

Summer 8-2022

The Association of Objectification and Discrimination with Partner Gender and Disordered Eating Behaviors in Bisexual Women

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**The Association of Objectification and Discrimination with
Partner Gender and Disordered Eating Behaviors in Bisexual Women**

By

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A Dissertation Submitted to the Faculties of Eastern Virginia Medical School, Norfolk State
University, and Old Dominion University in Partial Fulfilment of the Requirements of the
Degree of

DOCTOR OF PHILOSOPHY

CLINICAL PSYCHOLOGY

THE VIRGINIA CONSORTIUM PROGRAM IN CLINICAL PSYCHOLOGY
August 2022

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ABSTRACT

THE ASSOCIATION OF OBJECTIFICATION AND DISCRIMINATION WITH PARTNER GENDER AND DISORDERED EATING BEHAVIORS IN BISEXUAL WOMEN

Rachel A. Amerson
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Sexual minority women are at increased risk of negative outcomes compared to heterosexual women. Bisexual women report disparities when compared to both heterosexual and lesbian women. The disparities experienced by bisexual women also appear to vary based on the gender of their partner, with those partnered with men reporting more negative health outcomes than those partnered with women. One area in which heterosexual and sexual minority women's experiences differ is in the experience of objectification or being treated as a body rather than a person. While objectification has been linked to negative outcomes, such as body shame and disordered eating behaviors, in heterosexual women, the findings regarding sexual minority women have been inconsistent, with little research on the experiences of bisexual women, specifically. The current study aimed to expand the literature on bisexual women's experience of objectification and its relation to partner gender. Two groups of bisexual women, those currently in relationships with women and those currently in relationships with men, were recruited in order to test a model of objectification theory. Results indicated that objectification and discrimination were significantly related to disordered eating behaviors, but not to body surveillance or body shame. Additionally, partner gender moderated the association of discrimination with body surveillance, but no other hypothesized pathways. The results of this study suggest that the experiences of objectification and body image may be different for bisexual women compared to heterosexual and lesbian women.

ACKNOWLEDGEMENTS

I would like to thank the American Institution of Bisexuality's Bisexual Foundation for funding this project and my committee for their insights.

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CHAPTER I

INTRODUCTION

Body dissatisfaction is commonly experienced by women (Bucchianeri et al., 2013; Mond et al., 2013; Rodin et al., 1984). In studies of adult women from 18-42 years, up to 86% of women reported some level of body dissatisfaction, with over 30% reporting moderate or higher levels of body dissatisfaction (Mond et al., 2013; Tan et al., 2019). In college samples of men and women from 18-24, between 45% (Hong et al., 2015) and 69% (Ferrari et al., 2013) reported experiencing body dissatisfaction.

Although body dissatisfaction is common among women, it varies as a function of age (Bucchianeri et al., 2013; Green & Pritchard, 2003; Runfola et al., 2012). For example, in a sample of Spanish women, body dissatisfaction was lower in women over 55 than in younger women (Esnaola et al., 2010). Similarly, in a U.S. sample, college aged women reported more body dissatisfaction than their mothers, whose ages ranged from 38 to 58 (Forbes et al., 2005). Likewise, in an Australian sample, adults 51 to 75 reported higher body appreciation than those 18 to 49 (Tiggemann & McCourt, 2013). Also, in a longitudinal study that followed women from middle and high school for 10 years, body dissatisfaction increased from adolescence to emerging adulthood and continued to increase into young adulthood (Bucchianeri et al., 2013). These findings suggest that young adulthood is a time when body dissatisfaction may be particularly high for women.

Body dissatisfaction has been linked to negative outcomes, such as poor life satisfaction, depression, self-esteem, and disordered eating behaviors (Ganem et al., 2009; Ward & Hay, 2015). Disordered eating behaviors include unhealthy weight control practices such as bingeing, purging, fasting, or chronic dieting (Mintz & Betz, 1988). In samples of young women aged 17

and 24, between 23% (Nagata et al., 2018) and 65% (Mintz & Betz, 1988) reported some form of disordered eating behavior. Of those who engaged in disordered eating behaviors, 54% engaged in these behaviors daily, and 28% engaged in them more than once a day (Mintz & Betz, 1988). In fact, in Mintz and Betz's (1988) sample of undergraduate women, only 35% were classified as exhibiting normal eating behaviors. Among young women, some of the more common disordered eating behaviors reported during their lifetime include dieting and restricting behaviors (74-82%; Fitzsimmons-Craft et al., 2016; Mintz & Betz, 1988), excessive exercising (30-79%; Berg et al., 2009; Fitzsimmons-Craft et al., 2016), and binge eating (7-38%; Mintz & Betz, 1988; Nagata et al., 2018). Reports of less common disordered eating behaviors vary depending on the time frame being measured (the last two weeks vs. the last year), and include inducing vomiting (3-10%), taking laxatives, diuretics, or appetite suppressants (4-17%), and binge eating (7-28%; Berg et al., 2009; Fitzsimmons-Craft et al., 2016; Mintz & Betz, 1988; Nagata et al., 2018; Rohde et al., 2017). Given the high rate of disordered eating behaviors in young women, it is important to understand what factors are associated with them. Much of the extant research, however, has focused on the experiences of heterosexual women. Therefore, it is important to expand our knowledge to include the experiences of body dissatisfaction and disordered eating behaviors in sexual minority women (SMW) as well.

Health Disparities among Sexual Minority Women

Numerous health disparities have been documented between SMW (women who identify as a sexual orientation other than heterosexual) and heterosexual women. For example, lesbian and bisexual women were more likely than heterosexual women to experience psychological distress, such as depression and anxiety (Gonzales et al., 2015; Woodford et al., 2014).

Compared to heterosexual women, SMW were also at increased risk of heavy drinking, smoking, and illicit drug use (Gonzales et al., 2015; Operario et al., 2015).

SMW experience unique stressors compared to heterosexual women. These additional stressors are referred to as sexual minority stress (SMS) and may explain health disparities in this vulnerable group (Frost et al., 2015; Meyer, 2003; Woodford et al., 2014). For example, sexual minority men and women who experienced prejudice events were more likely to develop physical health problems such as cancer or hypertension, and chronic health conditions (Frost et al., 2015; Gonzales et al., 2015). Similarly, SMW who reported discrimination were at higher risk for mental illness (Bostwick et al., 2014; Mays & Cochran, 2001).

Additional disparities have been reported for disordered eating behavior and body image. Heterosexual women and SMW reported different experiences of disordered eating behaviors and factors that are related to disordered eating behaviors such as body image. For example, lesbian women were happier with their bodies and reported less body dissatisfaction than heterosexual women (Alvy, 2013; Miller & Luk, 2018; Polimeni et al., 2009; Wagenbach, 2003). Women who expressed same-sex attraction indicated less awareness of norms related to weight and less negative attitudes toward higher weight than women who expressed opposite-sex attraction (Bankoff et al., 2015). Similarly, heterosexual women also reported placing more importance on their appearance and more involvement in maintaining physical appearance than did lesbian women (Leavy & Hastings, 2010; Wagenbach, 2003). In samples of adult women, lesbian women had a lower drive for thinness, defined as the degree of concern with dieting and weight, than heterosexual women (Garner et al., 1983; Moore & Keel, 2003; Wagenbach, 2003) and were less concerned with dieting than heterosexual women (Wagenbach, 2003). Lesbian women were less likely to engage in weight control practices, such as cutting down on fats and

sugar, than heterosexual women (Polimeni et al., 2009; Moore & Keel, 2003). Likewise, lesbian women reported less disordered eating behaviors than heterosexual women (Engeln-Maddox et al., 2011; Kozee & Tylka, 2006). It is possible that these disparities may be explained by lesbian women's involvement in the lesbian, gay, and bisexual (LGB) community, which protects against body dissatisfaction and promoted healthy eating (VanKim et al., 2016).

Increased understanding of sexual minority and heterosexual women's differential body image experiences and disordered eating behaviors is essential to reducing health disparities and developing culturally tailored interventions. Disordered eating behaviors have been linked to the experience of objectification, or the experience of being treated as a body rather than a person, for both heterosexual and SMW (Fredrickson & Roberts, 1997). Experiences of objectification have been examined primarily in heterosexual women, and to a much lesser extent among SMW (e.g., Tiggeman & Williams, 2012). Even less is known about bisexual women in particular. Because many health disparities are particularly pronounced for women who identify as bisexual (Conron et al., 2010; Ehlke et al., 2020; Frost et al., 2015; Lehavot & Simoni, 2011; Przedworski et al., 2010), the current study aimed to address this gap in the literature by focusing on bisexual women's experiences of objectification.

Health Disparities in Bisexual Women

In 2011, the Institute of Medicine (IOM) released their Report on LGBT Health Issues that concluded current research has not adequately represented bisexual individuals in the study of sexual minority health (IOM, 2011). Bisexual women were more likely to have poor general health than lesbian women and rate their overall health as worse than heterosexual or lesbian women (Conron et al., 2010; Frost et al., 2015; Lehavot & Simoni, 2011; Przedworski et al., 2010). Similarly, bisexual women reported more physical health problems than heterosexual or

lesbian women (Amerson et al., 2019; Conron et al., 2010; Ehlke et al., 2020). Beyond physical health disparities, bisexual women were also more likely to experience mental distress such as tension, worry, or sadness than heterosexual women (Conron et al., 2010) and reported more depression, anxiety, and anger than heterosexual or lesbian women (Amerson et al., 2019; Bostwick et al., 2015; Ehlke et al., 2020; Kerr et al., 2013). Bisexual women in community and college samples also reported more suicidal ideation and self-harm than heterosexual or lesbian women (Conron et al., 2010; Kerr et al., 2013). Compared to heterosexual and lesbian women, bisexual women also engaged in more substance use (Bostwick et al., 2014; Feinstein & Dyar, 2017). In fact, in a sample of sexual minority adolescents, the disparity from heterosexual youth in alcohol use was greater for bisexual than gay and lesbian youth (Talley et al., 2014). Also, in samples of adult women, bisexual individuals engaged in more binge and hazardous drinking than heterosexual or lesbian women (Conron et al., 2010; Przedworski et al., 2010). Taken together, there is ample evidence that physical and mental health disparities are particularly pronounced for bisexual women compared to lesbian and heterosexual women.

Disordered Eating Behavior and Body Image in Bisexual Women

With regard to disordered eating behavior, bisexual women may be at higher risk compared to heterosexual women. For example, bisexual women reported more disordered eating behaviors than heterosexual women in a sample of adults (Davids & Green, 2011) and were more likely to misperceive themselves as overweight than heterosexual women in an adolescent sample (Hadland et al., 2014). Specifically, binge eating was more common in bisexual than in heterosexual women and purging was more common in bisexual women than in heterosexual or lesbian women in samples that included adolescents and young adults (Austin et al., 2009; Laska et al., 2015). Researchers also found that adolescent and young adult bisexual

women were more likely than heterosexual women to attempt to lose weight and to weight cycle (Hadland et al., 2014; Polimeni et al., 2009). When trying to lose weight, bisexual women more often used unhealthy weight control practices such as smoking and cutting meals to control weight than heterosexual women (Laska et al., 2015; Polimeni et al., 2009). Regarding physical activity, bisexual women were also less likely than heterosexual women to engage in strengthening activities (Laska et al., 2015). There is limited research comparing disordered eating behaviors between lesbian and bisexual women, and the research that does exist yields conflicting findings. In one study, bisexual women reported more purging behaviors than lesbian women (Austin et al., 2009); however, another study found no differences in disordered eating behaviors between lesbian and bisexual women (Henn et al., 2019). More research is needed to clarify how lesbian and bisexual women's experiences of disordered eating behaviors may be different.

Although disparities in disordered eating behaviors and physical activity have been reported, limited research on the body image of bisexual women specifically have yielded mixed results. Adult bisexual women reported lower general self-esteem than heterosexual and lesbian women, which was related to less body appreciation (Burnette et al., 2019; Davids & Green, 2011; Yean et al., 2013). However, the association of self-esteem to body image was weaker in bisexual women than in lesbian or queer women (Burnette et al., 2019). In samples of Spanish, German, and New Zealand participants, adult lesbian, heterosexual, and bisexual women did not report differences in body dissatisfaction or body image (Basabas et al., 2019; Henn et al., 2019; Moreno-Dominguez et al., 2019); however, in a U.S. sample of adult sexual minority women, bisexual women reported less body satisfaction than lesbian women (Steele et al., 2019). Another study by Fredrick and colleagues (2022a) found only small differences in body dissatisfaction

between heterosexual, lesbian, and bisexual women. Bisexual women also reported more frequent body checking than heterosexual or lesbian women, and more investment in their appearance than lesbian women (Moreno-Dominguez et al., 2019). Internalization of societal standards of beauty has also been found to be stronger in bisexual individuals than in heterosexual and gay and lesbian individuals (Fredrick et al., 2022b). Taken together, these findings demonstrate that bisexual women may perceive and interact with their bodies differently than heterosexual and lesbian women. However, the findings in the current literature have been inconsistent, and further research is needed to clarify bisexual women's experiences of body image.

Sexual Minority Stress Among Bisexual Women

Whereas much of the SMS and health disparity research has compared SMW in general to heterosexual women, some studies have found that bisexual women experience unique stressors and health disparities when compared to heterosexual and lesbian women. These disparities may occur because bisexual women often experience discrimination as part of the LGB community, as well as bisexual specific discrimination. Furthermore, bisexual individuals are often the targets of microaggressions, or comments that intentionally or unintentionally dismiss, belittle, or deny bisexuality (Bostwick & Hequembourg, 2014). Bisexual specific microaggressions include dismissals of bisexuality as a phase, confusion, or an illegitimate identity; fetishization or eroticization of bisexuality through assumptions of promiscuity or infidelity, or inappropriate sexual questions or propositions; pressure from others to change one's bisexual identity; and exclusion or erasure of bisexuality from events or conversations regarding sexual minority issues (Bostwick & Hequembourg, 2014; Flanders et al., 2019; Platt & Lenzen, 2013).

These unique experiences of anti-bisexual discrimination have been linked to negative health outcomes in bisexual men and women (Amerson et al., 2019; Feinstein & Dyar, 2017; Molina et al., 2015). For instance, the experience of bi-negativity, or negative attitudes toward bisexual individuals, perpetrated by others was related to depression and binge drinking in bisexual men and women; depression was also linked to internalized bi-negativity, or internalized negative attitudes about bisexuality, in a sample of women who self-identified as bisexual (Molina et al., 2015). Discrimination experienced from lesbian and gay individuals, but not heterosexual individuals, was related to more internalized bi-negativity in a sample of bisexual men and women (Arriaga & Parent, 2019). In a sample of bisexual men and women, anti-bisexual discrimination from heterosexual, but not lesbian or gay individuals, was linked to physical health and depressive symptoms indirectly through trauma (Arnett et al., 2019). Among men and women who reported attraction to both men and women, increased risk for mental health and substance use problems was linked to stress related to stigma and discrimination (Brewster et al., 2013; Feinstein & Dyar, 2017). Experiencing microaggressions was also associated specifically to greater anxiety, depression, and physical health problems in a community sample of self-identified bisexual women (Amerson et al., 2019).

Objectification Theory

One gap in the literature regarding bisexual women's experiences is how objectification may be associated with disordered eating behaviors and negative body image experienced as body shame and surveillance. Objectification Theory posits that all women are objectified, or treated as a body rather than a person, and that this experience of objectification leads to negative outcomes (Fredrickson & Roberts, 1997). Objectifying experiences include the extreme examples of sexual violence, sexual comments and harassment, as well as the everyday

experiences of being gazed at or viewed in a sexualized manner (Fredrickson & Roberts, 1997). Some of the negative outcomes of these objectifying experiences include body shame, a feeling of shame for not attaining the ideal body as defined by societal norms, and anxiety due to the knowledge that you could be evaluated at any time (Fredrickson & Roberts, 1997). Other outcomes include body surveillance and monitoring in which women adopt an observer's view of their own bodies and habitually survey their outward appearance (Fredrickson & Roberts, 1997). Objectifying experiences can also lead to disordered eating behaviors, which may be used as a way to change one's body (Fredrickson & Roberts, 1997).

In support of objectification theory, Calogero (2004) found that college women who anticipated a male gaze reported greater body shame than did college women who anticipated a female gaze, suggesting that the male gaze is uniquely objectifying and leads to negative outcomes. However, the presence of a male gaze is not necessary for these outcomes to occur. In a study by Harper and Tiggeman (2008), college women who were exposed to magazine images that featured women who represented the thin ideal reported greater appearance anxiety, negative mood, and body dissatisfaction than those who were shown a control image without a woman. This effect was found both when the picture included a male gazing at the woman, and when the picture only included the idealized woman. Studies have also demonstrated that the exposure to an objectifying media image resulted in greater self-objectification, or the act of viewing oneself as a body rather than a person, than the control condition (Harper & Tiggeman, 2008; Koval et al., 2019).

In samples of heterosexual women, objectification has been linked to negative outcomes including body surveillance, body shame, and disordered eating behaviors (Engeln-Maddox et al., 2011; Tiggeman & Williams, 2012). For example, sexually objectifying experiences, in

which one is treated as a body rather than a person, were associated with body surveillance, and body shame (Augustus-Horvath & Tylka, 2009; Engeln-Maddox et al., 2011; Tylka & Sabik, 2010). Objectifying experiences were also linked to self-objectification, which was linked to body surveillance (Hill & Fischer, 2008; Tiggeman & Williams, 2012). Similarly, body surveillance was linked to body shame, and both body surveillance and body shame were associated with disordered eating behaviors (Augustus-Horvath & Tylka, 2009; Engeln-Maddox et al., 2011; Tylka & Sabik, 2010). Together, objectification, body surveillance, and body shame explained a significant amount of the variation in disordered eating behaviors (Tiggeman & Williams, 2012). One model demonstrated that appearance anxiety, lack of internal awareness, and flow of consciousness, along with self-objectification, body surveillance, and body shame, explained 93% of the variance in disordered eating behaviors and 59% of the variance in depressed mood (Tiggeman & Williams, 2012). These findings support Fredrickson and Roberts' (1997) theory of objectification by demonstrating the link between objectifying experiences and negative outcomes.

The link between objectification and negative outcomes is not consistent across the lifespan, however. Older women reported differences in objectification and its related outcomes when compared to younger women (Augustus-Horvath & Tylka, 2009; Tiggeman & Lynch, 2001). Specifically, women over 25 report experiencing less sexual objectification than women 18 to 24 years old (Augustus-Horvath & Tylka, 2009). Women also reported less self-objectification and body monitoring and self-surveillance after the age of 39 (Augustus-Horvath & Tylka, 2009; Tiggeman & Lynch, 2001). Disordered eating behaviors were also reduced after the age of 30 (Tiggeman & Lynch, 2001). These findings suggest that the experience of objectification and the outcomes associated with it are experienced differently as women age.

Objectification Theory and Lesbian Women

Most research on Objectification Theory has focused on heterosexual women. When Objectification Theory is applied to SMW's experiences, conflicting findings emerge (Engeln-Maddox et al., 2011; Kozee & Tylka, 2006; Moradi & Tebbe, 2022). For example, in a sample of college lesbian women, objectification was linked to body surveillance, body shame, and disordered eating behaviors (Kozee & Tylka, 2006). In contrast, in community samples of lesbian women, objectifying experiences did not relate to body surveillance, body shame, or disordered eating behaviors (Engeln-Maddox et al., 2011; Moradi & Tebbe, 2022). Body surveillance, however, was associated with body shame and disordered eating behaviors in all samples (Engeln-Maddox et al., 2011; Kozee & Tylka, 2006; Moradi & Tebbe, 2022). Beyond the associations of objectification with body surveillance, sexual identity differences in body surveillance have been found. In community samples, heterosexual women reported more body surveillance than lesbian women (Engeln-Maddox et al., 2011; Fredrick et al., 2022c; Hill & Fischer, 2008), whereas in a college sample, lesbian women reported more body surveillance than heterosexual women (Kozee & Tylka, 2006). These disparate findings may be explained by demographic differences in samples. The women in the community samples were older than those in the college sample; additionally, the community samples of lesbian women were largely recruited from sexual minority specific events and may have been more connected to the lesbian, gay, and bisexual (LGB) community (Engeln-Maddox et al., 2011; Hill & Fischer, 2008; Kozee & Tylka, 2006). These findings demonstrate some inconsistency in the literature regarding objectification and body surveillance among SMW.

Sexual minority specific variables have also been examined in addition to the traditional variables of objectifying experiences, self-objectification, body surveillance, and body shame in

a sample of lesbian women. For example, sexual objectification was associated with heterosexist events, such as discrimination, rejection or harassment, and the internalization of societal appearance standards (Watson et al., 2015). Heterosexist events were also related to disordered eating behaviors in lesbian women (Watson et al., 2015). The literature on Objectification Theory suggests that for heterosexual women the experience of being objectified is linked to outcomes such as body surveillance, body shame, and disordered eating behaviors, as predicted by the theory (Fredrickson & Roberts, 1997). In samples of SMW, however, the literature is more mixed, with some evidence to support the model of objectification and other evidence suggesting that objectification may not be related to outcomes such as body surveillance and body shame in SMW. For SMW specifically, the experience of discrimination also appears to be an important factor in these outcomes (Watson et al., 2015). In order to clarify the associations of objectification with negative outcomes in SMW additional research is needed.

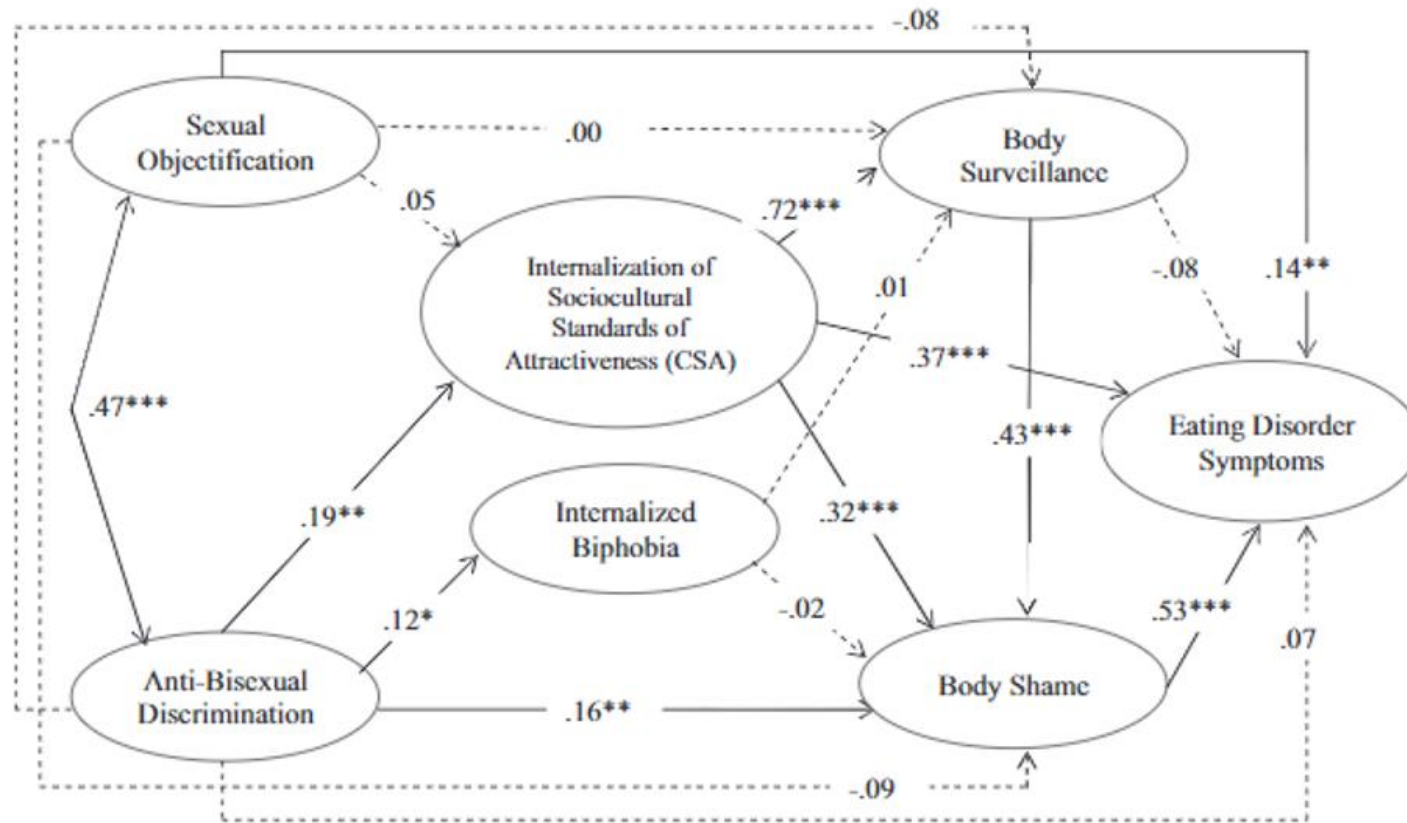
Objectification Theory and Bisexual Women

Objectification Theory has been examined in samples of sexual minority women, but the experiences of bisexual women specifically have been understudied. One notable exception is Brewster and colleagues (2014) who tested an Objectification Theory model in a sample of adult bisexual women (see Figure 1). Their model was based on previous studies with lesbian women and modified to include bisexual specific variables such as anti-bisexual discrimination and internalized bi-negativity.

Consistent with Objectification Theory, objectification was related to disordered eating behaviors in bisexual women (Brewster et al., 2014). Both body shame and internalization of societal standards were also associated with disordered eating behaviors. Body surveillance was associated with disordered eating behaviors indirectly through body shame but was not directly

Figure 1

Brewster et al. (2014) Model of Objectification Theory



related to disordered eating behaviors. Similar to other models tested in samples of sexual minority women, anti-bisexual discrimination was related to body shame, as well. The associations of anti-bisexual discrimination with body surveillance and disordered eating behaviors were mediated by internalization of societal standards and body shame.

The overall model was a good fit to the data, however there were some unexpected findings regarding the individual pathways (Brewster et al., 2014). Specifically, the pathways from sexual objectification to body surveillance and body shame were not significant. Anti-bisexual discrimination, however, was directly associated with body shame, and indirectly associated with body surveillance through internalization of social appearance standards. Overall, Brewster and colleagues (2014) concluded that anti-bisexual discrimination was more influential than objectification in model. They speculated that these findings may indicate that, given the sexualized nature of the discrimination that bisexual women experience, anti-bisexual discrimination targeted toward women is a form of objectification. It is likely that the anti-bisexual discrimination was more salient for this sample of women than forms of objectification that were not related to their sexual identity. The researchers also hypothesized that the gender of the women's partners may have an influence on their experiences of objectification and disordered eating behaviors and recommended this as a focus of future research.

Objectification, Body Image, and Partner Gender

Although it was not assessed, it is possible that the gender of the women's partners in Brewster and colleagues' (2014) sample may have influenced which type of discrimination (anti-bisexual vs. objectification) was more salient. There has been little research on the association of partner's gender with objectification, body image, and disordered eating behaviors. Previous research, however, has found that partner gender was related to other outcomes and experiences

for bisexual women. For example, in one study, bisexual women in relationships with women experienced more sexual minority discrimination than those in relationships with men (Dyar et al., 2014). Bisexual women in relationships with lesbian women reported less stress than those in relationships with straight men (Vencill et al., 2018). Bisexual women in relationships with women were also out to a greater degree than those in relationships with men (Dyar et al., 2014; Molina et al., 2015), which has been linked to lower psychological distress (Morris et al., 2001). Other researchers found that bisexual women in relationships with men reported more bisexual specific discrimination (Molina et al., 2015). Bisexual women in relationships with men also experienced more exclusion and rejection from gay men and lesbian women and greater depression than those in relationships with women (Dyar et al., 2014; Molina et al., 2015). Similarly, bisexual men with female partners reported experiencing more interpersonal hostility and assumptions of sexual irresponsibility than those with male partners (Sarno et al., 2020). These findings suggest that bisexual women who partner with men are at greater risk for psychological distress. Similarly, binge drinking and negative consequences of alcohol use are also reported more by bisexual women who are in relationships with men than those in relationships with women (Molina et al., 2015).

The limited research that does exist on bisexual women's partners gender and body image, disordered eating and objectification has yielded mixed findings (Kashubeck-West et al., 2018; Watson et al., 2018). In a sample of adolescent girls, those who were partnered with both men and women reported more disordered eating behaviors than those partnered only with men (Watson et al., 2018). However, in a sample of adult bisexual women, there was no difference in body surveillance, body shame, or body dissatisfaction between those in relationships with men and those in relationships with women (Kashubeck-West et al., 2018). Taken together, these

findings suggest that the experience of being a bisexual woman and the types of discrimination and health disparities experienced can differ based on the gender of one's partner.

Beyond the impact of partner gender on health disparities and discrimination, bisexual women who are in relationships with men also reported lower relationship satisfaction, which was linked to body surveillance, body shame, and body dissatisfaction, than bisexual women in relationships with women (Kashubeck-West et al., 2018). In addition, bisexual and lesbian women perceived that male partners pressured women to fit ideals of femininity and body shape and to be more objectifying and critical of their partner's body than female partners (Chielewski & Yost, 2013; Huxley et al., 2011). In contrast, female partners were perceived to be more understanding about the experiences of objectification (Huxley et al., 2011). These findings suggest that partner gender is related to bisexual women's relationship with their bodies; however, how partner gender is related to bisexual women's experiences of objectification and disordered eating behaviors merits further investigation.

Neuroticism

Certain personality traits, such as neuroticism, have also been linked to both body image and discrimination. For example, neuroticism was related to self-objectification and body surveillance such that those higher in neuroticism reported more frequent body surveillance (Miner-Rubino et al., 2002; Visser et al., 2014). Higher levels of neuroticism were also related to increased body shame, lower body satisfaction, and more negative appearance evaluation (Allen & Celestino, 2017; Davis et al., 2020; Holland et al., 2016; Kvalem et al., 2006). Neuroticism levels were also higher in eating disorder patients than in healthy controls (Podar et al., 2007). Neuroticism has also been linked to experiencing discrimination in a sample of older African Americans (Barnes et al., 2012). In a sample of Asian Americans and Latinx Americans, higher

levels of neuroticism were related to reporting more frequent overt discrimination and microaggressions (Lui, 2020). Neuroticism also moderated the relation between workplace discrimination and depression in a diverse sample of adults (Xu & Chopik, 2020). Additionally, neuroticism was a significant covariate of the association between discrimination and depression in gay and bisexual men (Huebner et al., 2005).

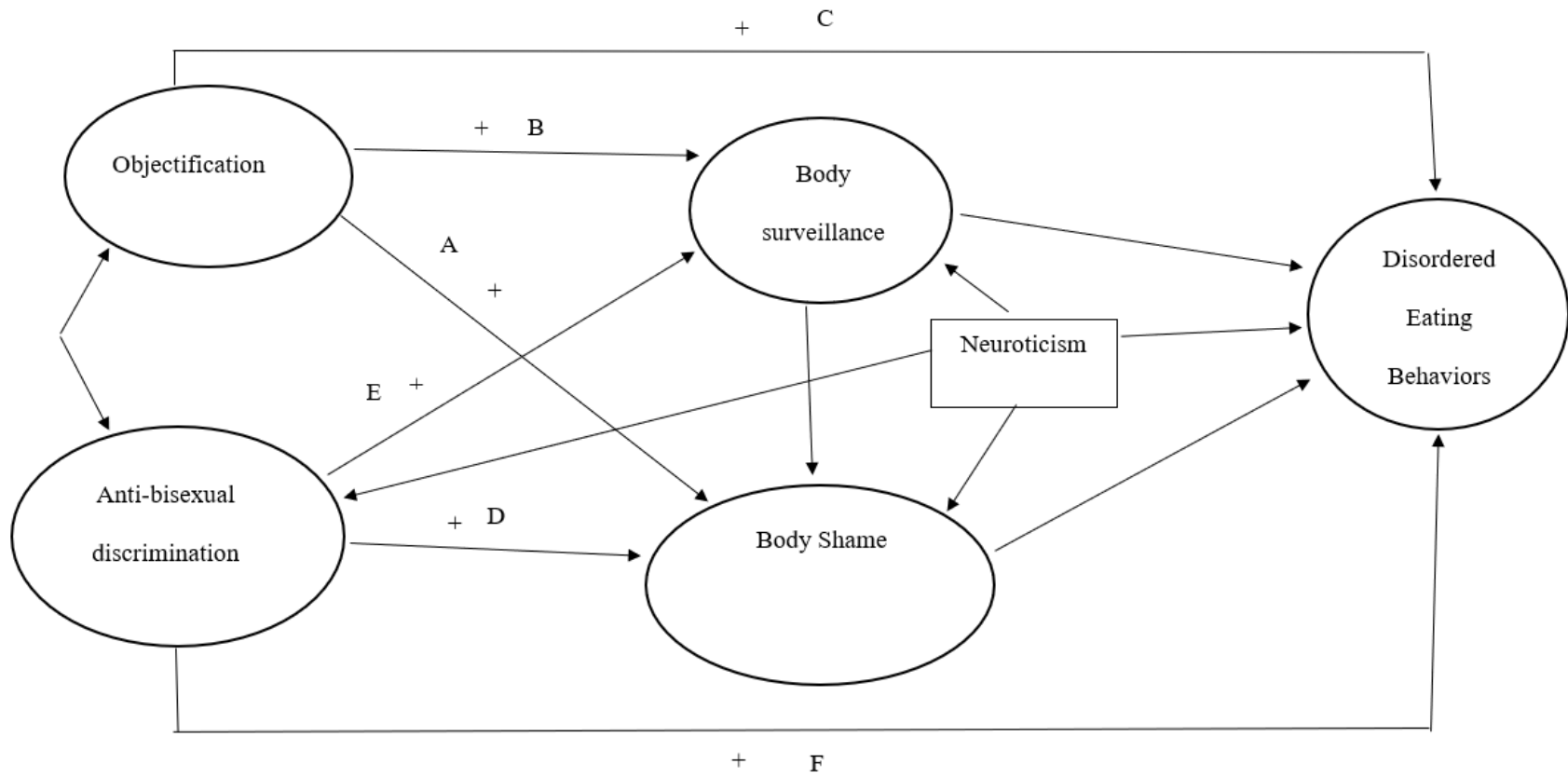
The Current Study

The research literature has expanded to include the experiences of bisexual women in many areas, including objectification (e.g., Brewster et al., 2014). However, there are still gaps in this literature regarding the relation of bisexual women's partners' gender to their experiences of objectification and disordered eating behaviors. The current study aimed to address this gap by examining a modified version of Brewster and colleagues' (2014) model in two samples of young bisexual women: those who are currently in relationships with women, and those who are currently in relationships with men (see Figure 2). Young women were chosen for the present study due to how the experience of objectification changes as women age and because of the high rates of disordered eating behaviors.

The model was simplified compared to Brewster and colleagues (2014) by removing internalized societal standards and internalized bi-negativity and neuroticism was added as a covariate to control for emotional reactivity. The model was simplified in order to reduce the number of participants required to obtain sufficient power for the analyses. Since objectification was related to body surveillance, body shame, and disordered eating behaviors in previous literature, it was expected to be associated with these variables in the current study (Brewster et al., 2014; Tiggemann & Williams, 2012; Kozee & Tylka, 2006).

Figure 2

Hypothesized Model



Based on qualitative studies in which men were identified as being more objectifying than women, it was expected that partner gender would moderate the relations between objectification and body-related variables and disordered eating behaviors (hypotheses 1-3; Chielewski & Yost, 2013; Huxely et al., 2011). Anti-bisexual discrimination was related to body shame in Brewster and colleagues' (2014) study, and a similar variable, heterosexist events, was related to disordered eating behaviors in a sample of lesbian women (Watson et al., 2015) therefore, it was expected that anti-bisexual discrimination would be associated with body-related variables and disordered eating behaviors in the current study. Based on Brewster and colleagues' (2014) recommendation for future research, as well as studies in which bisexual women in relationships with women experienced more sexual minority discrimination, it was expected that partner gender would moderate the relations between anti-bisexual discrimination and body-related variables and disordered eating behaviors (hypotheses 4-6; Dyar et al., 2014).

Hypothesis Set 1:

- 1A. Objectification would be positively associated with body shame (path A)
- 1B. Partner gender would moderate this association of objectification with body shame so that the association would be stronger for women in relationships with men than those in relationships with women.

Hypothesis Set 2:

- 2A. Objectification would be positively associated with body surveillance (path B).
- 2B. Partner gender would moderate this association of objectification with body surveillance so that the association would be stronger for women in relationships with men than those in relationships with women.

Hypothesis Set 3:

3A. Objectification would be positively associated with disordered eating behaviors (path C).

3B. Partner gender would moderate this association of objectification with disordered eating behaviors so that the association would be stronger for women in relationships with men than those in relationships with women.

Hypothesis Set 4:

4A. Anti-bisexual discrimination would be positively associated with body shame (path D).

4B. Partner gender would moderate the association of anti-bisexual discrimination with body shame so that the association would be stronger for women in relationships with women than those in relationships with men.

Hypothesis Set 5:

5A. Anti-bisexual discrimination would be positively associated with body surveillance (path E).

5B. Partner gender would moderate the association of anti-bisexual discrimination with body surveillance so that the association would be stronger for women in relationships with women than those in relationships with men.

Hypothesis Set 6:

6A. Anti-bisexual discrimination would be positively associated with disordered eating behaviors (path F).

6B. Partner gender would moderate the association of anti-bisexual discrimination with disordered eating behaviors so that the association would be stronger for women in relationships with women than those in relationships with men.

CHAPTER II

METHOD

Participants

The current study recruited bisexual women using Facebook advertisements (Appendix A), contacting participants from previous studies conducted in the Sexual Minority Health Lab at Old Dominion University (Appendix B), and contacting LGBT organizations across the nation (Appendix C). Eligibility requirements included: (1) self-identify as bisexual or report equal attraction to men and women; (2) identify as a woman who was assigned the female gender at birth; (3) age 18-30 years; (4) live in the United States; (5) and be in a current relationship with a cisgender partner. Advertisements were designed to target women whose online activity suggests that they may meet the eligibility requirements for the study. These ads employed Facebook's algorithm, which analyzes what pages a user has "liked" and shows the advertisements to those who have "liked" pages related to sexual minority topics. Due to low yield of eligible participants by the Facebook advertisements, alternate recruitment methods were used. Participants in previous studies who had provided their emails to be considered for future projects and LGBT organizations were contacted by email with a brief summary and the link to the current survey. Some of the organizations that were contacted included Old Dominion University's Sexual and Gender Alliance and Safe Space, the Research Center on Halsted, the Gay and Lesbian Alliance Against Defamation (GLAAD), Georgia Tech Pride, LGBT Health Link, LGBT Life Center, Hampton Roads Pride, Pflag, Bisexual Resource Center, and Pride Houston. Of these organizations, participants were recruited from Old Dominion University's Safe Space, Georgia Tech Pride, the Research Center on Halsted, and the LGBT Life Center.

A total of 1,430 people attempted to complete the survey. Seven hundred and fifty-seven met the eligibility requirements and of those who were eligible, 469 (326 in relationships with men and 143 in relationships with women) completed the EPSI and at least 50% of the other measures and were included in the analyses. Some eligible participants who did not answer some of the demographic questions were included in analyses. See Tables 1 and 2 for sample demographics.

Power Analysis

In order to determine the sample size needed for the current study a Monte Carlo analysis was conducted using Mplus (Muthen & Muthen, 2015). The recommendations of Muthen and Muthen (2002, 2015) were used to create the predicted models using data generated from parameters drawn from previous literature. The model was run across 10,000 replications and the results of each test were pooled together to provide the estimated power for each pathway included in the model (i.e., the probability of finding significant results), given a sample of 560 individuals, with 280 who indicate a current male partner and 280 who indicate a current female partner. The results of the Monte Carlo indicated that all pathways demonstrated adequate power (i.e., values greater than .80). Due to difficulties with recruitment, the sample size was reduced to 300 (150 with a current male partner, and 150 with a current female partner).

Measures

Objectification. The Interpersonal Sexual Objectification Scale (ISOS; Kozee et al., 2007; Appendix D) is a 15-item scale with two subscales assessing Body Evaluation and Unwanted Explicit Sexual Advances. Both subscales were used to create the latent variable of objectification. Sample items are “How often have you been whistled at while walking down a street” and “How often have you been touched or fondled against your will.”

Table 1.*Demographics*

		In Relationships with Men	In Relationships with Women	Total
		<i>M(SD) or n(%)</i>	<i>M(SD) or n(%)</i>	<i>M(SD) or n(%)</i>
Age (years)		23.42(3.47)	23.97(3.67)	23.59(3.54)
BMI (kg/m ²)		28.10(8.03)	29.48(8.97)	28.52(8.34)
Sexual Identity				
	Bisexual	306(93.9%)	137(95.8%)	443(94.5%)
	Queer	98(30.1%)	49(34.3%)	147(31.3%)
	Pansexual	83(25.5%)	33(23.1%)	116(24.7%)
	Gay	12(3.7%)	16(11.2%)	28(6%)
	Lesbian	2(0.6%)	14(9.8%)	16(3.4%)
	Asexual	8(2.5%)	6(4.2%)	14(3%)
	Questioning	7(2.1%)	2(1.4%)	9(1.9%)
	Heterosexual	6(1.8%)	0(0%)	6(1.3%)
	Other Sexual Identity	5(1.5%)	5(3.5%)	10(2.1%)
Sexual Attraction				
	Equal Attraction to Men and Women	203(62.3%)	82(57.3%)	285(60.8%)
	Mostly Attracted to Women	50(15.3%)	54(37.8%)	104(22.2%)
	Mostly Attracted to Men	71(21.8%)	7(4.9%)	78(16.6%)
Sexual History (Lifetime)				
	Men and Women	171(52.5%)	110(76.9%)	281(59.9%)
	Men Only	146(44.8%)	4(2.8%)	150(32%)
	Women Only	0(0%)	21(14.7%)	21(4.5%)
	No One	5(1.5%)	7(4.9%)	12(2.6%)
Sexual History (Past Year)				
	Men and Women	45(13.8%)	34(23.8%)	79(16.8%)
	Men Only	271(82.8%)	12(8.4%)	282(60.1%)
	Women Only	0(0%)	84(58.7%)	84(17.9%)
	No One	10(3.1%)	12(8.4%)	22(4.7%)
Relationship Status				
	Partnered, in an Exclusive Relationship	210(64.4%)	95(66.4%)	305(65%)
	Partnered, Married or in a Civil Union	64(19.6%)	22(15.4%)	86(18.3%)

Table 1.*Continued*

		In Relationships with Men	In Relationships with Women	Total
		<i>M(SD) or n(%)</i>	<i>M(SD) or n(%)</i>	<i>M(SD) or n(%)</i>
Ethnicity	Partnered, in a Relationship that is not exclusive	39(12%)	16(11.2%)	55(11.7%)
	Single, exclusively dating one person	8(2.5%)	5(3.5%)	13(2.8%)
	Single, dating a main partner but not in an exclusive relationship	5(1.5%)	5(3.5%)	10(2.1%)
	Hispanic, Latina, or Spanish Origin	33(10.1%)	16(11.2%)	49(10.4%)
	Not Hispanic, Latina, or Spanish Origin	294(89.9%)	127(88.8%)	421(89.6%)
Race	White	270(82.8%)	103(72%)	373(79.5%)
	Multiracial	29(8.9%)	12(8.4%)	41(8.7%)
	Asian, Asian American, Native Hawaiian, or Pacific Islander	10(3.1%)	12(8.4%)	22(4.7%)
	Black	5(1.5%)	7(4.9%)	12(2.6%)
	American Indian or Alaska Native	4(1.2%)	1(0.7%)	5(1.1%)
	Other Race	7(2.1%)	8(5.6%)	15(3.2%)

Table 2.*Sexual Attraction and Behavior of Bisexual Identified Participants*

	<i>n</i> (%)
Sexual Attraction	
Mostly Attracted to Women	104(23.6%)
Equally Attracted to Men and Women	259(58.7%)
Mostly Attracted to Men	78(17.7%)
Sexual History (Lifetime)	
Women Only	21(4.8%)
Men and Women	264(60.3%)
Men Only	141(32.2%)
No One	12(2.7%)
Sexual History (Past Year)	
Women Only	82(18.6%)
Men and Women	75(17%)
Men Only	264(59.9%)
No One	20(4.5%)

Respondents use a Likert scale from 1 (*never*) to 5 (*almost always*) and total and subscale scores are calculated by averaging the items. Higher scores indicate more experiences of objectification. The ISOS internal consistency ranged from .92 for the total scale, .91 for the body evaluation subscale, and .78 for the unwanted explicit sexual advances subscale in a sample of college women (Kozee et al., 2007). The scale demonstrated convergent validity in a sample of college women through a correlation with the Schedule of Sexist Events (SSE; Klonoff & Landrine, 1995) sexist degradation subscale ($r = .55$; Kozee et al., 2007). In the current study, the Cronbach's alpha for the total ISOS was .929.

The Objectified Body Consciousness Scale (OBCS; McKinley & Hyde, 1996; Appendix E) is a 24-item scale with three subscales measuring body surveillance, body shame, and control beliefs. The current study only used the body surveillance and body shame subscales. Sample

items are “I often worry about whether the clothes I am wearing make me look good” and “I feel ashamed of myself when I made the effort to look my best.” Respondents use a Likert scale from 1 (*strongly agree*) to 7 (*strongly disagree*). The body surveillance subscale includes six reverse scored items, and the body shame subscale includes two reverse scored items. Subscale scores are calculated by averaging the items with higher scores indicating higher levels of body surveillance and body shame. The OBCS internal consistency was .89 for the body surveillance subscale and .75 for the body shame subscale in a sample of college women. The scale demonstrated convergent and discriminant validity through a correlation between body surveillance and the public self-consciousness scale of the Self-Consciousness Scale ($r = .73$) and lack of correlation with the private self-consciousness or social anxiety subscales (Fenigstein et al., 1975; McKinely & Hyde, 1996). In the current study, the Cronbach’s alphas were .843 for the body surveillance subscale, and .871 for the body shame subscale.

Anti-Bisexual Discrimination. The Anti-Bisexual Experiences Scale (ABES; Brewster & Moradi, 2010; Appendix F) is a 17-item scale with three subscales measuring assumptions of Sexual Orientation Instability, Sexual Irresponsibility, and Interpersonal Hostility. The subscales were used to create the latent variable of anti-bisexual discrimination. Items include, “people have acted as if my bisexuality is only a sexual curiosity, not a stable sexual orientation” and “people have assumed that I will cheat in a relationship because I am bisexual.” Respondents use a Likert scale from 1 (*never*) to 6 (*almost all of the time*) and total scores are calculated by averaging the items. Higher scores indicate more experiences of anti-bisexual discrimination. In a community sample of bisexual men and women, the full scale ABES ($\alpha = .94$) and the subscales have demonstrated high internal consistency for the Sexual Irresponsibility ($\alpha = .82$), Interpersonal Hostility ($\alpha = .88$), and Sexual Orientation Instability ($\alpha = .94$) subscales. Test-

retest reliabilities for the full scale ABES and subscales after two and three week delays were .89 for the full scale and .88 for Sexual Orientation Instability, .79 for Sexual Irresponsibility, and .89 for Interpersonal Hostility subscales. The full scale demonstrated convergent validity through positive correlations with the Stigma Consciousness Questionnaire ($r = .54$; Pinel, 1999) and the Public Collective Self-Esteem subscale of the Collective Self-Esteem Scale ($r = .41$; Brewster & Moradi, 2010; Luhtanen & Crocker, 1992). In the current study, the Cronbach's alphas were .930 for the sexual orientation instability subscale, .843 for the sexual irresponsibility subscale, and .903 for the interpersonal hostility subscale.

Neuroticism. The International Personality Item Pool (IPIP; Goldberg et al., 2006; Appendix G) is a 10-item scale measuring neuroticism that was included in the model as a covariate to control for the impact that trait neuroticism may have on participants' reports of discrimination, body dissatisfaction, and disordered eating behaviors. Items include "I often feel blue" and "I panic easily." Respondents use a Likert scale from 1 (*very inaccurate*) to 5 (*very accurate*) with five items reverse scored. The total score is calculated by summing all items and higher scores indicate higher levels of neuroticism. The alpha coefficient for the neuroticism scale of the IPIP was .86 and it correlated positively ($r = .82$) with the neuroticism subscale of the NEO-PI-R (Costa & McCrae, 1992; Goldberg et al., 2006). In a sexual minority sample of men and women, the internal consistency for the neuroticism scale of the IPIP was .89 (Reed & Leuty, 2016). In the current study, the Cronbach's alpha was .877.

Disordered Eating Behaviors. The Eating Pathology Symptoms Inventory (EPSI; Forbush et al., 2013; Appendix H) is a 45-item scale with eight subscales measuring Body Dissatisfaction, Binge Eating, Cognitive Restraint, Purging, Restricting, Excessive Exercise, Negative Attitudes toward Obesity, and Muscle Building. The Binge Eating, Cognitive Restraint,

Purging, Restricting, and Excessive Exercise subscales were used to create the latent variable of disordered eating behaviors. Items include “I made myself vomit in order to lose weight” and “I stuffed myself with food to the point of feeling sick.” Respondents use a Likert scale from 0 (*never*) to 4 (*very often*) and subscale scores are calculated by summing the items. Higher scores indicate more disordered eating behaviors. Internal consistency scores for the EPSI ranged from .78 for the Purging subscale to .95 for the Excessive Exercise subscale in college and community samples (Forbush et al., 2013; Forbush et al., 2014). The Excessive Exercise ($r = .40$), Cognitive Restraint ($r = .62$), Purging ($r = .43$), and Restricting subscales ($r = .34$) were positively correlated with the Eating Disorder Examination Questionnaire total (EDE-Q; Fairburn & Belgin, 1994) total scale Forbush et al., 2013). The Purging subscale was positively correlated with the Drive for Thinness ($r = .36$), Bulimia ($r = .54$), and Body Dissatisfaction ($r = .37$) subscales of the Eating Disorder Inventory (EDI; Garner, 2004) based on a study by Forbush and colleagues (2013). The Excessive Exercise ($r = .35$) and Cognitive Restraint ($r = .68$) subscales were positively correlated with the Drive for Thinness subscale of the EDI. The Cognitive Restraint ($r = .44$) subscale was positively correlated with the Body Dissatisfaction subscale of the EDI. The Binge Eating subscale was positively correlated with the Bulimia subscale of the EDI ($r = .85$; Forbush et al., 2013). In the current study, the Cronbach’s alphas were .866 for the body dissatisfaction subscale, .908 for the binge eating subscale, .752 for the cognitive restraint subscale, .871 for the restricting subscale, .870 for the excessive exercise subscale, .655 for the muscle building subscale, .866 for the purging subscale, and .927 for the negative attitudes toward obesity subscale.

Demographics. Participants also completed a questionnaire (Appendix I) that collected information on their demographic characteristics. This questionnaire gathered information on the

participant's age, racial and ethnic identity, sexual identity, sexual attraction and behavior, their relationship status, and the gender of their current partner.

Procedure

Participants were recruited using Facebook ads and by contacting individuals who participated in previous studies and LGBT organizations by email. Individuals who clicked on the Facebook advertisement or the link provided in the email were taken to a Qualtrics survey in which the first page had an informed consent document that provided a short description of the study and its voluntary and anonymous nature. Individuals who chose to participate answered questions to ensure that they met the eligibility requirements before completing the rest of the study. Those who were not eligible were redirected to a message thanking them for their interest but explaining that they were not eligible to participate at this time, while those who were eligible were given access to the rest of the surveys.

Participants completed all the measures in Qualtrics and were then offered the chance to provide their email address to enter a raffle to win an Amazon gift card. Participants who chose to provide their email were redirected to a separate survey in order to keep their answers separate from this identifying information. Participants then provided their email addresses to be entered into a raffle and participants were selected at random to win one of five \$10, four \$25, or one \$50 Amazon gift cards.

CHAPTER III

RESULTS

Participants' responses to the survey were exported into an SPSS file to be cleaned and to test for violations of assumptions. The data were assessed for normality, outliers, multicollinearity, and linearity. Normality was assessed using histograms as well as skewness and kurtosis values. Outliers were assessed using boxplots. The purging subscale of the EPSI was skewed (2.289) and kurtotic (5.663) with several outliers. Therefore, the subscale was log10 transformed which reduced skewness (1.334) and kurtosis (.999) and eliminated the outliers. One outlier on the body surveillance subscale of the OBCS was windsorized from 1.14 to 1.74. Five outliers on the interpersonal hostility subscale of the ABES were windsorized from 5.60 to 5.10. Two outliers on the muscle building subscale of the EPSI were windsorized from 20 to 19. Multicollinearity were assessed using tolerance and variance inflation factor (VIF) values. Linearity was assessed using scatterplots. The variables showed no evidence of multicollinearity or nonlinearity in the current study. The data were examined for missing values and maximum likelihood estimation was used to estimate the missing values found in the OBCS.

Identifying Covariates

ANOVAs and correlations were used to identify potential covariates in the data, as well. Four covariates, including age, BMI, neuroticism, and reported attraction, were identified and added to the model. Age was significantly negatively correlated with body surveillance ($r = -.105, p = .023$), binge eating ($r = -.100, p = .030$), purging ($r = -.105, p = .023$), restricting ($r = -.221, p < .001$), excessive exercise ($r = -.118, p = .010$), and neuroticism ($r = -.185, p < .001$). BMI was significantly positively correlated with body surveillance ($r = .131, p = .004$), body shame ($r = .330, p < .001$), the sexual irresponsibility subscale of the ABES ($r = .119, p = .010$),

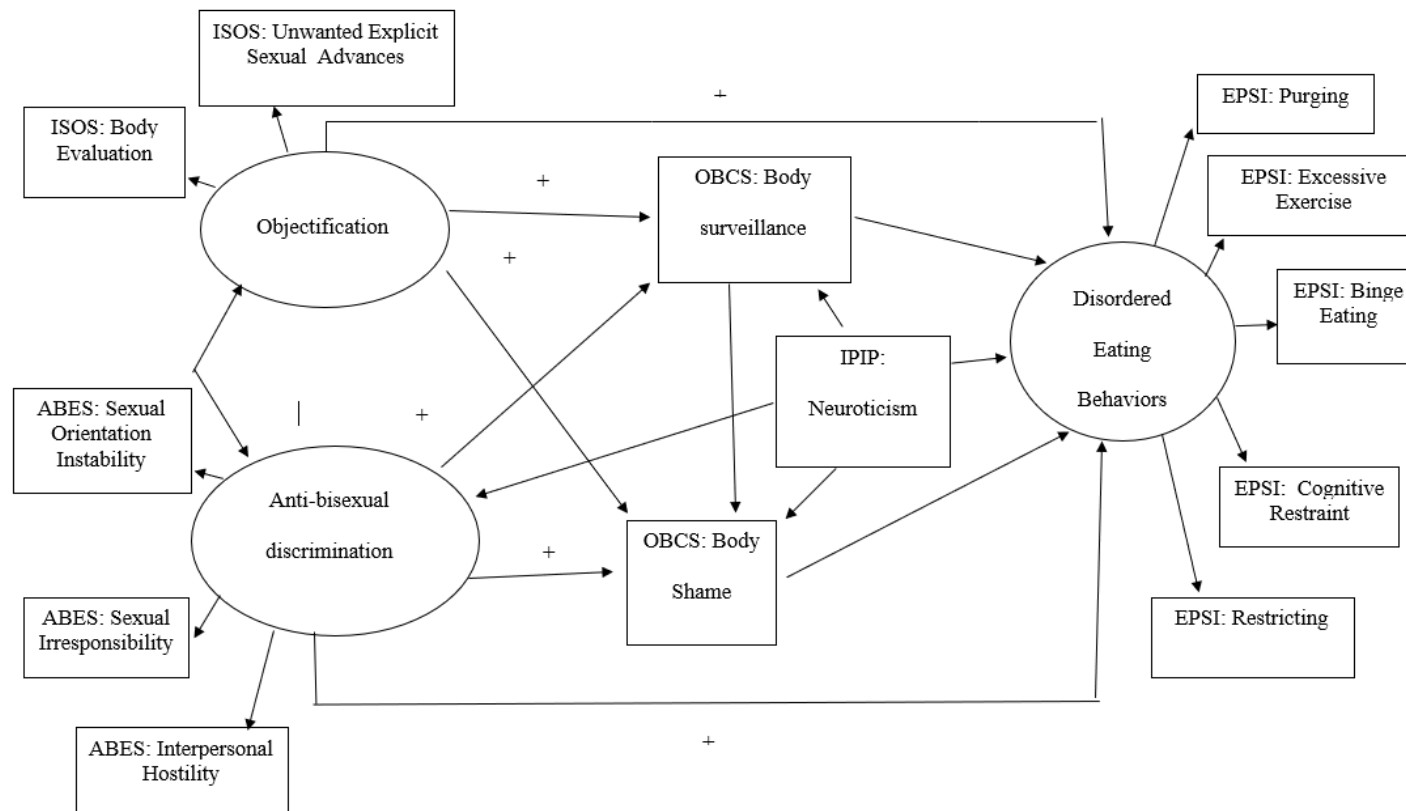
binge eating ($r = .251, p < .001$), purging ($r = .241, p < .001$), and neuroticism ($r = .152, p = .001$), and significant negative correlations with restricting ($r = -.173, p < .001$), excessive exercise ($r = -.092, p = .048$), and muscle building ($r = -.118, p = .011$). The sexual orientation instability subscale of the ABES varied significantly by reported attraction ($F(2, 464) = 3.732, p = .025$) such that those who were mostly attracted to men ($M = 2.933, SD = 1.157$) reported significantly fewer assumptions of sexual orientation instability than those who were mostly attracted to women ($M = 3.353, SD = 1.144, p = .037$) and those who reported equal attraction to men and women ($M = 3.298, SD = 1.127, p = .032$). The interpersonal hostility subscale of the ABES also varied significantly by reported attraction ($F(2, 464) = 5.800, p = .003$) such that those who reported being mostly attracted to men ($M = 1.979, SD = 0.887$) reported significantly less interpersonal hostility than those who reported being mostly attracted to women ($M = 2.162, SD = 1.008, p = .003$) and those who reported equal attraction to men and women ($M = 2.349, SD = 1.008, p = .010$). Restricting also varied by reported attraction ($F(2, 464) = 3.075, p = .047$) such that those who reported attraction mostly to men ($M = 12.962, SD = 5.103$) reported less restricting than those who reported equal attraction to men and women ($M = 14.793, SD = 6.027, p = .040$). Finally, interpersonal objectification varied by reported attraction ($F(2, 464) = 4.168, p = .016$) such that those who reported attraction mostly to men ($M = 2.550, SD = 0.635$) reported less interpersonal objectification than those who reported equal attraction to men and women ($M = 2.789, SD = 0.641, p = .013$).

Confirmatory Factor Analyses

Mplus version 8.2 (Muthen & Muthen, 2018) was used for confirmatory factor analyses (CFA) and path analyses shown in Figure 3. A CFA was conducted for each latent variable separately and for the full model in order to determine the fit of the model to the data. Fit was

Figure 3.

Model of Measures



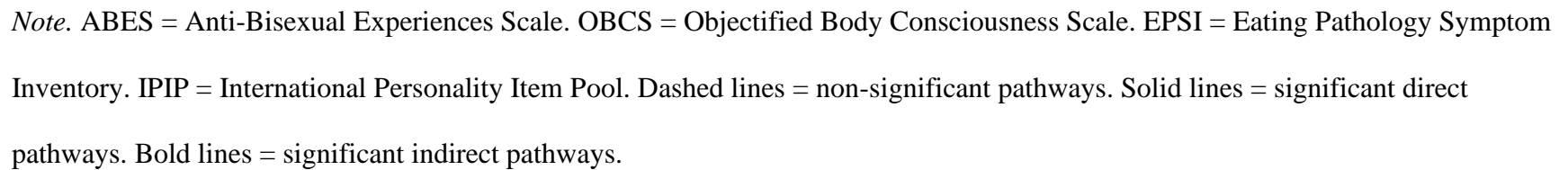
Note. ISOS = Interpersonal Sexual Objectification Scale. ABES = Anti-Bisexual Experiences Scale. OBCS = Objectified Body Consciousness Scale. EPSI = Eating Pathology Symptom Inventory. IPIP = International Personality Item

considered acceptable if the Model X^2 test of fit has $p > .05$, a comparative fit index (CFI) greater than or equal to .90, a Tucker-Lewis index (TLI) greater than or equal to .95, a root mean square error of approximation (RMSEA) less than .08, and a standardized root mean square residual (SRMSR) less than .08 (Hooper et al., 2008).

The model for the latent factor of the ISOS was not identified due to it only having two indicators, therefore the total ISOS score was used to create an observed factor for this scale. The CFA for the latent factor of anti-bisexual discrimination showed good model fit ($X^2(3) = 0.00$, $p < .000$; RMSEA = .000; CFI = 1.00; TLI = 1.00; and SRMR = .000) and did not require any adjustments. Standardized factor loadings for anti-bisexual discrimination ranged from .78 to .88.

The CFA for the EPSI showed poor model fit ($X^2(5) = 109.142$, $p < .000$; RMSEA = .086; CFI = .862; TLI = .847; SRMR = .097). After reviewing the modification indices, the cognitive restraint subscale was removed from the model and a respecified CFA was conducted. The respecified CFA still showed poor model fit ($X^2(2) = 55.413$, $p < .000$; RMSEA = .071; CFI = .881; TLI = .870; SRMR = .088). The muscle building subscale was added to the model ($X^2(5) = 109.142$, $p < .000$; RMSEA = .98; CFI = .964; TLI = .881; SRMR = .043), but fit was still poor. After reviewing the modification indices, muscle building was correlated with excessive exercise and binge eating was correlated with restricting. The respecified CFA showed good model fit ($X^2(2) = 4.961$, $p = .0837$; RMSEA = .056; CFI = .992; TLI = .961; SRMR = .016). The standardized factor loadings for the EPSI ranged from .23 to .92. The full model, including covariates, demonstrated good model fit ($X^2(67) = 253.28$, $p < .000$; RMSEA = .077; CFI = .910; TLI = .864; SRMR = .065) without any modifications needed. See figure 4 for the final study model

Final Model



Main Analyses

Once the full model demonstrated adequate fit to the data, a multigroup structural equation model (SEM) was conducted to test for moderation. The model was tested and compared using the chi square difference test in both groups of bisexual women, those in relationships with women and those in relationships with men in order to test the hypotheses. Descriptive information and correlations for the study variables are provided in tables 2 and 3.

Hypothesis set 1 tested the association of objectification with body shame and whether it was moderated by partner gender. In the full sample, hypothesis 1A was not supported, because the association of objectification with body shame was not significant in the full sample ($B = 0.105$, $SE = .072$, $p = .145$). Hypothesis 1B was also not supported, as there was no significant difference between those with male and female partners ($\Delta\chi^2(1) = 2.035$, $p = .153$).

Hypothesis set 2 tested the association of objectification with body surveillance and whether it was moderated by partner gender. Hypothesis 2A was not supported, as objectification was not significantly associated with body surveillance in the full sample ($B = -0.056$, $SE = .099$, $p = .571$). Hypothesis 2B was also not supported because there was no significant difference between groups ($\Delta\chi^2(1) = 3.048$, $p = .081$).

Table 3.*Descriptive Information*

Variable	<i>M</i> (<i>SD</i>)
Objectification	2.73(0.67)
Body Surveillance	4.10(0.89)
Body Shame	3.68(1.10)
Sexual Orientation Instability	3.25(1.15)
Sexual Irresponsibility	2.53(1.23)
Interpersonal Hostility	2.31(1.02)
Binge Eating	20.45(7.39)
Purging	0.91(1.33)
Restricting	14.35(5.94)
Excessive Exercise	10.30(4.90)
Muscle Building	7.43(2.73)
Neuroticism	35.61(8.08)

Table 4.
Correlations among Study Variables

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
1. ISOS	1.00														
2. Body Surveillance	0.02	1.00													
3. Body Shame	0.18**	0.58***	1.00												
4. SOISS	0.48***	0.08	0.21**	1.00											
5. SISS	0.52***	0.02	0.20**	0.69***	1.00										
6. IHSS	0.47***	0.04	0.19**	0.73***	0.65***	1.00									
7. Binge Eating	0.10*	0.25**	0.35**	0.14**	0.13**	0.08	1.00								
8. Purging	0.34**	0.37**	0.49***	0.27**	0.29**	0.19**	0.40***	1.00							
9. Restricting	0.33**	0.16**	0.17**	0.28**	0.25**	0.24**	-0.08	0.34**	1.00						
10. Excessive Exercise	0.23**	0.12**	0.28**	0.21**	0.17**	0.19**	0.22**	0.40***	0.31**	1.00					
11. Muscle Building	0.11*	0.03	0.07	0.04	0.07	0.05	0.10*	0.17**	0.22**	0.46***	1.00				
12. Neuroticism	0.19**	0.43***	0.50***	0.24**	0.24**	0.27**	0.32**	0.38**	0.28**	0.15**	0.04	1.00			
13. Age	-0.03	-0.10*	-0.06	0.04	0.05	-0.00	-0.11*	-0.11*	-0.22**	-0.12**	0.02	-0.19**	1.00		
14. Attraction	-0.06	0.05	0.10*	-0.11*	0.03	-0.14**	0.09	0.06	-0.05	0.03	-0.02	-0.00	-0.05	1.00	
15. BMI	0.08	0.13**	0.33**	0.10*	0.12**	0.05	0.25**	0.24**	-0.18**	-0.09*	-0.11	0.15	0.18	0.07	1.00

*Note. SOISS = Sexual Orientation Instability Subscale. SISS = Sexual Irresponsibility Subscale. IHSS = Interpersonal Hostility Subscale. Significant correlations are indicated by *($p < .05$), ** ($p < .01$), and *** ($p < .001$).*

Hypothesis set 3 tested the association of objectification with disordered eating behaviors and whether it was moderated by partner gender. In the full sample, objectification was significantly related to disordered eating behaviors ($B = 1.509$, $SE = .322$, $p < .001$ supporting hypothesis 3A. Hypothesis 3B was not supported, as there was no significant difference in this association between groups ($\Delta X^2(1) = 0.011$, $p = .916$).

Hypothesis set 4 tested the association of anti-bisexual discrimination with body shame and whether it was moderated by partner gender. In the full sample, hypothesis 4A was not supported as the association of anti-bisexual discrimination was not significantly related to body shame ($B = 0.090$, $SE = .052$, $p = .086$). Hypothesis 4B was also not supported, as there was no significant difference between groups ($\Delta X^2(1) = 0.588$, $p = .443$).

Hypothesis set 5 tested the association of anti-bisexual discrimination with body surveillance and whether it was moderated by partner gender. In the full sample, hypothesis 5A was not supported because anti-bisexual discrimination was not significantly related to body surveillance ($B = -0.052$, $SE = .053$, $p = .319$). However, multigroup analyses showed a significant difference between groups ($\Delta X^2(1) = 4.152$, $p = .042$). The association was significantly positive for those in relationships with women ($B = 0.059$, $SE = .085$, $p = .484$) and negative for those in relationships with men ($B = -0.105$, $SE = .065$, $p = .107$), which does not support hypothesis 5B.

Hypothesis set 6 tested the association of anti-bisexual discrimination with disordered eating behaviors and whether it was moderated by partner gender. For the full sample, the association of anti-bisexual discrimination with disordered eating behaviors was significant ($B = 0.525$, $SE = .228$, $p = .021$), supporting hypothesis 6A. However, hypothesis 6B was not supported as there was no significant difference between groups ($\Delta X^2(1) = 0.007$, $p = .933$).

Beyond the main hypotheses, there were additional significant pathways in the full sample model. The pathway between age and disordered eating behaviors was significant ($B = -0.168$, $SE = .049$, $p = .001$). Additionally, there was a significant group difference ($\Delta X^2(1) = 12.613$, $p < .001$) so that the association was significant for bisexual women in relationships with women ($B = -0.349$, $SE = .084$, $p < .001$) and non-significant for those in relationships with men ($B = -0.068$, $SE = .057$, $p = .233$). The pathway between age and neuroticism was also significant ($B = -0.512$, $SE = .105$, $p < .001$), however there was not a significant group difference ($\Delta X^2(1) = 0.46$, $p = .498$). The pathway between attraction and anti-bisexual discrimination was significant ($B = -0.155$, $SE = .076$, $p = .042$), however there was not a significant group difference ($\Delta X^2(1) = 1.235$, $p = .266$). The association between neuroticism and disordered eating behaviors was significant ($B = 0.077$, $SE = .025$, $p = .002$), however there was not a significant group difference ($\Delta X^2(1) = 1.001$, $p = .317$). The association between neuroticism and anti-bisexual discrimination was also significant ($B = 0.023$, $SE = .005$, $p < .001$), however there was not a significant group difference ($\Delta X^2(1) = 0.591$, $p = .442$).

Neuroticism was also significantly associated with body surveillance ($B = 0.047$, $SE = .005$, $p < .001$), however there was not a significant group difference ($\Delta X^2(1) = 0.581$, $p = .446$). The association between neuroticism and body shame was also significant ($B = 0.033$, $SE = .005$, $p < .001$), however there was not a significant group difference ($\Delta X^2(1) = 0.338$, $p = .561$). The association between BMI and neuroticism was significant ($B = 0.180$, $SE = .044$, $p < .001$), however there was not a significant group difference ($\Delta X^2(1) = 0.403$, $p = .526$). BMI was also significantly associated with body shame ($B = 0.029$, $SE = .004$, $p < .001$), however there was not a significant group difference ($\Delta X^2(1) = 0.15$, $p = .699$). BMI was also significantly indirectly associated with disordered eating behaviors through neuroticism ($B = 0.014$, $SE = .006$, $p = .015$).

and body shame ($B = 0.033$, $SE = .008$, $p < .001$). The association of sexual objectification with anti-bisexual discrimination was significant ($B = 0.344$, $SE = .036$, $p < .001$), however there was not a significant group difference ($\Delta X^2(1) = 0.033$, $p = .856$). The association of muscle building with excessive exercise was significant ($B = 4.589$, $SE = .594$, $p < .001$), however there was not a significant group difference ($\Delta X^2(1) = 0.067$, $p = .796$). The association of restricting with binge eating was significant ($B = -14.096$, $SE = 1.800$, $p < .001$). There was also a significant group difference ($\Delta X^2(1) = 8.699$, $p = .003$) so that the association was stronger for bisexual women in relationships with men ($B = -17.558$, $SE = 2.279$, $p = .001$) than for those in relationships with women ($B = -6.565$, $SE = 2.796$, $p = .019$). See Table 4 for a summary of the results.

Table 5.*Parameter Estimates from Full Sample and Unconstrained Group Invariance Models*

	Full Sample				Multigroup								X ² Diff
					Bisexual women in relationships with men				Bisexual women in relationships with women				
	B	β	SE	p	B	β	SE	p	B	β	SE	p	
Objectification → Body Shame	0.105	0.063	0.072	.145	0.162	0.100	0.087	.063	-0.025	-0.014	0.128	.846	.154
Objectification → Body Surveillance	-0.043	-0.031	0.072	.554	-0.-61	-0.044	0.089	.492	0.042	0.033	0.120	.729	.081
Objectification → Disordered Eating Behaviors	1.509	0.275	0.322	< .001	1.590	0.289	.383	< .001	1.345	0.241	0.520	.010	.916
Anti-bisexual Discrimination → Body Shame	0.090	0.080	0.052	.086	0.085	0.078	0.064	.183	0.061	0.053	0.091	.505	.443
Anti-bisexual Discrimination → Body Surveillance	-0.052	-0.057	0.053	.319	-0.105	-0.111	0.065	.107	0.059	0.072	0.085	.484	.042
Anti-bisexual Discrimination → Disordered Eating Behaviors	0.525	0.142	0.228	.021	0.602	0.162	0.280	.032	0.569	0.156	0.367	.121	.933
Body Surveillance → Body Shame	0.542	0.443	0.047	< .001	0.516	0.443	0.055	< .001	0.638	0.457	0.090	< .001	.193
Body Surveillance → Disordered Eating Behaviors	0.527	0.131	0.226	.020	0.942	0.239	0.272	.001	-0.303	-0.068	0.423	.474	.105
Body Shame → Disordered Eating Behaviors	1.133	0.344	0.221	< .001	0.884	0.261	0.249	< .001	1.579	0.498	0.367	< .001	.849
Age → Body Surveillance	-0.009	-0.034	0.011	.472	-0.014	-0.052	0.013	.305	0.004	0.018	0.018	.827	.242
Age → Neuroticism	-0.512	-0.233	0.105	< .001	-0.556	-0.239	0.126	< .001	-0.428	-0.189	0.194	.028	.498
Age → Disordered Eating Behaviors	-0.168	-0.166	0.049	.001	-0.068	-0.065	0.057	.233	-0.349	-0.354	0.084	< .001	< .001

Table 5.*Continued*

Neuroticism → Body Surveillance	0.047	0.435	0.005	< .001	0.052	0.457	0.006	.430	0.036	0.370	0.008	< .001	.445
Neuroticism → Body Shame	0.033	0.245	.005	< .001	0.032	0.242	0.007	< .001	0.036	0.261	0.009	< .001	.561
Neuroticism → Anti-bisexual Discrimination	0.023	0.193	0.005	<.001	0.021	0.178	0.006	< .001	0.026	0.219	0.009	.005	.442
Neuroticism → Disordered Eating Behaviors	0.077	0.174	0.025	.002	0.067	0.150	0.030	.025	0.111	0.255	0.041	.007	.317
BMI → Anti-bisexual Discrimination	0.005	0.039	0.005	.352	-0.004	-0.029	0.006	.559	0.019	0.171	0.009	.027	.023
BMI → Body Surveillance	0.009	0.083	0.005	.052	0.004	0.039	0.006	.430	0.011	0.124	0.008	.140	.241
BMI → Body Shame	0.029	0.223	0.004	< .001	0.028	0.211	0.006	< .001	0.030	0.241	0.008	< .001	.699
BMI → Neuroticism	0.180	0.186	0.044	< .001	0.163	0.163	0.054	.003	0.209	0.227	0.079	.008	.526
BMI → Disordered Eating Behaviors	-0.001	-0.003	0.021	.959	0.030	0.067	0.026	.253	-0.036	-0.090	0.035	.307	.031
Attraction → Objectification	-0.062	-0.060	0.048	.198	-0.100	-0.093	0.059	.093	-0.007	-0.066	0.095	.940	.899
Attraction → Anti-bisexual Discrimination	-0.155	-0.100	0.076	.042	-0.217	-0.137	0.094	.021	-0.006	-0.003	0.151	.969	.266
Attraction → Disordered Eating Behaviors	0.287	0.050	0.251	.253	0.751	0.127	.319	.019	-0.357	-0.056	0.481	.457	.036

CHAPTER IV

DISCUSSION

The current study sought to expand the understanding of bisexual women's experiences of objectification, discrimination, body image, and disordered eating behaviors. To achieve this goal, bisexual women's experiences of these variables were evaluated in the context of their romantic relationships by comparing bisexual women in relationships with women to those in relationships with men. The results of the current study support the findings of previous studies while adding to the knowledge on this topic.

Objectification

In contrast to expectations, objectification was not significantly related to body shame or body surveillance (Hypotheses 1A and 2A), nor did partner gender moderate these associations (Hypotheses 1B and 2B). These findings were somewhat surprising considering that objectification has been linked to body shame both directly and indirectly in lesbian women (Englen-Maddox et al., 2011; Kozee & Tylka, 2006). However, objectification was not related to body shame in a sample of bisexual women (Brewster et al., 2014) and was only indirectly related in a sample of heterosexual women in previous studies (Englen-Maddox et al., 2011). Similarly, objectification was related to body surveillance in heterosexual women (Englen-Maddox et al., 2011), however it was not related to body surveillance in other studies with lesbian, bisexual, and mixed samples (Brewster et al., 2014; Englen-Maddox et al., 2011; Moradi & Tebbe, 2022; Watson et al., 2015).

One explanation for the inconsistent findings is that the experiences of objectification and body image may differ based on sexual orientation. Bisexual women may experience more body shame than heterosexual women, although previous studies have not found differences in body

surveillance between bisexual and heterosexual women (Fredrick et al., 2022c; Holmes et al., 2021). It is also possible that objectification was not related to body shame or body surveillance in the current study because the objectification was not experienced as negative or distressing. Lameiras-Fernandez and colleagues (2018) found that bisexual and heterosexual women reported that objectifying comments were less concerning, and in some cases were enjoyed, when they were made by the women's male partners. The current study did not collect data on who perpetrated the objectifying experiences, but since most of the participants were in relationships with men, it is possible that they were less distressed by their partners' objectifying behaviors.

Sexual minority women may also experience different forms of objectification. For sexual minority women, experiences of objectification and discrimination may be so intertwined as to be indistinguishable (Brewster et al., 2014; Flanders et al., 2019; Platt & Lenen, 2013; Serpe et al., 2020). The Sexual Minority Women's Sexual Objectification Experiences Scale (Tebbe et al., 2021), a new scale developed to measure the unique experience of objectification for sexual minority women, may be of more use in future studies with bisexual women. In addition to body evaluations and sexual advances, this scale includes a subscale measuring the sexualization of sexual minority women's sexual identities, effectively addressing the unique, objectifying discrimination that sexual minority women experience.

Supporting hypothesis 3A, objectification was significantly related to disordered eating behaviors; however, partner gender did not moderate this association (Hypothesis 3B). This finding was surprising given that partner gender has been linked to other mental health factors such as depression and alcohol use (Dyar et al, 2014; Molina et al., 2015). It is possible that being in a relationship has a larger impact on disordered eating behaviors than partner gender. Feinstein and colleagues (2016) found that relationship involvement moderated the relation

between discrimination and anxiety in bisexual women so that those in relationships reported less anxiety; however, this moderation was not found for the relation of victimization and anxiety. In contrast, Whitton and colleagues (2018) found that adolescent bisexual girls in relationships reported greater distress than those who were single regardless of partner gender. These findings suggest that being in a relationship could be considered a protective factor or a risk factor for distress and mental health concerns regardless of partner gender. As the current study did not include any participants who were not in a relationship, comparisons could not be conducted to determine if relationship status acted as a protective or risk factor for disordered eating behaviors.

Anti-Bisexual Discrimination

Anti-bisexual discrimination was not significantly related to body shame in the full sample or either group, thus not supporting hypotheses 4A and 4B. This finding is inconsistent with studies of bisexual women (Brewster et al., 2014; Jhe et al., 2021; Polihronakis et al., 2021) but is consistent with Watson and colleagues (2015) study in which heterosexist events were not significantly related to body shame in a sample of sexual minority women who identified as primarily as lesbian, with some participants identifying as bisexual, pansexual, and queer. Anti-bisexual discrimination was also not related to body surveillance in the full sample (hypothesis 5A); however, there was a significant difference between groups in that the variables showed a non-significant positive relation for those in relationships with women, and a non-significant negative relation for those in relationships with men. This does not support hypothesis 5B because it cannot be said that the relation for those with women is stronger, but it is an interesting finding.

Another difference between the current study and Brewster et al. (2014) is that anti-bisexual discrimination was significantly related to disordered eating behaviors in the full sample (Hypothesis 6A) and in bisexual women in relationships with men, but not those in relationships with women in the current study. This supports hypothesis 6A, but not 6B, as there was not a significant group difference. This is

somewhat consistent with previous research that found that experiencing heterosexist events was related to disordered eating in a sample of sexual minority women (Watson et al., 2015); however, the fact that the current study did not find this association in bisexual women in relationships with women suggests that there may be a difference in heterosexist events and anti-bisexual specific discrimination.

A study by Katz-Wise et al. (2017) supports this interpretation with the finding that discrimination was related to poor health beyond the variance explained by sexual minority stress in a sample of sexual minority men and women. Although the current study did not collect data on who perpetrated the anti-bisexual discrimination, it is possible that this could explain the difference between models. Arriaga and Parent (2019) found that discrimination from lesbian and gay men was related to internalized negativity in bisexual men and women, however discrimination from heterosexual individuals was not. It is possible that bisexual women in relationships with men experience more discrimination perpetrated by lesbians and gay men than those in relationships with women.

Another possible explanation for why there was a significant relation between anti-bisexual discrimination and disordered eating behaviors for women in relationships with men, but not those with women is that bisexual women in relationships with men may be more likely to experience certain forms of discrimination than those in relationships with women. Sarno and colleagues (2020) found that bisexual men who had female partners reported experiencing more interpersonal hostility from heterosexuals and gay men and lesbians, and more assumptions of sexual irresponsibility from heterosexuals only. In the same study, bisexual men with male partners reported experiencing more assumptions of sexual orientation instability from heterosexuals and gay men and lesbians (Sarno et al., 2020). If the experience of bisexual women follows a similar pattern, it could explain the non-significant group difference in the current study.

Limitations and Future Directions

The current study contributed important information on bisexual women's experiences; however, it is not without limitations. The first limitation speaks to the generalizability of the results. Like many other studies on body image and disordered eating behaviors, the sample of the current study was

primarily White (Fredrick et al., 2020; Murray et al., 2021). This limits the generalizability of the current study to the experiences of White bisexual women, and future studies should seek to recruit more diverse samples in order to determine if the experience of bisexual women of color differ.

A second limitation of the current study is the definition of bisexuality used in our inclusion criteria. Only women who self-identified as bisexual or reported equal attraction to men and women were included in the study. This allowed for a more diverse sample in terms of reported attraction, sexual behavior (see Table 2), and identity. While 58.7% of those who identified themselves as bisexual also reported equal attraction to men and women; however, many others reported being mostly attracted to women (23.6%), and being mostly attracted to men (17.7%), suggesting a diverse experience of attraction among bisexual women. In terms of lifetime sexual behavior, 60.3% of bisexual identified women reported a history of sex with both men and women and 32.2% reported having sex with men only, with the remainder of the bisexual identified sample reporting a sexual history with women only, or no previous sexual behavior. Similarly, 59.9% of bisexual identified women reported having sex with men only in the past year, 18.6% reported having sex with women only in the past year, and 17% reported sex with both men and women in the past year. This indicates that among bisexual women, experiences of sexual attraction and behavior are diverse. While reported attraction was included as a covariate in the analyses, sexual behavior was not. Therefore, the current study cannot draw conclusions as to how these diverse experiences among bisexual women may impact discrimination, body dissatisfaction, or disordered eating behaviors.

In addition to the diverse experiences among the women who identified as bisexual, the current study also included women of different sexual identities who reported equal attraction to men and women. Given that there is little research currently on identities such as pansexual, queer, demisexual, and asexual, it is unclear if their experiences are equivalent to those of bisexual women, although it is likely that their experiences are as diverse as those of bisexual identified women. There is also some research to suggest that asexual individuals in particular experience unique forms of discrimination than those who use the label bisexual do not (Parmenter et al., 2021; Rothblum et al., 2020). Therefore, future research

should seek to clarify the experiences of non-monosexual individuals who do not use the term bisexual to describe themselves.

The current study also did not measure participants' outness, which has been linked to mental health outcomes and discrimination in previous research (Brewster et al., 2013; Chang et al., 2021; Feinstein et al., 2019). Increased outness has been linked to psychological well-being and indirectly related to lower depression through greater social support in lesbian, gay, and bisexual as well as bisexual specific samples (Brewster et al., 2013; Chang et al., 2021). In general sexual minority and bisexual specific samples increased outness was also related to increased discrimination and mental health concerns (Brewster et al., 2012; Chang et al., 2013; Feinstein et al., 2019). Greater outness was related to increased substance use and depression in bisexual individuals (Feinstein et al., 2019), and indirectly related to greater borderline personality disorder symptoms through greater discrimination (Chang et al., 2021). These findings indicate that outness, not assessed in this study, has an important impact on discrimination and mental health and should be considered in future research.

Another limitation of this study is that recruitment took place during the 2020-2021 COVID-19 pandemic. It is unclear how the pandemic may have impacted the experiences of body image, disordered eating behaviors, and relationships. One recent qualitative study found that the pandemic did impact women's body image due to a lack of social interaction and increased social media use (Quathamier & Joy, 2021). The individuals in this study reported that the social isolation provided a break from surveillance from others, which for some relieved them from self-surveillance; however, the larger reliance on social media resulted in more negative body image for some (Quathamier & Joy, 2021). Additionally, participants reported that the pressure to use lockdown to improve oneself resulted in them feeling less secure in their bodies.

The current study also did not measure relationship satisfaction, which has been linked to body satisfaction (Kashubeck-West et al., 2018); however, relationship satisfaction has been shown to have decreased on average during the pandemic (Schmid et al., 2021). Recruitment also may have been more difficult if women were sheltering in place and not entering into romantic relationships at this time.

Future studies should include a measure of relationship satisfaction in order to see if this may impact disordered eating behavior outcomes.

Conclusion

The current study added to the knowledge of bisexual women's experiences. The results suggest that the relation of objectification to body image and disordered eating behaviors may be different for bisexual women than for heterosexual and lesbian women. This highlights that including all sexual minority women in one group for comparison to heterosexual women should be done with caution. It reminds us that within the larger "sexual minority umbrella" women's experiences may be quite different. Additionally, the findings of the current study suggest that there may be some differences in bisexual women's experiences based on the gender of their romantic partner, but their relationship status (i.e., single vs. partnered) may have a larger impact than the gender of their partner. These findings add to the current literature while highlighting new questions for future research.

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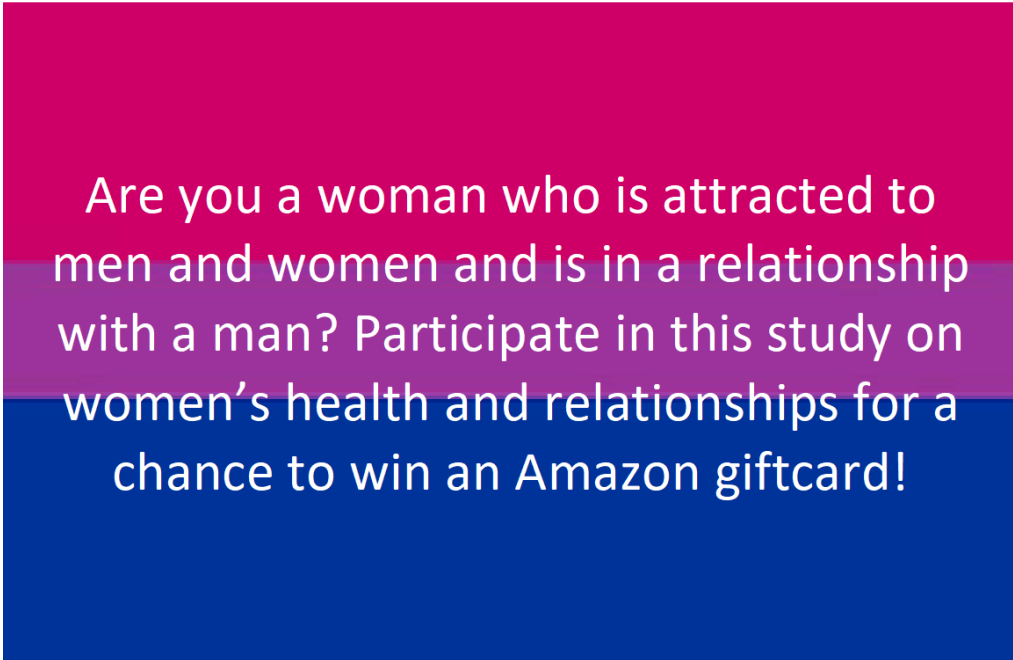
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Appendix A

Facebook advertisements



Are you a woman who is attracted to men and women and is in a relationship with a woman? Participate in this study on women's health and relationships for a chance to win an Amazon giftcard!



Are you a woman who is attracted to men and women and is in a relationship with a man? Participate in this study on women's health and relationships for a chance to win an Amazon giftcard!

Appendix B

Recruitment Email for Previous Participants

Hi,

I am contacting you because you were a research participant in one of our previous studies, and you indicated that you may be interested in participating in future research! Please consider taking part in our current study.

Are you a woman between the ages of 18 and 30? Do you identify as bisexual or experience attraction to men and women? Are you currently in a relationship?

If so, you can choose to participate in a research study about your health and experiences. The survey should take you approximately 20-30 minutes to complete. If you choose to complete the survey you will be given the opportunity to provide your email to be entered into a raffle for an Amazon gift card.

You can access the survey here:

(link)

Thank you,

Rachel
Sexual Minority Health Lab Representative

Appendix C

Recruitment Email for LGBT Organizations

Hello [Contact Name],

My name is Rachel Amerson. I am a research assistant in the Sexual Minority Health Lab at Old Dominion University in Norfolk, VA working under the supervision of Dr. Robin Lewis, a professor in the Psychology Department. We are contacting you to ask for your assistance in recruiting participants for an online study that we are currently conducting. The study examines bisexual women's experiences of objectification, discrimination, body image, and disordered eating behaviors in the context of their romantic relationships. The study is completely anonymous and has been approved by the Old Dominion College of Science Human Subjects Committee. In addition, participants who complete the survey will have the opportunity to enter a raffle for an Amazon gift card.

Since the survey is online, we can provide you with the online URL to pass along to potential participants. Also, we can provide additional information about the study and/or confirmation of approval by the research committee if needed. Any assistance that you can provide would be greatly appreciated.

Thank you,

Rachel Amerson

Appendix D

Interpersonal Sexual Objectification Scale

Please answer the following questions using the scale:

1 = never, 2 = rarely, 3 = occasionally, 4 = frequently, or 5 = almost always.

1. How often have you been whistled at while walking down a street?
2. How often have you noticed someone staring at your breasts when you were talking to them?
3. How often have you felt like or known that someone was evaluating your physical appearance?
4. How often have you felt like someone was staring at your body?
5. How often have you noticed someone leering at your body?
6. How often have you heard a rude, sexual remark made about your body?
7. How often have you been touched or fondled against your will?
8. How often have you experienced sexual harassment (on the job, in school, etc.)?
9. How often have you been honked at while walking down the street?
10. How often have you seen someone stare at one or more of your body parts?
11. How often have you overheard inappropriate sexual comments made about your body?
12. How often have you noticed that someone was not listening to what you were saying, but instead gazing at your body or body part?
13. How often have you heard someone making sexual comments or innuendos when noticing your body?
14. How often has someone grabbed or pinched one of your private body areas against your will?
15. How often has someone made a degrading sexual gesture toward you?

Appendix E

The Objectified Body Consciousness Scale

Please respond to the following statements with how much you agree with each statement.

1 = Strongly Disagree, 2 = Disagree, 3 = Somewhat Disagree, 4 = Somewhat Agree, 5 = Agree, 6 = Strongly Agree, or N/A = Not Applicable.

1. I rarely think about how I look.
2. I think that it is more important that my clothes are comfortable than whether they look good on me.
3. I think more about how my body feels than how my body looks.
4. I rarely compare how I look with how other people look.
5. During the day, I think about how I look many times.
6. I often worry about if the clothes I am wearing make me look good.
7. I rarely worry about how I look to other people.
8. I am more concerned with what my body can do than how it looks.
9. When I can't control my weight, I feel like something must be wrong with me.
10. I feel ashamed of myself when I haven't made the effort to look my best.
11. I feel like I must be a bad person when I don't look as good as I could.
12. I would be ashamed for people to know what I really weigh.
13. I never worry that something is wrong with me when I am not exercising as much as I should.
14. When I am not exercising enough, I question if I am a good enough person.
15. Even when I can't control my weight, I think that I am an okay person.

16. When I'm not the size I think I should be, I feel ashamed.

Appendix F

Anti-Bisexual Experiences Survey

Please respond to the following statements indicating how often you have experienced the described event using the scale:

1 = *Never*, 2 = *Rarely*, 3 = *Sometimes*, 4 = *Many Times*, 5 = *Often*, 6 = *Almost all the time*

1. People have addressed my bisexuality as if it means that I am simply confused about my sexual orientation.
2. I have been excluded from social networks because I am bisexual.
3. Others have pressured me to fit into a binary system of sexual orientation (i.e., either gay or straight)
4. When I have disclosed my sexual orientation to others, they have continued to assume that I am really heterosexual or gay/lesbian.
5. People have not wanted to be my friend because I am bisexual.
6. People have acted as if my sexual orientation is just a transition to a gay/lesbian orientation.
7. People have acted as if my bisexuality is only a sexual curiosity, not a stable sexual orientation.
8. People have assumed that I will cheat in a relationship because I am bisexual.
9. Others have treated me negatively because I am bisexual.
10. People have not taken my sexual orientation seriously because I am bisexual.
11. People have denied that I am really bisexual when I tell them my sexual orientation.

12. People have treated me as if I am likely to have an STD/HIV because I identify as bisexual.
13. People have stereotyped me as having many sexual partners without emotional commitments.
14. When my relationships haven't fit people's opinions about whether I am really heterosexual or gay/lesbian, they have discounted my relationships as experimentation.
15. Others have acted uncomfortable around me because of my bisexuality.
16. I have been alienated because I am bisexual.
17. People have treated me as if I am obsessed with sex because I am bisexual.

Appendix G

Neuroticism

Please respond to the following statements according to how accurately it describes you. Use the following scale when responding:

1 = Very Inaccurate, 2 = Moderately Inaccurate, 3 = Neither Accurate or Inaccurate, 4 = Moderately Accurate, 5 = Very Accurate

1. I often feel blue.
2. I dislike myself.
3. I am often down in the dumps.
4. I have frequent mood swings.
5. I panic easily.
6. I rarely get irritated.
7. I seldom feel blue.
8. I feel comfortable with myself.
9. I am not easily bothered by things.
10. I am very pleased with myself.

Appendix H

The Eating Pathology Symptoms Inventory

Below is a list of experiences and problems that people sometimes have. Read each item to determine how well it describes your recent experiences. Then select the option that best describes **how frequently** each statement applied to you **during the past four weeks, including today**.

Use this scale when answering:

0 = Never, 1 = Rarely, 2 = Sometimes, 3 = Often, 4 = Very Often

1. I did not like how clothes fit the shape of my body
2. I tried to exclude “unhealthy” foods from my diet
3. I ate when I was not hungry
4. People told me that I do not eat very much
5. I felt that I needed to exercise nearly every day
6. People would be surprised if they knew how little I ate
7. I used muscle building supplements
8. I pushed myself extremely hard when I exercised
9. I snacked throughout the evening without realizing it
10. I got full more easily than most people
11. I considered taking diuretics to lose weight
12. I tried on different outfits, because I did not like how I looked

13. I thought laxatives are a good way to lose weight
14. I thought that obese people lack self-control
15. I thought about taking steroids as a way to get more muscular
16. I used diet teas or cleansing teas to lose weight
17. I used diet pills
18. I did not like how my body looked
19. I ate until I was uncomfortably full
20. I felt that overweight people are lazy
21. I counted the calories of foods I ate
22. I planned my days around exercising
23. I thought my butt was too big
24. I did not like the size of my thighs
25. I wished the shape of my body was different
26. I was disgusted by the sight of an overweight person wearing tight clothes
27. I made myself vomit in order to lose weight
28. I did not notice how much I ate until after I had finished eating
29. I considered taking a muscle building supplement
30. I felt that overweight people are unattractive
31. I engaged in strenuous exercise at least five days per week
32. I thought my muscles were too small
33. I got full after eating what most people would consider a small amount of food

- 34. I was not satisfied with the size of my hips
- 35. I used protein supplements
- 36. People encouraged me to eat more
- 37. If someone offered me food, I felt that I could not resist eating it
- 38. I was disgusted by the sight of obese people
- 39. I stuffed myself with food to the point of feeling sick
- 40. I tried to avoid foods with high calorie content
- 41. I exercised to the point of exhaustion
- 42. I used diuretics in order to lose weight
- 43. I skipped two meals in a row
- 44. I ate as if I was on auto-pilot
- 45. I ate a very large amount of food in a short period of time (e.g., within 2 hours)

Appendix I

Demographics Questionnaire

What is your age (in years):

What sex were you assigned at birth, on your original birth certificate?

1 = Male

2 = Female

How do you describe yourself?

1 = Male

2 = Female

3 = Female to Male Transgender

4 = Male to Female Transgender

5 = Gender queer/non-conforming

6 = Other (specify) _____

There are many ways that individuals think of their sexual identity. Choose all that describe you.

Heterosexual/Straight

Lesbian

Bisexual

Queer

Asexual

Pansexual

Questioning

Gay

Other (specify) _____

People are different in their sexual attraction to other people. Which best describes your feelings?

1 = I am only attracted to women.

2 = I am mostly attracted to women.

3 = I am equally attracted to men and women

4 = I am mostly attracted to men

5 = I am only attracted to men

6 = Prefer not to answer

With whom have you had sex in your lifetime?

1 = women only

2 = women and men

3 = men only

- 4 = no one
- 5 = Prefer not to answer

During the past year, with whom have you had sex?

- 1 = women only
- 2 = women and men
- 3 = men only
- 4 = no one
- 5 = Prefer not to answer

How would you describe your relationship status?

- 1 = Single, not dating
- 2 = Single, dating, but without a main partner
- 3 = Single, dating a main partner but not in an exclusive relationship
- 4 = Single, exclusively dating one person
- 5 = Partnered, in a relationship that is not exclusive
- 6 = Partnered, in an exclusive relationship
- 7 = Partnered, married or in a civil union
- 8 = other

What sex was your current partner assigned at birth, on their original birth certificate?

- 1 = Male
- 2 = Female

How does your partner describe themselves?

- 1 = Male
- 2 = female
- 3 = Female to Male Transgender
- 4 = Male to Female Transgender
- 5 = Gender queer/non-conforming
- 6 = Other (specify)

What is your height? – Feet

What is your height? – inches

What is your best guess of your current weight in pounds?

What is your ethnicity?

- 1 = Hispanic, Latina, or Spanish origin
- 0 = Not Hispanic, Latina, or Spanish origin

Which racial group BEST describes you?

- 1 = African American or Black alone
- 2 = American Indian and Alaska Native alone
- 3 = Asian, Asian American, Native Hawaiian, or Pacific Islander alone
- 4 = European American, Caucasian, or White alone
- 5 = Multiracial
- 6 = Other (Specify) _____

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