Not Queer Enough: Bisexual Identity Among Cisgender Women and How Social Stigma and Structural Factors Are Creating Mental Health Disparities

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PH 135: Health Issues in a Multicultural Society

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March 13, 2025

Author Note

This research paper served as the culminating assignment for an undergraduate course, Health Issues in a Multicultural Society. Students were asked to select a health issue faced by a community that they identified with. This was a topic that I had lived experience of, but no prior academic or research experience with. I am proud of the research and writing skills I had the opportunity to apply in this paper, along with the personal connection to the material.

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Introduction

Bisexuality is broadly defined as "including those who could be classified as bisexual on the basis of multigender/sex attraction, sexual behavior, and/or choice of bisexual or another plurisexual self-identity (Dulai & Schmidt, 2023)". Bisexual individuals face a unique set of social challenges associated with their identity due to social stigmas and discrimination, bierasure and binegativity within the greater LGBTQ+ community, and relationship-related stress associated with mixed-orientation relationships. These social factors, combined with structural factors that create barriers to mental health care, have resulted in increasing mental health disparities among bisexual individuals, especially in women. Bisexual cisgender women disproportionately experience high rates of depression and depressive symptoms, necessitating a multi-pronged approach that addresses social and structural factors, cultural competency, and access to equitable mental healthcare. This paper aims to deconstruct the factors and social determinants of health that contribute to this health disparity, analyze available data and existing interventions, and propose culturally-informed and evidence-based solutions with the objective of improving mental health outcomes for bisexual cis women. As the researcher, my personal connection to this topic is that I identify as a bisexual cisgender woman. Additionally, I was diagnosed with Major Depressive Disorder (MDD), also known as clinical depression, in 2010 alongside other mental health comorbidities.

Cultural Background and Historical Context

Bisexual individuals have historically been mislabeled, stereotyped, and often ostracized within the larger LGBTQ+ community. Prominent bisexual figures in history and contemporary

media have frequently been incorrectly identified as gay or straight, depending on the genders of their known partners. One example of this bierasure is in the case of Freddy Mercury, lead vocalist and songwriter of the 20th century rock band Queen. Mercury tragically died of AIDS complications in 1991. At the time of his death, Mercury had been in a relationship with a man since 1985. Earlier in his life, he had been in a public long-term relationship with a woman, Mary Austin. His management has continued to this day to uphold that he was a gay man, despite him never coming out publicly or (to anyone's knowledge) privately as such. Austin claimed that he had come out to her as bisexual (Bi.org, n.d.). His bisexuality has been left out of his posthumous narrative by straight and queer communities alike.

Stereotyping of bisexual individuals, especially women, has led to widespread hesitancy to openly identify as bisexual. Bisexuality has been equated by those in both the straight and queer communities to infidelity in relationships and promiscuity. Bisexual identity is also prone to misconceptions as a transitional phase before one "admits" that they are gay (usually in regards to men) or as an experimental phase or attention-seeking behavior (usually in regards to women) (Shaw, 2022).

Negative attitudes towards bisexual individuals within the larger LGBTQ+ community have also ranged from being omitted from the narrative to outright exclusion and ostracization. One example of this exclusion goes back to the 1970s. The Gay Liberation Front (GLF) was organized in the wake of the Stonewall Riots, which are widely considered to be the catalyst of the U.S. LGBTQ+ rights movement that continues to this day. While the GLF played a critical role in transforming political consciousness around LGBTQ+ rights, bisexual individuals were not included in their objectives, as they were equated with being straight and considered to be "essentially straight (Shaw, 2022)," thus working against the GLF's objectives.

In addition to exclusion from the greater LGBTQ+ community, bisexual individuals are often excluded or omitted from scientific research and sexuality studies. Most research regarding mental health among sexual minorities in the 20th century, and continuing into the 21st, either grouped gay, lesbian, and bisexual individuals together without distinguishing stratified data or designated bisexual individuals as either gay/lesbian or straight depending on the gender of their current partner. As recently as 2007, analyses of sexuality studies showed that only 17.9% published studies that year reported separate data on bisexual participants (Ross et al., 2017). Improvements in these practices have emerged in the years since as a result of activism and calls to adequately represent bisexual individuals in studies. However, to this day only one systematic review, conducted by Pompili et al. in 2014, exists and one meta-analysis, conducted by Ross et al. in 2017, to examine mental health patterns in bisexual individuals (Ross et al., 2017) (Pompili et al., 2014).

Data Analysis & Comparison

Rates of depression and depressive symptoms are disproportionately high among bisexual individuals, especially bisexual cis women. According to a study by Dulai & Schmidt, depression symptoms were "1.78 times higher in women than in men, 1.73 times higher in bisexual individuals than in heterosexual individuals, and 3.15 times higher in bisexual women than in heterosexual men (2023)". The National Health Interview Survey conducted annually by the National Center for Health Statistics between 2019-2023 showed a similar trend (See Figure 1). In that time period, the annual percentage of U.S. adults aged 18 and over who reported regularly having feelings of depression ranged between 4.0-4.4% among straight individuals, 5.1-12.1% among gay or lesbian individuals, and 16.9-22.1% among bisexual individuals.

This mental health disparity that disproportionately affects bisexual individuals is also

evidenced in the same survey which collected data on adults who reported taking prescription medication for feelings of depression (see Figure 2). The percentage among straight individuals ranged from 9.5-10.8%, 15.4-21.8% among gay and lesbian individuals, and 23.0-32.4% for bisexual individuals between 2019-2023.

Percentage of regularly had feelings of depression for adults aged 18 and over, United States, 2019—2023

Year	Bisexual	Gay or Lesbian	Straight
2019	16.9	5.1	4.4
2020	21.1	10.5	4.0
2021	17.8	7.9	4.0
2022	22.1	12.1	4.4
2023	17.4	9.0	4.3

Figure 1: National Center for Health Statistics (2025)

Percentage of taking prescription medication for feelings of depression for adults aged 18 and over, United States, 2019—2023

Year	Bisexual	Gay or Lesbian	Straight
2019	23.0	15.4	9.5
2020	32.4	16.3	9.8
2021	28.2	18.4	9.9
2022	32.1	21.1	10.8
2023	26.3	21.8	10.5

Figure 2: National Center for Health Statistics (2025)

While the survey did not examine intersecting sexual orientation and gender identities, it also revealed mental health disparities between female and male adults aged 18 and over in the U.S. The annual percentage of females who regularly had feelings of depression between 2019-2023 ranged from 5.2-6.1%, while it ranged from 3.6-4.3% for their male counterparts. The percentage of U.S. adult females who reported taking prescription medication for feelings of depression between 2019-2023 ranged from 13.3-15.3%, compared to 6.1-7.6% among their male counterparts. Data was also collected on the percentage of U.S. adults who reported receiving mental health counseling in the past 12 months over that 2019-2023 period. The annual percentages ranged from 11.7-16.5% for females and 7.1-10.1% for males when sorting by sex. When sorting by sexual orientation, percentages ranged from 8.8-11.9% among straight individuals, 18.4-31.8% among gay or lesbian individuals, and 29.2-43.9% for bisexual individuals (National Center for Health Statistics, 2025).

Implications

This data tells us identifying as bisexual and female are each risk factors of having feelings of depression. It also gives us some insight into health behaviors surrounding mental health, exhibiting that bisexual individuals and females are more likely than their gay/lesbian, straight, and male counterparts to be on prescription medication for feelings of depression and to have received mental health counseling within the last 12 months.

Depression is one of the leading causes of disability, and studies have shown associations between people who report having experienced feelings of depression or depression disorders and deficiencies across several social determinants of health. A 2017 survey by Wilkinson et al. found that participants who reported to have experienced a depression disorder in their lifetime also reported experiencing a higher rate of financial insecurity, housing challenges, feeling

unsafe in their neighborhoods, food insecurity, and stress at a higher rate than participants who had not experienced depression. Despite no difference found in the proportion of individuals with health insurance between those who had and had not experienced depression, the participants who had experienced depression reported avoiding doctor visits due to financial burden at a higher rate (Wilkinson et al., 2023). The implication of bisexual cisgender women disproportionately experiencing depression and depressive symptoms compared to other groups is that they are also more likely to be disadvantaged in other social determinants of health.

Contributing Factors to Depressive Symptoms

Minority Stress Theory and Identity-Related Stress

The Minority Stress Model (Figure 3) was a framework conceived by Ilan Meyer in 2003 to guide research of health among sexual and gender minority populations. This model approaches understanding health disparities faced by sexual and gender minorities experienced as a result of stress stemming from stressors unique to these populations. These stressors are based in violence, stigma, and discrimination relating to marginalized identities, differentiating them from general stress (Frost & Meyer, 2023).

The impact of minority stress on health outcomes is a key social determinant of health for sexual and gender minority individuals, including bisexual cisgender women (Mereish et al., 2021). A unique minority stressor bisexual individuals face is two-fold discrimination from both straight and other sexual minority communities. The intersection of bisexual identity and gender minority identity as a woman leaves bisexual cis women at a further disadvantage, vulnerable to poor mental health outcomes. Bisexual individuals with additional intersecting minority identities, such as BIPOC, disabled, or trans women face furthermore stressors. Additional bi-

specific stressors studied by Mereish et al. in a 2021 survey were identified to be internalized heterosexism and sexual orientation concealment.

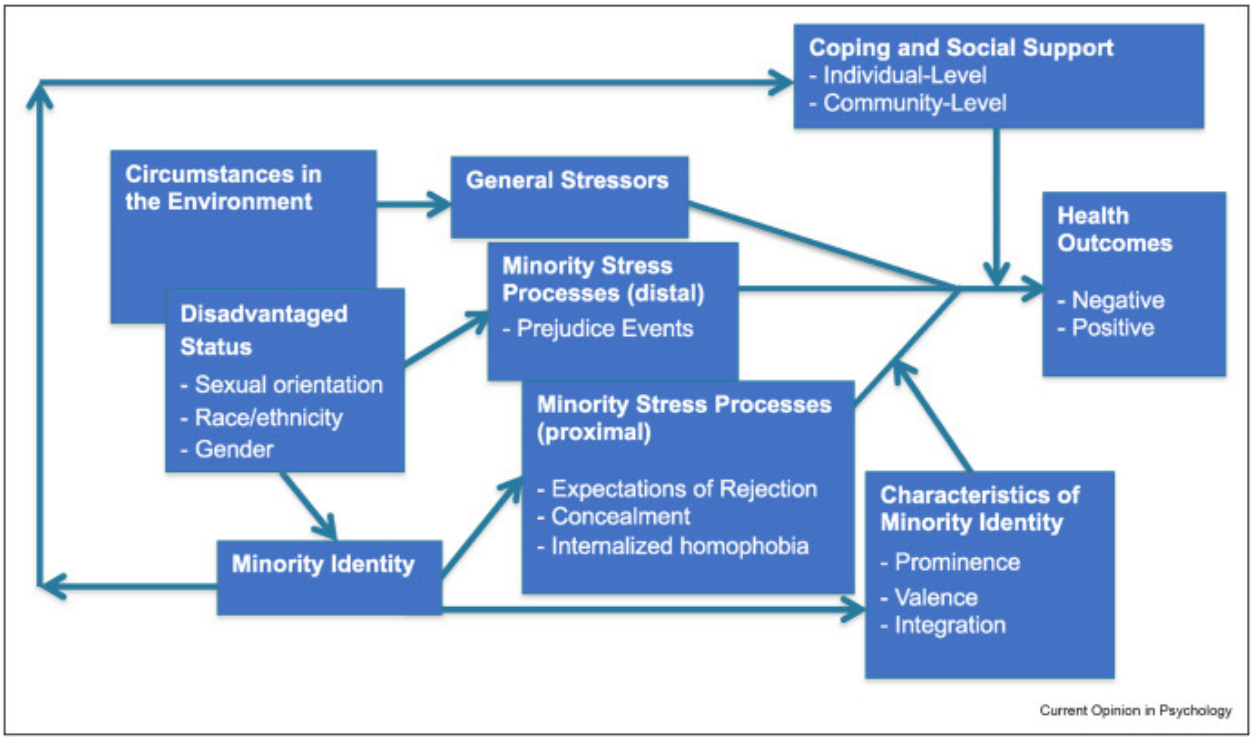

Figure 3: Frost & Meyer (2023)

Social Factors

Social connectedness is a social factor that contributes to mental health outcomes in marginalized populations, especially so in bisexual individuals. The discrimination erasure faced by bisexual people both within and outside of the LGBTQ+ community impacts feelings of isolation and loneliness, which are in turn associated with higher rates of mortality and morbidity (Schuler et al., 2021). Internalized heterosexism is another factor that contributes to poor mental health outcomes. Social messaging that reinforces a monosexist culture (i.e. that an individual is either straight or gay/lesbian) leaves bisexual people struggling to define and/or accept their sexual identity, which can impact feelings of depression (Chan et al., 2020). Even if an individual does identify as bisexual, outness introduces a new factor that impacts mental health

status: sexual orientation concealment. Fear of the social stigma associated with bisexual identity and discrimination from both straight and LGBTQ+ communities can create hesitancy to be open about one's identity with the people in their life. The gender and sexuality of a bisexual individual's partner(s) is also a significant bi-specific factor on mental health, especially so for women. A 2021 study found that bisexual women's outness, experiences of discrimination, and mental health was closely linked to their partner's gender and sexual identity. Participants with lesbian or bisexual cisgender women partners were more open about their identity and reported lower incidence of feelings of depression, while those with straight cisgender male partners were less out and more likely to experience depression (Hall et al., 2021).

Structural factors and social determinants of health

Bisexual cisgender women face significant economic, health, and social disparities, including higher poverty rates, lower college completion, and greater reliance on public assistance, which contribute to financial instability. Sexual minority women are also disproportionately represented in correctional facilities, where 42% of incarcerated women identify as a sexual minority (compared to making up about 5% of the general population). Incarceration exacerbates health risks through social isolation, victimization, and post-release economic and employment challenges. Additionally, bisexual cisgender women experience substantial barriers to healthcare access, with poverty and unemployment further limiting their ability to obtain necessary medical care (Schuler et al., 2021).

Public Health Initiative Case Study

An existing public health initiative in Santa Clara County that addresses this disparity is LGBTQ Wellness. They run peer support and social programs as well as offer mental health and cultural competency training for individuals and organizations to be able to serve LGBTQ+

individuals in Santa Clara County. LGBTQ Wellness takes an intersectional and multigenerational approach to fostering an inclusive and affirming culture at the individual and institutional levels. Their services provide direct social support for the LGBTQ community as well as allies and those looking to strengthen their allyship capacity.

Though they do not have programs specifically geared towards bisexual individuals, their services do address social and structural factors that contribute to the disproportionate rate of depression among bisexual cis women. The peer support groups include regular meetings for trans and nonbinary adults, disabled and neurodiverse LGBTQ+ adults, and Asian LGBTQ+ adults, and a social group for all LGBTQ+ adults. These peer support and social groups address the impact that lack of social connection can have on mental health, especially with the LGBTQ+ community.

I was unable to find mental health data for Santa Clara County adults that included intersectional information on the population's sexual orientation. Unable to verify the county-specific rates of depression among bisexual cis women, I will refer to the rising national rate of depression among this population (National Center for Health Statistics, 2025) as an indicator that programs that do not specifically address the needs of bisexual individuals, especially cis women, are not effective in reducing this disparity. This highlights the urgent need for action on every level of the Social Ecological Model to address the disproportionate rate of feelings of depression and depressive symptoms among bisexual cis women.

Recommendations and Solutions for Addressing Disparities

The Social Ecological Model can be used to develop a multipronged approach to address depression rates among bisexual cis women. Peer support and social groups with specified inclusivity for bi+ individuals can address multiple levels of the SEM. On the individual and

interpersonal level, peer support and social groups can enhance social connectedness and combat internalized heterosexism, along with hesitancy to be open about one's sexual orientation. On the policy level, education and economic equity should be made a priority for sexual minority advocates. This is especially true for women who identify as a sexual minority who are incarcerated. Social support programs need to be in place to reduce arrest rates through working with bisexual and sexual minority youth to promote community engagement, increase employment, and foster a strong education system that does not fail marginalized populations. Additionally, on the institutional level, mental health professionals should receive bi-specific training to inform providers of the unique stressors facing the bisexual community. It is not enough to lump LGBTQ+ individuals into one large group, as people of different sexual identities have varying needs. Medical providers should also receive the same training as part of medical school curricula to instill the importance of varying population needs in their care.

Reduction of minority stress is the key to mental health equity for bisexual cis women. At the community level, an intervention should include an information campaign to fight the social stigma that bisexual folx face. Other LGBTQ+ individuals should fight to make queer spaces truly inclusive for bisexual individuals.

Conclusion

Achieving equity in the mental health space for bisexual cisgender women is achievable, but requires advocacy and allyship from bisexual, other LGBTQ+, and straight individuals together to demand and fight for. Bierasure and invisibility in society and history have been hurdles to equity, but bisexual folx are valid and have a right to the resources and support they need to reduce this mental health disparity. Bisexual individuals should never feel like they are "not queer enough" to be open about their identity.

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