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An Exploration Of Bisexual+ Women's Preferences For Sexual Violence Vulnerability Reduction Interventions: A Multi-Ethnic, Multi-Racial Sample

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AN EXPLORATION OF BISEXUAL+ WOMEN'S PREFERENCES FOR SEXUAL VIOLENCE VULNERABILITY REDUCTION INTERVENTIONS: A MULTI-ETHNIC, MULTI-RACIAL SAMPLE

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Sara K. Kuhn
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ABSTRACT

Bisexual women are disproportionately victimized by sexual violence due to minority stress. Understanding their acceptability of and preferences for sexual violence vulnerability reduction interventions is critical for successful prevention efforts. Self-report data was collected online from 240 ethnoracially- and gender-diverse bi+ women and 65 heterosexual, white cisgender women (controls). Bi+ women preferred bi+ inclusive interventions. The sole intervention found significantly acceptable for most bi+ women (62%) was a modified, bi+ inclusive Bringing in the Bystander®. Yet, most bi+ women ranked the Sexual Assault Risk and Alcohol Use Reduction Program and Brief Drinking Intervention as most preferred. The Hookup Reduction Intervention was found least acceptable by all women. Confidentiality was ranked in the top five most important intervention elements by the majority of all women. Most bi+ women (80%; 49% of controls) reported adult sexual victimization histories. Anticipated stigma/victim-blaming may explain lower acceptability rates for interventions targeting victimized women over bystanders/perpetrators.

CHAPTER I

INTRODUCTION

Sexual violence is a public health crisis in the United States (Basile & Smith, 2011); yet sexual violence research is chronically underfunded (Waechter & Ma, 2015). Women are far more likely to be sexually victimized than men, with approximately 20% of women in the U.S. reporting having experienced sexual victimization at least once in their lives (Muehlenhard et al., 2017). Research has demonstrated sexual minoritized (SM) people are on average at least twice as likely to have experienced various types of sexual victimization than their heterosexual counterparts (Chen et al., 2020; Hughes et al., 2010; Mattocks et al., 2013). Sexual victimization is linked to negative physical and mental health outcomes (Basile & Smith, 2011; Dillon et al., 2013; Dworkin et al., 2017; Mattocks et al., 2013), particularly in relation to traumatic stress symptoms in women (Dworkin et al., 2017; Ullman & Brecklin, 2002). A recent systematic review of 10-24 year-olds found 60% had developed PTSD one year after experiencing sexual victimization (MacGregor et al., 2019).

Bisexual women are one of the most vulnerable groups for experiencing sexual victimization (Chen et al., 2020; Flanders et al., 2019; Hequembourg et al., 2013) and they are a steadily growing population. The CDC found bisexual women's rates of lifetime rape (46%) and other sexual victimization experiences (75%) were significantly higher than for both lesbian (13% and 46%, respectively) and sexual majority (17% and 43% respectively) women (Walters et al., 2013). In a national sample, lifetime prevalence for sexual victimization was found to be higher not only among bisexual identified women, but also among non-bisexual identified women who reported attraction to, or

sexual behavior with, both women and men (Liu et al., 2020). Additionally, national surveys have shown a recent increase in bisexual identification *and* behavior among women (Copen et al., 2016), particularly among Black Americans and other women of color (WOC; Bridges & Moore, 2018).

The Diversity of Bi+ or Plurisexual People

Sexual orientation is a holistic concept comprising sexual identity, sexual attraction, and sexual behavior. Plurisexual or multiattracted (i.e., feeling attraction to more than one gender of person, or regardless of gender) women include poly, pan-, omni-, and bi-sexual women. It can also include women who are attracted to, and/or engage in sexual behavior with, more than one gender of person but identify as monosexual (i.e., lesbian or straight). Plurisexual women can be two-spirit, fluid, biromantic, queer or questioning, transgender or cisgender, or none of the above. In this study, *bi+ women* is used as an umbrella term to refer to all plurisexual women as described here. The use of this term is not intended to minimize the differences between groups of plurisexual women, but to provide a holistic approach for researching plurisexual women through which meaningful comparisons among specific bi+ women's sexual identity groups (e.g., bisexual versus pansexual women) may potentially be made.

The bi+ umbrella is diverse, and research has documented the heterogeneous nature of bisexual identity (Choi, et al., 2019). For example, pansexual people reported higher levels of psychological distress over bisexual people in a New Zealand national sample (Greaves et al., 2019). Alternatively, bisexual-only identified people from Canada reported higher rates of various mental health and substance use issues over pansexual-only and other SM identified people (Bauer et al., 2016). One study found bisexual

participants reported higher levels of sexual identity prejudice from lesbian/gay people and less perceived connection to the LGBTQ+ community than did pansexual/queer/fluid participants (Mitchell et al., 2015). It is unknown how intervention preferences will differ among bi+ women groups. Johnson & Grove (2017) highlight the importance of not ignoring:

> the unique vulnerability factors and negative outcomes of sexual violence faced by sexual minority women, and bisexual women in particular . . . sexual minority women are [often] collapsed into the category of "lesbian/bisexual" or "LGB/T," potentially obscuring findings unique to this group and risking reification of the invisibility faced by sexual minority women in the larger culture. Future researchers must make a concerted effort to explore differences and similarities between and within sexual minority women . . . such that our stories might be told with greater depth and accuracy. (p. 445)

Minority Stress and Intersectionality

The minority stress framework elaborates multiple mechanisms for understanding these findings. Minority stress theory assumes that people who are often marginalized due to the social groups they belong to (e.g., sexual, gender, racial, and ethnic minoritized groups) are also exposed to higher levels of social stress—which is then compounded if they belong to multiple stigmatized groups, resulting in multiple minority stress (Meyer, 2003). Thus, bi+ WOC are subject to multiple vulnerabilities (Cyrus, 2017) which likely result in them being triply impacted by sexual victimization. A study on lesbian, bisexual, and two-spirit American Indian and Alaskan Native women found an 85% prevalence rate for sexual victimization associated with worse mental health outcomes (Lehavot et

al., 2010). The Report of the 2015 U.S. Transgender Survey, comprising respondents of various sexual (14% bisexual; 18% pansexual), ethnoracial (62% white), and gender (e.g., nonbinary, non-conforming, fluid) identities, found nearly half (47%) of participants experienced lifetime sexual violence, 10% were sexually assaulted in the past year, and 54% experienced intimate partner violence (James et al., 2016). To reduce the risk of sexual violence vulnerability in bi+ women, data is needed to identify bi+ women's preferences for sexual violence vulnerability reduction interventions (herein referred to as "sexual violence interventions"). If we increase our ability to provide appealing, informed, and culturally sensitive sexual violence interventions, we can more effectively address this public health crisis disproportionately impacting SM women.

The intersectionality framework developed by Crenshaw (1989) is particularly well suited to exploring ethnoracial and sexual identity factors as it looks at identity as being more complex than an additive approach (i.e., the added total of a "woman's experience," a "lesbian experience," and "the Black experience") allows. The intersectional approach pays particular attention to social groups at unacknowledged points of intersection and identities that transcend traditional social group boundaries or exist in spaces between or outside of these boundaries (Cyrus, 2017). Crenshaw (1989) argued our reliance on exploring single minoritized group identity discrimination (e.g., gender or racial) diminishes, overshadows, and renders unimportant the experiences of people with multiple intersecting minoritized identities. Imagine an "elderly, Black, lesbian, polyamorous, middle-class woman," a "young, Asian, pansexual, poor, immigrant woman," and a "heterosexual, white, Hispanic, wealthy, disabled woman" being categorized solely as "women." If a researcher attempts to investigate the

discrimination of women based on this group, the wide variety of potential discriminatory experiences targeting aspects of the participants' identities that are not "woman" within the group are negated and discounted in favor of a generalized, unified whole based on one identity characteristic.

Feminist psychology has been at the forefront of acknowledging women's experiences of targeted stigma and discrimination based on their intersecting identities (Bowleg, 2008). Yet, in psychological research, the concept of social identities and social inequality being inherently intersectional (interdependent and mutually vital) and not additive creates methodological challenges and complexity regarding measurement, data analysis, and interpretation (Bowleg, 2008). This is particularly true in quantitative research on diverse populations which has been historically and inherently additive (Parent et al., 2013).

Intersectional research should include a primary focus on relevant constructs that characterize minoritized people and their stressful experiences (e.g., strength of ethnic/sexual identities, stress, discrimination, stigma) over an emphasis on solely demographic questions to categorize them. Cyrus (2017) suggests mixed methods approaches can help reveal the subjective, manifold experiences of LGBTQ+ POC. Consistent with the spirit of intersectionality, quantitative data can be supplemented with a few qualitative and intersectional (i.e., holistic) open-ended questions that validate participants experiences even if left unanalyzed. For example, in keeping with Puckett and colleagues' (2020), one could supplement a list of responses for sexual identity with an open text-entry response option allowing participants to create/write in their chosen/holistic sexual identity.

These open-ended questions may also point to important future research questions and directions. Deconstructing identities to explore how they intersect can illuminate differences and similarities within LGBTQ+ POC groups to inform customized approaches for working with these diverse groups (Cyrus, 2017). Meyer (2010) proposes that research examining minority stress variables in separate studies investigates separate effect processes that do not tell the whole story—for example, studies on mental health disorder prevalence in LGBTQ+ POC that are separate from studies on the impact of this stress. As McCall (2005) asserts, to progress we must explore intersectional identities and employ creative research designs.

Intervention Needs for Women Minoritized by Sexual and Ethnoracial Identities

Bronfenbrenner's (1979) ecological theory of human development aligns well with intersectionality and provides a holistic approach for highlighting ecological factors impacting women's mental health outcomes (e.g., symptoms of posttraumatic stress disorder; PTSD) after being sexually victimized (Campbell et al., 2009). Ecological theory is steeped in the belief that human development constantly evolves through an individual's connection to multiple environmental systems and contexts (Bronfenbrenner, 1979; Campbell et al., 2009).

Campbell and colleague's (2009) ecological model for framing the impact of sexual violence on mental health outcomes suggests the implementation of multiple intervention strategies for sexual violence prevention. For example, including psychoeducation on rape myths within sexual violence interventions could positively impact those recovering from sexual violence by helping them overcome both self-blame when their experience does not align with typical rape stereotypes, and barriers for protecting themselves when

learning self-defense strategies. Therefore, in addition to diverse strategies reflected in intervention content, identifying preferences for sexual violence interventions can go a long way towards informing best practices for, and customization of, sexual violence interventions for multiply vulnerable groups of women such as bi+ women.

Intervention Acceptability

Considering the historical experiences of discrimination in mental health care for people who have been minoritized due to their sexual and ethnoracial identities, which can then lead to a reduction in help-seeking behavior and treatment completion (Greene & Blitz, 2012), it is critical to understand intervention acceptability among participants. Moreover, Swift and colleagues' 2011 meta-analysis of 18 studies found an association between client preferences for aspects of a treatment intervention (e.g., treatment type, therapist type, treatment content) and both increased willingness to participate in the intervention and treatment completion. In fact, clients whose preferences were accommodated were almost 50% less likely to dropout (Swift et al., 2011).

The concept of acceptability in this thesis will be framed through Sekhon's Theoretical Framework of Acceptability, version 2 (TFA2; Sekhon et al., 2017). Sekhon and colleague's (2017) definition of acceptability predicts participant willingness through perceptions that the intervention is appropriate, including their "anticipated or experienced cognitive and emotional responses to the intervention" (p. 1).

Further research questions to investigate include if anti-bisexual stigma and historical discrimination impacts bi+ women's acceptability of and preferences for interventions aimed at reducing vulnerability to sexual violence. Bi+ women's experiences of bisexual stigma have been positively correlated with adolescent and adult

sexual victimization histories (Flanders et al., 2019; McConnell & Messman-Moore, 2019). Bisexual women's experiences of child sexual abuse (CSA) have been indirectly linked, via heavy drinking, to adult sexual victimization experiences at mean and high levels of anti-bisexual stigma (McConnell & Messman-Moore, 2019).

Intervention Preferences

Consistent with minority stress theory, it has been demonstrated that SM women prefer interventions conducted in an inclusive environment for SM people with associated and relevant content (Martos et al., 2018; Seaver et al., 2008). Ethnoracially minoritized women, who reported concerns about stigma related to their ethnoracially minoritized status, were shown to prefer individual over group counseling (Nadeem et al., 2008). Minority stress theory would suggest these preferences reflect the need for increased personal inclusivity, relevancy, and confidentiality to guard against anticipated stigma and discrimination.

Cochran and colleague's (2008) research into women's treatment preferences after sexual assault found that 73% of women selected treatment efficacy as a primary reason for their treatment preference. Over half of women (59.3%) were wary of medication as treatment and 41% reported liking the talking component of cognitive behavioral therapy (Cochran et al., 2008).

Prior research suggests self-defense based interventions are popular with and beneficial for women, and many women who have never taken self-defense classes have considered enrolling (Hollander, 2010). Research has shown the majority of women enrolled in self-defense/assertiveness training have experienced CSA and/or adult sexual victimization, with percentage rates reaching as high as 75% (Brecklin & Ullman, 2004;

Hollander, 2010). Thus, women, particularly women who have experienced sexual violence, may prefer self-defense interventions over other interventions. However, research has not yet been conducted to demonstrate if bi+ women find sexual violence interventions acceptable and/or relevant to them, and what their specific preferences for interventions may be. Additionally, women may believe guns to be an effective method of personal protection against sexual violence. United States social survey research demonstrated 58% of women agree guns make a home "safer" (vs. 34% indicating the home becomes "more dangerous" (McCarthy, 2014).

The Current Study

The overarching goal of this study was to assist in combatting the national public health crisis of sexual violence by informing best practices for reducing sexual violence vulnerability in an especially vulnerable group: bi+ women. This author has found no published evidence this research has been conducted and hopes to fill a critical research gap for acceptability of and preferences for sexual violence interventions in a diverse group of bi+ women through a largely exploratory investigation. Study variables uniquely framed by minority stress theory included intersectional identities, the strength of SM and ethnoracial identities, sexual victimization histories, stigma and discrimination, and physical and mental health disability status.

Research Aims and Hypotheses

The primary aim of this study was to explore bi+ women's acceptability of and preferences for sexual violence interventions. Secondary aims were to explore potential predictors of preferences (e.g., CSA/adult sexual victimization histories; experiences of gender-, race-, or sexuality-based discrimination).

Hypothesis 1 (H1): Bi+ women will prefer, and find more acceptable, bi+ inclusive and relevant sexual violence interventions, particularly bi+ women who report moderate to high instances of bisexual stigma-producing experiences. H2: Bi+ ethnoracially minoritized women, who report a commitment to or exploration of their ethnoracial identities, will prefer ethnoracially relevant and inclusive sexual violence interventions. H3: There will be a positive relationship between CSA/adult sexual victimization history and acceptability of and preference for the Flip the Script™ (SARE Centre, 2020) self-defense intervention. H4: Sexual violence intervention acceptability rates will be attenuated for women who own or plan to own a gun.

CHAPTER II

METHOD

Participants

All 305 participants were women 18 years of age or older and residing in the U.S. or a U.S. Federal Territory or District at the time of study participation. Participants completed the entire study online through the Qualtrics XM experience management software platform. The study was expected to take approximately 30-60 minutes to complete, and participants were informed the study could take up to 60-90 minutes during the informed consent portion at the start of the study survey. Participants were allowed to take breaks and return to the survey within one month; thus, the time participants actually utilized to complete the study ranged from 17.67 minutes-30 days.

A total of 1,710 adult women met study criteria (i.e., "passed" the online screener) and participated in this study. Of these participants, 1,405 were excluded from further analysis for the following reasons: 1) the respondent did not answer at least one item on each measure (-1,342, $N = 368$), and 2) the response was identified as likely fraudulent based on Qualtrics XM anti-fraud screening tools (-63, $N = 305$). These anti-fraud tools included identifying low captcha scores, duplicate responses, potential bots, and respondents currently outside of the United States (U.S.)

The experimental group comprised 240 bisexual+ (bi+) women with a modal age of "20-29 years" and the following non-mutually exclusive racial and ethnic identities: 3% American Indian, Alaskan Native, or First Nations; 12% Black or African American; 13% biracial or multiracial; 16% Asian, Asian Indian, Native Hawaiian, or Pacific Islander; 39% white; 22% Hispanic. The majority of participants identified as a

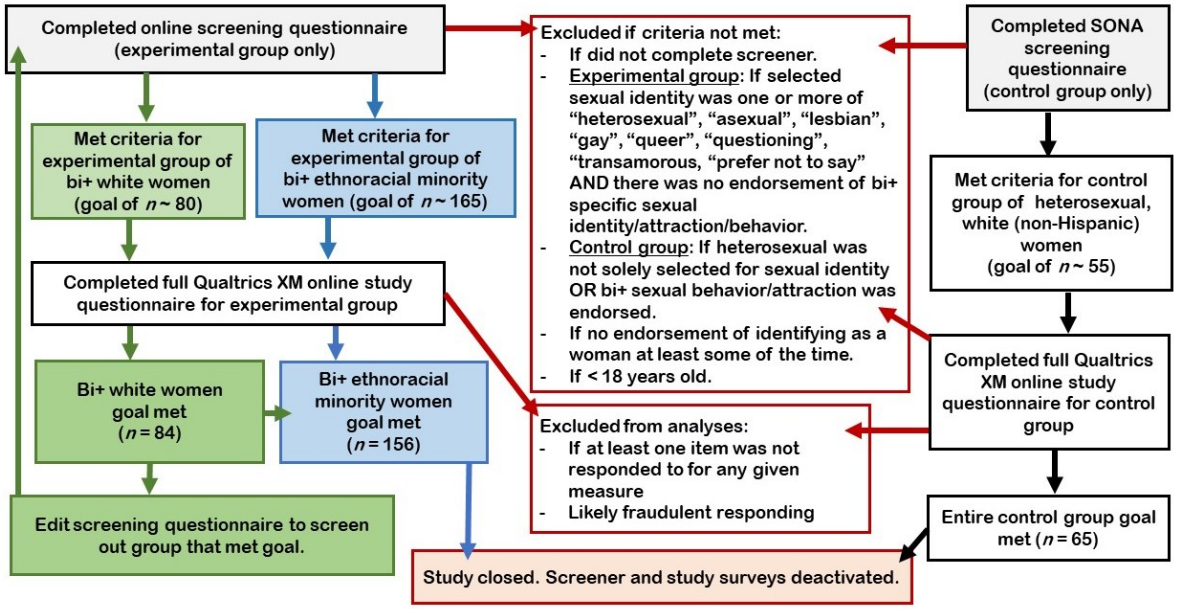
Person/Woman of Color or as a racialized person (58%), and/or with an ethnoracially minoritized identity (65%). Seventy-five percent of bi+ participants identified their gender as solely "woman" while 25% identified having multiple gender identities suggesting gender nonconforming/nonbinary identities. Ten percent of bi+ participants identified as transgender and 7% reported being unsure/questioning. The majority of the sample (90%) identified as bi+, with 2% identifying as solely monosexual and 8% identifying with ambiguous sexual identities (i.e., unclear if monosexual or bi+) such as gay, queer, and/or questioning. The majority of participants (52%) identified "bisexual or biromantic" as their only/primary sexual identity. Participants in the experimental group were recruited via social media platforms, LGBTQ+- and research-based websites, LGBTQ+ university and community groups and listservs, and paper advertisements. LGBTQ+ and LGBTQ+ BIPOC community groups and listservs proved the most fruitful recruiting strategy resulting in fewer fraudulent responses. Participants were paid $10 for their participation via an online gift card with a voluntary opportunity to be entered into a raffle to win one of five additional $25 gift cards.

The control group comprised 65 white (non-Hispanic), cisgender women with a heterosexual orientation (Modal age = "18-19 years"). Control group participants were recruited through a midwestern university's undergraduate psychology student SONA subject pool. They were compensated with 1.5 SONA credit hours for their participation.

See Figure 1 for participant screening and recruitment flow. See Table 1A in Appendix A for additional participant intersectional identity characteristics including disability status, immigration, religion, and others.

Figure 1

Participant Screening and Recruitment Flow Chart



Measures

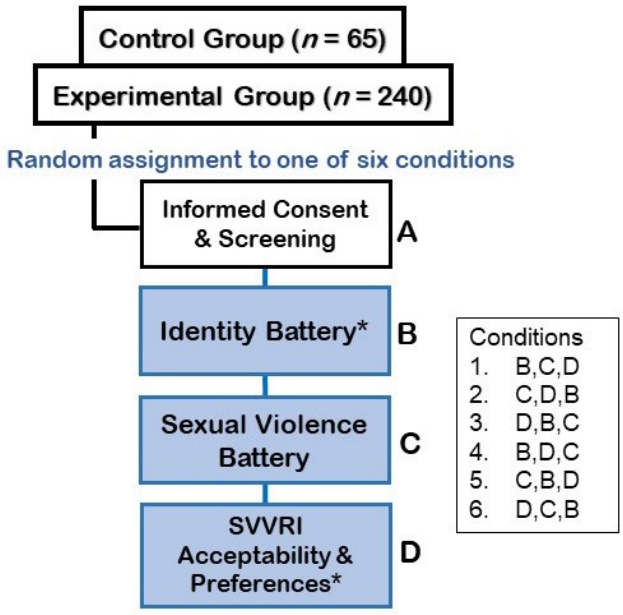
All measures in this study are self-report measures delivered together in one online study link. Considering research suggesting the heterosexism of standard measures (Anderson & Delahanty, 2019; Koss et al., 2007), those not previously used with or modified for people minoritized due to their sexual identity were modified to be inclusive of and relevant to bi+ women. One measure modified in this manner was the 12-item Sexual Experiences Survey – Short Form Victimization (SES-SFV; Koss et al., 2006), which also included Made to Penetrate (MTP) items from Anderson and colleagues' (2020) study in which they found victimization via MTP to be well-established in heterosexual relationships, largely perpetrated by women, and accounting for 33.8%–58.7% of cases of men's sexual victimization. It would be useful to assess the prevalence of this same phenomenon in sexual minoritized (SM) individuals, and if SM people would report higher instances of sexual victimization with the addition of MTP items.

Two measures previously created for SM people that were not bi+ inclusive in language were used in their original and adapted forms: the Anti-Bisexual Experiences Scale (Brief ABES; Brewster & Moradi, 2010) and Wilkerson and colleagues' (2016) single-item outness indicator. Further details on these adaptations are available open access online (https://osf.io/7rw2b) and empirical tests of these adaptations will be explored in another manuscript.

Figure 2 illustrates how participants were randomly assigned to one of six conditions in which the order of administration of three assessment battery blocks (B, C, D) were counterbalanced to account for participant fatigue and order effects (e.g., the potential impact of first answering questions about identity and discrimination or sexual victimization history on intervention acceptability and preferences).

Figure 2

Administration of Measures: Randomized Counterbalanced Conditions Flow Chart



Note. Identity Battery: demographic, intersectional identity, and discrimination variables. Sexual Violence Battery: lifetime sexual victimization history variables. SVVRI (Sexual Violence Vulnerability Reduction

Intervention) Acceptability & Preferences: North Dakota Sexual Violence Intervention Acceptability Measure (ND SVIAM) and additional intervention acceptability/preferences items. *Bi+ participants (experimental group) were directed to bi+ related measures; bi+ participants identifying with ethnoracial identities often minoritized were directed to measures centering ethnoracially minoritized identity status.

Identity Battery: Intersectional Identity and Discrimination

Rather than categorizing demographic variables as simply individual and additive characteristics, this study defined them as intersectional identity variables, reflecting the need to view these data as integral aspects of a person's holistic identity. Participants were asked their immigration status, country of birth, religion, age, highest education level, individual income, disability status/identity, and gender identity (e.g., woman, transgender, cisgender, two-spirit, nonbinary, bigender, genderqueer, gender fluid, gender nonconforming, other).

Perceived Socioeconomic Status. The MacArthur Scale of Subjective Social Status – Adult Version (MacArthur SSS Scale; Goodman et al., 2001) was used to measure participants' perceived socioeconomic (SES) status ranked in relation to others with a single-item image of a 10-rung ladder. Mental and physical health impacts a person's objective SES (e.g., education, job, income, etc.; Adler et al., 1994). Higher levels of subjective SES predict better overall health (Ostrove et al., 2000). The scale demonstrated adequate test-retest reliability (Operario et al., 2004), good convergent and discriminant validity (Cundiff et al., 2013), and has been shown to better predict various health outcomes over objective SES measures (Demakakos et al., 2008; Franzini & Fernandez-Esquer, 2006; Garza et al., 2017; Operario et al., 2004; Ostrove et al., 2000; Singh-Manoux et al., 2005). The SSS Scale has been used with diverse ethnoracial participants (Bullock & Limbert, 2003; Franzini & Fernandez-Esquer, 2006; Garza, et al.,

2017; Leu, et al., 2008; Ostrove, et al., 2000) and sexual and gender minoritized people (Arseneau et al., 2013; Santos & VanDaalen, 2018; Tebbe et al., 2019; VanDaalen, 2016).

Gun Ownership. Gun ownership was evaluated using four items from Halkovic (2017) that inquire about past, current, and future gun ownership of the participant or their family members, including if they carry a concealed weapon. The future/lifetime gun owner continuous variable was created by adding "1" for each of the following endorsements per participant: 1) owning a gun, 2) carrying a gun, 3) wishing to own a gun in the future, 4) family member owns a gun, and 4) previously owning a gun. "0" reflected women who were not future/lifetime gun owners.

Sexual Identity, Behavior, and Attraction. The Williams Institute's recommended items for sexual identity, behavior, and attraction (Sexual Minority Assessment Research Team; 2009) were used as a starting point for the development of three related items (i.e., sexual identity, sexual behavior, and sexual attraction; see Appendix B). A "check all that apply" instruction was used for the three items instead of confining participants to one choice. If participants selected more than one identity, they were asked which endorsed identity was the most meaningful to them with two additional options: "They are all of equal importance/meaning," and "Unsure/don't know." The time period used for the sexual behavior item was "from the age of 14" to be consistent with the measure of adult sexual victimization history administered (i.e., the Sexual Experiences Survey - Short Form Victimization).

Relationship Status. To assess relationship status inclusive of bi+ and minoritized relationships (e.g., polyamorous), participants were asked their partner(s)'

gender(s) and to "check all that apply" from a diverse and inclusive list of relationship types including monogamy, polyamory, and singledom (C. Flanders, personal communication, June 4, 2020).

Bi+ Identity. The 27-item Lesbian, Gay, and Bisexual Identity Scale (LGBIS; Mohr & Kendra, 2011) assesses eight constructs related to SM identity through its subscales: 1) Acceptance Concerns, 2) Concealment Motivation, 3) Identity Uncertainty, 4) Internalized Homonegativity, 5) Difficult Process, 6) Identity Superiority, 7) Identity Affirmation, and 8) Identity Centrality. The LGBIS and subscales demonstrated adequate six-week test-retest reliability (r = .70-.92) and internal consistency reliability (a = .72 - .94; Mohr & Kendra, 2011).

Modifications and Additions. Instructions and item language were edited to reflect the spectrum of bi+ identities instead of bisexual only, e.g., "For each of the following questions, please mark the response that best indicates your current experience as a bi+ person (meaning a person who does not identify as straight or lesbian, which may include multiattracted, bisexual, plurisexual, pansexual, polysexual, omnisexual, biromantic, two-spirit, queer, etc.)." In all instances, "same-sex" was changed to "same gender" (e.g., "I believe it is unfair that I am attracted to people of the same gender"). Items similar to those asking about heterosexual people were added for lesbian women (e.g., "I look down on lesbian women").

Ethnic Identity. Phinney & Ong's (2007) 6-item Multigroup Ethnic Identity Measure—Revised (MEIM-R) assessed participants' commitment to and exploration of their ethnoracial identities, irrespective of the specific cultural characteristics of each ethnoracial group. The MEIM-R has two factors: a sense of belonging to one's ethnic

group (i.e., commitment) and exploration of ethnic identity (Phinney & Ong, 2007). It demonstrated an overall Cronbach's alpha of 81, with .76 for exploration, and .78 for commitment (Phinney & Ong, 2007). Response options lie on a 5-point Likert type scale from "Strongly disagree" (1) to "Strongly agree" (5).

Modifications. Instructions were edited to eliminate outdated, racist terminology and to include a more diverse representation of various ethnoracial groups in the United States.

Racialized Identity. Participants were asked if they identify as a person/woman of color and/or racialized person with the following response options: "Yes," "No," and "Prefer not to say" (C. Flanders, personal communication, June 4, 2020).

Experiences of Bisexual Stigma. Dyar et al.'s (2019) 8-item brief version of the Anti-Bisexual Experiences Scale (Brief ABES; Brewster & Moradi, 2010) assessed participants' types of binegative experiences (i.e., discrimination, stigma) a person encounters due to their bisexual identity. Items were removed due to 1) low factor loadings, 2) redundancy, and 3) applicability to bisexual men over bisexual women (Dyar et al., 2019). The Brief ABES was shown to demonstrate similar correlations to the ABES for related constructs and be appropriate for use with diverse bi+ participants while retaining the original ABES 3-factor structure (i.e., instability stereotypes, sexual irresponsibility stereotypes, and general hostility factor). Respondents answer the survey items by indicating their binegative experiences from "heterosexual/straight" people, "gay/lesbian" people, or "unsure." A study on bi+ women found a Cronbach's alpha of .95 for ABES subscales (Flanders et al., 2019) while the Brief ABES demonstrated a

Cronbach's alpha of .81 to .95 for all subscales (Dyar et al., 2019). The original ABES, and a modified ABES were administered to participants via random assignment.

Modified ABES. Item language was altered to be inclusive of women's bi+ sexual behavior and attraction as well as sexual identity. Where the items ask what person/people exhibited the stigma, "bisexual/pansexual/plurisexual" people was added as a group/option alongside "straight/heterosexual" people and "gay men/lesbian women." "Others" was added to "unsure": "others/unsure." Response options for each item were separated into sexual identity, sexual behavior, and sexual attraction. For example, one item stated, "People have not taken my sexuality seriously," while a second item stated, "People have not taken my sexual activity with a certain gender of person seriously," and a third item stated, "People have not taken my sexual attraction to a certain gender of person seriously."

Microaggressions Toward LGBT People of Color. The 18-item LGBT People of Color Microaggressions Scale (LGBT-POC MS; Balsam et al., 2011) measured bi+ women of color (WOC) participants' experiences of discrimination. The LGBT-POC MS comprises three subscales: (a) Racism in LGBT communities, (b) Heterosexism in communities of color, and (c) LGBT relationship racism (Balsam et al., 2011). Response options are on a 6-point Likert type scale from "Did not happen/Not applicable to me" (1) to "It happened and it bothered me EXTREMELY" (6) and can be scored with a dichotomous "occurrence" score or a ranked "distress" score (Balsam et al., 2011). Research suggests the LGBT-POC MS is a valid and reliable measure for assessing the subscale constructs with adequate convergent and discriminant validity, and an overall Cronbach's alpha of .92 (Balsam et al., 2011) and .85 (Ramirez & Paz Galupo, 2019),

with subscale alphas ranging from .74 to .91 (Ramirez & Paz Galupo, 2019), and .81 to .89 (Balsam et al., 2011), among studies. The LGBT-POC MS been used in several studies with Asian American, Black/African American, Hispanic/Latinx, and Biracial/Multiracial LGB samples (Balsam et al., 2011; Li, 2016; Ramirez & Paz Galupo, 2019; Thomas, 2015).

Due to a study administration error, the highest option (5) on the LGBT-POC MS response scale (0-5), "It happened, and it bothered me EXTREMELY" (6), was not presented; thus, the highest endorsement of microaggressions available to participants was number 4 on the scale, "It happened, and it bothered my QUITE A BIT."

Sexual Violence Victimization Battery

Sexual violence victimization history will be operationalized as child sexual abuse (CSA) and/or adult sexual violence victimization.

Child Sexual Abuse. To assess CSA, two dichotomous items were utilized. One item was from the Trauma History Questionnaire (THQ) CHILD (Green, 1996), i.e., "Has anyone ever made you watch or do something sexual (For example, touching you in a sexual way, touching your private parts, making you see or touch their private parts, or making you watch them touch their own private parts?)." The second item was taken from The Child Maltreatment Interview Schedule (CMIS) – Short Form (Briere, 1992; i.e., "To the best of your knowledge, would you say that you were sexually abused as a child (before age 14)?."

Adult Sexual Violence Victimization Histories. Participants completed a modified 12-item Sexual Experiences Survey – Short Form Victimization (SES-SFV; Koss et al., 2006) with Made to Penetrate items (SES-SFV with MTP) from Anderson

and colleagues (2020). The two made-to-penetrate items reflect victimization by being made to penetrate someone's genitals, anus, or mouth with one's penis or another object (Anderson et al., 2020). A study on its psychometric properties for college-aged women supports using the SES-SFV in both online and in-person studies, demonstrating comparable disclosure rates to the original SES (Koss & Gidycz, 1985), good predictive validity, and adequate test-retest reliability (Johnson et al., 2017). The SES-SFV has been used in recent research with sexual (Anderson et al., 2017; Anderson et al., 2019; Canan et al., 2020; Flanders et al., 2019; Forsman, 2017; Hequembourg et al., 2013), gender, and ethnoracially diverse or minoritized samples (Anderson et al., 2019; Kolp et al., 2020; Rogers et al., 2017; Senn et al., 2014). It was found to be an adequate assessment of bisexual women's sexual violence experiences (Canan et al., 2020).

Modifications and additions. In keeping with both Hipp & Cook's (2017) and Anderson and colleagues' (2019) suggestions for inclusive sexual violence research, an altered version of the SES-SFV with MTP (Anderson et al., 2019) was used to better achieve appropriateness for and inclusivity of bi+ women. Language was altered to reflect non-heteronormative sexual behavior, gender neutrality/diversity, and diverse genitalia for participants and their perpetrators (e.g., "dildo or" was added in front of "penis"; she/he pronouns were changed to "their"; "woman" or "man" was changed to "someone"; "genitals" were added alongside "vagina"). The "butt" and "vagina" items for SES-SFV and MTP items were combined. Anthony and Cook (2012) found no significant differences in number of reported disclosures between original SES-SFV items and those altered with gender neutral/inclusive language.

Five further additions were made. Three of them were based on Canan and colleague's (2020) study on women. The first prompt was edited to incorporate the notion of being made to touch genitals. Secondly, sleep was added to "too drunk" and "out of it" on the relevant SES-SFV tactic for each item. Thirdly, "just doing the behavior without giving me the chance to say 'no' (e.g., surprising me with the behavior)," was added as a sixth tactic to each item since it was the most highly endorsed tactic and captured an additional 9% of victims (Canan et al., 2020). One item was added at the end of the SES-SFV to ascertain age (since age 14) at first and most recent sexual victimization. Finally, the participants' relationship to their perpetrator(s) and their perpetrator's gender and sexuality was collected in two items at the end of the SES-SFV.

Sexual Violence Vulnerability Reduction Intervention Acceptability and Preferences

Prior Knowledge of Interventions. Previous knowledge of sexual violence interventions were ascertained before presenting intervention descriptions by asking participants if they had heard of or taken any sexual violence interventions. Categories included Flip the Script™ (FTS), bystander interventions, self-defense, assertiveness training, drinking reduction interventions, hookup reduction interventions, and "other." Participants checked a box indicating if they only heard of the intervention or if they actually participated in it. When coding the variables used in analyses for prior knowledge, "0" indicated no knowledge or experience, "1" indicated hearing about the intervention only, and "2" indicated having actually participated in the intervention. Three variables were created for prior knowledge of FTS, bystander interventions, and all other interventions combined. To assess participants' perception of the interventions they have prior knowledge of, they were asked how positively or negatively they feel about

them on a 7-point Likert type scale from Extremely positive about it" (1) to "Extremely negative about it" (7).

Intervention Descriptions. Descriptions of five sexual violence interventions, 306-315 words each (see Appendix C, 1.0-7.0), were provided to participants for them to read and rank in order of preference: 1) Bringing in the Bystander® (BITB; Soteria Solutions, 2020), 2) FTS (SARE Centre, 2020), 3) a brief drinking intervention with motivational interviewing (Clinton-Sherrod et al., 2011), 4) a sexual assault risk and alcohol use reduction intervention (Gilmore et al., 2015), and 5) a hookup reduction intervention (Testa et al., 2020). Interventions 1 and 2 meet the American Psychological Association's Division 12 criteria for an evidence-based intervention (two randomized controlled trials conducted by independent teams). Interventions 3, 4, and 5 do not meet this criteria but incorporate elements to reduce women's heavy drinking. Heavy drinking has been identified as a vulnerability factor for women regarding the increasing likelihood of being harmed by sexual violence (Testa & Livingston, 2018). Additionally, increased alcohol use is a well-identified health disparity among SM individuals, with heavy drinking being higher among bisexual people (30% in the past month) compared to lesbian/gay (25.5%) and heterosexual people (19.6%; Shokoohi et al., 2022). Thus, it may be crucial to address heavy drinking in bisexual women in sexual violence intervention efforts, and therefore important to know which of these types of interventions are attractive to bisexual women.

A specific instruction regarding the COVID-19 pandemic preceded all items inquiring about intervention acceptability and preferences. It urged participants to "please envision a scenario in which the COVID-19 pandemic is over, and small and large groups

are able to gather together safely without concern for your own health and safety or the health and safety of others."

Bi+ Relevant and Inclusive Descriptions. In addition to the five standard intervention descriptions, two modified versions of standard sexual violence interventions were adapted to be inclusive of, and relevant to, bi+ women based on the LGBTQ-affirmative ESTEEM model (Pachankis et al., 2019). Interventions 1 (BITB®; 348 words) and 2 (Flip the Script™; 343 words) were modified, as they both have sufficient evidence demonstrating efficacy (see Appendix C). To reduce assessment effects. bi+ women in the experimental group were randomly assigned to one of the two modified interventions. Participants were presented with the original intervention description alongside the modified intervention description and were asked: "If you were to pursue this training to help prevent sexual assault or rape, which version of the training would you most likely prefer?"

Intervention Ranking. Control group participants were asked to rank the five sexual violence interventions on a continuum from "most likely to participate in" (1) to "least likely to participate in" (5). Experimental group participants were asked to rank all seven sexual violence interventions (five original and two modified) on a continuum from "most likely to participate in" (1) to "least likely to participate in" (7).

Importance of Intervention Elements. Thirty-one identified aspects from all intervention descriptions (e.g., format of delivery, specific content/topic inclusion, training in physical resistance strategies, individual vs. group formats, gender of facilitators, gender of participants, etc.) were extracted and placed in a list (see Appendix D). Participants rated the importance of each element on a Likert scale from "Very

important" (1) to "Not at all important" (5). Although the element "gender neutral language" was intended to be presented to both groups, due to an error in survey administration, it was only administered to the experimental group, thus, no rating data was collected on the importance of this element for the control group. However, participants were also asked to rank their "top five" intervention elements, and "gender neutral language" was included as an option for the control and experimental groups.

Acceptable Intervention Length. A separate item asked participants what length of intervention they would be willing to commit to with responses incorporating set intervention times from the five interventions: "5-10 minutes"; "30-45 minutes"; "90 minutes"; "12 hours". A qualitative item inquired: "If you were not willing to commit to one or more of the lengths of time listed, why is that?"

Intervention Acceptability. Participant acceptability of the sexual violence vulnerability reduction interventions (sexual violence interventions) was assessed through the lens of Sekhon et al.'s (2017) Theoretical Framework of Acceptability, version 2 (TFA2). TFA2 comprises the seven components of affective attitude, burden, ethicality, intervention coherence, opportunity costs, perceived effectiveness, and self-efficacy. Acceptability was assessed after participants have read all five sexual violence intervention descriptions and ranked them. A 12-item measure with 10 quantitative items and two qualitative items, the North Dakota Sexual Violence Intervention Acceptability Measure (ND SVIAM; Anderson et al., 2022), was created to assess acceptability (see Appendix E). In the initial study, the ND SVIAM was found to be face valid with high readability (Anderson et al., 2022). Likert scale responses were constructed to assess the

importance of each of the TFA2 constructs in relation to each presented sexual violence vulnerability reduction intervention.

When analyzing experimental group participant's acceptability scores, a total acceptability cut-off score of 44 was used (i.e., the sum of the lowest above-neutral response on all items on the ND SVIAM). If all items endorsed by a participant for an intervention were in the acceptable range, but 30% or less remained unanswered, the total score was considered acceptable for this analysis. Additionally, if the participant responded to only one of the three cost variables, the one acceptability response was assumed across the three variables.

Ethnic Identity Relevancy and Inclusiveness. The degree of relevance of ethnoracial identity was determined via open-ended comments on the ND SVIAM and MEIM-R scores. Three raters (the author, her research adviser, and an undergraduate research assistant) individually identified participants who mentioned inclusivity (in general terms or in relation to racial/ethnic inclusivity), intersectionality, or race/ethnicity as being important for inclusion in an intervention in their qualitative answers on the ND SVIAM. There were no disagreements between the three raters regarding the 13 identified participants using this criteria.

Procedure

The experimental group of bi+ women only were administered the measures targeted for sexual minoritized participants. Solely participants who identified as WOC or racialized people were administered the LGBT POC microaggressions scale. All participants, including the control group, were administered all other measures. Mental

health and sexual violence victimization resources were provided to participants at the top of every survey page and throughout the measures section (see Appendix F).

CHAPTER III

RESULTS

Power Analysis

A priori power analyses were conducted with G*Power version 3.1.9.4 (Faul et al., 2007) and the results from several related or similar studies (Iverson et al., 2016; Nadeem et al., 2008; Wells et al., 2013) were used to estimate likely effect sizes for chi-squares, *t*-tests, and ANOVAs. These power analyses suggested a total sample range of 156-272 to achieve *Power* = .80 for small to medium Cohen's *d* effects sizes (i.e., *d* = .39-.54) when implementing chi-squares, ANOVAs, and *t*-tests for both independent (Wells et al., 2013) and dependent (Iverson et al., 2016) group means. Thus, to ensure adequate power for study analyses, it was determined a sample of approximately 300 participants (control group, $n \sim 55$; experimental group, $n \sim 245$) would be collected to account for a diverse experimental group. Post-hoc power analyses presented in the Results were also performed using G*Power version 3.1.9.4 (Faul et al., 2007).

Data Cleaning

Preliminary checks were performed to assess normality, outliers, linearity, homogeneity of variance-covariance matrices, and multicollinearity for both groups. Shapiro-Wilk tests indicated DVs were not universally normally distributed in either group (control group: SAARR acceptability score, $p < .05$; experimental group: five of seven DVs, $ps < .05$); thus, the assumption of univariate normality was not supported for either group. According to Mahalanobis distance, there were no outliers in the control group and two outliers in the experimental group. These two outliers were included in analysis as they did not represent theoretically impossible phenomena. The Box's M test

indicated the assumption of homogeneity of variance-covariance matrices was met for the control group ($p = .54$), but not for the experimental group ($p < .001$). Levene's test was not significant for any DVs in either group, suggesting no issues with equality of error variances. A Pearson's correlation analysis suggested the assumption of multicollinearity was met for both groups (rs < .80).

If participants endorsed at least one item on either the child sexual abuse (CSA) items or SES-SFV with MTP indicating sexual victimization history, their data was retained for analysis, and missing data was assumed to be the modal response (i.e., 0). This is in accordance with research illustrating the use of available items is equivalent, and in some cases preferable, to multiple imputation in datasets with minimal missing data (Parent et al., 2013).

Analytic Strategy

Interaction effects are challenging in intersectional research. In an ANOVA, it is likely main effects for variables such as stigma and discrimination may mask interaction effects between these variables, particularly if they are all significant (Bowleg, 2008). Thus, where appropriate, alternative exploratory analyses were used to analyze categorical variables for sexual violence intervention acceptability and preferences, and predictors of preferences. Chi-square analyses were employed to examine differences among control and experimental groups. In summary, when testing hypotheses, chi squares were used to examine associations while exploratory simple and multivariate regressions were employed to predict preferences while controlling for relevant factors.

Assessment Battery Administration – Potential Order Effects

One-way MANOVAs were run discretely for each group to test for administration order effects on acceptability outcomes given the experimental and control group differed on the above notable variables. The independent variable (IV) was order of administration of the three assessment battery blocks (i.e., identity/stigma, sexual victimization, and sexual violence intervention preferences/acceptability) and the dependent variables (DVs) were ND SVIAM total acceptability scores on the five original sexual violence interventions for the control group and seven (including two modified) sexual violence interventions for the experimental group.

According to Pillai's Trace—which is more robust when assumptions of the MANOVA have not been met—no overall significant main effect was found for assessment battery block order on sexual violence intervention acceptability scores for either the control group, $V = 0.49$, $F(25, 295) = 1.30$, $p = .16$, or the experimental group, $V = 0.16$, $F(35, 1150) = 1.07$, $p = .36$. Since Pillai's Trace was not significant for either group, the post-hoc Scheffé, univariate, and other follow-up tests were not interpreted/conducted.

Differences Between Groups on Mental Health and Sexual Violence Variables

The experimental and control groups significantly differed on salient variables beyond sexual, gender, and ethnoracial identity that relate to health and intersectional identity such as mental health condition or disability (63% vs. 32%, respectively), $\chi^2(1, N = 240) = 14.06$, $p < .001$. The experimental and control groups were also significantly different regarding experiences of CSA (42.9% vs. 10.8%, respectively), $\chi^2(1, N = 305) = 22.78$, $p < .0001$, and adult sexual victimization history (80% vs. 49%, respectively). An exploratory between-groups *t*-test found that on average, experimental group participants

reported having had experiences of adult sexual victimization significantly more often (M = 38.97, SE = 67.55) than the control group (M = 12.45, SE = 25.69), $t(303) = -3.10$, p = .002. Lifetime sexual violence victimization rates were 84% for ethnoracially diverse bi+ women compared to 52% for controls.

Hypothesis 1 – Part One

Experimental group participants were randomly assigned to indicate their preference for a modified, bi+ inclusive version of either Bringing in the Bystander® (BITB) or Flip the Script™ (FTS). In the BITB condition, the majority of ethnoracially diverse bi+ women (63%) preferred the Modified (bi+ inclusive) BITB (M-BITB) while 17% preferred the original BITB in a one-to-one comparison (see Table 1). This was a significant difference, $\chi 2(1, N = 121) = 53.976$, $p < .0001$, with a large effect size (d = 1.08). In the FTS condition, over half of ethnoracially diverse bi+ women (61%) preferred the Modified (bi+ inclusive) FTS (M-FTS) while 9% preferred the original FTS. This was also a significant difference, $\chi 2(1, N = 119) = 68.676$, $p < .0001$, with a large effect size (d = 1.27). Thus, the first part of H1, that bi+ women will prefer bi+ inclusive and relevant sexual violence interventions, was supported. The degree of preference for bi+ inclusivity was not different between BITB and FTS conditions, $\chi 2(1, N = 240) = .0134$, p = .71. However, 21-30% of bi+ women either preferred them the same amount (BITB = 16%; FTS = 24%) or were not sure which they preferred (BITB = 5%; FTS = 6%). A post hoc power analysis revealed the analyses in Table 1 for both BITB and FTS were well powered (*Power* = 1.00) with large effect sizes (w = .87-.89).

Table 1

Bi+ Women's Preference for Original vs. Bi+ Inclusive (Modified) SVVRIs

Intervention Preference	BITB (N = 121) (n, %)	FTS (N = 119) (n, %)
Bi+ modified version	76, 62.8%	72, 60.5%
Original version	20, 16.5%	11, 9.2%
Prefer them the same amount	19, 15.7%	29, 24.4%
Not sure/don't know	6, 5.0%	7, 5.9%

Note. SVVRIs: Sexual Violence Vulnerability Reduction Interventions. FTS = Flip the Script™. BITB = Bringing in the Bystander®.

Additional Methods for Examining Hypothesis 1 – Part One

In addition to directly analyzing the one-to-one comparison of preference for bi+ inclusive vs. original BITB or FTS interventions, ethnoracially diverse bi+ women's preferences for bi+ inclusive interventions were examined through their a) ND SVIAM intervention acceptability rates, b) willingness to recommend M-BITB or M-FTS to a friend or a friend who had experienced sexual victimization, c) ranking of interventions, and d) importance rankings of intervention elements related to bi+ inclusivity.

ND SVIAM Acceptability Rates. Over half of ethnoracially diverse bi+ women (62%) rated M-BITB as acceptable according to ND SVIAM acceptability scores, which was statistically significant compared to the null hypothesis (e.g., more than a 50/50 chance) with a medium effect size (d = .69). However, the majority of bi+ women (52%) rated M-FTS as *not* acceptable, although this rating was not statistically significant compared to the null hypothesis (see Table 2).

Table 2

Bi+ Women's Acceptability of SVVRIs

SVVRI	Acceptable (score = ≥ 44) (n, %)	Not Acceptable (score = ≤ 43) (n, %)	Chi-square with Significance
M-BITB	147, 61.5%	92, 38.5%	$\chi^2(1, N = 239) = 25.23, p < .0001$

M-FTS	115, 48.3%	123, 51.7%	$\chi^2(1, N = 238) = .55, p = .46$
BITB	122, 50.8%	118, 49.2%	$\chi^2(1, N = 240) = .12, p = .73$
FTS	103, 42.9%	137, 57.1%	$\chi^2(1, N = 240) = 9.66, p < .01$
BDI	54, 22.5%	186, 77.5%	$\chi^2(1, N = 240) = 144.90, p < .0001$
SAARR	65, 27.1%	175, 72.9%	$\chi^2(1, N = 240) = 100.48, p < .0001$
HRI	28, 11.7%	212, 88.3%	$\chi^2(1, N = 240) = 281.06, p < .0001$

Note. SVVRI: Sexual Violence Vulnerability Reduction Intervention. BITB = Bringing in the Bystander®. FTS = Flip the Script™. M-BITB = Modified BITB. M-FTS = Modified FTS. BDI = Brief Drinking Intervention. SAARR = Sexual Assault Risk and Alcohol Use Reduction Program. HRI = Hookup Reduction Intervention.

Regarding ethnoracially diverse bi+ women's ND SVIAM scores across the five interventions, there were significant differences in acceptability ratings for FTS, Brief Drinking Intervention (BDI), Sexual Assault Risk and Alcohol Use Reduction Program (SAARR), and Hookup Reduction Intervention (HRI) in comparison to the null hypothesis: most participants found them *not* acceptable. Power for significant findings was high (*Power* = 1.00) with effect sizes ranging from medium to large (w = .23-.77) except for FTS (*Power* = .59, w = .14), indicating the true effect for FTS is still unknown. Although most bi+ women found BITB acceptable, there was not a significant difference between acceptable and *not* acceptable ratings for BITB, thus, the null hypothesis was retained (see Table 2). Therefore, the only intervention rated as acceptable with statistical significance by the majority of bi+ women was M-BITB, with a slight preference for BITB overall. The intervention found *not* acceptable by the greatest percentage of bi+ women (88%) was HRI, followed by BDI (78%) and SAARR (73%; see Table 2).

For white heterosexual, cisgender women, no interventions were rated as acceptable by the majority. In fact, four out of five interventions, with the exception of SAARR, were rated as *not* acceptable with significance by the majority of controls compared to the null hypothesis (e.g., more than a 50/50 chance). HRI was rated most

often as *not* acceptable by 82% of control participants, similar to the experimental group (see Table 3). Additionally, there was a significant difference between the percentage of bi+ women (50.8%) and that of white heterosexual, cisgender women (32.3%) who found BITB acceptable, $\chi 2(1, N = 305) = 7.01$, $p < .01$. Significant findings from Table 3 were well powered (*Power* = .81-1.00) with moderate to large effect sizes (w = .35-.63) except for FTS (*Power* = .56, w = .26), indicating the effect in this case may not be true or the sample size of 65 was not large enough to determine a potential effect.

Table 3

White Heterosexual, Cisgender Women's Acceptability of SVVRIs

SVVRI	Acceptable (score = ≥ 44) (*n*, %)	Not Acceptable (score = ≤ 43) (*n*, %)	Chi-square with Significance
BITB	21, 32.3%	44, 67.7%	$\chi^2(1, N = 65) = 16.17, p = .0001$
FTS	24, 36.9%	41, 63.1%	$\chi^2(1, N = 65) = 8.86, p < .01$
BDI	20, 30.8%	45, 69.2%	$\chi^2(1, N = 65) = 19.02, p < .0001$
SAARR	28, 43.1%	37, 56.9%	$\chi^2(1, N = 65) = 2.46, p = .12$
HRI	12, 18.5%	53, 81.5%	$\chi^2(1, N = 65) = 51.20, p < .0001$

Note. SVVRI: Sexual Violence Vulnerability Reduction Interventions. BITB = Bringing in the Bystander®. FTS = Flip the Script™. BDI = Brief Drinking Intervention. SAARR = Sexual Assault Risk and Alcohol Use Reduction Program. HRI = Hookup Reduction Intervention.

Prior Intervention Knowledge Predicting Acceptability. ANOVAs and ANCOVAs were run on intervention acceptability rates being predicted by prior knowledge of interventions for the full sample and both groups separately (see Appendix A, Table 2A). The independent variable was participants' prior knowledge of interventions, the covariate in the ANCOVAs was participant's perception of those interventions based on their prior knowledge, and the dependent variable was ND SVIAM intervention acceptability scores. The only significant results were found in the

experimental group: ethnoracially diverse bi+ women's acceptability rates for BITB and HRI were significantly predicted by prior knowledge when controlling for perception.

An exploratory between-groups *t*-test found that ND SVIAM acceptability rates for ethnoracially diverse bi+ women with prior knowledge of or experience with HRI (M = 32.16, SE = 9.42) were not statistically different than those without prior knowledge (M = 30.40, SE = 9.67), $t(239) = -.700$, $p = .90$, $d = -.19$. The same was true for bi+ women with prior knowledge of BITB (M = 42.90, SE = 7.23) and those without this knowledge (M = 42.81, SE = 6.89), $t(240) = -.104$, $p = .51$, $d = -.01$. Effect sizes were small, and power was inadequate for these analyses (*Power* = .05-.11).

Exploratory linear regressions revealed that as prior perception of the interventions increased in positivity for ethnoracially diverse bi+ women, their acceptability of BITB ($\beta = .49$, $R^2 = .24$, $F(1, 109) = 33.98$, $p < .001$) and HRI significantly increased ($\beta = .31$, $R^2 = .10$, $F(1, 222) = 23.59$, $p < .001$). For every 1 unit increase in the positivity of prior perception of the "other" interventions, there was a 2.35 unit increase in total acceptability score for HRI among bi+ women. For every 1 unit increase in the positivity of prior perception of bystander interventions, there was a 2.55 unit increase in total acceptability score for BITB among bi+ women (see Appendix A, Table 2A). Power was high for these analyses (*Power* = 1.00).

Bi+ Women's Willingness to Recommend. Participants were asked if they would be willing to recommend each intervention, both to "a friend," and to "a friend who had experienced sexual assault or rape." The majority of ethnoracially diverse bi+ women reported they would be willing to recommend both the modified, bi+ inclusive BITB (M-BITB; 74%; 54%, respectively) and FTS (M-FTS; 66%; 53%, respectively) in

both cases (see Table 4). Fewer bi+ women reported they would be willing to recommend an intervention to a friend who had experienced sexual violence than simply to a friend, which was a significant reduction in affirmative responses to recommend for six of seven interventions (See Table 5). HRI was the only intervention for which there was not a significant difference, but it also had the lowest endorsement rate for being willing to recommend to both a friend (26%), and to a friend who had experienced sexual violence (24%; see Tables 4 and 5).

Table 4

Bi+ Women's Willingness to Recommend SVVRIs to a Friend

SVVRI		Recommend to a friend?			Recommend to a friend who experienced sexual violence?		
	N	Yes (*n*, %)	Maybe/ unsure (*n*, %)	No (*n*, %)	Yes (*n*, %)	Maybe/ unsure (*n*, %)	No (*n*, %)
M-BITB	238	176, 73.9%	39, 16.4%	23, 9.7%	129, 54.2%	68, 28.6%	41, 17.2%
M-FTS	238	156, 65.5%	44, 18.5%	38, 16.0%	127, 53.4%	67, 28.2%	44, 18.5%
BITB	240	155, 64.6%	65, 27.1%	20, 8.3%	96, 40.0%	101, 42.1%	43, 17.9%
FTS	239	149, 62.3%	18, 7.5%	42, 17.6%	114, 47.7%	82, 34.3%	43, 18.0%
BDI	240	101, 42.1%	59, 24.6%	80, 33.3%	74, 30.8%	67, 27.9%	99, 41.3%
SAARR	239, 238	114, 47.7%	42, 17.6%	83, 34.7%	86, 36.1%	55, 23.1%	97, 40.8%
HRI	240	62, 25.8%	43, 17.9%	135, 56.3%	57, 23.8%	48, 20.0%	135, 56.3%

Note. SVVRI: Sexual Violence Vulnerability Reduction Intervention. BITB = Bringing in the Bystander®. FTS = Flip the Script™. M-BITB = Modified BITB. M-FTS = Modified FTS. BDI = Brief Drinking Intervention. SAARR = Sexual Assault Risk and Alcohol Use Reduction Program. HRI = Hookup Reduction Intervention.

Table 5

Bi+ Women's Willingness to Recommend SVVRIs to a Friend vs. a Friend with a Sexual Violence Victimization History

SVVRI	*N*	*DF*	χ^2	*p* value

M-BITB	238	1	20.02	< .0001
M-FTS	238	1	7.21	< .01
BITB	240	1	29.05	< .0001
FTS	239	1	10.27	.001
BDI	240	1	6.60	.01
SAARR	239, 238	1	6.60	.01
HRI	240	1	.26	.61

Note. SVVRI: Sexual Violence Vulnerability Reduction Intervention. BITB = Bringing in the Bystander®. FTS = Flip the Script™. M-BITB = Modified BITB. M-FTS = Modified FTS. BDI = Brief Drinking Intervention. SAARR = Sexual Assault Risk and Alcohol Use Reduction Program. HRI = Hookup Reduction Intervention.

For ethnoracially diverse bi+ women's willingness to recommend SVVRIs to a friend, "yes" responses were significantly greater for M-BITB compared to all other interventions (see Appendix A, Table 3A). "Yes" responses were significantly greater for both versions (modified or original) of BITB and FTS than for the remaining interventions. "Yes" responses for HRI were significantly fewer than for all other interventions. "No" responses largely followed the inverse pattern of "yes" responses with the exception of "no" responses for both versions of BITB being significantly less than for both versions of FTS. These data suggest a strong preference for recommending BITB to a friend over other interventions, and a moderate preference for recommending FTS. Given these results, and that "maybe/unsure" responses were significantly greater for BITB over M-BITB but significantly fewer for FTS over M-FTS, a bi+ inclusive version of BITB may increases bi+ women's willingness to recommend this intervention, although this may not hold true for FTS. See Appendix A, Table 3A for full details.

Regarding ethnoracially diverse bi+ women recommending SVVRIs specifically to a friend who has experience sexual violence, several differences were found (see Appendix A, Table 4A). No significant differences were found between "yes" responses

for BITB and SAARR. Additionally, "yes" responses for BDI and HRI were not significantly different. Another difference was that "yes" responses for M-FTS (as well as M-BITB) were significantly greater than for BITB. There were no significant differences in "no" responses between BITB and FTS, modified or not. These data suggest modified and original versions of BITB and FTS were more likely than other interventions to be recommended to a friend who had experienced sexual violence by bi+ women, while HRI was least likely to be recommended, second to BDI. Additionally, there were no significant differences in "maybe/unsure" responses for FTS versus M-FTS. See Appendix A, Table 4A for full details.

White Heterosexual, Cisgender Women's Willingness to Recommend. The majority of the control group reported they would be willing to recommend all interventions both to a friend and to a friend who had experienced sexual victimization, with one exception in the latter case for BDI (see Table 6). Unlike for bi+ women, there were no significant differences in white heterosexual, cisgender women's willingness to recommend based on if a friend experienced sexual victimization across interventions (See Table 7). HRI was the only intervention for which there was not a significant difference, but it also had the lowest endorsement rate for being willing to recommend to both a friend (51%), and to a friend who had experienced sexual violence (52%; see Tables 6 and 7).

Table 6

White Heterosexual, Cisgender Women's Willingness to Recommend SVVRIs to a Friend

SVVRI	Recommend to a friend?	Recommend to a friend who experienced sexual violence?

	N	Yes (*n*, %)	Maybe/ unsure (*n*, %)	No (*n*, %)	Yes (*n*, %)	Maybe/ unsure (*n*, %)	No (*n*, %)
BITB	65	45, 69.2%	18, 27.7%	2, 3.1%	43, 66.2%	13, 20%	9, 13.8%
FTS	65	50, 76.9%	11, 16.9%	4, 6.2%	48, 73.8%	15, 23.1%	2, 3.1%
BDI	65	39, 60%	16, 24.6%	10, 15.4%	29, 44.6%	19, 29.2%	17, 26.2%
SAARR	65	42, 64.6%	13, 20%	10, 15.4%	43, 66.2%	13, 20%	9, 13.8%
HRI	65	33, 50.8%	13, 20%	19, 29.2%	34, 52.3%	11, 16.9%	20, 30.8%

Note. SVVRI: Sexual Violence Vulnerability Reduction Intervention. BITB = Bringing in the Bystander®. FTS = Flip the Script™. BDI = Brief Drinking Intervention. SAARR = Sexual Assault Risk and Alcohol Use Reduction Program. HRI = Hookup Reduction Intervention.

Table 7

White Heterosexual, Cisgender Women's Willingness to Recommend SVVRIs to a Friend vs. a Friend with a Sexual Violence Victimization History

SVVRI	*N*	*DF*	χ^2	*p* value
BITB	65	1	.13	.72
FTS	65	1	.17	.68
BDI	65	1	3.07	.08
SAARR	65	1	.04	.85
HRI	65	1	.03	.86

Note. SVVRI: Sexual Violence Vulnerability Reduction Intervention. BITB = Bringing in the Bystander®. FTS = Flip the Script™. BDI = Brief Drinking Intervention. SAARR = Sexual Assault Risk and Alcohol Use Reduction Program. HRI = Hookup Reduction Intervention.

Regarding recommending SVVRIs to a friend for the control group, "Yes" responses for FTS and BITB were significantly greater than for HRI (see Appendix A, Table 5A). "Yes" responses for FTS were significantly greater than for BDI. There was no statistical difference in "yes" responses for the three interventions with the highest number of "yes" responses: FTS, BITB, and SAARR. No significant differences were found for "Maybe/unsure" responses. "No" responses were significantly greater for HRI than for both BITB and FTS. "No" responses for both BDI and SAARR were significantly greater than for BITB. Thus, for white heterosexual, cisgender women, there

appears to be a strong preference for recommending FTS and BITB to a friend and a moderate preference for recommending SAARR. See Appendix A, Table 5A for details.

For control participants recommending SVVRIs specifically to a friend who had experienced sexual violence, a few minor differences were found (see Appendix A, Table 6A). "Yes" responses were significantly greater for BITB, FTS, and SAARR than for BDI. "Yes" responses for FTS were significantly greater than for HRI. "No" responses for BDI and HRI were significantly greater than for the remaining three interventions. FTS had significantly fewer "no" responses than all other interventions. These data suggest a preference for recommending BITB, FTS, and SAARR over BDI and HRI to a friend with a sexual victimization history by white heterosexual, cisgender women. See Appendix A, Table 6A for full details.

Bi+ Women's Intervention Preference Rankings. An exploratory analysis of experimental group participants' ranking of interventions found that more ethnoracially diverse bi+ women ranked BITB (17.1%) and FTS (22.6%) as their first choice than M-BITB (1.7%) and M-FTS (0.4%). Order effects may have impacted participant choice as the intervention ranking was presented with BITB and FTS at the top of the list to rank and M-BITB and M-FTS at the bottom with the three other interventions sandwiched in-between. It is also possible participants did not discriminate between the modified and original versions of BITB and FTS in this item. Additionally, due to the order in which the interventions were presented (top-down) it is impossible to ascertain if participants who did not change the order were truly missing responses or if their preferred order was what was initially displayed to them. Thus, analyses were run for both possibilities,

however, there were no significant differences between the results. Therefore, missing responses were treated as truly missing.

When combining responses for modified and original versions (i.e., M-BITB combined with BITB, and M-FTS combined with FTS), the intervention most ethnoracially diverse bi+ women ranked first choice was BDI (27%), followed by SAARR and FTS (23% each; see Table 8). Ethnoracially diverse bi+ women's first-choice preference ranking for BITB, FTS, and SAARR did not significantly differ, however BDI was significantly more preferred over BITB, and all interventions were significantly more preferred over HRI. See Table 8 for complete intervention ranking results for the experimental group.

Table 8

Bi+ Women's SVVRI Preference Rankings with Group Differences Based on First Choice, N = *234*

Rank	BITB or M-BITB (*n*, %)	FTS or M-FTS (*n*, %)	BDI (*n*, %)	SAARR (*n*, %)	HRI (*n*, %)	First Choice Group Differences
1st	44, 18.8%[a]	54, 23.1%[b]	64, 27.4%[c]	54, 23.1%[d]	18, 7.7%[e]	[a,b]$\chi^2 = 1.30$, $p = .25$
2nd	33, 14.1%	42, 17.9%	48, 20.5%	80, 34.2%	31, 13.2%	[a,c]$\chi^2 = 4.86$, $p = .03$
3rd	98, 41.9%	61, 26.1%	13, 5.6%	17, 7.3%	45, 19.2%	[a,d]$\chi^2 = 1.30$, $p = .25$
4th	16, 6.8%	9, 3.8%	25, 10.7%	14, 6.0%	91, 38.9%	[a,e]$\chi^2 = 12.52$, $p < .001$
5th	42, 17.9%	156, 66.7%	8, 3.3%	5, 2.1%	23, 9.8%	[b,c]$\chi^2 = 1.14$, $p = .28$
6th	104, 44.4%	60, 25.6%	30, 12.8%	32, 13.7%	8, 3.4%	[b,d]$\chi^2 = .00$, $p = 1.00$
7th	63, 26.9%	75, 32.1%	46, 19.7%	32, 13.7%	18, 7.7%	[b,e]$\chi^2 = 21.25$, $p < .0001$
						[c,d]$\chi^2 = 1.14$, $p = .28$
						[c,e]$\chi^2 = 31.31$, $p < .0001$
						[d,e]$\chi^2 = 21.25$, $p < .0001$

Note. SVVRI = Sexual Violence Vulnerability Reduction Intervention. BITB = Bringing in the Bystander®. FTS = Flip the Script™. M-BITB = Modified BITB. M-FTS = Modified FTS. BDI = Brief Drinking Intervention. SAARR = Sexual Assault Risk and Alcohol Use Reduction Program. HRI = Hookup Reduction Intervention.

White Heterosexual, Cisgender Women's Intervention Preference Rankings.

An exploratory analysis of control group participants' ranking of interventions found that more white heterosexual, cisgender women ranked BITB (35%) as their first choice followed by FTS (29%; see Table 9). If first and second choice preferred interventions are combined, most control group participants preferred FTS (64%) and BITB (59%). For this group, order effects may also have impacted participant choice as the intervention ranking was presented with BITB and FTS at the top with the three other interventions presented underneath. For white heterosexual, cisgender women's first choice rankings, both FTS and BITB were significantly more preferred over SAARR and HRI, and BDI was significantly more preferred over HRI. No other significant differences were found. See Table 9 for complete results.

Table 9

White Heterosexual, Cisgender Women's SVVRI Preference Rankings with Group Differences Based on First Choice, N = *63*

Rank	BITB (*n*, %)	FTS (*n*, %)	BDI (*n*, %)	SAARR (*n*, %)	HRI (*n*, %)	First Choice Group differences
1st	22, 34.9% [a]	18, 28.6% [b]	14, 22.2% [c]	7, 11.1% [d]	2, 3.2% [e]	[a,b]$\chi^2 = .57$, $p = .45$
2nd	15, 23.8%	22, 34.9%	8, 12.7%	6, 9.5%	12, 19%	[a,c]$\chi^2 = 2.47$, $p = .12$
3rd	5, 7.9%	6, 9.5%	9, 14.3%	23, 36.5.%	20, 31.7%	[a,d]$\chi^2 = 10.00$, $p < .01$
4th	19, 30.2%	8, 12.7%	23, 36.5%	12, 19%	1, 1.6%	[a,e]$\chi^2 = 20.36$, $p < .0001$
5th	2, 3.2%	9, 14.3%	9, 14.3%	15, 23.8%	28, 44.4%	[b,c]$\chi^2 = .68$, $p = .41$
						[b,d]$\chi^2 = 6.02$, $p = .01$
						[b,e]$\chi^2 = 15.08$, $p = .0001$
						[c,d]$\chi^2 = 2.77$, $p = .10$
						[c,e]$\chi^2 = 10.18$, $p = .001$
						[d,e]$\chi^2 = 2.94$, $p = .09$

Note. SVVRI = Sexual Violence Vulnerability Reduction Intervention. BITB = Bringing in the Bystander®. FTS = Flip the Script™. BDI = Brief Drinking Intervention. SAARR = Sexual Assault Risk and Alcohol Use Reduction Program. HRI = Hookup Reduction Intervention.

Importance Rankings of Selected Intervention Elements for Bi+ Women.

Also related to the first part of H1, an exploratory analysis of intervention elements hypothesized to be related to inclusivity for bi+ women, found the majority of ethnoracially diverse bi+ women rated "women participants only" (62%), "women trainers or therapists only" (67%), "created especially for women" (70%), "created especially for bi+/sexual minority women," (74%) and "gender neutral language" (82%) as being either "very important" or "somewhat important" on a 5-point Likert type scale. These same elements were presented to the control group, to the exclusion of "created especially for bi+/sexual minority women" and "gender neutral language." Sixty percent of white heterosexual, cisgender women rated "women participants only" as somewhat/very important, 71% rated "women trainers or therapists only" as somewhat/very important, and 74% rated "created especially for women" as somewhat/very important. There were no significant differences in ratings for these three items between bi+ women and white heterosexual, cisgender women (*ps* > .53).

The top portion of Table 10 reflects how often these same elements were ranked as the most important (i.e., in the "Top 5") out of all 31 intervention elements by ethnoracially diverse bi+ women. When taking all 31 intervention elements into consideration, "created especially for bi+/sexual minority women" (34%) was ranked second most often as being in one of the top five positions, alongside "Guaranteed privacy and confidentiality" (49%) as the first most often ranked, "Physical self-defense strategies" (31%) in third place, "In-person format" (29%) in fourth place, and "Small group size (less than 10 participants)" (29%) in fifth place (see Table 10, bottom portion).

Table 10

Importance Rankings for Selected Intervention Elements for Bi+ Women, N = *237*

Intervention Elements	1st (*n*, %)	2nd (*n*, %)	3rd (*n*, %)	4th (*n*, %)	5th (*n*, %)	TOTAL
Intervention Elements Hypothesized to be Related to Inclusivity for Bi+ Women						
Women participants only	12, 5.1%	11, 4.6%	13, 5.5%	10, 4.2%	10, 4.2%	56, 23.6%
Women trainers or therapists only	7, 3.0%	22, 9.3%	9, 3.8%	9, 3.8%	12, 5.1%	59, 24.9%
Created especially for women	5, 2.1%	7, 3.0%	12, 5.1%	10, 4.2%	4, 1.7%	38, 16.0%
Created especially for bi+/sexual minority women	24, 10.1%	21, 8.9%	11, 4.6%	11, 4.6%	13, 5.5%	80, 33.8%
Gender neutral language	9, 3.8%	6, 2.5%	9, 3.8%	12, 5.1%	12, 5.1%	48, 20.3%
Intervention Elements Most Often Ranked in the Top Five for Bi+ Women						
1) Guaranteed privacy and confidentiality	26, 11.0%	29, 12.2%	24, 10.1%	18, 7.6%	19, 8.0%	116, 48.9%
2) Created especially for bi+/sexual minority women	24, 10.1%	21, 8.9%	11, 4.6%	11, 4.6%	13, 5.5%	80, 33.8%
3) Physical self-defense strategies	14, 5.9%	9, 3.8%	20, 8.4%	21, 8.9%	9, 3.8%	73, 30.8%
4) In-person format	15, 6.3%	14, 5.9%	21, 8.9%	10, 4.2%	9, 3.8%	69, 29.1%
5) Small group size (less than 10 participants)	15, 6.3%	14, 5.9%	16, 6.8%	10, 4.2%	13, 5.5%	68, 28.7%

Importance Rankings of Selected Intervention Elements for White Heterosexual, Cisgender Women. There were no significant differences in the rankings between bi+ women and white heterosexual, cisgender women for intervention elements hypothesized to be related to inclusivity for women (i.e., "women participants only," "women trainers or therapists only," and "created especially for women").

White heterosexual, cisgender women ranked the same intervention elements in their top five elements of importance as ethnoracially diverse bi+ women did with the exception of "created especially for bi+/sexual minority women" which was not an option presented to the control group. Additionally, the control group ranked "verbal self-defense strategies" fourth most often in their top five (31%), whereas this element did not make the top five for bi+ women. When comparing all items both the experimental and control groups included most often in their top five ranked choices, significant differences were found only for "small group size," $\chi 2 = 4.86$, $p = .03$, and "physical self-defense strategies," $\chi 2 = 7.59$, $p < .01$. White heterosexual, cisgender women ranked them significantly more often in their top five intervention elements of importance than ethnoracially diverse bi+ women.

"Gender neutral language" was included as an element presented in the list of elements to the control group for ranking, however, only 2 (3%) white heterosexual, cisgender women ranked it in their top five intervention elements. This represented a significant difference in ranking across groups, with controls ranking "gender neutral language" significantly less often in their top five elements of importance than bi+ women, , $\chi 2(1, N = 302) = 11.00$, $p < .001$.

Hypothesis 1 – Part Two

The second portion of H1, that preferring bi+ inclusive interventions would be more apparent for bi+ women who reported moderate to high instances of bisexual stigma-producing experiences, was not supported. Multinomial logistic regressions revealed no significance regarding Anti-Bisexual Experiences Scale (ABES) overall

mean scores—for either version of the ABES—predicting preference for bi+ inclusive interventions in the experimental group (see Appendix A, Table 7A).

Multinomial logistic regressions also showed no significance for the Heterosexism in Communities of Color Scale of the LGBT People of Color Microaggressions Scale (LGBT-POC MS) predicting preference for bi+ inclusive interventions for bi+ WOC. See Table 7A in Appendix A for detailed results.

Hypothesis 2

The degree of relevance of ethnoracial identity was determined via open-ended comments on the ND SVIAM, and secondly, via scores on the Multigroup Ethnic Identity Measure—Revised (MEIM-R). Eleven of 13 participants who indicated their desire for racial/ethnic inclusivity in interventions also identified as a person of color, a racialized person, or as having an ethnicity other than white, non-Hispanic (i.e., an ethnic minoritized person). A binary logistic regression revealed there was no significant relationship between these participants' commitment to or exploration of their ethnoracial identities as assessed by the MEIM-R, and their desire for racial/ethnic inclusivity in interventions compared to the other ethnoracially minoritized women (n = 145) in the experimental group (see Appendix A, Table 8A).

Hypothesis 3

That there would be a positive relationship between lifetime sexual victimization history and acceptability of and preference for the FTS self-defense intervention across the entire sample was not supported through exploratory linear regressions. The overall regression was neither statistically significant for CSA, $R^2 < .001$, $F(1, 303) = .04$, $p = .85$, nor for adult sexual victimization history, $R^2 = .002$, $F(1, 303) = .76$, $p = .38$. Thus,

neither CSA, β = -.01, p = .85, nor adult sexual victimization history, β = .05, p = .38, significantly predicted FTS acceptability scores on the ND SVIAM. These results remained the same when controlling for either variable.

This same analyses was run on the control and experimental groups separately. A significant relationship was found for the control group for CSA, R^2 = .117, $F(1, 63)$ = 8.31, p < .01, but not for adult sexual victimization history, R^2 = .024, $F(1, 63)$ = 1.55, p = .22, in that an acceptability of FTS was negatively correlated to experiences of CSA, β = -.34, p < .01. A post hoc analysis revealed the effect size was medium (r = -.34) and the analysis well powered (*Power* = .84). These results remained the same when controlling for either variable. Since CSA in this study was coded as the absence or presence of CSA history, FTS was found more acceptable by heterosexual, cisgender women without a CSA history. However, no significant relationship between CSA and/or adult sexual victimization history and acceptability of FTS was found among ethnoracially diverse bi+ women. Thus, the hypothesis for acceptability was not supported for either group, and an opposing hypothesis was supported for CSA for white heterosexual, cisgender women.

Preference for FTS was examined using participants' first ranked choice when ranking the interventions against each other. For this analysis, modified and original intervention versions were collapsed into one category (e.g., FTS and M-FTS) for the experimental group. For FTS ranked as first choice, rates ranged from 22.3%-30% for the full sample and control and experimental groups, and these rates were not significantly different from one another, $\chi^2(1, N = 227) = .86$, p = .35 (see Table 11). Rates were also not significantly different for women with or without lifetime sexual victimization histories. Additionally, first choice FTS preference rates neither significantly differed for

control vs. experimental groups for those who had experienced sexual victimization, $\chi^2(1, N = 230) = .40$, $p = .53$, nor for those who had not, $\chi^2(1, N = 67) = .07$, $p = .79$. See Table 11 for detailed results.

Table 11

Rates of FTS Ranked First or Second Preferred, as Compared to Presence or Absence of Lifetime Sexual Victimization History

Sample	Lifetime SV History	*N*	n, %	Chi Square
		FTS/M-FTS Ranked First Choice		
Full	Yes	230	53, 23%	$\chi^2 = .82$, $p = .36$
Full	No	67	19, 28.4%	
Control	Yes	33	9, 27.3%	$\chi^2 = .06$, $p = .81$
Control	No	30	9, 30%	
Experimental	Yes	197	44, 22.3%	$\chi^2 = .39$, $p = .53$
Experimental	No	37	10, 27%	
		FTS/M-FTS Ranked Second Choice		
Full	Yes	230	48, 20.9%	$\chi^2 = .61$, $p = .43$
Full	No	67	17, 25.4%	
Control	Yes	33	11, 33.3%	$\chi^2 = .08$, $p = .78$
Control	No	30	11, 36.7%	
Experimental	Yes	197	37, 18.8%	$\chi^2 = .14$, $p = .71$
Experimental	No	37	6, 16.2%	

Note. FTS = Flip the Script™. M-FTS = Modified FTS.

Hypothesis 4

That women who own a gun (currently or historically), have a family member who owns a gun, or who wish to own a gun (herein referred to as "future/lifetime gun owners") will have lower acceptability scores was not supported. Linear regressions showed future/lifetime women gun owners ($n = 137$) did not have significantly lower ND SVIAM acceptability scores than women who were not future/lifetime gun owners ($n = 168$; see Table 9A in Appendix A). However, future/lifetime women gun owners had

significantly higher acceptability scores for HRI compared to their peers ($\beta = .15$, $R^2 = .02$, $F(1, 303) = 7.11$, $p < .01$). For every 1 unit increase in the future/lifetime gun owner continuous variable, there was a 1.63 unit increase in total acceptability score for HRI.

Acceptability of Intervention Length

An exploratory chi-square analysis for acceptability of intervention length found 56% of all participants deemed 5-10 minutes acceptable, 79% found 30-45 minutes acceptable, 70% found 90 minutes acceptable, and 16% found 12 hours acceptable. There were no significant differences between experimental (56%, 79%, respectively) and control (59%, 82%, respectively) groups for acceptability of 5-10 minutes, $\chi^2(1, N = 305) = .15$, $p = .70$, or 30-45 minutes in length, $\chi^2(1, N = 305) = .23$, $p = .63$. However, there were significant differences between experimental (74%, 19%, respectively) and control (55%, 3%, respectively) groups for 90 minutes, $\chi^2(1, N = 305) = .8.20$, $p < .01$, and 12 hours in length, $\chi^2(1, N = 305) = 9.95$, $p < .01$, suggesting the control group had a lower threshold for intervention length

Opportunity Costs

Exploratory descriptives were conducted for all ND SVIAM quantitative acceptability items to ascertain whether any items were consistently in the acceptable or *not* acceptable ranges. If the means for all 10 acceptability items are averaged across interventions, Opportunity Costs items were the only items in the *not* acceptable range (e.g., below neutral on a 5-point Likert-type scale): “In order to attend [intervention], would you” a) “Pay $30 (OR pay a babysitter $30)?” b) “Miss class or work?” c) “Reschedule a date or outing?” The averaged means for items “a” (2.45), “b” (2.25), and “c” (2.70) were in the “probably not” (2) to “might or might not” (3) range. (see

Appendix A, Table 10A). These findings are in keeping with previous research that opportunity costs pose a particularly pernicious barrier to attending sexual violence interventions for women (Anderson et al., 2022).

CHAPTER IV

DISCUSSION

The majority of ethnoracially diverse bi+ women in this study preferred modified, bi+ inclusive versions of the two sexual violence vulnerability reduction interventions (SVVRIs) presented as modified: Bringing in the Bystander® (BITB) and Flip the Script™ (FTS). Four of the five unmodified sexual violence interventions were statistically significant for being in the *not* acceptable range, suggesting that for bi+ women, BITB is the most acceptable SVVRI. The majority of ethnoracially diverse bi+ women rated women participants only, women trainers/therapists, gender neutral language, and being created especially for bi+/sexual minority (SM) women, as important. Including physical self-defense strategies, an in-person format, and small group size were also ranked as important intervention elements by bi+ women.

Mental Health and Lifetime Experiences of Sexual Violence

The majority of ethnoracially diverse bi+ women reported having a mental health condition or disability (63%) compared to about 1/3 (32%) of white heterosexual, cisgender women. In keeping with previous research on the disproportionate impact of sexual violence on ethnoracially minoritized SM women (Lehavot et al., 2010), 84% of ethnoracially diverse bi+ women reported lifetime sexual victimization compared to 52% of white heterosexual, cisgender women. Given the well documented impact of sexual violence on mental health, the high rates of reported experiences of sexual victimization in bi+ women may at least in part explain the higher rates of reported mental health conditions in this group. That almost half of white heterosexual, cisgender women reported experiencing adult sexual victimization more than doubles the empirically

supported 20% statistic (Muehlenhard et al., 2017). One explanation may be that women who have experienced sexual victimization are drawn to either or both: a) participating in research centering their experiences, and b) studying psychology, since the women were recruited from an undergraduate subject pool of psychology majors.

Acceptability of and Preference for Bi+ Modified Interventions

When choosing between a bi+ inclusive or non-inclusive version of the same intervention, the majority of ethnoracially diverse bi+ women consistently preferred the bi+ inclusive, modified intervention (BITB: 63%; FTS: 61%), in keeping with previous research (Martos et al., 2018; Seaver et al., 2008). Acceptability scores further highlight that for the majority of bi+ women, BITB was the most acceptable intervention (62% and 51% found M-BITB and BITB acceptable, respectively).

However, data from ranking the interventions suggest additional interventions beyond BITB and FTS may be acceptable. The majority of ethnoracially diverse bi+ women ranked the Brief Drinking Intervention (BDI; 27%) followed by the Sexual Assault Risk and Alcohol Use Reduction Program (SAARR; 23%) and FTS (23%) as their first ranked choice, whereas the top ranked interventions were FTS (29%) and BITB (35%) for white heterosexual, cisgender women. Since SAARR and BDI were the only two sexual violence interventions described as containing an alcohol-reduction component, it may be that this aspect is attractive to bi+ women. One participant wrote that a facilitator for them attending SAARR would be to "assist in getting help to stop drinking alcohol," while when identifying barriers, another wrote: "i [sic.] don't agree with the premise that women need to avoid drinking to stop men from assaulting us." Considering the higher preference rates for the modified BITB and FTS interventions

demonstrated in this study, a bi+ modified version of SAARR and BDI may further increase preference and acceptability rates for these interventions among ethnoracially diverse bi+ women. Alternatively, perhaps the reflected preference is more about the fact that both interventions are administered confidentially in that SAARR utilizes an individual counseling session and BDI is conducted completely online.

Victim-Blaming as a Barrier

Potential causes for the above results could be that ethnoracially diverse bi+ women perceived FTS and other sexual violence interventions to be more victim-blaming than BITB. Previous research highlights that bisexual women who have experienced sexual victimization are not only perceived as more promiscuous than their lesbian and heterosexual counterparts (Dyar et al., 2021), but are met with more negative social evaluation when they disclose sexual victimization experiences (Sigurvinsdottir & Ullman, 2015), and thus, experience being blamed as survivors/victims. For example, one participant wrote what would make them less likely to participate was that "It puts the onus on potential victims," and that what would make them more likely to participate would be "If there was a bystander intervention too." This is consistent with suggestions from Orchowski et al. (2018), that combining elements from different interventions which share the same goal may be important.

FTS and the other presented sexual violence interventions target current or potential victims/survivors, whereas BITB targets bystanders and promotes community action to intervene on behalf of potential survivors/victims. In other words, BITB acts on a different level of the socioecological model. Thus, it is unclear whether any individually targeted sexual violence intervention would be acceptable for bi+ women.

Least Acceptable/Preferred Intervention

Ethnoracially diverse bi+ women and white heterosexual, cisgender women appeared to largely agree that HRI was neither acceptable nor preferred as a sexual violence vulnerability reduction intervention. It had the lowest willingness to recommend ratings across groups, with only about 1/4 (24-26%) of bi+ women willing to recommend it. Perhaps more telling, HRI had the lowest acceptability rates across groups, with 88% of ethnoracially diverse bi+ women and 82% of white heterosexual, cisgender women rating it in the *not* acceptable range.

These results suggest that perhaps focusing on reducing hookups is viewed at best as not relevant, and at worst even more victim-blaming or stigmatizing than other sexual violence interventions. One bi+ participant wrote "It seems a little shame based. Who tf [sic.] cares how many hook ups you have compared to other people. People shouldn't assault regardless" regarding barriers to participating in HRI, while another wrote "It seems to stigmatize people who enjoy or want casual sex or hookups."

Willingness to Recommend

Interestingly, most ethnoracially diverse bi+ women reported they would be willing to recommend modified, bi+ inclusive versions of both BITB and FTS to a friend, as well as to a friend who had experienced sexual violence. Yet, percentages reflect a significant reduction in willingness to recommend to a friend who had experienced sexual violence for both the bi+ inclusive M-BITB (from 74% to 54%) and M-FTS (from 66% to 53%), with just over half of bi+ women being willing to recommend in the latter case. This reduction in willingness to recommend to a friend with a sexual victimization history held true across four of the five original sexual violence interventions, with the

exception of HRI which had the lowest willingness to recommend rate (from 26% to 24%).

These results may signify an uncertainty about recommending to a friend who may feel victim-blamed for their own experience of sexual victimization by attending a sexual violence intervention given qualitative comments by participants reflecting this belief. For example, one bi+ woman participant wrote that what would make her less likely to attend FTS was "concerns about being triggered as a sexual assault survivor; the fact that I do not believe that it is women's responsibility to prevent themselves from being assaulted."

Additionally, the substantial research support for these two interventions (BITB, FTS), which was presented as information in the descriptions to participants, may have played a role in their willingness to recommend them to a friend. For example, if a bi+ women intended to recommend a sexual violence intervention to a friend, particularly to a friend who had experienced sexual violence, they would likely be invested in knowing the intervention has proven effective for reducing vulnerability to future victimization.

The majority of the control group was willing to recommend all sexual violence interventions both to a friend and to a friend who had experienced sexual victimization, with the exception of BDI in the latter case. Unlike for ethnoracially diverse bi+ women, there were no significant differences in white heterosexual, cisgender women's willingness to recommend based on if a friend experienced sexual victimization. This may reflect the lower rate of personal experience with lifetime sexual victimization for these women than for ethnoracially diverse bi+ women, and perhaps the thought of victim-blaming being less paramount in the minds of white heterosexual, cisgender

women. Alternatively, it could potentially represent more internalized rape myth beliefs in this socio-politically dominant group. The intervention with the highest percentage of white heterosexual, cisgender women willing to recommend was FTS (over 73% in both friend conditions). Overall, white heterosexual, cisgender women were willing to recommend BITB, FTS, and SAARR over BDI and HRI.

It is interesting to note that the majority of white heterosexual, cisgender women rated all sexual violence interventions as *not* acceptable but were still willing to recommend them to others. In the most extreme case, at least 30% of white heterosexual, cisgender women rated HRI as *not* acceptable but were still willing to recommend it.

Intervention Elements Related to Bi+ Inclusivity/Centering Women. The majority of ethnoracially diverse bi+ women rated intervention elements hypothesized to be related to inclusivity for bi+ women as important, including women participants only (62%), women trainers or therapists only (67%), being created especially for women (70%), being created especially for bi+/sexual minority (SM) women (74%), and gender neutral language (82%). In fact, when considering all 31 intervention elements, bi+ women ranked "guaranteed privacy and confidentiality" (49%) most often in their top five elements of importance and "created especially for bi+/sexual minority women" (34%) as second most often ranked in their top five elements of importance. The majority of white heterosexual, cisgender women (57%) also ranked guaranteed privacy and confidentiality in their top five intervention elements of importance. No differences were found in importance ratings between experimental and control groups for having women participants only with women trainers/therapists, and being created especially for women,

thus it seems a women-centered and confidential approach to sexual violence interventions is important to all women.

A preference for confidentiality in mental health treatment and sexual violence interventions is evidenced by minority stress theory in that it supports a need for heightened personal inclusivity, relevancy, and confidentiality to guard against anticipated stigma and discrimination. On college campuses, evidence suggests compelled disclosure of sexual victimization may silence, retraumatize, and disempower victims, who are largely women, and result in fewer survivors reporting their victimization experiences as well as negatively impact their mental health (Holland et al., 2018), which is certainly the opposite impact on mental health that is desirable within the context of a sexual violence intervention.

Given only 2 (3%) controls ranked "gender neutral language" in their top five intervention elements compared to 20% (n = 48) of the experimental group, which was a significant group difference, it does not appear to hold the same importance for white heterosexual, cisgender women as it does for ethnoracially diverse bi+ women. These data may represent a higher acceptance rate for transgender, gender non-conforming (GNC), and other gender minoritized people among ethnoracially diverse bi+ women that has not been reflected in historical tensions within the LGB and community around transgender acceptance (Devor, 2004).

Additional Intervention Elements of Importance

When comparing the importance of intervention elements across groups, the only significant differences found were that white, heterosexual cisgender women ranked small group size and physical self-defense strategies as significantly more often in their

top five intervention elements of importance compared to bi+ women. Still, physical self-defense strategies, small group size, and in-person formats were ranked most often in the top five for both groups, suggesting they are important intervention elements for all women. Given the association found in previous research between including participants' preferred intervention components and participant treatment completion, a focus on including preferred intervention components is crucial for widespread intervention efficacy (Swift et al., 2011). Small group size may be particularly important to ethnoracially minoritized women given research has shown a preference for individual over group counseling for those concerned with perceived stigma related to their ethnoracial identities (Nadeem, 2008).

Results indicated that the majority of all women in the sample preferred shorter intervention lengths, from 5-10 minutes (56%) to 30-45 minutes (79%) and 90 minutes (70%). Only about 1/6 (16%) of the sample found 12 hours acceptable, which reflects the length of FTS. There was a significant difference between acceptability of 90 minutes and 12-hour intervention lengths between groups, suggesting white heterosexual, cisgender women had a lower threshold for acceptability of longer intervention lengths. Ethnoracially diverse bi+ women may be willing to attend an intervention that is longer if it is meaningful, inclusive, and acceptable to them.

However, several qualitative comments by participants indicate they may have been under the mistaken impression that 12 intervention hours occurred all in one day due to lack of clarity in presentation of the item. One participant wrote what would make them more likely to participate in FTS would be "12hrs [sic,] spaced out over multiple meetings," and multiple comments were made in the barriers item that 12 hours was too

long. If it had been clear to participants that a 12-hour intervention occurs over the span of 2-3 days, it could potentially increase bi+ women's acceptability of this length of intervention. However, one study found 87% of participants reported time as a barrier to attending self-defense classes (Hollander, 2010). Better public messaging about why longer sexual violence interventions may be needed could help. For example, dismantling the risks associated with a lifetime of exposure to rape culture will likely take longer than 10 minutes, or half an hour, similar to interventions treating anxiety or depression.

Factors Influencing Acceptability

Contrary to research on characteristics of self-defense training participants (Brecklin & Ullman, 2004; Hollander, 2010), no positive relationship was found between adolescent/adult experiences of sexual violence and acceptability of or preference for the self-defense FTS intervention for either group of women. However, there was a negative relationship found between CSA and FTS acceptability for white heterosexual, cisgender women only, in that FTS acceptability rates were higher for those that did not report CSA (n = 58) compared to those that did report a CSA history (n = 7). However, this effect should be investigated with a larger sample.

Ethnoracially diverse bi+ women's prior knowledge of sexual violence vulnerability reduction interventions appeared to be linked to higher total acceptability scores for BITB and HRI only, as perceptions increased in positivity with prior knowledge. Prior knowledge and perception was not linked with any intervention acceptability scores for white heterosexual, cisgender women.

Since cost variables likely attenuated acceptability rates across the board for all sexual violence interventions among the entire sample—in keeping with previous

research using the ND SVIAM (Anderson et al., 2022)—it suggests sexual violence interventions need to be accessible, convenient, and free of monetary cost to be acceptable to all women. This finding is in keeping with research that cost (and time) is a real and identified barrier to health access and treatment (Hollander, 2010; Iverson et al., 2016).

Future/Lifetime Gun Owners and Intervention Acceptability

Interestingly, when it came to future/lifetime gun owners, across the experimental and control groups, they did not have attenuated acceptability scores for any sexual violence interventions; yet they showed significantly higher acceptability rates for HRI than non-gun owning participants. Future/lifetime gun owning women may not think guns alone will protect from them from sexual victimization. Contrarily, they may simply find gun owning an even more acceptable intervention than sexual violence interventions.

Potentially, future/lifetime women gun owners reflect membership in conservative political, social, and/or religious groups that may value a broad range of conservative values including the right to own firearms and the reduction or elimination of casual sex and/or sex outside of marriage (e.g., see Blee & Creasap, 2010; Garcia & Kruger, 2010; Yamane, 2017). Alternatively, future/lifetime women gun owners may hold more subtle or internalized beliefs stemming from these dominant themes present in much of mainstream American culture such as rape myth acceptance or internalized sexism.

Clinical Implications and Future Directions

Overall, ethnoracially diverse bi+ women found most sexual violence interventions largely *not* acceptable due to barriers that appear to include anticipated

victim-blaming and revictimization, opportunity costs, longer intervention lengths, and potential breaches of confidentiality, particularly regarding sexual identity and more broadly, intersectional identities. In-person interventions of small groups of participants inclusive of bi+ women seem to be preferred as long as confidentiality can be guaranteed. Additional investigation into unique intervention elements and descriptions, particularly regarding components and language that may appear less victim-blaming or *not* acceptable to bi+ women, would be useful. Modifying sexual violence interventions to be inclusive of SM people may attenuate participants' perceived victim-blaming of the intervention. Whether bi+ women will find longer (i.e., 12 hours) sexual violence interventions acceptable if there is a demonstrated commitment to personal inclusivity, relevancy, and confidentiality to guard against anticipated negative experiences, is also fodder for future research.

Physical self-defense strategies and individualized counseling as part of a sexual violence intervention that can also address substance use and/or mental health issues may be critically important. This is particularly true when considering ethnoracially diverse bi+ women's preference for these interventions and the wealth of literature documenting increased mental health symptomatology and alcohol/substance use in SM women/women of color who have experienced sexual victimization. It is crucial to consider the interplay of heavy drinking and symptoms such as depression interacting with experiences of antibisexual prejudice or internalized bi-negativity (Molina et al., 2015) which can result in increased rates of sexual victimization experiences (McConnell & Messman-Moore, 2019) without blaming victims/survivors. Additionally, a recent study found that heavy drinking does not decrease to the same degree with age for SM

women as it does for heterosexual women (Veldhuis et al., 2017), which may indicate a greater need for early intervention in SM women.

Given the acceptability of BITB by ethnoracially diverse bi+ women, additional studies examining new types of community-focused sexual violence interventions that are not limited to facilitation on college campuses or solely targeting current or potential survivors/victims may more greatly benefit bi+ women in the community and increase their acceptability of such a sexual violence intervention. For example, asking future/lifetime gun owning women if they believe guns to be sufficient protection against sexual violence victimization and investigating their preferences for sexual violence interventions could be a fruitful area of research. These data might serve to assist in developing psychoeducation for increasing awareness and reducing misconceptions about effective sexual violence defense strategies when targeting broader community groups.

Ethnoracially diverse bi+ women and white heterosexual, cisgender women differed significantly regarding having a mental health condition/disability and adult sexual victimization histories, with bi+ women experiencing significantly more of both. This may indicate why SAARR and BDI were ranked higher over sexual violence interventions (other than FTS) among bi+ women since both address potential heavy drinking or alcohol use disorders, and SAARR could likely address other mental health issues such as traumatic stress from sexual victimization in the individual counseling portion. Relatedly, a study on women veterans who experienced interpersonal violence found they preferred counseling that was confidential and individualized with a focus on physical safety, emotional health, and managing mental health symptoms (Iverson et al., 2016).

Given the overall lack of acceptability of most sexual violence interventions by ethnoracially diverse bi+ women, qualitative responses should be further analyzed to identify nuances regarding their acceptability of and preferences for sexual violence interventions. More specifically, it is of the utmost importance to further examine what racialized and ethnoracially minoritized SM women's intervention needs and preferences are to increase their acceptability of sexual violence interventions. For example, would ethnoracially minoritized women prefer a sexual violence intervention that is inclusive of and relevant to their ethnic or racial identities?

Limitations

This study only presented two examples of bi+ inclusive modified versions of sexual violence interventions. Another limitation of this study is in relation to the measurement of the importance of ethnoracially inclusive and relevant sexual violence interventions. The following item should have been administered to participants: "Would you prefer an intervention that is inclusive of and relevant to your ethnic or racial identity/identities? However, due to an error in survey administration, participants did not have the opportunity to view and answer this item. The length of this study, sheer number of items inquiring about aspects of acceptability and preferences for sexual violence interventions, and potential artifacts of methodology (e.g., intervention ranking items initially displayed in a preset order; intervention descriptions appearing in a specific order) may have produced participant fatigue or confusion and account for mixed findings. Further research should focus specifically on addressing acceptability and preferences of sexual violence interventions for other marginalized groups such as transgender and nonbinary individuals.

Conclusion

Generally, bi+ women were found to prefer sexual violence vulnerability reduction interventions that are inclusive of and relevant to them. Additionally, they found the presented bystander intervention to be the most acceptable and all other interventions *not* acceptable. Perceived victim-blaming may be the reason ethnoracially diverse bi+ women reported being less likely to recommend a sexual violence intervention to a friend who has experienced sexual violence victimization than simply to a friend, which was not the case among white heterosexual, cisgender women who recommended sexual violence interventions at the same rates regardless of whether a friend had experienced sexual violence. All women ranked women-centered elements, guaranteed confidentiality, physical self-defense strategies, in-person formats, and small group sizes as being important. Women preferred interventions that were 90 minutes in length or less. Future work should address acceptability of and preferences for interventions for transgender/GNC individuals as well as ethnoracially minoritized people and People of Color regardless of sexual identity status.

APPENDIX A

Table 1A

Additional Participant Intersectional Identity Variables

Response/category	Experimental (n = 240) (n, %)	Control (n = 65) (n, %)
Immigrant status		
Non-immigrant	221, 92.1%	65, 100%
Immigrant	19, 7.9%	--
Physical Disability		
No	223, 92.9%	65, 100%
Yes	17, 7.1%	--
Mental Health Disability		
No	90, 37.5%	44, 67.7%
Yes	150, 62.5%	21, 32.3%
Highest Education		
High school grad/GED	30, 12.5%	16, 24.6%
Trade/Technical/Vocational	2, 0.8%	1, 1.5%
Some college	95, 39.6%	46, 70.8%
2-year college degree	10, 4.2%	1, 1.5%
4-year college bachelor's	71, 29.6%	1, 1.5%
Master's	29, 12.1%	--
Doctorate	3, 1.3%	--
Student Status		
Yes	152, 63.3%	64, 98.5%
No	88, 36.7%	1, 1.5%
Yearly Income		
$0	24, 10.0%	5, 7.7%
$1-10,000	86, 35.8%	46, 70.8%
$10,001-20,000	30, 12.5%	10, 15.4%
$20,001-30,000	35, 14.6%	2, 3.1%
$30,001-40,000	21, 8.8%	--
$40,001-50,000	14, 5.8%	--
$50,001-60,000	10, 4.2%	1, 1.5%
$60,001-70,000	5, 2.1%	--
$70,001-80,000	1, 0.4%	--
$80,001-90,000	2, 0.8%	--
$90,000-100,000	1, 0.4%	--
$100,001-110,000	2, 0.8%	--
$110,001-120,000	1, 0.4%	--

$140,001-150,000	3, 1.3%	--
$200,001+	1, 0.4%	--
	Perceived Socioeconomic Status	
1	1, 0.4%	--
2	8, 3.3%	--
3	15, 6.3%	1, 1.5%
4	49, 20.4%	7, 10.8%
5	37, 15.4%	14, 21.5%
6	53, 22.1%	17, 26.2%
7	39, 16.3%	15, 23.1%
8	31, 12.9%	9, 13.8%
9	6, 2.5%	2, 3.1%
10	1, 0.4%	--
	Religion	
Christian/Protestant	48, 20.0%	38, 58.5%
None	44, 18.3%	4, 6.2%
Agnostic	35, 14.6%	5, 7.7%
Atheist	30, 12.5%	2, 3.1%
Catholic/Roman Catholic	16, 6.7%	14, 21.5%
Other	12, 5.0%	--
Eclectic	11, 4.6%	--
Spiritual/Spiritual but not religious	10, 4.2%	--
Buddhist	7, 2.9%	--
Pagan	6, 2.5%	--
Judaism	4, 1.7%	--
Hindu	4, 1.7%	--
Native American	3, 1.3%	--
Islam	2, 0.8%	--
Occult/mysticism	2, 0.8%	--
Unsure	1, 0.4%	1, 1.5%
	Relationship Status	
Dating	74, 30.8%	35, 53.8%
Single and wish to be partnered	53, 22.1%	20, 30.8%
Married/partnered	50, 20.8%	4, 6.2%
Single and wish to stay that way	23, 9.6%	6, 9.2%
Multiple casual relationships	10, 4.2%	--
Married/partnered and dating	7, 2.9%	--
Married/partnered and play with others	5, 2.1%	--
Multiple committed relationships	5, 2.1%	--
One primary partner and at least one casual relationship	5, 2.1%	--
Other	5, 2.1%	--
Divorced	2, 0.8%	--
Separated	1, 0.4%	--

Note. Subjective Socioeconomic Status (SSS) is on a scale from 1 (bottom ladder rung) to 10 (top ladder rung) on the MacArthur Scale of Subjective Social Status (Goodman et al., 2001). Response/category: in some cases, such as the SSS, the participant's exact quantitative response is shown. In other cases (i.e., for "Religion," responses were categorized by the researcher under the closest matching broader category (e.g., "Christian/Protestant"). Experimental = Experimental group. Control = Control group.

Table 2A

Prior Intervention Knowledge Predicting Acceptability

SVVRI	Analysis	*df*	*F*	*Partial* η^2	*p*
		Full Sample, $N = 305$			
BITB	ANOVA	2, 302	.973	.006	.379
	ANCOVA	1, 131	1.881	.014	.173
FTS	ANOVA	2, 302	.245	.002	.783
	ANCOVA	1, 98	.057	.001	.812
BDI	ANOVA	2, 302	1.629	.011	.198
	ANCOVA	1, 280	1.045	.004	.307
SAARR	ANOVA	2, 302	2.395	.016	.093
	ANCOVA	1, 280	2.715	.010	.101
HRI	ANOVA	2, 301	2.736	.018	.066
	ANCOVA	1, 279	3.727	.013	.055
		Experimental Group, $N = 240$			
M-BITB	ANOVA	2, 236	.820	.007	.442
	ANCOVA	1, 108	1.672	.015	.199
M-FTS	ANOVA	2, 235	.950	.008	.388
	ANCOVA	1, 78	.496	.006	.484
BITB	ANOVA	2, 237	1.656	.014	.193
	ANCOVA	1, 108	4.170	.037	.044
FTS	ANOVA	2, 237	.078	.001	.925
	ANCOVA	1, 79	.112	.001	.739
BDI	ANOVA	2, 237	1.055	.009	.350
	ANCOVA	1, 222	.847	.004	.359
SAARR	ANOVA	2, 237	1.397	.012	.249
	ANCOVA	1, 222	1.548	.007	.215
HRI	ANOVA	2, 236	2.505	.021	.084
	ANCOVA	1, 221	3.926	.017	.049
		Control Group, $N = 65$			
BITB	ANOVA	2, 62	.181	.006	.835
	ANCOVA	1, 20	2.784	.122	.111
FTS	ANOVA	1, 63	2.626	.040	.110
	ANCOVA	0, 17	--	.000	--
BDI	ANOVA	2, 62	.300	.010	.742
	ANCOVA	1, 55	.016	.000	.900
SAARR	ANOVA	2, 62	.616	.019	.543
	ANCOVA	1, 55	.650	.012	.424
HRI	ANOVA	2, 62	.415	.013	.662
	ANCOVA	1, 55	.890	.016	.350

Note. SVVRI: Sexual Violence Vulnerability Reduction Interventions. BITB = Bringing in the Bystander®. FTS = Flip the Script™. M-BITB = Modified BITB. M-FTS = Modified FTS. BDI = Brief Drinking Intervention. SAARR = Sexual Assault Risk and Alcohol Use Reduction Program. HRI = Hookup Reduction Intervention.

Table 3A

Comparison of "Yes," "Maybe/unsure," and "No" Responses across SVVRIs for Bi+ Women's Willingness to Recommend to a Friend

	1-Y	1-M	1-N	2-Y	2-M	2-N	3-Y	3-M	3-N	4-Y	4-M	4-N	5-Y	5-M	5-N	6-Y	6-M	6-N	7-Y	7-M	7-N
	χ^2	χ^2	χ^2	χ^2	χ^2	χ^2	χ^2	χ^2	χ^2	χ^2	χ^2	χ^2	χ^2	χ^2	χ^2	χ^2	χ^2	χ^2	χ^2	χ^2	χ^2
	p	*p*	*p*	*p*	*p*	*p*	*p*	*p*	*p*	*p*	*p*	*p*	*p*	*p*	*p*	*p*	*p*	*p*	*p*	*p*	*p*
1-Y	--	--	--	3.97 .046	--	--	4.84 .03	--	--	7.40 <.01	--	--	49.48 <.0001	--	--	34.27 <.0001	--	--	110.36 <.0001	--	--
1-M	--	--	--	--	.36 .55	--	--	8.02 <.01	--	--	8.96 <.01	--	--	4.92 .03	--	--	.12 .73	--	--	.19 .66	--
1-N	--	--	--	--	--	4.21 .04	--	--	.29 .60	--	--	6.30 .01	--	--	39.29 <.0001	--	--	43.03 <.0001	--	--	116.95 <.0001
2-Y	3.97 .046	--	--	--	--	--	.04 .84	--	--	.53 .47	--	--	26.27 <.0001	--	--	15.35 .0001	--	--	75.77 <.0001	--	--
2-M	--	.36 .55	--	--	--	--	--	5.01 .03	--	--	12.74 <.001	--	--	2.62 .11	--	--	.07 .80	--	--	.03 .87	--
2-N	--	--	4.21 .04	--	--	--	--	--	6.63 .01	--	--	.22 .64	--	--	19.20 <.0001	--	--	21.98 <.0001	--	--	83.82 <.0001
3-Y	4.84 .028	--	--	.04 .84	--	--	--	--	--	.27 .60	--	--	24.36 <.0001	--	--	13.86 .0002	--	--	72.78 <.0001	--	--
3-M	--	8.02 <.01	--	--	5.01 .03	--	--	--	--	--	32.06 <.0001	--	--	.39 .53	--	--	6.21 .01	--	--	5.81 .02	--
3-N	--	--	.29 .60	--	--	6.63 .01	--	--	--	--	--	9.17 .003	--	--	45.43 <.0001	--	--	49.39 <.0001	--	--	126.17 <.0001
4-Y	7.40 <.01	--	--	.53 .47	--	--	.27 .60	--	--	--	--	--	19.54 <.0001	--	--	10.27 .001	--	--	64.61 <.0001	--	--

4-M	--	8.96 <.01	--	--	12.74 <.001	--	--	32.06 <.0001	--	--	--	--	--	25.91 <.0001	--	--	11.08 <.001	--	--	11.65 <.001	--
4-N	--	--	6.30 .01	--	--	.22 .64	--	--	9.17 .003	--	--	--	--	--	15.52 .0001	--	--	18.06 <.0001	--	--	76.79 <.0001
5-Y	49.48 <.0001	--	--	26.27 <.0001	--	--	24.36 <.0001	--	--	19.54 <.0001	--	--	--	--	--	1.52 .22	--	--	14.20 .0002	--	--
5-M	--	4.92 .03	--	--	2.62 .11	--	--	.39 .53	--	--	25.91 <.0001	--	--	--	--	--	3.51 .06	--	--	3.21 .07	--
5-N	--	--	39.29 <.0001	--	--	19.20 <.0001	--	--	45.43 <.0001	--	--	15.52 .0001	--	--	--	--	--	.10 .75	--	--	25.62 <.0001
6-Y	34.27 <.0001	--	--	15.35 .0001	--	--	13.86 .0002	--	--	10.27 .001	--	--	1.52 .22	--	--	--	--	--	24.66 <.0001	--	--
6-M	--	.12 .73	--	--	.07 .80	--	--	6.21 .01	--	--	11.08 <.001	--	--	3.51 .06	--	--	--	--	--	.01 .93	--
6-N	--	--	43.03 <.0001	--	--	21.98 <.0001	--	--	49.39 <.0001	--	--	18.06 <.0001	--	--	.10 .75	--	--	--	--	--	22.48 <.0001
7-Y	110.36 <.0001	--	--	75.77 <.0001	--	--	72.78 <.0001	--	--	64.61 <.0001	--	--	14.20 .0002	--	--	24.66 <.0001	--	--	--	--	--
7-M	--	.19 .66	--	--	.03 .87	--	--	5.81 .02	--	--	11.65 <.001	--	--	3.21 .07	--	--	.01 .93	--	--	--	--
7-N	--	--	116.95 <.0001	--	--	83.82 <.0001	--	--	126.17 <.0001	--	--	76.79 <.0001	--	--	25.62 <.0001	--	--	22.48 <.0001	--	--	--

Note. SVVRI: Sexual Violence Vulnerability Reduction Intervention. 1 = Modified Bringing in the Bystander®. 2 = Modified Flip the Script™. 3 = BITB. 4 = FTS. 5 = Brief Drinking Intervention. 6 = Sexual Assault Risk and Alcohol Use Reduction Program. 7 = Hookup Reduction Intervention. Y = Yes. M = Maybe/unsure. N = No.

Table 4A

Comparison of "Yes," "Maybe/unsure," and "No" Responses across SVVRIs for Bi+ Women's Willingness to Recommend to a Friend who has Experienced Sexual Violence

	1-Y	1-M	1-N	2-Y	2-M	2-N	3-Y	3-M	3-N	4-Y	4-M	4-N	5-Y	5-M	5-N	6-Y	6-M	6-N	7-Y	7-M	7-N
	χ^2	χ^2	χ^2	χ^2	χ^2	χ^2	χ^2	χ^2	χ^2	χ^2	χ^2	χ^2	χ^2	χ^2	χ^2	χ^2	χ^2	χ^2	χ^2	χ^2	χ^2
	p	*p*	*p*	*p*	*p*	*p*	*p*	*p*	*p*	*p*	*p*	*p*	*p*	*p*	*p*	*p*	*p*	*p*	*p*	*p*	*p*
1-Y	--	--	--	.03 .86	--	--	9.65 <.01	--	--	2.01 .16	--	--	26.73 <.0001	--	--	15.71 .0001	--	--	46.35 <.0001	--	--
1-M	--	--	--	--	.01 .92	--	--	9.51 <.01	--	--	1.79 .18	--	--	.03 .87	--	--	1.87 .17	--	--	4.80 .03	--
1-N	--	--	--	--	--	.14 .71	--	--	.04 .84	--	--	.05 .82	--	--	33.43 <.0001	--	--	32.12 <.0001	--	--	78.36 <.0001
2-Y	.03 .86	--	--	--	--	--	8.60 <.01	--	--	1.71 .19	--	--	24.99 <.0001	--	--	14.38 .0001	--	--	44.11 <.0001	--	--
2-M	--	.01 .92	--	--	--	--	--	10.10 <.01	--	--	2.06 .15	--	--	.01 .94	--	--	1.62 .20	--	--	4.39 .04	--
2-N	--	--	.14 .71	--	--	--	--	--	.03 .87	--	--	.02 .89	--	--	29.55 <.0001	--	--	28.31 <.0001	--	--	72.71 <.0001
3-Y	9.65 <.01	--	--	8.60 <.01	--	--	--	--	--	2.88 .09	--	--	4.43 .04	--	--	.77 .38	--	--	14.47 .0001	--	--
3-M	--	9.51 <.01	--	--	10.10 <.01	--	--	--	--	--	3.08 .08	--	--	10.61 <.01	--	--	19.58 <.0001	--	--	27.32 <.0001	--
3-N	--	--	.04 .84	--	--	.03 .87	--	--	--	--	--	.001 .98	--	--	31.47 <.0001	--	--	30.19 <.0001	--	--	75.67 <.0001

4-Y	2.01 .16	--	--	1.71 .19	--	--	2.88 .09	--	--	--	--	--	14.32 <.001	--	--	6.58 .01	--	--	29.73 <.0001	--	--
4-M	--	1.79 .18	--	--	2.06 .15	--	--	3.08 .08	--	--	--	--	--	2.29 .13	--	--	7.29 <.01	--	--	12.36 <.001	--
4-N	--	--	.05 .82	--	--	.02 .89	--	--	.001 .98	--	--	--	--	--	31.09 <.0001	--	--	29.82 <.0001	--	--	75.04 <.0001
5-Y	26.73 <.0001	--	--	24.99 <.0001	--	--	4.43 .04	--	--	14.32 <.001	--	--	--	--	--	1.51 .22	--	--	2.96 .09	--	--
5-M	--	.03 .87	--	--	.01 .94	--	--	10.61 <.01	--	--	2.29 .13	--	--	--	--	--	1.45 .23	--	--	4.10 .04	--
5-N	--	--	33.43 <.0001	--	--	29.55 <.0001	--	--	31.47 <.0001	--	--	31.09 <.0001	--	--	--	--	--	.01 .91	--	--	10.78 .001
6-Y	15.71 .0001	--	--	14.38 .0001	--	--	.77 .38	--	--	6.58 .01	--	--	1.51 .22	--	--	--	--	--	8.60 <.01	--	--
6-M	--	1.87 .17	--	--	1.62 .20	--	--	19.58 <.0001	--	--	7.29 <.01	--	--	1.45 .23	--	--	--	--	--	.68 .41	--
6-N	--	--	32.12 <.0001	--	--	28.31 <.0001	--	--	30.19 <.0001	--	--	29.82 <.0001	--	--	.01 .91	--	--	--	--	--	11.47 <.001
7-Y	46.35 <.0001	--	--	44.11 <.0001	--	--	14.47 .0001	--	--	29.73 <.0001	--	--	2.96 .09	--	--	8.60 <.01	--	--	--	--	--
7-M	--	4.80 .03	--	--	4.39 .04	--	--	27.32 <.0001	--	--	12.36 <.001	--	--	4.10 .04	--	--	.68 .41	--	--	--	--
7-N	--	--	78.36 <.0001	--	--	72.71 <.0001	--	--	75.67 <.0001	--	--	75.04 <.0001	--	--	10.78 .001	--	--	11.47 <.001	--	--	--

Note. SVVRI: Sexual Violence Vulnerability Reduction Intervention. 1 = Modified Bringing in the Bystander®. 2 = Modified Flip the Script™. 3 = BITB. 4 = FTS. 5 = Brief Drinking Intervention. 6 = Sexual Assault Risk and Alcohol Use Reduction Program. 7 = Hookup Reduction Intervention. Y = Yes. M = Maybe/unsure. N = No.

Table 5A

Comparison of "Yes," "Maybe/unsure," and "No" Responses across SVVRIs for White Heterosexual, Cisgender Women's Willingness to Recommend to a Friend

	3-Y	3-M	3-N	4-Y	4-M	4-N	5-Y	5-M	5-N	6-Y	6-M	6-N	7-Y	7-M	7-N
	χ^2	χ^2	χ^2	χ^2	χ^2	χ^2	χ^2	χ^2	χ^2	χ^2	χ^2	χ^2	χ^2	χ^2	χ^2
	p	*p*	*p*	*p*	*p*	*p*	*p*	*p*	*p*	*p*	*p*	*p*	*p*	*p*	*p*
3-Y	--	--	--	.97 .32	--	--	1.19 .27	--	--	.31 .58	--	--	4.55 .03	--	--
3-M	--	--	--	--	2.17 .14	--	--	.16 .69	--	--	1.05 .30	--	--	1.05 .30	--
3-N	--	--	--	--	--	.70 .40	--	--	5.81 .02	--	--	5.81 .02	--	--	16.22 .0001
4-Y	.97 .32	--	--	--	--	--	4.27 .04	--	--	2.36 .12	--	--	9.52 <.01	--	--
4-M	--	2.17 .14	--	--	--	--	--	1.16 .28	--	--	.21 .65	--	--	.21 .65	--
4-N	--	--	.70 .40	--	--	--	--	--	2.83 .09	--	--	2.83 .09	--	--	11.71 <.001
5-Y	1.19 .27	--	--	4.27 .04	--	--	--	--	--	.29 .59	--	--	1.11 .29	--	--
5-M	--	.16 .69	--	--	1.16 .28	--	--	--	--	--	.39 .53	--	--	.39 .53	--
5-N	--	--	5.81 .02	--	--	2.83 .09	--	--	--	--	--	0.00 1.00	--	--	3.55 .06

6-Y	.31 .58	--	--	2.36 .12	--	--	.29 .59	--	--	--	--	--	2.52 .11	--	--
6-M	--	1.05 .30	--	--	.21 .65	--	--	.39 .53	--	--	--	--	--	0.00 1.00	--
6-N	--	--	5.81 .02	--	--	2.83 .09	--	--	0.00 1.00	--	--	--	--	--	3.55 .06
7-Y	4.55 .03	--	--	9.52 <.01	--	--	1.11 .29	--	--	2.52 .11	--	--	--	--	--
7-M	--	1.05 .30	--	--	.21 .65	--	--	.39 .53	--	--	0.00 1.00	--	--	--	--
7-N	--	--	16.22 .0001	--	--	11.71 <.001	--	--	3.55 .06	--	--	3.55 .06	--	--	--

Note. SVVRI: Sexual Violence Vulnerability Reduction Intervention. 3 = BITB. 4 = FTS. 5 = Brief Drinking Intervention. 6 = Sexual Assault Risk and Alcohol Use Reduction Program. 7 = Hookup Reduction Intervention. Y = Yes. M = Maybe/unsure. N = No.

Table 6A

Comparison of "Yes," "Maybe/unsure," and "No" Responses across SVVRIs for White Heterosexual, Cisgender Women's Willingness to Recommend to a Friend who has Experienced Sexual Violence

	3-Y	3-M	3-N	4-Y	4-M	4-N	5-Y	5-M	5-N	6-Y	6-M	6-N	7-Y	7-M	7-N
	χ^2	χ^2	χ^2	χ^2	χ^2	χ^2	χ^2	χ^2	χ^2	χ^2	χ^2	χ^2	χ^2	χ^2	χ^2
	p	*p*	*p*	*p*	*p*	*p*	*p*	*p*	*p*	*p*	*p*	*p*	*p*	*p*	*p*
3-Y	--	--	--	.89 .35	--	--	6.09 .01	--	--	0.00 1.00	--	--	2.58 .11	--	--
3-M	--	--	--	--	.18 .67	--	--	1.47 .23	--	--	0.00 1.00	--	--	.21 .65	--
3-N	--	--	--	--	--	4.77 .03	--	--	3.10 .08	--	--	0.00 1.00	--	--	5.38 .02
4-Y	.89 .35	--	--	--	--	--	11.38 <.001	--	--	.89 .35	--	--	6.40 .01	--	--
4-M	--	.18 .67	--	--	--	--	--	.62 .43	--	--	.18 .67	--	--	.78 .38	--
4-N	--	--	4.77 .03	--	--	--	--	--	13.76 <.001	--	--	4.77 .03	--	--	17.58 <.0001
5-Y	6.09 .01	--	--	11.38 <.001	--	--	--	--	--	6.09 .01	--	--	.77 .38	--	--
5-M	--	1.47 .23	--	--	.62 .43	--	--	--	--	--	1.47 .23	--	--	2.75 .10	--
5-N	--	--	3.10 .08	--	--	13.76 <.001	--	--	--	--	--	3.10 .08	--	--	.34 .56

6-Y	0.00 1.00	--	--	.89 .35	--	--	6.09 .01	--	--	--	--	--	2.58 .11	--	--
6-M	--	0.00 1.00	--	--	.18 .67	--	--	1.47 .23	--	--	--	--	--	.21 .65	--
6-N	--	--	0.00 1.00	--	--	4.77 .03	--	--	3.10 .08	--	--	--	--	--	5.38 .02
7-Y	2.58 .11	--	--	6.40 .01	--	--	.77 .38	--	--	2.58 .11	--	--	--	--	--
7-M	--	.21 .65	--	--	.78 .38	--	--	2.75 .10	--	--	.21 .65	--	--	--	--
7-N	--	--	5.38 .02	--	--	17.58 <.0001	--	--	.34 .56	--	--	5.38 .02	--	--	--

Note. SVVRI: Sexual Violence Vulnerability Reduction Intervention. 3 = BITB. 4 = FTS. 5 = Brief Drinking Intervention. 6 = Sexual Assault Risk and Alcohol Use Reduction Program. 7 = Hookup Reduction Intervention. Y = Yes. M = Maybe/unsure. N = No.

Table 7A

Stigma Predicting Preference for Bi+ Inclusive Interventions by Bi+ Women

Intercept/Predictor Variables	*B* (*SE*)	*p* value	95% *CI* *Lower*	*Upper*
Bringing in the Bystander® vs. Unsure/Don't Know[a]				
Intercept	4.50 (1.86)	.02		
ABES score	-1.32 (.68)	.05	.07	1.02
Modified Bringing in the Bystander® vs. Unsure/Don't Know[a]				
Intercept	4.14 (1.60)	.01		
ABES score	-.39 (.44)	.38	.29	1.61
Preferring M-BITB and BITB the Same Amount vs. Unsure/Don't Know[a]				
Intercept	3.01 (1.74)	.08		
ABES score	-.51 (.52)	.32	.22	1.65
Bringing in the Bystander® vs. Unsure/Don't Know[b]				
Intercept	.47 (1.67)	.78		
M-ABES score	.20 (.60)	.73	.38	3.98
Modified Bringing in the Bystander® vs. Unsure/Don't Know[b]				
Intercept	2.38 (1.50)	.11		
M-ABES score	-.10 (.55)	.86	.31	2.67
Preferring M-BITB and BITB the Same Amount vs. Unsure/Don't Know[b]				
Intercept	1.10 (1.71)	.52		
M-ABES score	-.12 (.63)	.85	.26	3.07
Flip the Script™ vs Preferring FTS and M-FTS the Same Amount[c]				
Intercept	-2.59 (1.41)	.07		
ABES score	.53 (.46)	.25	.69	4.23
Modified Flip the Script™ vs Preferring FTS and M-FTS the Same Amount[c]				
Intercept	.34 (.81)	.67		
ABES score	.13 (.31)	.67	.62	2.08
Unsure/Don't Know vs Preferring FTS and M-FTS the Same Amount[c]				
Intercept	-1.43 (1.64)	.38		
ABES score	-.11 (.66)	.87	.25	3.26
Flip the Script™ vs Preferring FTS and M-FTS the Same Amount[d]				
Intercept	-3.45 (1.52)	.02		
M-ABES score	.68 (.38)	.08	.93	4.17
Modified Flip the Script™ vs Preferring FTS and M-FTS the Same Amount[d]				
Intercept	.57 (.74)	.44		
M-ABES score	.04 (.24)	.89	.65	1.66
Unsure/Don't Know vs Preferring FTS and M-FTS the Same Amount[d]				
Intercept	-1.53 (1.50)	.31		

M-ABES score	-.05 (.51)	.92	.35	2.56
Bringing in the Bystander® vs. Preferring BITB and M-BITB the Same Amount[e]				
Intercept	-.572 (1.38)	.68		
Heterosexism in COC	.07 (.71)	.93	.27	4.31
Modified Bringing in the Bystander® vs. Preferring BITB and M-BITB the Same Amount[e]				
Intercept	-.02 (.99)	.99		
Heterosexism in COC	.72 (50)	.15	.78	5.44
Unsure/Don't Know vs. Preferring BITB and M-BITB the Same Amount[e]				
Intercept	-2.54 (1.76)	.15		
Heterosexism in COC	.76 (.79)	.34	.45	10.18
Flip the Script™ vs Preferring FTS and M-FTS the Same Amount[f]				
Intercept	-.13 (1.21)	.91		
Heterosexism in COC	-.23 (.53)	.66	.28	2.23
Modified Flip the Script™ vs Preferring FTS and M-FTS the Same Amount[f]				
Intercept	.94 (.84)	.26		
Heterosexism in COC	.07 (.35)	.84	.54	2.12
Unsure/Don't Know vs Preferring FTS and M-FTS the Same Amount[f]				
Intercept	-4.78 (2.37)	.04		
Heterosexism in COC	1.28 (.77)	.10	.80	16.15

Note. CI = Confidence interval. ABES = Anti-Bisexual Experiences Scale. M-ABES = Modified ABES. BITB = Bringing in the Bystander®. M-BITB = Modified BITB. FTS = Flip the Script™. M-FTS = Modified FTS. Heterosexism in COC = Heterosexism in Communities of Color Subscale from the LGBT People of Color Microaggressions Scale.

[a] R^2 = .08 (Cox & Snell), .10 (Nagelkerke); Model $\chi 2(3) = 5.37$, $p = .15$.

[b] R^2 = .01 (Cox & Snell), .02 (Nagelkerke); Model $\chi 2(3) = .79$, $p = .85$.

[c] R^2 = .03 (Cox & Snell), .03 (Nagelkerke); Model $\chi 2(3) = 1.46$, $p = .69$.

[d] R^2 = .07 (Cox & Snell), .08 (Nagelkerke); Model $\chi 2(3) = 3.89$, $p = .27$.

[e] R^2 = .05 (Cox & Snell), .06 (Nagelkerke); Model $\chi 2(3) = 3.26$, $p = .35$.

[f] R^2 = .06 (Cox & Snell), .07 (Nagelkerke); Model $\chi 2(3) = 4.25$, $p = .24$.

Table 8A

Importance of Ethnoracial Inclusivity in Interventions and Commitment to or Exploration of Ethnoracial Identity for Bi+, Ethnoracially Minoritized Women

Constant/Predictor Variables	*B* (*SE*)	*p* value	95% *CI*	
			Lower	*Upper*
Constant	-4.72 (1.32)	< .001		
MEIM-R: Commitment	.43 (.41)	.29	.69	3.40
MEIM-R: Exploration	.06 (.40)	.88	.49	2.34

Note. CI = Confidence interval. MEIM-R = Multigroup Ethnic Identity Measure—Revised. Hosmer & Lemeshow $\chi 2(8) = 1.77$, $p = .99$. $R^2 = .01$ (Cox & Snell), .04 (Nagelkerke). Model $\chi 2(2) = 2.92$, $p < .23$.

Table 9A

Future/Lifetime Gun Ownership Predicting SVVRI Acceptability Scores

Intervention	Linear Regression Statistics	Overall Regression Statistics
Modified Bringing in the Bystander®	(β = -.04, p = .55)	R^2 = .002, F(1, 237) = .37, p = .55
Modified Flip the Script™	(β = -.04, p = .53)	R^2 = .002, F(1, 236) = .40, p = .53
Bringing in the Bystander®	(β = -.002, p = .97)	R^2 < .00001, F(1, 303) = .002, p = .97
Flip the Script™	(β = .063, p = .27)	R^2 = .004, F(1, 303) = 1.21, p = .27
Brief Drinking Intervention	(β = -.046, p = .42)	R^2 = .002, F(1, 303) = .65, p = .42
Sexual Assault Risk and Alcohol Use Reduction Program	(β = .08, p = .16)	R^2 = .007, F(1, 303) = 2.02, p = .16
Hookup Reduction Intervention	(β = .15, p = .01)	R^2 = .02, F(1, 303) = 7.11, p = .01

Note. SVVRI = Sexual Violence Vulnerability Reduction Intervention.

Table 10A

North Dakota Sexual Violence Intervention Acceptability Measure (ND SVIAM) Acceptability Item Means

Item	BITB *N, M* (*SD*)	FTS *N, M* (*SD*)	BDI *N, M* (*SD*)	SAARR *N, M* (*SD*)	HRI *N, M* (*SD*)	M-BITB *N, M* (*SD*)	M-FTS *N, M* (*SD*)	Aver-age *M*
1	305, 5.82 (1.07)	305, 5.52 (1.29)	305, 4.80 (1.59)	305, 4.93 (1.60)	305, 3.93 (1.73)	239, 5.80 (1.16)	238, 5.57 (1.24)	5.20
2	305, 4.89 (1.38)	305, 4.73 (1.49)	305, 4.82 (1.68)	305, 5.31 (1.63)	305, 4.61 (1.77)	238, 5.50 (1.25)	238, 5.15 (1.50)	5.00
3	305, 5.81 (1.17)	305, 5.56 (1.37)	305, 4.76 (1.62)	305, 4.93 (1.63)	305, 3.82 (1.78)	239, 5.90 (1.13)	238, 5.53 (1.29)	5.19
4	305, 4.20 (.71)	304, 4.09 (.78)	304, 4.26 (.72)	305, 4.22 (.82)	305, 3.99 (.87)	237, 4.32 (.71)	237, 4.19 (.72)	4.18
5	305, 5.61 (1.09)	304, 5.44 (1.28)	305, 5.73 (1.12)	305, 5.65 (1.19)	305, 5.25 (1.36)	238, 5.90 (1.00)	238, 5.66 (1.17)	5.61
6	305. 2.87 (1.21)	304, 2.87 (1.26)	305, 2.13 (1.24)	304, 2.01 (1.23)	304, 1.66 (1.02)	237, 2.90 (1.28)	236, 2.72 (1.33)	2.45
7	302, 2.36 (1.10)	302, 2.42 (1.20)	304, 1.94 (1.07)	303, 2.00 (1.14)	302, 1.69 (.99)	237, 2.73 (1.23)	236, 2.63 (1.27)	2.25
8	303, 3.17 (1.14)	303, 3.05 (1.24)	304, 2.25 (1.19)	303, 2.27 (1.22)	303, 1.91 (1.13)	236, 3.20 (1.22)	236, 3.05 (1.26)	2.70
9	305, 3.74 (.82)	304, 3.78 (.96)	298, 3.10 (1.14)	304, 3.32 (1.13)	305, 2.76 (1.22)	238, 3.92 (.85)	237, 3.82 (.94)	3.50
10	305, 4.05 (.95)	304, 3.85 (1.03)	305, 3.65 (1.22)	304, 3.89 (1.15)	305, 3.43 (1.30)	238, 4.26 (.81)	237, 4.03 (.93)	3.88

Note. Item 1 = .Affective Attitude (7-point scale). Item 2 = Burden (7-point scale). Item 3 – Ethicality (7-point scale). Item 4 = Intervention Coherence A (5-point scale). Item 5 = Intervention Coherence B (7-point scale). Item 6 = Opportunity Costs A (5-point scale). Item 7 = Opportunity Costs B (5-point scale). Item 8 = Opportunity Costs C (5-point scale). Item 9 = Perceived Effectiveness (5-point scale). Item 10 = Self-Efficacy (5-point scale). BITB = Bringing in the Bystander®. FTS = Flip the Script™. BDI = Brief Drinking Intervention. SAARR = Sexual Assault Risk and Alcohol Use Reduction Program. HRI = Hookup Reduction Intervention. M-BITB = Modified BITB. M-FTS = Modified FTS.

APPENDIX B

Sexual Behavior and Attraction Items

Do you consider yourself to be: (Check all that apply*)*

- ☐ Asexual
- ☐ Bisexual or Biromantic
- ☐ Demisexual
- ☐ Fluid
- ☐ Gay
- ☐ Heterosexual or Straight
- ☐ Lesbian
- ☐ Multisexual/Plurisexual or Multiattracted/Pluriattracted
- ☐ Omnisexual
- ☐ Pansexual
- ☐ Polysexual
- ☐ Queer
- ☐ Questioning or uncertain
- ☐ Sapiosexual
- ☐ Transamorous
- ☐ Two-spirit
- ☐ You don't have an option that applies to me. I identify as (Please specify)__
- ☐ Prefer not to say

Which sexual identity is the most important or meaningful to you? [choice of those selected above] OR:

- ☐ They are all of equal importance/meaning
- ☐ Unsure/Don't know

Since the age of 14, who have you had sex with (any type of sex, including oral, anal or vaginal)? Check all that apply:

- ☐ men (transgender or cisgender)
- ☐ women (transgender or cisgender)
- ☐ transgender people
- ☐ Two-spirit, agender, nonbinary and/or gender fluid/queer/nonconforming people
- ☐ I have not had sex

People are different in their sexual attraction to other people. Which best describes your feelings? Check all that apply:

- ☐ Attracted to women (transgender or cisgender)
- ☐ Attracted to men (transgender or cisgender)
- ☐ Attracted to transgender people
- ☐ Attracted to two-spirit, agender, nonbinary and/or gender fluid/queer/nonconforming people?
- ☐ Unsure or not attracted to any

APPENDIX C

Sexual Violence Vulnerability Reduction Intervention Descriptions

1.0 Bringing in the Bystander®

The 90-minute Bringing in the Bystander® in-person group training program for women and men assumes everyone in the community has a responsibility to help end sexual assault against women. Bystander intervention is based on the idea that community values, beliefs, and interests play a large role in sexual assault perpetration and that bystanders can effectively intervene (disrupt or stop an incident from happening) in sexual assaults. Research shows positive changes for women and men in willingness to intervene after training. Sorority women reported a 28% increase in willingness to intervene, a 33% increase in confidence to intervene, and a 26% increase in their sense of bystander responsibility after participating.

Bringing in the Bystander® teaches you how to safely intervene in situations where a sexual assault is occurring, or likely to occur. It helps equip you with skills to identify problematic or dangerous behavior, develop empathy for those who have experienced sexual assault, practice safe and effective methods to intervene, and commit to taking action. Group training usually involves around 25-35 people (the minimum is 8 participants) and includes:

1. an introduction to bystander responsibility within communities;
2. local community examples and statistics;
3. active learning exercises about the range of sexual assault experiences; and
4. discussions about identifying risky situations and choosing safe, effective ways to intervene.

The program includes an interactive discussion about helping others or being helped by others in certain situations. The peer facilitators, one man and one woman who have attended a Bringing in the Bystander® College training workshop or a Train the Trainer workshop, or who have access to the curriculum, discuss what makes intervening more or less difficult in specific situations. They help the group define sexual assault and discuss real life examples. At the end of training, you will sign bystander pledges and receive ABC (Active Bystanders Care) cards as reminders of the decision making process for intervening.

Description adapted from: https://cultureofrespect.org/program/bringing-in-the-bystander/

2.0 Flip the Script™

Flip the Script™ is a 12-hour sexual assault resistance group training program for women, taught by women, that includes educational games, facilitated discussion, and practical activities. Trainers are under 30 years old and must attend the Flip the Script™ Train the Trainer workshop or be trained by an attendee of one. Women reported they were 22% less likely to experience rape or an attempted rape one year after training. Women also reported a 26% increase in how likely they believe it is that they will be raped by an acquaintance. Additionally, women reported a 29% increase in their belief in their ability to perform self-defense strategies just after taking Flip the Script™, with a 17% increase in this belief lasting for 1.5 years.

Twenty women participants, maximum, are in Flip the Script™ training. Modules include: 1) *Assess* early risk cues for sexual assault; 2) *Acknowledge* you are not to blame; 3) *Act* to defend your right to personal safety; and 4) *Enhance* your relationships and sexuality:

1. *Assess* helps you recognize you are most at risk of sexual assault from a person you know in a familiar setting and to identify high risk behaviors and situational cues. You will explore ways to reduce these risks without limiting your freedom.
2. *Acknowledge* guides you through recognizing and overcoming emotional reasons that may cause you to resist defending your rights in ways that do not conflict with your personal goals.
3. *Act* equips you with verbal and physical self-defense strategies for repelling sexual assault. You will have the opportunity to choose which resistance tools you find most comfortable and effective for various scenarios involving pretend male acquaintances.
4. *Enhance* focuses on boosting knowledge of your personal values and desires, empowering you to express them with romantic or sexual partners and more quickly recognize behavior that violates your choices.

Description adapted from: https://www.fau.edu/owlscare/flipthescript/

3.0 Brief Drinking Intervention

The Brief Drinking Intervention consists of one 30-45 minute individual counseling session, delivered by women and men who are master's-level counseling students, that aims to reduce episodes of heavy drinking. Heavy drinking is a risk factor for women making them more vulnerable to sexual assault, so addressing heavy drinking may help reduce risk of sexual assault. In 50% of sexual assaults, the person being assaulted, the person doing the assaulting, or both, are drinking. The Brief Drinking Intervention is a newer intervention with less research support, but initial research shows it is possibly effective in helping you increase your desire to make positive changes in your life and your confidence in your ability to make these changes. It also may help reduce heavy drinking. College women reported an approximately 11% decrease in their drinking three months after the session. They also reported about 18% fewer experiences of rape, including rape while being passed out.

In the counseling session, the Brief Drinking Intervention therapist is empathetic and focuses on helping you identify your current life goals and determine if specific drinking habits may be hindering you from achieving those goals. The therapist helps you to make self-motivational statements and discusses options with you for changing your drinking habits if you desire to do so. You will receive a personalized feedback profile which includes how much and how often you drink with your estimated blood alcohol content (BAC) and calorie intake, your drinking behavior in comparison to your peers, your estimated genetic risk, and how much you spend on alcohol. The Brief Drinking Intervention sessions include:

- tools to find out what is important to you and your level of confidence for making change,
- discussions on confidentiality and indecisiveness about drinking,
- an exploration of your own drinking behaviors like peak episodes and related problems,
- talking about potential and actual change, and if desired,
- developing your plan for change.

Description adapted from: Clinton-Sherrod, M. Morgan-Lopez, A. A., Brown, J. M., McMillen, B. A., & Cowells, A. (2011). Incapacitated sexual assault involving alcohol among college women: The impact of a Brief Drinking Intervention. *Violence Against Women, 17*(1), 135-154.

4.0 Sexual Assault Risk and Alcohol Use Reduction Program

The Sexual Assault Risk and Alcohol Use Reduction program takes 5-10 minutes and is completely online. It aims to reduce sexual assault risk, including sexual assaults that involve drinking. In half of sexual assaults, one or more people involved are drinking. This program is also a newer intervention with only preliminary research support showing it is possibly effective in reducing how often women report being raped while they are passed out/incapacitated by about 17% three months after taking the intervention. Only women with more severe sexual assault histories reported a decrease of about 18-19% in their heavy drinking, their number of sexual assault experiences, and in the severity of their sexual assault experiences after three months.

Sexual Assault Risk Reduction includes:

1. Sexual Assault Information
    a. Definition of sexual assault.
    b. Sexual assault risk factors (high risk locations, heavy drinking, characteristics of people who sexually assault others, etc.).
    c. Sexual assault community rates compared to your own perceived risk in easy-to-read charts.
2. Risk Reduction Strategies and Skills
    a. Interactive sexual assault sketch highlighting risk factors and your choices of active resistance strategies.
    b. Common barriers to sexual assault resistance, including having friends in common with the perpetrator, and ways to address barriers.
    c. Local community sexual assault and counseling resources.

Alcohol Use Reduction includes:

1. Information on drinking alcohol, like
    a. definitions of a standard drink;
    b. differences in blood alcohol content between women and men;
    c. beliefs about the rewards of drinking;
    d. alcohol's ability to increase your concentration on current events happening nearby and reduce your awareness of distant events; and
    e. your personal blood alcohol content and associated risks.
2. Your potential drinking-related negative consequences including risk for sexual assault and strategies to protect against risky drinking habits.
    a. A comparison of your drinking habits to actual drinking habits among peer women.

Description adapted from: Gilmore, A. K., Lewis, M. A., & George, W. H. (2015). A randomized controlled trial targeting alcohol use and sexual assault risk among college women at high risk for victimization. *Behaviour Research and Therapy, 74*, 38-49.

5.0 Hookup Reduction Intervention

This online intervention uses gender neutral language and takes about 5 minutes to complete. It aims to reduce hookups (defined as "a sexual encounter between strangers, friends, or acquaintances—people not in a relationship with each other. Physical interaction of some kind (e.g., kissing) is typical, but may or may not involve sexual intercourse. Hookups may involve drinking which can increase risk of sexual assault because drinking is involved in 50% of sexual assaults. This intervention is also a newer intervention that does not yet have full research support. Initial research showed that almost 80% of women believed others' hookups were more numerous than they actually were, and that this intervention is possibly effective in reducing the number of experiences of sexual assault women experience two months after taking the intervention compared to those that didn't take the intervention, but only by about 10%.

As part of the intervention, you will receive personalized feedback that shows how your hookups compare to those of other women in your peer group from surveys that have collected this information from hundreds of women.

- This feedback information is presented in bar graph form, showing your number of hookups and what you believe are the average number of hookups of other women in your peer group.
- You will be able to see how you compare to your peers by clicking a button which adds a third bar on the graph that represents the actual number of hookups of other women.
- Information is presented to you separately for hookups that involve drinking, and hookups that do not involve drinking.
- The same information provided in bar graph form will also be given to you written in full text.

You will be given percentages, like "XX% of women in your peer group reported never hooking up while drinking," and "XX% of women who are your peers reported never hooking up when not drinking."

Description adapted from: Testa, M., Livingston, J. A., Wang, W., & Lewis, M. A. (2020). Preventing college sexual victimization by reducing hookups: a randomized controlled trial of a personalized normative feedback intervention. *Prevention Science, 21*(3), 388-397.

6.0 Modified Bringing in the Bystander®

The 90-minute Bringing in the Bystander® in-person group training program for bi+ (multiattracted, bisexual, biromantic, pansexual, demisexual plurisexual, two-spirit, etc.) women assumes everyone in the bi+ community has a responsibility to help end sexual assault of bi+ women. Bystander intervention is based on the idea that the wider community's values, beliefs, and interests play a large role in sexual assault perpetration and that bystanders can effectively intervene (disrupt or stop sexual assaults). Sorority women reported a 28% increase in willingness to intervene, a 33% increase in confidence to intervene, and a 26% increase in their sense of bystander responsibility after participating.

Bringing in the Bystander® teaches you how to safely intervene in situations where a sexual assault is occurring or likely to occur. It helps you identify an assaulter's behavior, understand personal and societal stressors in the lives of bi+ women that create a vulnerability to sexual assault, develop an awareness of your emotions and empathy for those who have experienced sexual assault, grow communication and other skills for initiating safe and effective methods to intervene, and commit to taking action in your communities. Group training involves 8-35 bi+ women and includes:

1. an introduction to bystander responsibility within LGBTQ+ communities;
2. local community, bi+ women, and LGBTQ+ community examples and statistics;
3. active learning exercises about the range of sexual minority sexual assault experiences; and
4. discussions about identifying risk factors unique to bi+ women and choosing safe, effective ways to intervene.

The program includes an interactive discussion about helping and being helped by others. The two bi+ women facilitators, who have attended a Bringing in the Bystander® College training workshop or a Train the Trainer workshop, or who have access to the curriculum, discuss what makes intervening more or less difficult in specific situations unique to bi+ women and the larger LGBTQ+ community. They help the group define sexual assault in bi+ people's sex and relationships using real life examples. At the end of training, you will sign bystander pledges and receive ABC (Active Bystanders Care) cards as reminders of the decision making process for intervening.

7.0 Modified Flip the Script™

Flip the Script™ for bi+ women (multiattracted, bisexual, biromantic, pansexual, plurisexual, two-spirit, etc.) is a 12-hour sexual assault resistance group training program taught by bi+ women that includes educational games, facilitated discussion, and practical activities relevant to bi+ women's sex and relationships. Trainers are under 30 years old and must attend the Flip the Script™ Train the Trainer workshop or be trained by an attendee of one. Women reported they were 22% less likely to experience rape or an attempted rape one year after training. Women also reported a 26% increase in how likely they believe it is that they will be raped by an acquaintance. Additionally, women reported a 29% increase in their belief in their ability to perform self-defense strategies just after taking Flip the Script™, with a 17% increase in this belief lasting for 1.5 years.

A maximum of twenty bi+ women participants are in Flip the Script™ training. Modules include: 1) *Assess* early cues for vulnerability to sexual assault unique to bi+ women; 2) *Acknowledge* you are not to blame; 3) *Act* to defend your right to personal safety; and 4) *Enhance* your bi+ relationships and sexuality:

1. *Assess* helps you recognize you are most at risk of sexual assault from a person you know in a familiar setting, and to identify high risk behaviors and situational cues. You will explore ways to reduce these risks without limiting your freedom or sexuality.
2. *Acknowledge* guides you through recognizing and overcoming emotional reasons that may cause you to resist defending your rights in ways that do not conflict with your personal goals, sexuality, or sexual identity.
3. *Act* equips you with verbal and physical self-defense strategies for repelling sexual assault. You will have the opportunity to choose which resistance tools you find most comfortable and effective for various scenarios common to bi+ women involving pretend acquaintances of various genders.
4. *Enhance* focuses on boosting knowledge of your personal values and desires, empowering you to express them with romantic or sexual partners and more quickly recognize behavior that violates your choices.

APPENDIX D

Intervention Elements

How important are the below elements for you in any program that you might participate in to help reduce your risk of sexual assault?

5 = Very important
4 = Somewhat important
3 = Neutral/Unsure
2 = Somewhat not important
1 = Not at all important

1. Individual program
2. Group program
3. Small group size (less than 10 participants)
4. Large group size (20 or more participants)
5. In-person format
6. Online format
7. Counseling component (individual)
8. Women participants only
9. Women trainers or therapists only
10. Created especially for women
11. Created especially for bi+/sexual minority women [experimental group participants only]
12. Trainers or therapists who have been trained by the official program or its creators
13. Trainers or therapists under the age of 30
14. Guaranteed privacy and confidentiality
15. Focusing on your drinking habits
16. Focusing on your number of hookups
17. Focus on addressing barriers to resistance and reducing self-blame
18. Focus on bystander intervention strategies
19. Discussion on the range of sexual violence experiences
20. Discussion about identifying risky situations
21. Discussion on how to enhance your relationships and sexuality
22. Physical self-defense strategies
23. Verbal self-defense strategies (e.g., matching your response to threat level; using a strong and neutral tone; using body language; learning to de-escalate the attack)
24. Information on your calorie intake
25. Information on your blood alcohol content
26. Information on your alcohol consumption compared to your peers
27. Information on how your number of hookups compare to your peers
28. Information on sexual assault rates in your community compared to what you believe your risk to be
29. Local community examples and statistics
30. Evidence of effectiveness/research support
31. Gender neutral language on surveys and in program content

APPENDIX E

North Dakota Sexual Violence Intervention Acceptability Measure (ND SVIAM)

Affective Attitude
How positively or negatively do you feel about this program?

1 = Extremely negative about it
2 = Negative about it
3 = Slightly negative about it
4 = Neutral/Neither positive nor negative about it
5 = Slightly positive about it
6 = Positive about it
7 = Extremely positive about it

Burden
How easy or difficult do you think it will be for you to participate in this program?

1 = Extremely difficult
2 = Difficult
3 = Slightly difficult
4 = Neutral/Neither easy nor difficult
5 = Slightly easy
6 = Easy
7 = Extremely easy

Ethicality
How much do you agree with this statement:
This program aligns well with my personal value system.

1 = Strongly disagree
2 = Disagree
3 = Somewhat disagree
4 = Neutral/Neither agree nor disagree
5 = Somewhat agree
6 = Agree
7 = Strongly agree

Intervention Coherence
How clear is your understanding of this program?

1 = Not at all clear
2 = Somewhat not clear
3 = Neutral/Neither clear nor unclear
4 = Somewhat clear
5 = Very clear

How much do you agree with this statement:
I understand how this program works.

1 = Strongly disagree
2 = Disagree
3 = Somewhat disagree
4 = Neutral/Neither agree nor disagree
5 = Somewhat agree
6 = Agree
7 = Strongly agree

Opportunity Costs
In order to attend this program, would you (rate each from 1-5):

1 = Definitely not
2 = Probably not
3 = Might or might not
4 = Probably yes
5 = Definitely yes

a) Pay $30 (OR pay a babysitter $30)? ___
b) Miss class or work? ___
c) Reschedule a date or outing? ___

Perceived Effectiveness
How effective do you think this program will be in helping you to prevent sexual assault or rape?

1 = Not at all effective
2 = Somewhat not effective
3 = Neutral/Don't know
4 = Somewhat effective
5 = Very effective

Tell us more about what might STOP you from participating in this program:

Tell us more about what might make you MORE LIKELY to participate in this program:

Self-Efficacy
How confident are you that you could successfully engage in and complete this program?

1 = Not at all confident
2 = Somewhat not confident
3 = Neutral/Don't know
4 = Somewhat confident
5 = Very confident

Willingness to Recommend
Would you recommend this program to a friend?
☐ Yes
☐ No
☐ Maybe/unsure. Tell us more: _____

Would you recommend this program to a friend who had experienced sexual assault or rape?
☐ Yes
☐ No
☐ Maybe/unsure. Tell us more: _____

Measure based on: Sekhon, M., Cartwright, M., & Francis, J.J. (2017). Acceptability of healthcare interventions: An overview of reviews and development of a theoretical framework. *BMC Health Services Research, 17*, 88. https://doi.org/10.1186/s12913-017-2031-8

APPENDIX F

Mental Health Support Resources Provided to Participants

General Mental Health/Therapy

- At the top of each survey page: "Call 656-273-4673 or Text HOME to 741741 if you are upset or would like to talk to someone for free at any time. Call 1-800-THERAPIST or Go Here for information on confidential therapy near you."

Sexual Violence Victimization Support

- National Sexual Assault Hotline: 800-656-HOPE (4673)
    - Chat or mobile app: https://hotline.rainn.org/
- National Domestic Violence Hotline: 1-800-799-7233 (TTY 1-800-787-3224)
    - Text LOVEIS to 22522

Suicide Prevention

- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK(8255)
    - En Español: 1-888-628-9454
    - 24/7 Crisis Text Line: Text "HOME" to 741-741
    - TTY users: 711 then 1-800-273-8255
    - 24/7 Lifeline Online Chat: suicidepreventionlifeline.org/chat/

LGBTQ+, People of Color, and Community/Population Specific Support

- GLBT National Hotline: 1-888-843-4564 or http://www.glbthotline.org/
- Trans Lifeline: 1-877-565-8860
- The Trevor Project Support for Teens/Youth:
    - 24/7 TrevorLifeline for Teens/Young Adults: 1-866-488-7386
    - 24/7 TrevorText: Text START to 678-678
    - 24/7 TrevorChat: www.thetrevorproject.org/get-help-now/
    - www.TrevorSpace.org
    - Trevor Support Center: www.thetrevorproject.org/resources/
- StrongHearts Native Helpline: 1-844-762-8483
- Black, Indigenous, People of Color (emphasis on reducing traumatic interactions with police): www.callblackline.com; 1-800-604-5841
- Asian LifeNet Hotline (Cantonese, Mandarin, Japanese, Korean, Fujianese): 1-877-990-8585
- Veterans Crisis Line: www.veteranscrisisline.net; 1-800-273-8255

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