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Differences in Sexual Identity Dimensions between Bisexual and Other Sexual Minority Individuals: Implications for Minority Stress and Mental Health

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Abstract

Bisexual individuals experience poorer mental health than other sexual minority individuals. One explanation for this is that biphobia predisposes bisexual individuals to have a more ambiguous sexual identity and fewer opportunities for stress-ameliorating forms of coping and support. This study explores sexual identity and sexual identity dimensions—prominence, valence, integration, and complexity—in bisexual and other sexual minority individuals. We describe differences in sexual identity dimensions between bisexual and other sexual minority individuals and test two explanations for mental health disparities between them: whether sexual identity dimensions directly impact mental health and whether they moderate the impact of stress on mental health. Data came from a longitudinal study of a diverse sample of sexual minority individuals ($N = 396$, 71 bisexual respondents) sampled from community venues in New York City. Sexual identity was prominent for both bisexual and other sexual minority individuals, but bisexual individuals reported lower valence and integration of sexual identity in their identity structures. The hypothesis that sexual identity dimensions moderate the impact of minority stress on mental health was not supported. Following several longitudinal assessments, however, we concluded that identity valence (but not integration or complexity) and depressive symptoms were bi-directionally associated so that differences in valence between bisexual and other sexual minority individuals explained, in part, disparities in depressive symptoms.

Keywords

Sexual identity; Minority stress; Bisexuality; Mental health; Depressive symptoms

Research has consistently shown that sexual minority individuals experience worse mental health outcomes than heterosexual individuals (Institute of Medicine, 2011). This research has typically combined sexual minority respondents into one group, obscuring differences within the group. Yet, studies that assessed bisexual individuals separately from other sexual minority individuals have shown that bisexual individuals have a comparatively higher risk for mental health problems such as suicidality (Marshall et al., 2011), depressive symptoms (Ross et al., 2017), and other mood and anxiety disorders (Bostwick, Boyd, Hughes, & McCabe, 2010). Minority stress theory explains health disparities as related to prejudice and stigma, which predispose sexual minority individuals to excess stress that may lead to adverse health (Meyer, 2003). Social identity and identity structures potentially impact mental health, but studies on the relationship between sexual identity structures and mental health among sexual minority individuals remain scarce (Kertzner, Meyer, Frost, & Stirratt, 2009; Major & O'Brien, 2005; Meyer, 2003).

We seek to add to the literature on identity and minority stress by assessing whether differences in sexual identity explain disparities in mental health outcomes between bisexual and other sexual minority individuals. This study is novel in assessing how bisexual individuals differ from other sexual minority individuals on a range of sexual identity dimensions and in analyzing how sexual identity dimensions are related to mental health. A cross-sectional analysis of data from the same dataset used in this study found that identity valence was related to mental health disparities between bisexual and other sexual minority individuals (Kertzner et al., 2009). Here we examine two hypotheses for explaining mental health disparities between bisexual and other sexual minority individuals. First, we assess whether bisexual individuals differ from other sexual minority individuals in identity dimensions, and if so, whether differences in identity dimensions explain observed mental health disparities. Second, we test whether dimensions of sexual identity moderate the impact of stress on mental health and well-being (Meyer, 2003, p. 678). For example, that a minority stressor would have a greater impact on health outcomes when sexual identity is prominent than when it is secondary to a person's self-definition.

Characteristics of a Bisexual Identity

Research on the particularities of a bisexual identity can be classified in four broad themes (Sarno & Wright, 2013). First, bisexual individuals may be subject to biphobia both from outside and within the LGBT community (Roberts, Horne, & Hoyt, 2015; Rust, 2002). Examples of biphobia include its devaluation by the attitude that bisexuality is not a valid sexual identity and that it is a transitory stage in the development of a lesbian or gay identity (Brewster & Moradi, 2010; Hequembourg & Brallier, 2009). Second, bisexual individuals conceal their sexual identity more than lesbian women and gay men (Balsam & Mohr, 2007; Durso & Meyer, 2013; Mohr, Jackson, & Sheets, 2017). Concealment is a minority stressor that may increase risk for mental health problems (Meyer, 2003; Riggle, Rostosky, Black, & Rosenkrantz, 2017). Third, in part because of biphobia within the LGBT community, bisexual individuals are less connected with the community than other sexual minority individuals (Balsam & Mohr, 2007), which may deprive them of resources and opportunities for coping and social support (Kwon, 2013; Meyer, 2015). And fourth, bisexual individuals may have a somewhat more ambivalent stance towards their sexual identity than other sexual

minority individuals, like lesbian women and gay men. They report higher levels of internalized homonegativity (Cox, Berghe, Dewaele, & Vincke, 2010; Kuyper & Fokkema, 2011), identity confusion (defined as uncertainty about one's sexual identity), lower levels of identity centrality (defined as the importance of sexual identity for one's overall sense of self) (Balsam & Mohr, 2007; Dyar, Feinstein, & London, 2015), and greater variability in their sexual identity over time (Dyar et al., 2015; Galupo, Ramirez, & Pulice-Farrow, 2017; Weinberg, Williams, & Pryor, 1994).

Sexual Identity Dimensions

Sexual identity dimensions—for example, whether identity is viewed positively or negatively by a sexual minority person—may be important for understanding the impact of stress on health outcomes (Meyer, 2003). Sexual identities, like other social identities, have multiple dimensions that are interconnected in identity hierarchies (Ashmore, Deaux, & McLaughlin-Volpe, 2004; Roccas & Brewer, 2002; Rosenberg & Gara, 1985; Stirratt, Meyer, Ouellette, & Gara, 2008). Four dimensions have been discussed, sometimes using different terms: *Identity prominence* - also referred to as *identity centrality* or *identity importance* - addresses the importance of a sexual identity within one's identity hierarchy (Ashmore et al., 2004). *Identity valence*—or *private regard*—refers to the extent to which an identity is positively or negatively evaluated by an individual (Ashmore et al., 2004). *Identity integration* represents the degree to which a person's sexual identity shows close relationships to other identities in the person's identity hierarchy, or the extent to which multiple identities are perceived to share the same characteristics. *Identity complexity*, lastly, refers to the extent of cohesiveness versus differentiation within one's self-concept, or the extent to which multiple identities are conceived as a single convergent social identity (Roccas & Brewer, 2002; Stirratt et al., 2008). Identity integration and complexity are related yet distinct concepts: identity integration is concerned with the overlap in characteristics between several social identities; identity complexity taps the extent to which several identities converge to represent one higher-level social identity.

As discussed above, research has suggested that bisexual individuals are more ambivalent and less positive about their sexual identity than other sexual minority individuals (in particular lesbian women and gay men). Based on these observations, we test whether, *compared with other sexual minority individuals, the sexual identities of bisexual individuals would be characterized by lower identity prominence, valence, and integration, and higher identity complexity (H1).*

Sexual Identity as a Predictor of Mental Health

We also examine the direct impact of sexual identity dimensions on mental health and assess whether differences between bisexual and other sexual minority individuals in identity dimensions might explain mental health disparities between the groups. Research provides mixed results on the association between *identity prominence* and mental health. On the one hand, it has been argued that strong identification with a minority group might have detrimental consequences for the well-being of minority individuals, making minority individuals prone to view themselves as victims of discrimination (Major & O'Brien, 2005).

On the other hand, models of sexual identity development describe identity centrality as a positive component of the development of a sexual minority identity, for instance leading to lower levels of internalized homonegativity (Mohr & Kendra, 2011).

In terms of *identity valence*, negatively valued identity has been associated with depression and other negative mental health outcomes (Allen, Woolfolk, Gara, & Apter, 1996; Hughes, Kiecolt, Keith, & Demo, 2015). Traditional models of gay identity development have highlighted this component, showing that positive self-evaluations are signs of positive identity development, conducive for mental health (Cass, 1984; Troiden, 1989). For example, an earlier paper, using the same data as the data used in our study, reported a positive cross-sectional association between identity valence and both psychological and social well-being (Kertzner et al., 2009).

Traditional gay identity development models describe the association between identity integration and mental health (Cass, 1984; Troiden, 1989). These models view the integration of a sexual minority identity with a person's other identities as the final and optimal stage of sexual identity development, which, in turn, is related to high levels of self-acceptance and emotional well-being (Meyer, 2003). Empirical studies supported this claim, finding that high levels of identity integration were related with positive mental health for sexual minority individuals (Levitt et al., 2016).

Using a similar rationale, *identity complexity* may reflect the presence of incongruent self-concepts and may be associated with negative mental health outcomes. Furthermore, the maintenance of complex, diverse, and perhaps conflicting identities could create interpersonal strains and increased demands for an individual's time and attention (Simmel & Wolff, 1964; Stirratt et al., 2008).

Modern critics of gay identity development models have pointed out that the models err by describing identity development as a linear progression as well as for focusing on sexual identity as a primary identity rather than considering sexual identity at the intersection of other identities (Eliason & Schope, 2007). These critiques complicate what we can learn from gay identity development models but do not contradict the ideas examined here: that a positive and integrated identity, and a less complex identity structure, are associated with positive mental health. Based on these writings, we expect identity valence and identity integration to positively impact mental health and identity complexity to negatively impact mental health.

We thus assess whether identity dimensions are associated with a bisexual identity so that bisexual individuals will show a more negative sexual identity valence, less identity integration, and greater complexity than other sexual minority individuals, which, in turn, would explain mental health disparities between the groups. We hypothesize *that lower mental health in bisexual compared with other sexual minority individuals is mediated by differences in identity valence, integration, and complexity (H2)*.

Sexual Identity Dimensions as Moderators of the Impact of Stress on Mental Health

In addition, it has been argued within the minority stress framework that qualities of sexual identity dimensions might moderate the impact of minority stressors on mental health (Meyer, 2003). Here, identity dimensions can be thought of as the context for the experience of minority stress. For example, when a stressful experience occurs (e.g., anti-LGBT violence), a person who views her or his sexual identity negatively may experience a sense of dejection, identifying with the aggressor in rejecting her or his own sexual minority identity, magnifying the impact of the assault. In contrast, a person who viewed her or his identity positively may garner resilience and be better ready to initiate support, which, in turn, would ameliorate the negative impact of the stressful experience (Meyer, 2003). In line with this, research on ethnic minorities has shown that favorable evaluations of one's minority racial identity in the face of discrimination functions as a coping mechanism against negative societal opinions of people's social group (Ellemers & Haslam, 2012; Hughes et al., 2015).

Another identity dimension, *identity prominence*, may work to increase vulnerability to minority stressors. That is, minority stressors that threaten the person's prominent sexual minority identity may have a greater negative impact on his or her mental health as compared with a person who suffers similar stress but for whom the minority identity is less prominent (Thoits, 1991). For example, a lesser identity prominence might better allow the person to cope with the minority stressor through disengagement (Major & O'Brien, 2005). We hypothesize that *sexual identity dimensions moderate the association between minority stressors and mental health (H3)*.

Method

Sample and Procedure

Data came from project STRIDE, a study on the relationships between identity, stress, and mental health in a diverse LGB sample from New York City. Participants were sampled from venues selected to ensure a wide diversity of cultural, political, ethnic, and sexual representations. Recruitment venues included bars, nonbar commercial establishments, outdoor venues (e.g., parks), groups (e.g., Latin dance clubs), and events (e.g., gay pride). During recruitment, quotas were maintained to ensure that no one venue type/time was overrepresented by more than 3 participants in the final sample. At the venues, the research workers engaged potential respondents in a brief conversation to explain the purpose of the study and asked them to fill out a brief screening form that would determine eligibility for participation in the study. Respondents were eligible if they were 18–59 years old, resided in New York City for 2 years or more, self-identified as lesbian, gay, bisexual, or similar terms (e.g., queer); were male or female (and their gender identity matched sex at birth); and White, African American, or Latinx (or defined themselves using similar terms, e.g., Black). Eligible respondents were contacted by an interviewer and invited to complete the in-person research interview at the research office or at another convenient private space. Baseline data were collected between February 2004 and January 2005 ($N = 396$) and wave 2 data were

collected 12 months later ($N=371$), resulting in a 94% retention rate. Respondents were compensated \$80 for participation in the baseline interview and \$60 for participation at wave 2. Sample characteristics and differences between bisexual and other respondents are displayed in Table 1. Bisexual respondents included more women, more race/ethnic minorities, and they were less educated, more often in debt, yet less often unemployed.

Approval was granted by Western Institutional Review Board, 2003–2006, Protocol number: 20030059 and Columbia University Medical Center, since May 31, 2006, Protocol Number: IRB-AAAB9794.

Measures

Sexual orientation.

Bisexual identity status: was measured at wave 1 by asking respondents what best described their sexual orientation. Individuals who indicated *bisexual* as their sexual identity were categorized as bisexual here ($n=71$). Participants who chose *gay*, *lesbian*, or other labels indicating a sexual minority status (e.g., *queer*, *homosexual*) were included in a general *other sexual minority* category ($n=325$), which was used as reference to the bisexual participants. The large majority of respondents in this reference category identified as gay ($n=178$), lesbian ($n=111$), or homosexual ($n=16$); 15 respondents identified as queer, and 5 respondents used other terms to describe their sexual identity. Sexual identity was measured again at wave 2. As a robustness check, we reran our analyses, this time counting all respondents that identified as bisexual at either wave 1 or wave 2, as bisexual. The results (available upon request) did not change from the results reported here.

Furthermore, we compared bisexual respondents to a broad reference category of other sexual minorities, rather than separating the group by gender (e.g., lesbian women and gay men). This was done because our goal was to assess how bisexual men and women compare with others within the LGB population in terms of sexual identity. Whereas lesbian women and gay men might differ from each other in various ways, both groups differ in similar ways from bisexual individuals, in that both lesbian women and gay men are romantically and sexually attracted to others of one gender, which is the contrast of interest in our study. To assess this, we compared lesbian women and gay men in our sample on mental health and sexual identity (results available upon request). Lesbian women and gay men did not differ significantly in any of the sexual identity dimensions. They also did not differ much in mental health, except that lesbian women had higher level of depressive symptoms. This finding is in line with evidence that women experience more depression than men (e.g., Nolen-Hoeksema, 2001), and thus likely attributable to gender differences rather than to a difference between having a lesbian or gay identity.

Identity.

Sexual identity dimensions: measured at both wave 1 and wave 2 were used in our analyses. They were calculated on the basis of responses to an Assessment of Multiple Identities (AMI). Participants reported up to 12 personal, relational, and collective identities in response to the question, “Who am I?” (Kuhn & McPartland, 1954). Among these 12 identities, participants were asked to specify their gender, racial/ethnic, and sexual identities.

While participants were asked to enter an identity term describing these areas, they could enter the specific identity term they preferred (e.g., homosexual, bisexual, queer). Following the elicitation of identities, participants rated each identity on a set of 70 descriptive attributes, which were derived from the five-factor model of personality (Costa & McCrae, 1992). The attribute list included terms such as *talented*, *guilty*, *unhappy*, *attractive*, and *dependable*, and participants indicated whether each attribute *does not apply* (0), *applies to some extent* (1), or *applies to a great extent* (2) to an identity.

Dimensions of sexual identity were derived from the above AMI inventory, by conducting a Hierarchical Classes Analysis (HICLAS; De Boeck & Rosenberg, 1988). HICLAS software (De Boeck & Rosenberg, 1988) was used to analyze the identities and identity attribute ratings provided by the participants. Previous research suggests that the 70-item attribute list is a valid alternative to the free-response format for rating identities to which the HICLAS software was originally applied (Gara, Woolfolk, & Allen, 2002). A free-response format for rating identities would have taken hours to complete and thus was not optimal for administration as part of this study (Rosenberg & Gara, 1985).

The software follows an iterative process of differentiation to identify clusters of identities and their corresponding attributes. Each level of differentiation is termed a “Rank.” At the lowest level of differentiation (Rank 1), all identities and attributes are combined into a single, unified cluster. Each successive increase in Rank breaks the identities and attributes into increasingly differentiated and hierarchical sets of clusters. The dimensions reported here employ HICLAS results at Rank 4, which has previously demonstrated good psychometric properties for the modeling of identity interrelationships (Allen et al., 1996; Woolfolk, Gara, & Ambrose, 1999).

Prominence refers to the location of sexual orientation within the Rank 4 HICLAS model of identity interrelationships. Sexual orientation could be positioned at different tiers within the model, depending on the degree to which it is elaborated by attributes. Identities characterized by a greater number of attributes were located at higher tiers within the hierarchical model. The prominence of sexual orientation was coded 0 (indicating that the target identity was dropped from the model) to 4 (indicating that the identity was at the highest possible level within the model).

Valence was defined as the proportion of positive attributes from the attributes respondents chose to describe their sexual identity.

Integration was defined as the degree to which a target identity showed overlap with other identities within the identity model (that is, they shared precisely the same attributes). Integration was defined as a proportion, calculated as the number of identities that showed overlap with a target identity divided by the total number of identities respondents used to describe themselves.

Global self-complexity was defined as the total number of identity and attribute clusters within the identity model. Identity models may contain a highly complex structure with many clusters, or a simpler structure with fewer clusters. Complexity could range from 1 (a

single identity/attribute cluster) to 70 (70 individual and separate attributes), but a Rank 4 HICLAS commonly produces 5 to 15 clusters (Woolfolk et al., 1999).

Minority stressors.

Outness to family: was measured on a 4-point scale: *out to all*, *out to most*, *out to some*, *out to none*. We used outness to family (rather than friends, co-workers, or health workers) as a proxy for stress related to concealment (Meyer, 2003).

Chronic strain: was measured using 28 items referring to sources of strain from 9 areas of life: general or ambient problems, financial issues, work, relationships, parenting, family, social life, residence, and health (Wheaton, 1999) (wave 1 $\alpha = .73$; wave 2 $\alpha = .72$). On a scale of 1–3, respondents were asked to indicate whether statements such as “You’re trying to take on too many things at once” were *not true*, *somewhat true*, or *very true* for them at the time of the interview.

Everyday discrimination: was assessed using the Williams scale (1997). The 8-item scale assessed how often these experiences occurred over respondents’ lifetimes on a 4-point scale (1 = *often* through 4 = *never*): treated with less courtesy, less respect, and receiving poorer service than others, as well as being threatened or harassed, called names or insulted. It showed good reliability (wave 1 $\alpha = .84$; wave 2 $\alpha = .85$). We modified the scale to ask, for each item, whether it was related to sexual orientation, gender, ethnicity, race, age, religion, physical appearance, income level/social class, or some other form of discrimination. We used the total number of instances of discrimination related to sexual orientation.

Internalized homophobia: was measured using an 8-item scale, adapted by Frost and Meyer (2009) from Martin and Dean (1992). Items include statements such as “How often have you wished you weren’t gay?” Response options ranged from 1 = *often* to 4 = *never*. The scale had good reliability (wave 1 $\alpha = .86$; wave 2 $\alpha = .85$).

Stigma: was measured using a scale that assessed expectations of rejection and discrimination based on one’s sexual minority identity (adapted from Link, 1987). Items included for example, “Most people would willingly accept someone like me as a close friend”. Participants responded to a 6-item measure that utilized a 4-point scale ranging from (1) *agree strongly* to (4) *disagree strongly*. The measure was internally consistent (wave 1 $\alpha = .88$; wave 2 $\alpha = .88$). Responses were coded so that higher scores reflected more stigma.

Prejudiced events.: This measure was adapted from the Structured Event Probe and Narrative Rating scale (Dohrenwend, Raphael, Schwartz, Stueve, & Skodol, 1993). Assessment at step 1 was conducted by the interviewer, who recorded narratives of each life event that happened to the respondent. At step 2, each narrative was coded by two independent raters on several dimensions (e.g., magnitude) including whether or not prejudice was involved. To assess reliability, we evaluated the consistency between the raters. Of all possible event ratings ($N = 77,085$), only 2% were discrepant, indicating a high degree of reliability. Inconsistent ratings were evaluated in a consensus meeting among 3 or more raters (for more on this measure, see Kman, Palmetto, & Frost, 2006). The variable

used in this study was calculated as the total number of life events that were classified as involving prejudice.

Mental health indicators.—Both wave 1 and wave 2 mental health indicators were used in the analyses.

Depressive symptoms: were measured using the Center for Epidemiological Studies Depression scale (CES-D; Radloff, 1977). The CES-D is a 20-item self-report measure on depressive symptoms experienced over a 1-week period prior to the interview. The scale showed high internal consistency in this sample (wave 1 $\alpha = .92$; wave 2 $\alpha = .91$).

Psychological well-being: was measured using an 18-item self-administered assessment (Ryff & Keyes, 1995). This measure assesses psychological well-being across six domains: self-acceptance, positive relations with others, autonomy, environmental mastery, purpose in life, and personal growth. The internal consistency of the scale was sufficient (wave 1 $\alpha = .75$; wave 2 $\alpha = .77$).

Social well-being: was measured using a 15-item self-administered assessment (Keyes, 1998). The construct examines respondents' perception of their social environment and includes five dimensions of social well-being in this regard: social coherence, social integration, acceptance, contribution, and actualization. Internal consistency of the scale was sufficient (wave 1 $\alpha = .78$; wave 2 $\alpha = .75$).

Control variables.—We used the wave 1 measurements of our control variables. *Education* was operationalized as a dichotomous variable that distinguished participants who had obtained less than or equal to a high school diploma from the rest of the sample. We created an *unemployment* category, defined as non-student individuals who were seeking work. We assessed net worth by asking participants to calculate how much money they would have or owe after converting all assets to cash and paying all debts (Conger et al., 2002). Responses were then coded into a dichotomous net worth variable, with 1 indicating *negative net worth*. Furthermore, respondents were classified in three *age categories*: 18–29 years of age, 30–44, and 45–59. These categories approximate periods of post adolescent entry into and exploration of the LGB community; the subsequent and greater assumption of social roles related to partnership, child-care responsibilities, work, or community activities in young adulthood; and the deepening or broadening commitment of these roles in midlife, particularly as they relate to the wellbeing of future generations. *Gender*. Respondents were either male or female. No transgender respondents were included in the sample. *Ethnicity*. Respondents were part of one of three ethnic groups: White/Caucasian, Black/African American, or Hispanic/Latinx.

Analysis Plan

A schematic overview of our analyses can be found in Figure 1. First, we tested whether bisexual respondents differed from other sexual minority respondents in terms of sexual identity dimensions. To ascertain the stability of our findings, both wave 1 and wave 2 sexual identity dimensions were regressed on sexual identity status.

Using path analysis, we consequently examined whether sexual identity dimensions had direct associations with mental health (path 2a, Figure 1) estimating paths between each of four sexual identity dimensions and each of three mental health outcomes. We then tested whether a bisexual identity status was indirectly associated with mental health via sexual identity dimensions (paths 1 and 2a, Figure 1). Inference regarding the statistical significance of indirect effects was based on 95% bias-corrected confidence intervals (95% BC CI) of the specific paths using non-parametric bootstrap analyses (Preacher & Hayes, 2008) with 4,000 bootstrapped resamples of size = n . Bootstrap analyses were preferred over other methods for inference on the indirect effects, as bootstrapping is robust against non-normality of the sampling distribution of the indirect effect (Montoya & Hayes, 2016). We estimated both cross-sectional and longitudinal models. Baseline data was used in the cross-sectional analyses. In the longitudinal models, we estimated the effect of baseline sexual identity dimensions on mental health measured at wave 2, controlling for mental health measured at wave 1. Models were estimated using Full Information Maximum Likelihood (FIML) in order to compensate for missing data (Allison, 2003). Item missingness was low, ranging between 0% (most wave 1 measures) and 7.6% (psychological well-being wave 2). We allowed for correlated errors between sexual identity dimension and between mental health measures, thereby acknowledging potential inter-correlation amongst sexual identity dimensions and mental health measures respectively. In all analyses, we controlled for education, unemployment, negative net worth, age, gender, and ethnicity.

We then tested associations between sexual identity and mental health. In path 2b (Figure 1), we tested whether dimensions of sexual identity functioned as effect moderators of the association between minority stressors and mental health by running OLS regressions. Both cross-sectional (using baseline data) and longitudinal models were estimated. In the longitudinal models, we regressed mental health at wave 2 on minority stressors at wave 2, sexual identity dimensions at baseline, and the interaction between minority stressors and sexual identity dimensions, controlling for mental health at baseline. Three mental health indicators were analyzed as outcomes: social well-being, psychological well-being, and depressive symptoms. This resulted in testing a total of $6 * 3 = 18$ possible interaction effects per sexual identity dimension. The large number of tests conducted necessitated the usage of a multiple test procedure so that the False Discovery Rate (FDR) was controlled. The FDR refers to the rate of significant findings that are actually null findings (Storey & Tibshirani, 2003). To this end, p -values of the interaction effects were transformed into q -values, using the method of Benjamini and Hochberg (1995). Q -values were calculated per set of 18 parameter estimates of the interaction effects of each sexual identity dimension. Only parameter estimates with a $q < .05$ were interpreted as significant, leading to an expected value of 5% for the FDR (Benjamini & Hochberg, 1995; Storey & Tibshirani, 2003).

Results

Minority Stress and Mental Health of Bisexual Individuals Compared with Other Sexual Minority Individuals

Compared with other sexual minority respondents, fewer bisexual women and men were out to all their family members, and they had higher levels of internalized homophobia (Table 1). Bisexual respondents experienced less discrimination and fewer prejudice events compared with other respondents. At wave 1, bisexual respondents had lower social well-being than other sexual minority respondents; at wave 2, they had lower social and psychological well-being and more depressive symptoms than other sexual minority respondents (Table 1).

Identity Dimensions in Bisexual Respondents

Table 1 also shows that, at both wave 1 and wave 2, bisexual and other sexual minority respondents rated their sexual identities as important, with no differences in identity prominence between the groups. However, in both waves, bisexual individuals had lower identity valence, meaning they viewed their bisexual identity less positively than other sexual minority individuals. Bisexual respondents also had lower identity integration, showing that their bisexual identity was less integrated with their other personal and social identities in comparison to the other sexual minority respondents in our study. At wave 2, bisexual respondents also had higher identity structure complexity, meaning that they had comparatively less integrated identity hierarchy structures, which consisted of more clusters (similar differences in identity complexity were found at wave 1, yet these were not statistically significant).

Direct Effect of Identity Dimensions on Mental Health

In cross-sectional and longitudinal models, we assessed whether identity valence and identity integration were positively related to mental health, and whether self-complexity was negatively related to mental health. Results of the cross-sectional path analysis are depicted in Figure 2 (all path coefficients for both the cross-sectional and longitudinal path analysis can be found in Appendix A). The model fitted the data well ($\chi^2(20) = 17.4, p = .625$; $RMSEA = .000$, 90% CI [.000, .037]; $CFI = 1.000$). Results were consistent across the three mental health outcomes: higher identity valence was related to better mental health, whereas higher identity complexity was related to poorer mental health. The longitudinal model (Figure 3) fitted the data well too ($\chi^2(26) = 28.2, p = .349$; $RMSEA = .015$, 90% CI [.000, .043]; $CFI = 0.998$) but only the effect of identity valence on depressive symptoms was significant.

Identity Dimensions as a Mediator of Mental Health disparities between Bisexual and Other Sexual Minority Individuals

Bootstrap analyses on the cross-sectional path model showed indirect effects of bisexual identity on social well-being ($\beta = -.07$, 95% BC CI [-0.14, -0.03]), psychological well-being ($\beta = -.09$, 95% BC CI [-0.17, -0.03]), and depressive symptoms ($\beta = .06$, 95% BC CI [0.02, 0.11]), running via identity valence. These results show that lower valence of sexual

identity explained, in part, bisexual individuals' lower mental health (Figure 2). Longitudinal analyses showed a significant indirect path from bisexual identity status to depressive symptoms via identity valence ($\beta = .03$, 95% BC CI [0.003, 0.066]) but the results for psychological and social well-being were not significant in the longitudinal analysis.

To understand the findings regarding well-being we assessed variability in well-being over the one year follow-up. Results from the longitudinal path analysis showed that both social well-being and psychological well-being were relatively stable over time (stability coefficients: $\beta = .51$, $p < .01$, 95% CI [.43, .60]; $\beta = .61$, $p < .01$, 95% CI [.53, .70], respectively) compared with depressive symptoms (stability coefficient: $\beta = .33$, $p < .01$, 95% CI [.23, .43]), leaving little variation in social and psychological well-being to be explained by sexual identity dimensions.

To further probe the relationships between valence and depressive symptoms, we assessed the possibility of reversed causation by estimating a cross-lagged model (Figure 4). Results point to bi-directional effects: an effect of valence (at wave 1) on depressive symptoms at wave 2 ($\beta = -.11$, $p < .05$, 95% CI [-.21, -.02]), but also an effect of depressive symptoms at wave 1 on valence at wave 2 ($\beta = -.21$, $p < .01$, 95% CI [.32, .49]). The path coefficients of depressive symptoms on valence and valence on depressive symptoms were not significantly different from each other ($\chi^2(1) = 1.8$, $p = .18$).

Interaction Effect of Identity Dimensions on the Relationships Between Stress and Mental Health

We tested the hypothesis that sexual identity dimensions moderated the association between minority stressors and mental health by assessing whether sexual identity dimensions measured at baseline moderated any of 144 possible associations between minority stressors and mental health at baseline (4 identity dimensions times 18 possible moderations) and at wave 2 (4 identity dimensions times 18 possible moderations). Only one interaction was statistically significant at $q < .05$ (identity complexity increased the impact of discriminatory events on depressive symptoms at baseline). Therefore we conclude that our results do not support the moderation hypothesis in this study.

Discussion

Consistent with literature on health disparities, we found that bisexual individuals had poorer social and psychological well-being and more depressive symptoms than other sexual minority individuals. We assessed how bisexual individuals differed from other sexual minority individuals in terms of sexual identity dimensions and whether these differences explained health disparities between these groups. We found that sexual identity was prominent for both groups of respondents, but bisexual respondents reported lower valence and integration. In turn, identity valence had a significant impact on depressive symptoms, and differences in valence between bisexual and other sexual minority individuals partially explained disparities in depressive symptoms between the groups. The hypothesis that sexual identity dimensions moderate the impact of minority stress on mental health was not supported.

The findings are significant for showing the impact of identity on depressive symptoms and for beginning to explain disparities among sexual minority subgroups. The use of an extensive and flexible identity measure, which allowed each respondent to use her or his preferred identity term as a referent, is especially significant. Typically, studies of sexual minority individuals, including measures of identity, make little distinctions among subgroups, potentially missing important divergences (Balsam & Mohr, 2007; Dyar et al., 2015).

That identity valence is the only dimension that proved robust in our various assessments is interesting, if not surprising—identity valence has been discussed as an important aspect of identity development for decades now (Cass, 1984)—but work on bisexual identity development is lagging (Eliason & Schope, 2007). Our work does not inform about the causes of lower identity valence and integration among bisexual individuals, but some hypotheses can be offered. Structural constraints are significant and include greater stigma related to bisexuality, fewer role models, and fewer resources in the LGBT community. All of these may leave bisexual individuals less able than other sexual minority individuals to counter social biphobia and adopt positive bisexual identities (Roberts et al., 2015; Rust, 2002).

Our findings underscore the importance of longitudinal analyses for assessing the directionality of associations. Whereas our cross-sectional analyses suggested that both identity complexity and valence were substantially related to mental health, only a bi-directional association between valence and depressive symptoms was preserved when analyzing these associations over time. This suggests that results from cross-sectional research might overstate the impact of social identity on mental health.

This study is novel for being the first to investigate whether sexual identity moderated the association between minority stress and mental health. Although this was suggested in the theoretical paper that introduced the minority stress framework (Meyer, 2003), it had not yet been empirically tested. As this is the first study to test this hypothesis, which was not supported here, our results should be considered with some caution. Future researchers ought to test this intriguing hypothesis, for example using measures of other types of stressors than the mostly distal stressors we tested.

Limitations and Suggestions for Future Research

Several limitations are notable. First, the data was collected a little over ten years ago. To the extent that bisexual identity is now more positively held by bisexual people, our findings may be biased. However, we have no reason to believe that significant social changes in the status of bisexuality and in how bisexual identity is viewed have occurred, as observers continue to note that bisexual identity is stigmatized both within and outside the LGBT community (Dodge et al., 2012), and bisexual individuals continue to evidence lower mental health when compared with other sexual minority individuals. This is perhaps most clearly portrayed in a recently published meta-analysis by Ross and colleagues (2017), who summarized health disparities between bisexual and lesbian or gay individuals in studies using data collected between the 1990's and 2014. Health disparities between the bisexual and lesbian/gay group in studies using collected data collected in 2010 or later appeared to

be at least as large as disparities reported in studies using data from before 2010 (see Ross et al., 2017, Figure 2, authors' calculations). Similarly, since our data were collected, there has been an expansion of available labels for people with a non-binary sexual orientation (e.g., *pansexual*). The implications of our findings to other identity labels remain to be explored. However, despite the expansion of labels, bisexuality remains an important category. Furthermore, studies on individuals with plurisexual identities have shown that people with bisexual and other labels often show many commonalities in terms of sexual identity (Galupo et al., 2017).

A second limitation of this study is that, although we used a diverse sample of sexual minority individuals, it was recruited from sources in the LGBT community in New York City, raising concerns about generalizability. For example, connection to the LGBT community was probably higher in this sample than in the general population of bisexual individuals who are less connected to the LGBT community. This might have attenuated the differences we could find between bisexual and other sexual minority individuals. Studies that use probability sampling would be insightful to understanding how bisexual individuals who are not connected with the LGBT community might differ.

Conclusions

Despite these limitations, this study is important for showing that bisexual individuals stand apart as a distinct subgroup within the population of sexual minority individuals. Bisexual Americans comprise about half of the sexual minority population (Gates, 2011), but they receive little specialized attention in research and policy analysis. Researchers, policy makers, and public health workers ought to pay greater attention to understanding and addressing the issues that impact bisexual health. Further research could help in developing services and support specific to bisexual individuals and assess what interventions may improve bisexual identity valence. As our study suggests, improvement in valuation of bisexual identity may lead to improved mental health among bisexual individuals.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

Acknowledgements:

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Public significance statement:

This study suggests that bisexual individuals differ from other sexual minority individuals in notable ways. Bisexual individuals thought less positively about their sexual orientation and their sexual orientation was less well integrated with other parts of their identity. Furthermore, the fact that bisexual individuals thought less positive about their sexual orientation than other sexual minority individuals partly explained mental health disparities between these groups.

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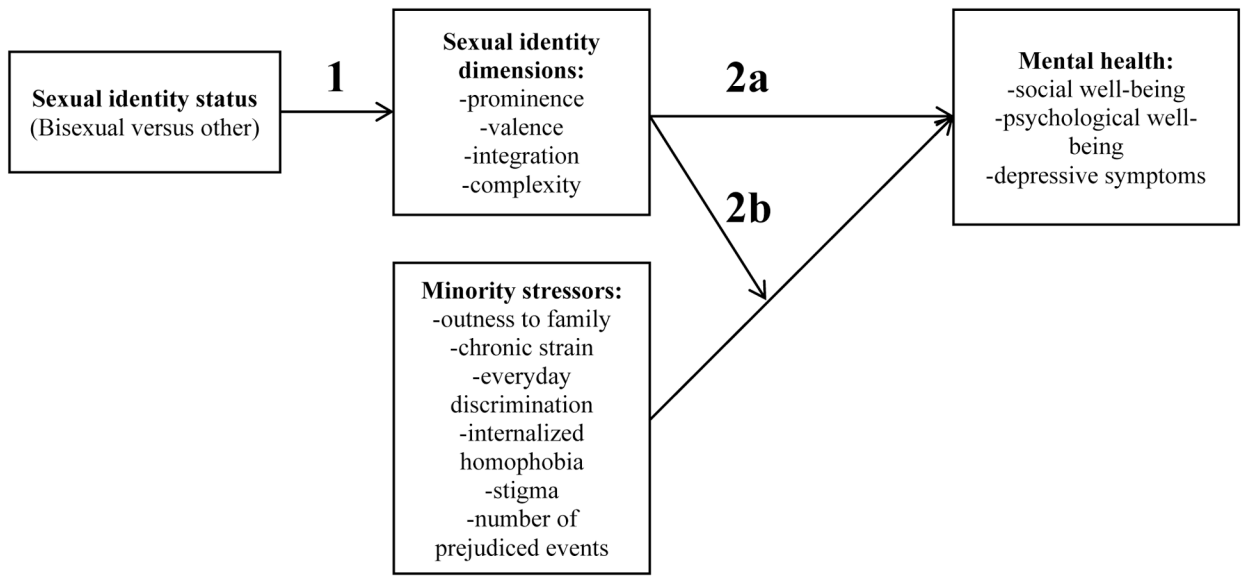


Figure 1.
Schematic overview of analyses

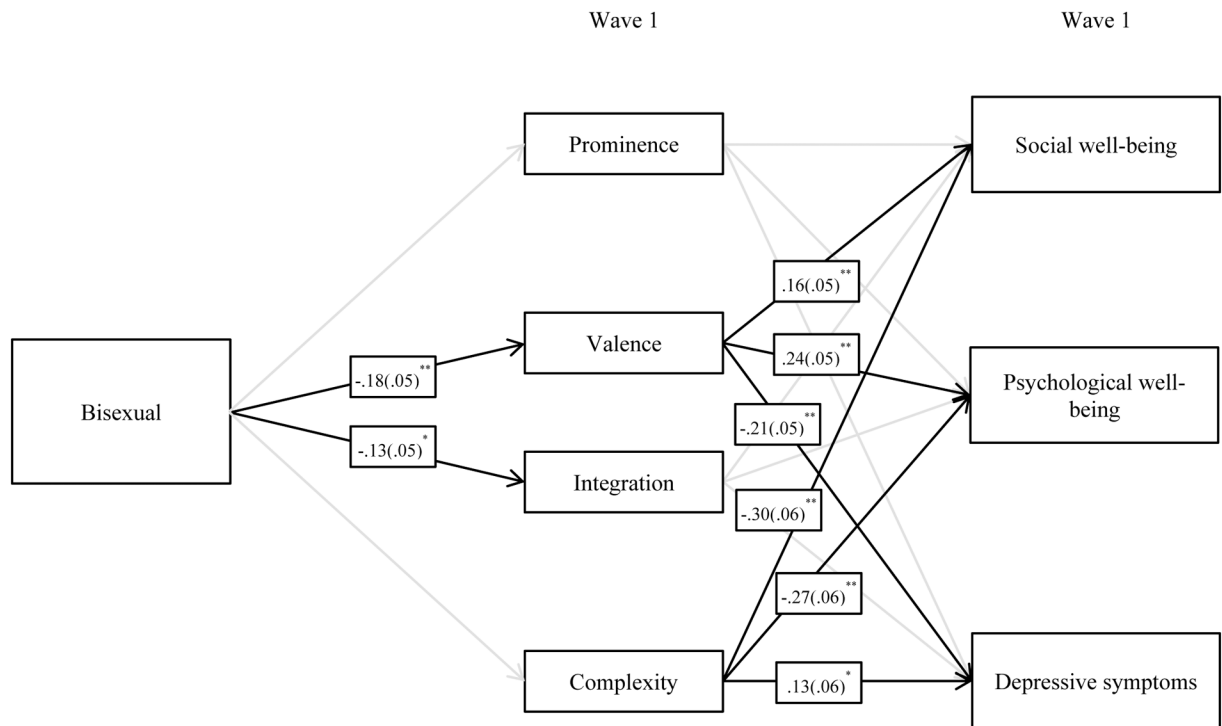


Figure 2. Summary of cross-sectional path analysis

Notes: 1. * $p < 0.05$, ** $p < 0.01$, two-sided.

2. Standardized effects. SE between parentheses. Significant effects in black, non-significant effects in gray.

3. Additional controls: education, unemployment, negative net worth, age, gender, and ethnicity.

4. Method = FIML, $N = 396$. $\chi^2(20) = 17.4$, $p = .625$; $RMSEA = .000$, 90% CI [.000, .037]; $CFI = 1.000$.

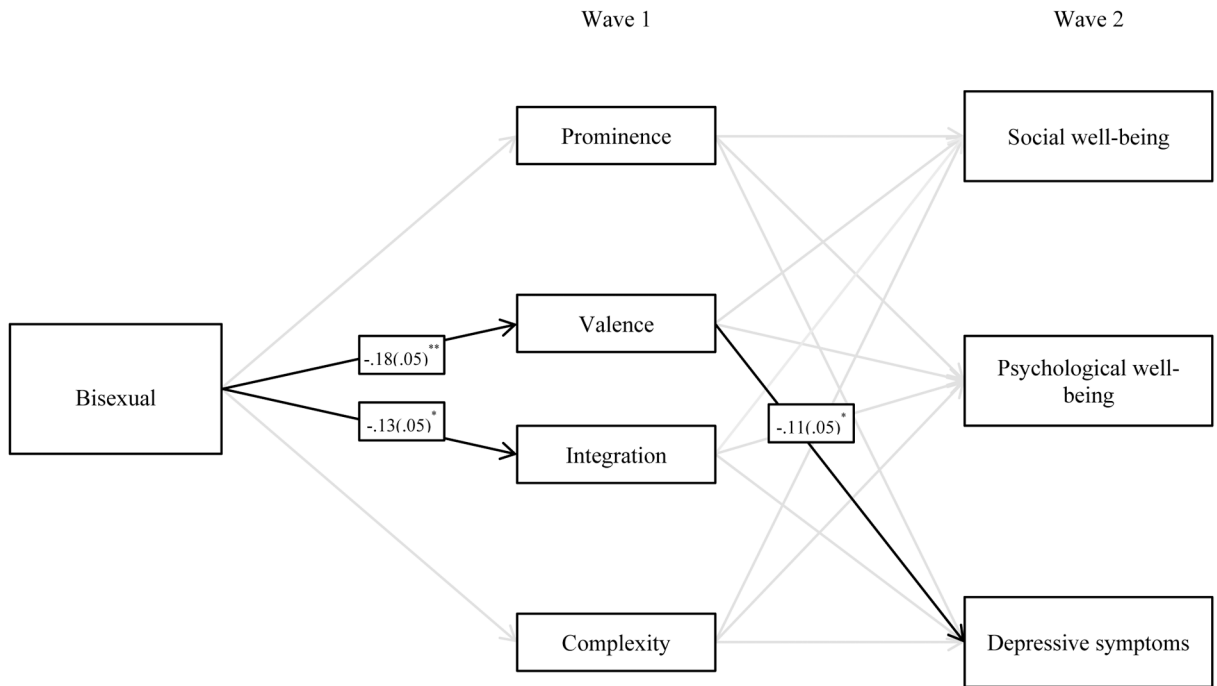


Figure 3. Summary of longitudinal path analysis

Notes: 1. * $p < 0.05$, ** $p < 0.01$, two-sided.

2. Standardized effects. SE between parentheses. Significant effects in black, non-significant effects in gray

3. Additional controls: education, unemployment, negative net worth, age, gender, and ethnicity

4. Method = FIML, $N = 396$. $\chi^2(26) = 28.2$, $p = .349$; $RMSEA = .015$, 90% CI [.000, .043]; $CFI = 0.998$.

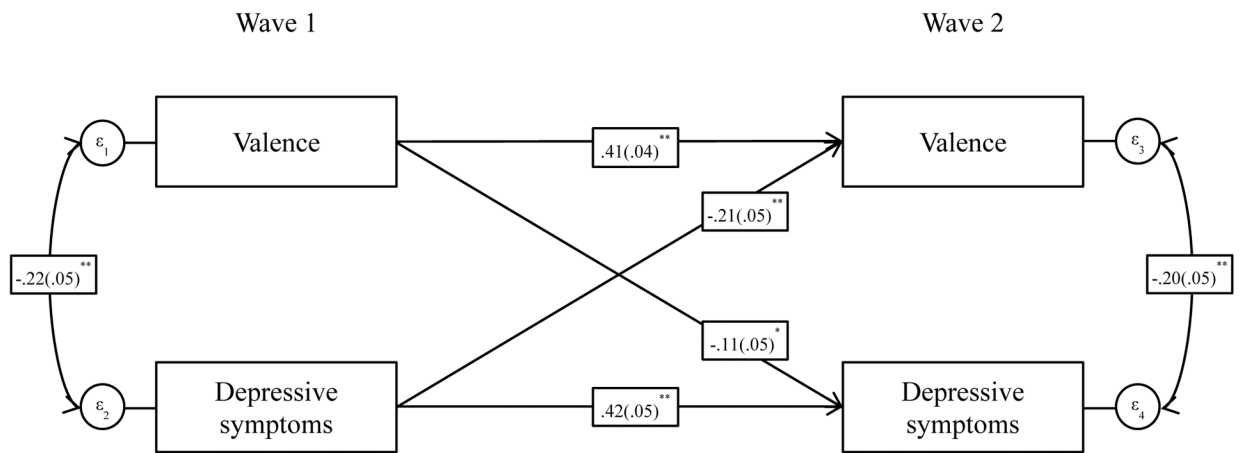


Figure 4. Cross-lagged path analysis valence and depressive symptoms

Notes: 1. * $p < 0.05$, ** $p < 0.01$, two-sided.

2. Standardized effects. SE between parentheses.

3. Controlled for effects of education, unemployment, negative net worth, age, gender, ethnicity, and sexual orientation on Wave 1 and Wave 2 valence and depressive symptoms.

4. Method = FIML, $N = 396$. $\chi^2(0) = 0$; $RMSEA = .000$; $CFI = 1.000$ (fully identified model).

Table 1.

Descriptive statistics by sexual orientation group

Variable	Mean (SD) / Proportion		
	Bisexual (n = 71)	Other sexual minority (n = 325)	
<i>Covariates</i>			
High school education or less	31%	20%	$z = 2.09^*$
Negative net worth (wave 1)	64%	54%	$z = 1.55$
Unemployed (wave 1)	15%	25%	$z = 2.32^*$
Age at wave 1: 18-29	52%	49%	$z = -0.79$
30-44	46%	45%	
45-59	01%	06%	
Female	61%	48%	$z = 1.97^*$
White	20%	37%	$\chi^2(2) = -7.94^*$
Black/African American	42%	31%	
Hispanic/Latinx	38%	32%	
<i>Minority stressors (wave 1)</i>			
Outness to family: out to none	24%	7%	$\chi^2(2) = -24.46^{**}$
Out to some	28%	21%	
Out to most	20%	21%	
Out to all	28%	51%	
Chronic strain	1.47 (0.25)	1.43 (0.22)	$t = 1.41$
Everyday discrimination	1.61 (2.02)	2.54 (2.04)	$t = -3.48^{**}$
Internalized homophobia	1.83 (0.78)	1.31 (0.47)	$t = 7.41^{**}$
Stigma	2.12 (0.77)	2.05 (0.77)	$t = 0.68$
Number of prejudiced events	0.45 (0.71)	0.83 (1.07)	$t = -2.86^*$
<i>Wave 1 mental health</i>			
Social well-being	4.47 (0.78)	4.85 (0.88)	$t = -3.28^{**}$
Psychological well-being	5.27 (0.75)	5.40 (0.77)	$t = -1.31$
Depressive symptoms	0.82 (0.56)	0.69 (0.56)	$t = 1.75$
<i>Wave 2 mental health</i>			
Social well-being	4.46 (0.76)	4.91 (0.81)	$t = -4.06^{**}$
Psychological well-being	5.23 (0.86)	5.51 (0.77)	$t = -2.67^{**}$
Depressive symptoms	0.88 (0.58)	0.68 (0.52)	$t = 2.86^{**}$
<i>Wave 1 sexual identity</i>			
Prominence	3.50 (0.93)	3.56 (0.77)	$t = -0.54$
Valence	0.64 (0.23)	0.73 (0.19)	$t = -3.50^{**}$
Integration	0.22 (0.20)	0.29 (0.23)	$t = -2.36^*$
Global self-complexity	10.29 (3.21)	9.83 (3.55)	$t = 0.98$
<i>Wave 2 sexual identity</i>			

Variable	Mean (SD) / Proportion		
	Bisexual (<i>n</i> = 71)	Other sexual minority (<i>n</i> = 325)	
Prominence	3.58 (0.76)	3.46 (0.83)	<i>t</i> = 1.09
Valence	0.69 (0.21)	0.78 (0.19)	<i>t</i> = -3.45**
Integration	0.22 (0.20)	0.31 (0.25)	<i>t</i> = -2.77**
Global self-complexity	10.88 (2.88)	9.42 (3.42)	<i>t</i> = 3.24**

Notes:

1.

* *p* < 0.05

** *p* < 0.01, two-sided.

2. Group differences in sexual identity dimensions remained significant when controlling for education, unemployment, negative net worth, age, gender, and ethnicity.