

A Multilevel Approach for Reducing Mental Health and Substance Use Disparities Affecting Bisexual Individuals

Brian A. Feinstein, *Northwestern University, Feinberg School of Medicine, Northwestern University, Institute for Sexual and Gender Minority Health and Wellbeing, United States*

Christina Dyar, *University of Cincinnati*

John E. Pachankis, *Yale School of Public Health, New Haven, CT*

Despite bisexual individuals being at increased risk for mental health and substance use problems, clinicians' ability to provide affirmative and competent care to bisexual clients is limited by their lack of bisexual-specific training. To address this common gap in training, this article provides a brief review of bisexual health disparities and the factors that influence them. Then, we describe a multi-level approach for improving the health and well-being of bisexual individuals. This approach addresses factors that influence health at the micro-level (e.g., strategies that clinicians can use to help bisexual clients cope with stigma-related stressors), mezzo-level (e.g., adaptations to clinical environments and training programs that promote bisexual-affirmative care), and macro-level (e.g., advocating for political change and implementing strategies to reduce prejudice against bisexual individuals at the population-level). Specifically, we describe how clinicians can adapt evidence-based interventions to tailor them to the needs of their bisexual clients. Additionally, we discuss the need for bisexual-affirmative clinical training and provide recommendations for how clinical training can be adapted to prepare clinicians to work effectively with bisexual clients. Finally, we describe how population-level interventions can be used to reduce prejudice against bisexual individuals in order to reduce bisexual health disparities. Given the striking health disparities affecting bisexual individuals, there is a critical need to develop, test, and disseminate interventions to improve the health of this population and to prepare clinicians to provide bisexual-affirmative care.

BISEXUAL individuals (i.e., those who report romantic and/or sexual attractions to more than one sex/gender, engage in sexual behavior with more than one sex/gender, and/or identify as bisexual) are at increased risk for mental health and substance use problems compared to monosexual individuals (i.e., those who are romantically and/or sexually oriented toward a single sex/gender, such as heterosexual and gay/lesbian individuals; e.g., Bostwick, Boyd, Hughes, & McCabe, 2010; McCabe, Hughes, Bostwick, West, & Boyd, 2009). While sexual identity often overlaps with attractions and behavior, some people who report bisexual attractions and/or behavior do not identify as bisexual; instead, they can identify with any other sexual identity label (e.g., gay, lesbian, heterosexual, queer¹; Rust,

2001). Mental health and substance use disparities affecting bisexual individuals are largely due to societal stigma (e.g., Brewster & Moradi, 2010; Meyer, 2003). Despite this, clinicians rarely receive training that includes information about bisexuality and addresses the skills needed to provide affirmative and competent care to bisexual clients.

To address this gap in training, we describe a multi-level approach for reducing the health disparities affecting bisexual individuals. Our approach addresses factors that influence health at the micro-level (e.g., strategies clinicians can use to help bisexual clients cope with stigma-related stressors), mezzo-level (e.g., adaptations to clinical environments and training programs that promote bisexual-affirmative care), and macro-level (e.g., advocating for political change and implementing strategies to reduce prejudice against bisexual individuals at the population-level). Before discussing these interventions, we provide a brief review of the literature on mental health and substance use disparities between bisexual and monosexual individuals as well as factors that influence them. This illustrative review is intended to provide context for discussing the interventions that can be used to address these disparities. In sum, the goals of this article are to provide practical recommendations that clinicians can use to improve the health and well-being of bisexual clients and to detail strategies that can be implemented at

¹ Queer can be used to represent a monosexual or a nonmonosexual identity. Some people identify as queer because it does not have a fixed meaning (Callis, 2014) and is an umbrella term for any sexual minority identity (Gray & Demarais, 2014). In a recent study, more than half of the participants who identified as queer reported that they had secondary sexual identities and there was a balance of monosexual and nonmonosexual secondary sexual identities (Galupo, Mitchell, & Davis, 2015).

Keywords: bisexuality; stigma; health disparities; interventions; provider training

various levels to reduce the stigma that causes the health disparities affecting bisexual individuals.

Mental Health and Substance Use Disparities

The prevalence of mental health and substance use problems is higher among bisexual individuals compared to monosexual individuals, but across studies these disparities often depend on gender and dimension of sexual orientation. In the U.S. population, the prevalence of mood/anxiety disorders is higher among bisexual women compared to heterosexual and lesbian women, and this is consistent across dimensions of sexual orientation (Bostwick et al., 2010). For instance, the lifetime prevalence of mood/anxiety disorders is higher among self-identified bisexual women (58.7% for mood disorders, 57.8% for anxiety disorders) compared to self-identified heterosexual women (30.5% for mood disorders, 31.3% for anxiety disorders) and lesbian women (44.4% for mood disorders, 40.8% for anxiety disorders). While bisexual men are also at increased risk for mood/anxiety disorders compared to heterosexual men regardless of how sexual orientation is defined, the pattern is different for bisexual versus gay men (Bostwick et al., 2010). The lifetime prevalence of mood/anxiety disorders is higher among self-identified bisexual men (36.9% for mood disorders, 38.7% for anxiety disorders) compared to self-identified heterosexual men (19.8% for mood disorders, 18.6% for anxiety disorders), but similar to self-identified gay men (42.3% for mood disorders, 41.2% for anxiety disorders). In contrast, the lifetime prevalence of mood/anxiety disorders is higher for behaviorally bisexual men compared to behaviorally homosexual men (46.5% versus 26.8% for mood disorders, 38.9% versus 25.0% for anxiety disorders).

Individuals who identify as bisexual also report higher lifetime and past-year suicidality compared to individuals who identify as heterosexual and gay/lesbian (Brennan, Ross, Dobinson, Veldhuizen, & Steele, 2010; Conron, Mimiaga, & Landers, 2010; Jorm, Korten, Rodgers, Jacomb, & Christensen, 2002). One study found that the lifetime prevalence of having seriously considered suicide was higher among men who identified as bisexual (34.8%) compared to men who identified as gay (25.2%) and heterosexual (7.4%; Brennan et al., 2010). Similarly, another study found that the past-year prevalence of having seriously considered suicide was higher among individuals who identified as bisexual (18.5%) compared to individuals who identified as gay/lesbian (4.2%) and heterosexual (3.0%; Conron et al., 2010). In this study, the disparity in past-year suicidality was particularly striking for women who identified as bisexual (25.7%) compared to women who identified as lesbian (2.5%) and heterosexual (2.9%), but the disparity was also present for men who identified as bisexual (11.1%)

compared to men who identified as gay (5.8%) and heterosexual (3.2%). In sum, there is robust evidence that bisexual women are at increased risk for mental health problems (including mood/anxiety disorders and suicidality) compared to heterosexual and lesbian women (across dimensions of sexual orientation). There is also strong evidence that bisexual men are at increased risk for mental health problems compared to heterosexual men (across dimensions of sexual orientation), but comparisons with gay men are mixed depending on how sexual orientation is defined.

Similar disparities have also been documented for substance use and disorders (Green & Feinstein, 2012). In the U.S., bisexuality (across dimensions) is associated with increased prevalence of substance use and dependence for women (McCabe et al., 2009). For instance, the past-year prevalence of heavy drinking, alcohol dependence, marijuana use, and other drug use was higher among women who identified as bisexual (25.0% for heavy drinking, 15.6% for alcohol dependence, 22.2% for marijuana use, 14.1% for other drug use) compared to women who identified as heterosexual (8.4% for heavy drinking, 2.5% for alcohol dependence, 2.6% for marijuana use, 3.1% for other drug use) and lesbian (20.1% for heavy drinking, 13.3% for alcohol dependence, 16.7% for marijuana use, 12.6% for other drug use).

Bisexual men were at increased risk for substance use/dependence compared to heterosexual men (across dimensions), but differences between bisexual and gay men depended on how sexual orientation was defined. For instance, the past-year prevalence of alcohol dependence and other drug use/dependence was higher among men who identified as bisexual (19.5% for alcohol dependence, 17.7% for other drug use, 5.1% for other drug dependence) compared to men who identified as heterosexual (6.1% for alcohol dependence, 4.5% for other drug use, 0.5% for other drug dependence), but similar to men who identified as gay (16.8% for alcohol dependence, 16.8% for other drug use, 3.2% for other drug dependence). In contrast, the prevalence of substance use/dependence was higher for behaviorally bisexual men compared to behaviorally homosexual men (e.g., 13.3% versus 7.0% for alcohol dependence). When bisexuality is expanded to include individuals who identify as “mostly heterosexual,” mental health and substance use disparities persist (Vrangalova & Savin-Williams, 2014).

The Role of Minority Stress in Bisexual Health Disparities

Sexual minority individuals experience health disparities because of chronic stress related to their devalued social status, including external stressors (e.g., discrimination) and internal stressors (e.g., internalized stigma; Meyer, 2003). Bisexual individuals also experience unique

stressors, such as discrimination from both heterosexual and gay/lesbian individuals and unique stereotypes about bisexuality (Brewster & Moradi, 2010). In regard to external stressors, bisexual individuals experience frequent microaggressions (e.g., subtle behaviors that insult or invalidate their identity), which are associated with anxiety (Flanders, 2015). The prevalence of victimization is also high among bisexual individuals, and for some types of victimization (e.g., threats of violence, physical assault, assault with a weapon) it is higher for bisexual individuals compared to gay/lesbian individuals (Katz-Wise & Hyde, 2012). Further, bisexual individuals are at increased risk for childhood sexual abuse compared to heterosexual individuals (Sweet & Welles, 2012) and bisexual women are at increased risk for rape and other sexual violence compared to heterosexual and lesbian women (Walters, Chen, & Breiding, 2013).

In addition to victimization, bisexual individuals contend with stereotypes that portray bisexuality as an unstable and illegitimate sexual orientation (e.g., bisexual individuals are experimenting or confused) and that depict bisexual individuals as sexually irresponsible (e.g., promiscuous, unfaithful; Brewster & Moradi, 2010; Mohr & Rochlen, 1999). A distinguishing aspect of antibisexual prejudice is that it can be perpetrated by heterosexual and gay/lesbian individuals. Bisexual individuals often feel excluded from the gay/lesbian community, and when they are involved in the community, they often report low levels of belonging (Hayfield, Clarke, & Halliwell, 2014; Hequembourg & Brallier, 2009). Further, bisexual individuals report difficulty finding or accessing bisexual communities, which are often limited to the Internet (Hayfield et al., 2014; Hequembourg & Brallier, 2009).

Together, experiences of discrimination and exclusion from the gay/lesbian community coupled with difficulty finding and accessing bisexual communities are theorized to contribute to bisexual individuals' increased risk for mental health and substance use problems (Balsam & Mohr, 2007). One study found that involvement in the LGBT community was associated with increased substance abuse for bisexual women, but not lesbian and queer women, and this was due in part to bisexual women experiencing more discrimination (Feinstein, Dyar, & London, 2016). Therefore, being involved in the LGBT community may be a stressor rather than a source of support for bisexual women. Although most of the queer women in the sample reported attractions to more than one gender, involvement in the LGBT community was not associated with substance abuse for them. The authors suggested that people may assume that queer is synonymous with gay/lesbian because it can be used as an umbrella term (Gray & Demarais, 2014) and treat queer women similar to lesbian women, but different than bisexual women. However, more research is needed to understand queer people's experiences.

Stereotypes about bisexuality can also present challenges to bisexual individuals' dating experiences. For instance, people who endorse stereotypes about bisexuality are less willing to date bisexual partners (Armstrong & Reissing, 2014; Feinstein, Dyar, Bhatia, Latack, & Davila, 2014, 2016). One study found that heterosexual individuals who more strongly endorsed these stereotypes expected to be more jealous and insecure if they were to date a bisexual individual (e.g., they worried that the bisexual partner would stop being attracted to their sex/gender and be unfaithful; Armstrong & Reissing, 2014). Bisexual individuals also experience binegativity from their partners in the form of jealousy, relationship insecurity, pressure to re-identify in a way that matches the gender-pairing of the relationship (e.g., identify as heterosexual in a different-gender relationship), and negative comments and beliefs about the stability of their bisexual identity (Bostwick & Hequembourg, 2014; Hequembourg & Brallier, 2009; Ross, Dobinson, & Eady, 2010). Together, this research indicates that bisexual individuals can experience prejudice from a source that would be expected to provide support—relationship partners.

Given their exposure to stigma, discrimination, and victimization, many bisexual individuals internalize this stigma, anticipate rejection from others, and struggle with whether or not to disclose their identity to others. Internalized and anticipated stigma are associated with negative mental health outcomes (e.g., depression), uncertainty about one's sexual identity, and concerns about disclosure in samples of bisexual individuals (Brewster, Moradi, Deblaere, & Velez, 2013; Dyar, Feinstein, Schick, & Davila, 2017; Mohr, Jackson, & Sheets, 2016; Paul, Smith, Mohr, & Ross, 2014; Schrimshaw, Siegel, Downing, & Parsons, 2013). Bisexual individuals are also more likely to conceal their sexual identity than gay/lesbian individuals (Balsam & Mohr, 2007; Dyar, Feinstein, & London, 2015). In a recent study, while gay/lesbian individuals privately and publicly identified as gay/lesbian, bisexual individuals used different sexual identity labels in public depending on the context, despite privately identifying as bisexual (Mohr et al., 2016). In this study, bisexual individuals were more likely to be open about being sexual minority individuals in general than they were to be open about being bisexual. In sum, bisexual individuals are exposed to numerous stressors related to their sexual orientation, including external stressors (e.g., discrimination, victimization) and internal stressors (e.g., internalized stigma, expectations of rejection), which contribute to their increased risk for mental health and substance use problems.

Evidence-Based Interventions to Reduce Bisexual Health Disparities

Given the health disparities faced by bisexual individuals and accumulating evidence that locates the source of these disparities in stigma-related social disadvantage/stress, the

mental health profession is in an important position to enhance the well-being of bisexual individuals. An emerging body of research provides a foundation from which to deliver evidence-based care to bisexual clients. Our discussion of evidence-based interventions will be divided into micro-, mezzo-, and macro-level interventions. Micro-level interventions refer to interventions that clinicians can use with bisexual clients to help them cope with bisexual-specific stress and to reduce their mental health and substance use problems. Mezzo-level interventions refer to interventions that can be used to adapt clinical environments to make them more welcoming to bisexual clients and to adapt clinical training to provide clinicians with bisexual-affirmative knowledge and skills. Macro-level interventions refer to population-level interventions that can be used to indirectly improve the health of bisexual individuals by reducing societal stigma. Our discussion of evidence-based interventions is intended to provide examples of interventions that have the potential to reduce bisexual health disparities rather than an exhaustive review.

Micro-Level Interventions

In this section, we describe interventions that clinicians can use with bisexual clients to reduce stigma-related stressors (e.g., internalized stigma, expectations of rejection) and mental health and substance use problems. Because there are no evidence-based interventions designed for bisexual individuals, we also provide general recommendations for delivering bisexual-affirmative interventions. While several interventions have been tested for efficacy with sexual minority individuals (e.g., motivational interviewing for substance use and sexual risk; Parsons, Lelutiu-Weinberger, Botsko, & Golub, 2014), below we review interventions that explicitly address coping with sexual minority stigma as a form of intervention. These interventions are informed by evidence-based principles, including facilitating awareness of the adverse impact of minority stress on sexual minority individuals' well-being; restructuring minority stress cognitions; empowering assertive behavior among sexual minority individuals; validating sexual minority individuals' unique strengths; connecting with a supportive community; and engaging in affirming, rewarding expressions of sexuality (Pachankis, 2014; Pachankis, 2015). Throughout our discussion of these interventions, we highlight exercises that may be particularly useful for bisexual clients. Given that these interventions have primarily been tested for efficacy in samples of sexual minority men and that most of the men in these samples self-identify as gay, we conclude this section with a discussion of additional clinical issues to consider when working with bisexual clients.

Examples of stigma-coping interventions that have been developed to address mental health and substance

use problems among sexual minority individuals include: (a) an LGB-affirmative, transdiagnostic, cognitive-behavioral intervention for young gay and bisexual men (Pachankis, Hatzenbuehler, Rendina, Safren, & Parsons, 2015); (b) a computer-based cognitive-behavioral intervention for depression for lesbian, gay, and bisexual (LGB) youth (Lucassen, Merry, Hatcher, & Frampton, 2014); (c) an expressive writing intervention for gay and bisexual men (Pachankis & Goldfried, 2010) and lesbian women (Lewis et al., 2005); and (d) an internalized stigma reduction intervention for same-sex attracted men (Lin & Israel, 2012).

Effective Skills to Empower Effective Men (ESTEEM)

Recently, Pachankis (2014) developed an LGB-affirmative, transdiagnostic, cognitive-behavioral intervention for young gay and bisexual men (ESTEEM). The goal of the intervention is to reduce mental and behavioral health problems by targeting minority stress (e.g., internalized stigma, rejection sensitivity, sexual identity concealment) and universal risk factors (e.g., emotion regulation, hopelessness, isolation, unassertiveness; Pachankis, 2014). A randomized controlled trial was conducted with young gay and bisexual men (ages 18–35) and results indicated that the intervention led to significant reductions in depression, alcohol use problems, and condomless sex compared to a waitlist (Pachankis, Hatzenbuehler, et al., 2015). Participants who received the intervention also reported significant reductions in minority stress and universal risk factors upon receiving the intervention. Despite its preliminary efficacy, only 5 out of 63 participants were bisexual, so it is unclear if findings generalize to bisexual men. However, drawing on ESTEEM, clinicians can teach bisexual clients how to become more aware of stigma-related stressors and their emotional impact, how to safely assert oneself in the face of these stressors, and how to build community supports to buffer against these stressors. These skills may be particularly important for bisexual clients, given that many of their unique stressors are subtle in nature (e.g., people assuming that they are heterosexual if they have a different-gender partner), which may lead to less awareness of their emotional impact.

Rainbow SPARX

Lucassen et al. (2014) adapted a computer-based cognitive-behavioral intervention for depression to make it relevant for LGB youth. The intervention (Rainbow SPARX) included standard cognitive-behavioral strategies for coping with depression (e.g., psychoeducation, cognitive restructuring, behavioral activation), but examples were adapted to be relevant to LGB youth. For instance, youth were guided to think about how stigma and discrimination affect their thinking and then were presented with education regarding cognitive distortions and how to challenge them. Content was also developed to increase

awareness of social influences on mental health and to encourage a strength-based view of oneself as LGB. The intervention was tested in a sample of 21 LGB youth (ages 13–19) and led to a significant decrease in depression from pre- to posttreatment, which was maintained at a 3-month follow-up.

Expressive Writing Interventions

Expressive writing interventions have also been used with gay and bisexual men (Pachankis & Goldfried, 2010) and lesbian women (Lewis et al., 2005). Expressive writing interventions ask clients to write about a traumatic stressor for 20 minutes on a given number of days. Expressive writing is assumed to work by facilitating cognitive-affective processing of emotionally unresolved stressors and promoting self-regulation as clients see themselves, through their writing, as possessing effective coping skills (Frattaroli, 2006). Expressive writing has reduced distress 3 months later among gay and bisexual male college students (Pachankis & Goldfried, 2010) and 2 months later among lesbian women (Lewis et al., 2005). These effects replicate findings from studies demonstrating that expressive writing can reduce distress, especially among highly stressed individuals who have limited outlets for support and stress processing (Frattaroli, 2006). Expressive writing for sexual minority individuals has its strongest effects for those with less support (Pachankis & Goldfried, 2010) and those who are less open about their sexual orientation (Lewis et al., 2005). Given evidence of disclosure concerns and lack of social support among bisexual individuals, expressive writing might prove particularly promising for bisexual clients. While pending efficacy trials with bisexual individuals, suitable adaptations might involve asking bisexual clients to write about the most difficult aspects of being bisexual, following the approach used for monosexual clients (Lewis et al., 2005; Pachankis & Goldfried, 2010).

Internalized Stigma Reduction Intervention

A computer-based intervention demonstrated preliminary efficacy for reducing internalized stigma among same-sex attracted men (Lin & Israel, 2012). The intervention was designed to increase awareness of stereotypes and challenge them, increase awareness of where misconceptions about sexual minority men come from (e.g., social influences), and increase positive feelings about one's sexual orientation. It was tested in a sample of 367 same-sex attracted men (ages 19–78). Compared to a general stress reduction intervention, men who completed the stigma reduction intervention reported lower internalized stigma. Although two-thirds of the sample identified as gay (66.2%), sizable proportions identified as other sexual identities, including bisexual (18.5%). The authors did not test whether intervention effects were different based on sexual identity, but these findings suggest that

internalized stigma can be reduced through portable clinical intervention.

Clinicians can draw on exercises from this intervention to help bisexual clients who manifest internalized stigma. For example, they can discuss stereotypes about bisexuality and the extent to which clients believe them. Clinicians are encouraged to assess the specific negative messages that their bisexual clients have internalized rather than assuming that all bisexual clients have internalized all negative messages about bisexuality. If a bisexual client has not internalized a specific stereotype (e.g., they do not believe the stereotype that bisexual individuals are more promiscuous than monosexual individuals), then the clinician can facilitate a discussion about how the client came to reject that specific negative message. That information can be used to help the client reject other negative messages. The intervention also asked participants to read about a man struggling to accept his same-sex attraction and write what they would say to comfort him, which clinicians can extend to bisexual clients by asking them what they would say to someone struggling to accept their bisexuality. Finally, the intervention presented participants with positive aspects of being a sexual minority individual, which clinicians can extend to bisexual clients by facilitating discussions about positive aspects of being bisexual (for examples, see Rostosky, Riggall, Pascale-Hague, & McCants, 2010).

General Recommendations

Given that none of the aforementioned interventions were designed for bisexual individuals, we provide additional guidance for bisexual-affirmative adaptations. First, it is important to provide bisexual-affirmative care regardless of whether or not a client's presenting problem relates to their sexual orientation. The American Psychological Association (2012) provides recommendations for delivering sensitively tailored interventions to all sexual minority individuals, including bisexual individuals, and psychologists are encouraged to follow the guidance contained therein. If a client discloses that they are bisexual, then the clinician has to consider if and how this information will influence their treatment approach. If a client's sexual orientation is not related to their presenting problem, then the therapist can provide bisexual-affirmative care by avoiding making assumptions about the client and their relationships based on their sexual orientation. If a clinician determines that a bisexual client's presenting problem is related to their sexual orientation (e.g., stigma-related stress), then they can implement bisexual-affirmative adaptations of the interventions reviewed above.

Given that some bisexual individuals do not disclose their sexual identity to romantic partners or have unaccepting partners (Bostwick & Hequembourg, 2014; Hequembourg & Brallier, 2009; Ross et al., 2010), they

may present for help with managing their identity within their relationship. Behaviorally bisexual men describe various reasons for not disclosing their same-sex sexual behavior to female partners, such as concerns about negative reactions, retaliation, and their partners ending their relationships (Schrimshaw, Downing, & Cohn, 2016). The issue of whether or not to disclose one's bisexual identity to one's partner presents a paradox. Non-disclosure can have negative consequences (Schrimshaw et al., 2013), but concerns are often realistic (Pachankis, Cochran, & Mays, 2015). Clinicians can help bisexual clients weigh the costs and benefits of disclosure, including whether concerns are rooted in evidence. For clients who decide to disclose their bisexual identity to their partners, clinicians can help them communicate effectively, cope with possible negative reactions, and seek support from other sources. Clinicians can also connect clients to supportive community organizations. Although there are no evidence-based interventions for mixed-orientation couples, there are theoretical models to guide clinicians (Buxton, 2006). An important direction for future research will be to develop and test interventions for mixed-orientation couples. Doing so has the potential to improve relationship functioning and well-being among bisexual individuals in relationships.

Mezzo-Level Interventions

In addition to delivering interventions to bisexual clients, clinicians can address the health disparities affecting bisexual individuals through institutional changes (e.g., adaptations to clinical environments and training programs). For instance, bisexual-affirmative care can begin before treatment. Clinicians can include questions about sexual orientation on intake forms with options for nonmonosexual identities. Additionally, clinicians can refrain from making assumptions about a client's sexual orientation and the gender of their partners (Ritter & Terndrup, 2002). If a client indicates on their intake form that they identify as bisexual, then the therapist should not assume that the client dates or has sex with partners of more than one sex/gender. In this example, it is possible that the client is attracted to men and women, but only interested in pursuing relationships with partners of a particular gender. Clinicians can also display "safe space" signs in their offices to communicate that they are allies of the bisexual community and that bisexual clients are welcome in their offices. It may be important for these signs to specifically indicate support for bisexual individuals as opposed to LGBT individuals in general (e.g., by including the word "bisexual" or a bisexual pride symbol).

Training clinicians to provide bisexual-affirmative care also represents an institutional strategy to reduce health disparities affecting bisexual individuals. Historically, the

movement to incorporate multiculturalism into clinical training has focused on racial and ethnic minority populations. In recent years, there has been increased attention to the need to broaden multicultural training to address the issues facing other marginalized communities, including sexual minority individuals (for a detailed discussion, see Hope & Chappell, 2015). Multicultural training could occur as part of formal education or as part of continuing education for practicing clinicians. Hope and Chappell (2015) suggest that models used to incorporate multiculturalism into clinical training can be extended to provide training in sexual minority affirmative care (i.e., addressing trainee attitudes, knowledge, and skills related to working with sexual minority clients). Despite their focus on training programs, the same domains could be addressed in continuing education. Below we describe how each domain could be addressed in bisexual-affirmative training. Of note, we use "trainee" to represent students and practicing clinicians.

In regard to attitudes, trainees could reflect on their attitudes toward bisexual individuals, including the extent to which they endorse stereotypes about bisexual individuals. They can also reflect on how their attitudes toward bisexual individuals may impact their ability to provide clinical services. Jones, Sander, and Booker (2013) provide recommendations for strategies to facilitate teaching about attitudes and beliefs in multicultural clinical training, including the use of self-assessment questionnaires, implicit association tests, literature and film, journaling, and interactive/experiential activities. Applied to bisexual-specific attitudes, trainees can complete self-report measures of negative attitudes toward bisexuality (Mohr & Rochlen, 1999) to increase their awareness of stereotypes about bisexual individuals and the extent to which they believe them. Then, trainees can discuss these stereotypes, where they come from, and how they can influence the delivery of services to bisexual clients.

In regard to bisexual-specific knowledge, trainees could benefit from receiving education about topics such as sexual orientation as a continuum, the diversity of nonmonosexual identities, the prevalence of bisexuality across dimensions of sexual orientation, the unique stressors that bisexual individuals experience, how those stressors impact development and well-being, and information debunking stereotypes about bisexual individuals. It is also important to depathologize sexual fluidity and nonmonogamy, both of which are often associated with bisexuality even though neither are exclusive to bisexual individuals. While attractions and identities are stable for many, including bisexual individuals, others report changes over time (Diamond, 2008). These changes are valid expressions of sexuality and identity, and should not be pathologized. If a client is experiencing distress related to recognizing changing attractions, then the clinician can help to normalize the

experience and help the client to understand and cope with the implications of their changing attractions. Similarly, nonmonogamy should be treated as a valid and healthy alternative to monogamy. Some people, regardless of sexual identity, choose relationship structures that allow for more than one partner with the consent of all involved. If a client is considering nonmonogamy, clinicians can help them identify and adjust to the potential challenges (e.g., by developing a relationship agreement). Couples-based HIV prevention and relationship education programs include developing relationship agreements as a strategy to reduce risk and increase relationship satisfaction (Newcomb et al., 2017).

In regard to skills, trainees should strive to create a therapeutic environment where clients feel comfortable disclosing their sexual orientation and to incorporate that information into the case formulation and treatment plan (Hope & Chappell, 2015). Creating an affirming therapeutic environment is important across treatment modalities (e.g., individual, group). Group treatment can present unique challenges to ensuring a safe environment for bisexual clients (e.g., a group member could make a negative comment about bisexuality), but group facilitators can discuss the need to respect diverse identities at the onset of the group and address nonaffirming comments if they occur. The cognitive-behavioral skills needed to work with sexual minority clients have been outlined elsewhere (Balsam, Martell, & Safren, 2006; Martell, Safren, & Prince, 2003) and these skills generally apply to working with bisexual clients. The above sections outline additional skills suggested for implementing bisexual-affirmative adaptations of existing evidence-based treatments strategies. Of note, preliminary support for the efficacy of training that addresses attitudes, knowledge, and behaviors related to working with sexual minority clients has been established both in graduate programs in the U.S. (Bidell, 2013) as well as among professionals in Eastern European contexts where homophobia is normative and sexual minority sensitive care is nearly nonexistent (Lelutiu-Weinberger and Pachankis, 2017). Future research should test the efficacy of such training as specifically applied to attitudes, knowledge, and behaviors related to working with bisexual clients.

Further, while it is important for training programs to address bisexual-affirmative care, it is also important for clinicians to educate themselves about bisexuality. Bisexual individuals have described negative experiences with mental health professionals, such as clinicians expressing judgment about bisexuality and asking intrusive questions (Eady, Dobinson, & Ross, 2011). As such, in addition to avoiding reinforcing stereotypes about bisexuality, clinicians are encouraged to educate themselves about bisexuality as much as possible in order to avoid burdening clients with the expectation that they them-

selves will serve as the sole source of information about their experience as a bisexual individual. The recommendation for clinicians to educate themselves is consistent with other guidelines for multicultural practice (e.g., for providing clinical services to racial and ethnic minority individuals; American Psychological Association, 2003).

Macro-Level Interventions

While micro- and mezzo-level interventions represent an important use of public health resources for reducing health disparities, population-level interventions that reduce stigma at its source in unjust societal structures possess the potential to indirectly reduce disparities for the entire population. Macro-level interventions can include the implementation of policies focused on reducing discrimination and promoting equitable treatment of diverse populations as well as strategies to reduce prejudice and improve attitudes toward marginalized groups at the population-level. As noted, multicultural training focuses on attitudes, knowledge, and skills related to working with diverse populations (Hope & Chappell, 2015). Another component that has received less attention is advocacy and action. In order to provide multiculturally competent care, clinicians must recognize the broader sociopolitical context and its influence on clients, and then act against systems of oppression (Jones et al., 2013). This type of advocacy can take place at a micro-level (e.g., sharing empirical knowledge about bisexual individuals with others), mezzo-level (e.g., encouraging one's institution to adopt practices that are inclusive of bisexual individuals), or macro-level (e.g., advocating for political change; Hope & Chappell, 2015). In regard to macro-level interventions, clinicians can advocate for nondiscrimination policies that protect bisexual individuals at their institutions and at the local, state, and national levels.

Clinical scientists can also play a role in developing, testing, and disseminating interventions to improve attitudes toward bisexual individuals at the population-level. Despite the lack of research on interventions to reduce bisexual stigma, studies have demonstrated that intergroup contact and multicultural education interventions are effective at improving attitudes toward gay/lesbian individuals (Bartos, Berger, & Hegarty, 2014; Pettigrew & Tropp, 2006). These interventions have not been tested at the population-level, but similar interventions have been used to reduce mental illness stigma at the population-level (Hansson, Stjernsward, & Svensson, 2016; Henderson et al., 2016). Therefore, intergroup contact and multicultural education interventions have the potential to promote a bisexual-affirmative sociocultural context if broadly disseminated. For that reason, we review intergroup contact and multicultural education interventions and potential adaptations to target prejudice against bisexual individuals.

Intergroup contact interventions promote positive contact between members of different groups to reduce negative attitudes toward the stigmatized group (Pettigrew, 1998). Research indicates that intergroup contact reduces prejudice against stigmatized groups, including sexual minority individuals (Bartos et al., 2014), when administered in diverse forms, including direct contact (interactions between majority and minority group members; Bartos et al., 2014), extended contact (knowing that one's friend has a friend who belongs to a minority group; Wright, Aron, McLaughlin-Volpe, & Ropp, 1997), vicarious contact (observing intergroup friendships in media; Bonds-Raacke, Cady, Schlegel, Harris, & Firebaugh, 2007; Levina, Waldo, & Fitzgerald, 2000; Schiappa, Gregg, & Hewes, 2006), and imagined contact (imagining an interaction with a minority group member; Miles & Crisp, 2014).

However, only a few studies have examined intergroup contact theory as it relates to bisexuality (Cox, Bimbi, & Parsons, 2013; de Bruin & Arndt, 2010; Lytle, Dyar, Levy, & London, 2016; Mohr & Rochlen, 1999) and none have tested intergroup contact interventions to reduce bisexual stigma. Two studies demonstrated that knowing a bisexual individual is associated with greater tolerance of bisexuality and perceptions of bisexuality as a stable sexual orientation among heterosexual individuals (de Bruin & Arndt, 2010; Mohr & Rochlen, 1999). Additionally, Lytle et al. (2016) found that knowing more bisexual individuals and having better quality contact with them was associated with greater tolerance of bisexual individuals, greater perceptions of bisexuality a stable sexual orientation, and lower anxiety when interacting with bisexual individuals for both heterosexual and gay/lesbian individuals. Because these studies were cross-sectional, correlational, and focused on direct contact, research is needed to test causality, the efficacy of different forms of intergroup contact, and strategies to disseminate intergroup contact interventions focused on reducing bisexual stigma at the population-level.

Multicultural education interventions focus on providing accurate information about stigmatized groups to reduce prejudice (Banks & Banks, 2013). Although multicultural education interventions have been shown to reduce prejudice toward gay/lesbian individuals (Bartos et al., 2014), their efficacy for reducing binegativity has rarely been tested. In an exception, Morrison, Gruenhagen, and Pedersen (2016) tested a multicultural education intervention that used two *New York Times* articles about the existence of male bisexuality (one supporting its existence and one denying its existence). These articles included a combination of fact- and personal narrative-based information. They found preliminary evidence that reading a bisexual-affirmative article may reduce negative attitudes toward bisexual individuals for gay participants, but not for heterosexual

participants. Research is needed to test whether or not multicultural education interventions are effective at reducing negative attitudes toward bisexual individuals and to determine the most effective ways of presenting information about bisexuality to maximize prejudice reduction. Once an effective multicultural education intervention is developed, then it will be critical to determine how to implement it at the population-level.

The accessibility of the Internet and television make the delivery of large-scale bisexual-stigma reduction interventions based on vicarious or imagined intergroup contact and multicultural education feasible. The media plays a critical role in perpetuating the invisibility of bisexuality, bisexual stereotypes, and hostility toward bisexual individuals. A content analysis of popular television shows in 2009 found that bisexual individuals were represented in less than .1% of screen time (compared to .5% for lesbian women and more than 3% for gay men; Stonewall, 2010) and all representations of bisexual individuals were negative. Discourse analyses find that depictions of bisexual characters are overwhelmingly stereotypical (Meyer, 2010; Stonewall, 2010), while representations of gay/lesbian characters are becoming less stereotypical (Raley & Lucas, 2006). The erasure of bisexuality and negative portrayals of bisexual individuals in media likely play roles in perpetuating bias against bisexual individuals (Garretson, 2015; Stonewall, 2010). Given the power and accessibility of media, it can be a powerful medium to disseminate population-level interventions to reduce binegativity.

Vicarious contact and multicultural education, implemented via television, are believed to have reduced negative attitudes toward gay/lesbian individuals. Positive portrayals of gay/lesbian television characters are associated with less negative attitudes toward gay/lesbian individuals (Bartos et al., 2014; Bonds-Raacke et al., 2007; Levina et al., 2000; Schiappa et al., 2006). These positive portrayals often depict friendships between heterosexual and gay/lesbian characters, functioning as vicarious intergroup contact interventions. Therefore, increasing positive and counterstereotypic portrayals of bisexual characters and portraying friendships between monosexual and bisexual characters may reduce negative attitudes toward bisexual individuals. Before wide-scale interventions can be implemented, research is needed to examine the effects of positive and negative portrayals of bisexual characters in media. Multicultural education could also be adapted to reach larger audiences via Internet and television. Brief educational interventions could be administered via public service announcements. The "Think B4 You Speak" campaign is believed to have increased awareness of homonegative microaggressions (Ad Council, 2012) and a similar approach could be taken for binegative microaggressions.

Conclusion

The available evidence suggests that bisexual individuals are at increased risk for mental health and substance use problems compared to heterosexual individuals and often compared to gay/lesbian individuals as well. Although the efficacy of mental health and substance use interventions has not been tested specifically with bisexual individuals, clinicians can draw on interventions that have been developed for sexual minority individuals in general to guide their work with bisexual clients. There is also a need for bisexual-specific clinical training to provide clinicians with the knowledge and skills to work effectively with bisexual clients. Finally, population-level interventions can be used to improve attitudes and reduce prejudice against bisexual individuals, which, in turn, can reduce health disparities affecting bisexual individuals. With growing recognition of the health disparities affecting bisexual individuals, there is a critical need to develop, test, and disseminate interventions to improve their health and to prepare clinicians to provide bisexual-affirmative care.

References

- Ad Council. (2012). *Making a difference: Gay and lesbian bullying prevention*. Retrieved from file:///C:/Users/Christina/Downloads/CaseStudy_GLESN.pdf
- American Psychological Association. (2003). Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists. *American Psychologist*, 58(5), 377–402.
- American Psychological Association. (2012). *Guidelines for psychological practice with lesbian, gay, and bisexual clients* (1935-990X 0003-066X). Retrieved from <https://www.apa.org/pubs/journals/features/amp-a0024659.pdf>
- Armstrong, H. L., & Reissing, E. D. (2014). Attitudes toward casual sex, dating, and committed relationships with bisexual partners. *Journal of Bisexuality*, 14, 236–264.
- Balsam, K. F., Martell, C. R., & Safren, S. A. (2006). Affirmative cognitive-behavioral therapy with lesbian, gay, and bisexual people. In P. A. Hays & G. Y. Iwamasa (Eds.), *Culturally responsive cognitive-behavior therapy: Assessment, practice, and supervision* (pp. 223–243). Washington, DC: American Psychological Association.
- Balsam, K. F., & Mohr, J. J. (2007). Adaptation to sexual orientation stigma: A comparison of bisexual and lesbian/gay adults. *Journal of Counseling Psychology*, 54, 306–319.
- Banks, J. A., & Banks, C. A. M. (2013). *Multicultural education: Issues and perspectives* (8 ed.). Hoboken, NJ: Wiley.
- Bartos, S. E., Berger, I., & Hegarty, P. (2014). Interventions to reduce sexual prejudice: a study-space analysis and meta-analytic review. *Journal of Sex Research*, 51(4), 363–382. <https://doi.org/10.1080/00224499.2013.871625>
- Bidell, M. P. (2013). Addressing disparities: The impact of a lesbian, gay, bisexual, and transgender graduate counselling course. *Counselling and Psychotherapy Research*, 13, 300–307.
- Bonds-Raacke, J. M., Cady, E. T., Schlegel, R., Harris, R. J., & Firebaugh, L. (2007). Remembering gay/lesbian media characters: Can Ellen and Will improve attitudes toward homosexuals? *Journal of Homosexuality*, 53(3), 19–34. https://doi.org/10.1300/J082v53n03_03
- Bostwick, W., & Hequembourg, A. (2014). 'Just a little hint': bisexual-specific microaggressions and their connection to epistemic injustices. *Culture Health & Sexuality*, 16(5), 488–503. <https://doi.org/10.1080/13691058.2014.889754>
- Bostwick, W. B., Boyd, C. J., Hughes, T. L., & McCabe, S. E. (2010). *Dimensions of sexual orientation and the prevalence of mood and anxiety disorders in the United States* (Vol. 100). US: American Public Health Assn.
- Brennan, D. J., Ross, L. E., Dobinson, C., Veldhuizen, S., & Steele, L. S. (2010). Men's sexual orientation and health in Canada. *Canadian Journal of Public Health*, 101(3), 255–258.
- Brewster, M. E., & Moradi, B. (2010). Perceived experiences of anti-bisexual prejudice: Instrument development and evaluation. *Journal of Counseling Psychology*, 57, 451–468.
- Brewster, M. E., Moradi, B., Deblaere, C., & Velez, B. L. (2013). Navigating the borderlands: the roles of minority stressors, bicultural self-efficacy, and cognitive flexibility in the mental health of bisexual individuals. *Journal of Counseling Psychology*, 60(4), 543–556. <https://doi.org/10.1037/a0033224>
- Buxton, A. P. (2006). Counseling heterosexual spouses of bisexual men and women and bisexual-heterosexual couples: Affirmative approaches. *Journal of Bisexuality*, 6, 105–135.
- Callis, A. S. (2014). Bisexual, pansexual, queer: Non-binary identities and the sexual borderlands. *Sexualities*, 17, 63–80.
- Conron, K. J., Mimiaga, M. J., & Landers, S. J. (2010). A population-based study of sexual orientation identity and gender differences in adult health. *American Journal of Public Health*, 100(10), 1953–1960. <https://doi.org/10.2105/ajph.2009.174169>
- Cox, S., Bimbi, D. S., & Parsons, J. T. (2013). Examination of social contact on binegativity among lesbians/gay men. *Journal of Bisexuality*, 13, 215–228.
- de Bruin, K., & Arndt, M. (2010). Attitudes toward bisexual men and women in a university context: Relations with race, gender, knowing a bisexual man or woman and sexual orientation. *Journal of Bisexuality*, 10, 233–252.
- Diamond, L. M. (2008). Female bisexuality from adolescence to adulthood: Results from a 10-year longitudinal study. *Developmental Psychology*, 44(1), 5–14.
- Dyar, C., Feinstein, B. A., & London, B. (2015). Mediators of differences between lesbians and bisexual women in sexual identity and minority stress. *Psychology of Sexual Orientation and Gender Diversity*, 2, 43–51.
- Dyar, C., Feinstein, B. A., Schick, V. R., & Davila, J. (2017). Minority stress, sexual identity uncertainty, and partner gender decision making among non-monosexual individuals. *Psychology of Sexual Orientation and Gender Diversity*, 4, 87–104.
- Eady, A., Dobinson, C., & Ross, L. E. (2011). Bisexual people's experiences with mental health services: a qualitative investigation. *Community Mental Health Journal*, 47(4), 378–389. <https://doi.org/10.1007/s10597-010-9329-x>
- Feinstein, B. A., Dyar, C., Bhatia, V., Latack, J. A., & Davila, J. (2014). Willingness to engage in romantic and sexual activities with bisexual partners: Gender and sexual orientation differences. *Psychology of Sexual Orientation and Gender Diversity*, 1, 255–262.
- Feinstein, B. A., Dyar, C., Bhatia, V., Latack, J. A., & Davila, J. (2016). Conservative beliefs, attitudes toward bisexuality, and willingness to engage in romantic and sexual activities with a bisexual partner. *Archives of Sexual Behavior*, 45(6), 1535–1550. <https://doi.org/10.1007/s10508-015-0642-x>
- Feinstein, B. A., Dyar, C., & London, B. (2016). Are outness and community involvement risk or protective factors for alcohol and drug abuse among sexual minority women? *Archives of Sexual Behavior*. <https://doi.org/10.1007/s10508-016-0790-7>
- Flanders, C. E. (2015). Bisexual health: A daily diary analysis of stress and anxiety. *Basic and Applied Social Psychology*, 37, 319–335.
- Frattaroli, J. (2006). Experimental disclosure and its moderators: A meta-analysis. *Psychological Bulletin*, 132, 823–865.
- Galupo, M. P., Mitchell, R. C., & Davis, K. S. (2015). Sexual minority self-identification: Multiple identities and complexity. *Psychology of Sexual Orientation and Gender Diversity*, 2, 355–364.
- Garretson, J. J. (2015). Does change in minority and women's representation on television matter?: A 30-year study of television portrayals and social tolerance. *Politics, Groups and Identities*, 3, 615–632.
- Gray, A., & Demarais, S. (2014). Not all one and the same: Sexual identity, activism, and collective self-esteem. *Canadian Journal of Human Sexuality*, 23, 116–122.

- Green, K. E., & Feinstein, B. A. (2012). Substance use in lesbian, gay, and bisexual populations: An update on empirical research and implications for treatment. *Psychology of Addictive Behaviors, 26*(2), 265–278. <https://doi.org/10.1037/a0025424>
- Hansson, L., Stjernsward, S., & Svensson, B. (2016). Changes in attitudes, intended behaviour, and mental health literacy in the Swedish population 2009-2014: An evaluation of a national antistigma programme. *Acta Psychiatrica Scandinavica, 134 Suppl 446*, 71–79. <https://doi.org/10.1111/acps.12609>
- Hayfield, N., Clarke, V., & Halliwell, E. (2014). Bisexual women's understandings of social marginalisation: The heterosexuals don't understand us but nor do the lesbians. *Feminism & Psychology, 24*, 352–372.
- Henderson, C., Robinson, E., Evans-Lacko, S., Corker, E., Rebollo-Mesa, I., Rose, D., & Thornicroft, G. (2016). Public knowledge, attitudes, social distance and reported contact regarding people with mental illness 2009-2015. *Acta Psychiatrica Scandinavica, 134 Suppl 446*, 23–33. <https://doi.org/10.1111/acps.12607>
- Hequembourg, A. L., & Brallier, S. A. (2009). An exploration of sexual minority stress across the lines of gender and sexual identity. *Journal of Homosexuality, 56*(3), 273–298. <https://doi.org/10.1080/00918360902728517>
- Hope, D. A., & Chappell, C. L. (2015). Extending training in multicultural competencies to include individuals identifying as lesbian, gay, and bisexual: Key choice points for clinical psychology training programs. *Clinical Psychology: Science and Practice, 22*, 105–118.
- Jones, J. M., Sander, J. B., & Booker, K. W. (2013). Multicultural competency building: Practical solutions for training and evaluating student progress. *Training and Education in Professional Psychology, 7*, 12–22.
- Jorm, A. F., Korten, A. E., Rodgers, B., Jacomb, P. A., & Christensen, H. (2002). Sexual orientation and mental health: Results from a community survey of young and middle-aged adults. *The British Journal of Psychiatry, 180*, 423–427.
- Katz-Wise, S. L., & Hyde, J. S. (2012). Victimization experiences of lesbian, gay, and bisexual individuals: A meta-analysis. *Journal of Sex Research, 49*(2-3), 142–167. <https://doi.org/10.1080/00224499.2011.637247>
- Lelutiu-Weinberger, C., & Pachankis, J. E. (2017). Acceptability and preliminary efficacy of a lesbian, gay, bisexual, and transgender-affirmative mental health practice training in a highly stigmatizing national context. *LGBT Health, 4*, 360–370.
- Levina, M., Waldo, C. R., & Fitzgerald, L. F. (2000). We're here, we're queer, we're on TV: The effects of visual media on heterosexuals' attitudes toward gay men and lesbians. *Journal of Applied Social Psychology, 30*, 738–758.
- Lewis, R. J., Derlega, V. J., Clarke, E. G., Kuang, J. C., Jacobs, A. M., & McElligott, M. D. (2005). An expressive writing intervention to cope with lesbian-related stress: The moderating effects of openness about sexual orientation. *Psychology of Women Quarterly, 29*, 149–157.
- Lin, Y. J., & Israel, T. (2012). A computer-based intervention to reduce internalized heterosexism in men. *Journal of Counseling Psychology, 59*(3), 458–464. <https://doi.org/10.1037/a0028282>
- Lucassen, M., Merry, S., Hatcher, S., & Frampton, C. M. A. (2014). Rainbow SPARK: A novel approach to addressing depression in sexual minority youth. *Cognitive and Behavioral Practice, 22*, 203–216.
- Lytle, A., Dyar, C., Levy, S. R., & London, B. (2016). Essentialist beliefs: Understanding contact with and attitudes towards lesbian and gay individuals. *British Journal of Social Psychology, 107*(1), 121–134. <https://doi.org/10.1111/bjso.12154>
- Martell, C. R., Safren, S. A., & Prince, S. E. (2003). *Cognitive-behavioral therapies with lesbian, gay, and bisexual clients*. New York, NY: Guilford Press.
- McCabe, S. E., Hughes, T. L., Bostwick, W. B., West, B. T., & Boyd, C. J. (2009). Sexual orientation, substance use behaviors and substance dependence in the United States. *Addiction, 104*(8), 1333–1345. <https://doi.org/10.1111/j.1360-0443.2009.02596.x>
- Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin, 129*(5), 674–697. <https://doi.org/10.1037/0033-2909.129.5.674>
- Meyer, M. D. E. (2010). Representing Bisexuality on Television: The Case for Intersectional Hybrids. *Journal of Bisexuality, 10*, 366–387.
- Miles, E., & Crisp, R. J. (2014). A meta-analytic test of the imagined contact hypothesis. *Group Processes & Intergroup Relations, 17*, 3–26.
- Mohr, J. J., Jackson, S. D., & Sheets, R. L. (2016). Sexual Orientation Self-Presentation Among Bisexual-Identified Women and Men: Patterns and Predictors. *Archives of Sexual Behavior, 45*(1), 1–11. <https://doi.org/10.1007/s10508-016-0808-1>
- Mohr, J. J., & Rochlen, A. B. (1999). Measuring attitudes regarding bisexuality in lesbian, gay male, and heterosexual populations. *Journal of Counseling Psychology, 46*, 353–369.
- Morrison, K. E., Gruenhage, J. M., & Pedersen, C. L. (2016). Challenging binaries by saying good bi: Perceptions of bisexual men's identity legitimacy. *Journal of Bisexuality, 16*, 361–377.
- Newcomb, M. E., Macapagal, K. R., Feinstein, B. A., Bettin, E., Swann, G., & Whitton, S. W. (2017). Integrating HIV prevention and relationship education for young same-sex male couples: A pilot trial of the 2GETHER intervention. *AIDS and Behavior, 21*, 2464–2478.
- Pachankis, J. E. (2014). Uncovering clinical principles and techniques to address minority stress, mental health, and related health risks among gay and bisexual men. *Clinical Psychology (New York), 21*(4), 313–330. <https://doi.org/10.1111/cpsp.12078>
- Pachankis, J. E. (2015). A transdiagnostic minority stress treatment approach for gay and bisexual men's syndemic health conditions. *Archives of Sexual Behavior, 44*(1), 1–11. <https://doi.org/10.1007/s10508-015-0480-x>
- Pachankis, J. E., Cochran, S. D., & Mays, V. M. (2015). The mental health of sexual minority adults in and out of the closet: A population-based study. *Journal of Consulting and Clinical Psychology, 83*(5), 890–901. <https://doi.org/10.1037/ccp0000047>
- Pachankis, J. E., & Goldfried, M. R. (2010). Expressive writing for gay-related stress: Psychosocial benefits and mechanisms underlying improvement. *Journal of Consulting and Clinical Psychology, 78*(1), 98–110. <https://doi.org/10.1037/a0017580>
- Pachankis, J. E., Hatzenbuehler, M. L., Rendina, H. J., Safren, S. A., & Parsons, J. T. (2015). LGB-affirmative cognitive-behavioral therapy for young adult gay and bisexual men: A randomized controlled trial of a transdiagnostic minority stress approach. *Journal of Consulting and Clinical Psychology, 83*(5), 875–889. <https://doi.org/10.1037/ccp0000037>
- Parsons, J. T., Lelutiu-Weinberger, C., Botsko, M., & Golub, S. A. (2014). A randomized controlled trial utilizing motivational interviewing to reduce HIV risk and drug use in young gay and bisexual men. *Journal of Consulting and Clinical Psychology, 82*(1), 9–18. <https://doi.org/10.1037/a0035311>
- Paul, R., Smith, N. G., Mohr, J. J., & Ross, L. E. (2014). Measuring dimensions of bisexual identity: Initial development of the Bisexual Identity Inventory. *Psychology of Sexual Orientation and Gender Diversity, 1*, 452–460.
- Pettigrew, T. F. (1998). Intergroup contact theory. *Annual Review of Psychology, 49*, 65–85. <https://doi.org/10.1146/annurev.psych.49.1.65>
- Pettigrew, T. F., & Tropp, L. R. (2006). A meta-analytic test of intergroup contact theory. *Journal of Personality and Social Psychology, 90*(5), 751–783. <https://doi.org/10.1037/0022-3514.90.5.751>
- Raley, A. B., & Lucas, J. L. (2006). Stereotype or success? Prime-time television's portrayals of gay male, lesbian, and bisexual characters. *Journal of Homosexuality, 51*(2), 19–38. https://doi.org/10.1300/J082v51n02_02
- Ritter, K. Y., & Terndrup, A. I. (2002). *Handbook of affirmative psychotherapy with lesbians and gay men*. New York, NY: Guilford Press.
- Ross, L. E., Dobinson, C., & Eady, A. (2010). Perceived determinants of mental health for bisexual people: a qualitative examination. *American Journal of Public Health, 100*(3), 496–502. <https://doi.org/10.2105/AJPH.2008.156307>
- Rostovsky, S. S., Riggall, E. D. B., Pascale-Hague, D., & McCants, L. E. (2010). The positive aspects of a bisexual self-identification. *Psychology & Sexuality, 1*, 131–144.
- Rust, P. C. (2001). Too many and not enough: The meanings of bisexual identities. *Journal of Bisexuality, 1*, 31–68.

- Schiappa, E., Gregg, P. B., & Hewes, D. E. (2006). Can One TV Show Make a Difference? Will & Grace and the Parasocial Contact Hypothesis. *Journal of Homosexuality, 51*, 15–37.
- Schrimshaw, E. W., Downing, M. J., Jr., & Cohn, D. J. (2016). Reasons for non-disclosure of sexual orientation among behaviorally bisexual men: Non-disclosure as stigma management. *Archives of Sexual Behavior. https://doi.org/10.1007/s10508-016-0762-y*
- Schrimshaw, E. W., Siegel, K., Downing, M. J., & Parsons, J. T. (2013). Disclosure and concealment of sexual orientation and the mental health of non-gay-identified, behaviorally bisexual men. *Journal of Consulting and Clinical Psychology, 81*(1), 141–153. <https://doi.org/10.1037/a0031272>
- Stonewall (2010). *Unseen on screen; Gay people on youth TV*. Retrieved from London, UK. http://www.stonewall.org.uk/sites/default/files/Unseen_on_Screen_2011_.pdf
- Sweet, T., & Welles, S. L. (2012). Associations of sexual identity or same-sex behaviors with history of childhood sexual abuse and HIV/STI risk in the United States. *Journal of Acquired Immune Deficiency Syndromes, 59*(4), 400–408. <https://doi.org/10.1097/QAI.0b013e3182400e75>
- Vrangalova, Z., & Savin-Williams, R. C. (2014). Psychological and physical health of mostly heterosexuals: a systematic review. *Journal of Sex Research, 51*(4), 410–445. <https://doi.org/10.1080/00224499.2014.883589>
- Walters, M. L., Chen, J., & Breiding, M. J. (2013). The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Findings on Victimization by Sexual Orientation. Retrieved from http://www.cdc.gov/violenceprevention/nisvs/2010_soreport.html
- Wright, S. C., Aron, A., McLaughlin-Volpe, T., & Ropp, S. A. (1997). The Extended Contact Effect: Knowledge of cross-group friendships and prejudice. *Journal of Personality and Social Psychology, 73*, 73–90.
- Brian A. Feinstein's time was supported by a grant from the National Institute on Drug Abuse (F32DA042708). John E. Pachankis' time was supported by a grant from the National Institute of Mental Health (R01MH109413). The opinions expressed in this article are the authors' own and do not reflect the views of the National Institutes of Health. The authors declare that there are no conflicts of interest.
- Address correspondence to Brian A. Feinstein, Ph.D., Northwestern University, Institute for Sexual and Gender Minority Health and Wellbeing, 625 N. Michigan Ave. #14-047, Chicago, IL 60611; e-mail: brian.feinstein@northwestern.edu.

Received: January 26, 2017

Accepted: October 20, 2017

Available online 24 November 2017