DOI: 10.26387/bpa.2023.00012

To be or not to be Bi in Italy: Psychological well-being in a sample of bisexual individuals

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ABSTRACT. Il presente studio ha l'obiettivo di indagare aspetti relativi al benessere psicologico della popolazione bisessuale presente in Italia, dato che in letteratura risultano esserci ancora pochi studi sull'argomento. Nello specifico, sono stati indagati aspetti di sviluppo dell'identità sessuale, sintomatologia ansiosa e depressiva e storie di traumi infantili in una popolazione composta da 326 individui bisessuali. Dai risultati sono emerse differenze significative per età e genere riguardo le dimensioni di sviluppo dell'identità sessuale. Tra gli sviluppi futuri, saranno necessari interventi che affrontino i fattori di stress unici associati all'identità bisessuale.

SUMMARY. Since the Italian bisexual community is largely underrepresented in the scientific literature, the purpose of the current study was to shed light on the experiences of Italian bisexual people and to investigate their psychological well-being. Specifically, aspects of sexual identity development, anxiety and depressive symptoms, and a history of childhood trauma will be investigated. 326 (% F = 73.9; 80.4% aged between 18-25) bisexual individuals completed an online survey. Results showed age and gender differences in aspects of sexual identity development. Bisexual young adults were less concerned with their sexual orientation and had more positive feelings about their LGB+ identity than older bisexual individuals. Bisexual men reported more uncertainty and concern about their sexual orientation, more internalized homonegativity, and more difficulties in their LGB+ identity development and acceptance than bisexual women. Bisexual individuals with higher sexual identity acceptance concerns reported more anxiety symptoms. Having experienced childhood traumata is associated with greater levels of anxiety and hopelessness. Interventions addressing the unique stressors associated with a bisexual identity are needed.

Keywords: *Bisexuality, Sexual orientation, Anxiety*

INTRODUCTION

The definition of sexual orientation is included in a broader concept of sexual identity (Shively & De Cecco, 1977). In fact, sexual identity comprises (i) gender identity (i.e., "a person's deeply felt, inherent sense of being a girl, woman, or female; a boy, a man, or male; a blend of male or female; or an alternative gender", APA, 2015, p. 834); (ii) gender expression (i.e., "the presentation of an individual, including physical appearance, clothing choice and accessories, and behaviors that express aspects of gender identity or role", APA, 2015, p. 861); and (iii) sexual orientation, defined as "a person's sexual and emotional attraction to another person and the behavior and/or social affiliation that may result from this attraction" (APA, 2015, p. 862).

Past research on sexual orientation was focused on a dichotomic view (i.e., heterosexual/same-sex sexual orientation) that further erased the notion of bisexuality as sexual orientation (e.g., Bieber, 1976; Freud, 1910); currently, the scientific community widely recognizes the presence of at least three sexual orientations, including heterosexuality, same-sex sexual orientation (gay or lesbian) and bisexuality (e.g., Kinsey, Pomeroy & Martin, 1948); more recently, asexuality was also included in the conceptualization of sexual orientations (Brotto & Yule, 2017).

Yoshino (2000) defines bisexuality as "the ability to feel more than an incidental sexual desire for both sexes" (p. 3), emphasizing the desire-based aspect of its conceptualization. Additionally, Miller and colleagues (Miller, André, Ebin & Bessonova, 2007) defined bisexuality as the capacity for romantic, emotional, or physical attraction for more than one sex or gender. More recently, the dictionary of the American Psychological Association (APA, 2015) conceptualizes bisexuality as a sexual behavior with or sexual attraction to both men and women.

Several large representative studies conducted in the US and Australia have attempted to quantify sexual orientations in the general population by asking participants how they self-identify, reporting that .9-2.6% and 1.4-3.6% identify as bisexual, respectively (e.g., Richters et al., 2014; Smith, Rissel, Richters, Grulich & De Visser, 2003). A more recent study reported that 5.5% of women and 2.0% of men self-identified as bisexual (Copen, Chandra & Febo-Vazquez, 2016). To date, no studies on the prevalence of bisexual individuals in the Italian population are available.

Sexual orientation identity development in LGB+ individuals and psychological well-being

Recent research on the development of sexual orientation identity has focused on the assumption that to understand better the phenomena, milestone-focused studies, rather than stage models, are preferred (e.g., Maguen, Floyd, Bakeman & Armistead, 2002). Milestones are defined as significant events in human development regarding life changes or achievements. Hall, Dawes & Plocek (2021) in their systematic review and meta-analysis, showed four milestones in sexual orientation identity development in lesbian, gay, bisexual, and other-identifying (LGB+) individuals, including self-identifying, coming out, sexual activity, and awareness of attractions. According to sexual identity development theory (Elizur & Mintzer, 2001), one of the tasks that LGB+ individuals have to face with is developing self-acceptance of their sexuality.

Sexuality self-acceptance is defined as accepting one's sexuality, which is achieved through depathologizing sexual orientations that differ from heterosexuality and through rejecting internalized negative attitudes (Elizur & Mintzer, 2001). A recent systematic review enlightened that bisexual individuals report lower sexuality self-acceptance compared to same-sex sexual orientation individuals and that the lower self-acceptance is associated with poorer mental health (Camp, Vitoratou & Rimes, 2020). In line with this, the existing data on mental health in bisexual individuals reveals a broad consensus: bisexual individuals suffer poorer mental health than other sexual orientation groups (e.g., Jorm, Korten, Rodgers, Jacomb & Christensen, 2002; Koh & Ross, 2006; Pompili et al., 2014; Steele, Ross, Dobinson, Veldhuizen & Tinmouth, 2009). Minority stress model (Meyer, 2003) is the major conceptual framework used to explain bisexual health inequalities and suggests that chronic stress connected to bisexual stigma and discrimination is linked to elevated risks for poor health outcomes. All sexual minorities face prejudice and abuse because of their sexual orientation, but bisexual people face additional challenges (for a review see Feinstein & Dyar, 2017). For instance, binegativity is defined as a stigmatization of bisexuality that reflects negative attitudes and stereotypes toward these individuals (Dyar & Feinstein, 2018), and in the literature, bisexual people face double discrimination from both heterosexual and same-sex sexual orientation individuals (Mulik & Wright, 2008; Ochs, 1996).

A large Canadian population-based study of 61,715 females found that bisexual women were much more likely than heterosexual or lesbian women to report mood and anxiety disorders, as well as bad or fair self-reported mental health; moreover, an alarming 45.4% of bisexual respondents reported suicidal ideation in their lifetime, compared to 29.5% of lesbian women and 9.6% of heterosexual women (Steele et al., 2009).

A study on 381 Italian bisexual individuals found a very high percentage of anxiety and depressive symptoms related to experience minority stressors, specifically anti-bisexual discrimination and internalized binegativity (Scandurra et al., 2020). Some studies (e.g., Brewster, Moradi, DeBlaere & Velez, 2013; MacLeod, Bauer, Robinson, MacKay & Ross, 2015) have confirmed that experiences of binegativity are linked to psychological distress and anxiety. Unsurprisingly, many bisexual people internalize others' negative attitudes regarding bisexuality and anticipate rejection and hostility as a result of their prior experiences with binegativity, discrimination, and trauma.

Additionally, bisexual women reported greater rates of depressive symptoms, stress, anxiety symptoms, and prior self-harm (Hughes, Szalacha & McNair, 2010; McNair, Kavanagh, Agius & Tong, 2005); they were nearly twice as likely as lesbian women and four times as likely as heterosexual women to state life "was not worth living" (Hughes et al., 2010). Similarly, more bisexual men (34.8%) reported considering suicide compared to same-sex sexual orientation (25.2%) or heterosexual men (7.4%) (Brennan, Ross, Dobinson, Veldhuizen & Steele, 2010). A meta-analysis on sexual minority individuals in US and Canada showed that LGB+ individuals significantly reported higher scores of childhood traumas compared to heterosexual individuals, for instance, bisexual men and women (*vs* same-sex sexual orientation individuals *vs* heterosexual individuals) reported more frequently to have experience parental physical abuse (Friedman et al., 2011). In line with this, several studies support the role of childhood trauma experiences as risk factors for developing psychopathology (for a review see McCroy, De Brito & Viding, 2012).

The current study

Since the Italian bisexual community is largely underrepresented in the scientific literature, and given the potential negative influence of the specific Italian culture on LGB+ population's lives (e.g., the Italian legal system not contemplating a law prohibiting hate crimes based on sexual orientation, only in 2016 same-sex civil unions were recognized, same-sex parents are not allowed to adopt children, bisexual identity not mentioned in any law) the main purpose of the current study was to shed light on the experiences of bisexual people in Italy and to investigate their psychological well-being. Specifically, aspects of sexual identity development, the presence of anxiety and depressive symptoms, and a history of childhood trauma will be investigated. As bisexual-specific minority stress may differ based on gender identity (Conron, Mimiaga & Landers, 2010; Katz-Wise, Mereish & Woulfe, 2017), we will first test whether there were significant differences in study variables in bisexual men and women. According to previous research (e.g., Hall et al., 2021), we hypothesized that bisexual men would report more difficulties in sexuality self-acceptance. Then, age differences in study variables will be explored by comparing groups of different ages (i.e., 18-25 years old, 26-30 years old, 31-35 years old, and more than 35 years old). Previous studies (e.g., Meyer, Russell, Hammack, Frost & Wilson, 2021; Puckett, Tornello, Mustanski & Newcomb, 2022) found that sexual and gender identity milestones (e.g., self-identification, coming out, etc.) occurred much earlier in younger cohorts than in older cohorts. However, minority stress remained unchanged, and mental health was better in the older cohorts. In Italy, Rosati and colleagues (Rosati, Pistella, Nappa & Baiocco, 2020) found in a sample of 266 Italian LGBQ+ aged 20-80 that younger generations became self-aware, self-labeled, and came out earlier than older generations. Scandurra et al. (2023) found no differences between age groups in identity affirmation. Instead, the youngest generation reported poorer psychological well-being than the older, with a small effect size. Given contradictory results, we cannot make specific hypotheses on this issue.

Finally, the association between sexual identity development, history of childhood trauma, anxiety, and depressive symptoms will be explored. Since previous research has found that a positive LGB+ identity is inversely associated with depressive symptoms and positively associated with psychological well-being (e.g., Petrocchi et al., 2020; Rostosky, Cardom, Hammer & Riggle, 2018), we hypothesized that lower-level of self-acceptance would be associated with higher levels of anxiety and depressive symptoms. Having experienced childhood trauma was

expected to be associated with higher anxiety and depressive symptoms.

METHOD

Participants

A sample of 326 bisexual individuals (% *F* = 73.9%) agreed to participate in the study. The majority of the sample were 18-25 years old (80.4%; *n* = 262), 12% (*n* = 39) were 26-30 years old, 3.1% (*n* = 10) were 31-35 years old, and 4.6% (*n* = 15) were more than 35 years old. Regarding educational qualifications, 62% reported having a high school diploma, 20.6% had a bachelor's degree, 8.3% had a master's degree, 5.27% had a middle school diploma, 3.1% had postgraduate education, and .9% declared having other educational qualifications.

Procedure

Participants were recruited using advertisements on social network groups and thematic forums. Participants were informed that participation was voluntary and anonymous and that confidentiality was guaranteed. A web link directed the participants to the study website. The first page of the study website explained the confidentiality of the data, and the informed consent was presented. If participants consented to engage in the study, they were directed to a second page containing basic demographic questions and the self-report questionnaires. No remunerative rewards were given. Ethical approval for this study was obtained from the institutional review board of the University of Florence.

Measures

– *Beck Anxiety Inventory*. The Italian version (Sica & Ghisi, 2007) of the 21-item *Beck Anxiety Inventory* (*BAI*; Beck, Epstein, Brown & Steer, 1988) was used to assess symptoms of anxiety (i.e., fear of losing control, inability to relax) during the last week, including the day of completion of the questionnaire. Participants answered on a four-point Likert scale ranging from 0 = not at all to 3 = severely. The final score ranges from 0 to 63, with higher scores indicating greater anxiety. The BAI showed good reliability and validity for assessing anxiety symptoms in both anxiety patients and nonclinical adults (Beck et al., 1988; Carlucci et al., 2018; de Beurs, Wilson, Chambless, Goldstein & Feske, 1997). Cronbach's alpha for the current study was .97.

– *Beck Hopelessness Scale*. The Italian version (Pompili et al., 2009) of the 20-item true/false *Beck Hopelessness Scale* (BHS; Beck, Weissman, Lester & Trexler, 1974) was used to assess hopelessness, or the severity of negative attitudes toward the future. Participants were instructed to respond to sample items with true or false while referring to the previous week (e.g., "I never get what I want"). The BHS showed good psychometric properties in general and clinical populations (Beck et al., 1974; Dyce, 1996; Kocalevent et al., 2017; Steed, 2001). Cronbach's alpha for the current study was .91.

– *Childhood Trauma Questionnaire – Short Form*. The Italian version (Sacchi, Vieno & Simonelli, 2018) of the *Childhood Trauma Questionnaire – Short Form* (*CTQ-SF*; Bernstein et al., 2003) was used to investigate whether participants had experienced trauma in their childhood. The CTQ-SF is a 28-item self-report questionnaire on a five-point Likert scale ranging from 1 = never true to 5 = very often true; the final score ranges from 5 (absence of traumatic events) to 25 (severe history of abuse). The five scales which composed the CTQ-SF and their definitions are: (i) Emotional Abuse (CTQ-EA), defined as a verbal assault of a child by an adult or older person that affects the child's sense of worth and well-being; (ii) Physical Abuse (CTQ-PA), defined as any physical assault committed by an adult or an older person toward a child that resulted in, or had the risk of, injury; (iii) Sexual Abuse (CTQ-SA), referred to any sexual contact or behavior between a child younger than 18 years and an adult or a person at least six years older; (iv) Emotional Neglect (CTQ-EN), the inability of caregivers to meet children's basic emotional and psychological needs; and (v) Physical Neglect (CTQ-PN), the inability of caregivers to provide child's basic physical needs such as food, safety, health care, and clothing. The scale performs equivalently across diverse clinical and nonclinical populations (Bernstein et al., 2003). Additionally, the scales have good internal consistency reliability (Thombs, Bernstein, Lobbestael & Arntz, 2009). Cronbach's alphas for each scale in the current study were α = .88 for CTQ-EA, α = .87 for CTQ-PA, α = .92 for CTQ-SA, α = .88 for CTQ-EN, and α = .87 for CTQ-PN.

– *Lesbian, Gay, and Bisexual Identity Scale – Revised version.* The *Lesbian, Gay, and Bisexual Identity Scale – Revised version* (*LGBIS-RV*; Mohr & Kendra, 2011) is a 27-item self-report measure used to investigate eight dimensions related to lesbian, gay and bisexual identity; for the present study, a preliminary Italian translation of this scale was used. Participants gave their answers on a seven-point Likert scale ranging from 1 = strongly disagree to 7 = strongly agree. The dimensions of the questionnaire are: (i) Concealment Motivation (LGBIS-CM), concern with and motivation to protect one's privacy as an LGB person (sample item "My sexual orientation is a very personal and private matter"); (ii) Identity Uncertainty (LGBIS-IU), uncertainty about one's sexual orientation identity ("I get very confused when I try to figure out my sexual orientation"); (iii) Internalized Homonegativity (LGBIS-IH), rejection of one's LGB identity ("If it were possible, I would choose to be straight"); (iv) Difficult Process (LGBIS-DP), perception that one's LGB identity development process was difficult ("Admitting to myself that I'm an LGB person has been a very slow process"); (v) Acceptance Concerns (LGBIS-AC), concern with the potential for stigmatization as an LGB person ("I think a lot about how my sexual orientation affects the way people see me"); (vi) Identity Superiority (LGBIS-IS), a view favoring LGB people over heterosexual people ("I look down on heterosexuals"); (vii) Identity Centrality (LGBIS-IC, the view of one's LGB identity as central to one's overall identity ("Being an LGB person is a very important aspect of my life"); and (viii) Identity Affirmation (LGBIS-IA) affirmation of one's LGB identity ("I am proud to be LGB"). The scale demonstrated good test-retest stability after six weeks and high internal consistency reliability. Cronbach's alphas for each scale in the current study were $\alpha = .71$ for LGBIS-CM, $\alpha = .82$ for LGBIS-IU, $\alpha = .82$ for LGBIS-IH, $\alpha = .88$ for LGBIS-DP, $\alpha = .81$ for LGBIS-AC, $\alpha = .75$ for LGBIS-IS, $\alpha = .74$ for LGBIS-IC, and $\alpha = .89$ for LGBIS-IA.

Statistical analysis

Statistical analysis was performed using IBM Statistical Package for the Social Sciences (SPSS), version 23.0 (IBM Corp., Armonk, NY, USA). Gender and age differences in the study variables were examined through a one-way ANOVA. To analyze the associations between anxiety, hopelessness, a history of childhood trauma, and sexual identity development dimensions, Pearson's correlations were computed.

RESULTS

Age and gender differences for the study variables are reported in Table 1 and Table 2, respectively.

Concerning age differences, significant differences were found between the highest (<35 years old) and the lowest (18-25 years old) age groups. Compared to participants who were older than 35, bisexual individuals who were between 18 and 25 years old reported significantly lower scores in concealment motivation ($F = 3.07$, $p = .028$; $M = 14.15$, $SD = 2.48$ and $M = 11.26$, $SD = 3.66$ respectively) and in identity superiority ($F = 4.60$ $p = .004$; $M = 7.15$, $SD = 3.65$ and $M = 4.75$, $SD = 2.51$respectively). Finally, the 18- to 25-year-old participants reported significantly higher scores in identity affirmation than those older than 35 ($F = 2.68$, $p = .047$; $M = 14.36$, $SD = 3.39$ and $M = 11.69$, $SD = 2.63$ respectively).

Regarding gender differences, men had lower scores for anxiety symptoms ($F = 7.19$, $p = .001$, men: $M = 17.63$, $SD = 11.84$; women: $M = 23.67$, $SD = 12.57$), emotional abuse experienced during childhood ($F = 6.19$, $p = .002$; men: $M = 8.78$, $SD = 4.61$; women: $M = 11.20$, $SD = 5.49$), and identity affirmation ($F = 21.45$, $p = .000$, men: $M = 11.91$, $SD = 4.09$; women: $M = 14.85$, $SD = 2.86$) than women. Men scored significantly higher than women on concealment motivation ($F = 16.95$, $p<.001$, men: $M = 13.68$, $SD = 3.47$; women: $M = 10.81$, $SD = 3.47$), identity uncertainty ($F = 5.44$, $p = .005$, men: $M = 13.55$, $SD = 5.80$; women: $M = 11.47$, $SD = 4.69$ internalized homonegativity ($F = 23.38$, $p<.001$, men: $M = 8.65$, $SD = 4.36$; women: $M = 5.42$, $SD = 2.91$), difficult process ($F = 4.33$, $p = .014$, men: $M = 10.95$, $SD = 3.76$; women: $M = 9.43$, $SD = 3.48$), acceptance concerns ($F = 10.04$, $p<.001$, men: $M = 12.17$, $SD = 4.24$; women: $M = 9.54$, $SD = 4.04$) and identity superiority ($F = 3.52$, $p = .031$; men: $M = 5.45$, $SD = 3.17$; women: $M = 4.55$, $SD = 2.23$).

Descriptive statistics and correlations are presented in Table 3. Sexual identity acceptance concerns were positively associated with anxiety levels ($r = .122$, $p<.05$). Statistically significant positive correlations were found between all the subscales of the CTQ and anxiety symptoms and hopelessness, indicating that the experience of childhood trauma was associated with greater levels of anxiety (CTQ-EA: $r = .262$,

Table 1 – Comparisons of the study variables between age groups

	18-25	26-30	31-35	>35			
	M±*SD*	*M*±*SD*	*M*±*SD*	*M*±*SD*	*F*	*p*	Bonferroni post hoc test
BAI	22.56±12.41	20.77±13.17	17.60±11.13	21.47±15.45	.69	.555	
BHS	8.60±5.22	8.74±6.21	5.20±5.29	8.93±5.85	1.34	.260	
CTQ-EA	10.60±5.27	11.57±6.34	9.89±6.68	9.6±4.14	.69	.561	
CTQ-PA	6.56±3.33	7.00±4.16	6.56±3.28	8.00±4.51	.86	.460	
CTQ-SA	6.93±4.32	6.68±4.19	6.78±4.05	7.29±4.23	.08	.972	
CTQ-EN	12.33±4.94	13.03±5.59	11.00±7.09	12.57±5.14	.43	.731	
CTQ-PN	6.91±2.43	9.08±3.49	6.56±1.94	7.71±3.71	1.45	.229	
LGBIS-CM	11.26±3.66	11.81±3.82	12.86±2.61	14.15±2.48	3.07	.028	“>35”>“31-35”>“26-30”>“18-25”
LGBIS-IU	11.96±5.16	11.64±4.92	11.71±4.72	11.92±4.21	.04	.987	
LGBIS-IH	6.14±3.55	6.03±4.16	5.14±1.77	8.08±2.78	1.44	.229	
LGBIS-DP	10.01±3.71	9.63±3.81	8.86±3.24	9.08±2.61	.49	.692	
LGBIS-AC	10.26±4.31	10.00±4.45	8.57±2.57	10.31±4.13	.38	.770	
LGBIS-IS	4.75±2.51	4.25±2.09	4.14±1.34	7.15±3.65	4.60	.004	“>35”>“18-25”>“26-30”>“31-35”
LGBIS-IC	16.07±4.27	16.91±5.09	16.33±5.01	17.25±4.73	.55	.649	
LGBIS-IA	14.36±3.39	13.83±3.71	14.43±2.37	11.69±2.63	2.68	.047	“18-25”>“31-35”>“26-30”>“>35”

Legenda. BAI = *Beck Anxiety Inventory*; BHS = *Beck Hopelessness Scale*; CTQ = *Childhood Trauma Questionnaire – Short Form*; CTQ-EA = CTQ-Emotional Abuse; CTQ-PA = CTQ-Physical Abuse; CTQ-SA = CTQ-Sexual Abuse; CTQ-EN = CTQ-Emotional Neglect; CTQ-PN = CTQ-Physical Neglect; LGBIS = *Lesbian, Gay, and Bisexual Identity Scale – Revised Version*; LGBIS-CM = LGBIS-Concealment Motivation; LGBIS-IU = LGBIS-Identity Uncertainty; LGBIS-IH = LGBIS-Internalized Homonegativity; LGBIS-DP = LGBIS-Difficult Process; LGBIS-AC = LGBIS-Acceptance Concerns; LGBIS-IS = LGBIS-Identity Superiority; LGBIS-IC = LGBIS-Identity Centrality; LGBIS-IA = LGBIS-Identity Affirmation.

Table 2 – Comparisons of the study variables between men and women

	Male (M)	**Female (F)**			
	M±*SD*	*M*±*SD*	*F*	*p*	Bonferroni post hoc test
BAI	17.63±11.84	23.67±12.57	7.19	.001	F>M
BHS	7.96±5.59	8.64±5.29	1.16	.191	
CTQ-EA	8.78±4.61	11.20±5.49	6.19	.002	F>M
CTQ-PA	6.27±2.98	6.82±3.67	.66	.515	
CTQ-SA	6.11±3.08	7.08±4.41	4.06	.018	F>M
CTQ-EN	11.41±5.11	12.67±5.06	2.02	.134	
CTQ-PN	6.71±2.24	7.14±2.74	.73	.483	
LGBIS-CM	13.68±3.47	10.81±3.47	16.95	.000	M>F
LGBIS-IU	13.55±5.80	11.47±4.69	5.44	.005	M>F
LGBIS-IH	8.65±4.36	5.42±2.91	23.38	.000	M>F
LGBIS-DP	10.95±3.76	9.43±3.48	4.33	.014	M>F
LGBIS-AC	12.17±4.24	9.54±4.04	10.04	.000	M>F
LGBIS-IS	5.45±3.17	4.55±2.23	3.52	.031	M>F
LGBIS-IC	15.87±4.69	16.41±4.36	.51	.601	
LGBIS-IA	11.91±4.09	14.85±2.86	21.46	.000	F>M

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Table 3 – Descriptive statistics and bivariate correlations between the study variables

	M±*SD*	BAI	BHS	CTQ -EA	CTQ -PA	CTQ -SA	CTQ -EN	CTQ -PN	LGBIS-CM	LGBIS -IU	LGBIS -IH	LGBIS -DP	LGBIS -AC	LGBIS -IS	LGBIS-IC	LGBIS -IA
BAI	22.14±12.60	1														
BHS	8.53±5.38	.366**	1													
CTQ-EA	10.64±5.40	.262**	.234**	1												
CTQ-PA	6.68±3.49	.186**	.107	.646**	1											
CTQ-SA	6.91±4.27	.194**	.118*	.343**	.293**	1										
CTQ-EN	12.39±5.08	.215**	.287**	.742**	.499**	.245**	1									
CTQ-PN	7.04±2.64	.222**	.118*	.579**	.527**	.248**	.615**	1								
LGBIS-CM	3.83±1.22	−.015	.023	−.124*	−.098	−.116	−.111	−.098	1							
LGBIS-IU	2.98±1.26	.118	.096	.03	.061	−.019	.036	.104	.361**	1						
LGBIS-IH	2.06±1.19	.017	.054	−.047	−.047	−.052	.002	.06	.426**	.436**	1					
LGBIS-DP	3.40±1.42	.001	.064	.04	.022	.069	.06	.08	.300**	.226**	.360**	1				
LGBIS-AC	3.29±1.21	.122*	−.006	.036	.031	.101	.066	.048	.324**	.278**	.376**	.429**	1			
LGBIS-IS	1.59±.85	.135*	.058	.043	.069	.063	.018	.086	.130*	.259**	.126*	.062	.209**	1		
LGBIS-IC	3.25±.88	−.017	−.062	.054	−.045	.024	.003	−.03	−.056	−.221**	−.066	.095	.146*	.189**	1	
LGBIS-IA	4.72±1.14	.029	−.024	−.018	−.059	.058	−.095	−.09	−.364**	−.347**	−.626**	−.206**	−.183**	.068	.291**	1

Legenda. BAI = *Beck Anxiety Inventory*; BHS = *Beck Hopelessness Scale*; CTQ = *Childhood Trauma Questionnaire – Short Form*; CTQ-EA = CTQ-Emotional Abuse; CTQ-PA = CTQ-Physical Abuse; CTQ-SA = CTQ-Sexual Abuse; CTQ-EN = CTQ-Emotional Neglect; CTQ-PN = CTQ-Physical Neglect; LGBIS = *Lesbian, Gay, and Bisexual Identity Scale – Revised Version*; LGBIS-CM = LGBIS-Concealment Motivation; LGBIS-IU = LGBIS-Identity Uncertainty; LGBIS-IH = LGBIS-Internalized Homonegativity; LGBIS-DP = LGBIS-Difficult Process; LGBIS-AC = LGBIS-Acceptance Concerns; LGBIS-IS = LGBIS-Identity Superiority; LGBIS-IC = LGBIS-Identity Centrality; LGBIS-IA = LGBIS-Identity Affirmation.

$p<.001$; CTQ-PA: $r = .186$, $p<.001$; CTQ-SA: $r = .194$, $p<.001$; CTQ-EN: $r = .215$, $p<.001$; CTQ-PN: $r = .222$, $p<.001$) and hopelessness (CTQ-EA: $r = .234$, $p<.001$; CTQ-SA: $r = 118$, $p<.05$; CTQ-EN: $r = 287$, $p<.001$; CTQ-PN: $r = .118$, $p<.05$).

DISCUSSION

To date, few studies have examined the psychological well-being of bisexual people in Italy. The current study attempted to enrich the existing evidence by investigating psychological difficulties and some related factors in a sample of Italian bisexual individuals, considering age and gender differences.

Regarding age differences in sexual identity development dimensions, we found that participants who were between 18 and 25 years old reported lower scores in concealment motivation and identity superiority and higher scores in identity affirmation than participants older than 35 years. Consistent with some previous studies (e.g., Meyer et al., 2021; Puckett et al., 2022) bisexual young adults seem to be less concerned with their bisexual orientation and have more positive feelings about their LGB identity than older bisexual individuals. Popular views of sexuality in Western societies have long maintained a firm binary construction wherein sexualities were either heterosexual or same-sex sexual orientation. Only recently have more individuals stepped outside monosexual identity categories to claim labels that better align with their attraction to more than one gender, such as bisexual (Copen et al., 2016). Age has also been identified as a factor related to LGB identity development, and several researchers have found younger ages of disclosure to be related to greater comfort with sexual orientation (e.g., Floyd & Stein, 2002). A study conducted among a sample of LGB adolescents and young adults (Bregman, Malik, Page, Makynen & Lindahl, 2013) found that the majority of LGB youth experienced identity affirmation (i.e., had minimal internalized homonegativity, and lower scores on the acceptance concerns, identity uncertainty, and difficult process subscales), highlighting the considerable resiliency of sexual minority youth against identity struggles in the face of societal stigma. Regarding gender differences, in accordance with our hypothesis, bisexual men reported more uncertainty and concern about their sexual orientation, more internalized homonegativity, and more difficulties in their LGB identity development and acceptance than bisexual women. Research also indicates that females are more likely to identify as bisexual and to vacillate between identity labels (Diamond, 2007). A recent systematic review and meta-analysis on sexual orientation identity development among LGB+ people (Hall et al., 2021) showed that females reached the main milestones in a shorter time than males. The authors suggested that the more prolonged process for males could be due to men having higher levels of internalized heterosexism, which may delay coming out and starting an LGB+ relationship.

Consistent with previous studies (e. g. Bostwick, Boyd, Hughes, West & McCabe, 2014; Persson & Pfaus, 2015), bisexuals in our sample report anxiety associated with hopelessness; mean scores (22.14±12.60) on the B*eck Anxiety Scale* (Beck et al., 1988) indicate moderate anxiety, which could reflect emotional difficulties that this population might face with. Bisexual individuals, in fact, face unique minority stressors related to their bisexual orientation, including anti-bisexual stigma or biphobia in heterosexual as well as in lesbian and gay communities (Brewster et al., 2013; Chmielewski & Yost, 2013; Mulick & Wright, 2002; Roberts, Horne & Hoyt, 2015). This could be also observed in mean scores obtained in our sample at the *Lesbian, Gay, and Bisexual Identity Scale – Revised version* (Mohr & Kendra, 2011) which are higher than normative data in the subscales of concealment motivation, identity uncertainty, internalized homonegativity and difficult process and lower in the subscale of acceptance concerns, identity superiority, identity centrality and identity affirmation; it is important to note that mean scores obtained by Mohr and Kendra (2011) had been computed on a sample composed of 70% of individuals with same-sex sexual orientation and 30% of bisexual individuals.

Consistent with previous studies (Balsam & Mohr, 2007; Chan, Operario & Mak, 2020; Kuyper & Fokkema, 2011), bisexual individuals seem more prone to protect their privacy as an LGB person and feel less involved in LGB+ community. This may be because, as reported in the literature (Feinstein, Dyar & London, 2017), coming out can expose bisexual individuals to double discrimination from both heterosexual and same-sex sexual orientation communities.

In line with previous studies (e.g., Chan et al., 2020), we found that bisexual individuals with higher sexual identity acceptance concerns reported more anxiety symptoms. Previous studies involving Italian sexual minority populations had already investigated the association between stigma and psychological health, concluding that these individuals might deal with additional stressors associated

with the not very accepting socio-cultural context in which they live (e. g. Pistella, Caricato & Baiocco, 2020). Finally, we found that experiences of childhood trauma were associated with greater anxiety and hopelessness.

Limitations

The limitations of the current study are mainly related to the sample characteristics. Recruiting via social media and adopting non-random sampling method limited the generalizability of the current findings to other more aged populations. Moreover, the sample was mainly composed of women. In addition, the use of self-report measures can lead to biases in respondents such as social desirability or lack of introspection. Future studies could shed light on the experience of bisexual individuals in Italy through larger and more representative samples and by considering comparisons with the heterosexual population. Moreover, cross-cultural studies are needed in order to evaluate the potential influence of the Italian socio-cultural context.

Implications

As suggested by Hendricks and Testa (2012), for counselling and/or psychotherapy interventions, clinicians need to assess the different dimensions of minority stress. Investigating the psychological well-being of the bisexual population and the possible causes of potential psychological distress could direct clinicians toward a better understanding of their specific vulnerabilities and needs. Without neglecting the uniqueness of the individual, an extremely vital topic in psychology, understanding the context and the social and cultural communities in which the individual is inserted remains important. The bisexual population faces unique stereotypes, prejudices and difficulties compared to other LGB+ sexual minorities. Knowledge of these challenges can certainly improve both in the assessment and treatment phases of therapy. Social and psychoeducational interventions are also necessary to transform the monosexist culture and eradicate binegativity in the LGB+ and wider communities.

CONCLUSIONS

Although explorative, the current study sheds light on some aspects of the psychological well-being of a sample of Italian bisexual individuals, a population highly underrepresented in the literature. Moderate levels of anxiety, as well as difficulties in bisexual identity development (e.g., identity uncertainty, internalized homonegativity and low level of involvement in the LGB+ community), were found. Moreover, those aspects seem to correlate, confirming what was previously reported by studies conducted in other countries (e.g., Chan et al., 2020), that bisexual individuals face unique stressors. Addressing bisexual-specific minority stress is necessary to improve the psychological well-being of individuals with a bisexual orientation. Still, fortunately, Italian bisexual youths seem to be more resilient against identity struggles in the face of societal stigma.

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