ABSTRACT

Title of Dissertation: EXPLORING YOUNG BI+ WOMEN'S INTERSECTING MENTAL HEALTH AND SEXUAL AND REPRODUCTIVE HEALTH EXPERIENCES IN CONTEXT: A MULTI-ANALYTIC METHOD QUALITATIVE STUDY

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Young bi+ women report worse mental health and sexual and reproductive health (SRH) outcomes compared to gay, lesbian, and straight young adults. They experience intersecting threats to their health and well-being due to their sexuality, gender, and stage of development. There is a lack of research on bi+ women's unique mental health and SRH experiences, and often bi+ women are overlooked due to bi-erasure and biphobia. Regressive policies related to LGBTQ+ and women's rights, including increased restrictions to reproductive healthcare after the *Dobbs v. Jackson Women's Health Organization* decision overturning abortion protections, further threaten bisexual women's health. This dissertation used a multi-analytic method qualitative approach to explore the intersecting mental health and SRH experiences of young bisexual women in the current socio-political context. Semi-structured in-depth interviews were conducted over Zoom with 16 young bi+ women from across the U.S. A narrative inquiry

approach was used to explore young bi+ women's mental health experiences and coping strategies. In addition, thematic analysis was used to investigate how young bi+ women describe their mental health as intersecting with their SRH in the current socio-political context.

The study yielded rich and nuanced information about challenges these young bi+ women experienced throughout their lives that affected their mental health and SRH. Experiencing trauma had far-reaching negative effects on their mental health. Participants discussed the challenges of forming their identity within the social context, particularly as bi+ women in a society that often invalidates bisexual identities and subjugates women. They also discussed the joys along with difficulties of navigating young adulthood. They further described coping with challenges in a variety of adaptive (e.g., therapy, exercise) and maladaptive (e.g., substance use, self-injury) ways. They discussed relying on social support such as partners, friends, family, therapists, and teachers. Participants desired more support with sexuality-related issues, particularly in early adolescence. These bi+ women described their mental health and SRH as intertwined and discussed how bodily autonomy and agency were essential to their well-being. The socio-political context, including social norms, rhetoric, and federal- and state-level policies, influenced participants' well-being.

The current study shows that young bi+ women face unique threats to their mental health and SRH. Practice implications include improving access to affordable and LGBTQ+-affirming healthcare and developing interventions attuned to the needs of young bi+ women. Policies are needed that uphold the choice and agency of young women in their reproductive health decision-making. Future research should continue to explore the needs and experiences of young bi+ women concerning their mental health and SRH including demographic differences along with potential mechanisms resulting in poorer health.

EXPLORING YOUNG BI+ WOMEN'S INTERSECTING MENTAL HEALTH AND SEXUAL AND REPRODUCTIVE HEALTH EXPERIENCES IN CONTEXT: A MULTI-ANALYTIC METHOD QUALITATIVE STUDY

by

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Preface

This dissertation is the original, unpublished, independent work of the author, Jennifer Lynn Robinson.

Dedication

This dissertation is dedicated to my wonderful participants. Thank you for trusting me with your stories. And to all the young bi+ women and queer youth who feel like they don't belong or are struggling with their identity – you are not alone.

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And thank you to my two cats, Sassafras and Willow – the best dissertation assistants.

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List of Abbreviations

CDC	Centers for Disease Control and Prevention
DACA	Deferred Action for Childhood Arrivals Program
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Queer, or other non-heterosexual identities
NCHS	National Center for Health Statistics
SAMHSA	Substance Abuse and Mental Health Services Administration
SRH	Sexual and Reproductive Health
WIC	The Special Supplemental Nutrition Program for Women, Infants, and Children

Chapter 1: Background, Theoretical Framework, and Significance

Young bi+ women's health is informed by their developmental stage, gender, and sexual identity. This chapter provides an overview of these factors to provide context for the current study, which sought to understand the mental health and sexual and reproductive health (SRH) needs and experiences of young bi+ women. This chapter also describes the theoretical framework that underpinned the study and the research questions that guided it.

Background

Young Adulthood

Young adulthood (ages 18-25 years old) is a critical time of development, particularly for young adults' mental health and SRH. Seventy-five percent of mental health disorders emerge before age 25, and young adults ages 18-25 have the highest prevalence of mental illness out of all adults (Kessler et al., 2007; Substance Abuse and Mental Health Services Administration, 2021). According to the National Survey on Drug Use and Health, in 2021, 11.3 million young adults ages 18-25 in the United States reported any mental illness in the past year and 8.6 million reported having a substance use disorder. This is higher than any other age group and is increasing from previous years (SAMHSA, 2022).

Young adulthood is a period of upheaval and change. The transition to adulthood comes with numerous challenges. Youth may be leaving home for the first time, coping with academic or career-related instability or challenges, and dealing with other life changes (Bradshaw et al., 2012; Grant & Potenza, 2010). Hormonal and neurodevelopmental changes during this time further explain the onset of mental disorders during this period. The prefrontal cortex is in a period of development that makes it vulnerable to environmental stressors that can lead to the onset of mental illness (Carlson et al., 2012). Developmental research shows that young

adulthood is an important time period where youth are finding a sense of self and identity, including their sexual identity, alongside forming social attachments and navigating friendships and romantic relationships (Bradshaw et al., 2012; Fish, 2022; Russell & Fish, 2019). Stress, especially chronic stress along with multiple stressful events, is linked with mental illness. As young adults take on more adult roles and responsibilities, they may experience stress that exacerbates mental health symptoms (Bradshaw et al., 2012). LGBTQ+ youth are coming out (i.e., revealing their sexuality to others) at earlier ages when they are vulnerable to peer victimization and mental health issues (Fish, 2022; Russell & Fish, 2019).

Mental health challenges among young adults have increased over the past decade and challenges related to the COVID-19 pandemic exacerbated this trend (Adams et al., 2022; Fish et al., 2021; Lipson et al., 2019, 2022). Before the pandemic, young adults had the highest rates of mental illness among all adults, and the increase in rates of mental illness had been increasing more drastically than that of other age ranges (Goodwin et al., 2020; Twenge et al., 2019). Since the pandemic, these rates have increased even more. For example, rates of anxiety increased from 9% to 21% and rates of depression increased from 9% to 39% (Daly & Robinson, 2021; Ettman et al., 2020). In 2021, 48% of young adults reported struggling with mental health challenges (Adams et al., 2022). Factors such as loneliness, isolation, grief and loss, and job and education instability contributed to mental health issues among young adults, exacerbated among those already vulnerable such as LGBTQ+ youth, those from lower socio-economic backgrounds, racial and ethnic minorities, those with foster care histories, and those with histories of trauma and maltreatment (Fish et al., 2021; Ganson et al., 2021; Roche et al., 2022; Shpiegel et al., 2022; Son et al., 2020). In 2020, 59% of young adults experienced employment loss for themselves or someone in their household (Ganson et al., 2021; Lee et al., 2020).

There is also a large unmet need and barriers to accessing mental healthcare within this population, and a third of young adults with mental health struggles reported unmet mental health needs in 2021 (Adams et al., 2022). Higher rates were reported among women, Hispanics, and those who were uninsured (Adams et al., 2022). Unaddressed mental health concerns can have devastating consequences. They can lead to distress, poor academic achievement, physical and mental health burdens, and dropping out of school (Breslau et al., 2008; Hunt & Eisenberg, 2010; Kessler et al., 2001; Morton, 2018). They can also lead to suicide, which is the second leading cause of death in people ages 10-34 (Garnett et al., 2022).

The age range when youth may first develop mental health challenges overlaps with the time period when young adults are forming their sexual identities and may experience their first sexual experiences and romantic relationships, which can be particularly fraught for LGBTQ+ youth who are figuring out their identity during this critical time period (Russell & Fish, 2019). LGBTQ+ youth experience stigma, discrimination, and othering during this time period which contributes to mental health challenges and results in worse health outcomes (Feinstein & Dyar, 2017; Ross et al., 2014). Additionally, young adults are vulnerable to poor SRH outcomes during this time when they are forming sexual identity and first experiencing sexual and romantic relationships. Young adults often engage in riskier sex, including sex with multiple partners and sex without a condom, than older adults. It is estimated that half of new STI cases is among adolescents and young adults ages 15-24 (Centers for Disease Control and Prevention, 2021). Young adults are more vulnerable to sexual assault, intimate partner violence, and exploitation, along with SRH outcomes such as STIs and unplanned pregnancies, than older adults (CDC, 2021; Mumford et al., 2020). The COVID-19 pandemic further impacted young adult's SRH during a critical time for their sexual development. For instance, social distance possibly limited

sexual encounters, but also potentially disrupted access to sexual and reproductive healthcare (e.g., screenings, treatment, contraception, and abortion) (Lindberg et al., 2020).

LGBTQ+ History and Context

People in the United States who identify as lesbian, gay, bisexual, transgender, queer, or other non-heterosexual identities (LGBTQ+) has doubled in the past 10 years to 7.1%, as society has seemingly become more accepting of non-heterosexual identities and relationships. Identifying as LGBTQ+ is particularly common among younger adults, with one in five young adults in "Generation Z" (the generation of young adults born approximately between 1997 and 2012) identifying as LGBTQ+ in a 2021 Gallup poll (Jones, 2022). One definition of bisexuality is as "the capacity for emotional, romantic, and/or physical attraction to more than one sex or gender, and that capacity for attraction may or may not manifest itself in terms of sexual interaction" (Feinstein & Dyar, 2017). Bisexual activist Robyn Ochs defines it as, "the potential to be attracted—romantically and/or sexually—to people of more than one sex and/or gender, not necessarily at the same time, not necessarily in the same way, and not necessarily to the same degree" (Ochs, 2014). Bisexual and bi+ have been used as umbrella terms to recognize individuals who experience potential for romantic and sexual attractions for more than one gender but may use different labels (e.g., pansexual, queer) (Bisexual Resource Center, 2023). Recent research indicates there has been an increase in people identifying both as bisexual and as other plurisexual identities (i.e., attraction to multiple genders or regardless of gender; e.g., pansexual). Bisexuality currently makes up the largest percentage of the LGBTQ+ population (57%) despite often being left out of the conversations around LGBTQ+ issues (Hayfield, 2022; Jones, 2022; Swan & Habibi, 2018).

There have also been changes in how people perceive the meaning of terms such as bisexual, pansexual, omnisexual, and queer. Pansexuality was originally defined by some as moving beyond the gender binary and attraction regardless of gender, as opposed to bisexuality, which was defined as only attraction to men and women. In recent years, however, bisexuality has often been viewed as inclusive of all genders and not just the binary of attraction to men and women. For instance, it can include attraction to trans, nonbinary, and genderqueer people (Hayfield, 2022). Younger people may also use terms differently than older people. For instance, those ages 18-25 in the Generations Study, a longitudinal cohort study of LGBTQ+ health with three different age cohorts, were more likely to identify as queer than the older cohorts ages 34-41 and 52-59 (7.1% versus 6.0% and 1%, respectively) (Goldberg et al., 2020).

Despite LGBTQ+ people being more accepted in society and more people self-identifying as LGBTQ+, these individuals continue to face threats to their well-being, including discrimination and violence, and have worse health outcomes than straight people (Feinstein & Dyar, 2017; Meyer, 2003; Ross et al., 2014). Young bisexual people experience worse mental health and SRH outcomes compared to monosexual (i.e., attraction to one gender, whether straight, gay, or lesbian) young adults (Alexander et al., 2016; Conron et al., 2010; Dunlop et al., 2020; Feinstein & Dyar, 2017; Fish et al., 2021; Higgins et al., 2019; Kerr et al., 2013). Furthermore, bisexual young adults experience higher rates of depression and post-traumatic stress disorder than bisexual adults, making the time period of young adulthood critical for this group (Ross et al., 2014). Importantly, during the COVID-19 pandemic, bisexual young adults reported worse mental health outcomes compared to other sexual minority groups (Fish et al., 2021). Despite the increase in those identifying as bisexual and related plurisexual identities,

there is a dearth of information regarding the causes of these disparities and how to reduce and ultimately eliminate them (Swan & Habibi, 2018).

Bi-erasure (i.e., the belief by both straight and queer communities that bisexual people's identities are not valid), causes bisexual youth to feel othered and stigmatized that causes them to feel like they lack a community and social support (Doan Van et al., 2019; Feinstein & Dyar, 2017). Feelings of belongingness and connection to community are both protective of mental health. Bisexual youth may choose not to come out to family, peers, or their healthcare providers due to fear of stigma and discrimination (Ehlke et al., 2020). There is a belief in both queer and straight communities that bisexuality is a "phase." However, the research clearly illustrates that bisexuality is not a phase and is stable across time (Diamond, 2008).

Bisexual Women's Health

Young bisexual women experience intersecting challenges related to both their gender and sexuality and experience worse mental health and SRH outcomes than monosexual young women. Bisexual women experience higher rates of mood and anxiety disorders, eating disorders, substance use, self-injury, suicidal ideation, and risk of suicide (Conron et al., 2010; Dunlop et al., 2020; Feinstein & Dyar, 2017; Kerr et al., 2013). The COVID-19 pandemic exacerbated existing mental health challenges and disparities among bisexual women. Compared to heterosexual women, bisexual women reported worse mental health, physical health, and quality of life during the pandemic. They also reported stress, loneliness, psychological distress, and fatigue (Fish et al., 2021).

Bisexual young women may fear being treated differently by health professionals or may have had poor experiences in the past with healthcare providers, leading to their healthcare needs being unmet. Their intersecting identities of being both women and bisexual cause them to be

more likely to be stigmatized within healthcare settings. For instance, healthcare providers have negative perceptions of bisexual people (Jabson et al., 2016). Also, in general, women have been mistreated by the healthcare system (Verdonk et al., 2009).

Bisexual young women have poorer SRH outcomes compared to straight and lesbian women. Bisexual young women are more likely to experience reproductive coercion, rape, physical violence, and stalking when compared to monosexual women (Alexander et al., 2016; Breiding & Black, 2014). Survivors of sexual violence often suffer from post-traumatic stress disorder, distress, depression, anxiety, and suicidal ideation (Alexander et al., 2016; Basile & Smith, 2011). Bisexual women report higher rates of sexual risk behaviors such as more sexual partners, trading sex for resources, and less contraceptive use. They also have higher rates of unintended pregnancies and sexually transmitted infections (Alexander et al., 2016; Higgins et al., 2019). Mental health and SRH can be intertwined, so consideration of both is important to understand the complete picture of bisexual women's mental health (Flanders et al., 2015; Timilsina, 2018). In addition, restrictions to reproductive health care as a result of the recent *Dobbs v. Jackson's Women's Health Organization* Supreme Court decision may disproportionately affect this already marginalized population (*Dobbs v. Jackson Women's Health Organization, 597 U.S. ___*, 2022).

Theoretical Framework

In 2011, the Institute of Medicine provided a framework to guide research to better understand LGBTQ+ health. This framework incorporates theories such as minority stress, life course, intersectionality, and social ecology. This framework for understanding LGBTQ+ health, and the theories it includes, drives this study (Institute of Medicine, 2011). Additional theories

such as the Theory of Gender and Power and the Reproductive Justice Framework also inform the current study (Connell, 1987; Ross, 2017; SisterSong, 2023; Wingood et al., 2000).

The Institute of Medicine Framework for Understanding LGBTQ+ Health

Minority Stress Model

The minority stress model has been used for the past 40 years to explain the disparities experienced by sexual minorities. Dr. Ilan Meyer's publications from the 1990s and early 2000s are often cited in the literature as the seminal work for understanding sexual minority stress and its impact (Meyer, 1995, 2003). His conceptualization greatly impacted how researchers understood sexual minority stress, but Dr. Virginia Brooks was actually the first researcher to describe sexual minority stress in her 1977 dissertation that was then later published in her book *Minority Stress and Lesbian Women* (Brooks, 1981; Rich et al., 2020). The minority stress model describes specific stressors that minoritized communities experience that contributes to health disparities. According to Dr. Brooks, minority stress is the "state intervening between sequential antecedent stressors of culturally sanctioned, categorically ascribed inferior status, resultant prejudice and discrimination, the impact of these forces on the cognitive structure of the individual, and consequent readjustment or adaptational failure" (Brooks, 1981). Her model uses a systems approach to understanding the factors that affect minority stress, including cultural, social, psychological, and biophysical influences. Both she and Meyer include prejudice and discrimination as mediating factors; however, Brooks also included economic factors in her model. This may be particularly salient for sexual minority women who must cope with the economic implications of living within a patriarchal capitalist society that often puts women at a disadvantage economically (Brooks, 1981; Rich et al., 2020).

Dr. Meyer's original work from 1995 focused on the chronic stress gay men experience as a result of their stigmatization from mainstream society. In this study, gay men who experienced chronic stressors related to stigma and discrimination experienced worse mental health outcomes. His 1995 study conceptualized minority stress as the consequence of three major factors: internalized homophobia, stigma, and experiences of discrimination and violence (Meyer, 1995). He then followed up with a conceptual framework that further explains how the stigma, prejudice, and discrimination that sexual minorities experience living within a heterosexist society can have a deleterious effect on health. His model was influenced by social stress theory which implicates the social environment in creating stress and leading to poor outcomes. The core of the model, which shows that stigma negatively affects health, also builds upon theories related to prejudice and stigma (Crocker et al., 1998; Goffman, 1963; Link & Phelan, 2001). In his 2003 paper, Meyer proposes a distal-proximal understanding of the minority stress process, distal referring to objective events and conditions, and proximal referring to subjective understandings of the individual (Meyer, 2003). The minority stress model has since been expanded to other sexual minority groups including lesbian and bisexual populations (Frost et al., 2022; Meyer, 2003; Meyer et al., 2021).

Life Course Perspective

LGBTQ+ people experience minority stress across age groups, but it is important to consider the age and cohort of the population to best understand their experiences of minority stress and the developmental and health implications. A life-course perspective considers both the developmental stage along with the socio-historical context and how those two converge. This framework recognized that experiences from earlier in life affect their outcomes later. Events may have differing impacts on individuals depending on their stage of development

(Institute of Medicine, 2011). For instance, coming out at a younger age may have a different developmental impact than those who come out later in life (Fish, 2022; Russell & Fish, 2019). Further, the IOM suggests the importance of recognizing the stage of life someone is in when conducting research with LGBTQ+ populations. Current research on LGBTQ+ young adults recognized a higher rate of mental illness and suicidal ideation, higher rates of substance use, less use of preventive health services, and experiences of stigma and discrimination. The IOM recognizes that it is important to understand differences based on age and cohort as the best approach to research LGBTQ+ health issues. The current study includes those in young adulthood, ages 18-25.

Intersectionality

Along with considering age and cohort, it is important to recognize that bisexual young women have multiple, intersecting identities that influence their perceptions, behaviors, and outcomes. Intersectionality, coined by Kimberlé Crenshaw in 1989, posits that experiences of systematic oppression based on gender, sexuality, race, ethnicity, disability, class, and other identities are uniquely combined to create discriminatory experiences for the individual (Cooper, 2016). The current study focuses on bisexual young women, but these young women belong to other groups that contribute to their experiences of minority stress, social support, community, mental health, substance use, and SRH.

Social-ecological Model

This model states that outcomes are a result of factors at multiple levels, including individual, interpersonal, organizational, community, and public policy. Bisexual young women's beliefs, attitudes, knowledge, and behavior are influenced by their social environment

and the different levels of the social-ecological model influence each of the other levels while ultimately affecting bisexual women's health (McLeroy et al., 1988).

Additional Theories: Theory of Gender and Power and Reproductive Justice Framework

Whereas IOM's framework for LGBTQ+ research provided a solid underpinning for the current study, theories focused specifically on women and reproductive justice further guided the current study. This is important as bisexual women exist within co-occurring systems of oppression beyond just their status as sexual minorities, but also as their status as women in a patriarchal society.

The Theory of Gender and Power describes the power differentials that affect women's lives, behaviors, and health outcomes (Connell, 1987; Wingood et al., 2000). It has been applied to health topics such as HIV (Wingood et al., 2000). Women are affected by unequal power and gender norms through multiple mechanisms such as sexual division of labor, sexual division of power, and cathexis (social norms and affective attachments). Because of this, women have unique risk factors that affect their health and well-being.

Reproductive Justice is "the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities," according to the SisterSong Women of Color Reproductive Justice Collective (L. Ross, 2017; SisterSong, 2023). The current study explored young bi+ women's mental health and SRH in the current socio-political context, which includes threats to their reproductive rights and justice as outlined by SisterSong. The current study was informed by both the understanding of the unequal power between women and men in a patriarchal society as outlined by the Theory of Gender and Power, along with the understanding that women have certain reproductive rights as outlined by the Reproductive Justice Framework.

Theoretical Framework for the Current Study

The current study incorporates elements of the theories and frameworks previously discussed to develop a guiding framework shown in Figure 1. For this study, bi+ young women are understood in context, including their relationships, organizations, and communities. Further, attention is paid to how public policy and larger systems influence young bisexual women's health, particularly intersecting systemic oppression and systems of power. Lastly, the current study is guided by the understanding that the developmental stage and socio-historical context of the young women in the study are important to consider.

The theoretical framework below informs my approach to the research including the development of the interview questions and analysis. For instance, participants were asked about factors influencing their mental health and SRH at various levels of this model, including their feelings towards their sexuality, relationships and community connectedness, and the social and political context, across their childhood, teenage years, and adulthood.

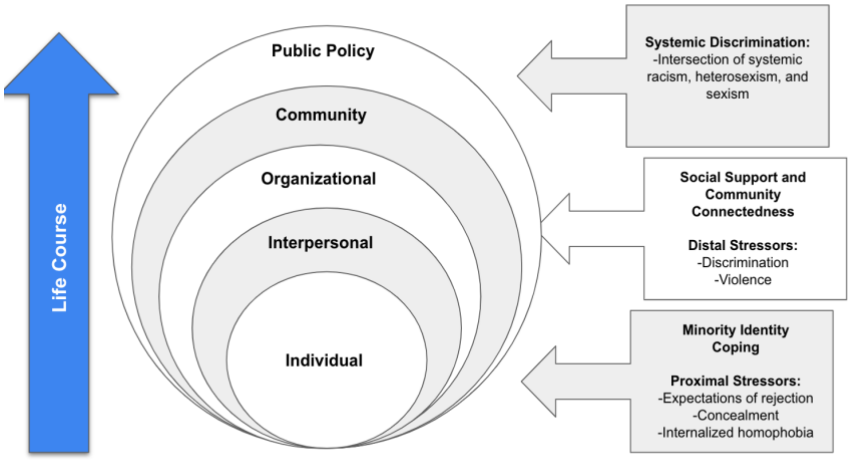

Figure 1. *Theoretical Framework for the Current Study.*

Significance

Although research has shown that bisexual young women experience worse mental health and SRH outcomes compared to straight and lesbian women, there is a current lack of understanding of what is driving these disparities. The minority stress model, which takes into account proximal (e.g., internalized homophobia) and distal (e.g., discrimination) stressors, implicates the stressors associated with being a sexual minority within a heteronormative society as affecting sexual minority individuals' mental health (Brooks, 1981; Meyer, 1995, 2003). Further, researchers have theorized for bisexual women particularly, that experiencing discrimination from both queer and straight communities may contribute to worse mental health outcomes due to a lack of social support and community connectedness (Ehlke et al., 2020).

The current study provides context and nuance to the current literature and inform future studies, along with programming and policy. By using narrative inquiry to elicit stories of mental health experiences from young bi+ women, in their own words, we gained a better understanding of factors influencing their mental health, and ultimately identified ways to better address these women's needs to reduce mental health disparities (Creswell & Poth, 2018). Further, the thematic analysis exploring the intersection of young bi+ women's mental health and SRH improved our understanding of how the current socio-political context shapes women's health and identified key areas for intervention to improve these intertwined outcomes (Braun & Clarke, 2006).

Research Questions

The current study included qualitative, semi-structured, in-depth interviews with young bi+ women ages 18-25 in the United States. The overarching research question of the study was:

What are the mental health and sexual and reproductive health needs and experiences of young bi+ women in the United States? This question was explored through three secondary questions:

1. What are young bi+ women's mental health experiences and challenges across the life course?
2. How do young bi+ women cope with challenges across the life course?
3. How do young bi+ women describe their mental health as intersecting with their sexual and reproductive health in the socio-political context?

Definition of Terms and Acronyms

Term	Definition
LGBTQ+	An acronym for “lesbian, gay, bisexual, transgender and queer” with a "+" sign to recognize the limitless sexual orientations and gender identities people use
Bisexual	Sexually or romantically attracted to people of any gender or regardless of gender. Sometimes used interchangeably with pansexual.
Bi+	A term inclusive of those sexually or romantically attracted to people of any gender but who may or may not identify themselves as bisexual.
Pansexual	Sexually or romantically attracted to people of any gender or regardless of gender. Sometimes used interchangeably with bisexual.
Omnisexual	Attraction to all genders
Plurisexual	Umbrella term that encompasses individuals who experience attraction to people of multiple genders
Queer	A term people often use to express a spectrum of identities and orientations that are counter to the mainstream
Heterosexual	Sexually or romantically attracted exclusively to people of the other sex (also referred to as straight)
Monosexual	Sexually or romantically attracted to one gender (e.g., straight, gay, lesbian)
Heterosexism	Discrimination or prejudice against non-heterosexual people with the presumption that heterosexuality is the norm
Biphobia	Prejudice against bisexual people
Bi-erasure	Belief that bisexual identity is not valid
Binegativity	Negative attitudes toward and stereotypes about bisexual people
Sexual minority	Umbrella term used to refer to anyone who is not heterosexual or straight (e.g., gay, lesbian, bisexual, pansexual, queer)
Outness/Coming Out	The process in which a person first acknowledges, accepts, and appreciates their sexual orientation or gender identity and begins to share that with others
Health Disparities	A type of preventable health difference that is closely linked with social, political, economic, and environmental disadvantage

Chapter 2: Literature Review

Introduction

Young bisexual women experience poorer mental health, substance use, and SRH compared to monosexual young people. They also report higher rates of victimization (Feinstein & Dyar, 2017). Young bisexual women face unique, distinct threats to their health due to their stage of development, sexuality, and gender (Baptiste-Roberts et al., 2017; Connell, 1987; Feinstein & Dyar, 2017; Hayfield, 2022; Russell & Fish, 2019; Wingood et al., 2000). Bisexual young adult health is under-researched despite representing the largest subgroup of the LGBTQ+ community and these disparities (Swan & Habibi, 2018); however, there have recently been initiatives to center the experiences of bisexual young adults to better address these disparities and emphasize bisexuality as a valid identity (Bostwick & Dodge, 2019).

Researchers have hypothesized various mechanisms that are driving these disparities, but there is not a clear consensus on what factors are contributing to these disparities or how best to address them to improve the lives and well-being of bisexual women. This literature review discusses the health disparities that bisexual young women experience, relevant factors implicated as driving these disparities, and current gaps in our knowledge about bisexual young women's mental health and SRH. This is the first known study using qualitative methods to explore the intersection of mental health and SRH among young bi+ women in the United States in the current socio-political context of reproductive and LGBTQ+ rights and the COVID-19 pandemic.

Mental Health Outcomes and Influential Factors

Mental Health and Substance Use Outcomes

Bisexual women experience higher rates of mood and anxiety disorders, eating disorders, substance use, self-injury, suicidal ideation, and risk of suicide compared to lesbian and heterosexual women (Chan et al., 2020; Conron et al., 2010; Dunlop et al., 2020; Feinstein & Dyar, 2017; Kerr et al., 2013; Ross et al., 2018; Russell & Fish, 2016). These outcomes are also commonly co-occurring, indicating a syndemic effect of social inequality on mental health, suicidality, and substance use outcomes (Bauer et al., 2016).

A 2022 meta-analysis looking across 26 studies found that LGB people had higher risks for mental disorders compared to straight people, but also that bisexual people had a higher risk for depression (OR = 2.70; 95% [CI = 2.21, 3.18]) and suicidality (OR = 4.81; 95% [CI = 3.63, 5.99]) compared to lesbian/gay people (Wittgens et al., 2022). According to the 2021 National Health Interview Survey, 17.8% of bisexual people had regular feelings of depression, compared to 7.9% of gay/lesbian people and 4% of straight people. 38.4% of bisexual people reported feelings of worry, nervousness, or anxiety, compared to 19.6% of gay/lesbian people and 10.3% of straight people (National Center for Health Statistics, 2022). In terms of lifetime rates, Bostwick et al. (2010) found that bisexual women reported higher lifetime rates of mood disorders (58.7%) and anxiety disorders (57.8%) compared to lesbian women (44.4% and 40.8%, respectively) and straight women (30.5%, 31.3%, respectively) (Bostwick et al., 2010).

An analysis using data from The Chicago Health And Life Experiences of Women study found that bisexual women had a higher risk of scoring 10 or more on the Center for Epidemiologic Studies Depression Scale (AOR=1.73) compared to lesbian women, although they did not show any statistically significant differences on anxiety, suicidal thoughts, and

substance use (Bostwick et al., 2015). In a study across 13 countries, using the World Mental Health Surveys, LGB participants reported higher rates of 12-month prevalence of anxiety disorders, mood disorders, eating disorders, and substance use compared to straight participants (OR 2.0-5.3, $p \leq 0.004$); however, although bisexual people were more likely to report these outcomes, the only one with statistically significant difference between bisexual and lesbian/gay participants was substance use (OR 3.7, $p < 0.001$) (Gmelin et al., 2022).

A 2012 review by Green and Feinstein also found that overall the research showed that lesbian and bisexual women are at higher risk for alcohol and drug use and related problems compared to straight women (Green & Feinstein, 2012). Research by McCabe et al. (2009) also showed increased rates of substance use among bisexual people compared to lesbian/gay and straight people, with 25% of bisexual women reporting heavy drinking (compared to 20% of lesbians and 8.4% of straight women), 22% reporting marijuana use (compared to 16.7% of lesbians and 2.6% of straight women), and 14% reporting other drug use (compared to 12.6% of lesbians and 3.1% of straight women). Bisexual women also had greater alcohol dependence (15.6% versus 13.3% of lesbians and 2.5% of straight women) (McCabe et al., 2009). Fish and colleagues (2018) found that lesbian and bisexual women had greater odds of binge drinking than straight women (aOR = 1.57, CI = 1.18, 2.09 and aOR = 1.83, CI = 1.45, 2.30 for lesbian and bisexual women, respectively) (Fish et al., 2018). Another nationally representative study also showed sexual minority women reporting higher odds of binge drinking than straight women (aORs ranging 1.52 to 3.27) (Fish, 2019).

Life Course Factors

Young bi+ women's stage of development influences their mental health, including their experiences with mental health challenges and their ability to cope with these challenges. Along

with mental health disorders often starting to manifest in adolescence and young adulthood, youth and young adults are forming their sexual identities, coming out, and having their first sexual experiences during the period of development where they experience intense interpersonal and social regulation of sexuality and gender (Russell & Fish, 2016, 2019). Sexual minority youth may experience stigma, discrimination, and othering during this period which contributes to mental health challenges (Feinstein & Dyar, 2017; Ross et al., 2014). Young LGBTQ+ adults also experience LGBTQ+-specific stressors such as family rejection and biased-based bullying from their peers, during a period when they are heavily reliant on family and peers for their emotional and social development and well-being (Russell & Fish, 2016). Research by Rice and colleagues showed that experiences of discrimination peak in early adulthood (Rice et al., 2021). Further, a study by Layland and colleagues showed that the association between discrimination and suicide attempts was strongest among young adults ages 18 to 25 and suggests early adulthood is a critical time to intervene (Layland et al., 2020).

Along with the developmental period, the life course framework considers the socio-historical timepoint that certain developmental stages occur. For instance, young adults today grew up during a time of significant social change and changing attitudes towards LGBTQ+ people, including policy changes affording more rights and protections for LGBTQ+ people (e.g., *Obergefell vs. Hodges* in 2015 making same-sex marriage legal nationally and the repeal of Don't Ask Don't Tell in the military in 2010) and increased acceptance of LGBTQ+ people. However, young LGBTQ+ adults still experience disparities compared to their peers and continue to face discrimination due to their sexuality, and in some cases disparities are widening, particularly among sexual minority women and girls (Fish, 2022; Russell & Fish, 2019). The recent social and political climate that includes increased divisive discourse around LGBTQ+

issues and enactment of regressive policies such as Florida's "Don't Say Gay" laws further marginalized LGBTQ+ people (American Civil Liberties Union, 2023).

The current study included young bi+ women ages 18-25 who would have been born between 1998 and 2005. They would have grown up during a time of shifting attitudes towards LGBTQ+ people in the early 2000s and seen same-sex marriage become legalized nationally in 2015 when they were pre-teenagers or teenagers. They also became teenagers and young adults during the Trump administration and during the COVID-19 pandemic, both of which serve as important socio-historical context in understanding the lives and trajectories of these young adults. Individual young adults in the study will have their own life course factors that influence their mental health and SRH depending on the context in which they grew up (Fish, 2022; Russell & Fish, 2019)**.**

Bisexual Marginalization

Minority Stress

The minority stress model, which takes into account proximal (e.g., internalized homophobia) and distal (e.g., discrimination) stressors, implicates the stressors associated with being a sexual minority within a heteronormative society as affecting sexual minority individuals' mental health (Brooks, 1981; Meyer, 1995, 2003). This model has been applied in studies investigating mental health outcomes in the LGBTQ+ community broadly (Frost et al., 2022; Meyer, 2003; Meyer et al., 2021). However, for the current study, it is important to also investigate how bisexual people, specifically, experience distinct minority stress (Bostwick & Dodge, 2019; Feinstein & Dyar, 2017).

Along with minority stress being implicated in affecting the health of LGBTQ+ individuals broadly, bisexual people face distinct stressors that contribute to health disparities

among bisexual people not only compared to straight people but also compared to lesbian and gay individuals (Bostwick & Dodge, 2019; Feinstein & Dyar, 2017; Fish et al., 2021). Bisexual people face distinct stigma from experiencing bi-erasure, biphobia, and bisexual marginalization (Doan Van et al., 2019; Feinstein & Dyar, 2017)**.** Sexual identity stress has been implicated in some studies as partially explaining the greater likelihood of poor mental health among bisexual people (Chan et al., 2020).

Smith and colleagues found that bisexual women experienced microaggressions (an average of 8.1 microaggressions in the previous 28 days, and at least one microaggression for more than 42% of days) and microaggressions were associated with negative affect and somatic complaints (Smith et al., 2022). In another study, co-occurring mental health, substance use, and suicide outcomes were associated with perceived discrimination among bisexual people (Bauer et al., 2016). Bostwick and colleagues also found that in a study of 112 bisexual women, most reported experiencing sexual orientation microaggressions, and this was significantly associated with mental health and substance use outcomes (Bostwick et al., 2021). Perceived discrimination can occur in multiple domains, including by gay and straight community members; friends, family, and partners; and healthcare providers (Doan Van et al., 2019). Bisexual youth have been shown to have worse psychological adjustment after experiencing bullying and victimization; thus, along with experiencing minority stress and discrimination, they may lack the ability to cope with these experiences (Poteat et al., 2009).

Social Support and Community Connectedness

Bisexual people experience biphobia and bi-erasure from both straight and gay/lesbian communities, thus making bisexual people more socially isolated and less likely to receive social support and community connectedness that is shown to be protective for other sexual minorities

(Doan Van et al., 2019; Ehlke et al., 2020). Researchers have examined this particular pathway, with some studies finding the constructs of social support and community connectedness along the pathway of bisexual-specific stigma or minority stress and mental health outcomes (Chan et al., 2020; Ehlke et al., 2020).

Qualitative research by Flanders and colleagues found that young, bisexual women feel bisexual stigma and social marginalization that they tie to their mental and sexual health. Particularly, the young women felt that due to bi-erasure, they were pressured to provide evidence of their bisexual identity, including by changing their relationship or sexual behavior. They also reported feeling excluded from the queer community (Flanders, Dobinson, et al., 2017). Since studies show that for gay people and lesbians support from their communities can improve their mental health, bisexual people's exclusion from these communities may be a partial driver for poor mental health (Cohen & Wills, 1985; Meyer, 2003).

In terms of quantitative studies that support this, one study across 13 countries reported that sexual minority women received less social support from their families (OR=0.5, $p<0.001$), which was also associated with having a mental health disorder (OR=0.8, $p<0.001$) (Gmelin et al., 2022). Ehlke et al. (2020) also found that bisexual women experienced greater minority stress and less social support, which was associated with physical and mental health problems according to a structural equation model they used to analyze survey data from 650 U.S. young adult lesbian and bisexual women (Ehlke et al., 2020). Additionally, a structural equation model using data from 931 LGB individuals in Hong Kong found that bisexual individuals were more likely to report identity uncertainty, conceal their sexual orientation, and have a weaker sense of connection to the LGBT community, which was then associated with worse mental health outcomes (Chan et al., 2020). McLaren & Castillo (2020) found that a sense of belonging to both

queer and straight communities was associated with lower levels of depressive symptoms. They further found that, in particular, connection with the lesbian community was more important for bisexual women who did not feel a sense of belonging to straight communities, which provides nuance to what type of social support may be most important and for whom (McLaren & Castillo, 2020).

However, other studies found that social support and community connectedness had a weaker effect on mental health than hypothesized when looking at a national survey of LGBTQ+ people (Frost et al., 2022; la Roi et al., 2022). One study found that community connectedness was not as protective for younger cohorts as for older cohorts (Frost et al., 2022). This suggests that further research is needed to determine how social support and community connectedness are involved in the pathway between stigma and mental health and also what types of social support and community connectedness are most beneficial for bisexual people. Further, it may indicate that some experiences of stigma and discrimination are so harmful that social support and community connectedness can only somewhat attenuate the negative effects.

There may also be differences in how minority stress and stigma may function within the bisexual+ umbrella. For instance, in an Australian study, pansexual women were more open about their sexuality, more connected to the LGBTQ+ community, and more conscious of sexual minority stigma. Although there were no differences in psychological distress and well-being in these groups, those who identified as pansexual had a stronger association between stigma consciousness and LGBTQ+ community connectedness and well-being, indicating that the mechanisms implicated in mental health may be different for these two groups (Morandini et al., 2022).

Outness

Although coming out (i.e., making one's bisexual identity known to others) as bisexual may put someone at more risk for identity-based discrimination, studies have shown that concealment of their sexual identities is associated with increased depression and anxiety. This appears to be even stronger for those who conceal their identity due to concern about being judged or treated negatively or concern about putting oneself at risk of physical harm versus those who conceal their identity due to not being comfortable with being bisexual or not viewing being bisexual as a large part of their identity (Feinstein et al., 2020, 2021). Tabaac and colleagues also found that there was a cascading influence from outness to one's family to wellness behaviors through social support from one's family and depression (Tabaac et al., 2015).

Relationships

Bisexual women's experiences, including outness, discrimination, and mental health outcomes, also differ on the gender and sexual identity of their partner. Bisexual women in relationships with straight men, and single women, are less likely to be out than bisexual women in relationships with lesbian women or bisexual men or women, and bisexual women in relationships with same-sex partners tend to be more open about their sexual identity overall (Dyar et al., 2014; Hall et al., 2021; Molina et al., 2015). Studies have varied with how experiences of discrimination and minority stress vary by the gender of a bisexual woman's partner. For instance, Hall and colleagues found that bisexual women who are in relationships with lesbian women or bisexual men or women report higher discrimination than bisexual women in relationships with straight men using the Everyday Discrimination Scale (Hall et al., 2021). However, Molina and colleagues found that women with single male partners or multiple partners experienced higher levels of binegativity using the Bisexual Minority Stress Scale and

that binegativity was associated with negative health outcomes and substance use (Molina et al., 2015). Bisexual women may experience discrimination from their partners that influences their relationships, outness, choice of partner and navigation of relationships, and mental health (Armstrong & Reissing, 2014; Bostwick & Hequembourg, 2014; DeCapua, 2017). In qualitative studies, bisexual women reported experiencing identity invalidation, stereotypes, hypersexualization (particularly among male partners), pressure to change, dating exclusion, and insecurity (Bostwick & Hequembourg, 2014; DeCapua, 2017).

In terms of mental health outcomes, some studies show that bisexual women who are in same-sex relationships have better mental health and less stress than those in relationships with men or are single (Dyar et al., 2014; Vencill et al., 2018). Studies have differed in the extent to which being partnered generally is protective of mental health, with Feinstein and colleagues finding that being partnered may help buffer the relationship between discrimination and depression and anxiety, whereas Whitton and colleagues found that being in a relationship was predictive of increased distress (Feinstein et al., 2016; Whitton et al., 2018). More research is needed to fully understand the complex interplay between relationship status, partner gender, experiences of binegativity and discrimination, and health outcomes.

Intersectionality

Bisexual women experience oppression and minority stress at the intersection of multiple marginalized identities, including gender, sexuality, race and ethnicity, religion, socio-economic status, disability, and immigration status. In terms of gender, bisexual women experience unequal gender and power dynamics that includes experiences of sexism, discrimination, and gender-based violence, alongside limits to their rights, all of which influence their health (Manandhar et al., 2018). In general, women are at higher risk for mental illness than men,

particularly mood and anxiety disorders (McLean et al., 2011; Salk et al., 2017; Van Droogenbroeck et al., 2018). According to the 2020 National Survey on Drug Use and Health, 25.8% of women experienced any mental illness in the past year compared to 15.8% of men (SAMHSA, 2021). A meta-analysis found that the gender difference in depression was greatest during adolescence compared to other developmental periods (Salk et al., 2017).

In terms of racial and ethnic identity, there is a lack of research investigating the intersecting experiences of marginalization among bisexual women of color, but research shows that bisexual women of color experience intersecting, multiplicative stressors that may affect their health. In one study with young bisexual women of color, Latina bisexual women had poorer health outcomes compared to Black bisexual women (Smith et al., 2022). In research by Layland and colleagues, Black and Hispanic sexual minority adults who experienced discrimination had higher odds of suicide attempts compared to white sexual minority adults who experienced discrimination (4.5 versus 3.6) (Layland et al., 2020). Bostwick and colleagues found that among bisexual women of color, intersectional microaggressions were significantly associated with higher levels of depression, anxiety, and poorer self-assessed mental health (Bostwick et al., 2021). Understanding these intersecting identities and intertwined factors is essential to getting the full picture of young bisexual women's mental health.

Mental Health Care

Young adults experience barriers to receiving mental healthcare, resulting in extensive unmet mental healthcare needs in this population. A third of young adults with mental health struggles reported unmet mental health needs in 2021 (Adams et al., 2022). Untreated mental illness can also lead to suicide, which is the second leading cause of death in people ages 10-34 (Garnett et al., 2022). LGBTQ+ individuals experience unique challenges related to accessing

affirming mental health care. Bisexual young women may fear being treated differently by health professionals or may have had poor experiences in the past. Their intersecting identities of being both women and bisexual cause them to be more likely to be stigmatized within the healthcare field. For instance, healthcare providers have negative perceptions of bisexual people (Jabson et al., 2016). Also, in general, women have been mistreated by the healthcare system (Verdonk et al., 2009). Lesbian and bisexual women seek mental health services more than heterosexual women (Kerr et al., 2013). Compared to straight and gay/lesbian people, bisexual women report higher rates of seeking counseling and taking psychiatric medication but also report higher rates of not accessing mental health care due to cost (NCHS, 2022).

Bi-Positivity, Strength, and Resiliency

Despite the stressors that bisexual women experience, they also show an incredible amount of resilience and strength, and some women have described the positive aspects of being bisexual, including freedom from social labels, honesty and authenticity, having a unique perspective, increased levels of insight and awareness, freedom to love without regard for sex/gender, freedom to explore relationships, freedom of sexual expression, acceptance of diversity, belonging to a community, understanding privilege and oppression and becoming an advocate/activist (Scales Rostosky et al., 2010). In another study, bisexual people found positive bisexual identity experiences at the interpersonal level, including by being friends with and dating people who "accept and care for [them]" and the joy of finding affirming spaces in their communities both in person and online (Flanders, Tarasoff, et al., 2017). In another qualitative study, Galupo and colleagues found that many bisexual biracial individuals identified positive aspects of having this dual identity, despite the hardships they experienced, including feeling unique, defying tradition, and finding small and intimate communities (Paz Galupo et al., 2019).

The positive aspects of bisexual identity are understudied; however, researchers have begun exploring the strengths of this identity alongside the challenges.

SRH Outcomes and Influential Factors

Bisexual women face threats to their SRH, leading to worse SRH outcomes. Bisexual women report higher rates of sexual risk behaviors such as more sexual partners and trading sex for resources. Bisexual women also have higher rates of unintended pregnancy and sexually transmitted infections (STIs) (Alexander et al., 2016; Feinstein & Dyar, 2017). Bostwick et al. (2015) found that bisexual women had 3.01 times the odds of ever being diagnosed with an STI compared to lesbian women (Bostwick et al., 2015). Bisexual women have unique threats to their SRH. In a qualitative focus group study, bisexual women reported modifying their sexual behavior to conform to the expectations of others around sexuality, which includes riskier sexual behavior (Flanders et al., 2022). Other qualitative research with sexual minority women suggests barriers to receiving contraceptive care such as fear of stigma and discrimination. Further, sexual minority women reported feeling that contraception is controversial for women generally but experience further marginalization as queer women (Higgins et al., 2019). For women figuring out their sexual identity, navigating contraception can be difficult. They also may not as regularly be engaging in sex that can lead to pregnancy, making them believe they do not need contraception (Higgins et al., 2019). There is also the incorrect assumption among some sexual minority women that sex with women does not lead to STIs, which leads to a decrease in using protection (Paschen-Wolff et al., 2020).

Experiences of Violence and Victimization

Experiences of violence, maltreatment, and neglect influence bisexual women's mental health and SRH across the life course. Young bisexual women who experience child

maltreatment are at risk for worse mental health outcomes (Russell & Fish, 2016). Bisexual young women are more likely to experience reproductive coercion, rape, physical violence, and stalking when compared to monosexual women (Alexander et al., 2016; Breiding & Black, 2014). Survivors of sexual violence often suffer from post-traumatic stress disorder, distress, depression, anxiety, and suicidal ideation (Alexander et al., 2016; Basile & Smith, 2011). Queer people generally are at higher risk for intimate partner violence (IPV) and bisexual people have the highest risk (Leemis et al., 2022). Bisexual stigma and stereotypes have been implicated as a factor related to experiencing sexual violence among bisexual people and are related to worse mental health symptoms (Flanders et al., 2020, 2021, 2022)**.**

The Intersection of Mental Health and SRH

Mental health and SRH can be intertwined, so consideration of both disparities is important to understand the full picture of bisexual women's mental health (Flanders et al., 2015; Timilsina, 2018). Factors such as stigma and experiences of violence can negatively impact both mental health and SRH (Alexander et al., 2016; Flanders et al., 2015, 2017, 2022). Further, their mental health can affect their SRH and vice versa. For instance, women with mental health challenges may have difficulty negotiating safe sex practices or accessing care. Relatedly, SRH outcomes like STIs or unplanned pregnancies can impact bisexual women's mental health. For bisexual women specifically, if they cannot safely practice sex that aligns with their sexuality and develop healthy sexual and romantic relationships without fear of stigma or discrimination, that affects both their mental health and SRH. Research supports the claim that young bisexual women's mental health and SRH are interconnected. For instance, in a study with African American women who have sex with women, depression was associated with sexual risk behaviors such as drug/alcohol use during sex, STI diagnoses, and exchanging sex for

money/drugs. Intimate partner violence and incarceration were also associated with exchange sex, use of alcohol/drugs during sex, and STI history (Muzny et al., 2018). Bisexual women report their mental health as intertwined with their SRH, all of which are influenced by bisexual stigma and social marginalization. For instance, bisexual women who feel pressured to "prove" their identity may change their sexual behaviors to conform to expectations (Flanders et al., 2015, 2017). Reproductive coercion and abortion stigma influence the psychological health of women pre-abortion (Steinberg et al., 2016). It is important to understand how mental health and SRH intersect to gain a full picture of bisexual women's health.

Social, Cultural, and Political Context

Bisexual women's mental health and SRH are influenced by the social, cultural, and political environment. In particular, bisexual women face threats to their reproductive rights in the changing political landscape (*Dobbs v. Jackson Women's Health Organization, 597 U.S. ___*, 2022). Further, although the LGBTQ+ community has had an increase in acceptance and landmark policies (e.g., *Obergefell v. Hodges*), there have recently been new pushes to restrict LGBTQ+ rights. LGBTQ+ people have experienced hate and discrimination through both national rhetoric, while also facing violent attacks targeting LGBTQ+ people (American Civil Liberties Union, 2023). Lastly, bisexual women exist within an ongoing pandemic that threatens their well-being, and studies have shown they experience disproportionate impacts of the effects of the pandemic (Fish et al., 2021). To fully understand the mental health and SRH experiences of bisexual women, it is essential to understand the social, cultural, and political contexts.

Reproductive Rights

Reproductive rights refers to having the ability to decide whether and when to have children, including access to contraception, prenatal services, safe childbirth, and safe and legal

abortion (The Institute for Women's Policy Research, 2023). Women's ability to exercise these rights has been restricted due to the recent *Dobbs v. Jackson Women's Health Organization* (2022) Supreme Court ruling, declaring that the Constitution does not confer a right to abortion and thus overruling *Roe v. Wade* (1973) and *Planned Parenthood v. Casey* (1992). (*Dobbs v. Jackson Women's Health Organization, 597 U.S.* ___, 2022). As a result, reproductive rights and access to abortion are now under the control of the states. After the *Dobbs* decision, states enacted legislation restricting reproductive health and abortion access including restrictions related to the timing of abortion (e.g., pre-viability), method, reason, age, provider, self-management, steps before receiving an abortion (e.g., receiving an ultrasound), and parental consent, along with outright bans to abortion. Fourteen states (Alabama, Arkansas, Idaho, Kentucky, Louisiana, Mississippi, Missouri, North Dakota, Oklahoma, South Dakota, Tennessee, Texas, Wisconsin, and West Virginia) have eliminated access to abortion, and other states imposed severe restrictions such as Georgia instituting bans on abortion after six weeks. There has also been pushback on some of these bans, however, including South Carolina's state supreme court ruling the state's 6-week ban as unconstitutional (Pollard, 2023). Some states have moved towards ensuring reproductive health access in their states in the aftermath of Roe being overturned, including Minnesota's Protect Reproductive Options Act that was signed into law in January 2023 and states that local government cannot restrict a person's ability to exercise the "fundamental right" to reproductive freedom (Kashiwagi, 2023). A systematic scoping review found that restricting access to abortion resulted in negative reproductive health outcomes. Further, women in states with restrictions to reproductive healthcare had to pay higher out-of-pocket costs and experienced difficulty finding abortion clinics. In states with restrictions on family planning, women had trouble finding providers and subsequently missed doses of their

contraceptives (Bossick et al., 2021). Reproductive health policy, particularly when severe restrictions are in place, influences women's ability to access reproductive healthcare and affects their health and well-being (Bossick et al., 2021).

These restrictions and their deleterious outcomes may disproportionately affect those already marginalized, including sexual and racial and ethnic minorities (Kozhimannil et al., 2022; Sutton et al., 2021). Bisexual women already experience SRH and mental health disparities (Alexander et al., 2016; Feinstein & Dyar, 2017). Lack of access to abortion and family planning exacerbates this disparity. Further, bisexual women may experience unique challenges due to their relationships with both men and women. Bisexual women with male partners must consider potential unplanned pregnancies amidst a lack of access to abortion services. Bisexual women in relationships with women may also be considering state policies' influence on them and their partners' ability to expand their families through methods such as in-vitro fertilization. Bisexual women in general may be considering how these policies might affect the healthcare they receive during pregnancy and the postpartum period (Cohen et al., 2022). Due to the interconnected nature of mental health and SRH, as women face attacks on their reproductive health and sexual agency with the Dobbs decision, it is more urgent than ever to explore young bisexual women's mental health and SRH.

Anti-LGBTQ+ Policies, Rhetoric, and Violence

Bisexual women live within the context of anti-LGBTQ+ rhetoric, threats to LGBTQ+ rights, and hate, discrimination, and violent attacks on LGBTQ+ people. Increasing hate from far-right extremists along with conservatives and religious groups, including a narrative that LGBTQ+ people "groom" children, has been fueling anti-LGBTQ+ violence and threats to their rights. LGBTQ+ people have had to face violence, with recent attacks including a mass shooting

at Club Q, an LGBTQ+ nightclub in Colorado Springs, Colorado in November 2022 (Center for Countering Digital Hate Inc & Human Rights Campaign, 2022; Levenson et al., 2022).

Recent policies threatening LGBTQ+ people's rights further exacerbate the challenges this population faces in the United States. In the first half of 2022, 162 anti-LGBTQ laws were introduced by lawmakers across 35 states, according to data from the American Civil Liberties Union (Cole, 2022). The Florida Parental Rights in Education Act, commonly referred to as the "Don't Say Gay or Trans" bill, passed in 2022 and prohibits discussion on sexual orientation or gender identity in schools. Alabama passed a similar law in 2022. And overall 20 states have introduced similar bills (Branigin, 2022). The Respect for Marriage Act, recently signed into law in December 2022, officially repealed the Defense of Marriage Act and codified the *Obergefell* ruling, thus protecting same-sex and interracial marriages across the United States. This Act was proposed, however, due to uncertainty over the protections from the *Obergefell* case after the Dobbs decision overturned *Roe v. Wade* when Justice Clarence Thomas said the court should "reconsider" the *Obergefell* decision (Forgey & Gerstein, 2022; Respect for Marriage Act, 2022).

Policies such as these can have a significant effect on LGBTQ+ people's mental health and well-being (Russell & Fish, 2016). Psychological distress has historically been associated with policies related to banning same-sex marriage, including LGBTQ+ people showing increased mood, anxiety, and alcohol use disorders in states that banned same-sex marriage in 2004-2005 (Hatzenbuehler et al., 2010). Studies have shown that LGBTQ+ youth living in areas without anti-bullying protections are more likely to attempt suicide than youth living in areas with these protections (Hatzenbuehler & Keyes, 2013).

Similarly, laws protecting LGBTQ+ people can have a positive effect on LGBTQ+ people's mental health and well-being. A 2022 study found that hate crime laws were associated with decreased rates of adolescent suicide attempts when sexual minorities were named as a protected class (Prairie et al., 2022). Further, policies that promote inclusive classrooms, the kind of which is banned in the "Don't Say Gay or Trans" bills, are positively associated with LGBTQ+ student well-being (Proulx et al., 2019; Snapp et al., 2015).

The COVID-19 Pandemic

Before the COVID-19 pandemic, young adults were experiencing significant mental health challenges, with the prevalence of mental health disorders increasing over the past decade (Goodwin et al., 2020; Twenge et al., 2019). The onset of the pandemic exacerbated this mental health crisis. Young adults experienced economic and educational instability and uncertainty, isolation and loneliness, illness and death, anxiety, and disruption of resources. Those who are at higher risk for complications and death related to COVID-19, such as people who are immunocompromised, face additional burdens as the pandemic continues and restrictions are lifted. The COVID-19 pandemic has exacerbated existing mental health disparities. People in lower income brackets, racial and ethnic minorities, those with disabilities, women, and LGBTQ+ individuals are disproportionately affected by the pandemic (Douglas et al., 2022; Tai et al., 2022). LGBTQ+ young adults may have had to return to unsupportive and unsafe homes during the beginning of the pandemic due to campus closures, thereby increasing experiences of minority stress and worsening their mental health. Further, these young people were isolated away from their communities and the resources they relied on, particularly affirming LGBTQ+-related resources and community (Fish et al., 2020; Gonzales et al., 2020; Salerno et al., 2020).

The pandemic disproportionately affected bisexual women compared to gay/lesbian and straight people, causing worse outcomes. In a U.S. national sample of adults (n = 2996) collected from online panels from April to May 2020, there was a decline in well-being among U.S. adults. In this study, bisexual people were found to have been most impacted by the pandemic. Compared to heterosexual and lesbian women, bisexual women reported worse mental health, physical health, and quality of life during the pandemic. They reported greater stress, loneliness, psychological distress, and fatigue both before and during the pandemic, and compared to other groups, had the greatest amount of decline in well-being from pre- to post-pandemic (Fish et al., 2021). This indicates that bisexual people may have been more vulnerable to challenges related to the pandemic, and disparities in resources and health that were already present were exacerbated by the pandemic.

Summary and Gaps in the Literature

The current literature shows that bisexual women experience mental health and SRH disparities. Researchers have started exploring the mechanisms that may be driving these health disparities and trying to better understand the factors leading to poor mental health and SRH outcomes among young bisexual women; however, the research is still limited and findings are mixed. Further, bisexual women are often included as a subset of larger LGBTQ+ communities and there are few studies specifically designed to address and understand young bisexual women's mental health. There is also a lack of understanding of how mental health and SRH intersect among this population, and how the larger socio-political context influences the health and well-being of young bisexual women. Few studies use qualitative methods to explore these young women's experiences. The current study provides important nuance and context about these young women's lives and address the current gaps in the literature on these topics.

Chapter 3: Methods

The current study included in-depth qualitative interviews with bi+ women ages 18-25 to investigate their mental health needs and experiences, including factors influencing their mental health and the intersection of their mental health and their SRH. Information from these interviews with young bi+ women provided context and nuance to the current literature and informs future research, along with interventions and policy. By using narrative inquiry to elicit stories of mental health experiences from young bi+ women, in their own words, we gained a better understanding of factors influencing their mental health, and ultimately identified ways to address these women's needs to reduce disparities (Creswell & Poth, 2018). Further, a thematic analysis exploring the intersection of young bi+ women's mental health and SRH aided our understanding of how the current socio-political context shapes women's health and identified key areas for intervention to improve these intertwined outcomes (Braun & Clarke, 2006). This chapter provides an overview of the methods of the study, including data collection and analysis, ways of ensuring quality and trustworthiness, and ethical considerations.

Philosophical Assumptions and Methodology

For qualitative studies it is important to consider the ontological, epistemological, axiological, and methodological aspects of the researcher (myself) and the current study. The assumptions underlying this study were that there are multiple realities and people may view reality differently based on their perspectives, the knowledge gained from the study is from the participants' own subjective experiences, and research is value-laden and my biases as the researcher influences the research. The current study drew from a variety of interpretive frameworks and was rooted in principles of transformative frameworks alongside feminist,

queer, and critical theories, all of which emphasize the context of people's experiences, marginalized identities, and using research to enact change (Creswell & Poth, 2018).

The current study used narrative inquiry methodology to answer the research questions and guide data collection and analysis for this project. Narrative research involves gathering stories from individuals about their lived experiences (Creswell & Poth, 2018). Narrative inquiry emphasizes the context of individuals' lives as well, including investigating the social, cultural, familial, and institutional context in which individuals live (Clandinin, 2013). This method involves gathering stories from individuals and then organizing them, either chronologically or through some other organized structure such as life course stages. The steps involved in data analysis are discussed later in this chapter. Narrative research has been used in a variety of disciplines including literature, history, anthropology, and public health (Creswell & Poth, 2018; Kim, 2016).

The current study also used thematic analysis; however, thematic analysis is generally understood as a method that can be paired with a variety of philosophical assumptions and other methodologies as opposed to a methodology in and of itself. Thematic analysis can be completed within realist/essentialist or constructionist paradigms. The current study employed a constructionist framework with the understanding that meaning and experience are "socially produced and reproduced" and sought to investigate sociocultural contexts and structural conditions. Specific steps of this method are described later in this chapter (Braun & Clarke, 2006, 2021).

Positionality and Reflexive Statement

I am a cis, white woman in her early 30s who identifies as bisexual and queer. I am from the Northeast and come from a middle-class, liberal, non-religious family, which informed my

upbringing and perceptions around LGBTQ+ topics. I have extensive experience and background in topics related to youth and young adult mental health and SRH and LGBTQ+ health. As an undergraduate, I co-founded and was president of an organization aimed at improving the mental health of college students, alongside working as a research assistant in a psychotherapy clinic. These experiences sparked my passion for mental health. I was also a psychology major and took extensive coursework in counseling and clinical psychology. I also worked as a volunteer crisis counselor and often worked with youth and young adults. In my master's program, I completed research projects related to psychosocial outcomes and SRH among women living with HIV. As a Research Assistant in the Community THRIVES Lab and Prevention Research Center, I have completed projects related to LGBTQ+ student mentorship and LGBTQ+ foster youth mental health and sexual health. I've also worked on projects related to SRH among youth experiencing homelessness and the mental health and parenting needs of young, maltreated mothers. I have always been passionate about and committed to LGBTQ+ rights and have engaged in advocacy for LGBTQ+ rights since I was young.

I recognize that my background may differ from those who are from different racial/ethnic groups, socioeconomic statuses, disabilities, different areas within the United States, or religious or political beliefs. I am in social groups that include both straight people along with LGBTQ+ people, but my interactions with both communities may vary from how my participants have experienced these communities. I am currently in a long-term partnership with a cisgender male (thus in a way "straight passing" and not experiencing potential discrimination that same gender couples may experience), although I have had past relationships with people of varying sexualities and gender non-conforming identities. I am progressive and a feminist, and I believe in equal rights along with a woman's right to abortion, contraception, and comprehensive

sexual education. I am nonreligious. I recognize that my background and beliefs affect how I think about topics related to mental health, SRH, and LGBTQ+ health. I am open to understanding the thoughts and viewpoints of my participants while recognizing that I come to the research with my own unique identities, experiences, opinions, and values that may intersect or diverge with theirs.

Data Collection

Sample

I interviewed 16 participants. Inclusion criteria was the following: ages 18-25 years old; cisgender woman; attracted to more than one gender or regardless of gender; resides in the United States, has internet access, and speaks English. The sample size of 16 interviews was enough to provide saturation and enough richness and detail to perform the qualitative analysis (Creswell & Poth, 2018). Depending on their purpose, narrative inquiry studies may include just one or two people; however, more participants are included when the researcher is interested in a larger collective story or comparing experiences between participants (Creswell & Poth, 2018; Huber & Whelan, 1999; Kim, 2016). This sample size is similar to those used in other narrative inquiry studies involving the LGBTQ+ population (Abes & Jones, 2004; Duran & Jourian, 2022; Kinitz & Salway, 2022).

Table 1 provides more information on participant characteristics. Participant were aged 19 to 25 years (M = 23.1). Seven participants identified as White, three identified as Hispanic, two identified as Black or African American, one identified as Middle Eastern/Arab American, one identified as Asian, and two identified as multi-racial (Asian and Hispanic and White and Hispanic). Most (N=10) identified as bisexual; however, three identified as pansexual, two as

both bisexual and queer, and one as bisexual, queer, and pansexual. Participants lived in 10 states: AZ, CA, FL, IL, KY, MA, NY, OH, PA, and TX.

Table 1. Participant Characteristics (N=16)

Pseudonym	Age	Race	State	Sexuality
Amy	22	Black or African American	AZ	Bisexual
Aria	19	White	TX	Bisexual
Betty	23	White	OH (grew up in IA)	Bisexual, queer
Eleanor	25	White	KY	Bisexual
Ella	23	Asian and Hispanic	KY (grew up in CA)	Bisexual
Jack	25	Hispanic	TX	Bisexual
Jennifer	21	Hispanic	AZ	Bisexual, queer
Margo	25	Middle Eastern/Arab American	FL	Bisexual, queer, pansexual
Neville	25	White and Hispanic	MA (grew up in NH)	Pansexual
Orange Turtle	23	Hispanic	NY	Bisexual
Paige	23	White	PA	Bisexual
Sam	24	White	IL (grew up in TN)	Bisexual
Sarah	21	White	PA	Pansexual
Sasha	22	Black or African American	NY	Pansexual
Shell	25	White	FL	Bisexual
Stella	23	Asian	CA	Bisexual

Recruitment Strategy

I used Prolific, an online platform used for recruiting and managing research participants, to recruit participants (see study description posted on Prolific in **Appendix A)**. I used purposive sampling to ensure a diverse group of participants, both in terms of race/ethnicity and geographical location. Participants completed a screening survey to determine eligibility in

Qualtrics, an online survey tool. The screening survey included information such as gender, sexuality, race and ethnicity, age, location, internet access, and language (see **Appendix B**). To ensure diversity in geographic location, I created three separate studies in Prolific to recruit from states with different levels of abortion access: Stream 1 included states that were labeled as having the most or very restrictive abortion policies at the time of recruitment (ID, TX, SD, ND, OK, MO, AR, LA, MS, AL, TN, KY, WV, AZ, GA), stream 2 included those labeled as having restrictive abortion policies (UT, KS, IA, WI, IN, OH, PA, NC, SC, FL), and stream 3 included those states with some through most protections (NV, WY, MT, MI, VA, DE, NH, RI, CA, OR, WA, CO, NM, MN, IL, MD, NJ, NY, VT, CT, MA, ME, AK, HI, DC). These groupings were developed based on the Guttmacher Institute's US Abortion Policies map from the most up to date information available when recruitment occurred in June 2023 (Guttmacher Institute, 2023a).

Interview Procedures

Participants were asked to complete a 60 to 90 minute in-depth semi-structured interview. All data collection methods were reviewed and approved by the University of Maryland Institutional Review Board prior to the start of the study.

Interview Format

Interviews were completed over Zoom in June 2023. The principal investigator completed 15 of the interviews and a Master's-level research assistant with qualitative interviewing training completed one interview. Remote interviewing has been commonly used and has been shown to be a useful tool in conducting qualitative interviews, both before but particularly during the COVID-19 pandemic (Archibald et al., 2019; Roberts et al., 2021; Salmons, 2016). Participants received the Zoom link via Prolific messaging system prior to the

start of the interview. Participants were told to keep their video on for the duration of the interview and were asked to ensure they were in a private, quiet space. Interviews were both audio- and video-recorded after the participant went through the informed consent process. Participants were asked to change their name on Zoom to that of a pseudonym prior to recording for confidentiality purposes.

Informed Consent

Participants received the informed consent form prior to the interview and then were re-linked to it at the start of the interview. At the start of the interview, the interviewer reviewed the informed consent document with the participant verbally to ensure understanding and answered any questions. After their questions were answered and they indicated their agreement to participate, the participant completed the Qualtrics form indicating they agreed to participate and submitted the survey. The informed consent form is in **Appendix C.** After the informed consent form had been reviewed and the participant had consented to participating in the interview and being recorded, the interviewer started the recording via Zoom's record feature.

Interview Guide

The in-depth interview guide included questions aimed at eliciting stories from women about their mental health, including their past experiences with mental health, access to care, diagnoses, and medication, along with coping methods and sources of support. They were also asked about their SRH, their sexuality, and experiences of stigma and discrimination. Lastly, they were asked about their needs as young bi+ women to improve their mental health and SRH. The complete interview guide can be found in **Appendix D**. The interview protocol was piloted with two women who were similar to the participants to ensure understanding and reduce

potential harm. From the pilot testing the interview guide was shown to be acceptable and clear to members of the target population.

Post-Interview

A health resource guide with mental health and SRH resources was provided prior to and after the interview (see **Appendix E**). Further, participants were asked to complete a brief demographics survey after the interview (see **Appendix F)** asking about income, employment, education, and insurance.

Data Analysis

All interviews were recorded and transcribed naturalistic verbatim. Transcripts were cleaned, formatted, and checked for accuracy by a member of the study team. Then, the principal investigator completed a final check for accuracy. Final, checked transcripts were imported into NVivo for coding (QSR International, 2022).

Aims 1 and 2. To examine young bi+ women's mental health experiences and coping strategies.

I used narrative inquiry to explore young bi+ women's mental health experiences and coping strategies. Using the analytic steps for narrative inquiry as described by Creswell and Poth (2018), I completed the following to analyze the interview data: 1. Read through the interviews, made margin notes, and formed initial codes, 2. Described the patterns across the objective set of experiences and identified and described the stories into a chronology, 3. Located epiphanies within stories and identified contextual materials, and 4. Restoried and interpreted the larger meaning of the story (Creswell & Poth, 2018). Each step is described below.

Step One: Read the interviews, make margin notes, and form initial codes. During this step, I read the transcripts one by one while listening to the audio. I then read the transcript

for a second time while making margin notes and forming initial codes that related to research questions 1 and 2 regarding bisexual women's mental health experiences and coping strategies.

Step Two: Describe the patterns across the objective set of experiences and identify and describe stories in a chronology. In Step 2, I used my margin notes and codes to identify patterns across the objective set of experiences. Further, I reorganized the participants' stories into a chronology.

Step Three. Locate epiphanies within stories and identify contextual materials. In this step, I identified epiphanies within the story, for instance when a participant first came out about their sexuality. These are important moments within a person's life and provided a focal point of the analysis to identify important experiences and life events according to the participant and what moments they felt were important to their mental health and SRH. I also identified contextual materials including context that the participant brought up (e.g., what state they live in) and contextual factors from the socio-political environment of the time period (e.g., the COVID-19 pandemic).

Step Four: Restory and interpret the larger meaning of the story. In this final step, I integrated my analysis in a way that "restories" the participants' interview, or identifying patterns and themes and then placing them into chronological order. In this stage, I analyzed the qualitative data and developed interpretations about the larger meaning of the story and how that connected to my aim of investigating young bi+ women's mental health experiences. I also identified patterns and themes across participants' stories to develop a collective narrative about young bisexual women's mental health experiences.

Aim 3. To investigate how young bi+ women describe their mental health as intersecting with their SRH in the socio-political context.

I used 6-step thematic analysis to analyze and develop themes to explore the intersection of mental health and SRH among young bi+ women (Braun & Clarke, 2006, 2021). I conducted the following analytic steps:

Step One: Familiarize self with the data. During this step, I familiarized myself with the data by reading and re-reading transcripts while listening to the audio.

Step Two: Generate initial codes. At this stage, I coded line-by-line to identify sections of text relevant to research question three regarding the intersection of mental health and SRH and the influence of the socio-political context. The codes reflected some feature (semantic or latent) of the data that was pertinent to the research questions.

Step Three: Search for themes. In step three, I organized my codes into broader themes and collated the relevant coded extracts within each theme. I developed a thematic map to illustrate my themes and sub-themes.

Step Four: Review themes. In this stage, I refined my themes by returning to my coded text in relation to each theme, and then reviewed the themes across the entire data set to see if the themes mapped onto the entire dataset.

Step Five: Define and name themes. In this step, I wrote a detailed account of each theme and sub-theme and named each theme in a way that was succinct and reflected the core meaning of the theme.

Step Six: Produce the final report. Lastly, when writing the results section of the dissertation, I wrote up my thematic analysis describing the themes and provided vivid examples within an overall narrative about the data relevant to the research questions.

Data Management

Data were stored using the University of Maryland Box, which is a secure cloud-based storage system. All participants provided a pseudonym, which served as a unique identifier that was used on all interview materials (e.g., demographic information, interview transcripts). I only reached out to participants via Prolific and used their Prolific ID and pseudonym as their unique identifiers. I did not collect or store participant names, email addresses, or phone numbers at any point to comply with Prolific's requirements. Informed consent forms and compensation documents were not associated with participant interview data or any personally identifiable information.

Ensuring Quality and Trustworthiness

The interview guide and study protocol developed by the researcher was reviewed by the dissertation committee each with expertise in some aspect of the research project (e.g., qualitative research, youth mental health and SRH, LGBTQ+ health) and of diverse backgrounds. Further, it was piloted with members of the Community THRIVES Lab, a diverse group of undergraduate and graduate students of various races, ethnicities, genders, sexualities, and backgrounds. The study was piloted with two women similar in characteristics to the study population. All had opportunity to provide feedback about the study protocol and revisions were made to incorporate this feedback with the goal of ensuring quality and trustworthiness.

I considered my positionality and engaged in reflexivity throughout the research to understand how my biases and values may have affected my research, analysis, and understanding of the issue. This included creating an audit trail of research memos and a reflexive journal. Further, I regularly engaged in peer debriefing with the Community THRIVES Lab, bringing my findings and reflections to others to discuss to ensure I was representing the

data in an authentic way. I used triangulation to enhance study rigor by examining interviews and study materials such as interviewer notes from multiple participants, having multiple researchers examine the data, and tackling the issue through multiple perspectives by using different theories and frameworks (e.g., social-ecological model, minority stress) in my design and analysis (Creswell & Poth, 2017). Further, I brought my findings back to the participants and the community through member checking by recording a brief presentation and report of my findings and sending it to my participants and providing opportunities for feedback (Creswell & Poth, 2018).

Ethical Considerations and Crisis Protocol

Bi+ young women are a marginalized population and thus extra care was taken to ensure their well-being before, during, and after the interview process. Interview questions were reviewed by members of the queer community and experts in queer health to reduce the risk that the interview would harm participants, further marginalize or re-traumatize them, or perpetuate harmful stereotypes about this population. Further, the guide was pilot tested with two bisexual women who provided feedback.

The research team consisted of a diverse mix of ages, races and ethnicities, genders, and sexualities. Care was taken to create a safe environment for participants and also to ensure that further harm was not perpetuated on this community through this research by using member checking, engaging with queer activists, scholars, and community members, and engaging in reflexivity to better understand biases.

Crisis Protocol

Mental health resources were disseminated prior to the interview to ensure that participants had resources on hand in case they became in crisis during the interview or if the

interview brought up anything for them that prompted them to seek help for their mental health concerns. Participants were directed to these resources again at the end of the interview (see **Appendix E**). The interviewer has been trained in mental health crisis support and listened empathetically when participants brought up mental health concerns. When a participant appeared to be in a mental health crisis, the interviewer walked the participant through the available resources and followed up with them after the interview. The interviewer provided the participant with the choice to stop or pause the interview if they were in crisis or requested it. One committee member is a trained and licensed clinical social worker. The interviewer followed up with that committee member to determine if further action needed to be taken. The research team followed up with participants and provided further resources as needed.

Compensation

Participants received $50 through the Prolific platform as compensation for their time. The amount of compensation was high enough to help with recruitment and compensate participants for their time, without the amount being too high that it could be deemed coercive.

Risks and Benefits

There were some risks to participation in this study. Due to the sensitive nature of the topics around mental health, SRH, and sexuality, especially among marginalized communities, participants may have felt negative emotions or distress arise when discussing these topics. The interviewer assessed the emotional state of the participant and recommended a pause or stop to the discussion as needed. Further, mental health resources were provided both before and after the interview. The participants were told that their participation in the study was voluntary and they could choose not to answer a question or could stop the interview at any time.

No research study can assure complete confidentiality; however, we took precautions to maintain confidentiality and privacy during this study to the best of our ability, especially since not all participants may not have been out about their sexuality, mental health, or SRH. A pseudonym was used, and we did not collect participants' real names, email addresses, or phone numbers. I only reached out to participants via Prolific's messaging system and identified them using their Prolific ID. Participants were advised to complete the interview in a safe, private location, and the interviewer was also in a private location to avoid someone overhearing the discussion. Video and audio recordings and transcripts were stored in password-protected files on University of Maryland's secure cloud-based storage system, Box, and were only accessible to the study team.

Some participants may have perceived a benefit to participating, such as finding relief and empowerment through sharing their stories and experiences. They may have also found it beneficial to provide their stories to help us better understand young bisexual women's mental health and SRH that could help benefit the community (Bay-Cheng, 2009).

Strengths and Limitations

This is a qualitative study and findings should be understood within that context. For instance, the findings are not meant to be generalizable to all bisexual young women or other communities. However, by completing in-depth interviews with this population, we explored the context and nuances that influence these young women's mental health and SRH, which can help researchers understand the complexities of this topic and add to the literature in this area. A strength of this study is the rigorous methods used to design the study and analyze the data, including using analytic steps from narrative research and thematic analysis developed and used by qualitative experts in the field (Braun & Clarke, 2006, 2021, 2022; Clandinin, 2006, 2013;

Creswell & Poth, 2017). Further, I practiced reflexive journaling, maintained a clear audit trail, engaged in regular peer debriefing with the Community THRIVES Lab regularly, and completed member checking.

Although a benefit of Prolific is pre-vetted participants and being able to purposively sample based on geographic location, participants within the Prolific system who agreed to a Zoom interview reflect a unique population that may differ from other bisexual women in the United States. For instance, these are participants who had a device that can join Zoom (e.g., iPhone, iPad, laptop), had access to a strong internet connection, and had access to a quiet, private location to complete the interview. Further, users on Prolific are higher educated than the general population, and there are also fewer Black or African-American users on the platform than is representative of the United States population (Palan & Schitter, 2018; Tang et al., 2022)

Summary

This chapter included an overview of all data collection and analysis activities, along with ethical considerations and strengths and limitations of the study. This study was informed by aspects of transformative frameworks along with feminist, queer, and critical theories. Data collection included 16 semi-structured, in-depth interviews with young bi+ women. I used narrative analysis and thematic analysis in analyzing my information.

Chapter 4: Findings

The purpose of this study was to explore the mental health and SRH needs and experiences of young bi+ women in the United States. The first aim of the study was to examine young bi+ women's mental health experiences and challenges across the life course. The second aim was to explore how these women cope with challenges they experience across the life course. The third aim was to investigate how young bi+ women describe their mental health as intersecting with their SRH in the socio-political context. A narrative inquiry approach was used for Aims 1 and 2 and thematic analysis was used for Aim 3. In this chapter, I discuss the narrative themes that I developed based on information related to Aims 1 and 2. I also describe the themes related to Aim 3 that I found from the thematic analysis.

Young Bi+ Women's Mental Health Experiences and Challenges across the Life Course

Participants discussed experiencing a variety of challenges over their lives that affected their mental health and well-being. Traumas at certain stages of development interrupted their development and caused harm not only at that stage but across their lives. Young bi+ women with trauma histories also discussed coping strategies exemplifying incredible resilience and strength and a commitment to caring for loved ones and improving their lives. Young bi+ women with multiple marginalized identities experienced intersecting forms of oppression that impacted their lives, across their life spans. The sample of women was incredibly diverse, and they had varied challenges and experiences across their lives. However, there were some key takeaways that highlight the challenges young bi+ women experience at different life stages, which are described below.

From the narrative inquiry, I developed three overarching narrative themes, all with sub-themes:

1. Experiencing Threats to Safety, Stability, and Security in Childhood has Far-Reaching Effects
    a. Safety as Fundamental
    b. Instability Begets Anxiety
    c. "Inheriting" Mental Health
    d. Growing Up Too Fast
2. Navigating Adolescence: Forming Identity in the Social Context
    a. Maintaining Authenticity while Fitting In
    b. Reconciling Identity with Family and Community Values
    c. Developing Sexual and Romantic Relationships
3. Developing Independence, Agency, and Self-Acceptance in Adolescence and Young Adulthood
    a. Barriers to Achieving Independence
    b. Finding Stability and Self-Acceptance

Theme 1. Experiencing Threats to Safety, Stability, and Security in Childhood has Far-Reaching Effects

When discussing their mental health, some participants discussed experiences of trauma or feeling unsafe, along with the effects of being in an unstable environment in childhood, and how that impacted them. These challenges not only affected them during the life stage in which they occurred but long afterward and affected their life through multiple domains. These participants discussed fear and anxiety that plagued them as children and adolescents, or difficulty forming relationships, because of trauma or lack of safety and stability. Their home and community environment were incredibly impactful on their mental health and development,

and tensions arose when their identity or values did not align with their home environment, or when they came from a home that was abusive or toxic. Along the same vein, those women who discussed feeling safe and supported in childhood talked about how that was a boon to their mental health and development. Within this theme, there are four sub-themes: *Safety as Fundamental, Instability Begets Anxiety,* "*Inheriting" Mental Health, and Growing Up Too Fast.*

Safety as Fundamental: The Impact of Exposure to Trauma and Violence in Childhood

Safety was discussed as paramount to young bi+ women's mental health. Lack of safety and fear in childhood impacted some participants' mental health both in childhood and throughout adolescence and adulthood. These participants discussed how this fear or experiences of trauma came from a variety of sources – from fearing for their families due to immigration laws to fearing for themselves due to living in a high crime neighborhood.

Jack, a 25-year-old Hispanic woman from Texas, discussed how growing up undocumented in a border town influenced her, particularly both the fears of her and her family being deported along with the burdens of trying to help her parents.

> Well, maybe a little sadness, but maybe mostly fear because my parents are both immigrants and also myself. I kind of took on a lot of things for them, because I was bilingual, and they were not. So a lot of pressure, um, especially with translation, because there are words that don't translate well [laughs], and it's not very easy for children to figure it out on their own, especially if their parents kind of can't help at all. So I would say, probably fear, a little sadness, just because um I understood what was going on between the 3 of us, and how it was different from most of the kids in my school um and something that I've never really wanted anyone to know, because there's always that fear that someone could say something, and something happens. So I would say, probably fearful um especially as a child. – Jack

This fear was compounded by witnessing a raid when she was younger:

> I have a very small memory of when I was a child. I had come back from school, and I guess someone in town had called immigration. And they did a raid where we were living in the area, um and my grandfather was there with us at that time getting my dad settled into his new job. And you know they just go around and they knocked, and if they have any suspicion they're allowed to enter and of course my grandfather was the only one that

> spoke pretty fluently at that time, and he was like, no I'm a U.S., citizen, this is my daughter. She's visiting me. I work here. Um I think that's probably something that stayed with me the most, because I never had any outwardly racism as a child too much at least, small jokes which I- jokes can be jokes for children. They're cruel sometimes. But that stays with me. That's you know, just hard-working people that were targeted by someone that saw them as anything other than. – Jack

That raid cemented the fear in her mind of her family being 'other' and perpetuated the idea of the tenuousness of her family's place in the United States along with the idea that her family could be targets just for being 'other'. This fear that she and her family experienced made it difficult for them to get close or comfortable to people in the community,

> Um I I never felt very comfortable, at least fully with um my kind of fellow Caucasian classmates and things like that, because I knew um that the way their parents thought is the way that they were going to think. Which is also probably the fear that I had as a child, that you know they might seem nice, but they could like call immigration, and that would be the end of everything. Um so um I definitely think that where I was at caused a lot of like fear, and, like probably some bad mental health days as a child for that. – Jack

Fear of immigration enforcement impacted her ability to form friendships and what she could do socially as a child and adolescent:

> I would say, I did have 2 very close friends when I was a child um but because of my situation… and also they were middle class, and we were not. So sometimes, the adults would kind of feel like maybe they shouldn't be around for too long. So I had no friends that slept over, and my parents also didn't like the idea of having like people over at the house. They were just very guarded. – Jack

Others also experienced traumatic events in their childhood that caused anxiety and affected their mental health. Margo, a 25-year-old Middle Eastern and Arab American woman from Florida, discussed how experiencing violence when she and her family were visiting relatives in Palestine impacted her and caused her to have post-traumatic stress disorder (PTSD), anxiety, and panic attacks afterwards.

> There was an event in my childhood that triggered PTSD, and I wasn't even aware of what it was even until much later, when my mental health continued to decline to the point where I wasn't really able to function like the rest of my peers were able to through elementary, middle and high school, I mean, I could perform well, but I had these…I had

> these [sigh] debilitating anxiety and panic attacks. I had OCD that wasn't being treated. [...] I am a Palestinian background, so my family has on occasion gone overseas in order for us to like, visit and connect with, you know, not only our roots, but the rest of the family that lives over there, and I think the first time I went I was really young like maybe 6, and I think in the part of the city that like my mom had decided to go shopping that day, and she took me along, and I think there was just some, there was like an outbreak of violence in the street, and I think it was because some people had been killed by Israeli soldiers, and there was just a big riot protest. […] After that. Um I started having really bad panic attacks. – Margo

After experiencing the event in Palestine, Margo experienced panic attacks, including one at the airport on the way home necessitating visiting the doctor both at the airport and multiple emergency room visits upon coming home. She described feeling like she was dying ("Oh my God! I'm dying!") and that something was wrong, but the doctors insisted she was fine. Margo continued to experience mental health issues through adolescence and young adulthood, including being diagnosed with PTSD, obsessive-compulsive disorder (OCD), anxiety, and panic disorder, among other mental health concerns throughout her life such as difficulty focusing and sleeping. Although there were other stressors in her life, she believes this traumatic event to have exacerbated her mental health issues, saying "For as long as I could remember I found myself. I was shy, prone to anxiety, but that event made it worse." including disrupting her sleep, "because I thought I would die if I went to sleep […] but it was just like the fear that, when I drifted off to sleep, you know, I wouldn't wake up." The lack of sleep then affected her mood even more. Experiencing this trauma was not the only aspect affecting her mental health over her life, however it did trigger symptoms for OCD, PTSD, and anxiety that then affected her over her life course.

Betty, a 23-year-old white woman who grew up in Iowa, discussed how she had OCD starting from a very young age. Her psychologist hypothesized that it may have been triggered

by a car crash she experienced as a young child, particularly her fear of house fires, however she puts more "stock" in other factors influencing her onset of OCD such as genetic predisposition.

> I had a lot of really irrational fears that were a little bit debilitating. So I was like at one point super afraid of like a house fire, and that would like, keep me up at night. And, um, I was really like obsessed with that. Um, so things like those–like those kind of just like irrational fears that manifested themselves in really, like intrusive ways. - Betty

As opposed to a singular traumatic event causing fear and anxiety, Sasha, a 22-year-old Black woman from New York, discussed how growing up in a violent neighborhood impacted her. Although she did not discuss being personally assaulted or attacked, being exposed to violence in her neighborhood and the fear that it perpetuated within her and her family greatly affected her, putting her "on edge" and making it so she could not spend time outside, which impacted her mental health and social development:

> "[Town in New York] wasn't – it's still not – the best environment, because there's a lot of shootings around here. It's a lot of gun violence, a lot of teen on teen crimes. Like last summer, or maybe just a few months ago, a kid got shot outside of a [fast food restaurant] not too far away from my house. So I was always on edge around my town. And even our high school was known for like having violent events there as well. I think it's gotten better now. But there was gang affiliation in my school, and things like that. So [town name], as a whole was always known to be a very negative place. [...] I felt like it wasn't fair because of the environment that I lived in. It made me limited because of my parents' fear of us going out, but I felt like I was losing out on a childhood because of it." – Sasha

This fear due to violence in her neighborhood continued throughout her life, into adolescence and young adulthood, leading to anxiety and isolation.

Further, some participants lived in fear not due to a singular traumatic event, but rather an abusive home life that instilled a pattern of fear and anxiety throughout their childhood and adolescence. For instance, Amy, a 22-year-old Black woman from Arizona who lived in Illinois during middle school, discussed her fear of being hit by her abusive grandmother who was "off her meds". She said she coped by making it a "rule" for herself to follow exactly what her grandmother said "to the T" so she doesn't "get hit."

Similarly, Shell, a 25-year-old white woman from Florida, described how her father could become abusive and combative when drinking, even though he was a "saint" when sober. She described a situation she witnessed when she was very young:

> He – him and my mom – were in a really bad fight, and he threw a book across the room, intending to, like, hit her or scare her, and I was standing right there, and, you know, she is like, 'very well, this is ending' you know. – Shell

Those participants who had experienced traumatic events or abuse in their childhood and who experienced chronic fears and anxieties surrounding these events discussed their mental health issues as starting earlier on in life than other participants who felt relatively safe and secure in childhood. Although they mentioned other factors (e.g., genetic predisposition) as also influencing their mental health, these traumatic events or experiences of chronic fear and abuse often served as a trigger for mental health issues in childhood. Participants who experienced traumatic events in childhood also discussed resiliency and finding ways to overcome adversity.

Participants who did not experience traumatic events in childhood or threats to safety described their childhood as being fairly happy, with mental health challenges, if they experienced them, occurring later such as in adolescence and young adulthood. Those who had relative safety and security in childhood also discussed how that helped them cope with challenges, such as Betty who experienced OCD as a child but received support and treatment that helped her cope with it.

Instability Begets Anxiety

Experiencing instability in childhood produced anxiety and, similarly, those who reported having stable childhoods discussed their childhoods as relatively happy for the most part. Instability took multiple forms, including family, financial, employment, food, and housing

insecurities, which intertwined together to create an unstable environment for the participants. This manifested in a variety of ways.

Amy, a 22-year-old Black woman from Arizona, discussed her experience of homelessness and financial instability growing up. In particular, she discussed how her socio-economic status changed a lot, and quickly, throughout her childhood, leading to anxieties and not knowing what her life would be like the following week. Her very early childhood she described as "relatively good." Her family at first moved around a bit because her father was in the military, but after her parents got divorced when Amy was in elementary school her family was "poor" and they were "moving around whether it was one or another reason" and they "didn't really have food to eat or a place to stay. Um so like I said, I moved around a lot. Been to a lot of apartments, uh been to a lot of different elementary schools." She also had responsibilities as the eldest child to take care of her younger siblings. Eventually in 6th grade her family moved to Illinois where her mental health took a major downturn and she experienced even greater struggles, including homelessness. She described middle school as the worst time of her life. She discussed how this instability, including housing and food insecurity, impacted her:

> Cause I've had like one week I could be somewhere, another week I could be somewhere else, and then a month from then I'm at a different socioeconomic status. So a lot of things changed throughout my childhood. […] In Illinois, we were part of this program that um had people like homeless, people that were homeless, live in like churches of many different religions. And so you'd stay for, I believe, like 1 or 2 weeks in like a church. And so we'd be moving around a lot, not have a lot of stuff on us. – Amy

Amy discussed the impact that these challenges had on her mental health, including depression and anxiety. She mentioned hoarding food, leading the other kids to believe she was wealthy since she always had food in her backpack. Amy discussed having suicidal ideation in middle school but not doing anything because she knew she had to take care of her siblings and "be strong" for them. The instability in middle school impacted her life even beyond that period,

even after her family was back in Arizona when she began high school and had more stability. Despite the move providing a more stable environment, there were still on-going impacts from the instability she experienced in the past that affected her mental health:

> I would say my siblings and my relationships were really toxic then, we would constantly yell at each other and be angry. Um and I think that's honestly based off of how we lived in Illinois, of just, like, um we were in a hostile environment then, and then coming to a stable environment. It doesn't really work. You have to like sort of break that down. And, you know, with my mom just being who she is and not having enough time, she couldn't help us through it. […] it's from a hostile environment to a more stable environment. It was a lot. Um my mental health was a lot better. Um but we just didn't know how to react to such a stable environment. – Amy

She also discussed how even after they were more financially secure and had "a ton of food in the house" she would continue to hoard food, even getting in trouble by her mother for yelling at her sister for telling her not to eat too much of their food.

Amy was not the only participant who described instability and the effect it had on mental health. Sarah, a 21-year-old white woman from Pennsylvania, described her life as chaotic and unstable:

> I've always had like a kind of chaotic life, I guess. I moved around like a ton when I was younger. I never really felt like I was in a super stable environment. I switched schools a billion times. So I–I think, as a kid, it's kind of hard to deal with like, s–super unstable environments like that. – Sarah

Like Amy, Sarah talked about moving around a lot in her childhood. When her dad lost his job, they had to move in with family in New Jersey, and this cycle repeated a couple of times in her childhood. The financial instability also led her family to "struggle to make ends meet," and she discussed how her dad worked a lot, which led him to not be around as much. She discussed the impact that this instability in childhood had on her. Particularly, she discussed how this impacted her social development at a critical period for forming friendships:

> I think, um, at that age especially, you're like, starting to like, find your little group of friends, and like, very, um, starting to get like, social awareness around like cliques, and

> like, school in general. And so I think, having to change schools that often like, never really being able to find my place affected me a lot. Um, just not being able to like, keep the friends I made, um, leaving very soon after–and like, I would keep in touch with some of them. but then, obviously, we're like 10 years old. We can't, really–We don't have phones, we don't really have a way to contact each other. So I think that affected me the most, just like, socially. – Sarah

Sarah also discussed her mom's mental health issues, which were exacerbated by their financial insecurity and moving around so much, that made it so that she was "not the most mentally stable person in the world," which contributed to the overall instability in her life.

Others discussed the impact of financial instability on their childhood, particularly those whose parents lost their jobs during the 2008 recession. Along with Sarah, Betty and Neville also had their parents lose their jobs during the recession. Although she categorized her family as middle class overall, Betty discussed how her mom losing her job during the recession was "stressful just having that instability." Neville, a 25-year-old White and Hispanic woman who grew up in New Hampshire, talked about how the financial crisis exacerbated her family's financial precarity and the impact that had on her family's mental health:

> I was definitely like in the lower social class, and then, when, like, when the recession hit, and I think it was 2009 – 2008 – 2009, that definitely hit my family really hard. So just struggling financially, which, of course, contributed to emotional and mental issues between like my parents and myself and everything. – Neville

For her, financial uncertainty led to increased anxieties not just for herself but for her family, which influenced their mental health and relationships with one another.

Like Amy, Aria, a 19-year-old white woman from Texas, and Shell, a 25-year-old white woman from Florida, experienced financial instability after their parents' divorces. Aria described her mom being stressed and working two jobs to support them, and their apartment "kind of sucks like sometimes, like the dishwasher wouldn't work or the toilet wouldn't work, there was like a roach infestation. So I just didn't like being home at the time, either." Shell's

parents divorced when she was in kindergarten and she discussed challenges occurring after that, especially due to her dad's addictions that led him to experience periods of homelessness and living in halfway houses and being unable to contribute financially to the family. She explained, "my mom worked a lot when her and my dad got divorced because he was not working from that point on to help facilitate any of our finances" which added stress and strained her relationship with her mom.

Sasha also experienced instability in her home life growing up, with her dad "in and out of the picture" in her childhood, and when he was home her parents would fight and "cause havoc," and she discussed the anxiety surrounding her family dynamic along with living lower income and her parents stress around employment and finances.

> I grew up with both of my parents that at a certain age it was more so co-parenting, I guess you would say situation. So, even with that, my dad still would come into the house, and him, and my mom would still argue and cause havoc. So all of that kind of would always have me on edge, where I guess it's probably made my anxiety worse even then, so my dad had a very stressful job. So he was always kind of in a negative mood, coming from work. So with that I've always felt on edge be able to like say anything wrong, or to fully speak my mind, because in his eyes it was deemed disrespectful.
> – Sasha

For some participants, despite being lower income, they felt like they were in a stable environment, such as Eleanor, a 25-year-old white woman from Kentucky, who said "we lived in a rural area, and we were definitely, like, I would say, lower income than like most of my friends, which at the time I didn't I – I again wasn't really super aware of that. I think my parents did do a good job of like making us feel like we were on the same level as everybody else."

Similarly, Paige, a 23-year-old white woman from Pennsylvania, felt like she had a "pretty good" childhood and a "non-chaotic home life" despite anxieties around financial strain during the recession and her parents divorcing when she was 11. She mentioned that although she witnessed arguments, her parents "tried to keep [her] out of it" and that the divorce ended up

being a “positive thing” that resulted in them being “happier.” After the divorce, she still spent a lot of time with both parents, who lived near each other, including going to her dad’s house after school every day for a few hours and alternating weekends, and it was “as balanced as it could be.” Despite this relatively amicable divorce process and commitment to stability, she still wished she had received mental health counseling at the time, particularly when her parents were fighting prior to the divorce.

“Inheriting” Mental Health and Trauma

Participants discussed the impact that their family members’ mental health had on their mental health and well-being growing up. Participants found themselves struggling with their family members’ experiences of mental illness alongside their own. Participants with parents who had mental illness had to take on more responsibility in the home, including caring for siblings, and experienced instability due to parental mental illness. In the case of siblings, participants felt responsible for their siblings’ well-being and worried and anxious for them, alongside pushing their own mental health concerns aside as to not wanting to be a burden. Multiple participants described challenges associated with family members’ mental health.

Sarah discussed her mom’s mental illness, and her eventual death when Sarah was 14, that impacted her and her family:

> She [mom] had like, hallucinations a lot of the time. Like, she, um…I mean, there was a lot. She, like, thought she was talking to celebrities, she thought she was talking to God, stuff like that. She didn't like me very much, just because she thought I was like, a demon of some sort. So, um, it was just a lot of that throughout my childhood, just hearing her like, talk about stuff like that. I-I think she was diagnosed bipolar. I assume she had something else going on, but nobody ever really knew. She kind of hid it pretty well […] think this was like–this started when we started moving around. I think maybe the stress kinda broke her a bit, and then it continued until I was around 14 and she passed away […] like we didn't have the best relationship. So it was like, me not…not feeling great, being around her and stuff like that. And then her passing away was definitely, very challenging. – Sarah

As the eldest child, Sarah took on a parenting role for her younger siblings, particularly after her mom passed away. In addition, however, was the lack of safety, security, and support from her mom growing up due to her mom's mental illness, and how that affected her relationship with her mom and her mental health throughout her life.

Similarly, Aria discussed her mom's anxiety and suicidal ideation and how that affected her:

> She wasn't good at like dealing with her anxiety at all. So like some days like in middle school. I would just come home, and she'd be talking about like how she was the worst mother in the world, and how she wanted to commit suicide and stuff so I think she didn't deal with her anxiety well. – Aria

In combination with her brother's anger issues, she described having a difficult home life.

> Me, him, and my mom. I feel like we're fighting all the time at home which sucked and my mom was like super anxious. She didn't communicate well, like at work or at home, and work stressed her out, and she would go home and get even more stressed out, and just like yell and cry, and all that. And my brother also had anger issues so like sometimes he just like punch a hole in the wall, or like break dishes, or whatever or like, break his controller like, break a trash can, or just random stuff. […] So I just didn't like being home at the time, either. – Aria

Here, Aria mentioned both the direct impact of her home not being great to live in at that point, but also described how she "inherited" her mother's anxieties, showing how mental health issues are perceived as passing down from parent to child through witnessing and internalizing parents' behaviors, even beyond genetic predisposition.

> And I think like my home space wasn't great at that point. and I think probably I inherited like some anxiety, and like some negative, like self-talk and stuff from her from like living with her during that period. – Aria

In contrast, Betty viewed her developing OCD as a child as primarily genetic and discussed how her dad and sibling also have OCD. Her parents had her receive treatment including therapy and medication as a child once they noticed she was experiencing symptoms, and her sibling also receives therapy.

Shell also discussed the impact of her family's mental health issues growing up, including both of her parents' difficulties with substance use and the impact of intergenerational trauma.

> When I was growing up. My father was out of the picture and in the picture, and he had a drinking problem, and so did my mom. From 0 to 5, I had my mom and my dad, and we were, you know, a family. And then when I was in kindergarten, they split up and he became really, I think, you know, overwhelmed with his traumas that I later learned about from his childhood that he could never work through or recover. – Shell

Shell later learned, after his death, that her father had experienced molestation as a child that had long-lasting effects on his mental health. Further she mentioned, "his family was really toxic, and they all passed away before I was born, because they all had drug and alcohol addictions and problems."

She also discussed how her mother's and grandmother's experiences of abuse by men influenced her own experiences and perceptions of men.

> So I think the the major theme in my life now is just that all of the women in my life are in in my generational life, like my mother and my grandmother have always kind of been pushed aside and told like, "Don't follow your dreams, you know. Question yourself, get validity from other people, especially men and do what everyone else thinks." – Shell

She spoke about generational traumas from both sides of her family, including experiences of abuse her parents and grandparents experienced, along with their mental health issues, and historical traumas as a woman of Jewish descent.

> Nobody was able to practice breaking down the generational traumas that had been going on before me. Nobody had had a chance to stop with things, so maybe, you know, it was a good thing that everything in my family ended up breaking down the way it did. So I was able to just have a lot of a long time, think and change things… – Shell

She mentioned that many of the things she struggled with her mom mentioned struggling with as well. When speaking of her presumed neurodivergence, she said:

> And so I struggled a lot in school, just the studious part of it, and my mom always said, "oh, I had that same problem," but she just thought it was that she was just dumb. But I

> think, you know, I'm just like my mother, and we've struggled with so many of the same things that she probably just needed a little bit of help and or a different way of learning" – Shell

Shell talked about how her mother and grandmother's issues with mental health related to weight and narrow definitions of the ideal body were passed down to her:

> I think when I went to middle school […] I think there was pressures of beauty ideals put on to me. I know my mother and my grandmother both struggle, still to this day, with mental health related to their weight, and a lot of unhealthy ideals were pushed upon me as a kid, and they didn't like realize it like the stomach comment today and they don't realize that they're like contributing to their own misery and their sadness. But so, I was expected to, and it was kind of silent, it was never like, "you know, you should look like this." – Shell

Other participants also discussed their mothers placing unrealistic beauty or body standards on them, causing them to have issues with food or body image. Orange Turtle, a 23-year-old Hispanic woman from New York, described a similar experience with her mother and grandmother:

> I think it's a generational thing, because, knowing my grandmother. she was very much like that with my mother, and so my mother was like that with me, and I don't know if I'll have children, but I hope that I wouldn't be like that with my -my children, but I guess you never know so. […] I still don't think it's right or nice to put your body image issues onto your children. – Orange Turtle

She described how she wished these comments had come from peers, as that would be "water off the back" and easier to emotionally process, but she felt differently about comments from family members. Orange Turtle took them much more to heart since they were coming from within her household and explained that as a child you believe what you are told, especially by your parents. She discussed it as amplifying mental health issues, saying, "being shy and anxious… but now I'm shy and anxious because of my appearance as well."

For Sam, a 24-year-old white woman who grew up in Tennessee, however, she felt that her family's experiences with mental illness made her less likely to bring up or seek help for her own mental health concerns.

> Um, my brother and my sister also developed some mental health struggles at that point.[...] pressure to be like, the stable and good one as the youngest as that last–the last chance, for my parents to have a normal kid, which is part of why, like, I never tried to get help because I didn't want to be more of a problem. Um, but, yeah, I think I still sort of see it as like, them, facing my–my problems kind of being, uh, side. I don't know kind of like, caused by, but then also like much less severe than their problems. – Sam

On the one hand, their mental health struggles were something that her family shared, Sam, laughing, mentioned her sister and her dad being on the same medication for depression. However, her hesitance to be a burden, and being the youngest with two older siblings with severe mental health issues, she did not seek help for her bulimia and other mental health concerns until she was 20. She wanted to be the only "normal" and "stable" child to her parents. Further, due to the attention that her brother and sister received due to their mental health issues, she received less attention and felt that she did not really have a "parental" relationship with her parents, and that she mostly took care of herself. Her family's mental health impacted her other ways as well. She discussed her brother experiencing severe mental health issues including addiction and having been involved in the criminal justice system.

> I'd say the only chall-I–my-my older brother, struggled with a lot of like, mental health and addiction problems that started when I was–He's 3 years older than me–so when he was in that kind of early middle school age, and I was a little bit younger, um, so I mean, it affected him more than it affected me. But I definitely, you know, having my parents very focused on that, and having him, you know, doing things around that I didn't quite understand at the time, um, was a little bit of a challenge. – Sam

Her sister also ended up having issues with depression in college, which required more attention from her parents as well. Sam's sibling having mental health and addiction issues affected her,

and as the youngest, it meant she received less focus from her parents, particularly for her mental health.

Other participants discussed their siblings' mental health issues and the impact their siblings' mental health had on them. And without resources or stable and supportive parents, situations of extreme mental health challenges were even more exacerbated and putting the participant in a stressful and overwhelming environment. Sasha's sibling, who is nonbinary and intersex, has schizoaffective disorder and a manic episode resulted in them being hospitalized, which was a traumatic experience for Sasha and her family. The event culminated in Sasha's sibling coming out as pansexual to their father, since they felt that hiding their sexuality was contributing to their poor mental health. However, Sasha's father, being homophobic, did not respond well to this, ultimately leading Sasha's father to leave their lives for good:

> So my sibling had gotten diagnosed with I think it's schizoaffective or something of that nature. And that really shifted the household, because I guess, for me personally, even dealing with my own mental things. That kind of made me dissociate a little bit because I felt like I was living in the nightmare, like. I don't want to accept it, though, with my reality because I guess I was assumed that it couldn't be in our family. And also the way my dad reacted made me feel worse because he actually had gotten mad at me that day that it happened for calling the, because I had called, the hospitals and they had told me to call 911 because they didn't want my sibling to hurt themselves. I called, and then the police people showed up to the house and they took my sibling to the hospital and then from there they was able to have them see a psychiatrist and get diagnosed. So they kept them in there like in solitary for a few days. So ever since my family came back home that day they decided to like live in their truth because they felt like part of the reason why maybe that happened was because all the stress they felt of the like being in the closet and dealing with school at the same time. So then ever since my sibling came out to my dad specifically things that work, because, as I mentioned before, he's extremely homophobic and my sibling does have a partner so he would just say irrational things like, oh, I think if your partner that made you this way, I feel like I lost a child. He would even name call me so a lot of things was happening at the time. That was just like something on top of another thing on top of another thing. So it's a lot of stress that year that I'm still trying to recover from this year. – Sasha

Sasha also described her sibling being a great source of support and comfort, with them being able to vent to each other, and how she would be "lost" if she were an only child.

Growing Up Too Fast

Participants discussed taking on responsibilities and more adult roles from a young age and how that made them mature faster. For instance, starting by kindergarten Jack was responsible for translating for her parents as they did not speak English, but she had picked it up quickly:

> I started um English classes immediately, like at 4 years old, 3 years old. So I started learning very quickly, and then I would say by kindergarten, first grade, I was kind of really taking on translation for them and then onward. I knew at that point I understood what my job was for them, and the fear that if I didn't do it right, something would happen. And I, you know, have to help my parents through it. – Jack

She not only felt great responsibility for the well-being of her family at a young age, but also significant fear, feeling if she mistranslated something there would be negative consequences. This caused her anxiety over her life. Further, she mentioned the logistical difficulties of acting as their translator, such as having to miss school to go to the doctor with a parent to translate for them. She expressed gratitude for the rare occasions when there would be a nurse or other person to help translate and frustration that even when they requested forms, such as health insurance forms, in Spanish, they would arrive only in English, and she would have to translate. She mentioned there were few resources in her town for Spanish-speaking people.

Others discussed taking on parenting responsibilities for their siblings due to either the loss or absence of a parent. They described this as stressful, but some also talked about the benefits of maturing quickly, including learning new skills and how to be independent earlier than their peers. For instance, after the death of her mother, Sarah took on parenting responsibilities for her younger siblings.

> I remember high school being particularly tough, um, especially because, like freshman year's when my mom passed away. So it was definitely a lot of struggling with that. […] I kind of had to parent my siblings afterwards. So it was definitely hard, um, doing that also with school. […] It was definitely stressful at first, I think. Like I-I never like, I

> didn't even, and I had to learn how to cook, I had to help them with, like, all their homework, while also doing my school. Um, I think it did help me, like, in general. Just because I like, matured very fast. I like, was definitely on a like, a higher maturity than I think I was–like my peers were. – Sarah

Amy also had responsibilities in her family as the eldest child. She talked both about the challenges but also talked about the strength they gained from being responsible for taking care of their siblings, and how it got her through difficult times.

> And then, being the eldest in like a single parent household. Um, having to take care of my siblings um while my mom worked um, you know just tryna be strong for my younger siblings. – Amy

Shell talked less about responsibilities in her home but discussed how she grew up faster due to her father's struggles, saying how having this relationship with him and being able to understand him as a human and see past his suffering, "made me have to grow up faster than one would have wanted to as a kid." He passed away when she was a young adult, which caused confusion and conflict for her, as they had a complicated relationship when she was growing up.

Theme 2. Navigating Adolescence: Forming Identity in the Social Context

Participants discussed challenges with forming their identity and figuring out who they were in adolescence. A common thread across participants was the difficulty of forming a sense of self within the pressures of the social environment, including navigating the values and expectations of peers, families, and communities. Participants discussed wanting to fit in and feeling compelled to conform to do so. They also discussed tensions when their identity did not match the desires of their families or if it was at odds with the social norms of their peers or communities. Forming this sense of self occurred simultaneously as participants were discovering and coming to understand their sexual identity, which added a layer of complexity, and for some, challenges to forming their sense of self. At times, participants felt like they were hiding aspects of themselves or did not feel accepted by others due to their identity.

Maintaining Authenticity while Fitting In

Aria discussed her struggles with feeling like she "didn't know who [she] was" and felt "disconnected from everyone" in adolescence. She experienced significant anxiety from academic pressure, and, in particular, robotics club, which also all of her friends were in. Trying to fit in with a group of "overachievers" made her try to overachieve as well, exacerbating her anxiety.

> I just wanted to do well, because I was in a friend group of a bunch of overachievers and I think like becoming friends with them made me want to overachieve, too, because at that point I was like A's B's, you know, whatever. But when I joined that friend group I was like no, all A's, fucking like do as much as I can for robotics, get leadership roles in it, even though I don't really care about it. Try and get awards for art and stuff like I felt like I needed to keep up with them. – Aria

Amy also discussed the tensions between being her authentic self and trying to fit in with her peers and make friends. She mentioned that in middle school, when she was in Illinois, she was being her "authentic self" and was "quite bullied for it." She described herself as being "naïve" in middle school, but when she moved back to Arizona for high school she knew to put on a "mask" to not get bullied:

> I would say the stu- the kids there were a lot less mean [laughs] in Arizona. A lot less mean to me, and I also was able to um change my personality. Um I knew who I was, but the way I would present myself to kids in Illinois, they didn't like that. So when I moved to Arizona, I put on like a fake mask. And then kids started to like me. And so I knew I just had to like live like this type of way. Um and not like the other way I lived cause I knew the other way would be a way for me to get bullied. – Amy

She also explained that, because of moving so much, she was then able to easily make friends, but to do that she had to 'fit my personality with whoever I was around. So, I had multiple different "me's."'

Ella, a 23-year-old Asian and Hispanic woman from Kentucky, also experienced bullying, which exacerbated her anxiety, particularly her social anxiety, and was a contributing

factor in eventually switching to homeschooling. She explained it as directly relating to her mental health issues, saying:

> That's another reason why- actually, the thing that kind of directly related to- one of the things that kind of directly triggered me having this, you know, these mental and health issues, one of the things, not the only thing, is me getting bullied. And it was like kids specifically talked about my family or something like that, so I think- something like that, so I think um that's kind of what I remember in my childhood. – Ella

Shell also had difficulty navigating social groups in adolescence, particularly due to her family's financial status along with what she perceived as her mom's pressuring of her to make friends with certain kind of "popular" or "rich" kids. This confused her and caused her to chase after people who she did not get along with and ignore people who may have been a better fit. It also created challenges with her forming her own identity and created anxiety around trying to figure out how to fit in with her peers.

> So, it's really confused with how, who I should be hanging out with, and what my intention should be as a middle schooler, and so I often, I would want to hang out with the kids who I thought were popular, which in my twisted middle school experience, they were all the rich kids, and you know, my mother was middle class at the time, and we couldn't afford the latest trends, or it -it was Hollister Jeans. And I was okay, like, if you weren't wearing name brand. You were basically nothing. And she didn't understand that her words saying like, "Hang out with the popular kids because you're popular," to me in my brain that meant, okay, well, there's like an algorithm to fit in with them. And I need this, you know, clothing. And I need to be able to be free on the weekends because they all hang out, and you know she didn't want to, she didn't see that it wasn't working. […] But so I I kind of avoided anyone who just wanted to be my friend, to be my friend, because it was like, "Well, that doesn't fit into the box that my mom wants." I have to try really hard to fit in with these kids who want absolutely nothing to do with me. – Shell

Instead of trying to fit in, Orange Turtle instead leaned into being a "misanthrope" as a reaction to switching schools where she did not know anybody. Despite making some friends eventually in high school, she continued the "façade" of being uncaring.

> Mental health wise - I think there was that sort of core shyness or social anxiety still there, but it was just kind of masked pretty well by I guess the- the reputation, or like character I created for myself in high school. – Orange Turtle

Reconciling Identity with Family and Community Values

Adolescence is often a period when people become more aware of the world surrounding them, question what they were taught, and form their own opinions and values. Participants struggled with reconciling their identities and values with those of their families and communities. The values of their family and communities impacted their formation of identity growing up and affected them and their views and opinions greatly, along with creating dissonance and anxiety when their identity (e.g., bisexuality) or views differed with their families' and communities' traditional values. Many participants described becoming more left leaning as they grew up and holding different views than their more traditional or conservative families or communities. This was salient for Aria who grew up in a conservative part of Texas:

> I think it was definitely conservative in [Texas town]. I mean, I think it like instilled me with some conservative values at the time that, like now, I don't really respect at all. Now I consider myself to be a very left leaning person. But I think it like to build the foundation of some more like conservative kind of like close minded values that stuck with me like part way through high school that I don't like. I mean that like they just influenced how I looked at the world in a way that now I just really don't like. I mean, definitely like my family at that time, like my dad would be like, oh, like gay people or like trans people are... Now he's like, significantly more chill on it. And I've had more conversations with him. But at the time it was definitely like a conservative environment. – Aria

Participants who grew up in religious households that hold specific beliefs and expected norms around sexuality, gender, and marriage, including those from Mormon, Catholic, Protestant, and Muslim households, often struggled with their own religion growing up and all participants who described growing up in a strict religious context discussed no longer being religious as they got older; however, some still had limited engagement with their religious practices to remain connected with or appease family members.

For the young bi+ women who grew up in more conservative interpretations of religious beliefs and practice, navigating their sexuality added on another layer of forming their identities

within the social context. Those who lived within more conservative or religious communities struggled with coming to terms with their sexual identities within religious frameworks of morality and ethics that were not inclusive.. Mental health and sexual identity intersected for many participants. For many, they experienced shame, anxiety, and fear related to their sexual identities. Amy, who grew up in a homophobic household, originally felt "disgust" towards anything LGBTQ+ and struggled with internalized homophobia.

Margo, who identifies as bisexual, pansexual, and queer, remarked upon realizing she was LGBTQ+ while living in a conservative Islamic family, community, and school:

> When I was, I believe, 15 or 16, my mental health had reached an all time low. It was at this point that I kind of understood, um, that I was on the LGBTQ spectrum, and I attended an Islamic school [laughs], so, *you know.* And I think that made me really depressed because in the Islamic religion, there's not really a place for the LGBTQ community and even back then I never, ever like I didn't ever admit anything or say anything. – Margo

Her religious upbringing impacted multiple dimensions of her life. For instance, she discussed gender roles for women in her community and how her friend did not report sexual abuse due to her fear that her reputation would be ruined, and she would be ostracized by her community, saying, "our families are religious and when it comes to girls it's always about you know their reputation [about why friend didn't report abuse]." Her Islamic school's lack of sexual education also made it challenging for her and her peers to recognize and navigate sexual abuse and sexual relationships.

Further, her community's interpretations of religious practice and values influenced their approaches to mental health, "She told them that she was depressed and that she kind of wanted help, and they kind of told her to pray more." Her religious beliefs intersected with her mental health when she was younger and in some cases exacerbated her experiences of mental illness:

> But of course, with the obsessive-compulsive disorder, you will continue to have unwanted recurring thoughts… and in the religion, it's kind of like yes your actions can be sins, but your thoughts can be depending on your intention. It was. I was always like terrified when I had like. Those unwanted thoughts about like inappropriate or upsetting thoughts about religion like No, it's not real. You're going to hell. All this other stuff like it is really kind of powered this idea that my - I don't know. My thoughts were constantly being broadcasted and observed by a higher being that was silently watching and judging every minute, every second, every minute of every day, and that it doesn't matter how I feel about it. The- that judgment is going to decide my fate. the fate of my soul. There's nothing I can do about it. There's nothing anyone can do about it because no one can, is more powerful than God, or whatever like that, you know. There were a lot of times where I wished I would just like, you know, actually die, because then I would be saved the trouble of having to live a life good enough to be considered worthy of heaven. – Margo

Margo experienced tremendous difficulty when her family discovered she was bisexual after seeing her out with a girl, including her parents telling her dangerous stereotypes like that she was going to get AIDS if she were gay.

Sam, on the other hand, grew up in a more progressive religious community, and discussed how her Reform Jewish upbringing influenced her values in terms of her commitment to civil rights and social justice. She discussed how her synagogue did not necessarily focus on prescriptive interpretation or practice of religious rules and expectations, but instead focused on other values important to their community:

> Um, and I definitely think that, like, learning about um, like my-my synagogue, would definitely would talk a lot about like the involvement of Jews, in like the civil rights movement and the involvement–like the way that, like the kind of social justice side of Judaism. Um, and so I definitely think that informed a lot of my values, um, like having-like you would have those types of conversations kind of from a pretty young age. – Sam

Along with religion, cultural norms also impacted participants' lives and well-being. Orange Turtle, who grew up in a Hispanic and Catholic family, said that family was the most important thing for her family and community. Although she felt that there were some benefits to this, it was difficult for her at times because it meant she had to give things up to help her family, such as delaying getting a job in order to take care of her grandparents.

> There's like a bit of a, I guess, a cultural thing where in certain cultures that's like family over everything. And I guess that's not something that I, not that I don't value family, I do. But it's not like I'm going to like shoot myself in the foot to, you know, help my family sometimes. – Orange Turtle

Several participants talked about the impact of cultural and societal norms around body image, femininity, gender roles, and beauty, and particularly the impact these had when they were perpetuated by family members, oftentimes impacting their mental health negatively and even contributing to the onset of eating disorders and other mental health concerns.

Shell and Stella both discussed the pressures of beauty and thinness standards in society and particularly emphasized by their mothers that affected them. Stella, a 23-year-old Asian woman from California, discussed how her mom's expectations around beauty and thinness affected her, along with femininity and gender roles:

> She expected me to be ultra-feminine. She wanted me to wear pretty dresses and skirts, but I was kind of a tomboy growing up. I didn't really want to be doing that. Um I dressed like a little more, yeah, just like tomboyish kind of like baggy clothes. Um I kind of acted boyish, which I'm like careful to say, because I also don't want to get into certain types of like what a boy is. Um but I think it just didn't align with what she expected of me, like you know she expected someone to be very, of me, to be very polite um to speak very calmly and quietly, but me like I tend when I was comfortable I was very loud. She didn't like that. Um, yeah. And yeah, she'd just expect me to be a very respectful and everything, even when I disagreed with things that she said. Um yeah, and she was also like, very um rigid about boys. – Stella

Sam, who struggled with bulimia in adolescence, also discussed how societal beauty standards affected her:

> I think that for me, on a personal level, like, the kind of, um, aesthetic like heroin chic, you know, style, um, definitely like, the kind of fat-phobia w-was more affecting for me personally, um, when I was a kid [...] I definitely think that like, seeing that there–that was kind of the yeah, this-the aesthetic value at the time. Um, of just very very thin people everywhere. – Sam

Developing Sexual and Romantic Relationships

Most participants discussed the importance of sexual and romantic relationships in their adolescence and how it impacted their understanding of their sexuality along with influencing their mental health and affecting their self-esteem.

Oftentimes, participants described feeling pressured to form relationships with and be attractive to boys, and how that affected their mental health. Stella discussed how her mental health and self-esteem would be affected when things did not go well with boys she had crushes on:

> When I was in middle school, I started having like more crushes on boys and stuff like that. So I think that also influenced my mental health because I think I was. I would get disappointed very frequently by them, because, like, I developed these really strong crushes, and then it wouldn't really go anywhere. And then I think I would just take it really, personally, I would think that it was because of I don't know. Maybe I was ugly. Maybe I wasn't funny enough, or whatever. – Stella

Shell also had difficulty with romantic and sexual relationships in middle school and high school, often feeling pressured into relationships along with feeling sexualized. Shell talked about her traumatic start to dating in eighth grade, saying,

> I got my first boyfriend in the middle of eighth grade, and he kissed me one day after school on Valentine's Day, and I was like what, you know, but I still didn't have the guts to break up with them until ninth grade of the next year. I didn't know what to say. You know, I didn't want to be mean to a person, so I just let him think we're a boyfriend and girlfriend […] So that opening up the to the dating scene, it was really traumatic.
> - Shell

She continued to have issues with relationships through adolescence. She talked about multiple toxic relationships in high school and the effect that they had on her mental health, including feeling like she "hated" herself at that time. She mentioned about one partner, in particular:

> But anyway, he would threaten to like kill himself every time I, he did anything that he didn't like, or, you know, brought up my mental health, or you know he would try to.
> – Shell

She discussed feeling sexualized growing up, and the challenges that came with it.

> Often, I was more worried about getting sent to the principal office with the clothes I was wearing in school, which happened a lot. And we're living in Florida. It's nearly 100 degrees all the time. What do you want us to wear, because the boys are getting distracted, which we internalize, you know. It was telling me dress appropriate for men because they're going to look at you either way, and they're going to sexualize you either way, and that's allowed. But you're not allowed to wear what makes you feel comfortable. – Shell

Looking back, she felt that she was "naïve" and that the boys and men she interacted with in high school were inappropriate with her.

> He was my best friend, for up until I was about 21, and invited him over to my new house to meet my friends, and he came over way late, and it's like you just grab my face and kiss me, and I like no talking about it, and I'm like "Well, thank you for ruining our 10 years of friendship goodbye", you know, and we haven't like talked since. And he was my best male friend growing up, and I realized, like as I've gotten older and now am 25, I've realized well, actually, 9 of the 10 males that I've ever interacted with have done something to me physically, and not asked or talked about it, or expected it. - Shell

She also discussed engaging in sexual activities despite being "super uncomfortable" because "this is what people do, you know." She felt like she "couldn't say no" and felt that her absent father contributed to this along with societal ideals and her perceptions of self:

> I was so intimidated and also, overwhelmed by the fact that a boy likes me because of all of these stereotypes that I was too chubby or not fit enough. - Shell

Stella described similar experiences where she engaged in sexual activities that she was not always comfortable with but consented to at the time. She found herself less comfortable with male partners because she felt "self-conscious" and like she had to "make them feel like they were doing a good job." However, with her girlfriend she said:

> I just felt safe with her, because I don't know, like we checked in with each other at like every point, and the sexual experience like, whether we were okay, whether it felt good and like, I felt comfortable with being honest. I knew it wasn't gonna hurt her feelings. – Stella

Sam described the challenges related to compulsory sexuality, also feeling a pressure to be attractive and to date men, similar to Shell and Stella.

> I think that if I hadn't felt so much pressure to be attractive to-to, um, men specifically, and hadn't been kind of anxious about, um my sexuality, that, like, I might have found a more like, alternative friend g–like, you know, tried less hard, to like fit in, which could have led to finding people who were like, a little bit more, um, accepting or a little bit more, I don't know, yeah. That could have been really helpful in addition to just like, yeah, society st–like not having all the images and magazines, and all the compulsory of their sexuality, that you know, you feel like you have to have a boyfriend by this age, and all of that, I think that that would have been definitely helpful. - Sam

Participants described varied first dating experiences, ranging from participants who first had relationships in middle school, high school, or who have not yet had a romantic or sexual partner. Participants dated individuals of varied genders and sexualities. Jack first realized she was bisexual in middle school and had a girlfriend in middle school, secretly, as they lived in a conservative town. She reported it being easy to keep it a secret as people assumed they were friends.

> I dated the girl when I was in middle school. Her name was [name of ex-partner] at least, whatever middle schoolers can call a relationship that's what we had […] Um but I was slightly attracted to some of the girls in my grade. I just, you know, really small town conservative, I'm like I cannot let any of them know. And with [name of ex-partner] I think it. It was kind of like kind of went over people's heads, because we're 2 girls. And they just thought we were like the closest, little best friends [laughing], and which is why I think it's easier to be gay as a girl than it is to be a boy, because no one's going to question you really [laughing]. – Jack

Paige also dated a girl, in high school, but was open about the relationship. However, they experienced some "minor homophobia" including the football team pushing back on her and her girlfriend receiving the superlative of "cutest couple" in the school yearbook. Some participants discussed not being allowed to date, but still doing so in secret:

> Um and then, after we had broken up um I had asked my mom. I was just like would it be okay of me with a bi guy, and she was dead no, she got very upset. She was like, no, and she was like, are you with a bi guy, and I was like, no, I'm not. I was thinking, oh, thank God! Um I was not allowed to date. Um so all the relationships that I had were quite private. - Amy

Experiences of sexual assault and abuse in adolescence significantly impacted participants' mental health and disrupted healthy sexual development in adolescence and young adulthood. Amy was incredibly impacted by abuse she experienced by her mother's boyfriend as a teenager, affecting her mental health and well-being both in adolescence and into adulthood. Her narrative describing the incident includes:

> There was also a situation with my mom's boyfriend at the time. Um he had came with us from Illinois. Um and again she wasn't listening to us a lot. Um I wasn't really fond of him when we were in Ill- in Illinois, but she didn't listen to us. She just thought I was just like a moody teenage- uh like a moody kid. Um so he came back with us, and um he molested me. And um so that was just some things that happened then. Um I kept that from her. She didn't know cause she worked at night. Um but I kept that from her because my dumb, teenager, braid- brain heard her say once, like, if this relationship doesn't work out, I'm never trying again. And I was just like I don't want my mom to give up on love. So I just kept quiet type of thing. Um so that was a challenge that I had to go through. – Amy

Although she did not want to expose this man's behavior due to wanting her mom's relationship to work out, he was eventually caught after he tried to inappropriately touch one of Amy's friends. Ultimately, he was put in jail for the abuse after she told everything to the police. Since the event, she has mentioned repressing the experience and not talking about it since telling the police, until this interview. She did not explicitly make the connection between her abuse and current mental health or relationship concerns; however, she did talk about poor current mental health along with difficulty in relationships, including a "disgust" whenever she is about to get into a relationship with someone, that she is planning on seeking therapy for.

Stella and Eleanor were also affected by experiences of sexual assault that greatly affected their mental health and well-being, reporting that they feel triggered or experience symptoms years after the event, necessitating seeking mental health treatment.

> When I was 19, I was sexually harassed by someone. And that is the reason why I recently started going in therapy again, because, although it's been years since that event**,** it still dwells on me um and I'm just now starting to like finally get over it. Um but that

> was the first one that I thought of, because there are still times when I get triggered now. – Stella

After Eleanor experienced sexual assault she spiraled and described thinking, "How that could happen to me. How I could let that happen to me, how my friends and family could let that happen to me" and she discusses working on healing after the event, "It's not like I ever have, like, fully recovered back to who I was before. But I like, I'm okay with that now."

Even those who did not discuss experiencing sexual abuse or assault or domestic violence themselves, some participants mentioned being impacted by abuse that others they were close to went through, and how that influenced their mental health and how they perceived relationships. Margo discussed the impact of her friend's sexual abuse, and "knowing what this man did," contributed to her mental health issues, including suicidal ideation and self-harm.

Jennifer talked about how witnessing her friend's relationships made her less interested in dating in high school:

> My best friend ummm had really tumultuous relationships, like there was some guy she dated who was okay, he wasn't terrible, but they were always like on and off, on and off, and it was just a whirlwind […] And since it's high school, first time relationships, they're always so intense so it's like, okay. So that was- that was a roller coaster. – Jennifer

She mentioned another friend having to get a restraining order against her boyfriend and having to be there for her friend.

Theme 3. Developing Independence, Agency, and Self-Acceptance in Adolescence and Young Adulthood

Participants expressed a desire for freedom and independence as they transitioned from adolescence to young adulthood. Several discussed moving away from trying to "fit in" or being inauthentic to finding social groups and partners that matched better with their values alongside accepting themselves and figuring out their identities. They talked about the added stressors that

come with young adulthood – including navigating finances, living situations, romantic partnerships, academics, and careers, sometimes without support. Some, particularly the participants who were older, felt that their lives had improved in the past several years as they found careers and stable partnerships and came into their own. Others, particularly some of the younger participants, felt still a difficulty with navigating young adulthood, either with acquiring independence, or with managing the struggles that come with this stage of life.

Barriers to Achieving Independence

Some participants discussed conflict between them seeking independence in adolescence and young adulthood and what their families desired from them, or that they lacked the resources or experienced other barriers that restricted them from accomplishing their goals. Participants who felt trapped in a state of arrested development and unable to gain independence and practice agency in their choices in adolescence and young adulthood felt stress, anxiety, and depression as a result, feeling like they were unable to find freedom and live their own independent lives.

As an example of something that several participants experienced regarding taking on a caregiving role for their family, Orange Turtle felt trapped by her role as caretaker for her grandparents, unable to start her career after graduate school so she can be available to them alongside prioritizing her own life and needs during a time when many of her peers could.

> It's like there's been like weeks where I'd have to take care of my grandparents, because, you know, my parents are at work, or at school, or whatever. So, it's like I have to step into this temporary like caretaker, home attendant role that I do not feel comfortable with or qualified for it all, and that was stressful. And it was almost like I felt, kind of underappreciated because it was never like asked. […] I wasn't like sad or depressed about it. I was angry, like an anger that I've never felt, and I didn't like feeling that way, because I think anger is such like a destructive emotion. – Orange Turtle

Sarah also had a parental role in her household after her mom passed, helping take care of her siblings and also contributing financially to the household. She continues to live at home

after taking a gap year and deciding to attend community college. Although she applied out of state, she did not feel ready to move and was concerned about the cost. She wants to move to New York where her partner and friends live, which is also more progressive and walkable, but she had to finish up her degree first before she can move, so it will be another two years before she can relocate.

> [Mental health is good] anytime I can get away from the house, really. So any trips I take, I-I usually will plan quite a few like, extended few week trips to my partner's house [in New York], just because it's very nice being there with him, kind of in, like, a more normal environment. Um, and definitely like, looking forward to being able to move and, cause like, pretty much, all of my friends are like, central in that area. So whenever I go there I get to experience like, everyone being there, which is really nice. And then I think, when I'm like, feeling really rough, I can just look forward to like, um, being able to move there and like, experience that every day. – Orange Turtle

Several participants discussed experiencing challenges related to transportation, for instance if they were unable to get a driver's license since it limited where they could go and their independence. Sasha mentioned being unable to drive and transportation is not 'perfect' and "Ubering everywhere can get expensive" which limits her movement and ability to access resources such as therapy. This compounded her feelings of having her freedom limited due to living in an unsafe neighborhood.

Some discussed how having a car and driver's license was related to freedom and independence. Stella, when she was 17, took her dad's car on "a little joy ride" and crashed it. She explained:

> I think um I just really wanted to have fun, and my idea of fun was driving. I- I think just the idea of it was very exciting to me, it was novel. I'd never been able to drive before, and like I wanted to be able to go different places at the time I was seeing someone um and he, he didn't necessarily encourage me. Well, I guess he was- he was supportive of the idea. He joked that he wanted me to come and see him and drive to him. Um but like the idea to drive was my idea originally. Um I don't know. I just thought it'd be fun. I thought it was like very freeing, because I think I don't know, I just really wanted to get out of the house. Um ho- home wasn't really somewhere that I wanted to be all the time. – Stella

Sarah, when describing challenges she had experienced over the past few years, mentioned challenges related to transportation along with difficulty in being able to obtain a driver's license and afford a car. She found this especially difficult as in her town you need a car to get around.

> Transportation is a huge issue, because again, my family is not super supportive. So it's been very hard for me. I've been pushing for like a license and a car and all that since I was-turned 16. So it's been kinda hard going through like years and years without anybody really helping me. Um, money again, because I work, um, I've worked since I graduated high school, but I also end up–My dad doesn't make a lot of money, so I end up having to-to support him, and then I can't save up for a car, or to move out or anything. Um, so definitely, money has been a problem and transportation. – Sarah

Jack also experienced challenges due to not being able to obtain a license, particularly due to her family's immigration status. Her parents had at first been able have driver's licenses as part of a special program for immigrants; however, that program was phased out, leaving them unable to drive legally. This also made it difficult for Jack to obtain a license when she normally could at 16. However, at 18, and after becoming a Deferred Action for Childhood Arrivals (DACA) recipient, an Obama-era program providing temporary protections and permits for those who came to the United States as children, she was finally able to obtain a license.

Jack also experienced additional challenges and tensions with attempting to find independence in young adulthood. Due to her parents' immigration status, she felt like she could not leave her hometown in Texas, despite it being very conservative and not a great environment for her. She did not want to move to Virginia to be with her partner and in a more progressive area because she was worried something would happen to her parents, that they would get deported, and that she would not be there to help. Since her parents obtained green cards and thus there is less concern of something happening, she now feels able to finally move away without feeling guilty or worried about her family. During the time she felt trapped in her town

and realizing she could not go to college or move away after high school, she was incredibly depressed. Now, in finally able to obtain independence and freedom in where she lives, she feels hopeful. Jack discussed the relief she feels now that her family has residency status and she can feel free to move, crying, she said:

> Now that they have residency um a lot is off my shoulders. Now, I don't have to take care of them anymore. […] I don't have to worry about them like something happening to them and then being deported. – Jack

Ella's transition to adulthood was also disrupted due to immigration issues. After high school, her parents, who were immigrants from Peru, had to leave the country. She and her brother, who grew up in California, had to decide between moving with her parents or living with an aunt in Kentucky. After initially moving with her parents, she then ultimately went to live with her aunt and brother in Kentucky. She described this as a "major life event […] that [she] never expected to happen" that greatly impacted her mental and physical health, including chest pains and breathing problems, that precipitated seeing doctors for her symptoms.

> "I was in my own little comfort- comforting bubble, and it got burst [Laughs] by something, yeah, by something very major that I was... so stunned... and my parents told me and my brother about it, and basically, we had to move." – Ella

She had difficulty adapting to the change, and especially due to her aunt's homophobic views and living in a conservative area with not much opportunity for her. There were additional challenges living somewhere that she did not grow up and had no other connections to. Her mental health and financial instability caused her to not have much choice in where or with whom she lives.

Margo also had little choice in where she lived after high school. When her parents found out she was intimate with her partner, which went against their religion, her father told her she had to leave her house and stop contact with her family. This ultimately led her to live with her

partner for two years until her father passed away and her mom let her move back home and she ultimately broke up with that partner.

> And I ended up leaving [her house]. Only like after a month of dating my current partner, I end up having to move in with them. It was pretty rough and rocky. I was feeling like given the choice, I probably wouldn't have continued pursuing a relationship with this person. But circumstances being what they were. I mean, like we made it work. – Margo

She also discussed the difficulty of moving somewhere and not having friends or family. Shell also moved in with a partner right after high school; although she married him but then ultimately divorced him, experiencing some periods of living in a van and homelessness after the divorce in her early twenties.

Participants who attended college had conflicting experiences – some found it to be a place that was freeing and affirming, whereas some others had difficulty navigating this transition to young adulthood and living independently. Neville mentioned she "was depressed every single day, like not sleeping, not eating" and had to take a leave of absence before going back to college. Others also felt that the transition to young adulthood stressful:

> College was probably the roughest period for my mental health, like throughout my lifetime. Um, and most of that was just like the compounding like young adulthood, like school, is hard, like, I'm learning about new financial stress–stressors since I'm living on my own, trying to figure out a career path, like all those things, just like, kind of, compounding. – Betty

Finding Stability and Self-Acceptance

As participants transitioned from adolescence to young adulthood, many described moving from primarily trying to fit in to moving towards self-acceptance and living more authentically. This period included finding friends and partners who matched their values and figuring out their identity and sexuality. As part of coming to terms with their sexuality, many participants disclosed their sexuality to others during the period of late adolescence and young adulthood, with varying reactions from others. Some are only open about their sexuality in

certain circles such as friends but not others such as more conservative or religious family members.

By the time she was in college, Amy had come to terms with her sexuality, partially supported by going to college and being exposed to a more welcoming and affirming environment. However, she was still very aware of her family's homophobic views and how her mother said she would abandon her if Amy ever brought a girl home. Of coming out to her mother, she said:

> But when I had told her my mentality then was, if she abandons me, she abandons me. That was my mentality. Um cause she had always told me all throughout my life if you bring a girl home, if you're gay, any of that stuff you're like, I'm abandon you like, that's disgusting, that's a sin. So in my head I was mentally callous to that, and I was just prepared to be abandoned. – Amy

Amy had been more aware and accepting of her sexuality when she was in elementary and middle school, but she said her mom, "beat me and put me in the closet" but moving to a "safe space for LGBTQ" at college allowed her to "[come] out of the closet again […] I came out at college where I felt more open and safe."

Jack was also able to become more accepting of herself and her sexuality along with finding friends and partners who matched her values by relocating. After not being able to go to a four-year-college due to immigration and financial reasons, she fell into a depression. But then she went to live with her aunt in a different city, who was more accepting than her parents. The city was both more progressive along with having a larger Hispanic community than her hometown, making her feel more welcome. There, she also had a girlfriend, who her aunt knew about, although she did not tell her parents. After high school she was also able to find friends who aligned more with her values, including a family friend who was also an immigrant. She said of her friends in high school, she felt closer to them than the "rich kids" so she "ignored

things from them […] let things slide" but as an adult she "I realized that they were probably not who I wanted to keep around me or my family, or anyone you know, close to me um just because of the rhetoric they had" so those friendships did not last after high school. However, in high school she did not have as much of a choice, as she was at least closer to them due to them both being lower income, and relied on them for support such as getting rides places, so she ignored their families' views towards immigrants and other beliefs.

Neville also experienced a downturn in mental health after high school. After experiencing depression and anxiety in high school but still getting her work done, once she got to college she had a "stressful and difficult time" where she reached "rock bottom" and ended up taking a leave of absence. However, she was able to seek help and received therapy and medication. She also talked about how in the years post-college she was able to move from being in a toxic relationship to a healthy one (her current one, who is a woman) and moving from a bad job to a better one with a healthy environment. Other participants, particularly the older ones, had similar experiences where they at first struggled in adolescence and young adulthood but in the past few years with help and support and coming to accept themselves and surround themselves with loving people they were able to learn coping skills and be in an environment that allowed them to better thrive.

Aria also noted her mental health has been better since high school, saying she used to be "consumed" by anxiety but since going to college, and when getting the "break" or "getting off the wheel" from being at home due COVID-19 restrictions when finishing high school, she is doing better. She notes that living on her own helps a lot along with making new friends. She felt like in college she could have a variety of friends from different groups including "gaming, studious, artsy, gay." She feels like school is less work in college than in high school and she is

no longer in the stressful environment that she was in high school when she was overwhelmed with trying to keep up with peers in the top classes and robotics club. She notes some normal challenges of young adulthood and college like making friends and managing a schedule and interpersonal conflicts, but overall feels more stable.

These stories from participants who had a difficult time in childhood or adolescence but who eventually were able to relocate to more affirming spaces illustrates even more the challenges of those participants who still feel stuck in their circumstances, such as Ella who is living with her aunt in Kentucky. And how not having the opportunity to go to college, such as in Jack's situation, may be a detriment to those in non-affirming or restrictive homes or communities.

Many participants also discussed the importance of the support and love they experienced from their partners and how that was important to their well-being. This is also in contrast to past relationships they had that may have been more toxic and harmful to their well-being. Several participants talked about the stability that their current partnership brings, and a few participants were either engaged or married. Betty said about her fiancé, who is a woman:

> In my current relationship, you know, countless benefits. Um, just like being loved and supported so consistently and so wholly by someone for almost 5 years. Now, it's just like the stability and the joy that we bring each other is that's great. – Betty

Similarly, Eleanor said about her husband:

> I think probably my like biggest source of joy. Is my husband, just like our like daily life just gotten through just getting me come home to him and hang out with him and just create the life that we have together. – Eleanor

Several participants were in long-term relationships, and several had partners who were long-distance. Margo found a lot of joy in her current partnership, despite it being long distance.

> But the biggest thing that's bringing me joy right now is um my relationship with my current partner. Um It's, I feel like it's a very it's it's relatively new, like, maybe a month

> or 2… officially dating. But it's um very healthy and loving and nurturing even though you know the past couple of days have actually been rough, and they're not even here in the state at the moment […] So it's just been rough on the both of us. But even despite that fact now, just talking to them and touching base. And it it it's like it's like a highlight of my day. – Margo

Participants such as Jack and Sarah have partners living in other states, but the prospect of soon moving in with them and leaving their hometowns brings them hope. Not all partnerships resulted in stability, however, as Shell described marrying right out of high school and moving across the country, but ultimately getting divorced soon after. However, she found that following her divorce from her husband she experienced a time of personal growth, despite challenges such as homelessness and financial instability, "I don't know if I developed any healthy coping mechanisms until I was like 22, maybe, and finally, like, you know, divorced, starting my life over." Now she is in a long-term healthy relationship, and they are searching for where they want to live, outside of Florida. Through her relationship she found she was able to heal some past traumas:

> My partner and I talked about this, how you know ironically, I wanted to be single for a really long time when we got together, and ironically, so did he but we decided to meet together anyways, which is cause, you know, some issues, but it's also helped us heal a lot of this issues that we thought were only possible to heal if we were alone. – Shell

Shell is also enjoying financial stability for the first time because of her work in adult entertainment and she and her partner are also taking programming classes online at the same time to grow their skills and careers.

Others also discussed finding their career paths in young adulthood, including figuring out their majors, attending college, graduate, and trade schools, and figuring out their career paths. Eleanor discussed the joy she felt switching her major from engineering to the humanities and how taking a ballroom class in college helped her find what she really liked:

> I took a like ballroom dancing class, like just very kind of off the wall. I've never danced in my life before […] I took that class and that kind of changed everything for me. The professor for that class. Like one day towards the end of the semester kind of like, sat us down and was like, […] I'm proud of you all for like taking this class because it's not a required class for anybody and it shows that you all are like interested in something more like you're interested in not only movement, but just like the art and the creativity. And you know you're here for more than just like the degree and she then went on to say that, like she had an engineering degree. and she is now a ballroom dancer, like a professional ballroom dancer, so she does not use her degree at all, and she was like, I like, strongly urged you all to just like, really think about like you all have done the first step, and so I like. I'm proud of you for that, and I want you to like, consider, and just make sure, like you're where you you want to be. And that spoke to me. I-I mean that pretty much like changed my life. I think things would been would have been very different if I had not had that conversation in that realization. but so thinking more about that, I was like, Yeah, I hate this. I hate engineering. I don't get to spend any of my time. How I want to be spending it like this was the only class I ever looked forward to and so I ended up change. I mean, I finished out that semester and engineering, of course, and then I changed my major to English and Geography." – Eleanor

Aria also discussed figuring out what she wanted to do, and how her own journey with mental health made her realize she wanted to help people with their mental health. Sam also discussed figuring out what career she wanted to do and how being involved in social justice movements and understanding systems, set her on a path to "rejecting capitalist tendency" and "make more intentional choices of like, how I'm going to be in the world and like, what…what I want my job to be, what I want, you know how I want to raise children, how you know-it's like, that, like, questioning more things and making…different, yeah, different choices, I guess then maybe I would have if I was just focus on trying to like…impress my parents or impress people who I knew and that sort of thing."

Young Bi+ Women's Coping Strategies across the Life Course

Participants described a variety of ways they coped with challenges and improved their mental health across their life course. The narrative inquiry elicited four themes:

1. Seeking Social Support
2. Escaping Problems

3. Finding Joy
4. Accessing Mental Healthcare

The strategies that participants used to manage their mental health often shifted during their lives, with them more often engaging in distraction or escape in childhood or adolescence, versus using cognitive reframing or using therapy or medication as they got older. Participants often relied on support from others, including friends and family, across their life course, with family playing a more significant support role in childhood (although still holding importance through adulthood) and friends being mentioned more often in adolescence and young adulthood. Mental health supports were helpful when it was targeted to participants' concerns (e.g., best practices for OCD), developmentally appropriate (e.g., approaches for children and adolescents were used), culturally competent, and LGBTQ+-affirming.

Theme 1. Seeking Social Support

Participants described social support as essential to their mental health and well-being and mentioned coping by talking to and receiving support from friends, partners, family, and other support people (e.g., teachers, guidance counselors). Those who received support discussed how it improved their mental health. Those who did not or do not receive support, or that the support was inappropriate or lacking, explained how it negatively affected them and how they wished for more support and that better support would have improved their lives, including Amy who felt that she needed "a strong person, someone to lean on." Several participants discussed the important role that a trusted adult played in their lives, or that they wished they had a trusted adult that could have helped them growing up. Different types of support, including instrumental, emotional, and informational, were important for participants with coping with various challenges.

For instance, Jack discussed the instrumental support her family received when she was a child and how essential this support was to her and her family's well-being, particularly due to their immigration status and language barriers. She mentioned support from a family friend who had also immigrated to the United States and who helped her mother navigate resources such as WIC (Special Supplemental Nutrition Program for Women, Infants, and Children) and helped translate for her family. She also discussed learning to speak English from a Hispanic teacher through Head Start, a federally funded program that promotes school readiness of infants, toddlers, and preschool aged children from families with low incomes. These resources and programs, paired with someone who helped her family navigate accessing them, were instrumental in her family's well-being.

Participants also discussed support from family and friends. Participants had varying levels of support from family and emotional closeness. Ella explained her parents helped her figure out challenges, "just me speaking- me having the help of my parents, and then just figuring out the solution then and there" and discussed how her parents helped her navigate academic challenges. Others felt less close to their families and did not feel like they could receive that type of support from them. For those participants, they discussed finding support people outside of the family. For instance, Eleanor, who did not feel emotionally close to her parents, felt that her friends were her "biggest support system":

> "I kind of lacked, like an emotional like connection or relationship with my parents. I really found that with my friends, and so we were like, we were very, very close now. We talked a lot about like the like awful things that we were scared of, and could just like really lean on each other, and like I knew that they were going to support me. I knew that they would continue to like be there for me throughout my life, like no matter what. And so that was, I mean, I definitely leaned on them, a lot" – Eleanor

Sarah also found a lot of support through friends, especially since they "know how difficult my family is."

Teachers and other school staff such as guidance counselors in high school, alongside professors and staff in college, were also integral to participants' mental health, particularly when they were not receiving support from others such as family members or did not feel like they could trust their family members with their emotions.

> "Yes, I actually remember there was a teacher that I confided in a lot my senior year. Um she was the one who ended up facilitating my transition to getting on anti-depressants. And um therapy. Because I was crying in her classroom, and I think it's because, like I, I just felt very safe with her. She is also Vietnamese, like me. And so I think that I also kind of identified like another figure in her as well, especially because she was much more receptive to handling me emotionally, not in a way that my mom was capable of um so. Yes, she was very, very, very helpful. So I think that if I had had, like a uh trustworthy adult figure in my life, then I think that would have been very helpful for me." – Stella

Multiple participants discussed that support from someone from someone from a similar background (e.g., culture or race or ethnicity) and cultural competency alongside LGBTQ-affirming support was essential. When the support person was mismatched or ignorant, such as when Aria went to a non-inclusive Christian therapist or Jack had a guidance counselor ignorant of the challenges of immigrant families, it was a detriment to the person's mental health as they not only did not receive the help they needed but also then were made to feel worse about themselves. For example, Margo and her friend when struggling with mental health issues were told to pray by their teachers at their religious school but received no further assistance beyond that. Jack reflected on wishing she had more support in navigating what to do after high school, particularly in the context of her and her family's immigrant status and financial situation.

> So I really wish that um there was a little more diversity in that kind of understanding for kids, and especially for situations like mine that are a little different. Um like, I said um my counselor, for colleges very just like college, college, college. You can't do anything but college. Otherwise you're not going to succeed. And that really affected me. I think most most of all, because when I couldn't get in. I was like depressed. I was depressed for months because I graduated and I was still at home, and everyone was at college. – Jack

Aria felt that the staff at her school could have done a better job at intervening with how competitive and stressful school activities were becoming, so much so that it was affecting students' mental health. She said about what would have made her mental health better in high school:

> Maybe like a school counselor who actually like, knew what they were talking about for mental health stuff, and like, could recognize those symptoms in other people. Because I feel like people were so competitive in classes, obviously. But like in robotics like, that's the most competitive environment I've ever been in […] that still is like the most like fast paced awful and we were supervised by like these adult mentors the entire time. And now I look back and I'm like, how did they not like look at that and see these high schoolers like running themselves into the ground and be like No, go home today like. So I guess I wish I had more adults who, like, stepped in and intervened someone who recognized that I was like so anxious all the time, and that, like I like hated. I hated myself so much in high school, and I wish there was just like someone to recognize that and step in or maybe like more information on mental health stuff. […] So maybe like more education on what mental health stuff like looks like […] just like some kind of screening with like a trusted adult, where, like you can just say all the shit that's going through your head because I mean, I never talked about my thoughts with my family so like. And I wasn't going to talk about it like my teachers. So who's supposed to know some sort of trusted adult is a resource that I would have benefited from I think. – Aria

Several wished that they had a queer or bisexual role model or support person, particularly, and how that would have helped them better understand their sexuality. Betty, who struggled with her sexuality in adolescence, said:

> So I think, like having other people, especially people who identified as bi, or queer, or something like, more in the middle of the spectrum would have been helpful, um, to like validate that. And like, that's a real sexuality, and I think that would have been good. – Betty

Participants varied in how connected and supported they felt by the LGBTQ+ community, with some, particularly those with same-sex partners, feeling very connected and gaining a lot from that connection, versus others, particularly those who are not as out about their sexuality and with cisgender straight male partners, felt either disconnected from the queer community or less welcomed due to their partner's gender or due to being bisexual. Several

participants felt that a main benefit of their sexuality was this connection to the queer community.

> I mean, I definitely think that, like, the people that I like are mostly in the queer community, and I get access to that (laughs) by being queer and that's cool. Um, and like, I think…yeah, I mean, I think this like the-the…and the people are a big benefit. It tends to be people there like, more open minded, and have more, ar-are I think, more prone to like, question the way the world is, because they've already gone against the way the world is in like, a very clear away. So that means that there's kind of a willingness to do that, and to like, think about ways to do that. Um, so I think that's like, definitely a benefit." – Sam

Paige discussed meeting her friends in college by joining an LGBT group chat for her college the summer before her freshman year. This provided a form of social support for her along with providing connection to the queer community and allowing her to find an affirming space.

> We started talking in there like the summer, you know, when I graduated high school before I started college. And I mean there's still some of my best friends today. it was, there were probably almost like a hundred people in that group, and I obviously only keep in touch now with a few of them. But it was a big source of you felt like you had a network even before you started school. So it really is my anxiety about you know, going to college and trying to find friends and stuff. And I ended up living with most of them freshman year like so it was a huge source of support that I found for college before I even, you know, officially started. – Paige

However, some also felt that they were limited in their connectedness either due to not being out about their sexuality, lack of acceptance in the LGBTQ+ community in regard to bisexual people, living with non-accepting family members, or living in unsafe areas for queer people. Jennifer felt that those around her would not be "the most comfortable" with her being more connected to the LGBTQ+ community, and so by "keeping that under wraps" she is not as connected to the community. Stella felt difficulty fitting into the LGBTQ community because:

> "I feel like there, it is like a little difficult for me to kind of fit in, just because like I feel like I just don't look like I'm part of the community. And so I feel like I almost like fight for my spot or like prove that I'm part of the community, cause even then I feel like some people don't really like that recognize bisexuality as like a valid sexual orientation, anyway, even within the community." – Stella

Ella also discussed feeling not particularly connected to the LGBT community due to not being out and not being in an affirming household or area in Kentucky; however, she found some connection through social media. Others as well mentioned finding queer content through platforms like TikTok, Twitter, Instagram, and Tumblr that allowed them some connection to the queer community despite not being connected to the community in person.

Theme 2. Escaping Problems

Participants described a variety of strategies for managing their mental health and coping with challenges across stages of life. In childhood, many participants described not really having many coping strategies at that age, not understanding what coping was, and that they mostly "lived through it" (Betty) or "felt their feelings" (Stella). For coping in adolescence, participants described using escape and distraction, through social media, reading, writing, daydreaming, creating stories, watching TV, and playing video games.

> Um, I feel like I was on social media a lot more as like a distraction, I think, like that's kind of always been my coping mech–coping mechanism is just like distracting myself. So like I spent a lot of time on Tumblr, and, like Instagram, was new at that time, so like I was always on that, too – Betty

Several participants discussed finding escape through worldbuilding, fantasy, creating stories, and writing. Sasha said, "I would write a lot back then, especially I would make little fantasy stories and I guess I would use that as my escape."

Many discussed finding an escape through reading, and Amy said she was "really into reading, so I would just like divulge myself in books" and Sarah said reading was an "escape" of hers. Several participants discussed spending a lot of time at the library in childhood and adolescence, finding it a safe space where they could spend time reading and also accessing technology there. Jack would spend hours at the public library while her mom did laundry, going to read their "all the time" including on the weekends for teen programs where they watched

movies and did arts and crafts. She said, “I think the library really helped because I could just like get so many books and read them. And you know, kind of keep myself busy.”

Some participants played video games online with friends, with Sarah finding that particularly helpful since she was moving around so much and so it was hard for her to maintain friendships in person.

> I started playing video games a lot (laughs). Um, I made that–that was kind of–especially because I was moving around so much and I couldn't maintain a group of friends. When I-I started playing games, a lot, met people online, and then it was very easy to keep in tou–contact with them, even if I moved. So I think that definitely helped me a lot, just kind of having like, an escape like that if I needed to. – Sarah

Several participants discussed using substances to cope in adolescence and young adulthood, particularly cannabis. Participants found cannabis use helpful, especially during very stressful times in their life or to aid in sleep, but some were also concerned that it was becoming “maladaptive” and at times have tried to lower their use or stop entirely. Sam said about using cannabis:

> I started, yeah, smoking a lot, just to kind of be like, “I don't want to think about this anymore, I need some time off of thinking about this, and of doing all of this stuff”. Especially to help me go to sleep, like, I stopped being able to go to sleep as well, as quickly. I've always been a very good sleeper (laughs), and I wasn't able to sleep very well. So, um, yeah, and I do think that even if it became kind of maladaptive like, it was really helpful to have available to me like, in again, just like to help me get through those kind of…short term parts, like, just like when, like in those yeah, in those specific like weeks when they really tough, it was like, thank God, I have some–some escape from this. – Sam

Aria also regularly uses cannabis, every day she will “smoke or take an edible” but views it as helpful because it makes her “a bit less anxious” and allows her to focus on conversations she’s having with people instead of worried about “peripheral shit.” Whereas some participants used cannabis to escape or relax, Stella discussed micro-dosing mushrooms as a way to help her “come to certain conclusions” and help her mental health and heal from trauma.

Several participants also talked about using self-harm or their eating disorder, including bulimia, as a form of coping with challenges, particularly in adolescence. Shell felt that she did not form any "healthy coping mechanisms" until adulthood, and instead in adolescence would engage in potentially harmful forms of coping like self-harm and bulimia to help her cope:

> I had a little bit of a self-harm period in early high school, which, you know, my mom ended up finding out about, and I ended up getting help. But that was a way where I felt like maybe because everyone else was causing me so much pain and nobody wanted to deal with it, that if I caused my own pain, I could heal myself from it, and it would be fine. […] I developed an eating disorder, and in eleventh grade was bulimic and I would like to throw up all my meals and that got really bad. I was like at 1 point, only 94 pounds when I was in twelfth grade." – Shell

Sam felt that as she recovered from her eating disorder, she "replaced" it with cannabis instead:

> I'm dealing with is kind of the replacement of my eating disorder with drugs instead, um, and specifically with weed instead. Um, and like using that and kind of a similar way, and it being a little bit less damaging, but still–And so I think that that kind of cycle started then, um, and is something I'm-I'm a little bit–like it's-it's getting better. But it's still definitely something that I'm like, working on right now. – Sam

Theme 3. Finding Joy

Some participants described managing their mental health mostly through positive experiences and activities that brought them joy such as art, music, crafts, writing, reading, journaling, leadership programs and clubs at school, spending time with friends or family, exploring, exercising, spending time in nature, meditating, spending time with pets, and playing sports. Participants described enjoying things that "normal teenagers" (Amy) get to do, with several participants talking about being able to hang out with friends, join school clubs, and going to social activities like prom as times they remember feeling joy. Neville talks about joyful times in high school and particularly how she thinks they affected her mental health:

> Probably whenever I was with friends, um, I had like a couple of different best friends in high school, um so whenever I was with them [I was happy]. I also played sports. I did

> synchronize swimming, and Taekwondo so. I didn't like synchronize swimming, but when I was at Taekwondo it definitely helped my mental health, because it's not only the physical exercise, but it's a more intense, you know, martial arts. So you're getting your frustrations out. So that was that was super helpful. I don't think I fully like understood that that was almost a coping mechanism at the time. But looking back at it definitely was was helpful in getting out frustrations. – Neville

Paige talked about "thinking of the positives" and "focusing on having fun" along with talking with her parents and friends as ways of coping with challenges. She would also "do like therapy in my head in a way, and just kind of like process how I feel about things, and kind of like just talk to myself in my head."

Betty also tries to focus on things that make her happy and tries to avoid ignoring her feelings and not rely as much on distraction techniques.

> Um so I think, like I–I work out pretty frequently. Um, doing like weightlifting type of exercises. Um, I like to crochet, um watch TV. Just like finding other hobbies that make me happy and like, fill some of that like, distraction, kind of coping mechanism, I guess. Um, but trying not to rely too much on the distraction part of it, and trying to kind of like. acknowledge my feelings as I feel them, and like…before they kind of spiral out of control into the anxiety that takes over. Um, so yeah, I guess just like that's–that's I don't know if that's a great answer, but like doing things that make me happy and not ignoring my feelings when I have them. – Betty

Shell discussed coping strategies like nature meditation and yoga, along with the joy she feels from singing:

> But when I'm all alone, I just like my thoughts become a song, and all of my emotions come out with my words, and I think internally, I, you know, I'm still afraid to upset people with my inner truth, so I don't want to sing in front of people, because then I'm afraid, well, something that I'm you know, feeling deep down that I may not know how to voice yet might come out. – Shell

Theme 4. Accessing Mental Healthcare

People had varying experiences with mental healthcare, with some feeling it "changed everything" (Neville) versus some others having negative or neutral experiences who did not feel it was particularly helpful. Most participants had some form of formal mental healthcare at some

point in their lives, and those who had not usually wanted it but could not access care due to insurance, cost, transportation, and stigma within their family.

Several participants first received therapy and/or medication as children. Those that did found it less useful when it did not feel particularly geared towards them, and more helpful when it was. Betty was first diagnosed with OCD as a child, and although looking back she wishes her therapist had incorporated more techniques specifically geared towards her specific issues such as cognitive behavioral therapy like what her younger sister now receives, she felt that "just being able to talk about it was helpful. Because I think the isolation of it was really a factor in making it difficult. So even if the therapy wasn't directly helpful, it was nice to talk to someone about it." Participants also reported difficulty in knowing how helpful therapy or medication was for them at that age because at that young of an age, as Betty put it, "when you're 8, your parents take you places, and you talk to the people that your parents want you to talk to" and Ella similarly saying "it was something that I just had to go to." Ella also felt like therapy would have been more helpful if they used approaches geared towards children.

> The approach that was used for me as a kid wasn't really maybe the best, or at least I didn't really... get it, or understand it much, but I feel like nowadays there's way better approaches and environments for kids to deal with these unlike in my time. – Ella

Several participants who discussed receiving therapy in childhood or adolescence talked about how they were surprised and frustrated when they realized that what they told the therapist was not confidential and then the therapist told their parents everything they said.

> And then I went to one session with an old woman that I didn't relate to at all who asked me if she could use like Christian therapy stuff like in the session, and I was just like, I don't vibe with this woman. This is not my kind of therapist, so I had one session, and I remember I like cried during the session when I was explaining stuff, and I overheard her afterwards telling my dad like oh, yeah, like, she cried when she was talking about stuff that means she has depression or something adjacent to that. I was just like no, this is not the place for me. So I didn't go back, and my dad didn't really pressure me into like trying anything else again, or like, ask me about it. – Aria

Others found therapy less helpful because they felt pressure or anxiety related to therapy.

> This lady is being the person, but I would meet her with her like once or twice a month, but it honestly gave me more pressure. I felt more anxiety meeting with her, because, like um I'm supposed to meet with her, the advice she's supposed that she gives me and helps me out with. It's supposed to help me, and I'm supposed to, you know, do better. But every time I meet with her, I just felt anxiety and like stress. I'm like, I'm gonna have to meet with this lady. And it was it was really bad. I hated it. – Amy

Jack also cited that, along with barriers like cost, another reason she did not want to continue therapy was that she felt like "because I have to be sad for a while to… like kind of explain why I'm sad to fix the sadness" and that the results of therapy did not happen "immediately." However, she regrets not continuing with one therapist she had after high school because "it probably would have helped a lot, especially because […] she was like in her early thirties, I think. Um so she seemed to kind of really understand what I was going through, and it was very comforting that- that someone did understand."

Participants discussed challenges accessing therapy and medication, including practical challenges such as citing high costs, insurance difficulties, limited transportation options, and long waitlists to access care, alongside other barriers such as stigma.

> Um in a way a little bit embarrassing because of the whole stigma that comes with going to therapy. Once you say you have a therapist people automatically assume that you're crazy, or something or something's off with you because people automatically assume that your friends and family are enough to talk to, but since that this is supposed to be unbiased. sometimes you need that in your life to help you have a balance of like you have your friends and family support still, but then you have this person that you could go to that doesn't necessarily know every detail about your personal life but it still help you in your current, or even pass things that you're trying to still get through. – Sasha

Orange Turtle also feels limited by a combination of cost and stigma within her family:

> I haven't undergone anything like like a therapy like a, you know, actual professional services. I think that's something that would be helpful if something I want to try, and that almost everyone that I know has kind of recommended. But it's just kind of a- a financial limitation, and I think my parents are a bit traditional in the sense, or they don't really believe in therapy and that sort of thing. – Orange Turtle

Eleanor at first struggled with therapy, feeling like she put up a wall, but after going to therapy after a traumatic event she discussed the positives, saying, “But after, like the very the first, like super traumatic thing happened to me. I started getting into therapy seeking help for that. And so I learned a lot of strategies to deal with that specific situation. but also a lot of strategies that apply to, you know, anxiety, depression.” Neville also found therapy useful for her, particularly after she felt she was at “rock bottom”:

> I, I think that everyone should have a therapist, I think that it's, you know it's super helpful, not just when you're in crisis mode or anything. I mean, it's it's something that it. It's just helpful to speak to an unbiased person. who can give you insight onto how you're feeling. And um it's it's definitely expensive, especially if you're not able to use insurance. So there's a there's a financial sort of downfall to it. But I think that if someone has the accessibility to it that that everyone should take up that offer. Um it's it's super helpful in it over the past 2, 3 years. It it's helped me a lot and helped me realize a lot of negative behaviors that I was doing and to ways to fix them. – Neville

Many participants also had experience taking medication to help manage their mental health, with anti-depressants being the most common. Some found it useful and others experienced side effects such as weight gain or feeling “foggy” (Jack). They also mentioned the difficulty of withdrawing from anti-depressants and the challenging withdrawal effects that can occur. Some, like Betty and Eleanor, found them helpful but are slowly weaning off them since they feel like they are in a more stable place and have other coping mechanisms to help them. Others, like Jack, tapered off too quickly and felt bad side effects, “I did not taper off correctly, so the side effects were awful. I was just like just like feeling of doom at some points to because of the withdrawal. It was just like awful.”

Young Bi+ Women's Intersecting Mental Health and Sexual and Reproductive Health Needs and Experiences in Context: A Reflexive Thematic Analysis

From the thematic analysis, I found that overall participants felt that their mental health and SRH were "connected" (Neville) and "intertwined" (Shell). They provided various examples of how these aspects of their health impacted each other, including how their mental health affected their SRH, how their SRH affected their mental health, and factors that affected both aspects of their health. Additionally, they provided examples of ways that bi+ women's mental health and SRH could be better supported. These are outlined in the following themes:

1. Bodily Autonomy and Agency as Essential: The Impact of Sexual and Reproductive Health Issues and Experiences on Mental Health
2. "It's a Negative Feedback Loop": Mental Health and Sexual Behaviors Intertwine
3. Common Factors Affecting Mental Health and Sexual and Reproductive Health
4. Desired Supports to Improve Bi+ Women's Mental Health and Sexual and Reproductive Health

Theme 1. Bodily Autonomy and Agency as Essential: The Impact of Sexual and Reproductive Health Issues and Experiences on Mental Health

Participants generally felt that their SRH impacted their mental health, across various domains. They felt overall that the "body and mind are connected" and that "if reproductive or sexual health is not doing well, then the mental health is going to be affected as well" (Neville). They felt that autonomy in their reproductive decision-making and access to services was essential. Further they explained having varying experiences with contraception methods along with the impact of reproductive health concerns on their mental health and overall well-being.

A common thread across interviews was women's desire for bodily autonomy and agency, and the frustration that arose when they were restricted from having that autonomy, whether due to policies (e.g., lack of access to abortion), stigma (e.g., around abortion, contraception, sex), negative healthcare experiences, or sexual assault or abuse. Participants discussed mental health in relation to potential pregnancies, past pregnancies or pregnancy scares, fear around what would happen if they were to become pregnant, and their desire to, or to not, have children.

Neville discusses her decision to not have children and the pushback she received when deciding to get a salpingectomy (i.e., fallopian tube removal).

> Before I got the surgery, and before I had um access to people who were accepting of that, and were willing to listen to me on that, that definitely took a toll on my mental health a little bit because it was just frustrating to not have anybody listen to me, or believe me, when I, when I said these things about not wanting children. – Neville

She expressed frustration at the comments she would get when people found out that she never intended to have children and received the procedure, such as that she would regret it, along with the initial difficulty of finding a doctor who would perform the procedure, "It was really difficult to find a doctor that would allow me to do it at such a young age," but then she was able to go to Planned Parenthood who were "immediately open to providing me with this resource" and "very non-judgmental." She expressed relief that "I never have to worry about [unplanned pregnancy] even though she is currently dating a woman. Many participants echoed Neville's feeling of relief that they were protected from unplanned pregnancy through using other types of contraception.

> I think, like existing with like Nexplanon, even though I have no plans to like- even though I have no plans to have sex with anyone right now. It does make me feel just like more confident, secure existing, knowing that, like, I am protected against an unwanted pregnancy. I think it like kind of decreases my anxiety a little bit and it makes me feel

> like, if I did enter a relationship with someone who had a penis, I would feel like less like, it's one less thing to worry about. It's less stress. – Aria

Others still felt some anxiety despite using contraception, particularly those in more conservative or religious families or states who may not have the same access to resources should they become pregnant.

> So I have comfort in [using contraception]. Um but there's always that fear with my parents being Catholic their way they are, and Texas being conservative. The way it is that if something were to happen that was against what I wanted like becoming pregnant on any form of birth control that I wouldn't have um the option to to end it, because I mean, obviously, I don't want it if I'm on birth control. Um and that's always the fear is just, you know, something could go wrong, and then I'm stuck with it for the rest of my life because of where I am and who I'm surround with. – Jack

Paige discusses paranoia around pregnancy scares and the importance of autonomy in reproductive decision-making on mental health and how knowing you have access to resources should you become pregnant helps alleviate the stress:

> It is a huge stressor […] but I think having autonomy is the biggest source of not having it affect your mental health, you know, like I think you know, if you're like oh, shit I'm pregnant […] you know you have those like negative thoughts about it. But in the back of your mind you know that you can go to a health care provider, or planned parenthood, or something like that. That's a huge source of comfort and support, and the idea of that being taken away is like terrifying. So I think they're very interconnected. […] for my friend, who had gotten an abortion before, I mean, that was a huge source of I mean, the procedure itself can negatively affect your mental health. But I think not having the option would be even worse. So I think they definitely have a close relationship that you know mental health and reproductive health and having options right or having the ability to get birth control or something. – Paige

Further, those who did not have access to contraception felt that was limiting to them. Sarah was first put on birth control in high school to help alleviate cramps, but when her grandmother found out she made her stop taking them due to concerns about breast cancer risk and also that it would mean Sarah would have sex. Since she was a minor, she had to follow what her grandmother said. However, she recently started birth control again since she is an adult. Orange Turtle's mom similarly did not want her going on birth control as a teenager that was recommended for

acne because of the implications around sex. Since Orange Turtle is still on her parent's insurance, she is unable to access birth control which causes stress and anxiety for her. Orange Turtle talked about being worried about it showing up on their insurance statements, which would be a problem for her since her household is very religious and more conservative about sex. Not being able to access contraception negatively impacted her mental health.

> I think I would feel a bit more comfortable in doing the things that I enjoy if I had better access to certain like you know, reproductive care like […] birth control. I feel like there is still anxiety related to sex, and accidentally being pregnant from not having access to that. That's probably a major issue. – Orange Turtle

Those who did have access to SRH services, along with having positive sexual experiences, felt that improved their mental health:

> I think the fact that I do have good, um, like sexual and reproductive health, contributes to having a positive–having positive mental health experiences. Uh, I think like, if I didn't have access to services I needed, or if I had, like, a negative relationship with sex, or poor communication with my partner, that would certainly have a negative impact on my mental health. Again, luckily that's not the case. But I think that…part of the reason that my mental health is, um, in a good place is because I don't have challenging or negative experiences in that a–in those other areas right now. – Betty

Others similarly felt that if they did not have access to SRH services that would negatively affect their mental health, with Margo saying, "if I have inadequate access to sexual and reproductive health services […] then I have a lot more anxiety about it" and "If I didn't have the support or the resources I do now... because it would be so much more risk […] you are an adult with agency and you want intimacy with you partner that you trust… you don't want to be like I'm going to jail [for accessing care]." She further discussed how trust in your partner around safety in SRH helps improve mental health because it reduces stress and anxiety, saying "you need your partner to be in your corner" when having sexual relationships.

Participants also felt that their agency and autonomy was taken away, and their mental health subsequently impacted, when they were sexualized, taken advantage of sexually, sexually

abused or assaulted. These experiences caused long-lasting trauma for participants who experienced them, including causing PTSD, anxiety, depression, and relationship and intimacy issues directly after the event and years after, along with having difficulty telling others due to embarrassment and shame or feeling like "no one was gonna believe me" (Stella). Eleanor felt her experience "shook up [her] whole world" and had a huge impact on her mental health, and ever since she has been working to stabilize it and learned strategies in therapy to help her. Although she's doing better, she still feels that there are "some moments that like that specific event comes up" and that she "can get caught in that kind of head space." Stella also talked about the long-lasting impacts of her sexual assault and how she still gets triggered.

Participants who did feel agency over their SRH, including being able to have sex with partners they trust and comfort and support in their sexualities, reported feeling happier as a result.

> Um, I mean, I definitely think that I'm in a better mood when I'm having more sex. Um, I think that it's, um, and that like, yeah, feeling safe doing that. It's obviously an important part of it. – Sam

Participants discussed a variety of experiences using contraception, including benefits and challenges, side effects, and effect on their mental health. Most participants reported using some form of contraception at some point in their life and discussed a variety of methods such as condoms, rhythm method or fertility awareness, hormonal birth control, hormonal and non-hormonal intra-uterine devices (IUDs), and the implant. Amy reported not using contraception as she has not yet had sex and talked about not wanting a birth control device "inside" of her. Most reported using a form of contraception instead of or along with condoms. Many of those who talked about being on hormonal contraception (e.g., hormonal IUD, birth control pills, or implant) talked about starting it for reasons other than sex, such as to alleviate symptoms related

to Polycystic Ovary Syndrome (PCOS), painful or irregular periods, or acne, and several started these methods at younger ages such as 14, 15, and 16 due to these concerns. Several participants used multiple methods over adolescence and young adulthood. Several participants discussed side effects of birth control such as headache, mood swings, weight gain, and less sexual interest. However, they also had positive effects such as less cramping, leveling out hormones, and less anxiety due to feeling protected from an unplanned pregnancy. For several participants, especially those who experienced heavy periods, they liked that birth control lessened or got rid of their periods, and particularly how that eased their day-to-day activities as they did not have to be “on edge” about being "embarrassed” at school or in other activities due to heavy periods.

Jack described her frustrations after experiencing negative side effects getting the implant:

> I think it did affect my mental health for a little bit there um definitely a lot of weight gain when I got it put in um nothing had changed other than type of birth control method I was using. I was 145 pounds at that time, and then when I got it removed, I was 230, so I definitely think it did affect you know my my weight and just kind of my body. Um I had a lot of headaches to constant headaches about like 4 to 5 a week um from like lunch time until bedtime. Just horrible headaches! Um and when I went to my doctor it was a previous doctor that I had. She did not think that there was any correlation between the two, my my birth control, and what I was feeling. Um told me to just drink more water and exercise more, and I was just like I have not changed anything in my life [laughing] except for this for the birth control method. So once it was time to switch it out and get replaced. I was just like, I don't want it. Just take it out. Let me just do birth control pills. And that's what I did. – Jack

Paige similarly experienced moodiness, headaches, and weight gain after taking birth control, for her, the pill, but talked to her provider and was able to switch to a brand of birth control that worked better for her.

> I'd say overall, it's been okay. I think when I first started I dealt with like a little bit of moodiness or headache occasionally. I do think it affected probably like my eating habits, and, like probably caused some weight gain. But it's hard to say, you know, because I was also in college. So it's like, was it the stress? Was it the college? Was it the birth control, you know. Probably a little bit of everything. So, but I do associate it with weight

> gain. But overall and so when that happened, I talked to my provider, and we switched a brand that she thought, would be better and since then you know, it's been overall pretty good for me. So I don't really have any complaints. – Paige

Several participants discussed difficulty remembering to take the pill every day. Shell particularly felt stressed about having to take a pill every day, but also did not want anything "inserted." Shell linked difficulty remembering the pill to difficulty with self-regulating she experienced.

> Yeah, I was always taking the pill, I've always been really afraid of surgical anything, so I never wanted to do the IUD or the thing people get inserted in their arm, because that just scared me really bad. And I was always, you know, I had a hard time regulating anything, emotions, time, etc., growing up so I'd often forget to take, remember, control, and often like would forget for a really long time to the point where I, you know, be like my, can I take it? This is gonna really affect me, and it always bothered me that, you know, if I stop taking this thing, these pills for a certain amount of time, and then sort of taking it back. I could really mess up my internal system, and that it was like, Whoa! You know, I, maybe I shouldn't be taking this in the first place, if it has that much like, responsibility on me to take them. I'm supposed to -to not get any of those bad consequences. So yeah. – Shell

Beyond contraception and pregnancy prevention or abortion, participants discussed other reproductive health concerns that affected their mental health. Several participants discussed issues with heavy or painful periods or similar issues. Two participants, Sam and Sasha, discussed having PCOS. Sasha discussed the negative impact that PCOS had on her mental health, including how her severe symptoms of bleeding and cramping affected her day to day life and caused pain and embarrassing situations.

> At one point I was bleeding every day, so that kind of affected my mental health because I felt like I couldn't do certain things like other people could, because I was always on edge worrying about embarrassing situations, or I was always in pain because it would cost me to have excruciating cramps. So I felt like I was just miserable. And I still went through that even now, in my adult years. – Sasha

She went on birth control at 16 which helped her have lighter periods and improved her day-to-day, but it also came with other side effects such as headaches and being more emotional. She also discussed her fears over how PCOS may affect fertility:

> Well, the major thing I can think of is because of my PCOS. It could be disheartening because I was always scared of will I be able to have kids in the future without the multiple miscarriages or without worrying about having a dangerous pregnancy, so that affected my mental health a lot. When I found out that I had it. it made me feel like there was a possibility that my dream of becoming a mom was gonna get cut short. – Sasha

Sam discussed getting an IUD due to her PCOS symptoms. However, she also discussed how her eating disorder could have caused the shift in hormone levels that made it seem like she had PCOS, which she had not disclosed to her doctor, so she is currently unsure of her diagnosis. She and her female partner may want children in the future, and Sam discussed purposefully seeking out a queer physician to remove her IUD so she can have a more affirming and supportive discussion with someone who was knowledgeable of queer issues and fertility options for same-sex couples. Similar to Neville, who wanted her doctor to affirm her choice to not have children, Sam discussed similarly finding a doctor who could affirm her and her partner's choice to potentially have children someday.

Theme 2. "It's a Negative Feedback Loop": How Mental Health and Sexual Behaviors Intertwine

Almost half of the participants discussed how their mental health influenced their sexual desire, behaviors, relationships, and dating. Amy experienced molestation from her mother's boyfriend as an adolescent, an experience that has reverberated through her life even as she chose to ignore it and not speak of it after he was caught, and she told the police everything. She discusses her worsening mental health the past few years and also the "disgust" she feels when she thinks of forming an intimate relationship with someone. Despite this, she desires a partner

and the support that comes along with having a strong committed relationship. However, in her current mental health state she does not feel like she can date.

> Honestly, if I had a better mental health I'd probably be out there [laughs]. […] if mentally I was more stable um I would first, I would probably, like, you know, try and experiment things. But other- I would try to find like a stable relationship. Um because one thing that I had told myself was, I want to take care of myself first before getting a relationship with someone else. Um and so that's [laughs] take care of myself. It's been that long, it's been this long, and I still haven't taken care of myself. So I've been single all this time cause I just don't want to um one take care of someone else while feeling like this, and I don't want someone else to care to me when I'm feeling like this. Um when I was speaking to the dude that I'm speaking to now um when I was feeling a lot worse about myself then. Um I always had high anxiety, and I was just comparing myself to literally anything. And I was just like he's not gonna like me. I feel gross like I'm not the right girl for him, like my mental health, took a huge hit every time I spoke to him. – Amy

She goes on to discuss other challenges around dating such as self-consciousness about her weight and body image issues ("I'm uh I'm pretty big um and so that's like an anxiety I have still to this day is just my weight around him") along with internalized homophobia she still feels due to the homophobic household she grew up in ("internalized homophobia that I haven't gotten rid of um which is just like thinking of getting in a relationship with a girl, um I sometimes feel gross about it"). However, she also feels that the loneliness and lack of support from not having a partner negatively affects her mental health, in turn.

Betty also felt that her mental and sexual health can be a "negative feedback loop" where if she is in an anxious state, she is less interested in sex, so then she will think about not having sex which causes anxiety and stress because she is feeling like she may be "doing something wrong," which causes her and her partner to cycle when one or both of them have rough patches and are not having sex as often as a consequence. Despite she and her partner being very open and communicative, along with being understanding when someone is not interested in sex, Betty feels like she is not getting the positive mental health boost when they are not having sex.

Neville, Shell, and Stella also talked about the complex ways that their mental health impacted their sexual desires and behaviors. Shell felt like she was consistently taken advantage of in her youth due to her inability to say no that was in some ways a consequence of her mental health at that time. Stella talked about when she was vulnerable or sad, she made choices that were maybe not the best for her:

> Hm in the past like if I was feeling like a little more lonely, or like maybe a little more sad, it would make me a little more vulnerable to um ending up having sex with like guys who really don't deserve to have sex with me um or me being like a little more impulsive like if I have like poorer self esteem then I might be more inclined to have sex with someone just to feel like I'm like desirable. – Stella

She also discussed how after her sexual assault she thought she was "fine" because she was still having sex and forming relationships but realized later she was experiencing hypersexuality as a result of her assault.

Neville talked about both becoming less sexually active when depressed and anxious, but also "acted out" sexually as well.

> So like looking looking back on that because my mental health was so poor at the time it definitely caused me to make decisions that I wouldn't necessarily that I wouldn't normally make sexually. And yeah, either was not in the mood for sex at all, or I would act out sexually. So it definitely affected me. – Neville

Theme 3. Common Factors Affecting Mental Health and SRH

Participants described several factors that affected both their mental health and SRH. For example, participants' well-being was embedded within the socio-political context and systems in which they lived. For instance, policy changes, economic factors, healthcare access, education, social and cultural norms, experiences of marginalization and discrimination, social movements, and the overall political climate were described as affecting their mental health and SRH through multiple pathways.

Policy changes such as the decision in *Dobbs v. Jackson's Women's Health Organization* in 2022 that overturned *Roe v. Wade* and made abortion and reproductive healthcare inaccessible in many states affected participants' mental health and SRH, both directly in care that they are able to access and SRH decisions, along with tertiarily as they cited anxiety around the policy changes and worry for themselves and friends and families along with feeling concerned about the overall trajectory of women's rights in the United States. Several participants also discussed how these policies affect their decisions on where to live in the future, and their decisions on if, when, where, and how to have children. This was particularly salient for those in same-sex relationships who already face additional barriers to having children. Sam, who expressed wanting children with her partner someday, mentioned the challenges that the *Dobbs* decision brings up for pregnancy intentions and ensuring she is in a safe location to be pregnant if that is the route they choose.

> My girlfriend's in medical school, she's going to be going to residency soon, you don't have too much control about where you live. And I think that like, we talk a lot about how we can make sure that it's somewhere that's safe. Because, you know, even because once we are pregnant like, you could need to terminate for a number of reasons. And like, even that–you know. So it's like making sure that we're somewhere where that's safe and legal. Um, and yeah, so I think it-it definitely like, affects kind of those big decisions about where to live, um, where to work, what kind of health care to have. - Sam

Several participants plan to move to a different state as soon as they can, partially due to the restrictive policies and socio-cultural environment in their current area:

> I guess, by definition sexual and productive health especially in the state I'm especially in the state I'm in, in Kentucky, [Laughs] I know about- it's- it's actually been bad for those who want ummmm yeah, for those- for those of us and LGBT folks who want, yeah, access, that's actually very bad here, but I don't really need to access that, because right now, yeah, that's it. So really, my wellbeing in relation to that, honestly, I guess- I guess right now, I would say it's not really bad, but it's not really great, either, because of what I know about Kentucky. But then, again, I don't plan on staying here in Kentucky for like forever. – Ella

Jennifer, who had an abortion in Arizona right before the *Dobbs* decision went into effect, discussed her worry over being able to get the procedure since there were restrictions due to COVID-19, but luckily was able to go to Planned Parenthood since they were not closed. However, due to requirements for waiting until she was six weeks for an appointment and additional restrictions with scheduling an appointment, she ultimately was in her second trimester when getting the abortion and was charged more for it, which was a strain on her due to her financial situation. She also discussed having to go in for two appointments: one to get an ultrasound and hear the heartbeat and one for the procedure. She discussed how she was grateful that at least it happened prior to *Dobbs*, saying, "I'd rather not have gotten pregnant at all, but at the very least I got pregnant before *Roe v. Wade* got overturned" and discussed how she worries for those who have less resources and support than her.

Some participants described the challenges receiving an abortion post-*Dobbs* for people that they knew. Jack discussed how a friend's little sister had to travel out of state for an abortion due to restrictions in Texas:

> Yeah. A friend of mine, her little sister got pregnant, so she had to drive to New Mexico, I think, to get an abortion. Um so that was, I mean because there is that ban. […] So they had to travel to New Mexico for that which I mean going all the way out there is just like it seems like a lot just to kind of fix something that was unplanned. And I know she was on birth control, which is just so much worse. When I think about it because, you know, she's actively trying to protect herself, and it's not really her fault if her birth control failed on her in that way, and the fact that she has to travel so far is just it's expensive. I mean all that gas money. It's it's very far away from where we're at, too. So it's just like unfortunate. – Jack

Jack plans on moving to a more progressive state that provides better options for her in terms of reproductive healthcare, affirmation of her sexuality, and one that is more racially and ethnically diverse. Jack, since she is from Texas, also discusses how she would not be able to get an abortion in her state if she were to become pregnant, but that she feels lucky that her partner lives

in another state that has less restrictions on abortion access. Despite this, she is still worried due to the potential for being sued for aiding and abetting abortions.

> I do live in Texas. So if I were to end up being pregnant um I probably couldn't get an abortion here in Texas. But also I have the option of going to Virginia um which still does have abortion access statewide. So you know, for me there was always that back up, and you know I have support in Virginia, too, with a partner. So when [the *Dobbs* decision] happened, I had a little fear, especially because Texas also has some laws and implemented where um if they find out you aided an abortion, doctor or otherwise, you can actually get sued. Um so you know, doctors were always very cautious after that, you know, um, the Planned Parenthood, they don't do any abortions anymore, pill or otherwise. Um so there was always that fear of like, what if, you know, what if I do get pregnant and I fly to Virginia, and they find out, and I get sued for some reason, even though it doesn't affect them in Texas. Um so there was that fear. – Jack

Resources at Planned Parenthood were commonly brought up by participants when discussing sexual and reproductive healthcare, with participants generally having positive experiences and viewing it as an essential resource for things like abortion care, access to contraception, STI testing, and comprehensive SRH information readily accessible. Several participants discussed providers at Planned Parenthood as being more inclusive, affirming, and competent in LGBTQ+ issues, along with being more supportive in a variety of pregnancy intentions with a focus on choice (e.g., Neville getting a salpingectomy). However, some participants talked about the pushback against Planned Parenthood that is occurring alongside restrictions on SRH more generally, including some areas not welcoming Planned Parenthood or them being shut down, particularly post-*Dobbs*.

> So I feel like Planned Parenthood is a is a perfect resource for everyone, but unfortunately it's not available, you know. It's not welcomed everywhere. Um at least, for I'm at there's a planned parenthood, but it's an hour away. And it could be even more so, depending where you live. Um luckily it's in the area that's very well hidden, so they haven't closed down or anything. they're located in a medical kind of kind of metroplex. So it's just like any other doctors place. – Jack

Most participants, even if they have not yet experienced direct restrictions due to the policy change (e.g., having to access an abortion since the decision) discussed feeling overall

fear and general worry for themselves, their friends and family, and for women's rights in general. Aria, who lives in Texas, worries about abortion policies in her state:

> I would cross state lines like, I don't even know what I would do if I was put in that situation. It's terrifying. I feel so bad for anyone who has to deal with it. It makes me glad that I'm not in a relationship right now that I don't have to have that stress on my plate. – Aria

Along with abortion laws and the overall context around access to sexual and reproductive healthcare, participants also discussed the impact that anti-LGBTQ+ hate and discrimination, along with the uptick of anti-LGBTQ+ laws, had on their mental health and SRH. Further, bi-erasure and bisexual marginalization impacted them.

> Bi-erasure, or whatever that is um just for people to say, like, like, no, you like guys like your, you want to experiment type of thing. I- I hate that. I feel I get angry and upset at that. Just like don't diminish the fact that yeah, I have majority relationships and experience with with dudes. But that doesn't erase the fact that I do like girls. – Amy

Betty struggled with her sexuality in adolescence, which affected her mental health, in turn. Further, she described stigmatizing experiences when accessing healthcare, such as being marked down as "high risk" since she is not using contraception, despite being in a committed relationship with a woman:

> Um, I think one thing that always comes up, whether it's like, specifically related to gynecological care, or if it's just like, the fact that I'm a female and I have a health care appointment, they always tend to ask about like your sexual history. And like, "Are you using birth control?" And I always say "no". And then they're like, "oh, like, why not". And then they like, I'm like labeled in like my health care record, I'm labeled as like "participating in high risk sexual activity", because I don't use contraceptives. Um, so I mean, I always explain but they always ask, So that's like…It's-it's not something that's like, over-overly negative. But it's just kind of like, a failure of, um, oh what's the word? Um…It's just not very like, equitable, like informed health care in that way, like, I think if you're gonna ask about someone's use of contraceptives you should be aware of, like, the number of different ways people can participate in sex, and so I think it's just like– And I think nowadays people, like medical students and like other health care professionals are being trained in that way so it's like, something that's improving. Um, but it's just like, historically, that's just like, just a little sore spot for me that I'm like, that's such a stupid thing. – Betty

Eleanor discussed feeling “attacked” due to the rhetoric that was frequent around the 2016 and 2020 elections, and how that made her struggle even more with her sexuality and have a fear of coming out. She also then was concerned about those around her, feeling like politics then became a “moral question” of the people around her in her life, “are these good people who like accept people who are not straight around me? And so it was like, well, my parents are not so. I'm not going to tell them. I can't trust them.” She said that more recently she’s felt like she’s seen less polarization so has been more comfortable in her sexuality and thinks of coming out to her parents.

Jack lives in a conservative, small, rural town in Texas that is majority White, and she described a significant increase in marginalizing and discriminatory experiences she faced around the 2016 and 2020 elections and the Trump presidency, especially as she had a public-facing job as an optician and was regularly speaking with those in her community. This particularly affected her due to multiple marginalized identities as a woman, a bisexual woman, a Hispanic woman, and someone who is a DACA recipient, all of which were identities that she felt were under attack and politicized during that time. She discussed her experiences during that time and the effect it had on her, crying,

> Um and after I graduated oh, that thing Trump took over in 2016. I can't quite remember it. It seems like forever. Um there was a lot of just like political discourse everywhere when I started working in, you know, retail optical um and where I'm in a very red area, and there was always just like everywhere, from all side, from all sides, and for some reason I'm not sure why, uh middle aged white man always want to have political talks with me, probably because I'm not white, and I'm not a man, and they want to know my opinion. 24/7. And I'm just like I'm not here to do that, guys. I'm here to give you glasses so you can see you don't kill anyone in a car accident because you didn't see that exit sign. Um it happened a lot a lot those years. And it happened even more, you know, during his second term run. And it's just so tiring, I would say, because, like you don't want to hear from me. We both know you don't want to hear from me. You just want to start something which I think became a lot more um when he ran for President and became President. - Jack

She discussed the “example” he set for people and how it increased harassment towards her as people felt emboldened in their behaviors.

> Um just because of what type of person he [Trump] is and what kind of example he set for people to kind of act like. He's very loud mouth, very kind of say whatever I want to say, and consequences can come back later. Um I think that definitely like mental health wise, it became so bad just because um the things he said, and he also tried to get rid of DACA during his presidency, and that would have been my entire livelihood. Everything I had would have been gone. So it was very like frightening. And just like. what am I going to do? And it's very hard to see people so happy over him doing something like that while I could lose everything. Like I'm just trying to live and work, and I never wanted any of them to know either. – Jack

Theme 4. Desired Supports to Improve Bi+ Women’s Mental Health and Sexual and Reproductive Health

Participants discussed desiring a variety of supports and resources that would help their mental health and SRH, including more comprehensive, LGBTQ+-affirming, and culturally competent resources, services, and providers. Participants were concerned with the lack of education in the realm of both mental health and SRH and lack of support as impacting both their mental health and SRH. Participants noted that they received non-inclusive sex education which lacked examples of non-heterosexual couples and did not include sexual health issues of LGBTQ+ individuals. Further, some received abstinence only education that did not provide information on contraception options and included stigmatizing language.

> I feel like me and my friend group, we just taught ourselves about like sexual health stuff where you kind of just learn from like existing in the world, or like looking stuff up online. But I remember like taking my high school health class over the summer. and like there was like this, like shitty, like cartoon, and it was like thinking about like good thoughts, like exercise, and like all the bad thoughts. And it was like drugs and sex. And I was like, Okay, like, what a what a thorough education! – Aria

Aria goes on to express that she wishes she had had more sexual health education, including one more thorough including “the fact that multiple sexualities exist,” healthy relationships, and contraception, along with holding space for students to discuss their

experiences in a comfortable environment. Aria expressed a desire for better mental health and SRH supports in high school and how that could have changed her "mental health trajectory":

> …counseling for like mental health stuff in general, I think anyone could benefit from that. Some sort of like screening in schools that's not just like a shitty thing that you just check the box and move on like something that's like actually built there to try and help the kids who are in the system. I think that would be great. - Aria

Other participants also felt that more comprehensive sex education that is provided at a younger age when youth are starting to figure out their sexualities and relationships would improve young bi+ women's mental health and SRH.

> Ummm, I think one of the first things would be to have like information easily available. Ummmm 'cause like- like, I said earlier, like I- I saw my attraction from women like pretty early on, but I never had a word for it until later, because I don't think I even knew gay and straight were a thing. But then, when I started learning about sexualities, it was only gay or straight, like one or the other, there was- that's it. And, I didn't even know that, like- about gender identity or anything like that. It's just you're gay or you're straight. Nothing else. And then, when I started learning about it, it was like- I was so like, oh I'm- I was like, "Oh, I'm straight. I just think women are pretty." I just- I think it'd be nice to date one, but [laughs] I'm still straight. Ummm and I was just- it took a while to even be like, Oh, like that- that's also me. So, I think having information like easily and readily available, is probably the most important thing – Jennifer

Sam agreed that education was essential, particularly for younger girls. She mentioned how affirming and helpful it was to learn about compulsory heterosexuality and realizing the impact it had on her mental health and SRH growing up, including her eating disorder and relationships. She found learning about compulsory heterosexuality "groundbreaking" and feels that these conversations should be occurring in schools, although she recognizes that these conversations are becoming increasingly restricted and even criminalized across the country.

> I think that having more even in schools like…conversation about what the difference is between feeling like sexuality where you are like the subject of that sexuality, versus when like, you're the object of that sexual–like when you're being like, what the difference between feeling, like other people like, your goal is to be attractive to other people versus your goal is like, be happy yourself, and like, find pleasure in your life. Um, I just think like, having more–It's really sad that, like, those conversations are being shut down more and more because I feel like, even just like six years ago, when I was in

> high school, seven, eight years ago, when I was in high school, like, those conversations, were more allowed than they are now. And like being able to have like, adults being allowed to talk about that kind of stuff to children so that they can know what the options are. Um, and not just be like saying it's really easy to…talk yourself out of things, I think, especially when you're b–like when you're bi as opposed to being fully gay it's like, you can easily talk yourself out of being attracted to the–to the same gen-that, like, anything except for the opposite gender. And like, I think, yeah. It would be nice if people could live more fully. – Sam

Betty believed that information about sex and sexuality should occur at younger ages and that more information and acceptance around different sexualities would have improved her mental health and SRH as an adolescent:

> Um, elementary, or middle, or high school, and like having conversations about that with younger people, and like normalizing [different sexualities], I think, would save a lot of people from experiencing mental health concerns throughout their life. Um, because I know, for a lot of queer people, their queerness sparked a lot of mental health concerns, um, as you know, when they were young people. So I think that would be something that would be helpful thinking back. That's not necessarily relevant to me right now, but it would have had implications for me currently, if I had had different support as a child or as a teenager. – Betty

Participants also discussed the importance of having spaces, resources, and programs tailored towards them and how that would improve their mental health and SRH.

> That's been really helpful is having facilities that specifically cater to our community like that's where I got um my free STI test. And I just felt really safe there because I knew that they were going to accept me. They weren't gonna be weird. And they were also going to be privy to speci- the issues that are specific to LGBTQ+ community um cause obviously like the the needs a a straight person, may be different from someone who is bisexual, or like the issues that um they experience would be different. So yeah, so just as long as there are more spaces that were specifically cater to us, I think that would be really helpful. – Stella

These spaces could be particularly crucial for those in non-affirming or low-resource households and communities.

> I think there should be more open communities, even buildings that specify LGBT, plus communities and sexual health, because a lot of because of a lot of our community was rejected and uninformed. A lot of us turned to the wrong people, or wrong information, or ignorant to a lot of topics that other people don't have to deal with. So I feel like there

> should be more open buildings and community that help everyone and not to specific people. – Sasha

While some focused on recommending sexual health programs for younger people, Sasha also recommended continuing education for adults, especially those who may not have received that information at a younger age. She also discusses the importance of reducing stigma around LGBTQ+ and sexual health topics.

> I think programs such as well, they already do sexual health programs like in high school but I think if they had more programs like that for adults like health classes, advice on when they get check ups, advice on when you feel like you might have been at risk for something but you might be too embarrassed to go get checked because of like basically programs that help a lot of people even in our community get rid of a certain stigma and take away a lot of the shame, like communities that help people bring more awareness without the shame and embarrassment that probably a lot of people in our community face. - Sasha

She expresses a wish for more information on concerns such as PCOS along with diverse LGBTQ+ communities. She says, thinking of her intersex sibling, "I wish there was more community for people like my sibling. I wish basically, there was more communities that was diverse even sexually, because I feel like, because the world is so stagnant that it's gonna take us longer to get a lot of the resources that we need for people in our community." Others like Sarah also recommended support groups, particularly for people struggling with their sexualities.

Jennifer also desired spaces for a diverse group of LGBTQ+ people, feeling that it was important for queer people of different genders and sexualities to interact, as opposed to being siloed by gender and sexuality:

> But just, like offering spaces for people to- like me, and to like establish relationships with other queer people, I think would be really nice, because, I feel like, at least- at least in like in my school, you- the queer kids that were there they all kind of gathered together, ummmm so like my friend trans and gay, me bi, a friend asexual, we- Et cetera- we just kind of gathered together. And what I saw in college was that- I only went to like 3 meetings for the- the [stutters] LGBTQ group but they, kinda- from what I saw they kind of gathered with like their own, like by sexuality, by gender identity. That's like [pause] I think it would be nice to really intermingle with each other instead of just kind

> of staying def- definitively and only by the- your just- your sexuality and you're- just your gender identity. Ummmm, because like, yeah, you're in the group that's there to help you, and to- so for you to feel safe and for you to learn more. But ummm part of that is conversing with everyone else, not just staying in one; with the one that you are.
> – Jennifer

Participants talked about how Planned Parenthood helped support them in their SRH, including providing free or low-cost services, providing thorough and affirming information that is easily accessible, being non-stigmatizing, and having providers trained to work with LGBTQ+ populations.

> Um I will say that Planned Parenthood is a very good resource. That's usually where I do most of my research for like um implants and things like that or birth control their website, and they have an app too it's very nice. That I have on my phone, and I always look there for anything. Um you know, places like that, and especially because they're so open with the LGBTQ+ um you know they're not going to turn anyone away, and they do over hormone replacement therapy there, too. So, I- I feel like Planned Parenthood is a is a perfect resource for everyone, but unfortunately it's not available, you know. It's not welcomed everywhere. Um at least, for I'm at there's a Planned Parenthood, but it's an hour away. And it could be even more so, depending where you live. Um luckily it's in the area that's very well hidden, so they haven't closed down or anything. They're located in a medical kind of kind of metroplex. So it's just like any other doctors place. Um definitely online resources. That's I mean, that's the best place to go is online. I do a lot of my research for my implant on Tik Tok, unfortunately [laughing], which was full of horror stories which luckily was not mine. But I mean that was a very good one, because it showed me how it was inserted um and things like that. And you know you really can't. I mean, they try to. But you really can't ban like social media. So I- I think it's a really good resource for doctors, and like advocates to be on for young people. just because I mean, most of us have almost fully unrestricted cell phone use and like Internet use.
> – Jack

Multiple participants talked about finding resources online, including Jack mentioning a Reddit thread that provides a master list of doctors in different areas and states who are more accepting of procedures such as hysterectomies along with accessing birth control. Betty agreed that a lot of time she could just Google information, but that having supports early on in life around sexuality was still essential.

Summary

This chapter included findings from the current study for aims one, two, and three. These findings provide rich and nuanced information about the mental health and SRH needs and experiences of young bi+ women. Participants described a variety of challenges in childhood, adolescence, and young adulthood. They also used a mix of both adaptive and maladaptive coping strategies. They described their mental health and SRH as interconnected and influenced by the various aspects of the socio-political context.

Chapter 5: Discussion

This final chapter provides a discussion of the findings provided in chapter four in the context of the research question and embedded within the current relevant literature and theory along with strengths and limitations and recommendations for practice, policy, and research. I then present my closing reflexive statement and overall conclusions.

Discussion of Findings

The first aim of this study was a narrative inquiry examining how young bi+ women experience and cope with their mental health concerns. Aim 1 elicited two overarching themes: 1) Challenges Affecting Mental Health across the Life Course, and 2) Coping with Challenges across the Life Course. The second aim included a reflexive thematic analysis to investigate how young bi+ women describe their mental health and SRH intersecting and the influence of the socio-political context on their mental health and SRH. Aim 2 elicited four themes: 1) Bodily Autonomy and Agency as Essential: The Impact of Sexual and Reproductive Health Issues and Experiences on Mental Health, 2) "It's a Negative Feedback Loop": How Mental Health and Sexual Behaviors Intertwine, 3) Common Factors Affecting Mental Health and Sexual and Reproductive Health, 4) Desired Supports to Improve Bi+ Women's Mental Health and Sexual and Reproductive Health.

Early Childhood Adversity

A common theme within participants' narratives about their childhood was the importance of safety, stability, and security in childhood, and particularly how experiencing threats to this can have far-reaching impacts, which caused anxiety during childhood and affected their mental health and well-being, along with how they view and interact with the world, through to adulthood. This aligns with the Centers for Disease Control and Prevention's

Essentials for Childhood Framework that highlights the importance of assuring safe, stable, and nurturing environments for children is critical for children's growth and development (National Center for Injury Prevention and Control, Division of Violence Prevention, 2021). The quantitative literature shows that bi+ women experience threats to these critical components to development. Bi+ women experience higher rates of childhood victimization, including verbal or physical abuse, childhood sexual abuse, neglect, household dysfunction, and bullying (Zou & Andersen, 2015) along with having a higher number of adverse childhood events (ACEs) (McCabe et al., 2020). These adverse experiences in childhood are related to PTSD, substance use, and mental health disorders, all of which bi+ women have higher rates of than monosexual people (Chan et al., 2020; Dunlop et al., 2020; Feinstein & Dyar, 2017; McCabe et al., 2020; Ross et al., 2018; Russell & Fish, 2016).

Along with experiences of trauma in childhood, many participants described experiencing economic precarity in childhood that had a profound impact on them and their well being. Experiences of poverty in childhood impacted the trajectory of their mental health, including feelings of instability as mentioned in theme one of research question one, along with influencing access to resources. Bi+ young women have a higher rated of living in poverty compared to monosexual people, and bisexual people below the poverty line have increased likelihood of depression, PTSD, and perceived discrimination (Badgett et al., 2013; Ross et al., 2016). The interaction between poverty, sexual identity, and mental health is complex and not well understood; however, some research implicates poverty as a major contributor in mental health disparities experienced by bisexual people with potential pathways including early life experiences impacting financial stability, sexual identity and employment, the intersection of class and sexual orientation discrimination on access to support, and lack of access to culturally-

competent care (Gorman et al., 2015; Ross et al., 2016). Along with economic precarity, some participants experienced homelessness during their lives, either in childhood or young adulthood. Although a common factor implicated in youth LGBTQ+ homelessness is family rejection, some research complicates this notion and discusses how family instability due to poverty and class influences their experiences of sexuality and marginalization within their families (Robinson, 2018).

The narrative theme regarding threats to safety, stability, and security in childhood both reinforce the quantitative findings in the literature while providing depth and nuance into bi+ women's experiences, which can help create attuned programmatic and policy interventions for this particularly vulnerable population both through early childhood intervention along with mental health and substance use interventions for bi+ adolescent girls and women who may have experienced adverse childhood events. This also reinforces that bi+ women are an important population that require more attention and services to address these disparities.

Challenges in Adolescence

Participants discussed the challenges of navigating adolescence, including forming their identity within the social context. Participants described struggled with figuring out who they are while also trying to "fit in" with their peers. Adolescence is a crucial period for development of identity and the self, all while there is increased attention to peer relationships and social identity (Erikson, 1968; Goldbach & Gibbs, 2017). For LGBTQ+ adolescents, this is often a time period when they are figuring out their own sexualities, including questioning their identities, self-identifying, and possibly coming out to others and forming sexual and romantic relationships (Hall et al., 2021; Russell & Fish, 2016, 2019). Many participants discussed challenges figuring out their sexuality in adolescence and some had difficulty coming out to others, including

experiencing negative reactions or discrimination. Experiencing bullying, violence, stigma, and discrimination during adolescence can hinder this period of identity and social development, particularly as LGBTQ+ individuals are coming out at younger ages that overlap with these critical developmental periods (Fish, 2022; Russell & Fish, 2016, 2019). For instance, negative reactions to disclosures about sexuality result in worse mental health outcomes (Ryan et al., 2015). The findings reflect the challenges that bi+ adolescent girls can have navigating their identities.

Figuring out their queer identity during adolescence exacerbated challenges for participants around identity formation, particularly for those in households that held stigmatizing views towards queer people or adhered to strict gender roles. Many participants struggled with their sexuality in adolescents, which was compounded by confusion around what it meant to be bi+, due to both straight and gay communities sometimes not viewing bisexuality as a valid identity. Scholars on bisexual health have proposed "double discrimination" as a potential cause for mental health disparities among bisexual people – experiencing discrimination by both queer and straight communities along with missing out on the benefits of connection to the LGBTQ+ community such as buffering the effects of minority stress on mental health (Doan Van et al., 2019; Ehlke et al., 2020). This was reflected in the findings as participants discussed complex relationships with the overall LGBTQ+ community, with some feeling light they had to "fight for their spot" or that bi+ women were not always welcomed in queer spaces. Those who had access to queer role models, peers, spaces, and resources were better able to navigate their sexualities, showing that support with sexuality-related stressors, specifically, is crucial for bi+ adolescent girls. Bi+ women having support, particularly support in their sexuality, and affirming communities is essential to their well-being (Hayfield, 2022). Adolescence is a crucial time when

they are forming their sexual identity, but they are still likely restricted by their circumstances – often legally tied to their families, schools, and often without means to move elsewhere (Russell & Fish, 2019). As anti-LGBTQ+ laws and policies continue to be enacted, queer youth are particularly impacted as they often are unable to have the agency to move to a more affirming area or access supportive communities (Cole, 2022).

Participants who experienced sexual assault and abuse during adolescence and young adulthood also had a disruption in their sexual development during a critical time, which ultimately affected their mental health and sexual health. Bi+ women experience higher rates of violence and victimization, with 61% of bi+ women experiencing intimate partner violence in their lifetime and 46% of bi+ women experiencing rape in their lifetime, and most experiences of victimization first occur in adolescence in young adulthood (Leemis et al., 2022; Walters et al., 2013). These experiences exacerbate mental health concerns, leading to PTSD impacting their daily lives (Leemis et al., 2022). Participants in this study expressed significant mental health effects after their sexual abuse experiences, including PTSD, depression, and anxiety. They also discussed how it exacerbated confusion over their sexual identity along with difficulty forming romantic and sexual relationships or causing them to engage in sexual behavior they may not have otherwise. Healthy relationships and resources for survivors of sexual assault would be crucial to comprehensive programming for bi+ adolescent and young adult women, along with attention to these issues by healthcare providers and counselors.

Transitioning to Young Adulthood

Participants discussed the challenges and joys of transitioning to young adulthood. Young adulthood is a critical time of development, including a time of upheaval and change as young adults navigate moving out and being responsible for education, employment, and finances with

less support than they may be used to (Bradshaw et al., 2012; Grant & Potenza, 2010). This is also a critical period for mental health. Seventy-five percent of mental health disorders emerge before age 25, and young adults ages 18-25 have the highest prevalence of mental illness out of all adults (Kessler et al., 2007; SAMHSA, 2021) LGBTQ+ young adults, in particular, are at risk for worse mental health outcomes during young adulthood (Fish et al., 2019). Participants did discuss mental health struggles during this period and challenges of young adulthood such as navigating living independently, coping with difficulties in college and employment, and financial burdens. However, they also discussed the joys around developing independence, agency, and self-acceptance during this time. College, although challenging for some, for others it was a time of finding community and people whose values aligned with theirs, including finding LGBTQ+ affirming spaces for those who came from less affirming homes and communities. A study by the Williams Institute and Point Foundation found that 22% of LGBTQ+ students intentionally chose colleges further from home due to seeking a more welcoming and affirming environment and 33% reported doing so to get away from their families (O'Neill et al., 2022).

Those who were in their mid-20s discussed finding stability in their careers and partnerships, along with being more comfortable in their identities. Many navigated difficult times earlier in young adulthood but then were able to find support and resources by finding affirming communities and receiving mental health supports. Those who were unable to develop the independence they wanted were often limited due to financial and systemic barriers, such as those with immigrant families. Bi+ women from immigrant families are an understudied population; this study shows that they are a crucial group to provide resources for as they navigate both sexuality-related stressors along with marginalization and challenges due to their

families' immigrant status. Other systemic challenges causing disruption to attaining freedom and independence beyond financial included issues related to healthcare, crime and violence, and transportation.

Coping across the Life Course

Participants' discussion of coping across the life course adds to the coping literature while addressing the gap in the literature in how young bi+ women cope. Coping refers to strategies that individuals use to reduce negative feelings or overcome challenges and can include both cognitions and behaviors. The literature around coping discusses "adaptive" versus "maladaptive" coping, such as behaviors that are viewed as healthier that may improve resilience, such as attending therapy, versus other behaviors that may be detrimental, such as substance use (McLaughlin et al., 2010; Nadal et al., 2011). Participants discussed both maladaptive (e.g., substance use, self-harm) and adaptive strategies for coping (e.g., therapy, art).

Since bi+ women are more likely to use substances and have substance use disorder, it is important to understand how bi+ women use substances to cope (Feinstein & Dyar, 2017; McCabe et al., 2009). Findings from the current study showed that some participants discussed using cannabis to help them cope with stress, relieve stress, relax, and sleep. This aligns with Dyar et al. (2022)'s findings that bi+ individuals are motivated to use cannabis after experiencing bi+ stigma, which ultimately results in problematic cannabis use (Dyar et al., 2022). As recreational cannabis possession is decriminalized and regulated at the state-level, with use among young adults reaching "historic highs" in recent years, this is an important area of future inquiry for bi+ women's health (National Institute on Drug Abuse, 2022). Participants did not talk much about using other substances, such as alcohol, to cope, although one participant discussed micro-dosing psilocybin mushrooms to help with her mental health. A few participants

also discussed how their eating disorders were a form of coping. Although in the current study the participants did not explicitly mention eating disorders as a coping mechanism for anti-bisexual discrimination in particular, Watson et al. (2016) found that anti-bisexual discrimination was associated with disordered eating behaviors and was mediated by internalization. They also found that anti-bisexual discrimination was related to coping via detachment and drug and alcohol use (Watson et al., 2016). Other studies show that anti-bisexual discrimination may lead to internalization of heterosexist norms and beauty ideals that in turn contribute to disordered eating (Brewster et al., 2014; Szymanski et al., 2011). This pressure to fit to be feminine and thin and adhere to gender roles was brought up by multiple participants and by some as a factor influencing their eating disorder and poor mental health, including Stella, Shell, and Sam. Participants who described themselves as larger and did not fit into the thin ideal and beauty standards for women described the negative impact on their mental health.

Some participants also discussed self-harm as a way that they coped with feelings of stress. This aligns with some studies showing that bisexual people have an elevated risk for self-injury, including a recent meta-analysis showing that bisexual people had six times the odds of engaging in self-injury compared to other sexualities. Self-injury is associated with mental health concerns such as anxiety, depression, and exposure to negative life events (Dunlop et al., 2020). Further research into bi+ women's methods for coping along with their experiences of self-injury will be important to better intervene to reduce self-injury in this population and promote more adaptive methods of coping.

In terms of adaptive methods of coping, participants also discussed how social support, finding joy, and accessing mental healthcare helped them cope with challenges. Social support from the LGBTQ+ community can be particularly crucial for adolescents and young adults.

Student-led LGBTQ+-focused clubs in K-12 and college have numerous positive benefits for queer students, particularly if paired with other initiative such as protective policies for LGBTQ+ students and access to education, information, and resources (Russell et al., 2021). Participants in the study had complex and varying relationships with family, experiences of stigma and marginalization from family members, and family support, all of which they described as influencing their well being. Family support and acceptance among LGBTQ+ youth is associated with positive mental health outcomes, including lower distress, suicidality, and depression, along with higher self-esteem (Mustanski & Liu, 2013; C. Ryan et al., 2010; Snapp et al., 2015). Accessing mental healthcare for some participants was a positive experience, however participants also discussed the challenges of finding accessible, affordable, and culturally competent mental healthcare. Bisexual people are more likely to have an unmet need for mental healthcare, so examining the factors that bi+ women describe as challenges to receiving care is instrumental to improving bi+ women's mental health (Steele et al., 2017).

The Intersection of Mental Health and Sexual and Reproductive Health

The findings from aim three emphasize the importance of understanding and addressing mental health and sexual and reproductive health together and how issues with one can affect the other. Bodily autonomy and agency were shown to be essential to young bi+ women's mental health, SRH, and well-being. Participants in the study desired choice in what happened with their bodies, including access to contraception and abortion. When that autonomy is removed, through policies, restrictive families and communities, or through force (e.g., reproductive coercion or rape) participants experience deleterious outcomes. As both women's rights and LGBTQ+ rights have become increasingly under threat, there needs to be increased attention on ways to promote

policies and programs that protect bi+ women's health and, in particular, their autonomy and choice (Steele et al., 2017).

Along with having poorer mental health outcomes, young bi+ women also report higher risk sexual behaviors (e.g., multiple sexual partners, trading sex for resources) along with poorer SRH outcomes (e.g., unintended pregnancies, STIs) compared to straight and lesbian women (Bostwick et al., 2015; Everett et al., 2017; Flanders et al., 2022; Goldberg et al., 2016; Higgins et al., 2019; Paschen-Wolff et al., 2020). Findings from the current study showed that participants' sexual motivations and behaviors were complex. Some participants were limited in accessing reproductive resources due to insurance (e.g., being on their parent's insurance or lack of insurance). Others discussed negative reproductive healthcare experiences (e.g., lack of providers with LGBTQ+ competency). Multiple participants felt that they engaged in sexual behaviors that they either regretted or felt were not the best choices for them, due to either feeling pressured or because of past trauma. Some participants found navigating sexuality and sexual experiences difficult due to societal pressures, compulsory heterosexuality, past experiences of sexual abuse, and confusion around their sexual identities. Participants felt that open communication and consent between partners was essential for positive sexual experiences and that choice and access to LGBTQ+-competent and comprehensive SRH healthcare and education was important to their well-being. The findings align with other studies that show that young bi+ women's mental health and SRH intertwine and further provide important areas for intervention and further inquiry (Flanders et al., 2015; Timilsina, 2018).

Theoretical Framework

A dominant framework for studying LGBTQ+ mental health is the Minority Stress Model (Brooks, 1981; Meyer, 1995, 2003). This conceptual framework explains how the stigma,

prejudice, and discrimination that sexual minorities experience living within a heterosexist society can have a deleterious effect on health. Aspects of Meyer (2003)'s model includes both proximal (e.g., expectations of rejection, concealment, internalized homophobia) and distal (prejudice events) that then affect mental health outcomes. As part of this model, coping and social support act as buffers between the effects of minority stress and mental health outcomes (Meyer, 2003). The current study illustrates aspects of this model. For instance, multiple participants described both proximal and distal stressors and discussed the effect that they had on their mental health outcomes. Amy, for instance, talked about the homophobia she grew up with from her mother, and how that in turn resulted in her concealing her identity and having internalized homophobia, which contributed to her depression and anxiety. Margo also experienced homophobia from her parents, with them telling her she would get AIDS and displaying other homophobic and stigmatizing beliefs to her, that impacted her mental health. Participants who have not yet disclosed their sexuality discussed expectations of rejection and how that prevents them from being fully out. Participants who did have a social support system, particularly people who they had disclosed to and who were supportive, discussed the benefits of receiving this support. For instance, Paige talked about how grateful she was to have met her friends through an LGBTQ+ group chat for her college.

However, for bi+ women in particular, dynamics beyond minority stress due to their sexuality alone play a role as they also experience challenges related to their gender. Further, for those with multiple marginalized identities such as people of color and those from immigrant families face additional challenges. Participants talked about the intersection of their sexual identity and gender, and the difficulties of living within a patriarchal society. This aligns with the Theory of Gender and Power (Connell, 1987; Wingood et al., 2000). Further, women were

concerned about women's reproductive rights in light of the *Dobbs* decision (*Dobbs v. Jackson Women's Health Organization, 597 U.S. ___*, 2022). Their mental health and well-being cannot be disentangled from the fact that they are women living in a patriarchal society during a time when women's rights are increasingly under attack. For bi+ women, particularly, marrying concepts from LGBTQ+ mental health frameworks such as the minority stress model, along with feminist theories such as Theory of Gender and Power and Reproductive Justice, is essential to fully understanding young bi+ women's lives and the best approaches to improve their health and well-being (Connell, 1987; Ross, 2017; SisterSong, 2023; Wingood et al., 2000). These findings also align with Diamond and Alley's (2022) call for inclusion of social safety to our understanding of minority stress due to the importance of reliable social connection, inclusion, and protection to well being along with incorporating the effects of other forms of marginalization such as race, ethnicity, socioeconomic status, religion, citizenship, neurodiversity, and physical ability (Diamond & Alley, 2022). Many participants in the study discussed these intersecting forms of oppression as fundamental to their well being and mental health trajectories.

Strengths and Limitations of the Study

This dissertation addresses an understudied topic for a population that experiences significant health disparities. Few studies have investigated mental health and SRH together for young bi+ women. Further, few studies inquire into the socio-political context and how it affects young bi+ women. As the *Dobbs* decision occurred recently, in the summer of 2022, this dissertation provides the opportunity to provide timely findings about how this legislation is impacting young bi+ women. Narrative inquiry elicited rich nuanced information about participants' lives from childhood to present day, emphasizing narratives of their lived

experiences while also considering important context from their lives. Both narrative inquiry and reflexive thematic analysis are rigorous qualitative methods that use an iterative, inductive approach so that findings are grounded in the stories of participants. By recruiting young bi+ women from diverse backgrounds across the United States, I was able to see the rich diversity of experiences that compose this population while also identifying common threads across participants. I also employed used a variety of strategies to enhance rigor including reflexive journaling, maintain a clear audit trail, engage in peer debriefing with the Community THRIVES Lab, and completing member checking. I also used triangulation by examining recordings, memos, interview notes, and transcripts from multiple participants to analyze the data, along with having multiple members of the research team review the transcripts and themes.

This is a qualitative study and findings should be understood within that context. For instance, the findings are not meant to be generalizable to all bi+ young women or other communities. However, by completing in-depth interviews with this population, we were able to explore the context and nuances that influence these young women's mental health and SRH, which helps us understand the complexities of this topic and adds to the literature in this area.

Although a benefit of Prolific is pre-vetted participants and being able to purposively sample based on geographic location, participants within the Prolific system who agreed to a Zoom interview reflect a unique population that may differ from other bisexual women in the United States. Prolific is found to be generalizable to the general population, except for in education and race. Prolific users are higher educated than the general public; further, there are fewer Black and African American users on the platform than would be representative of the United States (Palan & Schitter, 2018; Tang et al., 2022). Also, these are participants who have a device that can join Zoom (e.g., iPhone, iPad, laptop), have access to a strong internet

connection, and have access to a quiet, private location to complete the interview. Our recruitment strategy may not have captured young bi+ women who were particularly low resource, since they may not have had the required technology, or women who are not as open about their sexuality. Further, discussions included sensitive topics related to mental health and SRH. Those who are less comfortable with these topics would not have necessarily volunteered to be interviewed, and participants who were interviewed may have withheld some information, despite attempts on my end to ensure their information was private and confidential and that they were comfortable speaking with me. Since the study description advertised to Prolific users mentioned that the interview would include discussion about topics such as mental health, sexual and reproductive health, and sexuality, young bi+ women who have had salient experiences or challenges with these topics may have been more likely to be willing to participate in these interviews than other young bi+ women, influencing who was in my sample. Since interviews were over Zoom, I could not control the environment of the participant beyond telling them to join in a private, quiet location. Since some participants lived with their families, roommates, or partners, they may have held back some of what they said if they were worried about being overheard. The other limitation is that participants were asked to think back to their childhood and adolescence, which may involve some recall bias, as they may not remember all experiences fully or completely accurately. However, as this study was focused on how the events of the past affect them today, the focus of the analysis was on the continued emotional impact of these events rather than prioritizing complete accuracy in what participants said. Participants' stories must be understood in that context that participants may misremember some aspects, may not have been aware of the full situation as they were children, or could be leaving out key details

about the event in question. Despite this, interviews elicited rich, meaningful data that provides a detailed look at young bi+ women's lives.

Implications

The current study has numerous implications for practice, policy, and further research on bi+ women's health. Findings from the current study emphasize the need for widespread reform in the areas of healthcare and LGBTQ+ and women's rights.

Healthcare Reform and Training

Findings from the current study suggest reform in healthcare, education, and programming and interventions to improve the health of bi+ young women and reduce health disparities is paramount. In terms of healthcare, participants desire providers for both SRH and mental health who are competent in LGBTQ+ health broadly, along with issues specific to young bi+ women. This includes having obstetrician-gynecologists who do not assume patients' sexualities and who understand that there are various sexualities and ways to have sex and relationships that have different implications for sexual health. Bi+ women explicitly said they need mental healthcare providers, including school counselors, therapists, and psychiatrists, who view bisexuality and pansexuality as valid identities and know how to talk to young women about their sexuality in an affirming way. Participants also discussed wanting providers who are knowledgeable about those with multiple marginalized identities and who are culturally competent. They further wanted therapy that was tailored for their needs and issues. Although there has been a push to train mental health providers in LGBTQ+ competent counseling, there is a significant lack of these providers available, particularly in rural areas and more conservative areas (Fish et al., 2023; Martos et al., 2018). Further, young bi+ women may not be able to access these providers due to lack of ability and knowledge in finding queer-friendly providers,

along with issues with transportation, cost, and insurance, along with stigma, as participants in the study experienced and has been shown in other studies (Jabson et al., 2016; National Center for Health Statistics, 2022; Verdonk et al., 2009).

Currently, young adults can remain on their parents' health insurance until they turn 26 (Assistant Secretary for Public Affairs, 2022). Although participants were appreciative of this resource, for some it was not sufficient or could unintentionally create barriers to healthcare. For instance, participants who were on their parents' insurance worried about privacy and would forego care such as therapy or contraception due to having a lack of ability to access their insurance without going through their parents or worrying that the care they received would appear on their parents' statements. Participants also talked about the difficulty of navigating care, especially around stigmatized issues like contraception and therapy, as during adolescence caregivers could gatekeep certain resources (e.g., refusing to allow them to get contraception). Having ways for youth and young adults to access care through their parents' insurance but maintain confidentiality, and improved education on how to access care, would be important moving forward. Further, among those participants who were approaching the age limit, there were worries about how to access insurance once they were no longer on their parents. Other participants were unable to use their parents' insurance, instead finding other sources for insurance, and one participant was uninsured. Participants discussed also navigating finding healthcare that was affordable and took their insurance, and some did not receive the care they needed for both mental health and SRH due to issues with cost and insurance. Multiple participants found mental healthcare to be particularly cost prohibitive. Policymakers should focus on ways to make both SRH and mental healthcare more affordable and accessible,

particularly for youth and young adults who struggle with navigating finding and accessing healthcare.

Sex Education

The findings from the current study have implications for education, including SRH and mental health education and programming in K-12 schools and in college, along with implications for teachers, extracurriculars, guidance counselors, and more. Participants desired sexual health education be more comprehensive and include information on topics such as healthy relationships, contraception, and different sexualities. They also felt that it was crucial to have this information at younger ages as youth start questioning their sexuality. Currently not all states require sex education and the content of these programs vary; more adolescents report getting information to delay sex or wait until marriage and less reported learning about contraception (Guttmacher Institute, 2022). Further, this programming happens at later ages, sometimes after an adolescent has already engaged in sex, with less than half of adolescents reporting receiving sex education before first having sex in one recent nationally representative analysis (Lindberg & Kantor, 2022). Despite studies showing that abstinence-only sex education is associated with higher adolescent pregnancies, federal funding for abstinence-only programming increased during the 2010s, and there is no federal funding for comprehensive sex education programs, which are the gold standard (Guttmacher Institute, 2021; Stanger-Hall & Hall, 2011). Comprehensive sex education, which includes a broad range of topics including biology and development, relationships, communication, and sexual health that is medically accurate and LGBTQ+ inclusive, similar to what the participants in the current study wanted, is associated with decreased sex in adolescence, fewer sexual partners, and increase contraception use along with reducing homophobia and expanding understanding of gender norms while

reducing intimate partner violence, all of which improves the health of young bi+ women (Goldfarb & Lieberman, 2021; United Nations Educational, Scientific and Cultural Organization, 2018). Acts such as the Real Education and Access for Healthy Youth Act seek to eliminate funding for abstinence-only sex education and instead establish grants for comprehensive sex education programs (H.R.3312 - 117th Congress (2021-2022), 2021).

Mental Health and SRH Interventions for Bi+ Women

More comprehensive mental health and SRH interventions attuned to the needs of young bi+ women and adolescents, both within school-based sex education curricula along with outside programming, could improve young bi+ women's health and reduce health disparities. Currently there are few interventions explicitly designed and tailored for bi+ people, and those that exist are generally geared towards men, and to the extent that the author is aware no current interventions exist for young bi+ women that address mental health and SRH needs together (Feinstein et al., 2019). Findings show that having more tailored interventions for young bi+ women would be beneficial for their well-being due to the unique stressors that young bi+ women experience, for instance lack of community connectedness due to this discrimination and invalidation of bisexuality as a valid identity (Doan Van et al., 2019; Feinstein & Dyar, 2017). Further, young bi+ women experience the additional challenges of increased sexualization and higher rates of assault and victimization leading to poor mental health and SRH outcomes (Alexander et al., 2016; Breiding & Black, 2014; Brewster et al., 2014; Szymanski et al., 2011; Watson et al., 2016). A comprehensive intervention for young bi+ women could address these unique challenges while allowing for young bi+ women to form connections with others like them.

Reproductive Rights

Participants across the U.S. described feeling worry, fear, and anxiety around the 2022 *Dobbs* decision overturning *Roe v. Wade* and implications for them in terms of where to live, their careers, relationships, pregnancy and parenting intentions, access to abortion and contraception, and reproductive health. As of August 2023, despite the majority of the public supporting abortion rights, abortion is banned in 14 states (Guttmacher Institute, 2023b; Santhanam, 2023). Four participants lived in states with outright abortion bans, Texas and Kentucky. Two participants lived in Arizona; at the time of the interview Arizona was labeled as a "very restrictive" state for abortion, but since has been recategorized as "restrictive" and abortion is banned of 15 weeks after pregnancy (Guttmacher Institute, 2023b). Jennifer, who received an abortion in Arizona right before the *Dobbs* decision occurred, talked about the difficulties of navigating her abortion, including how wait times, needing to schedule after six weeks, and requirement of two appointments ultimately ended with her having to have her abortion in her second trimester, even though she knew she wanted an abortion well before then. Thus, this illustrates how even in states that do not have outright bans but who ban after a certain number of weeks of pregnancy can still be incredibly restrictive for someone seeking an abortion and may end up with them being unable to obtain one in time. Jack discussed that due to Texas' ban on abortion a friend's sister had to travel out of state to obtain one, which was very difficult and was a considerable cost in terms of time and money.

Five participants lived in states categorized as "restrictive" at the time of the interview, including Florida, Ohio, and Pennsylvania. Since the *Dobbs* decision, there have been policies proposed and struck down that both increase and restrict access to abortion, and thus access to abortion is in flux and uncertain in many states. For instance, in Ohio, on Aug. 8, 2023, voters

rejected a ballot measure (Issue 1) that would make it more difficult to amend the State Constitution. By rejecting this, it will be easier for an abortion-rights amendment to pass in November (Astor, 2023; Carr Smyth & Hendrickson, 2023). Florida's policies around abortion are also in flux, as Governor DeSantis signed a 6-week abortion ban into law; however, it is not yet in effect, as there is ongoing litigation (Izaguirre, 2023; KFF, 2023a). There has also been recent court rulings aimed at restricting mifepristone, which is widely used for medication abortion (Marimow & Stein, 2023). Table 2 outlines the abortion laws for each state that participants were living at the time of the interview (Guttmacher Institute, 2023b; KFF, 2023a).

Table 2. Abortion Laws by State (as of August 2, 2023)

State	Participants	Restriction Category	Abortion Policy
Arizona	Amy, Jennifer	Restrictive *Very restrictive at time of interview	Abortion is banned at 15 weeks and later; shield law protecting abortion providers *Pre-Roe ban blocked Oct. 2022
California	Stella	Very protective	State constitution protects abortion rights, abortion banned at fetal viability; shield law protecting abortion providers
Florida	Margo, Shell	Restrictive	Abortion is banned at 15 weeks and later *Abortion banned after 6 weeks signed by Governor April 2023 but not currently in effect. State Supreme Court recognized right to abortion under State constitution.
Illinois	Sam	Protective	Abortion banned at fetal viability; shield law protecting abortion providers
Kentucky	Eleanor, Ella	Most restrictive	Abortion completely banned with very limited exceptions
Massachusetts	Neville	Protective	Abortion banned at 24 weeks; shield law protecting abortion providers
New York	Orange Turtle, Sasha	Very protective	Abortion banned at fetal viability; shield law protecting abortion providers
Ohio	Betty	Restrictive	Abortion is banned at 22 weeks and later
Pennsylvania	Paige, Sarah	Restrictive	Abortion is banned at 24 weeks and later
Texas	Aria, Jack	Most restrictive	Abortion completely banned with very limited exceptions Criminal and civil penalties associated with abortion

Policymakers should focus on creating and enacting policies that emphasize SRH choice and access to comprehensive care, including abortion, emergency contraception, and

contraception. Further, young women who access abortions or travel out of state to receive care need protections from litigation. Many participants discussed how essential access to Planned Parenthood was for them to access both services and education. Having access to these essential services are imperative to young bi+ women's mental health and SRH.

LGBTQ+ Rights

Currently there are a historic number of anti-LGBTQ+ bills (Cole, 2022). The Florida Parental Rights in Education Act, commonly referred to as the "Don't Say Gay or Trans" bill, passed in 2022 and prohibits discussion on sexual orientation or gender identity in schools. Alabama passed a similar law in 2022. Overall, 20 states have introduced similar bills (Branigin, 2022). Participants discussed the impact that these policies have on them, with many emphasizing these laws make them feel as if their home state is not a safe place for them. Participants felt that trans people were particularly being targeted by anti-LGBTQ+ laws. They were worried for trans loved ones and the trans community in general. They were also concerned about what the future would hold for them – for instance, some participants were worried that same sex couples could be affected by future policies targeting LGBTQ+ people.

Immigration Policies

Further, participants mentioned other policy impacts such as around immigration. For young bi+ women from immigrant families, their well-being and livelihood was tremendously impacted by immigration policy, including policies such as DACA. Other policies mentioned including ways for immigrant families to have social security numbers and driver's licenses, along with support for accessing affordable college for students who were not born in the United States whose parents are undocumented. Participants who were from immigrant families discussed the anxiety and uncertainty when there has been pushes to repeal DACA such as

during the Trump administration and through present day. In 2022, the Biden administration published a rule that would codify DACA, but there is a level of uncertainty and restrictions that have stalled progress. For instance, it excludes anyone who entered the country or was born after 2007, which reduces the number of young adults who qualify for it. The pathway for these young adults is uncertain. The American Dream and Promise Act of 2021 seeks to provide pathways to lawful permanent resident status for undocumented immigrants and those who were brought to the U.S. as children (KFF, 2023b; Text - H.R.6 - 117th Congress (2021-2022), 2021). Focus should be paid to better pathways to citizenship and resources for immigrant families.

Future Research

There are few studies specifically investigating young bi+ women's health. This exploratory study provides several avenues for future research. A larger, representative survey could show how prevalent the mental health and SRH challenges along with coping strategies that young bi+ women employ is in a larger population. From the current study there are several potential factors implicated from the participants themselves that are important to explore further, including experiences of stigma and bisexual marginalization, compulsory heterosexuality and gender norms, and experiences of violence. Additionally, experiences of social support and connectedness to the LGBTQ+ community are other areas of further exploration. Participants in the current study expressed complicated feelings about their connection to the LGBTQ+ community at large, which was somewhat dependent on their location, level out "outness" to others, and the gender of their partner. This should be further explored both quantitatively and qualitatively in a larger study with a diverse sample of young bi+ women.

Further research needs to be completed into the experiences of young bi+ women of color and looking at differences in experiences between racial and ethnic groups. The bi+ women of color in my sample discussed significant challenges at the intersection of their gender, sexuality, race and ethnicity, and immigrant status. However, further studies investigating these experiences will be essential to elucidating the challenges these women experience and better ways to create culturally tailored programming to address these issues. It is important that future studies take an intersectional approach to young bi+ women's health (Bowleg, 2012; Cooper, 2016).

Findings from the current study also show that young bi+ women in more conservative and less affirming areas are at particular risk to their mental health and SRH. A quantitative study comparing mental health and SRH outcomes between states among this population could help determine if my qualitative findings also reflect what is occurring at the population level. Also, participants expressed concern and worry about what the *Dobbs* decision meant for them and their well-being. Since it has only been a year since the ruling, not many participants have yet been directly impacted. Continuing to monitor young bi+ women's mental health and SRH particularly in more restrictive states will be essential to determining how these policies impact their health and well-being.

Closing Reflexive Statement

This dissertation expanded my idea of what it means to be a bi+ woman, and I learned more about this incredibly diverse group of women while also learning more about myself in the process. I was continuously surprised and moved by the stories of my participants. Hearing about the struggles that these women faced, including violence at the interpersonal and systems level,

was incredibly difficult and heartbreaking. However, I was honored that they were willing to share these stories with me, and I believe these stories to be incredibly important.

Many stories that the participants told I found myself relating to. They shared difficulties in childhood and adolescence with fitting in, drama in friend groups, and the woes and joys of dating. They talked about transitioning to young adulthood and figuring out their majors and future careers. They also discussed the difficulties of being a woman in a patriarchal society – of sexualization, of victimization, of feeling pressure to adhere to certain beauty standards. Many of these experiences are, unfortunately, common among women. For bi+ women, there are multiple layers to these experiences as they also come to terms with their sexuality in a society that largely deems their identity as invalid.

There were also many times when I was distinctly aware of the privilege that I've had in my life that many of the participants lacked – U.S. citizenship, access to education, access to healthcare, a middle-class background and lack of financial insecurity, safety and security. Despite being objectively aware of privileges, hearing some of these women's stories about homelessness, fear around deportation, abuse, made me recognize all the spaces in which I have been lucky and privileged. And it reaffirmed by commitment to equity and belief that resources need to be available for people who experience these struggles. Often, people do not think about what it looks like when policies directly impact a person. Although I knew what DACA was, it was not until I heard about the incredible impact it had on Jack's life that I realized the challenges that immigrants experience through multiple domains and how essential these policies and programs are for immigrant families.

At the end of the interview, almost all the participants thanked me and said they appreciated being able to share their stories and experiences. Some of these women told me

things that they said they have not told anybody. At the same time, these were experiences that they seemed anxious and determined to share – to discuss their struggles or the challenges that them, their families, and their friends faced. To have the space to confront and process the difficulties of being a bi+ young women and all the challenges surrounding that. For one participant, I was the only person they had shared their sexuality with. For others, they shared traumatic experiences that they had not shared with anyone. I respect and am grateful for that level of trust in me.

One hypothesis for why bi+ women experience worse mental health outcomes is due to a lack of community connectedness. I like to think that these interviews provided a space for connection and affirmation – allowing women to tell their stories and explore their sexualities in a way that is not often allowed. Many of the women seemed relieved and comforted by the experience of talking about their sexuality, expressing that it is not something they have often had the opportunity to talk about or has been dismissed or invalidated by others. This experience has opened up my eyes about the importance of bi-visibility and how often bisexual people are sidelined despite making up the largest percentage of the LGBTQ+ community. This experience has renewed my commitment to providing safe and affirming spaces and community for LGBTQ+ people in wherever I am, whether it is at work, in the classroom, or even in social situations.

Conclusion

Ultimately, the current study provides richness and depth along with greater understanding to young bi+ women's mental health and SRH experiences. This information can help us elucidate the causes along with identify better ways to address mental health and SRH concerns, which is particularly important as bi+ women experience significant mental health and

SRH disparities compared to their straight and gay counterparts. This study illustrates how mental health and SRH interconnect and how treating them both together can be beneficial for young bi+ women's health and help them achieve optimal well-being. Further, this study shows that their health and well-being is impacted by the socio-political context in multifaceted ways, including through rhetoric, discrimination, restrictive policies, social and cultural norms, and stigma.

Appendix A: Study Description in Prolific

The purpose of this research project is to explore the mental health and sexual and reproductive health experiences of young bi+ women who are attracted to more than one gender or regardless of gender. This research project first includes completing a brief (<1 minute) questionnaire to provide background information relevant to the study (e.g., gender, sexuality) and provide your availability for a follow-up interview. You will be compensated $0.20 for this initial survey. After we have confirmed that you are eligible for the study using the background information provided, you will receive a message through Prolific to schedule a two-hour video interview over Zoom. If you are deemed ineligible, your survey responses will be deleted immediately and not used for research.

Interview questions will include topics such as mental health, sexual and reproductive health, and sexuality. Types of questions that may be asked include:

- Tell me about your current mental health.
- How do you feel that your mental health and sexual and reproductive health connect?
- What types of resources or sources of support might help women like you?

The interview will be audio and video recorded so that the researchers may return to what was said and analyze it for important information. You will need to be in a quiet, private location where you can speak openly during the interview. You will also need to have an internet connection and a device that can support using video and audio for the duration of the Zoom call. You will receive a bonus payment of $50 in your Prolific account within 3 business days of completing the interview and questionnaire.

If you have any questions, you can contact the principal investigator at jrobin20@umd.edu or contact her through Prolific's messaging system.

Appendix B: Screener Survey

Exploring Young Bi+ Women's Intersecting Mental Health and Sexual and Reproductive Health Experiences

The purpose of this research project is to explore the mental health and sexual and reproductive health experiences of young bi+ women who are attracted to more than one gender or regardless of gender. The following brief questionnaire will provide background information relevant to the study (e.g., gender, sexuality). You will be compensated $0.20 for this initial survey. You will receive a completion code after completing this survey.

0. What is your Prolific ID? Please note that this response should auto-fill with the correct ID. [auto-generated from Prolific; required prior to starting the survey]

1. What is your age? _____ [Fill in the Blank; restricted to numbers only; If <18 or >25 ineligible]

2. What is your gender? (Check all that apply)
    a. Cisgender Woman (i.e., assigned female at birth and currently identify as a woman)
    b. Cisgender Man (i.e., assigned male at birth and currently identify as a man) [ineligible]
    c. Transgender Woman [ineligible]
    d. Transgender Man [ineligible]
    e. Genderfluid [ineligible]
    f. Genderqueer [ineligible]
    g. Non-binary [ineligible]
    h. Not sure [ineligible]
    i. Another gender not listed (please specify): _____ [fill in the blank] [ineligible]

3. What is your sexual orientation? (Check all that apply)
    a. Asexual [ineligible]
    b. Bisexual
    c. Gay [ineligible]
    d. Lesbian [ineligible]
    e. Omnisexual
    f. Plurisexual
    g. Pansexual
    h. Straight or heterosexual [ineligible]
    i. Queer
    j. Not sure [ineligible]

k. My sexual orientation is not listed here. It is (please specify): _____ [fill in the blank]

4. Are you sexually or romantically attracted to two or more genders, or regardless of gender?
    a. Yes
    b. No [ineligible]

5. What racial or ethnic category do you most identify with? (Check all that apply)
    a. Asian
    b. Black or African American
    c. Hispanic or Latino
    d. Native American (American Indian) or Alaska Native
    e. Native Hawaiian or Other Pacific Islander
    f. White
    g. My race or ethnicity is not listed here. It is (please specify): _____ [fill in the blank]

6. Do you currently live in the United States?
    a. Yes
    b. No [Ineligible]

7. What state do you currently live in? If you live in more than one state (e.g., if you are a college student) please list all of them: _____ [fill in the blank]

8. Do you have internet access that would support a 60-90 minute Zoom call with video?
    a. Yes
    b. No [ineligible]

Thank you for completing the survey!

Your completion code for this initial survey is **[CODE].** Please save this code to receive your $0.20 in Prolific for this survey.

If you are deemed eligible for the follow-up interview study, you will receive a message through Prolific's messaging system with more information within 24 hours.

If you have any questions, please contact the principal investigator through Prolific's messaging system or at jrobin20@umd.edu.

Appendix C: Informed Consent

Project Title	Exploring Young Bi+ Women's Intersecting Mental Health and Sexual and Reproductive Health Experiences
Purpose of the Study	This research is being conducted by Jennifer Robinson at the University of Maryland, College Park. We are inviting you to participate in this research project because we would like to hear about your mental health and sexual and reproductive health experiences. The purpose of this research project is to explore the mental health and sexual and reproductive health experiences of young women who are attracted to more than one gender.
Procedures	This research project includes one 60-90 minute interview over online videoconferencing platform (i.e., Zoom). Interview questions will include topics such as mental health, sexual and reproductive health, and sexuality. Types of questions that may be asked include: Tell me about your current mental health. How do you feel that your mental health and sexual and reproductive health intersect? What types of resources or sources of support might help women like you? The conversation may include conversation about sexual and reproductive health services such as abortion that may be illegal in your state. The interview will be audio and video recorded so that the researchers may return to what was said and analyze it for important information. Recording the interview is a requirement for participation in this study. If at any point you need to pause the recording briefly, let me know and we can pause the interview and recording. This interview will not include information like name, birthdate, and address to keep your participation confidential.
Potential Risks and Discomforts	We want you to know about possible risks to participating so you can make the best choice for yourself about whether or not to participate in this research project. There is a possibility that you may feel uncomfortable with some of the questions asked. Please remember that you can choose not to answer a question or can pause or stop the interview at any time.

	This interview may bring up questions or feelings related to your mental health, sexual and reproductive health, and sexuality. If you feel like you need additional support related to these topics, please find a health resource guide here: https://tinyurl.com/yc6xh46t
Potential Benefits	There are no direct benefits from participating in this research. However, we hope that in the future other people might benefit from this study through improved understanding of young bi+ women's mental health and sexual and reproductive health.
Confidentiality	Keeping your information confidential is important to us. We will work to keep the information you share with us (including any recordings or anything written down) confidential by keeping all materials in password-protected files on UMD's secure cloud-based storage. Interview transcripts and demographic data will use a pseudonym (fake name) and not be attached to your real name or other identifying information. The study team will only contact you through the Prolific messaging system and will not have access to your name or email address. Only the study team will have access to interview data such as transcripts and recordings. Study data will be destroyed 3 years after study completion. If we write a report or article about this research project, your identity will be protected to the maximum extent possible. We will be asking you questions about your sexual and reproductive health during the interview. During this conversation, you may discuss reproductive healthcare you have accessed such as abortion, which, depending on where you live, may be legally restricted in your state. We will NOT be disclosing any information related to your use of reproductive healthcare, including contraception or abortion, to law enforcement. Your information may be shared with representatives of the University of Maryland, College Park or governmental authorities if you or someone else is in danger or if we are required to do so by law. For example, if you share that someone, including yourself, were abused or neglected as a child in the past or present day, the researchers are legally required to report the information to child protective services and to university authorities to make sure the victim(s) are safe. If there is indication of harm to yourself or others, the interviewer will need to break confidentiality to connect you with the appropriate authority for follow-up to make sure you are safe and get the care that you need and to comply with legal requirements.
Compensation	You will receive $50 to compensate you for your time through the Prolific system as a bonus payment.

Right to Withdraw and Questions	Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits to which you otherwise qualify. If you decide to stop taking part in the study, if you have questions, concerns, or complaints, or if you need to report an injury related to the research, please contact the investigator by using the "contact the researcher" button in Prolific or at the following contact information: Jennifer Robinson 4200 Valley Dr., Suite 1234, College Park, MD 20742 Jrobin20@umd.edu (732) 614-2311
Participant Rights	If you have questions about your rights as a research participant or wish to report a research-related injury, please contact: University of Maryland College Park Institutional Review Board Office 1204 Marie Mount Hall College Park, Maryland, 20742 E-mail: **irb@umd.edu** Telephone: 301-405-0678 For more information regarding participant rights, please visit: **https://research.umd.edu/research-resources/research-compliance/institutional-review-board-irb/research-participants** This research has been reviewed according to the University of Maryland, College Park IRB procedures for research involving human subjects.
Statement of Consent	Selecting "I agree" below indicates that you are at least 18 years of age, you have read this consent form or have had it read to you, your questions have been answered to your satisfaction and you voluntarily agree to participate in this research study. You can request a copy of the consent form by contacting the research team using the "contact the researcher" button and using your Prolific ID email.

Appendix D: Qualitative In-Depth Interview Guide

Now that we have reviewed the informed consent and started the recording, we are going to begin the interview. Today's date is [DATE] and I am speaking with [PSEUDONYM].

I. Introduction *(Approx. 1 min)*

1. To start us off, what is something that is bringing you joy right now? This could be a hobby, a TV show, friends or family, or anything else you would like to share.

II. Mental Health *(Approx. 40-45 mins)*

Now I am going to ask you some questions related to your mental health. **Mental health** refers to our emotional, psychological, and social well-being and affects how we think, feel, and act.

2. Tell me about your current mental health, in general.

We are now going to walk through some different stages of your life and discuss your mental health during these different stages.

3. I want you to think back to your childhood [can clarify this would be early childhood and around elementary school].
    a. What was your mental health like in childhood, to the extent that you can remember?
        i. Probe: Could you tell me more about that?
        ii. [If not mentioned] Where did you grow up? Who were you living with at the time?
    b. What challenges did you experience during this time, if any?
        i. Probe: What contributed to these challenges?
        ii. Probe: What helped you cope with these challenges?
        iii. Probe: What would have made your mental health better during this time? (e.g., support, resources)
    c. [If have time/doesn't overlap with coping] When was your mental health good or did you experience joy during this time? Can you tell me about it?
    d. To the extent that you can remember, thinking about the social, cultural, and political environment during your childhood, how did that impact you, if at all?
        i. Probes: Examples like social environment in school, community, online, social media; political like laws and policies, political climate; economic factors
        ii. [If not mentioned] How about religion? Was your family religious at all?
            1. Probe: How did that impact you, if at all?
        iii. Probe: How did that affect your mental health, if at all?

4. Now I want you to think back to when you were a teenager, so around middle school and high school.
    a. What was your mental health like during that time?
        i. Probe: Could you tell me more about that?
        ii. [If not mentioned] Where were you living during that time? With whom?
    b. What challenges did you experience during this time, if any?
        i. Probe: What contributed to these challenges?
        ii. Probe: What helped you cope with these challenges?
        iii. Probe: What would have made your mental health better during this time? (e.g., support, resources)
    c. [If have time/doesn't overlap with coping] When was your mental health good or did you experience joy during this time? Can you tell me about it?
    d. Thinking about the social, cultural, and political environment during that time, how did that impact you, if at all?
        i. Probes: Examples like social environment in school, community, online, social media; political like laws and policies, political climate; economic factors; religion
        ii. Probe: How did that affect your mental health, if at all?
5. Now thinking back to the past few years since you were a teenager and present day… [changes depending on age of participant]
    a. How has your mental health been?
        i. Probe: Could you tell me more about that?
    b. What challenges have you been experiencing the past few years, if any?
        i. Probe: What contributed to these challenges?
        ii. Probe: What helped you cope with these challenges?
        iii. Probe: What would have made your mental health better during this time?
    c. [If not mentioned] How was your mental health impacted by the COVID-19 pandemic, if at all?
    d. [If have time/doesn't overlap with coping] When has your mental health been good or have you experienced joy the past few years? Can you tell me about it?
    e. What actions do you currently take to manage your mental health?
        i. Probe: How do you currently cope with challenges?
    f. [If have time/has not been discussed] What are some sources of support you have that help your mental health?
        i. Probe: Who do you reach out to when you are struggling with your mental health?
            1. Probe: How does reaching out to that person or those people go for you?
        ii. Probe: To what extent do you receive support from your friends?
        iii. Probe: How about your family?

iv. Probe: How about your community?

g. Thinking about the social, cultural, and political environment over the past few years and currently, how has that been impacting you?
    i. [If not mentioned] Have there been any policies or laws you can think of that have affected you?
        1. Probe: local, state, national
    ii. Probe: How did that affect your mental health, if at all?
h. Probe: What else has impacted your mental health in the past few years, for better or worse?

Formal Supports (diagnoses, therapy, medication)
[Skip as needed if already mentioned in previous section]

6. [If not already mentioned] Have you ever been diagnosed with a mental health disorder?
    a. [If yes] When were you diagnosed? By whom?
        i. How did you feel about your diagnosis?
7. How do you feel about therapy, generally?
    a. Have you ever received counseling or therapy for your mental health?
        i. [If yes] Tell me about your experience receiving counseling or therapy.
            1. What challenges did you experience receiving counseling or therapy?
            2. What benefits did you have from receiving counseling or therapy?
        ii. [If no] Did you ever consider receiving counseling but did not receive it?
            1. [If yes] What barriers did you experience in seeking counseling?
8. How do you feel about people taking medication for their mental health?
    a. Have you ever taken any medication for your mental health?
        i. [If yes] Tell me about your experience taking medication for your mental health.
            1. What challenges did you experience taking medication for your mental health?
            2. What benefits did you have from taking medication for your mental health?
        ii. [If no] Did you ever consider taking medication for your mental health but did not receive it?
            1. [If yes] What barriers did you experience in accessing medication for your mental health?

III. Sexuality and Relationships *(Approx. 20-25 minutes)*
Next we are going to discuss sexuality and relationships.

9. How do you define your sexuality?
10. When did you first realize that you were [bisexual]?

11. In what contexts are you open about your sexuality to others?
    a. [If yes] When did you first tell other people about your sexuality? How did that go?
    b. [If not] Tell me more about why you aren't open with others about your sexuality.
12. What perceptions do you think others have about [bisexuality]?
13. What challenges do you feel you experience due to your sexuality, if any?
    a. Probe: Have you experienced discrimination based on your sexuality?
14. What benefits do you feel you experience due to your sexuality, if any?
15. Are you currently in a romantic or sexual relationship? Tell me about it.
    a. What is the gender and sexuality of your current partner(s)?
    b. Probe: How do you and your partner(s) get along?
16. Tell me about your past romantic or sexual partners, if any.
    a. What were their genders and sexualities?
    b. How open were you about your sexuality with your past partners?
17. What types of challenges have you experienced in your romantic and sexual relationships and dating life overall?
18. What benefits have you found from your romantic and sexual relationships?
19. Tell me about your relationship to the LGBTQ+ community.
    a. To what extent do you feel connected to the LGBTQ+ community?
    b. To what extent do you feel like the LGBTQ+ community embraces [bisexuality]?
        i. Probe: Why do you think that is?
20. How do you feel that your experiences as a [bisexual] woman have influenced your well-being, if at all?
21. Reflecting on the current national discourse surrounding LGBTQ+ issues, such as the representation on social media and in the news, how has this impacted you as a [bisexual] woman?
22. Reflecting on current national, state, and local policies affecting LGBTQ+ people, how has this impacted you as a [bisexual] woman, if at all?
    a. Probe: Tell me about what it is like to be a [bisexual] woman in the current political climate.

IV. Sexual and Reproductive Health *(Approx. 20-25 minutes)*

For this next part, I am going to ask you some questions about your sexual and reproductive health. **Sexual and reproductive health** is defined as a state of physical, emotional, mental, and social well-being in relation to sexuality and the reproductive system. Sexual and reproductive health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination, and violence. This also includes the ability to reproduce and the freedom to decide if, when, and how often to do so. Sexual and reproductive health concerns may be related to access to birth control and abortion, fertility and pregnancy, sexually transmitted infections, gynecological health, and more.

23. Keeping that definition in mind, tell me about your sexual and reproductive health, in general.
    a. What issues or challenges have you experienced related to your sexual and reproductive health?

Next I am going to ask you about your sexual and reproductive healthcare experiences.

24. Have you ever experienced any challenges accessing sexual and reproductive healthcare? This could be the ability to go to well-woman exams (or annual checkups), screenings for sexually transmitted infections, receiving birth control or emergency contraception such as Plan B, or receiving abortion care.
    a. What methods do you currently use to prevent pregnancy or sexually transmitted infections, if any? [ask for specific kind if birth control, etc.]
    b. Have you ever been pregnant? Tell me about that experience was like for you.
25. Tell me about a time when you had a positive experience receiving sexual and reproductive healthcare.
26. To what extent have you been affected by recent policy changes in your city or state around access to reproductive healthcare such as abortion and contraception.
    a. The Supreme Court recently removed federal protections for access to abortions through the *Dobbs* decision in the summer of 2022. Tell me about how you feel this affected you, if at all.
        i. How have you seen it affecting your peers?
        ii. How have you seen it affecting your community?

V. The Intersection of Sexual and Reproductive Health and Mental Health

27. How do you feel that your mental health and sexual and reproductive health connect?
    a. Probe: Can you provide an example of when your sexual and reproductive health affected your mental health?
    b. Probe: How about when your mental health has affected your sexual and reproductive health?
28. Thinking about your needs as a young [bisexual] woman and the needs of your peers, what types of resources or sources of support might help improve the mental health and sexual and reproductive health of women like you.

VI. Closing

29. Thank you for sharing all of that. Is there anything else you'd like to add about your mental health or sexual and reproductive health experiences?
30. I've asked you a lot of questions today. Do you have any questions for me?

Appendix E: Health Resource Guide

If you need mental health or sexual and reproductive health support, please see the resources below. If it is an emergency, please call 911 or go to your nearest emergency room.

Organization	Description	Website	Phone Number
988 Suicide and Crisis Lifeline	The Lifeline provides 24/7, free and confidential support for people in distress, prevention and crisis resources	988lifeline.org	Call or text **988** to connect with a trained counselor
Substance Abuse and Mental Health Services Administration	Resource to help find treatment for substance use and mental health disorders	findtreatment.gov	For help finding treatment: 800-662-HELP (4357)
Trevor Project	LGBTQ+ youth mental health	thetrevorproject.org	Reach a counselor: Call: 1-866-488-7386 Text: 678-678
Planned Parenthood	Sexual and reproductive healthcare and information (e.g., STI testing, birth control, physical exams)	plannedparenthood.org	Find a clinic: 1-800-230-PLAN
Department of Health & Human Services Clinic Locator	Local federally qualified health centers for free or low-cost sexual and reproductive healthcare, including birth control	opa-fpclinicdb.hhs.gov	
RAINN	Anti-sexual violence organization	rainn.org	National Sexual Assault Hotline: 800-656-HOPE
National Domestic Violence Hotline	Domestic violence support	thehotline.org	Call 1.800.799.SAFE (7233) or text START to 88788 to connect with an advocate
Bedsider	Birth control support network	bedsider.org	

Appendix F: Demographics Survey

Demographics

What is your Prolific ID? _____

1. What is the highest level of education you have completed?
    a. Some high school
    b. High school diploma
    c. Some college or currently attending college
    d. Associate's degree
    e. Bachelor's degree
    f. Master's degree
    g. Doctoral degree
    h. Trade school

2. Are you currently a student?
    a. Yes
    b. No

3. Are you currently employed?
    a. Yes, full-time
    b. Yes, part-time
    c. No

4. What is your total annual household income?
    a. Less than $29,000
    b. $30,000 - $49,000
    c. $50,000 - $74,000
    d. $75,000 or more
    e. Not sure

5. Do you currently have any kind of health insurance?
    a. Yes
    b. No

Thank you for completing the interview and survey! We greatly appreciate your contribution to our understanding of bisexual women's health.

If you feel like you would like additional support related to your mental health, sexual and reproductive health, or sexuality please use this health resources guide: https://tinyurl.com/yc6xh46t If it is an emergency, please call 911 (or 988 for mental

health crises) or go to your nearest emergency room.

If you have any follow-up questions about the study or your participation, please contact the principal investigator through Prolific, at jrobin20@umd.edu, or at (732) 614-2311.

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