asked what sexual identity they *most* identified with just 62% selected one of these two identities. This finding fits with previous research revealing that bisexual people often use multiple identity labels simultaneously and can move fluidly between labels (Diamond, 2008; Dodge et al., 2012; McLean, 2007). This is despite their patterns of attraction and behaviour usually remaining consistent over time (Diamond, 2008). Additionally, these findings reveal that although all respondents to the *Who I Am* study fit the inclusion criteria of experiencing at least one of the three dimensions of bisexual identity, attraction or behaviour, approximately 20% did not identify as bisexual or pansexual and almost 40% did not identify either of these as their most fitting identity label. This inconsistency in bisexual identification, despite the vast majority of participants reporting bisexual attraction and behaviour, may be reflective of the difficulty and complexity of finding, applying and maintaining an identity label that fits with their bisexual experience, a challenge that has been reported by numerous researchers (Balsam & Mohr, 2007; Bradford, 2004; Dodge et al., 2012; Ross et al., 2010; Weinberg et al., 1994). Indeed, the current study's participants' responses supported this finding with over half the sample reporting it had been very difficult or somewhat difficult to find an identity that fitted with their attraction and/or experience. Scholars

have suggested that this difficulty likely arises from bisexuality being outside of the accepted social norms of dichotomous homosexual or heterosexual sexual identities (Clausen, 1999; Weinberg et al., 1994). This is reflected in the responses of *Who I Am* participants many of whom reported feeling pressure to identify as heterosexual, gay or lesbian.

The vast majority (96%) of *Who I Am* respondents reported attraction to more than one gender. It is well documented that bisexual attraction is diverse, with bisexual people reporting varying degrees of homosexual and heterosexual attraction (Kinsey, Pomeroy, & Martin, 1999; Richters et al., 2014; Smith et al., 2003; Weinberg et al., 1994; Zinik, 2000). Using the Kinsey scale (Kinsey et al., 1948) as a means to conceptualise bisexual attraction as existing along a continuum between exclusively heterosexual and exclusively homosexual, it has been suggested that bisexually attracted people may centre around the mid-point of this scale with equal attraction to both men and women (Kinsey et al., 1948). However, previous research has debunked this theory, finding that bisexual people with equal attraction to men and women are quite rare (Weinberg et al., 1994; Zinik, 2000). Recent studies have reported that when bisexual attraction is split into three groups (mostly same-sex attracted, equal attraction to both sexes and mostly opposite-sex attracted) an overwhelming majority of respondents who fall into one of these three categories indicate attraction to mostly the opposite-sex (Richters et al., 2014; Smith et al., 2003). In contrast, cisgender *Who I Am* respondents were most likely to report equal attraction to all genders with just 25% reporting mostly different-sex attraction. Similarly, while comparative data are lacking with regard to transgender or gender diverse people's experiences of bisexual attraction, equal attraction to all genders was most commonly reported by this gender group in the current study.

Previous scholarly endeavour has revealed that bisexual behaviour is not necessarily synonymous with either bisexual identity (Blumstein & Schwartz, 1999) or

bisexual attraction (Klein, 1993). This is reflected in the current study in which a much larger proportion of respondents reported bisexual attraction (96%) or behaviour (79%) than identity (62%). Sexual intimacy with multiple genders was common for cisgender participants with 76% reporting this in their lifetime and nearly 30% in the past year, a finding consistent with previous research (Badcock et al., 2014; Li et al., 2013; McLean, 2004; Weinberg et al., 1994). Transgender and gender diverse participants in the current study reported similar rates of sex with multiple genders as cisgender participants, however they were more likely to engage in sexual activity exclusively with other transgender and gender diverse people or no one. As with bisexual attraction, experiences of transgender and gender diverse bisexuals' sexual behaviour has received limited scholarly attention, thus comparative data are unavailable and the current study presents a significant contribution to this field.

With the growing awareness of bisexuality's association with deleterious mental health outcomes (Bostwick et al., 2010; Bostwick et al., 2007; Conron et al., 2010; Hughes et al., 2010; Jorm et al., 2002; Koh & Ross, 2006; Leonard et al., 2012; Li et al., 2013; Persson et al., 2015; Pompili et al., 2014; Steele et al., 2009), there has never been a more pressing time to gain greater insight into how variations of bisexual experiences might relate to mental health. In this study, we found that people who reported all three dimensions of bisexual orientation (identity, attraction and behaviour) had poorer mental health than those who did not indicate they identified as bisexual (those who reported bisexual attraction and/or behaviour only). In addition, participants in this 'identity, attraction and behaviour' category were also found to have greater odds of higher levels of psychological distress than those who reported bisexual identity and attraction but not behaviour. These findings may point to bisexual identity as being associated with poor mental health, a finding that fits with the writings of numerous theorists and researchers who have highlighted the challenge of maintaining a bisexual identity in a society that

reinforces bisexual invisibility, erasure and discrimination (Balsam & Mohr, 2007; Bradford, 2004; Clausen, 1999; Dodge et al., 2012; Ross et al., 2010; Weinberg et al., 1994).

Even though we found differences between these sub-groups within this study, all sub-groups experienced significantly higher levels of psychological distress and poorer mental health than we see in the general population (Bostwick et al., 2010; Slade, 2009). For example, 20% of respondents in this study who reported bisexual attraction only, 33% of those reporting bisexual behaviour only and 28% of those reporting bisexual attraction and behaviour had attempted suicide, figures that are substantially higher than the 3.3% of the broader population (Slade, 2009). Thus, although the implications of this research suggest that people who identify as bisexual are particularly vulnerable with regard to mental health, it is of paramount importance that there is an understanding that people under the bisexual umbrella who do not identify as bisexual but may be bisexually attracted and/or behaving, still experience far poorer mental health than the general population (Bostwick et al., 2010; Slade, 2009) and that translating these findings into practice should be done with this in mind.

Limitations

This study was only available online and, although a broad recruitment strategy was employed, the vast majority of participants who took part in this study were alerted to it via online platforms. Thus, potential respondents who did not have access to the internet were unlikely to find out about the study, and if they did, would not have been able to participate. In addition, the survey's reliance on self-reporting and respondents being given the freedom to skip questions they did not wish to answer resulted in reporting bias and missing data. Finally, the necessary use of convenience sampling

means that the findings of this study may not be representative of the broader bisexual population.

Conclusion

Bisexuality is a characteristically diverse sexual orientation that can be conceptualised as existing across three dimensions; bisexual identity, bisexual attraction and bisexual behaviour. With the increasing acknowledgement that bisexual people experience poorer mental health than other sexual orientation groups, there has never been a more pressing time to understand the diverse experiences of bisexuals and shed light on how these differences might relate to poor mental health. This paper has presented findings from the *Who I Am* study, one of the largest studies of bisexual people to date. In this sample bisexual attraction was highly prevalent, while bisexual behaviour was less so and bisexual identity the least reported of the three dimensions. This research supports previous findings that finding and applying a bisexual identity is complex and often challenging, and a history of sexual behaviour with multiple genders is common for bisexual people. In contrast to previous theorising and research, equal attraction to all genders was the most frequently reported experience of bisexual attraction. Although respondents with any combination of bisexual identity, attraction and/or behaviour were found to have substantially poorer mental health than the broader population, those whose experiences included a bisexual identity were more at risk of this, with those who reported experiencing all three dimensions being most vulnerable. These findings provide much needed new insights that advance the understanding of the diversity of the bisexual experience and will work to better inform future research and mental health service provision.

Ethical Standards

All procedures performed in this study involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed Consent

Informed consent was obtained from all individual participants included in the study.

References

ABS, Australian Bureau of Statistics (2012). Information Paper: Use of the Kessler Psychological Distress Scale in ABS Health Surveys, Australia, 2001-08. (4817.0.55.001). Retrieved 2003/2018 http://www.abs.gov.au/ausstats/abs@.nsf/lookup/4817.0.55.001Chapter92007-08

Angelides, S. (2001). *A history of bisexuality*. USA: The University of Chicago Press.

Badcock, P. B., Smith, A. M. A., Richters, J., Rissel, C., De Visser, R. O., Simpson, J. M., & Grulich, A. E. (2014). Characteristics of heterosexual regular relationships among a representative sample of adults: The second australian study of health and relationships. *Sexual Health, 11*(5), 427-438.

Balsam, K. F., & Mohr, J. J. (2007). Adaptation to sexual orientation stigma: a comparison of bisexual and lesbian/gay adults. *Journal of Counseling Psychology, 54*(3), 306.

Blumstein, P. W., & Schwartz, P. (1999). Bisexuality: Some social psychological issues (1977). In M. Storr (Ed.), *Bisexuality: A critical reader*. London: Routledge.

Bostwick, W. B., Boyd, C. J., Hughes, T. L., & McCabe, S. E. (2010). Dimensions of sexual orientation and the prevalence of mood and anxiety disorders in the United States. *American journal of public health, 100*(3), 468. doi: 10.2105/AJPH.2008.152942

Bostwick, W. B., McCabe, S. E., Horn, S., Hughes, T., Johnson, T., & Valles, J. R. (2007). Drinking patterns, problems, and motivations among collegiate bisexual women. *Journal of American College Health, 56*(3), 285-292. doi: 10.3200/JACH.56.3.285-292

Bradford, M. (2004). The bisexual experience: Living in a dichotomous culture. In R. C. Fox (Ed.), *Current Research on Bisexuality*. New York: Harrington Park Press.

Brennan, D. J., Ross, L. E., Dobinson, C., Veldhuizen, S., & Steele, L. S. (2010). Men's sexual orientation and health in Canada. *Canadian Journal of Public Health / Revue Canadienne de Sante'e Publique, 101*(3), 255-258.

Callis, A. S. (2014). Bisexual, pansexual, queer: Non-binary identities and the sexual borderlands. *Sexualities, 17*(1-2), 63-80. doi: 10.1177/1363460713511094

Carrier, J. M. (1999). Mexican male bisexuality (1985). In M. Storr (Ed.), *Bisexuality: A critical reader*. London: Routledge.

Clausen, J. (1999). Extract from my interesting condition (1990). In M. Storr (Ed.), *Besexuality: A critical reader*. London: Routledge.

Conron, K. J., Mimiaga, M. J., & Landers, S. J. (2010). A population-based study of sexual orientation identity and gender differences in adult health. *The American Journal of Public Health, 100*(10), 1953-1960.

Diamond, L. M. (2008). Female bisexuality from adolescence to adulthood: Results from a 10-year longitudinal study. *Developmental Psychology, 44*(1), 5-14.

Dodge, B., Schnarrs, P., Reece, M., Martinez, O., Goncalves, G., Malebranche, D., . . . Fortenberry, J. D. (2012). Individual and social factors related to mental health concerns among bisexual men in the midwestern United States. *Journal of bisexuality, 12*(2), 223-245. doi: 10.1080/15299716.2012.674862

Drucker, D. J. (2010). Male sexuality and Alfred Kinsey's 0-6 scale: Toward "a sound understanding of the realities of sex". *Journal of Homosexuality, 57*(9), 1105-1123. doi: 10.1080/00918369.2010.508314

Eisner, S. (2013). *Bi: Notes for a bisexual revolution*. California: Seal Press.

Ellis, H. (1915). *Studies in the psychology of sex: Sexual inversion* (3rd ed. Vol. 2). Philadelphia: F. A. Davis Company.

Esterberg, K. G. (2011). The bisexual menace revisited: or, shaking up social categories is hard to do. In S. Seidman, N. Fischer, & C. Meeks (Eds.), *Introducing the new sexuality studies 2nd edition*. USA and Canada: Routledge.

Ford, C. S., & Beach, F. A. (1951). *Patterns of sexual behavior*. USA: Harper & Row.

Freud, S. (1920) Three contributions to the theory of sex In S. E. Jelliffe & W. A. White (Series Ed.), *Nervous and mental disease monograph series* (2nd ed.). Washington D.C.: Nervous and Mental Disease Publishing Company.

Geary, R. S., Tanton, C., Erens, B., Clifton, S., Philip, P., Wellings, K., Mitchell, K. R., Datta, J., Gravningen, K., Fuller, E., Johnson, A. M., Sonnenberg, P. & Mercer, C. H. (2018). Sexual identity, attraction and behaviour in Britain: The implications of using different dimensions of sexual orientation to estimate the size of sexual minority populations and inform public health interventions. *PLoS ONE, 13*(1).

George, S. (1999). Extracts from women and bisexuality (1993). In M. Storr (Ed.), *Bisexuality: A critical reader*. London: Routledge.

Hughes, T., Szalacha, L. A., & McNair, R. (2010). Substance abuse and mental health disparities: Comparisons across sexual identity groups in a national sample of young Australian women. *Social Science & Medicine, 71*(4), 824-831. doi: 10.1016/j.socscimed.2010.05.009

Jorm, A. F., Korten, A. E., Rodgers, B., Jacomb, P. A., & Christensen, H. (2002). Sexual orientation and mental health: results from a community survey of young and middle-aged adults. *The British journal of psychiatry : the journal of mental science, 180*, 423.

Kessler, R. C., Andrews, G., Colpe, L. J., Hiripi, E., Mroczek, D. K., Normand, S. L. T., . . . Zaslavsky, A. M. (2002). Short screening scales to monitor population prevalences and trends in non-specific psychological distress. *Psychol. Med., 32*(6), 959-976. doi: 10.1017/S0033291702006074

Kinsey, A. C., Pomeroy, W. B., & Martin, C. E. (1948). *Sexual behavior in the human male*. Philadelphia: W. B. Saunders Company.

Kinsey, A. C., Pomeroy, W. B., & Martin, C. E. (1999). Extracts from sexual behaviour in the human male (1948). In M. Storr (Ed.), *Bisexuality: A critical reader*. London: Routledge.

Klein, F. (1993). *The bisexual option: Second edition* (2nd ed. ed.). New York & London: Routledge Ltd.

Koh, A. S., & Ross, L. K. (2006). Mental health issues: a comparison of lesbian, bisexual and heterosexual women. *Journal of Homosexuality, 51*(1), 33.

Leonard, W., Lyons, A., & Bariola, E. (2015). A closer look at private lives 2. Melbourne, Australia: Australian Research Centre in Sex, Health and Society, La Trobe University

Leonard, W., Pitts, M., Mitchell, A., Lyons, A., Smith, A., Patel, S., . . . Barrett, A. (2012). Private Lives 2: The second national survey of the health and wellbeing of GLBT Australians. Melbourne, Australia: Australian Research Centre in Sex, Health and Society, La Trobe University.

Li, T., Dobinson, C., Scheim, A., & Ross, L. (2013). Unique issues bisexual people face in intimate relationships: A descriptive exploration of lived experience. *Journal of Gay & Lesbian Mental Health, 17*(1), 21-39. doi: 10.1080/19359705.2012.723607

Mathy, R., Lehmann, B., & Kerr, D. (2004). Bisexual and transgender identities in a nonclinical sample of north Americans: Suicidal intent, behavioral difficulties, and mental health treatment. *Journal of bisexuality, 3*(3-4), 93-109. doi: 10.1300/J159v03n03_07

McLean, K. (2004). Negotiating (non)monogamy: bisexuality and intimate relationships. *Journal of bisexuality, 4*(1-2), 83-97.

McLean, K. (2007). Hiding in the closet? Bisexuals, coming out and the disclosure imperitive. *Journal of sociology, 43*(2), 151-166.

McNair, R., Kavanagh, A., Agius, P., & Tong, B. (2005). The mental health status of young adult and midlife nonheterosexual Australian women. *Australian and New Zealand Journal of Public Health, 29*(3), 265.

Persson, T. J., Pfaus, J. G., & Ryder, A. G. (2015). Explaining mental health disparities for non-monosexual women: Abuse history and risky sex, or the burdens of non-disclosure? *Social Science & Medicine, 128*, 366-373. doi: 10.1016/j.socscimed.2014.08.038

Pompili, M., Lester, D., Forte, A., Seretti, M. E., Erbuto, D., Lamis, D. A., . . . Girardi, P. (2014). Bisexuality and suicide: A systematic review of the current literature. *11*(8), 1903-1913.

Richters, J., Altman, D., Badcock, P. B., Smith, A. M. A., De Visser, R. O., Grulich, A. E., . . . Simpson, J. M. (2014). Sexual identity, sexual attraction and sexual experience: The second australian study of health and relationships. *Sexual Health, 11*(5), 451-460.

Ross, L. E., Dobinson, C., & Eady, A. (2010). Perceived determinants of mental health for bisexual people: a qualitative examination. *American journal of public health, 100*(3), 496. doi: 10.2105/AJPH.2008.156307

Sittitrai, W., Brown, T., & Virulrak, S. (1999). Extracts from patterns of bisexuality in Thailand (1991). In M. Storr (Ed.), *Bisexuality: A critical reader*. London: Routledge.

Slade, T., Johnston, A., Teesson, M., Whiteford, H., Burgess, P., Pirkis, J., Saw, S. . (2009). The Mental Health of Asutralians 2: Report on the 2007 National Survey of Mental Health and Wellbeing. Canberra.

Smith, A. M. A., Rissel, C. E., Richters, J., Grulich, A. E., & De Visser, R. O. (2003). Sexual identity, sexual attraction and sexual experience among a representative sample of adults. *Australian and New Zealand Journal of Public Health, 27*(2), 138-145.

Steele, L., Ross, L., Dobinson, C., Veldhuizen, S., & Tinmouth, J. (2009). Women's sexual orientation and health: Results from a Canadian population-based survey. *Women & Health, 49*(5), 353-367. doi: 10.1080/03630240903238685

Stekel, W. (1999). Extracts from bi-sexual love (1920). In M. Storr (Ed.), *Bisexuality: A critical reader*. London: Routledge.

Sunfrog. (2013). Pansies against patriarchy: Gender blur, bisexual men, and queer liberation. In N. Tucker (Ed.), *Bisexual politics: Theories, queries and visions* (pp. 319-324). New York & London: Routledge.

Udis-Kessler, A. (2013). Identity/politics: A history of the bisexual movement. In N. Tucker (Ed.), *Bisexual politics: Theories, queries and visions* (pp. 17-30). New York & London: Routledge.

Weinberg, M. S., Williams, C. J., & Pryor, D. W. (1994). *Dual attraction : understanding bisexuality*. New York: Oxford University Press.

Yoshino, K. (2000). The epistemic contract of bisexual erasure. *Stanford Law Review*, *52*(2), 353-461.

Zinik, G. (2000). Identity conflict or adaptive flexibility? Bisexuality reconsidered. In P. Rust (Ed.), *Bisexuality in the United States: A Social Science Reader*. New York: Columbia University Press.

Chapter 8

Service Access

"I think they're [health professionals] just as confused about bisexuality as everyone else!"

– *Who I Am* participant

This chapter presents the paper *'Bisexuals' Experiences of Mental Health Services: Findings from the Who I Am Study'* as submitted to the International Journal of Mental Health where it is currently under review. This paper marks the final 'findings' paper of the thesis and presents an exploration of the experiences of health service use among the sample. This article examines associations between mental health and experiences of service use delineating relationships between these experiences and poor mental health in direct response to the research question. It also presents an overview of access to, and experiences of, health services by bisexual people and how these differ between different gender groups. In order to improve the provision of mainstream mental health care for this vulnerable group within the population, an understanding of the current state of access is essential. In addition, with the increasing number of specialist services being developed to cater specifically to those with diverse sexuality and gender, providing a focussed account of bisexuals' experiences and needs in relation to such services will assist in future directions which will enhance bisexual participation and the cultural competence of service providers practicing in these spaces.

Under Review: Taylor, J., Power, J. & Smith, E. (2018). Bisexuals' experiences of mental health services: Findings from the Who I Am study. Submitted to *The International Journal of Mental Health.*

Bisexuals' Experiences of Mental Health Services:

Findings from the *Who I Am* Study

Julia Taylor, Jennifer Power & Elizabeth Smith

Abstract

Despite bisexual people being found to have significantly poorer mental health than their gay, lesbian and heterosexual counterparts, research into their experiences of mental health service use remains sparse. This paper presents findings from one of the largest studies of bisexual people to date (n = 2,651) and examines their access to, and experiences with, mental health services. The *Who I Am* study surveyed adults living in Australia who reported bisexual identity, attraction and/or experience. Results of univariate analyses and chi square tests are presented to quantify experiences of mental health service use and how this use is associated with gender and psychological distress. Results of an ordinal logistic regression analysis identify psychosocial predictors of disclosure/non-disclosure of bisexuality in the healthcare setting. Findings suggest that while bisexual people are highly engaged in mental health services, there are barriers to disclosure of their sexual orientation including having bad experiences of disclosure to professionals in the past. In addition, the majority of respondents reported wanting more access to services specialising in working with bisexual people. Gender and psychological distress were found to be significantly associated with most service use variables. A number of clinical implications and future research directions can be drawn from these findings.

Keywords: bisexual mental health; LGBT mental health service use; bisexual service use; mental health services

Introduction

It is now well established that sexual minority status is associated with a high prevalence of poor mental health (Brennan, Ross, Dobinson, Veldhuinzen & Steele, 2010; Jorm, Korten, Rodgers, Jacomb & Christensen, 2002; Leonard et al., 2012; Leonard, Lyons & Bariola, 2015; McNair, Kavanagh, Agius & Tong, 2005; Meyer, 2003; Pitts, Smith, Mitchell & Patel, 2006). Thus, accessibility to culturally competent mental health services is a priority for the lesbian, gay, bisexual and transgender (LGBT) community (Veltman & Chainmowitz, 2014). In order to inform the provision of such services, numerous studies have examined access to, and experiences of, mental health services for LGBT people (Alencar Albuquerque et. al., 2016). While these studies provide important insights about service use by the LGBT community as a whole, few have examined the groups under the 'LGBT umbrella' separately in order to provide a more nuanced analysis.

Bisexuality has been described as an umbrella term (Eisner, 2013) incorporating those who experience bisexual identity and/or attraction and/or behaviour (Yoshino, 2000). Bisexuality is characterised by diversity. Some bisexual people are in heterosexual relationships, some are in same sex relationships; some people identify as bisexual and do not participate in bisexual sexual behaviour while others have multiple partners of different genders but do not identify as bisexual (Li, Dobinson, Scheim & Ross, 2013; Page, 2004). It has been reported by previous scholars of bisexuality (Blumstein & Schwartz, 1999) that no prototypical bisexual exists and instead this population can be characterised by their consistent lack of consistency.

Bisexuality has been found to be more prevalent than homosexuality, with a recent population based study in Australia finding approximately one in ten people reported bisexual attraction (Richters et al., 2014). We now have extensive and reliable data across

various Western countries suggesting that bisexual people experience significantly poorer mental health than their same-sex attracted, gay or lesbian, counterparts (Bostwick, Boyd, Hughes & McCabe, 2010; Bostwick et al., 2007; Conron, Mimiaga & Landers, 2010; Eisner, 2013; Hughes, Szalacha & McNair, 2010; Jorm et al., 2002; Koh & Ross, 2006; Leonard et al., 2012; Li et al., 2013; Persson, Pfaus & Ryder, 2015; Pompili et al., 2014; Steele, Ross, Dobinson, Veldhuizen & Tinmouth, 2009). Despite this, there is limited research examining bisexual peoples' specific experiences of, or access to, mental health services. As bisexual people have unique life experiences that differ from other sexual minority groups, relying on LGBT research and clinical directives is inadequate at best, and more often, may be entirely inappropriate when working to support this population. Much of the research on which current mental health care for bisexual people is based, has emerged from broader LGBT studies with either no differentiation between bisexual participants and other sexual orientations or, where sexuality groups are separated, the size of the bisexual sample is very small. It is essential that mental health workers have access to this more nuanced information in order to build evidence based skills and knowledge for working with bisexual people, thereby providing more informed practice and the provision of culturally competent care.

Though the literature on mental health service use by bisexual people is limited, some useful information can be gleaned from current knowledge. Bisexual people are more likely to have accessed professional help for their mental health than gay, lesbian (Leonard, Lyons & Bariola, 2015) or heterosexual people (Loi, Lea & Howard, 2017). Despite this, the perception that service providers will have a lack of knowledge with regard to bisexuality is a significant barrier to accessing professional support for mental health (Page, 2004), with bisexuals commonly reporting that service providers are neither knowledgeable of nor inclusive of bisexual clients (Dobinson, Macdonnell, Hampson, Clipsham & Chow, 2005). In addition, perceived negative attitudes among mental health

workers towards bisexuality can be a significant barrier to accessing mental health care for bisexual people (Li et al. 2013; Page, 2004). Experiences of disclosing bisexuality to service providers vary, with some bisexuals reporting acceptance and understanding following disclosure, while others report being subjected to biphobic attitudes, inappropriate sexual comments and inapplicable care (Dobinson et al. 2005).

This paper aims to provide further insights into bisexual peoples' access to, and experiences of, mental health services. Relevant data from the recent *Who I Am* study, one of the largest studies of bisexual people to date (n = 2,651), will be presented, and differences in service use between gender groups and according to levels of psychological distress will be explored. In addition, barriers to disclosing bisexuality to health professionals are explored by identifying associated demographic characteristics and common bisexual life experiences. This new knowledge is intended to inform mental health service providers to enable them to improve access to, and the quality of, mental health care for the bisexual population with the ultimate aim of improving mental health outcomes for bisexual people.

Method

The *Who I Am* study was a cross sectional survey of Australian adults conducted online between September 2016 and March 2017.

Sample

Convenience sampling was identified as the only appropriate sampling method for this characteristically hidden and dispersed population. Participants were able to take part in the survey if they were over the age of 18, living in Australia and identified as bisexual and/or were attracted to more than one gender and/or had sexual experiences with more than one gender. The vast majority of participants were recruited via online Facebook advertising and the study was also advertised via relevant email networks, online media,

radio and print advertising which was distributed to sexual health centres, LGBT organisations and universities across the country. Advertisements varied to increase potential engagement across localities, genders and ages. All advertising had consistent *Who I Am* branding but wording differed to specifically name 'bisexual' or 'pansexual' identified people as well as those who are 'attracted to more than one gender', irrespective of sexual identity. The domain name 'whoiamsurvey.com' was purchased to simplify advertising material and increase ease of finding the survey online.

Survey instrument

The survey instrument was devised by the researchers following an extensive process of drafting, consultation, and piloting. The consultation process involved seeking input from stakeholders in LGBT, bisexual specific and mental health organisations in Australia. Piloting was conducted prior to the survey opening online with a sample of potential participants.

The survey instrument incorporated the Kessler Psychological Distress Scale (K10) (Kessler et al., 2002), a standardised 10 question inventory commonly used in population based research (ABS, 2012). The survey also included a series of basic demographic questions as well as a range of questions relating to bisexual life experiences and mental wellbeing. This paper focuses specifically on the findings of survey questions relating to experiences of health services. Only initial questions determining eligibility were compulsory and all other survey questions were able to be answered or skipped at the discretion of the respondent. Phone numbers for psychological support were provided at the start and end of the survey as well as alongside any questions deemed by the researchers to be potentially emotionally sensitive.

Data analysis

Data were analysed using IBM SPSS Version 25 software. Initially, univariate frequency analyses were conducted on demographic and service access variables. K10 scores were computed into four categories depicting levels of psychological distress (low [10-15], moderate [16-21], high [22-29] and very high [30-50]) for the purposes of analysis and ease of comparison to other research studies, with category parameters taken from the Australian Bureau of Statistics' K10 score groupings and categorisation for surveys (ABS, 2012). A series of chi-square tests of independence were conducted to assess potential associations between service access variables and K10 categories and also between service access variables and gender. Post-hoc analyses were conducted on all statistically significant (<.05) associations to identify which groups differed significantly from the null hypothesis which was that no relationship between variables existed. Adjusted residuals from post-hoc analyses were considered to significantly deviate from expected counts if they were greater than 2.0.

Finally, a cumulative odds ordinal logistic regression model with proportional odds was run to assess whether demographic or bisexual life experiences were predictive of participants' levels of comfort disclosing their sexuality to health professionals. Collinearity diagnostics were run and, with the variance inflation factor (VIF) allowance set at <2.0, the assumption of multicollinearity was found not to have been violated. The assumption of proportional odds was met, as assessed by a full likelihood ratio test comparing the fit of the proportional odds model to a model with varying location parameters, $\chi^2(13) = 15.343$, $p = 0.286$. Results were considered significant at $P < .05$

Ethics

Ethics approval for the study was granted by both the La Trobe University Human Research Ethics Committee and the community based ACON (formally AIDS Council of New South Wales) Research Ethics Review Committee.

Results

A total of 2,651 respondents participated in the *Who I Am* study, an unprecedented number in research focussed on bisexual individuals. The majority (64%) were women whose gender identity was consistent with normative expectations of their biological sex (cisgender), while there was a significant cohort (19%) of transgender and gender diverse participants, with the remaining 17% of the sample being cisgender men (Table 1). The sample was well-spread demographically with participation from all states and territories in Australia and, while the majority of the sample yielded from inner and outer suburbia (80%), 20% were from rural and regional areas (Table 1). This sample was more highly educated (ABS, 2017) but had lower income (Richters et al. 2014) than Australian population averages (Table 1).

Table 1 - Sample characteristics

Characteristic	***n***	**Frequency**	**Percent (%)**
Gender	2,484	-	-
Cisgender Man	-	410	16.5
Cisgender Woman	-	1,600	64.4
Transgender or gender diverse	-	474	19.1
Age group (in years)	2,651	-	-
18-24	-	1,236	46.6
25-44	-	1,144	43.2
45+	-	271	10.2
Aboriginal and/or Torres Strait Islander origin	2,581	-	-
Yes	-	70	2.7
No	-	2,511	97.3
Ethnicity	2,585	-	-
Anglo/Australian	-	2,178	84.3
Other	-	407	15.7
State or territory currently residing	2,620	-	-
VIC	-	891	34.0
NSW	-	612	23.4

WA	-	260	9.9
QLD	-	280	10.7
TAS	-	216	8.2
ACT	-	189	7.2
SA	-	150	5.7
NT	-	22	0.8
Local area description	2,619	-	-
Capital city/inner suburban	-	1,395	53.3
Outer suburban	-	685	26.2
Regional centre	-	340	13.0
Rural or remote	-	199	7.6
Highest level of education achieved	2,499	-	-
Year 10 or below	-	61	2.4
Year 11	-	65	2.6
Year 12	-	711	28.5
Apprenticeship/trade certificate/TAFE certificate/Tertiary diploma	-	498	19.9
Undergraduate university degree	-	745	29.8
Postgraduate university degree	-	419	16.8
Total pre-tax income per year	2,569	-	-
$0	-	91	3.5
$1 - $29,999	-	1,062	41.3
$30,000 - $49,999	-	413	16.1
$50,000 - $79,999	-	440	17.1
$80,000 - $99,999	-	147	5.7
$100,000 - $124,999	-	111	4.3
$125,000 - $149,999	-	43	1.7
$150,000 - $199,999	-	28	1.1
$200,000 or more	-	25	1.0
Prefer not to answer	-	209	8.1

Mental Health

Over half (61%) of respondents reported high or very high psychological distress as measured by the K10 inventory. Transgender and gender diverse participants reported the highest levels of psychological distress with 72% in the 'high' or 'very high' ranges, followed by cisgender women, 60.9% of whom reported high or very high distress. Cisgender men reported the lowest levels of psychological distress with 48.6% within the 'high' or 'very high' groups.

Experiences of Service Access

The vast majority of *Who I Am* respondents (83%) had accessed professional help for mental health concerns at some point in their lives, while 32% had accessed these services in the past four weeks (Table 2). If concerned about their mental health, respondents indicated that they were most likely to seek support from family and friends, while psychologists and General Practitioners (GPs) were the next most frequently identified confidants respectively (Table 2). Sixteen percent of the sample indicated that they would not feel comfortable disclosing their bisexuality to a health professional, while 32% stated that they might disclose depending on the situation (Table 2). Of those participants who had told one or more health professionals about their bisexuality, approximately half (52%) had had good experiences of this (Table 2), although 49% of respondents felt that health professionals in general were either not very or not at all knowledgeable about working with bisexual people. Half of respondents (56%) indicated that they would like more access to services specialised in working with bisexuals (Table 2).

Table 2 - Experiences of Service Access

Service Access Experience	*n*	Frequency	Percent (%)
Have you ever seen a health professional for mental health concerns?	2,054	-	-

Yes	-	1,713	83.4
No	-	641	16.6
In the past 4 weeks have you seen a health professional for mental health concerns?	2,057	-	-
Yes	-	663	32.2
No	-	1,394	67.8
If you were concerned about your mental health, who would you most likely turn to?	2,064	-	-
Family/friends (including partner/s)	-	775	37.5
Psychologist	-	470	22.8
GP/Doctor	-	354	17.2
Counsellor/psychotherapist	-	170	8.2
Psychiatrist	-	96	4.7
No-one/would not seek help	-	168	8.1
Other	-	31	1.5
Would you feel comfortable telling a health professional your sexuality?*	1,932	-	-
Yes	-	1,005	52.0
Maybe/depends	-	613	31.7
No	-	314	16.3
If you have told one or more health professionals about your sexuality how was your general experience of this?*	1,108	-	-
Good experience/s	-	572	51.6
Good and bad experiences	-	215	19.4
Bad experience/s	-	113	10.2
Neutral	-	208	18.8
In general, how knowledgeable are health professionals about working with people whose sexual identity, attraction and/or behaviour incorporates people of the same gender and at least one other gender?	1,748	-	-
Very knowledgeable	-	314	18.0
Somewhat knowledgeable	-	99	5.7
Some are knowledgeable and some are not	-	335	19.2
Not very knowledgeable	-	122	7.0
Not at all knowledgeable	-	714	40.9
Unsure	-	137	7.9
Would you like to have more access to services specialised in working with people whose sexual identity, attraction	1,989	-	-

and/or behaviour incorporates people of the same gender and at least one other gender?			
I'm not interested in accessing these services	-	455	22.9
I am happy with the access I have to these services	-	424	21.3
I feel I have some access to these services but would like more	-	600	30.2
I feel I have no access to these services but would like to	-	510	25.6

*These questions were preceded by this explanation: 'In the following questions your 'sexuality' refers to your sexual identity, sexual attraction and/or sexual behaviour that incorporates people of your own gender and at least one other gender.'

Service Access by K10 Category

Respondents with high levels of psychological distress were most likely to have accessed mental health services, but also were the least likely to seek help if they were concerned about their mental health and the least likely to feel comfortable disclosing their bisexuality to health professionals (Table 3). Furthermore, higher levels of psychological distress were associated with wanting greater access to services specialised in working with bisexuals, with respondents in the very high distress group significantly more likely to report wanting this (P <0.001) (Table 3). By contrast, those who reported lower levels of distress were less likely to have accessed mental health services, more likely to report they would seek help if they were concerned about their mental health, more likely to feel comfortable disclosing their bisexuality to health professionals and less likely to report wanting greater access to specialised bisexual mental health services (Table 3). Despite these significant associations, the reaction people had received from health professionals when they disclosed their sexual identity was not associated with levels of psychological distress (P = 0.40), nor was respondents' perceptions of how knowledgeable health professionals are in working with bisexual people (P = 0.98).

Table 3 - Experiences of Service Access by K10 category

Service Access Experience	**Low Distress (10-15)**	**Moderate Distress (16-21)**	**High Distress (22-29)**	**Very High Distress (30-50)**	χ^2	p	ϕ_c
Have you ever seen a health	-	-			109.08	<0.001	0.243

professional for mental health concerns?					(1)		
Yes	66.4% (-9.6)	79.6% (-2.4)	88.1% (3.6)	91.4% (6.4)	-	-	-
In the past 4 weeks have you seen a health professional for mental health concerns?	-	-			197.69 (1)	<0.001	0.315
Yes	10.1% (-9.9)	20.6% (-5.7)	34.8% (1.6)	50.0% (11.5)	-	-	-
If you were concerned about your mental health, who would you most likely turn to?	-	-			34.36 (1)	<0.001	0.132
Family/friends (including partner/s)	40.7% (1.3)	41.8% (2.0)	35.6% (-1.2)	35.1% (-1.6)	-	-	-
Psychologist	18.9% (-2.0)	23.4% (0.3)	24.5% (1.1)	23.3% (0.3)	-	-	-
GP/Doctor	19.2% (1.2)	17.7% (0.4)	19.8% (2.1)	12.8% (-3.5)	-	-	-
Counsellor/psychotherapist	12.3% (3.2)	7.6% (-0.5)	7.8% (-0.3)	6.4% (-1.9)	-	-	-
Psychiatrist	4.7% (0.0)	3.5% (-1.3)	3.8% (-1.3)	6.5% (2.5)	-	-	-
No-one/would not seek help	1.4% (-5.1)	5.2% (-2.4)	6.8% (-1.3)	15.0% (7.7)	-	-	-
Other	2.8% (2.4)	0.7% (-1.4)	1.7% (0.5)	1.0% (-1.2)	-	-	-
Would you feel comfortable telling a health professional your sexuality?*	-	-			19.235 (1)	<0.001	0.084
Yes	63.9% (4.9)	51.1% (-0.3)	49.3% (-1.4)	47.5% (-2.5)	-	-	-
Maybe/depends	25.7% (-2.7)	32.6% (0.3)	32.6% (0.4)	34.4% (1.6)	-	-	-
No	10.4% (-3.2)	16.3% (0.0)	18.1% (1.3)	18.1% (1.4)	-	-	-

Would you like to have more access to services specialised in working with people whose sexual identity, attraction and/or behaviour incorporates people of the same gender and at least one other gender?	-	-	-	-	68.09 (1)	<0.001	0.119
I'm not interested in accessing these services	31.5% (4.1)	28.9% (3.2)	19.1% (-2.6)	17.9% (-3.6)	-	-	-
I am happy with the access I have to these services	27.7% (3.2)	23.0% (1.0)	22.8% (1.0)	15.0% (-4.5)	-	-	-
I feel I have some access to these services but would like more	22.5% (-3.4)	28.2% (-1.0)	31.2% (0.7)	34.7% (3.0)	-	-	-
I feel I have no access to these services but would like to	18.2% (-3.5)	19.9% (-3.0)	26.9% (0.9)	32.4% (4.6)	-	-	-

Note: Adjusted residuals appear in parentheses below observed percentages

*This question was preceded by this explanation: 'In the following questions your 'sexuality' refers to your sexual identity, sexual attraction and/or sexual behaviour that incorporates people of your own gender and at least one other gender.'

Service Access by Gender

Cisgender men were least likely to report having seen a health professional for mental health concerns while transgender and gender diverse participants were most likely to (Table 4). Although cisgender men were least likely to have accessed professional support for mental health concerns, if they did, they were most likely to access GPs (Table 4). While transgender/gender diverse respondents were the most likely gender group to report that they would not seek help if concerned about their mental health and additionally were least likely to turn to family for support (Table 4). Cisgender women were significantly less likely to report that they would not seek help for mental health concerns (Table 4).

Table 4 - Significant associations between experiences of service access and gender

Service Access Experience	Cisgender Man	Cisgender Woman	Transgender or gender diverse	Chi-square statistic χ^2(df)	Sig. (*p*)	Cramer's V (ϕ_c)
Have you ever seen a health professional for mental health concerns?	-	-	-	44.813 (2)	<0.001	0.149

Yes	72.1% (-5.8)	83.7% (0.6)	90.8% (4.5)	-	-	
In the past 4 weeks have you seen a health professional for mental health concerns?	-	-	-	32.071 (2)	<0.001	0.126
Yes	21.7% (-4.2)	31.5% (-0.6)	41.5% (4.6)			
If you were concerned about your mental health, who would you most likely turn to?	-	-	-	52.205 (12)	<0.001	0.113
Family/friends (including partner/s)	41.1% (1.5)	38.4% (1.1)	31.8% (-2.7)	-	-	
Psychologist	17.1% (-2.7)	23.3% (0.6)	26.1% (1.7)	-	-	
GP/Doctor	22.5% (2.8)	17.3% (0.5)	11.8% (-3.1)	-	-	
Counsellor/psychotherapist	6.3% (-1.3)	8.9% (1.4)	7.6% (-0.5)	-	-	
Psychiatrist	5.1% (0.5)	3.5% (-3.1)	7.6% (3.3)	-	-	
No-one/would not seek help	6.6% (-1.1)	7.2% (-2.3)	12.8% (3.7)	-	-	
Other	1.3% (-0.4)	1.4% (-0.8)	2.2% (1.3)	-	-	
Would you feel comfortable telling a health professional your sexuality?*	-	-	-	6.786 (1)	0.009	0.072
Yes	63.9% (4.3)	50.0% (-2.5)	50.1% (-0.8)	-	-	-
Maybe/depends	22.1% (-3.8)	33.6% (2.4)	33.0% (0.6)	-	-	-
No	14.0% (-1.1)	16.4% (0.4)	16.9% (0.4)	-	-	-

Note: Adjusted residuals appear in parentheses below observed percentages

*This questions was preceded by this explanation: 'In the following questions your 'sexuality' refers to your sexual identity, sexual attraction and/or sexual behaviour that incorporates people of your own gender and at least one other gender.'

Cisgender men were most likely to feel comfortable disclosing their bisexuality to health professionals with 64% reporting this, while cisgender women were significantly less likely to report this (Table 4). In contrast no significant association was found between being transgender or gender diverse and level of comfort disclosing bisexuality to health professionals. For those participants who had disclosed their bisexuality to a health professional, there was no significant association between their gender and their experiences of this disclosure ($P = 0.15$). Cisgender men were significantly more likely than the null hypothesis would predict to report that health professionals were very knowledgeable about working with bisexuals; cisgender women were significantly less likely to report this and transgender and gender diverse respondents were the least (Table 5). Furthermore, cisgender men were the least likely to report wanting access to services specialised in working with bisexual people while transgender and gender diverse participants reported this with the greatest frequency (Table 5).

Table 5 - Perceptions of health professionals' knowledge and wanting access to specialised services by gender

Service Access Variables	**Cisgender Man**	**Cisgender Woman**	**Transgender or gender diverse**	**Chi-square statistic χ^2(df)**	**Sig. (*p*)**	**Cramer's V (ϕ_c)**
In general, how knowledgeable are health professionals about working with people whose sexual identity, attraction and/or behaviour incorporates people of the same gender and at least one other gender?	-	-	-	86.657 (12)	<0.001	0.158
Very knowledgeable	35.2% (7.7)	16.0% (-2.6)	11.4% (-3.6)	-	-	
Somewhat knowledgeable	4.9% (-0.6)	5.4% (-0.5)	6.8% (1.1)	-	-	
Some are knowledgeable and some are not	17.0% (-0.9)	20.6% (2.1)	16.1% (-1.7)	-	-	

Not very knowledgeable	5.3% (-1.1)	6.6% (-0.8)	9.3% (1.9)	-	-	
Not at all knowledgeable	28.3% (-4.2)	39.8% (-0.6)	50.1% (4.3)	-	-	
Unsure	7.3% (-0.3)	8.8% (2.3)	4.6% (-2.5)	-	-	
Would you like to have more access to services specialised in working with people whose sexual identity, attraction and/or behaviour incorporates people of the same gender and at least one other gender?	-	-	-	51.636 (6)	<0.001	0.115
I'm not interested in accessing these services	31.0% (3.6)	24.2% (1.6)	13.4% (-5.1)	-	-	-
I am happy with the access I have to these services	27.0% (2.6)	20.7% (-1.0)	19.4% (-1.1)	-	-	-
I feel I have some access to these services but would like more	25.0% (-2.1)	29.1% (-1.2)	36.9% (3.3)	-	-	-
I feel I have no access to these services but would like to	17.0% (-3.7)	26.0% (0.7)	30.3% (2.4)	-	-	-

Note: Adjusted residuals appear in parentheses below observed percentages

Predictors of Levels of Comfort to Disclose Bisexuality to Health Professionals

Several demographic characteristics and common bisexual life experiences were found to be significant predictors of respondents' levels of comfort in disclosing their bisexuality to health professionals. The cumulative odds ordinal logistic regression model significantly predicted the dependent variable (level of comfort disclosing bisexuality) over and above the intercept-only model, $\chi^2(13) = 132.487$, $p = <0.001$. Respondents were found to be significantly less comfortable disclosing their bisexuality to health professionals if they were younger in age (OR 0.971, CI 0.954 – 0.989, $P = 0.002$), more highly educated (OR 1.189, CI 1.031 – 1.371, $P = 0.02$), had higher levels of internalised

biphobia (OR 1.209, CI 1.029 – 1.421, *P* = 0.02) or were less 'out' to their immediate family. In addition, feelings of invisibility were predictive of comfort disclosing with those more frequently wishing their bisexuality was more visible being less comfortable disclosing their bisexuality to health professionals (OR 1.184, CI 1.034 – 1.356, *P* = 0.01). Finally, the odds of being comfortable disclosing bisexuality to a health professional were significantly increased when participants had previous good experiences of this (OR 2.514, CI 2.023 – 3.125, *P* <.001). Detailed regression results can be found in Table 6.

Table 6 – Predictors of comfort in disclosing bisexuality to a health professional

Independent Variables	**OR (95% CI)**	***P***
Age	0.971 (0.954-0.989)	0.002
Local area description	0.999 (0.845-1.180)	0.99
Highest level of education achieved	1.189 (1.031-1.371)	0.02
Pre-tax income	0.983 (0.909-1.063)	0.67
How many partners do you have?	1.010 (0.823-1.239)	0.92
Have you ever been treated badly because of your sexuality?*	1.086 (0.896-1.316)	0.40
Do you ever feel your sexuality is bad or wrong?*	1.209 (1.029-1.421)	0.02
Do you ever wish your sexuality was more visible to those around you?*	1.184 (1.034-1.356)	0.01
Who in your life is currently aware of your sexuality – immediate family?	0.713 (0.559-0.908)	0.006
Who in your life is currently aware of your sexuality – close friends?	0.689 (0.454-1.044)	0.08
How often do you participate in LGBTI community events?	0.887 (0.744-1.057)	0.18
How often do you have contact with LGBTI friends or acquaintances?	0.901 (0.748-1.086)	0.27
If you have told one or more health professionals about your sexuality how was your general experience of this?*	2.514 (2.023-3.125)	> 0.001

*This question was preceded by this explanation: 'In the following questions your 'sexuality' refers to your sexual identity, sexual attraction and/or sexual behaviour that incorporates people of your own gender and at least one other gender.'

Discussion

Accessing professional support for mental health concerns was very common among *Who I Am* respondents with 83% having accessed these services at some point in their lives and one in three having done so in the past four weeks. This indicates substantially greater mental health service use than the broader population with a representative sample of Australians reporting just 12% accessed services for their mental health in the twelve months preceding the study (Slade et. al., 2009). These findings are consistent with previous research reporting that same-sex attracted individuals are more likely to access mental health care (Cochran, Sullivan & Mays, 2003) and within this population bisexuals report accessing these services more frequently than their gay or lesbian counterparts (Leonard, Lyons & Bariola, 2015; Loi, Lea & Howard, 2017).

As with previous research (Leonard, Lyons & Bariola, 2015; Owens, Riggle & Scales Rotosky, 2007), the *Who I Am* study found that those with higher psychological distress were more likely to have accessed professional help for their mental health. In addition, in keeping with findings relating to both the general population (Parslow & Jorm, 2008; Slade, et. al., 2009) and the LGBT community (Leonard, Lyons & Bariola, 2015; Owens, Riggle & Scales Rotosky, 2007), the current study found that cisgender men engaged the least in mental health services when compared to other gender groups. It is important to note here that, in the current study, they also had the lowest levels of psychological distress. Although cisgender women were more likely to access mental health services than cisgender men, a finding that mirrors other studies (Leonard, Lyons & Bariola, 2015; Owens, Riggle & Scales Rotosky, 2007; Parslow & Jorm, 2008; Slade et. al., 2009), it was transgender and gender diverse *Who I Am* respondents that experienced both the highest levels of psychological distress and the highest rates of engagement in mental health services with over 90% accessing these services at some point in the past and 42% having accessed these services in the four weeks preceding the

study. Again, this finding is consistent with the findings of previous research (Leonard, Lyons & Bariola, 2015).

Who I Am respondents did not differ from the broader population (Slade et. al., 2009) with regard to which service providers they would choose to access if they were concerned about their mental health, with psychologists and general practitioners (GPs) being the most frequently reported. Cisgender men were most likely to identify GPs as their preferred access point and transgender or gender diverse the least likely, while the reverse was true for psychologists. In addition, respondents with very high psychological distress were significantly more likely to report that they would *not* seek help if they were concerned about their mental health while those with low distress were the least likely to report this.

When asked if they would feel comfortable disclosing their bisexuality to a health professional, only half (52%) of the *Who I Am* sample answered affirmatively. Bisexuals have been found to be less likely to disclose their sexuality to health professionals than gay or lesbian people (Leonard et al., 2012). Perceived prejudices and fear of discrimination can lead bisexuals to keep their sexuality hidden when accessing mental health services and, for some, these fears can deter them from accessing these services at all (Li et. al., 2013; Owens, Riggle & Scales Rotosky, 2007; Page, 2004). Due to significant mental health disparities between individuals who belong to sexual minority groups and the broader population, the disclosure of sexual minority status in the healthcare setting assists in ensuring the provision of culturally competent and clinically relevant healthcare and potentially lead to improved outcomes for these at risk groups (Brooks et. al., 2018; Petroll & Mosack, 2011).

Findings from the current study support previous literature reporting that bisexuals experiencing more serious mental health problems are less likely to disclose their

bisexuality to service providers (Page, 2004). In addition, in the current study, gender was significantly associated with comfort in disclosing sexual orientation to service providers with cisgender men most likely to report feeling comfortable disclosing and cisgender women less likely to. This presents a different picture to previous research with LGB adults in the United States which revealed that bisexual men are less likely than bisexual women to be 'out' to their healthcare providers (Durso & Meyer, 2013).

Understanding patterns of nondisclosure of sexual orientation among bisexual people is a necessary step towards improving the mental health of this population with previous research revealing that nondisclosure in itself is a significant predictor of future mental health (Durso & Meyer, 2013). The current study found that being younger and having increased internalised biphobia was significantly predictive of lower levels of comfort in disclosing sexuality to health professionals, findings that are consistent with previous LGB research (Durso & Meyer, 2013). However, in contrast to previous sexual minority research (Durso & Meyer, 2013), *Who I Am* respondents with higher levels of education were less likely to feel comfortable disclosing their bisexuality in the healthcare setting. Not surprisingly, those who had disclosed their bisexuality in the past and had good experiences of this were more likely to feel comfortable disclosing again. While some scholars have examined socio-demographic characteristics alongside comfort disclosing minority status (Durso & Meyer, 2013; Petroll & Mosack, 2011), the current study provides important new insights with regard to bisexual individuals.

While approximately one in two *Who I Am* respondents reported they would feel comfortable disclosing their bisexuality, of those that had, just 10% had had bad experiences of this and a further 19% reported both good and bad experiences. This is in-line with previous research examining experiences of mental health services for LGBT people (Alencar Albuquerque et. al., 2016) and bisexual people specifically (Dobinson et al., 2005; Eady, Dobinson & Ross, 2011), with them reporting that a disclosure of sexual

minority status to health service providers can elicit a range of responses from acceptance and support to homophobia and discrimination.

Tied in with decisions of whether to access mental health services and, when accessing these services, whether or not to disclose one's bisexuality, are perceptions of how knowledgeable service providers are about bisexuality. The majority (67%) of *Who I Am* respondents reported that they believe health professionals are either not at all knowledgeable, not very knowledgeable or that some are knowledgeable and some are not about bisexuality, a finding consistent with previous research (Dobinson et al., 2005). Cisgender men were most likely to report thinking that health professionals are generally knowledgeable about bisexuality while transgender and gender diverse respondents reported the reverse. Whether or not this perception is accurate remains unclear. The perceived lack of knowledge by health professionals around bisexuality has been identified as an important issue for bisexual people and one that presents a barrier to accessing mental health support in this population (Page, 2004).

An important finding of the current study is that the majority of respondents (56%) reported wanting more access to services specialised in working with people who have bisexual attraction, identity and/or experience. This finding was most common among transgender and gender diverse participants with 67% of this cohort wanting more access to these services, while 55% of cisgender women reported this and 42% of cisgender men. Furthermore, *Who I Am* respondents with very high levels of distress were significantly more likely to report wanting more access to these specialist services. In light of the growing understanding of the increased mental health needs of sexual minority groups and their barriers to accessing mainstream services, the past decade has seen an increasing emergence of specialised LGBT mental health service provision (Martos, Wilson & Meyer, 2017). A previously identified issue with these services relates to geography in that they tend to be available only in larger cities and in areas of

concentrated LGBT populations (Martos et. al., 2017). There is, however, another significant barrier that may exist for bisexual people: despite their sharing of sexual minority status with gay and lesbian people, bisexuals often report feeling outside of the LGBT community and even discriminated against and marginalised within these spaces (Ault, 1994; Brennan & Hegarty, 2012; Dobinson et al., 2005; Feinstein, Dyar, Bhatia, Latack & Davil, 2014; Li et al., 2013). Thus, although these specialised services exist, because they most commonly target LGBT population as opposed to bisexual people specifically, for bisexuals in need of mental health support fear of stigma and discrimination may prevent access to such services.

There are several clinical implications and future research recommendations arising from the findings presented herein that, if implemented, may have the potential to improve the current very poor mental health statistics associated with bisexual people. The authors support previous calls (Alencar Albuquerque et. al., 2016; Eady et. al., 2011) for the education of service providers about LGBT mental health and barriers to service access for this population, with this study indicating the necessity of a particular focus on GPs and psychologists. In addition, separating bisexuals out as a group at particular risk with unique needs and issues is essential to ensure accurate information is being delivered. Future research examining the knowledge of service providers relating to LGBT issues and, more specifically, bisexuality, would play an important role in informing such education programs. In addition to increasing the knowledge of service providers, addressing issues of perceptions of the lack of knowledge service providers have about bisexuality by current or prospective bisexual clients/patients and providing clinical settings where bisexual people feel safe to disclose their sexuality, is an important step towards addressing the barriers to service access that currently exist for this population. Even where service providers may be knowledgeable about bisexuality and able to assist bisexual clients with mental health concerns, if the client is unaware of this

then it may present a missed opportunity for mental health intervention. Using visual cues specifically targeted at bisexuals (as separate from the LGBT community that many bisexuals do not feel a part of) such as posters, pamphlets, window stickers and bisexual flags may assist in identifying services as safe places for bisexuals. Furthermore, this study provides a clear message that more access to services specialised in working with bisexual people is needed. While there is an increasing number of LGBT organisations providing specialised services and clinicians specialising in working with this community, the authors were unable to find one single health service or service provider in Australia that focussed specifically on working with bisexual clients. This presents a significant gap. Finally, research further examining bisexuals' interactions with mental health service providers is needed to shed greater light on this topic with the aim of improving access for bisexual people.

Limitations

In order to adequately address the aim of this research and target the relevant population, convenience sampling was the required sampling method for the *Who I Am* study. Thus, despite the large sample size, it is not possible to determine the generalisability of the findings to the broader bisexual population. Furthermore, as the survey relied on self-reporting and respondents were able to skip questions at their discretion, reporting bias and missing data were limitations. Finally, this study was conducted entirely online and the majority of recruitment occurred in the online space. As a result, potential respondents who did not have access to the internet were essentially excluded from the study.

Conclusion

While bisexual people have consistently been found to experience higher rates of poor mental health than their lesbian, gay and heterosexual counterparts, research

examining their experiences of accessing support services is limited. This paper has sought to extend the current knowledge in this area by reporting bisexuals' access to, and experiences of, mental health services by presenting findings from one of the largest studies of bisexual people to date. Although there were high levels of engagement with mental health services by respondents, only one in two reported that they would feel comfortable disclosing their bisexuality to service providers with previous bad experiences of disclosure in the healthcare setting significantly increasing the odds of bisexuals not wanting to disclose in the future. In addition, the majority of respondents felt that health professionals are either not at all knowledgeable, not very knowledgeable or some are knowledgeable and some are not about working with bisexual clients/patients. The majority of participants would like more access to services specialised in working with bisexual people. Some associations between experiences of service access and gender were observed. In addition, psychological distress was found to be significantly associated with most service access variables. A number of clinical implications can be drawn from this research, though more research is needed in this field to gain deeper insight into how bisexual people interact with mental health services to further enhance and improve access for this population.

Disclosure statement

The authors have no financial interests or other benefits arising from the publication and application of this study.

References

ABS, Australian Bureau of Statistics (2012). Information Paper: Use of the Kessler Psychological Distress Scale in ABS Health Surveys, Australia, 2001-08. (4817.0.55.001). Retrieved 2003/2018 http://www.abs.gov.au/ausstats/abs@.nsf/lookup/4817.0.55.001Chapter92007-08

ABS, Australian Bureau of Statistics. (2017). Census of population and housing: Reflecting australia - Sories from the Census, 2016. Canberra: Australian Bureau of Statistics.

Alencar Albuquerque, G., De Lima Garcie, C., Da Silva Quirino, G., Alves, M., Belnm, J., Dos Santos Figueiredo, F., … Adami, F. (2016). Access to health service by lesbian, gay, bisexual, and transgender persons: Systematic literature review. *BMC International Health and Human Rights 16*(2). 2.

Ault, A. (1994). Hegemonic discourse in an oppositional community: Lesbian feminists and bisexuality. *Critical Sociology 20*(3), 107-122.

Blumstein, P. W. & Schwartz, P. (1999). Bisexuality: Some social psychological issues (1977).In M. Storr (Ed.), *Bisexuality: A Critical Reader.* London: Routledge.

Bostwick, W. B., Boyd C. J., Hughes T. L. & McCabe, S. E. (2010). Dimensions of sexual orientation and the prevalence of mood and anxiety disorders in the United States. *American journal of public health 100*(3), 468.

Bostwick, W. B., McCabe S. E., Horn, S., Hughes, T., Johnson, T. & Valles, J. R. (2007). Drinking patterns, problems, and motivations among collegiate bisexual women. *Journal of American College Health 56*(3), 285-292.

Brennan, D. J., Ross, L. E., Dobinson, C., Veldhuizen, S. & Steele. L. S. (2010). Men's sexual orientation and health in Canada. *Canadian Journal of Public Health / Revue Canadienne de Sante'e Publique 101*(3), 255-258.

Brennan, T. & Hegarty, P. (2012). Charlotte wolff's contribution to bisexual history and to (sexuality) theory and research: A reappraisal for queer times. *Journal of the History of Sexuality 21*(1), 141-161.

Brooks, H., Llewellyn, C. D., Nadarzynski, T., Pelloso, F. C., De Souza Guilherme, F…& Jones, C. J. (2018). Sexual orientation disclosure in health care: a systematic review. *The British Journal of General Practice. 68*(668), 187-196.

Cochran, S. D., Sullivan, J. G. & Mays, V. M. (2003). Prevalence of mental disorder, psychological distress, and mental health services use among lesbian, gay, and bisexual adults in the United States. *Journal of Consulting and Clinical Psychology 71*(1), 53-61.

Conron, K. J., Mimiaga, M. J. & Landers, S. L. (2010). A population-based study of sexual orientation identity and gender differences in adult health. *The American Journal of Public Health 100*(10), 1953-1960.

Dobinson, C., Macdonnell, J., Hampson, E., Clipsham, J. & Chow, K. (2005). Improving the access and quality of public health services for bisexuals. *Journal of Bisexuality 5*(1), 39-77.

Durso, L. E. & Meyer, I. H. (2013). Patterns and predictors of disclosure of sexual orientation to healthcare providers among lesbians, gay men, and bisexuals. *Sexuality Research and Social Policy 10*(1), 35-42.

Eady, A., Dobinson, C. & Ross, L. E. (2011). Bisexual people's experiences with mental health services: A qualitative Investigation. *Community Mental Health Journal 47*(4), 378-389.

Eisner, S. (2013). *Bi: Notes for a bisexual revolution*. California: Seal Press.

Feinstein, B.A., Dyar, C., Bhatia, V., Latack, J. A. & Davil, J. (2014). Willingness to engage in romantic and sexual activities with bisexual partners: Gender and sexual orientation differences. *Psychology of Sexual Orientation and Gender Diversity 1*(3), 255-262.

Hughes, T., Szalacha, L. A. & McNair, R. (2010). Substance abuse and mental health disparities: Comparisons across sexual identity groups in a national sample of young Australian women. *Social Science & Medicine 71*(4), 824-831. doi: 10.1016/j.socscimed.2010.05.009.

Jorm, A. F., Korten, A. E., Rodgers, B., Jacomb, P. A. & Christensen, H. (2002). Sexual orientation and mental health: results from a community survey of young and middle-aged adults. *The British Journal of Psychiatry : The Journal of Mental Science 180*, 423.

Kessler, R. C., Andrews, G., Colpe, L. J., Hiripi, E., Mroczek, D. K., Normand, S. L. T., Walters, E. E. & Zaslavsky A. M.(2002). Short screening scales to monitor population prevalences and trends in non-specific psychological distress. *Psychoogy Medicine 32*(6), 959-976. doi:

Koh, A. S. & Ross, L. K. (2006). Mental health issues: a comparison of lesbian, bisexual and heterosexual women. *Journal of Homosexuality 51*(1), 33.

Leonard, W., Lyons, A. & Bariola, E. (2015). A closer look at private lives 2. Melbourne, Australia: Australian Research Centre in Sex, Health and Society, La Trobe University

Leonard, W., Pitts, M., Mitchell, A., Lyons, A., Smith, A., Patel, S., Couch, M. & Barrett, A.. (2012). Private Lives 2: The second national survey of the health and wellbeing of GLBT Australians. Melbourne, Australia: Australian Research Centre in Sex, Health and Society, La Trobe University.

Li, T., Dobinson, C., Scheim, A. & Ross, L. (2013). Unique issues bisexual people face in intimate relationships: A descriptive exploration of lived experience. *Journal of Gay & Lesbian Mental Health 17*(1), 21-39.

Loi, B., Lea, T. & Howard, J. (2017). Substance Use, Mental Health, and Service Access among Bisexual Adults in Australia. *Journal of Bisexuality 17*(4), 400-417.

Martos, A. J., Wilson, P. A. & Meyer, I. H. (2017). Lesbian, gay, bisexual, and transgender (LGBT) health services in the United States: Origins, evolution, and contemporary landscape. *PLoS ONE 12*(7).

McNair, R., Kavanagh, A., Agius, P. & Tong, B. (2005). The mental health status of young adult and midlife nonheterosexual Australian women. *Australian and New Zealand Journal of Public Health 29*(3):265.

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Cnceptual issues and research evidence. *Psychological Bulletin 129*(5), 674-697.

Owens, G. P., Riggle, E. D. B. & Scales Rotosky, S. (2007). Mental health services access for sexual minority individuals. *Sexuality Research and Social Policy 4*(3), 92-99.

Page, E. H. (2004). Mental health services experiences of bisexual women and bisexual men: An empirical study. In R. C. Fox (Ed.) *Current Research on Bisexuality*. New York: Harrington Park Press.

Parslow, R. A. & Jorm, A. F. (2008). Who uses mental health services in Australia? An analysis of data from the National Survey of Mental Health and Wellbeing. *Australian and New Zealand Journal of Psychiatry 34*(6), 997-1008.

Persson, T. J., Pfaus, J. G. & Ryder, A. G. (2015). Explaining mental health disparities for non-monosexual women: Abuse history and risky sex, or the burdens of non-disclosure? *Social Science & Medicine 128*, 366-373.

Petroll, A. E. & Mosack, K. E. (2011). Physician awareness of sexual orientation and preventive health recommendations to men who have sex with men. *Sexually Transmitted Diseases 38*(1), 63-67.

Pitts, M., Smith, A., Mitchell, A. & Patel, S. (2006). Private lives: A report on the health and wellbeing of GLBTI Australians. Melbourne: Australian Research Centre in Sex, Health and Society, La Trobe University.

Pompili, M. , Lester, D., Forte, A. Seretti, M. E., Erbuto, D., Lamis, D. A., … Girardi, P. (2014). Bisexuality and suicide: A systematic review of the current literature. *11*(8), 1903-1913.

Richters, J., Altman, D., Badcock, P. B., Smith, A. M. A., De Visser, R. O., Grulich, A. E., … Simpson, J. M. (2014). Sexual identity, sexual attraction and sexual experience: The second australian study of health and relationships. *Sexual Health 11*(5), 451-460.

Slade, T., Johnston, A., Teesson, M., Whiteford, H., Burgess, P., Pirkis, J. & Saw, S. (2009). The Mental Health of Asutralians 2: Report on the 2007 National Survey of Mental Health and Wellbeing. . Canberra.

Steele, L., Ross, L., Dobinson, C., Veldhuizen, S. & Tinmouth, J. (2009). Women's sexual orientation and health: Results from a Canadian population-based survey. *Women & Health 49*(5), 353-367.

Veltman, A. & Chaimowitz, G. (2014). Mental health care for people who identify as lesbian, gay, bisexual, transgender, and (or) queer. *Canadian Journal of Psychiatry 59*(11), 1-7.

Yoshino, K. (2000). The epistemic contract of bisexual erasure. *Standford Law Review 52*(2), 353-461.

Chapter 9

Conclusions

"I actually love being bisexual. It is part of who I am. My acceptance of my sexuality allows me to feel like a whole person."

– *Who I Am* participant

The *Who I Am* study undertaken for this thesis aimed to generate new and much needed knowledge in relation to its guiding research question: why do bisexual people experience poor mental health? The intention was to share findings broadly in an effort to improve the mental health of this population by enabling better informed service provision, policy development and future research. This aim is reflected in the breadth of academic journals that were targeted to publish the study's findings, covering both academic and health/mental health practice-based journals.

One of the great successes of this project was the sheer number of respondents to the survey. With 2,651 respondents, this study is the largest bisexually focussed study conducted in Australia to date, and to the author's knowledge, the largest in the world. This achievement translated to a rich spread of data that was able to be explored using a range of statistical techniques. Although random sampling was not applicable to this project and thus the representativeness of the sample cannot be determined, with an unprecedented sample size this research provides valuable information on the mental health and wellbeing of an under-researched group. In addressing the aim and research

question, this study has generated a significant contribution to the limited understanding of the high prevalence of poor mental health in bisexual people.

Major Findings

This study supports previous research, finding that bisexual people experience high rates of poor mental health (Bostwick et al., 2007; Brennan, Ross, Dobinson, Veldhuizen, & Steele, 2010; Conron, Mimiaga, & Landers, 2010; Hughes, Szalacha, & McNair, 2010; Jorm, Korten, Rodgers, Jacomb, & Christensen, 2002; Koh & Ross, 2006; Leonard, Lyons, & Bariola, 2015; McNair, Kavanagh, Agius, & Tong, 2005; Persson, Pfaus, & Ryder, 2015; Steele, Ross, Dobinson, Veldhuizen, & Tinmouth, 2009). The vast majority of cisgender participants reported high or very high psychological distress and more than one in four had attempted suicide. These statistics were worse for transgender and gender diverse respondents with higher levels of psychological distress and nearly half of these respondents having attempted suicide at some point in their lives.

How people felt about their own bisexuality was found to be highly predictive of their mental health in the current study, with those reporting that they felt their sexuality was 'bad or wrong' experiencing higher levels of psychological distress. This finding was consistent across gender groups. However, other life experiences that were associated with poorer mental health were different for cisgender respondents than they were for transgender or gender diverse respondents. Intimate relationships played a key role in mental health for cisgender participants. Those in heterosexual relationships were found to be particularly vulnerable to psychological distress as were cisgender respondents whose partners were unsupportive of their bisexuality. Connection to an LGBTI community was not found to be associated with mental health for this cohort. Interestingly, the opposite was true for transgender and gender diverse respondents. While intimate relationships were not related to mental health for transgender or gender

diverse participants, their connection to community was important. Being less connected to these communities was predictive of poorer mental health.

When examining the sample's experiences of the three dimensions of bisexuality described by Yoshino (2000) - bisexual identity, attraction and behaviour - alongside mental health, identity was found to be significantly associated with higher levels of psychological distress. Participants who experienced bisexual attraction and/or bisexual behaviour, but who did not identify as bisexual, enjoyed better mental health. It is important to note here, however, that people in all of these groups experienced higher rates of poor mental health than both the broader Australian (heterosexual) population and the LGBTI population.

Finally, experiences of service access were explored in order to examine associations with mental health and provide insights to enable a more informed approach to mental health service provision for bisexual people. While study respondents were found to be highly engaged with mental health services, barriers persisted with regard to disclosure of a bisexual orientation to healthcare clinicians with many participants reporting feeling that service providers lacked knowledge and skill in working with bisexual people. Furthermore, the majority of the *Who I Am* sample indicated they would like increased access to services that specialise in working with bisexual people.

Why do Bisexual People Experience Poor Mental Health?

Unlike previous survey research that has reported on bisexual mental health with a focus on the 'what' (as in, 'what' is the state of bisexual peoples' mental health) this study was novel in that it aimed to answer the 'why'. This has led to a number of 'major findings' (summarised above) that are now open to interpretation. My own journey of conducting this study has allowed me to glean insights on this topic not just from the *Who I Am* findings, but also from the broader literature and from the four years spent in

conversations, sharing, listening and immersing myself in the topic. Along this journey I have met many mental health support workers, bisexual advocates and activists, researchers and other professionals who work across disciplines and sectors with an interest in gaining a greater understanding of bisexuality. In addition, I have had the privilege of meeting many bisexual people and hearing their stories in person, via email and in the hundreds of thousands of words they took the time to write during their completion of the *Who I Am* survey with much of this data still awaiting analysis. This rich experience has allowed me to engage deeply with the topic and now, at the study's conclusion, I am able to draw these experiences together to shape my own interpretations of the study's findings in answering this question of 'why'. Though the answer is complex and there are many factors at play here, my opinion is that most of these have stemmed from invisibility and, perhaps to a lesser extent, biphobia.

Despite the invisibility of bisexuality in contemporary Western culture pervading even the scholarly literature on the topic (Angelides, 2001; Klein, 1993) bisexual peoples' personal experiences of invisibility *have* been reasonably well documented previously (Ault, 1994; Eisner, 2013; Ochs, 2011; Ross, Dobinson & Eady, 2010). The findings of the *Who I Am* study provide strong evidence that this invisibility plays a key role in the high prevalence of poor mental health in this population. For cisgender respondents, being in a heterosexual relationship was predictive of poor mental health. It is likely that this relates closely to the invisibility of bisexuality in our culture. Fitting in with the dominant heterosexual culture has sometimes been framed as a protective factor for mental health (Mohr & Daly, 2008). However, the significant invisibility and de-legitimisation experienced by those *bisexual* people who 'blend in' with this group may be related to deleterious impacts on their well-being. The lack of openly bisexual role models in public life or the media adds a further layer of invisibility, which further exacerbates this issue. Bisexual people who 'fly under the radar' and seemingly assimilate

into the dominant heterosexual culture may be struggling to find narratives that help them make sense of their own experiences, or feel comfortable and confident in their experiences of sexuality. This invisibility of bisexuality may directly impact the capacity of heterosexual people to understand and provide support for their bisexual spouses/partners, which may further fuel poor mental health and feelings of invisibility in this group.

This lack of visibility has provided a breeding ground for misconceptions, negativity and erasure of the bisexual in our broader culture. While experiences of biphobia were not found to be predictive of poor mental health in this study, they were correlated with it. *Who I Am* participants' responses provided a strong sense of the pain caused by even micro-biphobic-aggressions, not necessarily because they were enormously traumatic or inflicting great pain or hurt in themselves, but more because there was no place where bisexual people felt free from them. This biphobia is experienced in both the LGBTI community and the heterosexual community. For many bisexual people these are the only communities they have access to. So while biphobia was not the leading factor here, it likely contributes to the more significant predictors of poor mental health (for example partners' lack of support and internalised biphobia). As such, it is certainly an important piece of the puzzle.

In drawing together the findings of this study to present a cohesive whole it is essential to revisit the theoretical underpinnings that have guided the study and explore what contributions this research can make to these theories and their application in this field. Key theories identified at the outset of this project as particularly relevant included the social determinants of health, heteronormativity and compulsory monosexuality. This research not only fits within these theories, it also provides further evidence of their relevance to the field of bisexual mental health.

The notion that social environments and the social groups we belong to can impact, and even determine, our wellbeing has been used to explore many areas of health (Braveman & Gottlieb, 2014). This study provides further evidence of bisexual people, as a social group, collectively having poorer mental health than other sexual orientation groups. In addition, this research posits that within this broad 'bisexual' social grouping, there are specific groups that experience even poorer mental health (for example cisgender bisexuals in heterosexual relationships and those who identify as bisexual as opposed to those who are bisexually attracted and/or behaving without a bisexual identity). Horner & Roberts (2014) argue that sexual orientation is a social determinant of health in and of itself. This theory is supported and extended by the findings of the current study positing that even within sexual orientation categories, social groupings can be useful in identifying individuals who may be particularly vulnerable to poor mental health.

Heteronormativity describes society's pervasive requirement that its members adhere to a heterosexual orientation as the only acceptable sexuality thereby rendering lesbian, gay and bisexual orientations as unacceptable (Warner, 1991). Further, compulsory monosexuality has been presented as a conceptual lens through which the challenges faced by bisexual people specifically can be better understood a theory that presents society's acceptance of monosexual (homosexual and heterosexual) attraction only (Germon, 2008). These theories describe a significant lack of acceptance of 'the bisexual' within society, a concept that is strongly supported by the major findings of this research and its final conclusions which suggest that both the invisibility of bisexual people and bisexuality along with biphobia and internalised biphobia are major contributors (either directly or indirectly) to the high prevalence of poor mental health in this population.

Finally, it is important to revisit the definition of bisexuality used to guide this research and explore how this project might contribute to the theorising of defining bisexuality within a mental health context and what implications this has for future research in this field. As outlined at the commencement of the thesis and throughout the chapters of this dissertation, the definition of the term 'bisexual' used in this study was driven by the study's aim to shed light on the reasons behind the poor mental health of bisexual people. Thus, after extensive deliberation, an adaptation of Yoshino's (2000) three dimensional approach to bisexuality to include those who identify as bisexual and/or are attracted to more than one gender and/or have had sexual experiences with more than one gender was utilised. Yoshino's (2000) definition was broadened for this study to include those with occasional or incidental bisexual experience as previous research has reported that any bisexual experience is related to poorer mental health outcomes (Bostwick, 2014). The findings of this research justify and support the use of this inclusive approach within bisexual mental health research with substantially less participants reporting a bisexual identity while the vast majority reported bisexual attraction and *all* groups reporting poorer mental health than the broader national population and the LGBTI population as presented in Chapter 7.

Current research in the area of bisexual mental health most commonly focuses solely on people who identify as bisexual. Upon reflection of Yoshino's (2000) three dimensional definition and this study's broader adaptation of that, and given the findings of this study in relation to these three dimensions, it would be recommended that future research in this field should employ this broader approach. If the study of bisexual mental health continues to exclude those people who fall outside of the self-identifying bisexual group, it will continue to fail to recognise or address the high incidence of deleterious mental health of the majority of bisexual people – those who experience bisexual attraction and/or behaviour without a bisexual identity.

Limitations of the Research

The necessary use of convenience sampling and thus the inability to reliably generalise the findings of the *Who I Am* study to the broader population is a limitation of this research. This was an unavoidable limitation of this study as random or probability sampling is generally inapplicable to hidden populations such as bisexuals due to the non-existence of a reliable sampling frame and the limited accessibility to the population (Ellard-Gray, 2015). As leading medical journals generally only publish findings from studies involving randomised sampling, we have been unable to publish findings from the *Who I Am* study in these journals that tend to have larger medical readerships.

This survey was only available online and recruitment largely relied on online advertising. Thus, potential participants without access to the internet were unlikely to know the study was being conducted or have means to participate.

Furthermore, as this research relied on self-reporting and participants were able to complete or skip questions at their discretion, reporting bias and missing data was a limitation of the study. For example, questions that required a free text response were often left blank and skipped by participants.

The same questions were asked of all study participants regardless of their gender. Experiences that relate to living as a bisexual person such as exposure to discrimination, engagement with the LGBTI community and levels of 'outness' may also relate to experiences of gender diversity. As this study only examined these experiences in relation to sexuality the intersection between gender and sexuality may not have been captured in a way that sufficiently illustrated the nuances of these experiences for transgender and gender diverse participants.

As this research was required to fit within the time confines of a PhD program, a substantial amount of data has remained unanalysed and therefore unreported on in this thesis.

Implications and Future Research

The *Who I Am* study provides numerous implications for service provision for bisexual people. First, these data reiterate the high prevalence of poor mental health in this population; ergo, mental health professionals need to be aware of the increased likelihood of deleterious mental health when working with bisexual people. Furthermore, the current study adds substantial detail to previous understandings of why bisexual people experience poor mental health and which groups of bisexuals might be particularly vulnerable; findings that will assist in directing clinical assessment and intervention. The finding that the majority of the sample indicated their need for increased access to bisexual specific services and felt that mental health services were lacking knowledge and skill in working with bisexual people provides data to support advocacy initiatives to fund services to upskill their clinicians to work competently with bisexual people and understand their needs, encourage a more focussed approach to the presentation of services as 'bisexual friendly' and motivate service providers to specialise in this area of need.

The *Who I Am* study will prove valuable to policy development. The findings of the current study provide a nuanced analysis of the current state of bisexual mental health and the reasons behind it and will provide a significant step forward in the provision of knowledge that will inform future policy, planning and strategic directions in both the government and non-government sectors. Evidence relating to the experiences of bisexual people and how these relate to mental health has been sorely needed for some time as, to date, agitations for support for the bisexual community have been hindered by the paucity

of quality research. In particular, policies and strategies relating to mental health within government (both at a national and state-based level) and non-government (across research and support organisations) sectors will benefit from more detailed information than previously available relating to a large proportion of the population, most of whom experience poor or very poor mental health. This study and others before it (Bostwick et al., 2007; Brennan, Ross, Dobinson, Veldhuizen, & Steele, 2010; Conron, Mimiaga, & Landers, 2010; Hughes, Szalacha, & McNair, 2010; Jorm, Korten, Rodgers, Jacomb, & Christensen, 2002; Koh & Ross, 2006; Leonard, Lyons, & Bariola, 2015; McNair, Kavanagh, Agius, & Tong, 2005; Persson, Pfaus, & Ryder, 2015; Steele, Ross, Dobinson, Veldhuizen, & Tinmouth, 2009), clearly identify the need for the bisexual population to be a high priority when developing strategic directions for mental health now and into the future. The prevalence of bisexuality in our society along with the very high rates of poor mental health in this group indicate that this is not an issue that can continue to be ignored, nor is it an issue that can be addressed under the guise of it being a small specialised area of expertise. Bisexual mental health is a mainstream issue that requires attention broadly across health and mental health sectors.

While the *Who I Am* study presents new knowledge and useful information relating to bisexuality and mental health, more research is badly needed in this area. In terms of future research implications, the current study provides a broad overview of bisexuality and how it relates to mental health with the specific identification of associations between mental health and a range of bisexual life experiences. These findings point to a plethora of topics shown to be associated with mental health and bisexuality that now require deeper examination. This includes key findings such as the clear link between internalised biphobia and poor mental health across gender groups, the identification of heterosexual relationships as a predictor of poor mental health among cisgender bisexuals and the importance of connection to an LGBTI community for

transgender and gender diverse bisexual people – all of which warrant further investigation and more nuanced examinations of how they relate to mental health in this population. Finally, there is much future research still to be conducted on the data generated by this study. Due to the time constraints imposed by the PhD program and the considerable amount of *Who I Am* data resulting from the unexpected large participant numbers, free-text answers relating to intimate relationships, the positives and challenges of being bisexual and why participants believe bisexuals have poor mental health, among others, remain unanalysed. These along with examinations of the data through different lenses such as age and geographic location are yet to be conducted and these will provide further detail about *Who I Am* participants' experiences of being bisexual. These further analyses alongside those already conducted will provide a basis for deeper theorising on the relationships between mental health and bisexuality.

Bi+ Australia

Already this research has led to an exciting development on the Australian bisexual landscape: the development of the new national organisation Bi+ Australia. This organisation, founded by the author in 2018, aims to improve the mental health of bisexual Australians through support, education and research. Bi+ Australia's mission is to support people who are attracted to more than one gender and enhance the understanding, acceptance, inclusion and celebration of bisexuality and pansexuality in Australia. Bi+ Australia is actively translating the *Who I Am* findings into practice through its Support Service, which offers counselling support to bisexual Australians and their families, and via its Education Hub which provides online education relating to bisexual inclusive practice for service providers which can be accessed from anywhere in the world. In addition, the Research Centre of this organisation is already actively working on new projects directly generated out of this study's findings and partnering with academic institutions to ensure the continuation of high quality bisexual research in

Australia aimed at improving mental health outcomes. More information about Bi+ Australia can be found at www.biplusaustralia.org.

Concluding Remarks

The *Who I Am* study has been welcomed and celebrated by those who have participated in it as well as those who will incorporate the findings of the study into their work. The appreciation, enthusiasm and support for this project occurred as a quite unexpected, but welcomed, development along the research journey. It is this engagement, feedback and appreciation that has spurred on this research and enabled the need for it to be the forefront driver of the project at every stage. With the support and guidance of all interested parties, the *Who I Am* study has progressed unhindered through every potential challenge and successfully achieved its aim. This study is dedicated to bisexuals everywhere; may it help you through your journey, may it help others' to understand you better and may it provide one small step toward a better future where you will feel accepted, included, supported and celebrated.

References

Angelides, S. (2001). *A History of Bisexuality*. Chicago: University of Chicago Press.

Ault, A. (1994). Hegemonic discourse in an oppositional community: Lesbian feminists and bisexuality. *Critical Sociology, 20*(3), 107-122.

Bostwick, W. B., McCabe, S. E., Horn, S., Hughes, T., Johnson, T., & Valles, J. R. (2007). Drinking patterns, problems, and motivations among collegiate bisexual women. *Journal of American College Health, 56*(3), 285-292. doi: 10.3200/JACH.56.3.285-292

Bostwick, W. B., Boyd, C. J., Hughes, T. L., West, B. T. & McCabe S. E. (2014). Discrimination and mental health among lesbian, gay, and bisexual adults in the United States. *American Journal of Orthopsychiatry, 84*(1), 35.

Braveman, P. & Gottlieb, L. (2014). The social determinants of health: It's time to consider the causes of the causes. *Public Health Reports, 129*(1), 19-31.

Brennan, D. J., Ross, L. E., Dobinson, C., Veldhuizen, S., & Steele, L. S. (2010). Men's sexual orientation and health in Canada. *Canadian Journal of Public Health / Revue Canadienne de Sante'e Publique, 101*(3), 255-258.

Conron, K. J., Mimiaga, M. J., & Landers, S. J. (2010). A population-based study of sexual orientation identity and gender differences in adult health. *The American Journal of Public Health, 100*(10), 1953-1960.

Eisner, S. (2013). *Bi: Notes for a Bisexual Revolutio*n. California: Seal Press.

Ellard-Gray, A., Jeffrey, N.K., Choubak, M., & Crann, S.E. (2015). Finding the hidden participant: Solutions for recruiting hidden, hard-to-reach, and vulnerable populations. *International Journal of Qualitative Methods, 14*(5), https://doi.org/10.1177/1609406915621420.

Germon, J. E. (2008). Kinsey and the politics of bisexual authenticity. *Journal of Bisexuality, 8*(3-4), 243-258.

Horner, J. & Roberts, N. J. (2014). Time to recognise sexual orientation as a social determinant of health. *Medical Journal of Australia, 200*(3), 137.

Hughes, T., Szalacha, L. A., & McNair, R. (2010). Substance abuse and mental health disparities: Comparisons across sexual identity groups in a national sample of young Australian women. *Social Science & Medicine, 71*(4), 824-831. doi: 10.1016/j.socscimed.2010.05.009

Jorm, A. F., Korten, A. E., Rodgers, B., Jacomb, P. A., & Christensen, H. (2002). Sexual orientation and mental health: results from a community survey of young and middle-aged adults. *The British journal of psychiatry : the journal of mental science, 180*, 423.

Klein, F. (1993). *The Bisexual Option: Second Edition*. New York & London: Routledge Ltd.

Koh, A. S., & Ross, L. K. (2006). Mental health issues: a comparison of lesbian, bisexual and heterosexual women. *Journal of Homosexuality, 51*(1), 33.

Leonard, W., Lyons, A., & Bariola, E. (2015). A closer look at private lives 2. Melbourne, Australia: Australian Research Centre in Sex, Health and Society, La Trobe University

McNair, R., Kavanagh, A., Agius, P., & Tong, B. (2005). The mental health status of young adult and midlife nonheterosexual Australian women. *Australian and New Zealand Journal of Public Health, 29*(3), 265.

Mohr, J. J. & Daly, C. A. (2008). Sexual minority stress and changes in relationships quality in same-sex couples. *Journal of Social and Personal Relationships, 25*(6), 989-1007.

Ochs, R. (2011). Why we need to "get bi". *Journal of Bisexuality, 11*(2-3), 171-175.

Persson, T. J., Pfaus, J. G., & Ryder, A. G. (2015). Explaining mental health disparities for non-monosexual women: Abuse history and risky sex, or the burdens of non-disclosure? *Social Science & Medicine, 128*, 366-373. doi: 10.1016/j.socscimed.2014.08.038

Ross, L. E., Dobinson, C. & Eady, A. (2010). Percieved determinants of mental health for bisexual people: A qualitative examination. *American Journal of Public Health, 100*(3), 496.

Steele, L., Ross, L., Dobinson, C., Veldhuizen, S., & Tinmouth, J. (2009). Women's sexual orientation and health: Results from a Canadian population-based survey. *Women & Health, 49*(5), 353-367. doi: 10.1080/03630240903238685

Warner, M. (1991). Introduction: Fear of a queer planet. *Social Text, 9*(4), 3-17.

Yoshino, K. (2000). The epistemic contract of bisexual erasure. *Stanford Law Review*, *52*(2), 353-461.

Supplementary Material

Media Article 1

RETRIEVED FROM:

http://www.lotl.com/News/Spotlight-On-Bisexual-Mental-Health-2437/?fbclid=IwAR0I5Ha_wvBvunegqOwKEwO96OqtAdv-UtPFQDA3e5tHamMbHZLSDDAaJmY#.W8e1YZW_4o8.facebook

Spotlight On Bisexual Mental Health

The largest study of bisexual Australians has led to the formation of a new organisation aimed at improving their mental health through support, education and research.

BY LOTL STAFF

Published: 2018.10.18 08:56 AM

IMAGE: BI+ AUSTRALIA

Bi+ Australia is the brainchild of La Trobe University researcher Julia Taylor and follows the completion of her *Who I Am* study – a survey of more than 2600 bisexual Australians.

Mrs Taylor, from La Trobe's Australian Research Centre in Sex, Health and Society, said her study found the rate of poor mental health in the bisexual community was worse than previously thought.

"The aim of the *Who I Am* study was to shed light on the little-understood reasons for poor mental health among people who are attracted to the more than one gender," Mrs Taylor said.

"What we found was high levels of psychological distress among the majority of participants. "They told us they had to pretend to be straight in some situation and gay in others.

"They faced questions about their sexuality from members of both the heterosexual and LGBTIQ+ communities.

"Many participants reported being told their sexuality wasn't real. Gay men and lesbians tried to convince them they were really gay or lesbian and straight people insisted they were just experimenting.

"The very high rates of poor mental health and suicidality in this group are shocking and confirm why we need to do more to support bisexual people."

Mrs Taylor plans to publish her findings in the coming months to highlight the extent of the problem.

In the meantime, she has launched Bi+ Australia - the first national organisation dedicated to improving mental health outcomes for bisexual people.

Bi+ Australia offers specialised counselling to bisexual Australians and their families and includes an education hub for service providers and the public, as well as a research centre.

“Our mission is to support people who are attracted to more than one gender and enhance the understanding, acceptance, inclusion and celebration of bisexuality and pansexuality in Australia,” Mrs Taylor said.

Access to Bi+ Australia services and more information is available here.

Media Article 2

RETRIEVED FROM:

https://www.gaystarnews.com/article/tackling-bisexual-invisibility-with-australias-first-national-bi-organization/#gs.tRZ8=II

Tackling bisexual invisibility with Australia's first national bi+ organization

Researcher Julia Taylor launched Bi+ Australia after her research found poor mental health in the bisexual community

Bisexual people and allies attend the world's first Bi Pride parade in Los Angeles (Photo: Facebook)

17 October 2018 11:52 GMT

Rik Glauert

Researcher Julia Taylor launched Australia's first national organization to support bisexual people this week.

Bi+ Australia aims to improve the mental health of the community through support, education and research.

Taylor, from La Trobe's Australian Research Centre in Sex, Health and Society, founded the organization after completing the largest ever study into Australia's bisexual community. She surveyed more than 2,500 people.

The Who I Am study aimed to shed light on the reasons behind the very high prevalence of poor mental health among bisexual people, Taylor told Gay Star News.

'The sense of feeling like you are invisible if you do not prescribe to the binary of straight or gay and having no community to belong to is a very real issue for bi people', she said.

Taylor quoted one respondent of her survey, who said: 'You have to pretend to be straight in some situations and gay in others and there's nowhere that you really belong so you end up with this fractured self.'

Taylor said she wants to translate her findings into practice. She talked to Gay Star News a bit more about the organization and the reality for bisexual Australians:

What is Bi+ Australia's mission?

Our mission is to support people who are attracted to more than one gender and enhance the understanding, acceptance, inclusion and celebration of bisexuality and pansexuality in Australia.

Although we are based in Australia and providing counselling services to Australians, our Education Hub provides online education for service providers both nationally and internationally and our research activities will be of interest from across the globe.

What sort of issues do bisexual Australians face?

Some issues commonly reported by this community include: Feeling invisible in society can stem from their being almost no visible role models and bisexual people commonly being incorrectly presumed gay/lesbian or straight based on the gender of their partner.

Many participants in the Who I Am study reported being told their sexuality wasn't real. Gay men and lesbians tried to convince them they were really gay or lesbian and straight people insisted they were just experimenting.

Bi people report not feeling a sense of belonging anywhere, with bisexual people often experiencing biphobia and discrimination in both heterosexual and LGBTI communities. Invisibility for bisexual and pansexual Australians is a key issue that can have a profound impact on mental wellbeing.

Bisexual people talk a lot about the invisibility persisting even after they come out because people just don't understand that 'bisexual' is a stable orientation.

How do these differ from the rest of the LGBTI community?

Gay and lesbian people in Australia often have very different experiences from bisexual people with regard to visibility, coming out and community connection. There are more and more visible gay and lesbian role models in mainstream media in Australia and overseas.

Society has a growing acceptance and understanding of gay and lesbian identities which can make these sexual orientations more readily understood and acknowledged and gay and lesbian people are able to access a broad network of LGBTI communities across the nation for support.

The awareness and understanding of transgender and gender diverse people has significantly increased in the past decade and so gender diversity is becoming more visible and more commonly represented in the mainstream media. It is important now that we learn from the hard work of the other groups under the LGBTI rainbow banner and start to work towards an increasing awareness, visibility, acceptance and celebration of bisexuality.

What services will you offer?

Bi+ Australia's Support Service provides counselling support for anyone who is attracted to more than one gender or questioning their sexuality and their loved ones. Our counsellors can support people to better deal with and overcome issues relating to invisibility in their lives. In addition, our Education Hub is dedicated to ensuring that bisexuality is no longer invisible to service providers and we are working hard to ensure that service providers from anywhere, both nationally and internationally, can take advantage of our online education to assist them to work inclusively and competently with bisexual people.

Finally, our Research Centre is focussed on increasing knowledge about bisexual people by conducting, supporting and promoting bisexual research both nationally and internationally in an effort to overcome the profound silence around bisexuality in research and literature to date.

What could the rest of the LGBTI community do better to support bisexual individuals?

It is absolutely essential that LGBTI communities are inclusive and supportive of bisexual people and their diverse attractions and experiences.

Whether bisexual people are in heterosexual relationships or same-sex relationships they still belong under the rainbow flag.

Bisexuality is a stable and relatively common sexual orientation and although the challenges bisexual people face might be different to those of other sexual minority groups, there are many commonalities and much we can all learn from one another.

Bisexual people experience alarmingly high rates of poor mental health and we all need to do our bit to ensure that bisexual people feel safe, welcome and valued in LGBTI communities.

What do you hope to achieve?

We need to talk about bisexuality! The biggest issue for bisexual people is that they are essentially invisible in the broader community – an absurd concept when we look at the figures of just how many bi+ Australians there are.

If you know people who have come out to you as bisexual tell them you support who they are. If you hear someone being biphobic or ignorant about bisexuality educate them. If you are a bisexual person, take care of yourself and access support if you need it. It's time we start supporting, including and celebrating this diverse group of people in our society and stop the silence!

Media Article 3

RETRIEVED FROM:

http://www.starobserver.com.au/news/national-news/national-organisation-dedicated-improving-bisexual-mental-health-launched-australia/172318?fbclid=IwAR2SbaDJNi0wljZtQ9To-8WKo93JAgULtHfp8w35u9TGyuvW-4VQxrrQRgM

NATIONAL NEWS

NATIONAL ORGANISATION DEDICATED TO IMPROVING BISEXUAL MENTAL HEALTH LAUNCHED IN AUSTRALIA

The organisation will offer specialised counselling to bisexual Australians and their families, and will include an education hub for service providers and the public.

MATTHEW WADE — OCTOBER 9, 2018

Bisexual Pride Flag (Source: Wikimedia Commons)

A new national organisation aimed at improving the mental health of bisexual people in Australia has been established, following a study that was conducted last year.

The *Who I Am* study was conducted by La Trobe University researcher Julia Taylor and aimed to explore the reasons for poor mental health in bisexual people.

It was the largest study of bisexual Australians, and Taylor said the study's results were worse than they had previously anticipated.

"The aim of the *Who I Am* study was to shed light on the little understood reasons for poor mental health among people who are attracted to more than one gender," she said.

"What we found was high levels of psychological distress among the majority of participants.

"They told us they had to pretend to be straight in some situation and gay in others.

"They faced questions about their sexuality from members of both the heterosexual and LGBTI communities. Many participants reported being told their sexuality wasn't real, with gay men and lesbians trying to convince them they were really gay or lesbian and straight people insisting they were just experimenting.

"The very high rates of poor mental health and tendency towards suicide in this group are shocking and confirm why we need to do more to support bisexual people."

Fuelled by her findings – which she intends to publish in the coming months – Taylor has also officially launched Bi+ Australia, the first national organisation dedicated to improving mental health outcomes for bisexual people.

The organisation will offer specialised counselling to bisexual Australians and their families, and will include an education hub for service providers and the public, as well as a research centre.

"Our mission is to support people who are attracted to more than one gender and enhance the understanding, acceptance, inclusion, and celebration of bisexual and pansexuality in Australia," she said.

Last month, bisexual advocate Steve Spencer penned a piece for the *Star Observer* on Bi Visibility Day, held annually on September 23.

He highlighted the widespread misinformation and stigma around bisexual people, and how they can often prevent bisexual men from coming out about their sexuality.

"…Guys, almost always my age or younger, have faced brutal opposition to their bisexuality from within the LGBTI community," he wrote.

"I'm calling time on this crap – no-one should have to hide or feel like they're lesser than for being who they are."