Bisexual Women's Experiences of Microaggressions and Microaffirmations and their Relation to Suicidality

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Abstract

Bisexual women have been found to report worse mental health outcomes, including elevated rates of suicidality, compared to both heterosexual and lesbian women. The purpose of this study is to examine bisexual women's daily experiences with sexual identity microaggressions and microaffirmations as they relate to rates of suicidal ideation and behavior. The study utilized a 5-day online daily-diary study design. The first day participants completed a large survey with information on demographics, sexual identity, social support, and self-esteem. For days 2 through 5 participants completed daily diary entries consisting of the bisexual identity Microaggression and Microaffirmation Scales, and a measure of suicidal ideation and attempt. The data were analyzed quantitatively using a random coefficient multilevel model assessing the relationship between microaggressions and microaffirmations and suicidality within individuals at Level 1, and how those relationships may differ between individuals at Level 2 based on social support, internalized binegativity (having negative feelings about oneself due to bisexual identity), connectedness to LGBT community, and self-esteem. There was a significant relationship between daily microaggressions and suicidality at Level 1 and between self-esteem, internalized binegativity, trans identity and suicidality at Level 2.

INTRODUCTION

Rationale for Current Study

Research examining the mental health outcomes of lesbian, gay, bisexual, trans, and queer (LGBTQ) people has shown that this population has poorer mental health outcomes compared to heterosexual individuals (Gilman et al., 2001; Brennan et al., 2010; Sandfort, Bakker, Schellevis, & Vanwesenbeeck, 2006). These mental health outcomes include affective disorders, substance use disorders, and suicidal behavior (Cochran & Mays, 2007; Gilman et al., 2001; Sandfort, de Graaf, Bijl, & Schnabel, 2001; Pakula, Shaker, Martin, & Skinner, 2013). Bisexual individuals, in particular, have consistently been found to have worse mental health outcomes compared to both heterosexual and lesbian/gay samples, including higher rates of suicidal ideation and attempts (Tjepkema, 2008; Conron, Mimiaga, & Landers, 2010; Pompili et al., 2014).

Most of the early population-based studies on sexual minority individuals' mental health have grouped gay and/or lesbian populations together with bisexual people or excluded bisexual individuals all together (Kaestle & Ivory, 2012). However, bisexual individuals experience stigma that is unique to their bisexual identity (Flanders, Robinson, Legge, & Tarasoff, 2016) and thus it is important to examine the experience of bisexual individuals as a distinct group. More recent studies have started looking at the experiences of bisexual individuals separate from those of monosexual individuals (people who are attracted strictly to one sex and/or gender) because bisexual populations often report poorer mental health outcomes compared with both heterosexual and lesbian/gay samples (Bostwick, Boyd, Hughes, & McCabe, 2010; Steele et al., 2009; Brennan et al., 2010).

These health disparities can be understood using the minority stress framework, which states that members of stigmatized groups experience additional social stressors that can have negative impact on their mental health (Meyer, 2003). According to the minority stress framework, the unique stigma and discrimination that bisexual individuals experience due to their sexual identity are added social stressors that may account for bisexual people's worse mental health outcomes. However, the framework also recognizes positive factors associated with a minority identity and research has found social support to be associated with resilience against minority stress for marginalized individuals (Crockett et al., 2007), as well as bisexual people (Ross et al., 2010). It is possible that social support is a source of well-being for bisexual people, and therefore the study included positive factors as well as negative ones. In line with the minority stress framework, the current research investigated how social support and stressors relate to the mental health outcomes of bisexual women. Specifically, the study explored bisexual women's daily experiences with sexual identity microaggressions and affirmations in order to elucidate their relation to suicidal ideation and behavior.

LGBTQ Mental Health Literature

Research that has compared bisexual individuals to their gay and/or lesbian counterparts has found that bisexuals report higher rates of anxiety and depression (Tjepkema, 2008; Jorm et al., 2002), as well as higher rates of self-harm behaviors (Balsam, Beauchaine, Mickey, & Rothblum, 2005). Population-based studies in the United States have found that bisexual individuals have greater rates of current sadness, as well as report higher levels of binge drinking (Conron et al., 2010). Furthermore, bisexual individuals have consistently been found to have

high risk of suicidal behavior (Conron et al., 2010; Marshal et al., 2008; Brennan et al., 2010). In a systematic review of the literature on suicidality, Pompili et al. (2014) found that individuals identifying as bisexual had a higher risk of suicidal ideation and attempts compared with both heterosexual and homosexual people.

Similar results have been reported for bisexual women specifically. Studies comparing bisexual women's mental health outcomes with those of lesbian individuals have found that bisexual women report higher rates of anxiety and depression (McNair, Kavanagh, Agius, & Tong, 2005; Koh & Ross, 2006), poorer self-ratings of mental health (Case et al., 2004), and higher rates of suicidality (Koh & Ross, 2006; Case et al., 2004). In a survey conducted by Koh and Ross (2006), bisexual women were found more likely to report prior suicide attempts compared to both heterosexual and lesbian women. Bisexual women also reported more frequent thoughts (in the past year) about suicide than did heterosexual and lesbian women. In a recent study, Peter et al. (2017) examined the trends in suicidality among heterosexual and sexual minority students for the 15-year period between 1998 and 2013 in a Canadian population-based cohort study. The results indicated that across all years, bisexual and lesbian girls had a higher prevalence of suicidal ideation and suicide attempts than all other groups (heterosexual girls/boys, mostly heterosexual girls/boys, gay boys, bisexual boys). Further, bisexual girls were found to report the highest odds of suicide attempts compared to heterosexual girls across all years, except for 2003, and they had a greater increase in recent years in suicidality compared to all other sexual orientation groups.

Conceptual Framework

Research exploring the mental health disparities between sexual minority individuals and heterosexual individuals has cited the minority stress framework in order to explain these differences in health outcomes. This conceptual framework was developed by Meyer (2003) to address the high prevalence of mental health problems in sexual minority populations. His framework explains that prejudice, stigma and discrimination create an environment that is stressful and hostile for sexual minority individuals, which creates a higher burden of stress, ultimately leading to mental health problems. The model identifies stress processes, such as expectations of rejection, experiences of prejudice events, internalized homophobia and concealing one's identity. Research has found a relationship between psychological distress and each of the minority stressors from Meyer's model, such as discrimination (Eaton, 2014), expectations of rejection (Hatzenbuehler, 2008), victimization (Mustanski & Liu, 2013), identity concealment (Kosciw, Palmer, & Kull, 2015), and internalized homophobia (Puckett, Surace, Levitt, & Horne, 2016; Newcomb & Mustanski, 2010).

A recent study conducted by Puckett et al. (2016), examined the experiences of minority stress and mental health of different groups of sexual minority women. Specifically, it aimed to compare lesbian/gay, bisexual, and queer women, to further our understanding of between group differences in sexual minority groups. The results demonstrated that different groups encountered some minority stressors more than others. Lesbian/gay and queer women were at a higher risk of experiencing victimization, discrimination, and expectations of discrimination than were bisexual women. Bisexual women, on the other hand, were at a higher risk of experiencing internalized heterosexism and higher levels of identity concealment than lesbian/gay and queer

individuals. Bisexual and queer women had the highest rates of psychological distress even though they differed in the types of minority stressors most often encountered. The results of this study further illustrate the need to examine the experiences of different sexual minority groups separately, as they may vary in the types of stressors they face and in the way those stressors relate to psychological well-being.

The minority stress framework also recognizes stress-ameliorating factors related to a minority identity, like positive coping which is common and beneficial to marginalized individuals (Clark, Anderson, Clark, & Williams, 1999). A minority identity is associated with important resources that protect minority members from the adverse effects of minority stress as well, such as group solidarity (Branscombe, Schmitt, & Harvey, 1999). The importance of ameliorative coping processes when faced with stigma has been reported in LGB populations as well (Morris, Waldo, & Rothblum, 2001; Kertzner, 2001). A study of LGB youth found that self-acceptance and family support ameliorated the adverse effects of antigay violence on mental well-being (Hershberger & D'Augelli, 1995). A minority identity can be a source of resilience and strength as well when an individual has opportunities for social support and affiliation that can ameliorate the effect of stressors (Miller & Major, 2000). Specifically, social support has been found to buffer the negative impact of social stressors on mental health (Ross et al., 2010).

Bisexual women experience unique stigma related to their sexual identity, which may explain their increased vulnerability for suicidality. Little research has examined whether positive factors, such as social support, serve as a buffer in this case and ameliorate the effects of stressors on suicidal ideation and behavior. The higher prevalence of suicidality among bisexual women may be explained through the minority stress framework.

Bisexual Stigma and Mental Health

Prejudice against bisexual individuals is defined as biphobia - "the denigration of bisexuality as a valid life choice" (Bennett, 1992, p. 207). A major assumption of biphobia is that bisexuality is not a legitimate and stable sexual identity. Bisexual individuals are seen as either confused about their sexual orientation, in a state of transitioning to a lesbian/gay identity, or as trying to benefit from heterosexual privilege when in reality they are lesbian/gay (Yost & Thomas, 2012; Ochs, 1996; Rust, 1993).

Microaggressions, initially developed with regard to racial and ethnic minorities, are defined as "the brief, commonplace, daily verbal, behavioral, and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative ... slights and insults to the target person or group" (Sue, et al., 2007, p. 271). These subtle forms of discrimination were negatively associated with mental and physical well-being of sexual minority individuals (Woodford, Howell, Silverschanz, & Yu, 2012). A recent qualitative study conducted by Bostwick and Hequembourg (2014) provides support that there are microaggressions specific to bisexual identity. Bisexual microaggressions also stem from monosexism, which entails the systematic denial of sexual identities that are not attracted to only one sex or gender (Ross, Dobinson, & Eady, 2010). Bostwick and Hequembourg (2014) have also found that bisexual women experience microaggressions, such as dating exclusion, from both heterosexual and queer communities. This again supports the notion that there is unique stigma associated with a bisexual identity.

Even though more recent lines of research have examined stigma that is unique to bisexual individuals, most of minority stress research has not been based on the perspective of bisexual people (e.g. Israel & Mohr, 2004). In order to address this issue, Flanders, Robinson, Legge, & Tarasoff (2016) investigated bisexual (and nonmonosexual) individuals' perceived daily experiences of negative sexual identity events. The authors collected daily data in the span of 28 days of participants' encounters with negative sexual identity experiences and used a constructivist grounded theory approach to analyze participants' reports of negative identity experiences, identifying a social ecological model (Bronfenbrenner, 1979). According to this model, the reported negative encounters fell in intrapersonal, interpersonal and social-structural levels. At the intrapersonal level, participants reported experiences of discomfort disclosing one's bisexual identity and internalizing common negative attitudes toward bisexuality. At the interpersonal level the greatest number of negative sexual identity experiences were reported, including romantic relationship issues due to bisexual identity, and bisexual stereotypes (views of bisexuals as attention-seeking or hypersexual). At the social-structural level, participants identified negative identity experiences such institutional erasure and bisexual stereotypes (e.g. bisexuality as illegitimate and bisexuals as prone to infidelity). The results of this study have helped elucidate the daily negative sexual identity experiences reported by bisexual individuals that may relate to mental health, as well as identify some of the unique stigma associated with a bisexual identity and the biphobic and monophobic attitudes that bisexuals encounter on a daily basis.

Another qualitative examination of bisexual individuals' discrimination experiences explored perceived factors (positive and negative) that were significantly associated with

bisexual individuals' mental health (Ross, Dobinson, & Eady, 2010). The factors identified by participants included experiences of biphobia and monosexism, common social attitudes and beliefs about bisexuality, partner and intimate relationships, struggles with identity, and self-acceptance. Bisexual people's experiences with prejudice and discrimination were perceived to affect their mental health directly (such as anxiety about and fear of sexual identity violence), as well as indirectly though their impact on individuals' interpersonal relationships and their feelings of self-esteem and self-worth. The results of these studies illustrate the far-reaching impact of biphobia and monosexism on bisexual individuals' mental health, and call for more research that systematically explores bisexual individuals' experiences through the use of validated measures.

Positive Experiences and Mental Health

Most of the research on sexual minority mental health has focused on stressful and discriminatory experiences. However, the minority stress framework recognizes that a minority identity can also lead to resilience and that it is important to consider positive/supportive factors, such as social support and affiliation. Therefore, research should examine the association between positive sexual identity experiences and mental health as well. Positive psychology researchers have similarly recommended considering positive factors as well as negative ones, since learning how people cope successfully can be just as important for our understanding of overall health (Seligman & Csikszentmihalyi, 2000). The amount of LGBTQ research examining positive experiences and the amount of strength-based research is limited, and this absence of

positive psychology research limits our knowledge of LGBTQ mental health (Vaughan et al., 2014).

To address this gap in research on positive aspects of a sexual minority identity, Rostosky, Riggle, Pascale-Hague, and McCants (2010) conducted an online survey and employed a qualitative methodology to explore the positive aspects of a bisexual identity. An international sample of 157 adults responded to an open-ended question about the positive aspects of bisexual identity. The participants in the study identified 11 positive aspects of bisexual identity located at the different levels of the social ecological model (Bronfenbrenner, 1979). The most frequently described positive aspects at the intrapersonal level were – freedom from labels, roles and social 'rules' and honest and/or authentic self. At the interpersonal levels, the most frequent positive identity aspects were freedom to love without regard for sex/gender and freedom to explore diverse relationships and experiences. At the societal level, participants most often identified belonging to a community as a positive aspect. These findings demonstrate that there are positive aspects of bisexual identity as recognized by bisexual individuals. Yet research examining the link between positive sexual identity factors and mental health has been mostly lacking.

One exception is a daily diary study conducted by Flanders (2015) on bisexual mental health. It investigated microaffirmations (positive identity experiences) in relation to mental health in addition to negative external experiences. Microaffirmations are defined as "apparently small acts… that are public and private, often unconscious but very effective, which occur wherever people wish to help others to succeed" (Rowe, 2008, p. 46). Some of the positive identity events identified in this study were inclusion in the LGBTQ community and the presence of social support from family and friends. The findings indicated that microaffirmation

experiences were negatively associated with anxiety and stress. This illustrates the importance of examining positive experiences and their association to mental health outcomes as well.

Daily Diary Methodology

Increasing amounts of research investigating LGBTQ individuals' experiences with microaggressions has utilized daily-diary study designs due to certain advantages associated with these designs. There is evidence that individual reports differ when they are retrospective account of events compared to concurrent reports of events (Schwartz & Sudman, 1994). These discrepancies are most likely due to bias in participants' memories of events – people may not remember the frequency and/or intensity of their experiences accurately, which would then lead to memory-bias in their accounts (Schwarz, 2007). Another advantage of collecting daily measures is that daily reports allow researchers to obtain a deeper understanding of participants' everyday experiences and of their well being in comparison to the limitations of single occasion measurements, as well as provide information about the frequency of experienced events. Although, daily-diary studies have been used to investigate the impact of discrimination for marginalized groups, research using validated measures and focused specifically on the daily negative and positive experiences of bisexual individuals has been mostly lacking with some recent exceptions (e.g. Flanders, 2015).

The Current Research Project

Bisexual women have reported higher suicidal ideation and attempts compared to both heterosexual and lesbian women (Pompili et al., 2014). Recent research has also demonstrated

that bisexual individuals experience unique stigma and microaggressions due to their sexual identity (Bostwick & Hequembourg, 2014), whereas research on the relationship between microaffirmation experiences and mental well-being has been mostly lacking with a few exceptions (e.g. Flanders, 2015). Suicidality is a serious public mental health concern with possible fatal consequences, and it is necessary to identify factors that influence suicidal ideation and behavior and use this knowledge to devise adequate and effective interventions.

No study to date has assessed bisexual women's rates of suicidality in relation to daily experiences of microaggressions and microaffirmations. Therefore, the current study employed a daily-diary methodology to investigate the association between bisexual women's experiences with microaggressions (negative sexual identity experiences) and microaffirmations (positive sexual identity experiences) and their reports of suicidal thoughts and behaviors. Based on the minority stress framework, it was hypothesized that daily experiences with microaggressions will be positively associated with bisexual women's reports of suicidality, whereas daily experiences with microaffirmations will be negatively associated with suicidality. Further in line with the minority stress framework, it was hypothesized that social support, connectedness to LGBT community, and self-esteem would act as a buffer and negatively associate with suicidality, whereas internalized binegativity would be associated positively with suicidality scores.

Method

Design

The study was in the form of a 5-day daily diary study. On the first day participants completed measures of social support, self-esteem, connectedness to LGBT community scale,

internalized binegativity, and a demographic form. For days 2-5 participants completed the daily diary measures (microaggression and microaffirmation scales, and a measure of suicidality) each day.

Participants

A total number of 82 participants filled out the Day 1 survey and at least one diary entry. Four participants had multiple responses on a number of the surveys and a number of late daily diary entries; their data was deemed unreliable and, therefore, their responses were excluded from the final analysis. This left a total sample size of 78 participants, aged between 18 and 58 years and an average of 24 years. The majority of participants identified as cisgender women (51.2%), bisexual (61.5%) and white (65.4%). Detailed demographic information about the sample can be found in Table 1.

Procedure

Upon obtaining approval from the Institutional Review Board, participants were recruited using convenience sampling. For Mount Holyoke College student participants, there was a study posting on SONA and fliers were put up in designated areas on campus. The rest of the participants were recruited through social media postings and through fliers put in designated areas in the community, as well as other Five College Consortium school campuses. Inclusion criteria to participate in the study were that participants self-identify as women, are at least 18 years old, have access to the Internet, read and write in English, live in the US or Canada, and

report a non-monosexual orientation (attracted to people of more than one gender and/or sex). Individuals who did not meet these criteria were excluded from participating in the study.

Participants who expressed interest in the study were assigned ID numbers and provided a link to the study on Survey Monkey (an online survey software). All communication linking identifying information and ID numbers was destroyed after ID assignment. On their initial access to the study, participants were presented with an informed consent form that they responded to by clicking a button at the bottom of the form before continuing to the study measures. After informed consent was obtained, participants continued on to the Day 1 survey. For the daily diary entries, they received a reminder e-mail for days 2-5 with a link to that specific day's entry. After completing the 5-day study, participants were thanked for their time and offered compensation in the form of an Amazon gift card of up to $20.00 value.

Measures

Day one measures. The following measures were used on the first day of the study: Rosenberg Self-Esteem Scale (Rosenberg, 1965), Medical Outcome Study Social Support Scale (Sherbourne & Stuart, 1991), Connectedness to the LGBT community scale (Frost & Meyer, 2012), and the Bisexual Identity Inventory (Paul, Smith, Mohr, & Ross, 2014). Participants completed a demographic form and provided information about their sexual identity (some options include bisexual, multisexual, queer, two-spirit, etc.), their gender identity (some options include two-spirit, gender fluid, woman, etc.) and whether they identify with the trans spectrum. Participants also answered questions about their relationship status, age, racial, ethnic or cultural identity/identities, education status, employment status, and yearly household income.

The Rosenberg Self-Esteem scale is a short measure aimed at one's overall sense of self-worth (Rosenberg, 1965). This is a 10-item scale that asks individuals to rate their agreement with statements on global self-esteem (e.g. "On the whole, I am satisfied with myself", "All in all, I am inclined to feel I am a failure."), and the questions are answered on a 4-point Likert scale, with 1 indicating "Strongly Disagree" and 4 indicating "Strongly Agree". It has been used widely with different populations, including gay men in order to assess internalized homophobia and self-esteem (Alexander, 1987). Researchers have reported high coefficient alphas for the Rosenberg Self-Esteem scale (ranging from 0.72 to 0.88), and test-retest coefficient of 0.82 (after a one week period) (Murray & McClintok, 2005). In the current study, the scale had high reliability with a Cronbach's alpha of 0.91.

The Medical Outcome Study Social Support Scale (Sherbourne & Stuart, 1991) is a measure used to assess dimensions of social support, and consists of 19 items aimed at informational and emotional support, adequacy of tangible support, positive social interactions and affectionate support. The items are scored on a 5-point Likert scale where a higher score corresponds to a higher level of perceived support. In a United States population of chronically ill adults, the Social Support Scale was established to have high reliability and validity – its internal consistency with a Cronbach's alpha was greater than 0.91 for all of the subscales. The scale had high reliability in the current study as well (Cronbach's alpha = 0.95)

The Connectedness to the LGBT Community scale is an 8-item measure that assesses individuals' affiliation to LGBT communities (Frost & Meyer, 2012). It consists of 8 items that measure the extent to which people feel favorable towards and connected to their local LGBT community, with statements such as, "You feel you are a part of the LGBT Community in your

area" and "It is important for you to be politically active in the LGBT Community in your area". The items are rated on a 4-point Likert scale with 1 indicating "Strongly Agree" and 4 indicating "Strongly Disagree". The internal consistency of the Connectedness to LGBT Community Scale is satisfactory with a Cronbach's alpha of 0.81 (Frost & Meyer, 2012). In the current study, the scale had a satisfactory Cronbach's alpha of 0.83.

The Bisexual Identity Inventory was developed to measure aspects of bisexual identity (Paul, Smith, Mohr, & Ross, 2014). It consists of 24 items, such as, "I am comfortable being bisexual", "I feel that I have to justify my bisexuality to others", and "Bisexual identity is just a fleeting fad". Participants are asked to circle the statements that relate to them personally. Exploratory and confirmatory factor analyses revealed a 4-factor structure of the Inventory (Anticipated Binegativity, Internalized Binegativity, Identity Affirmation, and Illegitimacy of Bisexual Identity), and its reliability was satisfactory with internal consistency reports from .73 to .93 (Paul et al., 2014). The current study focused on the Internalized Binegativity subscale, as past research has found a link between psychological distress and internalized heterosexism/homophobia (Puckett et al., 2016; Newcomb & Mustanski, 2010), and included it as a Level 2 predictor variable in the multilevel model. Internalized Binegativity reflects "the harboring of negative feelings about oneself resulting from identifying as bisexual" (Paul et al., 2014). This subscale includes items such as, "My life would be better if I were not bisexual" and "Being bisexual prevents me from having meaningful intimate relationships". The reliability for the subscale in the current study was satisfactory (Cronbach's alpha = 0.72).

Daily diary measures. On days 2-5, participants completed the following daily diary measures each day: microaggression scale, microaffirmation scale, and a measure of suicidal behaviors and ideation.

The Microaggression Scale (Flanders, Robinson, & LeBreton, 2017) consists of 38 items representing events that are threatening to individuals' bisexual identity or events that negatively affirm their bisexuality. Some items from the Scale include: "Someone said they don't understand bisexuals", "Someone made sexual advances toward me when I told them I'm bi", and "Bisexuality was excluded from LGBT space or discussion". Participants rated the items using a 5-point Likert scale, where 1 indicates did not happen/not applicable to me, 2 indicates it happened, and it bothered me not at all, 3 indicates it happened and it bothered me a little bit, 4 indicates it happened, and it bothered me quite a bit, and 5 indicates it happened, and it bothered me extremely. They were also asked to report the source of these negative experiences – whether it was mostly heterosexuals, equally heterosexuals and lesbian/gay individuals, mostly lesbian/gay individuals, mostly bisexuals or whether the participants are unsure of the exact source. The scale had high reliability in the current study (Cronbach's alpha = 0.96)

The Microaffirmation Scale (Flanders, Robinson, & LeBreton, 2017) is a measure of events that affirm participants' bisexual identity in a positive way. It consists of 16 items representing positive identity experiences including the following: "Someone was attentive to discussions of bisexuality", "Someone provided emotional social support", and "Someone challenged biphobia when they saw it". Participants were asked to rate the items on a 5-point Likert scale where 1 indicates did not happen/not applicable to me, 2 indicates it happened and it did not feel affirming, 3 indicates it happened and it felt a little affirming, 4 indicates it happened

and it felt quite affirming, and 5 indicates it happened and it felt extremely affirming. They were also asked to provide a source for these positive experiences (whether it was mostly heterosexuals, equally heterosexuals and lesbian/gay individuals, mostly lesbian/gay individuals, mostly bisexuals or whether the participants are unsure of the exact source). In the current study, the scale had high reliability with a Cronbach's alpha of 0.92.

The Suicidal Behaviors Questionnaire, developed by Linehan (1981), and modified by Osman et al. (2001), was used as a measure of suicidality in the current study. The questionnaire is a 4-item measure tapping into dimensions of suicidality and has been found to have good reliability with a Cronbach's alpha ranging from .75 to .80 (Cotton, Peters, & Range, 2001). For the purposes of the current study, the wording of the items was modified so that the questionnaire can be used as a daily measure of suicidal behaviors and ideation. The first item asking about lifetime suicide ideation and attempt (Have you ever thought about or attempted to kill yourself?) was changed to: "Today have you thought about or attempted to kill yourself." The answer choices were collapsed into a dichotomous Yes/No response option. The second item measuring the frequency of suicidal ideation for the past year was omitted from the current study, as it did not translate well into a daily measure. The third item concerning threats of committing suicide was modified to, "Have you told someone today that you were going to commit suicide, or that you might do it?" with a Yes/No response option. The last item asking about the likelihood of future suicidal behavior was used as it appears in the original measure (How likely is it that you will attempt suicide someday?). The responses for the last item were measured on a 7-point scale ranging from never to very likely. The modified version of the scale used in the current study had good reliability with a Cronbach's alpha of 0.83.

Statistical Analysis

The current study aims to investigate the relationship between daily experiences of sexual identity microaggressions and microaffirmations and bisexual women's suicidal ideation and behavior. The collected data were analyzed quantitatively using a random coefficient growth mixed-model (through the Mixed Model Function on SPSS v22) with two levels - repeated daily diary measures (level one) nested within each participant (level two), in order to determine the relationship between daily experiences of microaggressions and affirmations and suicidal behavior, and whether variables related to social support and self-esteem moderate these relationships. Past research has used multilevel modeling, which is an analytic tool used when the data have a multilevel nested structure (Mustanski, 2007), to analyze data from daily diary entries because it permits analyses of changes within individuals from day to day and analyses of factors that may influence the variability between persons (e.g. Lee-Flynn et al., 2011; Flanders, 2016; Kashdan & Nezlek, 2012).

The data were entered in a vertical format at Level 1, and no participant (from the sample of 78 participants) was excluded regardless of missing diary entries. Upon review of the data, it appeared that data were missing at random (MAR), as there was no indication of systematic patterns of missing data within or between participants. Cases with partial data were kept in the multilevel models. Maximum likelihood estimation was utilized. The multilevel modeling process corrects for missing data based on patterns of variance and covariance (Hox, 2010); therefore, the retention of participants with partial data is justified. There were no missing data at Level 2 as all participants completed the large first day study with the Level 2 variables. In total,

66.2% of participants completed all of the entries and the rest of the participants missed from a range of 1 to 3 daily diary entries.

First, the simple effect of time was analyzed. The first model tested whether there were any main effects for the time variable (on which day of the study did participants complete the daily diary measures) to see whether time was associated with suicidality scores. Next, to address the study hypotheses the independent variables microaggressions and microaffirmations at Level 1 (within individuals) and social support, self-esteem, connectedness to LGBT community, and internalized binegativity at Level 2 (between individuals) were entered into the multilevel model and tested for main effects on suicidality scores. In order to account for any sample specific bias, an ANOVA was conducted to determine if a significant relationship existed between the demographic variables education level (up to some college/university and a Bachelor's degree or higher), sexual identity (bisexual identity, bisexual plus another identity, and identity other than bisexual), yearly household income (under $19,999, between $20,000 and $59,999, and over $60,000), trans identification, and identification as a person of color and suicidality scores. Demographic variables were included in the final multilevel model in which suicidality scores significantly differed across levels and tested for main effects along with the original study variables in answering the main questions of the current study.

Results

Descriptive Statistics

The scores for the Suicidal Behaviors Questionnaire could vary from 0 to 7. The average score for all of the daily diary entries was 1.9 (S.D. = 1.7), with 20.5% of participants reporting a

score of 0 and 16.7% of participants reporting a score >4. Table 2 contains more detailed information about the suicidality scores for the different days of the study.

Participants reported a total number of 871 Microaggressions Scale items through the course of the study. The Microaggressions Scale scores could range from 1 to 5, where 1 indicates no microaggression experiences and higher scores indicate microaggression experiences with a varying degree of distress for the participants (low scores indicating less perceived distress). The overall average of microaggressions score for the study was 1.24 (S.D. = 0.46) with a range from 1 to 3.24. Detailed information about the average scores for each day of the study can be found in Table 3. Over the course of the study, the most frequently experienced microaggression was "A bisexual character on a show was not labeled as bisexual", followed by "Someone discussed an LGBTQ issue that erased bisexuality". Table 5 contains frequency information about the items from the Microaggressions scale combined for all four daily diary entries.

Participants reported a total number of 1,109 Microaffirmations Scale items through the course of the study. The Microaffirmations Scale scores could range from 1 to 5, where 1 indicates no microaffirmation experiences and higher scores indicate microaffirmation experiences with a varying degree of affirmation for the participants (low scores indicating less affirming experience). The overall average of microaffirmations score for the study was 1.84 (S.D. = 0.78) with a range from 1 to 5. Detailed information about the average scores for each day of the study can be found in Table 4. Over the course of the study, the most frequently experienced microaffirmation was "Someone provided emotional social support", followed by "Someone was happy for me regardless of the sex or gender of my partner". Table 6 contains

frequency information about the items from the Microaffirmations scale combined for all four daily diary entries.

In each diary entry participants were asked to provide a source for the microagressions and microaffirmations they experienced – mostly heterosexuals, equally heterosexuals and lesbian/gay individuals, mostly lesbian/gay individuals, mostly bisexuals, or whether the participants are unsure of the exact source. A frequency analysis revealed that most participants were unsure of the source of a great number of microaggressions (45.1%). Mostly heterosexual individuals were carrying out the microaggressions of which the source was clear (26.9%). Equally heterosexual and lesbian/gay individuals were seen as the source of 13.8% of experienced microaggressions and mostly lesbian/gay individuals were seen as the source of 6.5% of microaggressions. Participants were less uncertain about the source of microaffirmations – only 26.2% of microaffirmations went without a reported source. Mostly heterosexual individuals carried out 22.5% of microaffirmations, equally heterosexual and lesbian/gay individuals were responsible for 20.4%, and mostly lesbian/gay individuals were reported to be the source of 9.5% of affirmations. Unlike microaggressions, participants attributed 17.5% of affirmations to mostly bisexual individuals.

Multilevel Models

The first model examined whether there was an association between time (the different day on which the diary entries were completed) and suicidality. Based on the model estimate (-.06, S.E = .04, p = .172) there was not a relationship between time (of diary entry) and suicidal

behavior and ideation. This indicates that suicidality did not increase or decrease as a function of time.

The second model examined the relationship between daily experiences of microaggressions and microaffirmations as Level 1 predictors and suicidality. I included self-esteem, social support, internalized binegativity, and connectedness to LGBT community as Level 2 predictors in the model. At Level 1 only microaggressions were associated with suicidality in the overall model with a *p* value of .001 (*b* = .37, S.E. = .11). A unit increase on the microagression scale was associated with a 0.37 unit increase in suicidality. At Level 2, internalized binegativity (*b* = .41, S.E. = .16, *p* = .014) and self-esteem (*b* = -.11, S.E. = 0.33, *p* = .001) were significant predictors of suicidality. A unit increase in self-esteem was associated with a 0.11 unit decrease in suicidal behavior and ideation, whereas a unit increase in internalized binegativity was associated with an 0.4 unit increase in suicidal behavior and ideation. There did not appear to be a relationship between microaffirmations, social support, connectedness to LGBT community and suicidality. The data for this model can be found in Table 7.

Next, the relationship between the demographic variables and suicidality was examined in order to control for any influence that may arise due to sample characteristics. Sexual identity (split into three categories – bisexual identity, bisexual plus another identity, and identity other than bisexual), identification with the trans spectrum, education level (split into two categories – education up to some college/university and a Bachelor's degree or higher), identification as a person of color, and yearly household income (split into three categories – under $19,999, between $20,000 and $59,999, and over $60,000) were included in the test of between-subject

effects with suicidality as the dependent variable. There was a significant relationship between trans status and suicidality, with trans participants reporting significantly higher rates of suicidality; therefore, identification with the trans spectrum was included as one of the Level 2 covariates in the final model. The data for the final model can be found in Table 8.

The final model included all of the previous predictors with trans status added as a covariate. Trans status was significantly associated with suicidality (b = 2.04, S.E. = .55, p = .000), where trans status corresponded to a 2.04 unit increase in suicidality scores. Microaggressions remained significantly associated with suicidality (b = .37, S.E. = .11, p = .001) after the inclusion of trans identification in the model (a unit increase in miroaggressions still corresponded to a 0.37 unit increase in suicidality). At Level 2, internalized binegativity and self-esteem also remained significant in the model - a unit increase in self-esteem (b = -.09, S.E. = .03, p = .002) was associated with a .09 decrease in suicidality and a unit increase in internalized binegativity (b = .42, S.E. = .15, p = .008) was associated with a 0.42 increase in suicidality.

Correlational Analysis

A correlation analysis was conducted to illuminate the relationships between all study variables since not all of them were significant factors in the multilevel model. At the 0.01 significance level, the suicidality score was positively correlated with microaggressions and internalized binegativity and negatively correlated with self-esteem. At the 0.05 significance level, suicidality was negatively correlated with social support and positively correlated with microaffirmations. Detailed information about all correlations can be found in Table 9.

Discussion

The overall average score for the Microaggressions Scale was low, which indicates that participants did not report experiencing many of the items from the scale and did not report being bothered very much by the microaggressions they did experience. Participants had a higher average score for the Microaffirmations Scale, which indicates that they reported more microaffirmation experiences than they did microaggressions and they rated them as more affirming than they rated microaggressions as bothersome. Even though the average score on the Microaffirmations scale was higher than the Microaggressions scale, it was still a low average score – participants reported more microaffirmation experiences, yet they did not rate all of them as highly affirming. It is also important to note that the lower average for the Microaggressions scale is likely influenced by the fact that it consists of 37 items, whereas the Microaffirmations scale consists of 16. Because the Microaggressions scale encompasses a wider range of negative experiences, it would not be expected that participants would experience a high number of them on a day-to-day basis.

When asked about the source of the negative experiences (coming from mostly heterosexual individuals, equally heterosexual and lesbian/gay individuals, mostly lesbian/gay individuals, or mostly bisexual individuals), participants did not know the exact source of a large number of microaggressions and the most frequently reported source were mostly heterosexual individuals. It is interesting to note that no participant reported experiencing microaggressions from bisexual individuals, which indicates that people do not experience bisexual identity microaggressions within the bisexual community itself. When asked about the source of the positive experiences, participants were able to report the source of a higher percentage of

microaffirmation experiences than they did microaggressions. This might indicate that positive sexual identity experiences are more overt and clear, and it is easier to recognize their source. Mostly heterosexual individuals and equally heterosexual and lesbian/gay individuals were reported as the source of nearly half of the experienced microaffirmations. It is important to note that mostly bisexual individuals were seen as the source of a little over a quarter of microaffirmation experiences. This is an indication that bisexual individuals not only do not experience microaggressions coming from the bisexual community, but they also receive support regarding their sexual identity from the bisexual community. The sources of negative and positive identity experiences were not included as predictors in the statistical analyses because participants were unsure of the source of a great number of microaggression and microaffirmation experiences.

Multilevel Model Results

Level 1 Variables. The results of the multilevel models support that microaggressions are positively associated with suicidality. Experiencing a higher number of microaggressions was associated with an increase in suicidality scores. Meyer's minority stress model (2003) identifies a number of stressors that relate to being part of a minority group, including discrimination, victimization, and internalized homophobia, which were associated with mental well-being in past research. The data from this study support previous research findings that minority stress experiences of sexual minority women are related to more psychological distress. The minority stress framework can be used to explain the current study results – bisexual women's

experiences of daily microaggressions targeting their sexual identity are an added stressor that may partly account for the higher suicidality rates among bisexual individuals.

Even though past research has not examined the relationship between bisexual women's daily experiences of microaggressions and microaffirmations and suicidality specifically, the current study's findings are in line with previous research exploring sexual minority groups' experiences of discrimination and microaggressions and mental health outcomes (Brennan et al., 2010). Links have been found between microaggressions and stress, anxiety, and well-being for sexual minority groups (Nadal et al., 2011; Woodford et al., 2012), specifically for bisexual individuals in a daily diary study (Flanders, 2015), and for other marginalized groups in a daily diary study (Torres & Ong, 2010). Bisexual women's daily experiences of sexual identity microaggressions were found to be associated with suicidal ideation and behavior. This suggests that not only overt discrimination and violent victimization but also subtle daily negative experiences can impact mental health, and suicidality in particular, in adverse ways. As not all microaggressions are intentionally perpetrated, it is important to raise awareness of the kinds of microaggressions bisexual individuals experience and their negative associations with mental well-being.

Microaffirmations were not a significant predictor of suicidality in the multilevel models. This finding did not confirm the study hypothesis that positive sexual identity experiences would have a "buffering effect" and correlate negatively with suicidal ideation and behavior – namely, that more microaffirmation experiences would be associated with lower suicidality scores. The minority stress framework states that opportunities for social support and affiliation can ameliorate the effect of stressors, but the current study's results do not support this as

microaffirmation experiences were not associated with suicidality scores. The relationship between daily positive sexual identity experiences and suicidality appears to be a more complex one than previously hypothesized. These findings contradict the results of a previous study that explored the relationship between positive sexual identity experiences and mental well-being and found positive identity experiences to be associated with a decrease in anxiety and stress (Flanders, 2015). It is possible that having one's bisexual identity be salient in everyday experiences is related to negative mental health outcomes, which might explain the null findings in the current study. Microaffirmations may not be beneficial for individuals with higher levels of internalized binegativity, in particular, as these positive identity experiences would remind them of their bisexual identity which they may perceive in a negative way. However, there is an overall lack of research examining the link between positive identity experiences and sexual minority mental health outcomes with validated measures and future research is needed to elucidate this relationship.

Level 2 Variables. The results from the multilevel models indicate that there is an association between self-esteem, internalized binegativity, trans identification and suicidality. Higher self-esteem scores corresponded to decreases in suicidality. Trans identification and higher internalized binegativity scores were associated with increased suicidality scores. No other factors at Level 2 (age, income, education, social support, connectedness to LGBT community) contributed substantially to the multilevel models and were related to suicidality.

The current study did not employ stringent exclusion criteria and anyone who reported a sexual orientation indicating attraction to more than one gender and who felt that the label "woman" applied to their experiences could participate. The sample was not restricted only to

participants who identified as bisexual cis women and it included a small subset of participants identifying with the trans spectrum. Trans status appeared to be the only demographic variable that was a significant predictor of suicidality scores and, therefore, it was included in the final model. This finding is consistent with past literature – numerous studies have found that transgender individuals have worse mental health outcomes than heterosexual and LGB counterparts (Irwin, Coleman, Fisher, & Marasco, 2014; Steele et al., 2017). High suicide rates among transgender individuals have also been reported (Grossman & D'Augelli, 2007) – with suicide attempt rates as high as 45% (National Transgender Discrimination Survey, 2010). These results are also in line with the minority stress framework and research – trans individuals experience added stressors that are due to the stigmatization of their trans identity that influence their mental health outcomes and can partially explain higher suicide rates for trans individuals.

However, other factors remained significant after adding trans status in the final multilevel model, which indicates that they predict suicidality scores above and beyond what trans identification accounts for. Self-esteem and internalized binegativity were the two other predictors significantly associated with suicidality. Self-esteem has been found to have a positive moderating effect and to be associated with lower rates of anxiety and depression (Mann, Hosman, Schaalma, & de Vries, 2004; Greenberg et al., 1992). This buffering effect was observed in the current study as well – higher scores of self-esteem were associated with lower suicidality scores.

Previous research has reported a link between internalized heterosexism/homophobia and psychological distress in LGBTQ individuals (Puckett et al., 2016; Newcomb & Mustanski, 2010). Internalized homophobia has been found to be a significant correlate of anxiety and

depression symptoms, substance abuse, and suicidal ideation (Meyer & Dean, 1998; Williamson 2000; DiPlacido, 1998). Internalized binegativity specifically has been shown to associate positively with depression, consistent with other paralleling research (Paul et al., 2014; Newcomb & Mustanski, 2010). Internalized homophobia is recognized in the minority stress framework as well as one of the stress processes sexual minority individuals face. In support of this previous research and the minority stress framework, the current study found that more internalized binegativity was associated with higher rates of suicidality.

There was not a relationship between social support and suicidality or connectedness to LGBT community and suicidality. It is surprising that social support and community predictors were not associated with suicidality, as social support and affiliation have been found to ameliorate the effects of stressors (Ross et al., 2010; Miller & Major, 2000). The null findings for social support specifically may be due to methodological limitations. The current study employed The Medical Outcome Study Social Support Scale (Sherbourne & Stuart, 1991) as the measure for social support; yet, it might be the case that this measure is not applicable to bisexual individuals the same way as other populations. A recent study has found some common mental health measures to work differently among bisexual-identified groups than other populations (MacLeod et al., 2015).

Furthermore, previous studies have shown that the relationship between bisexual individuals and the larger LGBTQ community is a complicated one, with bisexuals feeling excluded from both queer and heterosexual communities and having difficulties in finding support in queer women's communities (Hayfield, Clarke, & Halliwell, 2014; Hequembourg & Brallier, 2009). Balsam and Mohr (2007) have found that, in response to stigma, bisexual

individuals feel less connected to sexual minority communities than do lesbian/gay individuals, and that bisexual individuals do not relate sexual minority communities to social support and well-being. This might in part account for the current null findings for the community predictor.

Correlations

A correlation analysis indicated that there was a strong positive correlation between suicidality and microaggressions and internalized benagitivity – more microaggression experiences and higher internalized binegativity were associated with higher suicidality scores (at the .01 significance level). A strong negative correlation existed between suicidality and self-esteem and social support – higher self-esteem and social support scores were associated with lower suicidality scores (at the .05 significance level). There was a positive correlation between suicidality and microaffirmations (at the .05 significance level) – more microaffirmation experiences were associated with higher suicidality scores. It is interesting to note the direction of the relationship between suicidality and microaffirmations – an inverse relationship between the two variables was expected and not confirmed by our correlation analysis.

Implications

The current study adds to the small but growing literature that examines bisexual individuals' experiences and health outcomes. As bisexual individuals, and bisexual women specifically, have consistently been found to report elevated risk of suicidal ideation and attempts, it is important to examine factors that may relate to suicidality. To the principal investigator's

knowledge, no study to date has examined the relation between bisexual women's daily sexual identity experiences and suicidality. The results of this study support the notion that daily subtle negative experiences are related to adverse mental health outcomes, such as suicidal ideation and behavior. Self-esteem, internalized binegativity, and trans status were also shown to predict suicidality in the current study. These findings help identify potential factors to target in suicide intervention and prevention efforts. It is important to raise public awareness of microaggressions that bisexual individuals face daily and their impact on mental health, and campaigns that aim to reduce microaggression experiences may help bridge the gap in mental health outcomes. Programming that works toward decreasing internalized binegativity and increasing self-esteem can also be used as suicide prevention efforts.

Limitations

One of the limitations of the current study is that a convenience sample was used. The participants self-selected from university and Interned-based communities and, therefore, the sample might not be representative of the general bisexual population. Furthermore, the sample was relatively homogenous when it comes to racial identity, with the majority of participants identifying as White. Considering the minority stress framework, it might be important to have a more racially diverse sample in order to explore mental health outcomes for individuals with multiple minority identities (e.g. sexual, racial, religious) (Bostwick & Hequembourg, 2014). The daily diary measures were collected for four days only and a longer study may be better able to detect relationships between study variables. Another important limitation may be that the Suicidal Behaviors Questionnaire (Linehan, 1981) was modified in order to be used as a

temporal measure of suicidality in the current study. However, the original measure was developed to assess suicidality over a long period of time and it may not have translated well into a measure to be used in a daily diary study. The relationships in the current study are not causal and the results cannot determine that increase in microaggression experiences causes increase in suicidality. However, these results build on supportive evidence and they support that the two variables are related.

Future Research

Participants reported a source for their microaggression and microaffirmation experiences in the current study – whether their experiences were directed from heterosexual, lesbian/gay, or bisexual individuals. It is interesting to see whether certain negative or positive experiences would be more influential towards bisexual individuals' well-being depending on the perpetrator. Future research can explore whether it would be more harmful to experience microaggressions from lesbian/gay individuals than heterosexual individuals and whether microaffirmations coming from the lesbian/gay community would be more ameliorative than affirmations from the heterosexual community. Unfortunately, many participants in the current study were unsure of the source of the micro aggression and affirmation experiences, and therefore it was difficult to determine the relationship between the source of these experiences and suicidal ideation and behavior.

One of the study hypotheses was not supported by the study results – namely, that sexual identity microaffirmation experiences of bisexual women would predict a decrease in suicidality. It is possible that having one's sexual identity be salient in itself can impact mental health in

adverse ways. This may be particularly true in cases where individuals have higher rates of internalized biphobia, perceive their sexual identity negatively, and have low self-esteem. There is a dearth of research exploring the relationship between positive sexual identity events and mental health outcomes, and future research should examine this relationship.

In the current study, participants completed the daily diary measure once each day for four days. Future research can use shorter time frequencies between responses (once every two hours) in order to collect a more accurate account of the day-to-day experiences of sexual minority individuals.

Conclusion

In conclusion, the participants' daily experiences of microaggressions were associated with daily reports of suicidality over the course of four days. Self-esteem, internalized binegativity and trans status were also significantly associated with daily reports of suicidality. The findings of this study support the notion that daily subtle negative experiences are related to adverse mental health outcomes, such as suicidal ideation and behavior, and are in line with the minority stress framework. These findings have implications for suicide intervention and prevention efforts and point to the importance of daily sexual identity microaggression experiences relating to suicidality. This study adds to the growing literature on discriminatory experiences and sexual minority mental health outcomes by implementing a daily diary study examining bisexual women's experiences of microaggressions, microaffirmations and suicidality.

Tables

Table 1

Participant Demographic Information

Variable	N (%)
Sexual Identity	
Bisexual	48 (61.5%)
Demisexual	6 (7.6%)
Pansexual	19 (24.3%)
Queer	25 (32%)
Two-Spirit	2 (2.5%)
Asexual	2 (2.5%)
Fluid	2 (2.5%)
Gender Identity	
Bigender	4 (5.1%)
Cis woman	40 (51.2%)
Gender queer	4 (5.1%)
Gender fluid	9 (11.5%)
Trans woman	2 (2.5%)
Two-spirit	2 (2.5%)
Woman	20 (25.6%)
Identify with the Trans spectrum	
Yes or Sometimes	7 (8.9%)
Racial/Cultural Identity	
American Indian/Alaska Native	3 (3.8%)
Asian Indian	3 (3.8%)
Black	3 (3.8%)
Chinese	5 (6.4%)
Filipino	3 (3.8%)

Puerto Rican	3 (3.8%)
Latino/a/x	6 (7.6%)
White	64 (82%)
Perceived as a Person of Color	
Yes or Sometimes	23 (29.4%)
Highest Education	
High school	1 (0.12%)
Some College	44 (56.4%)
College Degree	13 (16.6%)
Some Graduate School	5 (6.4%)
Graduate Degree	11 (14.1%)
Household Income	
Under $20,000	23 (29.4%)
$20,000-$59,999	18 (23%)
Over $60,000	25 (32%)

Table 2

Average Overall Suicidality Scale Scores.

Day	1	2	3	4	TOTAL
Mean	2.12	1.96	1.92	1.77	1.97
Std. Error of Mean	.2	.22	.22	.22	.19
Std. Deviation	1.78	1.78	1.83	1.85	1.73
Minimum	0	0	0	0	0
Maximum	7	7	7	7	7

Table 3

Average Overall Microaggressions Scale Scores.

Day	1	2	3	4	TOTAL
Mean	1.38	1.23	1.11	1.1	1.24
Std. Error of Mean	.07	.06	.03	.03	.05
Std. Deviation	.61	.55	.24	.25	.45
Minimum	1	1	1	1	1
Maximum	3.65	3.59	2.11	2.51	3.24

Table 4

Average Overall Microaffirmations Scale Scores.

Day	1	2	3	4	TOTAL
Mean	2.06	1.75	1.65	1.57	1.84
Std. Error of Mean	.11	.12	.1	.08	.08
Std. Deviation	.98	.96	.82	.71	.78
Minimum	1	1	1	1	1
Maximum	5	4.88	4.5	4.5	5

Table 5

Frequency of Microaggressions Scale Items

Item	Total Number of Reports
1. Someone suggested my bisexual identity is a phase	22
2. Someone told me I don't belong in LGBT spaces	13
3. Someone said they don't understand bisexuals	36
4. Someone dismissed bisexuality as a fad	33
5. Someone dismissed bisexuality as just a way to get attention	28
6. Someone suggested I am confused about my bisexual identity	21
7. Someone indicated bisexuals are untrustworthy	23
8. Someone showed mistrust toward me because I'm bi	12
9. Someone implied bisexuals are unreliable	16
10. Someone suggested I would leave them for someone of another gender	22
11. A romantic partner asked for details about my sexual behavior with people of other genders	27
12. Someone was offended when I turned down their sexual advances	22
13. Someone asked me what genitals I like	14
14. Someone asked me about my past sexual experiences when I told them I'm bi	28
15. Someone asked whether I have had sex with a woman	25
16. Someone asked whether I have had sex with a man	23
17. Someone asked how many men I have had sex with	18
18. Someone asked me to prove that I'm bi by discussing my sexual history	13
19. Someone asked how I knew that I was bisexual	30
20. Someone asked which gender I prefer the most	30
21. Someone heterosexual seemed to assume I would hit on their romantic partner(s)	10
22. Someone made sexual advances toward me when I told them I'm bi	14
23. Someone asked if I wanted to have a threesome when I told them I'm bi	24
24. Someone assumed that coming out as bi is a way of saying I'm open for	19

anything sexually	
25. Someone indicated that bisexuals aren't part of the LGBT community	30
26. Someone made me feel ashamed to date men	28
27. A bisexual character on a show was not labeled as bisexual	61
28. Someone discussed an LGBTQ issue that erased bisexuality	48
29. Someone defined bisexuality as reinforcing of gender binaries (i.e., the idea that there are only two genders)	31
30. Someone gave me less support than they gave people of other sexual identities	26
31. Someone who is gay or a lesbian was uncomfortable around me	10
32. Bisexuality was excluded from LGBT space or discussion	41
33. Someone made me feel I had to be hyperaware of my bisexuality at an LGBT event	12
34. Gay men or lesbians saw me as an ally more than as part of the community	22
35. Someone assumed I cannot be bisexual because of my other identities	15
36. I was pressured to constantly validate my other identities because I'm bi	13
37. Someone called my other identities into doubt because I'm bi	11
TOTAL:	871

Table 6

Frequency of Microaffirmations Scale Items

Item	Total Number of Reports
1. Someone understood bisexuality easily	84
2. Someone accepted my being bi without any questions	93
3. Someone acknowledged my bisexuality without making a big deal out of it	100
4. Someone let me figure out my sexuality for myself without making assumptions	45
5. Someone recognized biphobia as a serious issue	53
6. Someone challenged biphobia when they saw it	26
7. Someone acknowledged that being bi is not always easy	50
8. Someone respected my opinions about bisexuality	68
9. Someone asked sincere questions about bisexuality	33
10. I commiserated with other bisexual people about biphobia	43
11. Someone supported the relationships of other bisexual people	56
12. Someone was attentive to discussions of bisexuality	47
13. Someone did something to show their support of bisexuality	63
14. Someone was happy for me regardless of the sex or gender of my partner	99
15. Someone provided emotional social support	152
16. Someone supported my relationships	97
TOTAL:	1,109

Table 7

Multilevel Model 2

Variable	Estimate	Std. Error	Sig.
Microaggressions	.374	.116	.001*
Microaffirmations	-.069	.05	.166
Social Support	.000	.012	.958
LGBT Community	-.023	.295	.938
Self-Esteem	-.11	.033	.001*
Internalized Binegativity	.417	.166	.014*

Table 8

Multilevel Model 3

Variable	Estimate	Std. Error	Sig.
Microaggressions	.372	.115	.001*
Microaffirmations	-.070	.049	.16
Social Support	.006	.011	.562
LGBT Community	-.042	.274	.877
Self-Esteem	-.097	.03	.002*
Internalized Binegativity	.421	.154	.008*
Trans Status	2.04	.555	.000*

Table 9

All Variable Correlations

Variable	1	2	3	4	5	6	7
1. Suicidality		.31**	.28*	-.47**	-.24*	.1	.42**
2. Microaggressions			.65**	-.22*	-.11	.14	.28*
3. Microaffirmations				-.08	.21	-.01	.14
4. Self-Esteem					.35**	-.24*	-.36**
5. Social Support						-.21	-.41*
6. LGBT Community							.02
7. Internalized Binegativity							

NOTE: n = 78, measures used: Suicidal Behaviors Questionnaire, Microaggressions Scale, Microaffirmations Scale, Rosenberg Self-Esteem Scale, Medical Outcome Study Social Support Scale, Connectedness to LGBT Community Scale, Bisexual Identity Inventory. The Connectedness to LGBT Community Scale is reverse scored – lower scores on the scale correspond to higher connectedness to LGBT community and vice versa.

**. Correlation significant at the 0.01 level (two-tailed).

*. Correlation significant at the 0.05 level (two-tailed).

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APPENDICES

Appendix A

Demographic Questionnaire

1. What is your **sexual identity**? (*Check all that apply)*
   - ☐ Asexual
   - ☐ Bisexual
   - ☐ Demisexual
   - ☐ Fluid
   - ☐ Multisexual
   - ☐ Omnisexual
   - ☐ Pansexual
   - ☐ Plurisexual
   - ☐ Queer
   - ☐ Two-spirit
   - ☐ You don't have an option that applies to me. I identify as (*Please specify*) _____

2. Do you identify with the trans spectrum?
   a. Yes
   b. No
   c. Sometimes
   d. Unsure

3. Which of the following describes your **gender identity**? (*Check all that apply*)

- ☐ Two-spirit
- ☐ Agender
- ☐ Bigender
- ☐ Genderqueer
- ☐ Gender fluid
- ☐ Cisgender man
- ☐ Trans man
- ☐ Trans woman
- ☐ Cisgender woman

☐ Man
☐ Woman
☐ You don't have an option that applies to me. I identify as (*Please specify*)
_____

4. During your lifetime, to whom have you been sexually attracted? (*Check all that apply*)
☐ Two-spirit people
☐ Agender people
☐ Bigender people
☐ Genderqueer people
☐ Gender fluid people
☐ Cisgender men
☐ Trans men
☐ Trans women
☐ Cisgender women
☐ Men
☐ Women
☐ People of another gender. (*Please specify*) _____

5. During your lifetime, with whom have you been sexually involved? (*Check all that apply*)
☐ Two-spirit people
☐ Agender people
☐ Bigender people
☐ Genderqueer people
☐ Gender fluid people
☐ Cisgender men
☐ Trans men
☐ Trans women
☐ Cisgender women
☐ Men
☐ Women
☐ People of another gender. (*Please specify*) _____

6. Which best describes your current relationship status? (*Check all that apply*)
☐ Dating

☐ Divorced
☐ Married/partnered
☐ Married/partnered and dating
☐ Married/partnered and play with others
☐ Multiple casual relationships
☐ Multiple committed relationships
☐ One primary partner and at least one casual relationship
☐ Separated
☐ Single and wish to be partnered
☐ Single and wish to stay that way
☐ Widowed
☐ Other (specify)_____

7. If you are in a relationship or relationships, what is/are the gender of your partner(s)? (Please list all if you have more than one partner)

☐ Two-spirit people
☐ Agender people
☐ Bigender people
☐ Genderqueer people
☐ Gender fluid people
☐ Cisgender men
☐ Trans men
☐ Trans women
☐ Cisgender women
☐ Men
☐ Women
☐ People of another gender. (*Please specify*) _____

8. What is your age? _____

9. How do you define your racial, ethnic or cultural identity/identities? (*Check all that apply*)
   - Mexican, Mexican American, Chicano
   - Puerto Rican
   - Cuban
   - Latino

- White
- Black, African American
- American Indian, Alaska Native
- Asian Indian
- Chinese
- Filipino
- Japanese
- Korean
- Vietnamese
- Other Asian
- Native Hawaiian
- Guamanian or Chamorro
- Samoan
- Other Pacific Islander
- You don't have an option that applies to me. I identify as _____

10. Are you perceived as a person of color and/or as a racialized person?

☐ Yes

☐ No

☐ Sometimes

☐ I don't know

11. Do you belong to a religious affiliation or community of worship?
    a. Yes
    b. No
    c. If yes, what is your religious affiliation or community of worship? _____

12. Has your lived experience included any of the following: (Please check all that apply)
    a. Disability or chronic illness (please specify)_____
    b. Homelessness/ unstably housed
    c. AIDS/HIV
    d. Mental health problems (please specify)_____
    e. Problems with drugs or alcohol
    f. Child protection services (CAS or DCF)
    g. Incarceration
    h. Rape
    i. Childhood sexual abuse
    j. Any other important issue that has impacted on your lived experience: _____

13. What state or province are you from?
    a. Drop down list of Canadian Provinces and American States

14. What type of area do you currently live in (answer based on where you currently reside)?
    a. Rural
    b. Suburban
    c. Urban
    d. Unsure

15. What is your highest level of education so far?

☐ Some high school
☐ Completed high school or GED program
☐ Some trade school or apprenticeship
☐ Completed trade school or apprenticeship
☐ Some college or university
☐ Completed college or university undergraduate degree (example: BA, BSc, BFA)
☐ Some graduate or professional education
☐ Completed graduate or professional degree (example: MA, PhD)
☐ Other (*please specify*) _____

16. What is your employment status? (*Check all that apply*)

☐ Full-time paid work
☐ Part-time paid work
☐ Caring for child(ren) or other family members at home
☐ Homemaker
☐ Looking for work
☐ Not employed
☐ On disability
☐ Retired
☐ Self-employed
☐ Student
☐ Underemployed (working fewer hours than I'd like or at a job not matching my qualifications)
☐ Other (*please specify*) _____

17. What was your individual income last year, before taxes? Please estimate.

☐ Less than $10,000
☐ $10,000 - $19,999
☐ $20,000 - $29,999
☐ $30,000 - $39,999
☐ $40,000 - $59,999
☐ $60,000 - $79,999
☐ $80,000 - $100,000
☐ Greater than $100,000

18. What was your combined household income before taxes last year? Include all sources such as student loans, social assistance, etc. Please estimate.

☐ Less than $10,000
☐ $10,000 - $19,999
☐ $20,000 - $29,999
☐ $30,000 - $39,999
☐ $40,000 - $59,999
☐ $60,000 - $79,999
☐ $80,000 - $100,000
☐ Greater than $100,000

- I don't know

19. How many people are supported by your household income? Please **include yourself** as well as people who are supported by this income but do not live with you, such as grown children you are supporting, or relatives in or outside of Canada to whom you send money, even if you are not their sole source of support.

The household income supports _____ person/people.

20. How do you find you manage on your present family income?
    a. It is difficult all the time
    b. It is difficult some of the time
    c. It is not too bad
    d. It is easy

Appendix B

Rosenberg Self-Esteem Scale

Respond 1-4, from Strongly disagree to Strongly agree

1. On the whole, I am satisfied with myself.
2. At times I think I am no good at all.
3. I feel that I have a number of good qualities
4. I am able to do things as well as most other people.
5. I feel I do not have much to be proud of.
6. I certainly feel useless at times.
7. I feel that I am a person of worth, at least on an equal plane with others.
8. I wish I could have more respect for myself.
9. All in all, I am inclined to feel I am a failure.
10. I take a positive attitude toward myself.

Appendix C

Medical Outcome Study Social Support Scale

E1. About how many close friends or relatives do you have? By close relatives I mean people you feel at ease with and can talk to about what is on your mind. _____

E2. People sometimes look to others for companionship, assistance or other types of support. How often is each of the following kinds of support available to you if you need it?

	None of the Time	A Little of the Time	Some of the Time	Most of the Time	All of the Time
a. Someone to help you if you were confined to bed	1	2	3	4	5
b. Someone you can count on to listen to you when you need to talk	1	2	3	4	5
c. Someone to give you good advice about a crisis	1	2	3	4	5
d. Someone to take you to the doctor if you needed it	1	2	3	4	5
e. Someone who shows you love and affection	1	2	3	4	5
f. Someone to have a good time with	1	2	3	4	5
g. Someone to give you information to help you understand a situation	1	2	3	4	5
h. Someone to confide in or talk to about yourself or your problems	1	2	3	4	5
i. Someone who hugs you	1	2	3	4	5
j. Someone to get together with for relaxation	1	2	3	4	5
k. Someone to prepare your meals if you were unable to do it yourself.	1	2	3	4	5
l. Someone whose advice you really want	1	2	3	4	5
m. Someone to do things with to help you	1	2	3	4	5

	get your mind off things					
n.	Someone to help with daily chores if you were sick	1	2	3	4	5
o.	Someone to share your most private worries and fears with	1	2	3	4	5
p.	Someone to turn to for suggestions about how to deal with a personal problem	1	2	3	4	5
q.	Someone to do something enjoyable with	1	2	3	4	5
r.	Someone who understands your problems	1	2	3	4	5
s.	Someone to love and make you feel wanted	1	2	3	4	5

Appendix D

LGBT Community Scale (Connectedness to the LGBT Community Scale)

In answering the following questions, please indicate to what extent you agree with each of the following statements.

1. You feel you are a part of the LGBT Community in your area.

Strongly Agree	*Agree a Little*	*Disagree Somewhat*	*Strongly Disagree*
1	*2*	*3*	*4*

2. Participating in the LGBT Community in your area is a positive thing for you.

Strongly Agree	*Agree a Little*	*Disagree Somewhat*	*Strongly Disagree*
1	*2*	*3*	*4*

3. You feel a bond with the LGBT Community in your area.

Strongly Agree	*Agree a Little*	*Disagree Somewhat*	*Strongly Disagree*
1	*2*	*3*	*4*

4. You are proud of the LGBT Community in your area.

Strongly Agree	*Agree a Little*	*Disagree Somewhat*	*Strongly Disagree*
1	*2*	*3*	*4*

5. It is important for you to be politically active in the LGBT Community in your area.

Strongly Agree	*Agree a Little*	*Disagree Somewhat*	*Strongly Disagree*
1	*2*	*3*	*4*

6. If you work together, gay, bisexual and lesbian people can solve problems in the LGBT Community in your area.

Strongly Agree	*Agree a Little*	*Disagree Somewhat*	*Strongly Disagree*
1	*2*	*3*	*4*

7. You really feel that any problems faced by the LGBT Community in your area are also your own problems.

Strongly Agree	*Agree a Little*	*Disagree Somewhat*	*Strongly Disagree*
1	*2*	*3*	*4*

8. You feel a bond with other women of your sexual identity group.

Strongly Agree	*Agree a Little*	*Disagree Somewhat*	*Strongly Disagree*
1	*2*	*3*	*4*

Appendix E

Bisexual Identity Inventory

The purpose of this scale is to measure the extent to which you identify with each of the following statements as it relates to identifying as a bisexual individual. Please circle the corresponding number for each item as it relates to you personally.

---

1. People probably do not take me seriously when I tell them I am bisexual.
2. I am grateful for my bisexual identity.
3. I am comfortable being bisexual.
4. I am reluctant to tell others of my bisexual identity.
5. I am proud to be bisexual.
6. Bisexual individuals are in denial about being gay.
7. I feel that I have to justify my bisexuality to others.
8. Identifying as bisexual is just the first step toward becoming gay.
9. I feel freedom with people of different genders.
10. Being bisexual is rewarding to me.
11. It's unfair that I am attracted to people of more than one gender.
12. People might not like me if they found out that I am bisexual.
13. When I talk about being bisexual, I get nervous.
14. I am not a real person because I am bisexual.
15. I wish I could control my feelings and aim them at a single gender.
16. I think that bisexual individuals are just indecisive.
17. Being bisexual is a cop out.
18. Bisexual identity is just a fleeting fad.
19. I am okay with my bisexuality.

20. My life would be better if I were not bisexual.

21. Being bisexual prevents me from having meaningful intimate relationships.

22. I think that being bisexual is just a temporary identity.

23. Bisexuality is not a real identity.

24. I would be better off if I would identify as gay or straight, rather than bisexual.

Note. Researchers may use this scale without contacting us to obtain permission. However, we ask that reports of to Nathan Grant Smith. To obtain subscale scores, average the following items: *Illegitimacy of Bisexuality* (6, 8, 14, 16, 17, 18, 22, 23); *Anticipated Binegativity* (1, 4, 7, 12, 13); *Internalized Binegativity* (11, 15, 20, 21, 24); *Identity Affirmation* (2, 3, 5, 9, 10, 19). [a] Suggested alternate wording: *I feel freedom with people of different genders*. [b] Suggested alternate wording: *It's unfair that I am attracted to people of more than one gender*. [c] Suggested alternate wording: *I wish I could control my sexual and romantic feelings by directing them at a single gender*.

Appendix F

Daily Diary Measures

SBQ-R Suicide Behaviors Questionnaire (Modified)

1. Today have you thought about or attempted to kill yourself? (Yes/No)

2. Have you told someone today that you were going to commit suicide, or that you might do it? (Yes/No)

3. How likely is it that you will attempt suicide someday? (Check one only)

Never**,** No chance at all, Rather unlikely, Unlikely, Likely, Rather likely, Very likely

Microaggression Scale

5-point Likert scale, 1 (did not happen/not applicable to me), 2 (it happened, and it bothered me not at all), 3 (it happened and it bothered me a little bit), 4 (it happened, and it bothered me quite a bit), 5 (it happened, and it bothered me extremely)

Someone suggested my bisexual identity is a phase

Someone told me I don't belong in LGBT spaces

Someone said they don't understand bisexuals

Someone dismissed bisexuality as a fad

Someone dismissed bisexuality as just a way to get attention

Someone suggested I am confused about my bisexual identity

Someone indicated bisexuals are untrustworthy

Someone showed mistrust toward me because I'm bi

Someone implied bisexuals are unreliable

Someone suggested I would leave them for someone of another gender

A romantic partner asked for details about my sexual behavior with people of other genders

Someone was offended when I turned down their sexual advances

Someone asked inappropriate questions about my bisexuality

Someone asked me what genitals I like

Someone asked me about my past sexual experiences when I told them I'm bi

Someone asked whether I have had sex with a woman

Someone asked whether I have had sex with a man

Someone asked how many men I have had sex with

Someone asked me to prove that I'm bi by discussing my sexual history

Someone asked how I knew that I was bisexual

Someone asked which gender I prefer the most

Someone heterosexual seemed to assume I would hit on their romantic partner(s)

Someone made sexual advances toward me when I told them I'm bi

Someone asked if I wanted to have a threesome when I told them I'm bi

Someone assumed that coming out as bi is a way of saying I'm open for anything sexually

Someone indicated that bisexuals aren't part of the LGBT community

Someone made me feel ashamed to date men

A bisexual character on a show was not labeled as bisexual

Someone discussed an LGBTQ issue that erased bisexuality

Someone defined bisexuality as reinforcing of gender binaries (i.e., the idea that there are only two genders

Someone gave me less support than they gave people of other sexual identities

Someone who is gay or a lesbian was uncomfortable around me

Bisexuality was excluded from LGBT space or discussion

Someone made me feel I had to be hyperaware of my bisexuality at an LGBT event

Gay men or lesbians saw me as an ally more than as part of the community

Someone assumed I cannot be bisexual because of my other identities

I was pressured to constantly validate my other identities because I'm bi

Someone called my other identities into doubt because I'm bi

When these negative experiences happened, who did them?

1. Mostly heterosexual people
2. Equally heterosexual and gay/lesbian people
3. Mostly gay/lesbian people
4. Bisexual people
5. Unsure

Is there anything else you would like to tell us about your negative or stressful experiences related to your sexual identity today?

Microaffirmation Scale

5-point Likert scale, 1 (did not happen/not applicable to me), 2 (it happened, and it bothered me not at all), 3 (it happened and it bothered me a little bit), 4 (it happened, and it bothered me quite a bit), 5 (it happened, and it bothered me extremely)

Someone understood bisexuality easily

Someone accepted my being bi without any questions

Someone acknowledged my bisexuality without making a big deal out of it

Someone let me figure out my sexuality for myself without making assumptions

Someone recognized biphobia as a serious issue

Someone challenged biphobia when they saw it

Someone acknowledged that being bi is not always easy

Someone respected my opinions about bisexuality

Someone asked sincere questions about bisexuality

I commiserated with other bisexual people about biphobia

Someone supported the relationships of other bisexual people

Someone was attentive to discussions of bisexuality

Someone did something to show their support of bisexuality

Someone was happy for me regardless of the sex or gender of my partner

Someone provided emotional social support

Someone supported my relationships

When these positive experiences happened, who did them?

1. Mostly heterosexual people
2. Equally heterosexual and gay/lesbian people
3. Mostly gay/lesbian people
4. Bisexual people
5. Unsure

Is there anything else you would like to tell us about your positive or supportive experiences related to your sexual identity today?