Brief on

Bisexual Mental Health

For the House of Commons Standing Committee on Health

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A growing body of literature has found that bisexual people experience poorer mental health compared to both heterosexual people and lesbian and gay people (1-6). Notably, two recent systematic reviews have found that bisexual people have elevated rates of anxiety and depression (1), as well as suicidal ideation (2). Contributing to poor mental health inequities is the fact that bisexual women report higher rates of sexual victimization when compared with heterosexual or lesbian women (7).

Bisexuality is an umbrella term for a range of identities and behaviours in those sexually and/or romantically attracted to people of more than one gender (8). While other umbrella terms include plurisexual or nonmonosexual (9,10), "bisexual" and "bisexuality" will be used for the purpose of this brief. Other identities under the bisexual umbrella include pansexual, polysexual, omnisexual, and fluid, used by people who may or may not also identify as bisexual (8,9,11). People who identify as queer and Two-Spirit may also fall under the bisexual umbrella (8). As with all umbrella terms, bisexuality covers a diversity of peoples with different experiences and intersecting identities.

Conversely, the term monosexual denotes people who are attracted to one gender; that is, heterosexual and homosexual people. Monosexism refers to a range of behaviours including prioritizing homosexual and heterosexual orientations and denial of bisexuality (12). Relatedly, biphobia refers to subconscious or conscious bias, negativity, prejudice, and/or discrimination against bisexual people (1).

Biphobia can exist as heterosexism (or negative attitudes towards same sex relationships or attractions), attitudes that question the authenticity of bisexual identities, hyper focus on the sexual desires and practices of bisexual people (often by representing them as sexually deviant), and attitudes related to bisexual people as disloyal and less trustworthy (13).

Bisexual invisibility and erasure are seen in activism settings, in media, in policy, and in people's conceptions of their own orientation (1). This erasure is problematic, especially

considering that bisexual people constitute the largest sexual minority among women, comprising 0.9% (85,000) of Canadian women (14). Together with about 0.7% of Canadian men who identify as bisexual (59,000 individuals), bisexuals constitute the largest sexual minority group in Canada (14).

Bisexual people often experience biphobia in lesbian/gay communities in addition to experiences of heterosexism both in relationships with heterosexual people as well as in heterosexual communities (1,10,15). Minimal support specifically from LGBTQ2 communities, and resultant isolation contributes to poorer mental health (1,6,10,15). These experiences of discrimination, invisibility, and a lack of bisexual identity affirming mental health support have serious implications for bisexual mental health (1). Although largely understudied, research shows that these inequities are heightened for bisexual people who are racialized (6).

The commonly held assumption that bisexual women with male partners escape discrimination related to sexual orientation and associated poor mental health is not supported in the literature. Research has found that bisexual women partnered with men reported higher levels of depressive symptoms than those partnered with women (4,15). Those with male partners in the past five years report higher levels of anxiety (4). In the context of becoming a parent, research has also found that bisexual women who are partnered with men experience higher rates of postpartum depression (5).

Experiences of bisexual stigma are associated with higher rates of lifetime sexual violence and verbal sexual coercion (7). Young women report experiences of sexual violence tied to biphobia (6). They report violence related to the need to prove sexual orientation to others as well as violence tied to poor self-confidence, which some women connected to lower capacity to self-advocate (6). Following experiences of sexual violence, bisexual women are less likely to report these experiences and less likely to access sexually transmitted infection testing (7). Experiences of sexual violence are linked to biphobia and compromise the mental health of many bisexual women (6,7).

Recommendations for Mental Health Care Provision, Research, and Policy

Recommendation 1: Consider unique experiences of bisexual people in mental healthcare provision.

Research has shown that bisexual people experience poor mental health related to experiences of biphobia (1-6,15-18). A systematic review of the literature on depression and anxiety among bisexual people in relation to their heterosexual and lesbian/gay peers demonstrated that bisexual people have worse mental health outcomes than heterosexual people, and either the same or worse in relation to lesbian or gay people (1). Studies based on scores of current symptoms of depression, rates of mood disorder diagnoses, and rates of lifetime mood disorder diagnostic criteria all either showed that bisexual people had equal or worse health outcomes related to lesbian or gay people and worse compared to heterosexuals (1). Studies on sexual orientation and anxiety showed similar disparities for bisexual people. Studies looking at scores of current anxiety symptoms, prevalence in anxiety disorder diagnoses in the last year, or lifetime rates of generalized anxiety disorder diagnoses reported poorer health outcomes relative to both heterosexual people and lesbian or gay people (1). Furthermore, disparities were greater among women than among men (1). A second systematic review of literature on suicidality reported higher levels of suicidal ideation and suicide attempts in bisexual people compared to lesbian or gay participants and heterosexual people (2). Disparities were greater among women compared to men (2).

Despite the fact that bisexual people experience mental health inequities, they are often poorly served by mental health systems (11). Eady, Dobinson, & Ross (11), found that bisexual people reported encountering anti-bisexual and dismissive remarks from mental health providers (e.g., “Oh, I think that’s disgusting” in reference to bisexual identity and stating that bisexuals need to identify as gay or straight).

Conversely, validation of a service user’s bisexuality can foster self-esteem and improve mental health (19). It is important to note that knowledge of working with bisexual people is distinct from working with lesbian or gay people – health care providers should receive

education focused specifically on bisexuality (6,11,19). Bisexual health should be integrated into the education of health care providers to decrease discriminatory treatment. Best practices include not assuming that people are heterosexual, not assuming orientation based on gender of a person's sexual or romantic partner, validating people's sexual orientations, not assuming mental health issues are related to bisexuality, and self-reflection on the part of providers on their own beliefs, biases, and assumptions about bisexuality (6,11,19).

Recommendation 2: Do not pool bisexual people in groups of LGBQ data.

Research on LGBQ communities often neglects to include bisexual people (1). Indeed, many studies on LGBTQ2 people using bisexuality in their titles or keywords contain little or no focus on bisexuality (20). In a content analysis of 223 articles on LGBTQ psychology, less than 1% were focused on bisexual populations (20). Multiple studies with "bisexual" in their title, abstract, or list of keywords only reported findings on gay men and lesbian women (20). In a recent systematic review specifically searching for bisexual mental health research, 75% of articles were excluded because they did not include bisexual specific results (1).

Bisexuals have different experiences of oppression than other LGQ people, and different health disparities (1). Pooling identity categories of LGBQ data makes it impossible to direct health policy specific to bisexual people. A lack of segregated data on bisexual people contributes to their erasure and a lack of policy creation specifically aimed at bisexual Canadians. Researchers, public health practitioners, and health care publication editors can all contribute to improved research on bisexual people. Reports based off federal surveys, national data collection systems, and Canadian administrative health data should similarly report bisexual data desegregated from other LGBTQ2 data.

Bisexual people are often not identified as a group with unique needs and challenges and are thus often overlooked by policy makers (1). This must change in order to support the health of bisexuals in Canada, particularly because bisexual people are the largest sexual minority

group (14). Bisexual people face stark mental health inequities in relation to other sexual orientations. Rates of depression, anxiety and suicidality are higher among bisexuals compared to heterosexuals and either similar or higher compared to lesbians or gay men. Improvements in the mental health care of bisexuals and research on bisexual people can contribute to mental wellness for bisexual Canadians.

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