Understanding young bisexual women's sexual, reproductive and mental health through syndemic theory

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ABSTRACT

OBJECTIVES: We sought to understand how young bisexual women in Toronto perceive their sexual and reproductive health needs, the challenges to achieving those needs, and the factors contributing both positively and negatively to their sexual and reproductive health.

METHODS: We conducted a community-based research project that included an advisory committee of young bisexual women, academic partners, and a community health centre. Four 2-hour focus group sessions were conducted with a total of 35 participants. Data were analyzed through a constructivist grounded theory approach using Nvivo software.

RESULTS: Participants' discussion of their sexual and reproductive health indicated that they perceived social marginalization, particularly biphobia and monosexism, as a significant challenge to their health. Participants also discussed their sexual, reproductive and mental health as interconnected.

CONCLUSIONS: Young bisexual women in this study perceived their sexual, reproductive and mental health as interconnected and negatively influenced by social marginalization. This perception is in line with syndemic research that illustrates the interrelationship between psychosocial and sexual health. Researchers should further explore the utility of syndemic theory in understanding the complexity of young bisexual women's health.

KEY WORDS: Bisexuality; sexual health; mental health; young adult

La traduction du résumé se trouve à la fin de l'article.

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Lesbian, gay, bisexual, transgender and queer (LGBTQ) research has found that LGBTQ people report poorer mental and sexual health outcomes compared to heterosexual and cisgender people.^{1–4} Research that considers bisexual people independently from LG individuals has found that bisexuals report worse health outcomes compared to heterosexuals,^{1,3,4} and compared to LG people.^{3,5–7} Research illustrates that sexual stigma is associated with health disparities observed between sexual minorities and heterosexuals.⁷ Stressors related to bisexual identity, such as systemic disbelief in bisexuality as a legitimate sexual identity, have been investigated as determinants of health disparities experienced by bisexual people.^{3,8}

North American and Australian research found bisexual women report higher rates of negative mental health outcomes compared to monosexual women (i.e., women attracted to one sex and/or gender). Bisexual men and women have reported higher rates of anxiety, depression, and negative affect in comparison to monosexuals,⁹ and higher rates of distress in the past 30 days.¹⁰ Bisexual women reported higher rates of several mood and anxiety disorders in comparison to monosexual women,^{3,5} as well as higher rates of suicidality and self-harm compared to heterosexual women.^{3,11} Bisexual youth have reported higher rates of depressive and post-traumatic symptoms, as well as suicidality, than bisexual adults.¹² Young bisexual women have reported the highest rates of suicidality among LGB youth.¹³

Bisexual women report higher rates of negative sexual and reproductive health (SRH) outcomes in North America. Young

bisexual women have been found to be less likely than heterosexual women to use condoms during vaginal intercourse,¹⁴ and be less likely to have had a Papanicolaou test in the past year.¹⁵ Bisexual and mostly heterosexual (i.e., people with mostly other-sex attractions/behaviour) women were 40% more likely to be diagnosed with a sexually transmitted infection (STI) compared to heterosexual women,¹⁵ and more likely to report an STI history than lesbians and queer women with no male partners.^{3,16} Bisexual women have reported greater rates of severe adult sexual victimization and revictimization than lesbian women¹⁷ and higher rates of intimate partner violence (IPV) compared to heterosexuals,¹⁸ and bisexual people overall have reported a higher rate of IPV and injury from IPV compared to LG individuals.¹⁹ IPV occurs at higher rates among younger individuals, indicating rates of IPV may be higher among younger bisexual women.²⁰

Bisexual people have reported higher substance use rates compared to monosexual individuals. A Canadian study found bisexual people reported higher rates of problem drinking and

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illicit drug use in the past year compared to the general population.¹² Bisexual women have reported higher alcohol severity scores than lesbians,¹⁷ and have the highest reported levels of alcohol, tobacco and other drug use compared to monosexual people.²¹ Bisexual youth have reported higher rates of substance use over time compared to LG youth.²²

The existing research demonstrates that bisexual people, including young bisexual women, experience negative mental health and SRH outcomes. Researchers have proposed that these health disparities are driven by social marginalization associated with stigma, biphobia and monosexism.^{3,5,8,9}

Syndemic theory is used to investigate psychosocial and sexual health among LGBTQ people;²³ it describes increased burdens of health issues due to an interaction of illnesses that stem from social inequities.²⁴ Specifically, a syndemic is the occurrence of at least two comorbid health conditions within an individual or population that mutually reinforce one another to create a higher burden of illness, and this synergistic interaction is driven by oppressive social conditions,²⁵ such as sexual minority stigma. However, the majority of LGBTQ syndemics research focuses on gay and bisexual men. A search of four medical and academic databases with the terms “syndemic” and “bisexual” found 166 results, only 7 of which included sexual minority women, with a total of 6 studies that included bisexual women as an independent group. These studies were conducted in the US with youth and adults. Topics included the association of IPV and HIV status,²⁶ and trajectories of substance use among LGB youth.²²

These search results indicate a lack of research on bisexual women’s health from a syndemic perspective. The focus on HIV/AIDS within syndemics literature,²⁴ and the exclusion of LBQ women from most HIV/AIDS research, may in part account for the exclusion of bisexual women in syndemics research.²⁷ Our findings indicate that syndemic theory should be applied in health research with bisexual women in order to more fully understand the complexity of bisexual women’s health.

METHODS

As past research has pathologized LGBTQ individuals, and as youth are disempowered within research, it is important to prioritize the voices of young bisexual women. We conducted a qualitative community-based research project where academic and community partners worked together with an advisory committee of young bisexual women to develop and direct the research. The community partner has extensive experience working with LGBTQ youth and providing SRH services to young sexual minority women. The lead community investigator has been involved in research, community building, and service provision for and with bisexual youth and adults for over 10 years, and identifies as bisexual.

Data collection

Data were collected through four 2-hour focus groups, each with 7–12 participants. A total of 35 people participated. Focus groups were conducted in August 2014. A semi-structured focus group guide was used in the sessions. The primary goals included identifying young bisexual women’s perceptions of: 1) the challenges to their SRH, 2) the factors contributing to their SRH, 3) their SRH needs, 4) perceived causes of young bisexual

women’s SRH disparities, and 5) suggestions for change. Before each focus group, participants gave written informed consent, completed a demographic questionnaire, and received a small honorarium.

Participants

A convenience sample of participants was recruited in the Greater Toronto Area through LGBTQ organizations, youth services, social media, listservs, paper advertisements, and youth advisory committee members’ social networks. Women (defined as anyone who identified as a woman, including transgender women and other people who felt the label “woman” applied to them) ages 16–29 who identified under the “bisexual umbrella,” including women who identified as bisexual, pansexual, omnisexual, fluid, queer, and/or were attracted to people of more than one gender and/or were sexually active with more than one gender, were invited to participate.

A total of 56 people were screened by the research coordinator. We used purposive sampling to ensure representation of diversity in gender identity (i.e., cisgender and transgender), ethnocultural background, ability and age in our selection of 35 participants. Participant demographic data are shown in Table 1.

Table 1. Participant demographic information

Variable	n	%
Gender identity		
Woman	34	97%
Genderqueer	3	9%
Trans woman	2	6%
Femme	1	3%
Ambiguous	1	3%
Bigender	1	3%
Sexual identity		
Bisexual	20	57%
Queer	12	34%
Pansexual	9	26%
Other*	10	29%
Ethnocultural identity		
Black African	3	9%
Black Caribbean	4	11%
Chinese	1	3%
Filipino	2	6%
Jewish	4	11%
South Asian	2	6%
West Asian	1	3%
West Indian	1	3%
White	25	71%
Age (years)		
16–18	2	6%
19–21	7	20%
22–24	11	31%
25–27	11	31%
28–29	4	11%
Highest level of education		
Some high school	3	9%
Some trade school	1	3%
Some college or university	15	43%
Completed college or university	10	29%
Some post-graduate	1	3%
Completed post-graduate	6	17%
Annual household income		
<\$10,000	2	6%
\$10,000–\$19,999	12	34%
\$20,000–\$29,999	6	17%
\$30,000–\$39,999	3	9%
≥\$40,000	9	26%

* Other sexual identities reported include: universal, dyke, poly, kinky, multisexual, sexual, fluid, and attracted to multiple genders and sexes.

Data analysis

Focus group sessions were audio recorded and transcribed verbatim. Each transcript was analyzed independently by two researchers using a constructionist grounded theory approach. Grounded theory is recommended when engaging in exploratory research of social processes, and constructivist grounded theory is a methodological framework that recognizes the importance of researcher reflexivity, such as our positionality as LGBT community members, as an active element in the analysis process.²⁸ We do not adopt a positivist viewpoint of data analysis, but rather recognize that our experiences inform the ways in which we engage with the analysis process, and as such our findings are “a product of the research process, not simply observed objects.”²⁸, p. 402 Nvivo 9 was used to code the data. Disagreements in coding between researchers were resolved in group meetings. After the initial coding process, selective coding procedures were implemented to explore relationships between the separate themes to understand how participants perceived the interrelationships between their SRH and mental health. The advisory committee of young bisexual women verified the codes.

RESULTS

The analysis of the focus group data revealed that participants discussed their experiences of mental health, SRH and substance use in a manner consistent with the syndemic framework.²⁴ Participants detailed how domains of their health interacted with one another in such a way that health outcomes were exacerbated due to other health experiences, and related these occurrences back to the social marginalization they experienced as young bisexual women. The interactions addressed here are between mental and sexual health, including: sexual risk behaviour; mental health and sexual violence; mental health, sexual health and substance use; and mental health, resilience and support.

Mental health and sexual health

Participants discussed the interaction between mental and sexual health, including how these interactions were influenced by social marginalization. One participant described how the lack of an accepting community affected this interaction:

“Not having a community, or an accepting community, I feel has made it so that there's just a complete lack of opportunity to be sexual with anyone who isn't a cis, het male... And that lack of opportunity to be sexual in the way that I want to, and that is healthy for me, I think is [pause] detrimental to my mental health as well, and it means that I start thinking, ‘Oh, there's something wrong with me, there's something wrong with my desires, my preferences [pause] who I am...’”

Another participant articulated how dealing with mental health issues as a result of social marginalization led to greater difficulties in navigating sexual situations:

“[E]veryone's talked a lot about feeling very sexualized or that our sexual orientation are, like, a performance for men, or being unable to find [pause] community in which to [pause] like, even find female partners who are ok with the fact

that we have male partners...it can lead to a lot of confusion, and lower self-esteem, less confidence...and the kind of propositions that we receive...people were talking about the threesomes...I think that it kind of adds up to a [pause] bisexual women receive more propositions about various stuff, but have less like [pause] self-confidence...less support, more confusion about ‘Where do I fit?’ and ‘What can I say? Is it worth it?’”

Some participants also discussed how mental health and sexual risk behaviors were interconnected and simultaneously exacerbated by social marginalization:

“[S]omething that's tied into depression a lot is low self-esteem as well, which I think could be associated with being bisexual and having all the stressors that are involved, and having low self-esteem can also, I don't know, I guess make you feel like it's ok to involve yourself in risky sexual situations, like almost like you deserve it, or you need to engage in this in order to please your partner, or this is what you need to give them, as part of your sexuality.”

Another participant expressed how feeling pressured to engage in certain sexual behaviours as a result of exposure to biphobic stereotypes influenced her mental health:

“[W]hen I've come out in the past I've been asked to [pause] physically demonstrate that I'm bisexual... when I was younger I was like, ‘Well, yeah ok, I definitely have to have the checklist of partners on all of these sides of the columns, so that—and they have to be going on concurrently, so that I can prove beyond a shadow of a doubt, I can supply you with 5 references that I am bisexual today.’ ...and it's increased depression I felt, because I've had happy monogamous relationships that I've really destroyed over the idea of, well, everyone keeps telling me I can't be bi and have this monogamous relationship...”

The influence of social marginalization on health was not only limited to sexual identity, but also other intersecting identities for some participants, such as race and ethnicity:

“I remember making out with a lot of people in high school just because I felt on the outskirts and it was also, people were saying that I was a lesbian, and coming from a [Caribbean] background, you can't be a lesbian, and so [pause] like, ‘Oh, maybe I should make out with this guy’... I think that a lot of bisexual women have several partners just because they're trying to create a façade and they're trying to defeat another façade, and it's a self-esteem issue at play.”

Mental health, navigating consent, and sexual violence

Participants linked mental health with challenges in navigating consent and experiences of sexual violence, and related this to marginalization of their bisexual identity. One participant directly tied lack of community support for young bisexual women to difficulties in navigating consent:

“I think the teen pregnancy and the multiple partners and everything does come from navigating consent and from self-esteem, because I feel that if [young bisexual women]

don't feel we have the community to support us, then we just have to go to anyone who says 'hello' to us and gives us a smile, and so [pause] it's not necessarily 'I'm consenting to have sexual relations with you,' it's just, 'I'm not saying no.' "

Another participant discussed how mental health connected to her sexual health in terms of navigating consent:

"[I]f I'm of sound mind and I understand myself and my feelings and what's getting tossed at me, then I can take care of my physical entity better...when I've been in therapy I've outed myself as bisexual; I can't remember my therapist ever addressing my bisexuality...there's something about acknowledging that, that would have made it possible for me to have a lot of the discussion I needed to with my therapists, surrounding consent."

A participant also stated how difficulty in successfully navigating consent could affect mental health:

"It also gets confusing, because I'm rather kinky as well, and into some pretty serious BDSM stuff, so it's like, to draw the line there between consent, consensual non-consent...and mental health-wise it's definitely impacted that, because I don't really have anyone I can talk to about this that I feel safe talking to, not even my mom."

Beyond navigating consent, participants reported incidences of other types of sexual violence, and how that interacted with their mental health:

"[O]ne of the things that happens to me is that I dissociate, so [pause] a lot of sexual health risk things have happened when I'm just kind of [pause] gone. Like, left my body, just going through the motions, and kind of watching, and then it's like, 'Oh no! Stop!' and it's like, 'Oh, look at me keep going right now, with no control over this whatsoever, that I'm consciously connected to'...so much of this has not been about a healthy expression of who I am and what I desire so much as just like... 'Ok, here's my body, tear it up!' "

Mental health, sexual health and substance use

Participants discussed how substance use affected their experiences of SRH and mental health. While some participants explained that substance use was positively interwoven into their sexual experiences, other individuals felt it had been problematic:

"It's always important to highlight substance abuse and addiction in our communities, queer community more generally...just that that's an issue, and how that connects with mental health, and how that might connect as well with unsafe sexual practices."

Another participant linked substance use to difficulty in safely negotiating sexual encounters:

"[S]ometimes I'll get high and have sex, but sometimes I'll get high and then be concerned about having sex that's like kink sex, because [pause] sometimes I may not know the limit or the other person may not know the limit, especially if we are both getting intoxicated."

A participant also expressed how issues relating to sexual identity, sexual risk and addiction came together for her:

"For bisexual people who have sex with people from across the gender spectrum, or both men, women, however you define bi, it's like all the risk, it's there and [pause] sometimes there can be a lot more of it, and also, if you're dealing with addiction issues on top of that, it's just like intersectional problems, just all meeting in the middle."

Resilience and support

While much of participants' discussion around mental health, sexual health and substance use centered on ways in which negative outcomes interacted with one another across these domains, some participants discussed support they received in relation to these health challenges. A few participants felt they received support from their health care service providers:

"[T]he centre we are in right now, if you identify as bisexual, no matter where in [Ontario] you live, you can have a family doctor and/or counselor here...And I come here, it's awesome, and my therapist is here, and I have a family doctor here, and they have all kinds of other services and support groups and stuff here too that are really great, that I totally recommend."

Another participant discussed how a supportive relationship partner helped her manage trauma from past sexual violence in the context of sexual encounters:

"I had gone through a lot of sexual abuse as a child and I was sexually assaulted as a teenager, and as an adult as well. And [pause] he was super understanding, in every sense of the way, he could almost feel if I felt uncomfortable during sexual times and would always check in...he was just an amazing person, so after all the bullshit that I went through, and then to have, or be with someone that was so understanding was a really great experience."

Other participants detailed how community groups and friends offered support around their sexual health:

"[B]eing involved in the feminist community and having a lot of sex positive experiences and knowledge being thrown around, and knowing that having sex with who you want to have sex with is empowering, and having sex is empowering, and [pause] just having partners who are very open to the fact that my sexuality doesn't [pause] completely define my life, but it is a part of my life."

Suggestions for change

Participants offered suggestions for change to improve mental and sexual health outcomes. This included educating doctors and the general public about bisexuality in order to decrease the marginalization that young bisexual women experience:

"[I]n terms of mental health, I would really love a fact sheet that says, 'These are fair questions to ask people who identify as bisexual, and this is just you being biphobic.' "

And:

"I would want...physical sexual health providers to either [pause] be able to talk about the mental and emotional side

of things as well, because so much of it for me is tied together so strongly, or for them to be able to refer to someone and not have it be a 9-month wait...I've accessed 6 or 7 different counseling services in my lifetime, and anytime I've tried to talk about my anxiety related to [pause] relationships, coming out, anything like that [speaks haltingly, as though speaking through tears] it's been really brushed off, and pushed right back to my hetero relationship."

DISCUSSION

Our data suggest that young bisexual women perceive biphobia and monosexism as significant challenges to their SRH and mental health. This is consistent with research that has found social marginalization to be a predictor of health.^{7,29} Participants' discussion of different domains of their health as interactive indicates they do not perceive their mental health to be independent from their SRH. This reinforces the importance of a syndemic framework for understanding young bisexual women's health.

Past literature within syndemic theory has found that experience of social stressors increases the risk of STI transmission, substance use, and other negative mental health outcomes for gay and bisexual men.³⁰ This is congruent with the health experiences detailed by our participants, and this corroboration increases the likelihood of our data's generalizability. Further, participants' desire for a holistic approach to health care aligns with previous findings.³¹

Young bisexual women experience high rates of negative sexual and mental health outcomes. While research has found evidence of these health disparities, to our knowledge the current research is one of the first studies that investigates how young bisexual women perceive these negative health outcomes as interacting and reinforcing one another. We found that young bisexual women describe biphobia and monosexism as instrumental in their experience of health, highlighting the need to challenge these systemic forms of oppression to reduce marginalization and promote health.

Limitations and future research

Study limitations include the convenience sampling strategy, and the geographical restriction to Toronto. These factors limit participants to those who saw the recruitment materials and live in a relatively progressive urban area. Our findings may not apply to young bisexual women in other parts of Canada. However, as biphobia and monosexism were identified as negatively affecting participants' health, we anticipate that individuals living in less tolerant social climates would potentially experience worse health outcomes.³²

Due to the nature of focus group methodology, all participants had to be comfortable identifying themselves as bisexual within a group of people and speaking in the group. This limited participants to those who were comfortable disclosing their sexual identity, and thus may not be representative of young bisexual women overall.

Future research should take into account the findings that young bisexual women experience their health as complex and interconnected, and that they would therefore benefit from research that investigates health from a more holistic perspective. Syndemic theory is uniquely situated for this challenge,

particularly considering the role social marginalization plays in contributing to negative health outcomes.

CONCLUSION

Study findings suggest that young bisexual women perceive their mental health and SRH as interdependent, and as influenced by biphobia and monosexism. As such, it is important that future LGBTQ health research expands to include syndemic frameworks of understanding with both bisexual women specifically and sexual minority women more broadly.

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RÉSUMÉ

OBJECTIFS : Nous avons cherché à savoir comment les jeunes femmes bisexuelles à Toronto perçoivent leurs besoins de santé sexuelle et génésique, les difficultés à combler ces besoins et les facteurs qui contribuent positivement et négativement à leur santé sexuelle et génésique.

MÉTHODE : Nous avons mené un projet de recherche communautaire incluant un comité consultatif de jeunes femmes bisexuelles, de partenaires des milieux universitaires et de représentants d’un centre de santé communautaire. Quatre séances de discussion collective de deux heures chacune ont été menées avec 35 participantes en tout. Les données ont été analysées selon l’approche constructiviste de la théorisation ancrée à l’aide du logiciel Nvivo.

RÉSULTATS : La discussion par les participantes de leur santé sexuelle et génésique a indiqué qu’elles perçoivent la marginalisation sociale, particulièrement la biphobie et le monosexisme, comme posant un défi considérable pour leur santé. Les participantes voient également leur santé sexuelle, leur santé génésique et leur santé mentale comme étant interreliées.

CONCLUSIONS : Les jeunes femmes bisexuelles de notre étude perçoivent leur santé sexuelle, leur santé génésique et leur santé mentale comme étant interreliées et négativement influencées par la marginalisation sociale. Cette perception est conforme à la recherche syndémique, qui illustre l’interpénétration entre la santé psychosociale et sexuelle. Les chercheurs devraient pousser leur exploration de l’utilité de la théorie syndémique pour comprendre la complexité de la santé des jeunes femmes bisexuelles.

MOTS CLÉS : bisexualité; santé sexuelle; santé mentale; jeune adulte