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Bisexuality, Biphobia, and its Effects on Sexual Identity, Religious Identity and Mental Health:

Examining Clinical Implications

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A Clinical Research Project submitted to the Faculty of the Florida School of Professional Psychology at National Louis University in partial fulfillment of the requirements for the degree of Doctor of Psychology in Clinical Psychology.

Tampa, Florida
December, 2023

The Doctorate Program in Clinical Psychology
Florida School of Professional Psychology
at National Louis University

CERTIFICATE OF APPROVAL

Clinical Research Project

This is to certify that the Clinical Research Project of

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has been approved by the
CRP Committee on December 8th, 2023
as satisfactory for the CRP requirement
for the Doctor of Psychology degree
with a major in Clinical Psychology

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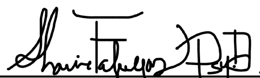

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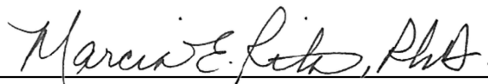

Member: Marcia Pita, Ph.D.

Abstract

Bisexuality is a sexual orientation, sometimes known as "bi," that includes sexuality in which certain people are attracted to more than one sex and gender. Bisexuality differs from other sexual- and gender-nonconforming experiences (McInnis et al., 2022). According to Ross et al. (2018), bisexuality is frequently described as an invisible sexual orientation, and only in the last 20 years has research on biphobia and bisexuality increased (McInnis et al., 2022). Experiences unique to bisexuality include bisexual invisibility from a societal level (Dyar et al., 2015), bisexuals are more prone to experience sexual orientation instability (Bostwick et al., 2014), and bisexual people report poorer physical and mental health, and higher rates of sexual assault (Israel, 2018). Also, biphobia leads to statements that cast doubt on the validity of the bisexual identity, such as "bisexuality is a phase" (Human Rights Campaign, n.d.). This literature review's objectives are to investigate the significance of comprehending bisexuality and biphobia, the effects of biphobia on bisexual identity, the junction of sexual identity and religious identity, and the adverse effects of biphobia on the mental health of bisexual individuals. Objectives also include discussing protective factors to improve the well-being of bisexual people. This project includes a broad review of peer-reviewed, published academic journals to provide a comprehensive and current review of the topic, resulting in the following research questions: (1) How does biphobia impact bisexual identity? (2) How does biphobia impact the intersectionality of bisexuality and religious identity? (3) How does biphobia impact mental health and other conditions for clinical attention? (4) How can understanding bisexuality and biphobia influence clinical treatment to promote protective factors and improve mental health disparities for bisexual people? Limitations, clinical implications, and recommendations for future research are examined and discussed.

BISEXUALITY, BIPHOBIA, AND ITS EFFECTS ON SEXUAL IDENTITY, RELIGIOUS IDENTITY AND MENTAL HEALTH: EXAMINING CLINICAL IMPLICATIONS

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DEDICATION

I dedicate this project to my beautiful family, Dr. William Ramirez, Diana Ramirez, Alejandra Ramirez, and my niece and nephew, David and Isabella Avalos-Ramirez. David and Isa, I hope Nano's dreams influence all your life/academic goals. I want to thank all my supporters who believed in me and motivated me throughout this journey, such as my partner Kate, my friends, and supervisors at the University of Pittsburgh, Florida Gulf Coast, and the University of Southern Florida, St. Petersburg, who are now considered my lifelong friends and forever colleagues. In addition, I could not be more grateful to my fur babies, Oscar, Winston, and Leo, for providing all the emotional support through this journey.

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CHAPTER I. INTRODUCTION

History of Same-Sex Relationships

Same-sex attraction has been studied throughout history. Dover mentioned that Plato's works (*Symposium* and *Phaedrus*) reveal that in Athenian society, same-sex attraction was regarded as a "strong" attraction, and Athenians viewed these types of attractions as a "homosexual desire and emotion as normal" (1989, p. 12). Barkan (2012) discussed the history of same-sex attraction and refers to Crompton's work in *Homosexuality and Civilization* (2003), that same-sex attraction in China and Japan in ancient times was suggested to be accepting of same-sex relationships without reservation (Crompton, 2003). Barka stated that in China, "Confucianism" (an ancient Chinese system of thought) considered women inferior. Male friendships were encouraged and ultimately unconsciously encouraged same-sex relationships among men. In ancient China, same-sex attraction between men and women, however, was viewed as normal and "healthy sexual outlets" despite Confucianism's belief in women's inferiority (Barkan, 2012).

History of Stigmatization of Sexual Minorities

Barkan mentioned that at the end of the Roman Empire, Europe became a "Christian continent" (2012). Same-sex attraction was considered a sin, and European governments "outlawed" same-sex relations. During this era, people were executed if a person was discovered engaging in same-sex relationships. For about 14 centuries, many people were executed for engaging in same-sex relationships (Barkan, 2012). Crompton (2003) mentioned that historically, individuals who identified as gay men and lesbians were subjected to severe forms of punishment, such as stoning, burning at the stake, hanging, or beheading, also stating that different governments applied these atrocities and "routines of terror" as a punishment for same-

sex relationships. Barkan also mentioned that in Europe, during World War II, Hitler's persecution of gay men was the precedent for Europe's history of persecution against same-sex relationships (2012).

Since the rise of Western civilization, despite historians educating modern societies that same-sex attraction was largely common in ancient Greece, Japan, and China, as well as demonstrating anthropological records disputing that same-sex attraction is "far from rare." However, current Western "Judeo-Christian" traditions influence and "condemn" same-sex attraction, resulting in current intolerance of non-heterosexual orientations, non-binary gender expressions, and transgender identities, resulting in homophobia, biphobia, and transphobia. Today's societies continue to hold beliefs and assumptions that people "are" and "should be" heterosexual, reinforcing a "heteronormative (social construct)" and "heterosexism (the norm/belief)" society. Heterosexism views and beliefs exclude the needs, concerns, human rights, and experiences of lesbians, gays, transgender people, bisexuals, queers, and others in the (LGTBQ+) community (Barkan, 2012).

History of Psychopathologizing Same-Sex Attractions

Historically, same-sex relationships have been viewed as a "choice" or a "social construct." Same-sex relationships were pathologized until 1973 when the American Psychological Association (APA) eliminated "homosexuality" from the *Diagnostic and Statistical Manual*, second edition (DSM-II). Sigmund Freud theorized that same-sex behaviors were influenced by psychological pain and psychological regression. He believed that humans are born bisexual and that engaging in same-sex behaviors allowed for a normal phase of heterosexual development (Drescher, 2015). After Freud's death, psychoanalyst Sandro Rado published his theory on same-sex attractions, mentioning that heterosexuality was the "norm"

and that "homosexuality" was a "phobic avoidance" toward the opposite sex as a result of bad parenting (Drescher, 2015). APA was highly influenced by these psychoanalysts' writings and included arguments against "homosexuality" being classified as a "sociopathic personality disorder" in the first edition of the DSM (Drescher, 2015).

History of Bisexuality

In her book *Bi: The Hidden Culture, History, and Science of Bisexuality*, Julia Shaw (2022) examined the origins of bisexuality. According to Shaw, both the labels "homosexual" and "heterosexual" were invented by Karl-Maria Kertbeny. In letters, pamphlets, and books, Kertbeny expressed his opposition to sodomy regulations and how they violated human rights; Kertbeny developed the words "homosexual" and "heterosexual" to describe same-sex behaviors and opposite-sex behaviors in his writings. The author also mentions that the word "bisexual" can be traced throughout history when the term was used to describe plants or creatures that possess both male and female reproductive parts. However, the word "bisexual" was first defined as a term to explain sexual attraction to both sexes and was coined by neurologist Charles Gilbert Chaddock (Shaw, 2022).

In the mid-1940s, Alfred Kinsey conducted the most famous study using a six-point scale to measure human sexuality by asking people to disclose their sexual identity on a scale from "fully heterosexual" to "entirely homosexual." Through his research findings, Kinsey derived from his data that some participants were along a continuum between the dichotomous terms. Thus, based on his result, Kinsey proposed that heterosexuality was perhaps not the default but that bisexuality is likely to be the default for human sexual identity. In the 1960s, Dr. Fritz Klein was the first known author to publish about bisexuality in the literature in a book called *The Bisexual Option.* Psychologists during this period created the Klein grid to encompass the

multiple dimensions of sexual preference (Shaw, 2022). Then, in the 1970s, one of the community's early supporters of lesbians, gays, bisexuals, transgender people, queers, and others (LGBTQ+), Brenda Howard advocated for bisexual rights in the states. She is also known as "the Mother of Pride" and successfully incorporated the bisexual community into the 1993 March on Washington, when the movement was mainly concentrated on the homosexual and lesbian communities (Shaw, 2022).

Defining Bisexuality and Biphobia

Bisexuality is a sexual orientation, commonly known as bi, which includes an umbrella of sexuality where certain people are attracted to more than one sex and gender. Robyn Och's most well-known definition of bisexuality is the following: Bisexuality is "the potential to be attracted—romantically and/or sexually—to people of more than one sex and, or, gender, not necessarily at the same time, not necessarily in the same way, and not necessarily to the same degree" (Trevor Project, 2021). There are many different forms of discrimination bisexual people encounter. *Bi-erasure* is one of the many forms of discrimination; this type of bias entails denying the existence of a person's bisexual identity, assuming a bisexual person is heterosexual (straight passing relationship) or gay/lesbian (a relationship with a partner of the same sex or gender), or mislabeling a bisexual person as heterosexual or gay or lesbian (Gay and Lesbian Alliance Against Defamation, n.d.). *Binegativity* encompasses negative beliefs and stereotypes about bisexual individuals (Dyar & Feinstein, 2018). Additionally, *internalized biphobia* explains the phenomenon when a bisexual person views and feels negative about themselves due to their bisexual identity. Bi-erasure/bi-invisibility, binegativity, and internalized biphobia are minority stressors that likely result in the concealment of bisexuals' sexual orientation (Brewster et al., 2013).

Understanding Biphobia

Biphobia is antagonism or prejudice toward bisexual people. Biphobia results in remarks based on disinformation and stereotypes that challenge the legitimacy of the bisexual identity, such as bisexuality is a phase or bi people are confused. Biphobia exists within and outside the queer community (Human Rights Campaign, n.d.). Galupo et al. (2015) noted that bisexual individuals reported more prejudice from individuals who identified as gay or lesbian than those who self-identified as pansexual/queer/fluid. The available literature mentions that bisexual folks experience stressors specific to their bisexual identity. Everyday stressors bisexual people experience include internalized biphobia, stigma, and discrimination.

Statement of Problem

Paul et al. (2014) noted that current literature demonstrates a gap regarding the bisexual experience. Most investigators researching the topic of bisexuality have found that bisexual people are usually included within the same-sex context (gay and lesbian community) without distinguishing bisexuality as its different sexual orientation. Paul et al. (2014) mentioned that gay and lesbian individuals have been examined both theoretically and empirically (p. 452), increasing clinical knowledge and improving client care.

Current data have revealed that bisexual individuals experience different stages of identity development and adverse outcomes of minority stressors that gay or lesbian individuals may not experience. The researchers also noted a lack of quantitative instruments to measure the dimensions of bisexual identity (Paul et al., 2014, p. 452). Bostwick et al. (2014) found various articles indicating that bisexual folks are more likely to be excluded from the gay and lesbian community, thus increasing feelings of internalized biphobia. Also, bisexual people are more likely to experience sexual orientation instability that may be a byproduct of prejudice or

stereotypes specific to bisexuality. Common stereotypes of bisexual people include the following: Bisexuals are promiscuous, bisexual people are incapable of monogamous relationships, and bisexual people are experimenting with their sexuality (Brownfield et al., 2018; Wandrey et al., 2015). The belief that bisexuality is just a transition phase and that the bisexual person will eventually identify with the gay or lesbian community or identify as heterosexual has demonstrated adverse effects among bisexual folks (Brewster & Moradi, 2010; Garelick et al., 2017; Wandrey et al., 2015). As a result of these negative stereotypes, bisexual folks experience sexual orientation instability, such as confusion about identity and invalidation from others regarding their identity. Bisexual individuals experience biphobia from heterosexual and gay/lesbian communities. They are also likely to encounter bisexual invisibility at a societal level (Dyar et al., 2015), including erasure within other identities (intersectionality of identities) such as religious affiliation, political associations, gender, ethnicity, race, age, disability, and other groups (Barnes & Meyer, 2012; Rodriguez et al., 2013; Sarno et al., 2020; Shilo et al., 2016; Zelle & Arms, 2015).

Many researchers have studied how the religious experiences of sexual minorities influence the intersectionality between both identities. Rodriguez et al. (2013) argued that past research mainly focused on lesbian and gay individuals, ignoring bisexual experiences with religious identities or experiences. However, in the past decade, Rodriguez et al. (2013) mentioned that current research is focusing more on bisexual experiences and discussing what role religion plays in the lives of LGBTQ+ people. Western Judeo-Christian traditions condemn same-sex attraction, creating intolerance of non-heterosexual orientations, non-binary gender expressions, and transgender identities. These beliefs result in homophobia, biphobia, and transphobia as today's societies continue to believe and assume that people are and should be

heterosexual. This view reinforces a heteronormative (social construct) and heterosexist (the norm/belief) society (Rodriguez et al., 2013). Although data support that religion or affiliations serve as protective factors against various stressors, for people in the LGBTQ+ community, the intersectionality of identities (sexual orientation and religion or affiliation) is likely to result in both protective and harmful psychosocial risks (Longo et al., 2013).

Biphobia and bisexual invisibility create stressors for bisexual individuals linked to adverse mental health outcomes. Some of these stressors include dismissal of their bisexual orientation, challenges to accepting their sexual orientation, lack of acceptance from romantic partners, and isolation from heterosexual and gay/lesbian communities. Research indicates that bisexual people described little support from friends and less positive family support than other sexual orientations. Moreover, bisexual people report poorer physical and mental health, high rates of poverty, and higher rates of sexual assault among bisexual men and women (Israel, 2018).

According to the Centers for Disease Control and Prevention's (CDC) National Youth Risk Behavior Surveillance (YRBS) data collection from 2019, 7% of young people identify as bisexual, whereas 2% of youth identify as gay or lesbian. Ellen Kahn is the Senior Director of Programs and Partnerships at the Human Rights Campaign (HRC). After data from the CDC's YRBS were released in 2019, researchers stated that when the YRBS started collecting data on sexual orientation in 2015 and gender identity in 2017, the data collected showed that LGBTQ kids have worse health outcomes than their straight peers (HRC, 2020).

The HRC's analysis of the CDC's 2019 YRBS study found:

- 16% of gay and lesbian youth and 11% of bisexual youth have been threatened or injured with a weapon on school property, compared to 7% of straight youth.

- 29% of gay or lesbian youth and 31% of bisexual youth have been bullied on school property, compared to 17% of straight youth.
- 21% of gay and lesbian youth and 22% of bisexual youth have attempted suicide, compared to 7% of straight youth.

The Trevor Project (2019) found that 48% of bisexual youth considered suicide, while 27% of bisexual youth have attempted suicide within the previous 12 months. In contrast, 37% of gay/lesbian youth considered suicide, and 19% of gay/lesbian youth attempted suicide. These results show that more than half of bisexual youth are likely to consider and attempt suicide at a higher rate when compared to gay and lesbian peers. In addition, various research on biphobia demonstrates that bi people experience discrimination from both the heterosexual community because of heterosexist views and from the gay and lesbian community for not having exclusive same-sex/gender relationships and attractions (Bostwick et al., 2014; Galupo et al., 2015; Paul et al., 2014; Trevor Project, 2019).

Purpose of Literature Review

This project was designed to help professionals learn about bisexuality and be informed about the impact of biphobia on bisexual identity, intersectionality between sexual identity and religious identities, and mental health among bisexual people. With the findings in this project, clinicians were able to understand and conceptualize the needs and the therapeutic concerns of bisexual-identifying individuals with recognition of the impact of biphobia on sexual identity, religious identity, and mental health among bi people to implement evidence-based treatments.

Research Questions

The following research questions were examined in this study:

1. How does biphobia impact bisexual identity?

2. How does biphobia impact the intersectionality of bisexuality and religious identity?
3. How do biphobia and minority stressors impact mental health and other conditions for clinical attention? Prevalence of anxiety, mood disorders, domestic violence?
4. How can understanding bisexuality and the adverse outcomes of biphobia (e.g., impact on bisexual identity, religious identity, mental health, and other conditions for clinical attention) guide clinical treatment to increase protective factors to help improve mental health disparities among bisexuals in clinical practice?

Chapter II provides information on theories of human sexuality from biopsychosocial perspectives, including concepts on the development of sexual orientation and religious identity. Theories of cognitive dissonance and the minority stress theory (MST) are then discussed to help clinicians understand how cognitive dissonance and minority stressors impact the formation of sexual identity and the integration of sexual identity with religious identity, as well as the impact of minority stressors on mental health and other areas of clinical concerns among bisexual people. The APA guidelines and recommendations are also provided in Chapter II to enable practitioners to deliver "affirmative psychological practice" to sexual minority clients throughout their lives using interventions, testing, assessment, diagnosis, teaching, research, and other scopes of practice.

Chapter III examines research and foundations on sexual identity development among bisexual-identifying people. In this chapter, differences in sexual identity development between bi people and other sexual minority individuals are explored and compared on various dimensions of sexual identity and stages of development (i.e., age). The hypothesis inspected in this chapter is that reducing the experience of biphobia, prejudice, and harmful stereotypes strengthens sexual orientation identity development among bisexual people.

Chapter IV investigates the impact of biphobia on religious identity. This chapter proposes that there is a positive correlation between biphobia and one's religious identity. Thus, in clinical practice, if a bi-identifying client experiences cognitive dissonance between their bisexual identity and their religious identity (intersectionality of identities), minority stressors (biphobia, rejection, and discrimination) are more likely to affect a cohesive relationship between the two identities (bisexual and a connection with their identified religion).

Chapter V focuses on the prevalence of anxiety disorders, mood disorders, and other conditions of concern among bisexual-identifying individuals. This chapter reviews articles demonstrating that bisexual people are more likely to experience depression, anxiety, and overall "poorer mental health" (Ross et al., 2018), increased suicidal ideation, and are exposed more to domestic abuse than heterosexual, gay, or lesbian people. This chapter provides evidence that bisexual people who experience biphobia have an increased prevalence of mental health concerns and experience more negative life stressors than non-bisexual-identifying people.

Chapter VI identifies protective factors and evidence-based clinical interventions such as increasing social and community support, building positive views of bisexual identity, instilling pride, and other agents to reduce the negative outcomes that may result from experiencing biphobia. This chapter confirms that implementing protective factors positively correlates with strengthening bisexual identity and overall mental health improvement/wellness. Chapter VII summarizes the research findings of biphobia, prejudice, negative stereotypes, and their impact on bisexuality. This chapter also recapitulates the hypotheses for this literature review, discusses the clinical implications and limitations of this study, and recommends future research to aid in developing a bisexual identity model. Chapter VII highlights the importance of developing a

bisexual identity model to help clinicians understand and conceptualize bisexual-identifying individuals' needs and therapeutic concerns.

Research Procedure

This literature review includes a broad review of articles, national organizations, and books accessed through EBSCO, Google Scholar, and professional associations. Peer-reviewed academic journals were used to search and provide a comprehensive and up-to-date review of the topic. Databases used for this review included APA PsycArticles, APA PsycInfo, EBSCOhost, Google Scholar, and PubMed. The key terms used in the search process included *bisexuality*, *biphobia*, *prejudice*, *stereotypes*, *sexual orientation development*, *sexual identity*, *bisexual identity*, *binegativity*, *bi-erasure*, *bi-invisibility*, *cognitive dissonance*, *intersectionality*, *religion*, *internalized biphobia*, *mood disorders*, *anxiety disorders*, *suicidal ideation*, *mental health*, *comorbidity*, *affirmation*, *pride*, and *protective factors*.

Articles published within the last decade were the primary choice to guarantee the evolution of research toward current data development. The investigators' credibility and contribution to scientific research were considered for this literature review. In addition, other sexual and gender minorities were included and discussed in this study, as the current data on bisexuality are limited. The limited research on the bisexual experience highlights the need for greater research on the bisexual experience.

CHAPTER II. THEORIES AND APA GUIDELINES

Human Sexuality from a Biopsychosocial Framework

Human sexuality has been studied by various professionals using a biopsychosocial (BPS) framework. Calabrò et al. (2019) stated that sexual experiences are influenced by biological responses (i.e., neurological interactions, hormones, and neurotransmitters). Different parts of the brain influence sexual-related functions. For example, the thalamus receives external erotic stimuli, the amygdala and the septal regions of the brain activate sexual drive, the hypothalamus provokes autonomic sexual responses (e.g., erection, genital contractions, bodily secretions for sexual initiation), and the prefrontal cortex results in the initiation of sex. Hormonal and neurotransmitter interactions influence sexual responses such as sexual arousal and desire (Calabrò et al., 2019). In turn, biological processes enact cognitive and behavioral interactions (psychological) to activate desire, motivation, sexual activity, and overall sexual satisfaction. Psychological factors influencing human sexuality include motivation, attachment, impulse control, mindfulness, and emotional responses (Dosch et al., 2016). In addition, within the BSP framework of human sexuality, social factors such as cultural, relational, socioeconomic, and environmental factors also guide the initiation and desire for sexual activity. Human sexuality is broad and fluid. However, the BPS sexuality framework also applies to same-sex individuals and its interactions between sexuality and sexual orientation development.

Sexual Orientation Development from a Biological Perspective

In recent years, literature on sexual development from a biological perspective has increased. From a biological foundation, researchers have found in various studies that biology has some influence on the development of same-sex attractions. Researchers have also found that same-sex attraction may have a heritable link within some clusters of families (Bailey et al.,

1999; Pattatucci & Hamer, 1995). Also, different studies suggest that gay men may "possess a genetic sequence" on the male X chromosome that may stimulate hormonal factors in the brain influencing sexual attraction (Hamer et al., 1993; Hu et al., 1995). Other studies found that neurohormonal and neuroanatomical differences between heterosexual, gay, and lesbian people exist (Hammack, 2005).

In 1991, LeVay found neuroanatomical differences in the hypothalamus between gay and heterosexual men. He reported that the hypothalamus of self-identified gay men demonstrated a more "feminine" hypothalamus. Hammack (2005) argued that same-sex attraction is not a result of a single biological mechanism but an interaction of biological processes during the gestation stage. He also indicated that genetic, hormonal, and anatomical processes may influence sexual and emotional experiences that are "powerfully perceived" by same-sex attractions (Hammack, 2005).

Hammack argued that biological foundations, such as hormones, genetics, and anatomical processes, result in sexual and emotional experiences (2005). Hammack (2005) and Fisher (1998) indicated that affectional bonding and sexual desire operate independently and can be conceptualized as distinct experiences. For example, people can form emotional bonds and even consider being in love without experiencing sexual desire (asexual experiences). Therefore, biology is not the only factor that forms sexual desires or sexual orientation. Hammack (2005) and Harter (2003) discussed that the onset of puberty and social and cognitive development forms the sense of self. Therefore, as children form a sense of self and move into the adolescent stage of development, awareness of the self, sociocultural experiences, and biological sexual desires develop into one's sexual identity.

Sexual Orientation Development From a Life Span Model

From a human developmental perspective, sexual desire begins during puberty. However, preschool children start becoming aware of their bodies as early as 3 years of age. During the preschool stage of development, children engage in physical exploration with other school-age peers (exposure or stimulation of genitals; O'Donovan, 2010). Lehmiller (2018) argued that "regardless of sexual orientation," middle-school-age children may experience their first sexual attraction at 10. Researchers discussed that during the adolescent stage of development, the formation of sexual attraction and sexual desire begins to solidify, and the formation of romantic relationships begins to emerge (Dolgin, 2011).

According to the Pew Research Center (2013), teens who identify within the LGBTQ+ community start to recognize sexual attraction to same-sex peers. Russell et al. (2009) stated that during this stage of development, teens who identify as gay, lesbian, bisexual, questioning, or transgender start to perceive their sexual orientation during the adolescent stage of development. In Erikson's psychosocial theory of development, adolescents navigate identity vs. role confusion, often navigating "Who am I?" throughout this stage of development. Teens who develop a strong sense of identity integrate their experiences, values, beliefs, and relationships into a sense of self, self-awareness, independence, and commitment, among other benefits for identity formation (Bishop, 2013). Sexual orientation development for LGTBQ+ teens may be challenged by what Erikson named "role confusion" (Bishop, 2013). The HRC's analysis of the CDC's YRBS findings reported in 2019 that 16% of gay and lesbian youth and 11% of bisexual youth had been threatened or injured with a weapon on school property, compared to 7% of straight youth. Twenty-nine percent of gay or lesbian youth and 31% of bisexual youth have been bullied on school property, compared to 17% of straight youth (HRC, n.d.). Therefore, from

Erikson's psychosocial theory of development, negative experiences among LGTBQ+ teens are likely to impact "identity vs. role confusion," thus challenging commitment in social relationships, influencing mental well-being, and forming a weak sense of self (including one's sexual identity). In early adulthood, Erikson's 6th stage of development, intimacy vs. isolation, could impact intimate relationships and challenge relationships if one's sexual identity may not have been solidified during the 5th stage of Erikson's stage of development (Bishop, 2013).

Sexual Orientation Development from Psychoanalytic Theories

Historically, same-sex relationships are viewed as a "choice" or a "social construct." Same-sex relationships were psycho-pathologized until 1973 when the American Association of Psychology (APA) eliminated "homosexuality" from the *Diagnostic and Statistical Manual*. Bisexuality is "a sexual orientation," commonly known as "bi," which includes an umbrella of sexuality where certain people are attracted to more than one sex and gender. Robyn Och's most popular definition of bisexuality is the following: Bisexuality is "the potential to be attracted—romantically and, or, sexually—to people of more than one sex and/or gender, not necessarily at the same time, not necessarily in the same way, and not necessarily to the same degree" (Trevor Project, 2021). Sigmund Freud theorized that same-sex behaviors were influenced by psychological pain and psychological regression. Freud held the belief that human beings possess inherent bisexuality, and that participating in same-sex activities facilitates a typical progression toward heterosexual development (Drescher, 2015). Freud acknowledged in his writings that a same-sex relationship does not bring any advantages, although it should not be stigmatized or considered pathological (Freud & Freud, 1992).

Sexual Orientation Development from a Sociological System

Dr. Paula Rust is a pioneer in bisexuality studies. She is a sociologist who has published theoretical and empirical studies on sexual identity development and its influence on sexual orientation. In her research, Rust (1996) explored environmental and social factors that demonstrate sexuality as nonlinear and that one's sexual identity development is likely to continue throughout life. Rust's research discusses the concept of sexual identity as a sexual landscape. In 1996, she found that bisexual women's identities were malleable due to the sexual landscape changes. She argued that inner sexual identity experiences do not necessarily shift. For example, internal feelings and attractions remain unchanged, but environmental and interpersonal shifts (sexual landscape) allow for identity shifts. Therefore, Rust's sexual landscape model influenced social constructionist ideas of sexual identity, such as emphasizing how culture, historical era, and social settings interact with sexual identity (Gordon & Silva, 2015).

Social constructionism argues that societies and cultures provide the "truths" by which we live, accept, and adapt as a belief in one's society (Gordon & Silva, 2015). According to the social constructionism theory, there is a link between sexuality, biology, and culture. This link says that sexuality is a biological possibility that is shaped by culture (Gordon & Silva, 2015). From a social constructionist perspective, sexual orientation is influenced by thoughts, attractions, feelings, and culturally significant behaviors to categorize different sexual orientations (Gordon & Silva, 2015). From a social constructionist point of view, however, the writers made it clear that sexual orientation is not based on an inner being. Because of this, societies put a great deal of weight on the sex or gender of a romantic partner, which shapes our identities and is an essential principle in society (Gordon & Silva, 2015).

Theories of Lesbian, Gay, Bisexual Identity Development

Many people in the LGTBQ+ community define themselves as people with emotional and physical attraction to a person or people of other sexual or gender minorities (Anderton et al., 2011). Establishing a sexual identity for sexual minorities is a complex and multifaceted process. Researchers have found that different identity model measurements educate and guide professionals in understanding the stages of sexual orientation and identifying different stages of the LGTBQ+ experience. As cited by Anderton et al. (2011), the common themes among the various LGTBQ+ identity developmental model stages include:

- initial awareness of same-sex attraction
- denial of one's sexual orientation
- acceptance of identity
- internalized homonegativity
- confusion regarding one's identity
- disclosure of sexual orientation
- pride of one's sexual identity

These stages found in various LGTBQ+ identity developmental models are not linear; Thus, a person may move from one stage of the identity development model in either direction (e.g., initial awareness to acceptance or acceptance of identity back to confusion). In a clinical setting, clinicians may use the LGBTQ+ identity developmental models to aid a client in exploring one's sexual identity. LGBTQ+ identity development models strengthen treatment processes when clinicians explain the associations of identity model factors and the impact of those variables on prejudice, rejection, mental health outcomes, and other minority stressors (e.g., family rejection and internalized homonegativity).

Cass Identity Model

In her linear, six-stage model, Cass (1979) contended that individuals move from identity confusion and comparisons through acceptance and confidence to identity synthesis. There is a conflict between the presumption of heterosexuality and same-sex sexual desires during the first stage, identity confusion (Cass, 1984). The following stage is identity contrast, where people assess their sexual orientation compared to heterosexuals and frequently feel excluded from societal norms (Cass, 1984). Stage three of identity tolerance helps the navigation of exclusion in a heteronormative society by having sexual minorities actively seek out other LGBTQ+ people (Cass, 1984). People acquire identity pride after accepting their sexual orientation or acknowledging their LGBTQ+ identity (Cass, 1979). However, the individual's expression and feelings of rage toward experiences and messages of homophobia and heterosexism that can exist in our culture make up a significant portion of this stage. Recognizing that sexual orientation is just one identity element is part of Cass's model: identity synthesis, the last stage (Cass, 1984).

D'Augelli's Model of Lesbian, Gay, and Bisexual Identity Development

D'Augelli's lesbian, gay, and bisexual identity model explains how LGB identities progress as LGB people integrate internal and external developments to create a sense of self (Goodrich & Brammer, 2019). Six interactive processes make up the nonlinear model. Throughout their lifespan, LGB people may see more pronounced development in some processes than others and potentially experience a regression to a previously established process. (Goodrich & Brammer, 2019).

D'Augelli developed the following nonlinear LGB sexual identity model in 1994 and revised and included integral data in 2006.

- Exiting heterosexual identity: recognition of same-sex attraction.
- Developing a personal LGB identity status: from an individual experience, the person integrates their sexual identity as their own through thoughts, feelings, and desires (D’Augelli, 1994). In this stage, the person is likely to challenge internalized homophobia and biphobia through community connection or romantic relationships to provide meaning to one’s sexual identity.
- Developing an LGB social identity: creating connections and support and experiencing affirming and safe spaces within the LGB and heterosexual communities.
- Becoming an LGB offspring: sharing one’s sexual identity within the family system and compromising interactions or relationship styles with members of the family after disclosing one’s sexual identity.
- Developing an LGB intimacy status: integration of “personal, couple-specific, and community norms” to achieve one’s needs (Goodrich & Brammer, 2019, p. 154).
- Entering an LGB community: engaging and committing to social and political action against social barriers.

According to D’Augelli, to achieve a strong sense of identity, one must be aware of one’s identity and societal oppression and actively seek to overcome these social challenges (Goodrich & Brammer, 2019). The development of the LGB identity introduced by D’Augelli’s model of sexual orientation development involves leaving heterosexuality, creating an LGB social identity, joining the LGB community, and participating in social justice activism (D’Augelli, 1994, 2006). According to D’Augelli’s (1994, 2006) approach, identity development is a series of processes that occur randomly and are adaptable throughout a person’s life.

Religious Identity Development

Defining religion(s) and faith continues to evolve, but defining both concepts does not capture their historical or modern understandings, practices, and beliefs throughout cultures (Kim, 2020). Likewise, faith can be considered the strength of a belief in a higher power. Bishop (2016) mentioned that to fully comprehend faith, it is essential to consider the intuitive, cognitive, and practical dimensions of faith to understand the application of the concepts, views, and beliefs in people's identities (Bishop, 2016). James W. Fowler is known for creating the faith development theory.

Fowler's Stages of Faith

James Fowler's stages of faith include six stages of development. Influenced by Piaget's, Kohlberg's, and Erikson's developmental theories, James Fowler discussed and introduced the following stages of faith in 1981:

1. Intuitive-projective (applicable for preschool children in which ideas of religion are influenced by society and family).
2. Mythic-literal (usually applicable to school-age children, but some adults might remain in this stage. In this stage, religion is practiced and applied from a literal perspective).
3. Synthetic-conventional (in this stage, preteens and teens attempt to integrate their beliefs influenced by family, intrapersonal, societal, and environmental factors. Adults are likely to remain in this stage).
4. Individual-reflective (usually begins in young adulthood. People start to recognize different ways of viewing and applying their views. Tensions arise between group vs. individual beliefs and objectivity vs. subjectivity).

5. Conjunctive (most common stage for middle adulthood. During this stage, the individual will likely recognize their faith as subjective and multidimensional).
6. Universalizing: Only some people reach this stage. In this stage, the person is committed to their faith without worrying about subjectivity and doubts about others' views or beliefs (Fowler, 1981; Levy & Edmiston, 2014). Fowler's stages of faith model should be used more than just to understand and implement others' religious identity development and integration with other identities. However, it is essential to recognize that Fowler's stages of faith have established a strong foundation for understanding the process of spiritual identity development.

Theory of Cognitive Dissonance

The cognitive dissonance theory explains how increased tension, or conflict, between two psychologically inconsistent thoughts or beliefs, influences human internal and external experiences (Festinger, 1957). Dissonance is likely to increase psychological distress, which makes people more motivated to alter their beliefs or behaviors or refrain from thought patterns, likely to increase dissonance. The conflict between beliefs or behaviors can be minimized by eliminating dissonant cognitions, introducing congruent cognitions, or minimizing the significance of dissonant cognitions. (Festinger, 1957).

The Intersection of Cognitive Dissonance, Religion Identity, and Bisexual Identity

Self-identified religious LGB people may have two contradictory beliefs, causing internal tension, also known as dissonance (Anderton et al., 2011). People try to change one or more aspects that do not go together to reduce dissonance; however, the dissonance between two firmly held beliefs about oneself sustained over a long period is likely to increase psychological distress (Festinger, 1957).

Race/ethnicity, gender, sexual orientation, religion, age, and socioeconomic status are just a few facets of one's identity that people can simultaneously embody (Hays, 2016). In this section of the literature review, the intersectionality between sexual identity and religious identity is discussed from a cognitive dissonance perspective. As noted above, self-identified religious LGB people may have two contradictory beliefs, causing internal tension. Both identities (religious identity and sexual identity) occur in early childhood. In Fowler's stages of faith, stage one, intuitive-projective and stage two, mythic-literal, can be viewed as the foundations of group affiliation and respective beliefs during childhood. On the contrary, although children begin to explore their bodies around 3 years old (O'Donovan, 2010), exploring sexual identity (usually) begins during puberty.

Cognitive dissonance is likely to occur for self-identified religious LGB people because one's religious beliefs and church community views regarding same-sex relationships do not align with one's sexual identity. In religious environments that discourage same-sex attractions, behaviors, and identities, LGBTQ+ individuals may experience significant cognitive dissonance between their sexual and religious preferences. (Anderton et al., 2011; Kashubeck-West et al., 2017). It is more challenging for people to balance their sexual orientation with their religious views as a result of internalized homophobia, biphobia, transphobia, and prejudice against the same-sex desire that results from heteronormative affirming teachings (Lapinski & McKirnan, 2013).

Minority Stress Model Theory

Minority stress is the additional stress members of stigmatized social groups may experience due to their social status (Meyer, 2003). The MST is a helpful conceptual framework for determining how stressful experiences, such as prejudice, microaggressions, and

discrimination against LGBTQ+ people and the association of these stressors affect overall health outcomes for sexual minorities. Meyer (2003) proposed the minority stress model, which identifies discrimination, violence, and victimization as primary sources of stress, potentially increasing the risk of LGBTQ+ individuals experiencing psychological difficulties (Meyer, 2003).

Meyer (2003) discussed how sexual minorities are affected by two types of minority-related stressors. Meyer noted that the stressors he examined in this study include external stressors (e.g., discrimination, biphobia, homophobia) and internal stressors (e.g., concealment of identity, internalized homophobia, internalized biphobia, fear of rejection, and internalization of society's beliefs and stereotypes against sexual minorities). Meyer also emphasized that these groups of minority-related stressors are interconnected and bidirectional (2003). The MST proposed distinct minority stressors that may aid in explaining possible outcomes of disparities in overall poorer mental health among LGBTQ+ individuals.

Based on recent data, the MST has been applied and studied mainly among gay and lesbian people. In recent times, however, research on applying the MST and bisexuality has been investigated more. According to the identity model (Meyer, 2003) and other bisexual studies, the bisexual population (Bostwick & Hequembourg, 2014; Brewster & Moradi, 2010; Dodge et al., 2016; Roberts et al., 2015) is more likely to experience mental health stressors and a higher risk of suicide if they experience proximal stressors such as hiding their bisexual identity and internalized heterosexism and distal stressors such as biphobia. To improve the mental health of bisexual people, Mereish et al. (2017a) discovered that proximal and distal stressors are related to loneliness. As a result, their findings emphasized the importance of including loneliness and

minority stressors, particularly in the bisexual community, to include preventive interventions in mental health treatment plans.

APA Guidelines for Psychological Practice with Sexual Minority Persons

APA provides guidelines for clinicians to implement in psychotherapy when working with sexual minorities. These guidelines give practitioners the ability to provide affirmative psychological practice by utilizing interventions, testing, assessment, diagnosis, education, research, and other scopes of practice to sexual minority clients throughout their lifespan. The 16 guidelines include ongoing research that provides clinicians with knowledge and awareness in the application of specific clinical care to persons with diverse sexual orientations. A brief discussion and overview of the guidelines provided by APA-Division 44: Society for the Psychology of Sexual Orientation and Gender Diversity is below.

Foundational Knowledge and Awareness

- Guideline one. Clinicians understand the spectrum of people's sexual orientations and intersectionality with other identities and contexts.
- Guideline two. Clinicians understand the differences between sexual orientation and gender identity when working with persons of sexual minorities.
- Guideline three. Clinicians affirm people's bisexual identities and maintain awareness of monosexist biases.
- Guideline four. Clinicians are aware of the harm of implementing the change of sexual orientation and do not treat sexual orientation as a mental illness.

Impact of Stigma, Discrimination, and Sexual Minority Stress

- Guideline five. Clinicians are aware of and recognize institutional discrimination against sexual minorities and work toward the promotion of social change.

- Guideline six. Therapists understand, implement, and conceptualize treatment by including distal minority stressors that impact sexual minorities.
- Guideline seven. Therapists understand, implement, and conceptualize treatment by including proximal minority stressors that impact the mental, physical, and psychosocial health of sexual minorities.
- Guideline eight. Clinicians highlight and recognize sexual minorities' resiliency and resistance against stigma and discrimination.

Relationships and Family

- Guideline nine. Therapists strive to show respect and knowledge of the diversity of relationships among sexual minorities.
- Guideline 10. Therapists consider the importance and complexity of sexual health among sexual minorities.
- Guideline 11. Therapists understand and respect clients' relationships with families of origin or families of choice.
- Guideline 12. Psychologists strive to understand the challenges, experiences, and strengths of their client's parents and their children.

Education and Vocational Issues

- Guideline 13. Clinicians strive to understand the K-12 and college/university settings experiences that may impact sexual minority students.
- Guideline 14. Clinicians strive to understand career and workplace challenges that may impact sexual minority people.

Professional Education, Training, and Research

- Guideline 15. Mental health professionals work to increase their own and others' understanding of psychological concerns pertaining to members of sexual minorities in order to enhance training programs and educational institutions.
- Guideline 16. For the purpose of reducing health inequalities and promoting psychological health and well-being, mental health professionals work to adopt affirming attitudes toward members of sexual minority communities and individuals in all aspects of planning, conducting, disseminating, and applying research to provide mental health care.

These guidelines provide recommendations to improve the psychological treatment of sexual minorities. These recommendations offer guidance to psychologists and psychologists-in-training who want to improve their understanding, increase their expertise in this area of practice, and provide skills in psychological work with sexual minorities (APA Task Force, 2021).

CHAPTER III. BIPHOBIA AND ITS IMPACT ON SEXUAL IDENTITY

Sexual identity refers to the self-concept of one's sexual orientation. Sexual identity encompasses various stages to integrate acceptance and pride in one's sexual orientation. Many members of the LGTBQ+ community define themselves as people who have an emotional and physical attraction to a person or people of other sexual or gender minorities. For sexual minorities, establishing a sexual identity is a complex and varied process (Anderton et al., 2011). A person exploring their sexual identity will likely seek professional help to help identify one's sexual identity and ultimately understand their sexual orientation. Clinicians might utilize one of the LGTBQ+ identity developmental models to assist a client in understanding their sexual identity. Researchers have found that different identity model measurements educate and guide professionals in understanding the stages of sexual identity and identifying different stages of the LGBTQ+ experience to aid sexual minority clients. Per Anderton et al. (2011), most identity models discuss sexual identity from these nonlinear stages:

- initial awareness of same-sex attraction
- denial of one's sexual identity
- acceptance of one's sexual identity
- internalized homonegativity
- confusion
- disclosure of identity
- pride in one's identity

Although LGBTQ+ identity developmental models boost treatment processes, societal norms impact the sexual identity process. Negative experiences from sexual minority stressors, such as microaggressions, external and internal invalidation of one's sexual identity, experienced

homophobia, biphobia or other phobias toward sexual minorities, and other forms of oppression, often result in a negative development of one's sexual identity.

As mentioned throughout this review, bisexual people who experience biphobia are more likely to experience sexual identity ambiguity (La Roi et al., 2019, p. 40). Sexual identity dimensions (positive or negative views of one's sexual identity) are introduced to help understand the effects of biphobia and other minority stressors on sexual identity and health within bisexual people (La Roi et al., 2019). The hypothesis inspected in this chapter is that increased experienced biphobia weakens the development of bisexual identity among bisexual people. The research completed in this chapter discusses the effects of biphobia, discrimination, and harmful stereotypes on sexual identity development and how these negative stressors could negatively influence sexual identity development.

Sexual Identity Dimensions Between Bisexuals and Other Sexual Minorities

La Roi et al. (2019) examined the various dimensions of sexual identity, minority stressors, and mental health of bisexual individuals compared to other sexual minorities' experiences. The authors also investigated whether sexual identity dimensions influence mental health inequalities between bisexuals and other sexual minorities and whether sexual identity factors mitigate the effects of stressors on mental health (La Roi et al., 2019, p. 40). La Roi et al. (2019) introduced and discussed the following sexual identity dimensions: identity importance, identity valence (how individuals evaluate their sexual identity as positively or negatively), identity integration (how various identities, including one's sexual identity, are perceived to have a close relationship with one another), and identity complexity (the extent that an individual views their self-concept; La Roi et al., 2019; Meyer, 2003; Sarno & Wright, 2013).

Various literature found that bisexual people's identity experiences are encapsulated in four themes: Bisexual identity is scrutinized by both nonsexual minorities and sexual minorities; bisexuals hide their bisexual identity more when compared to other sexual minority groups; bisexuals are more likely to report fewer feelings of belonging within the LGBT+ community; and bisexuals are more likely to experience ambivalence toward their bisexual identity, such as identity confusion (Balsam & Mohr, 2007; Brewster & Moradi, 2010; Cox et al., 2010, as cited in La Roi et al., 2019, p. 41; Durso & Meyer, 2013; Paul et al., 2014; Roberts et al., 2015; Sarno & Wright, 2013) and "lower identity centrality" (Mohr & Kendra, 2011, as cited in La Roi et al., 2019, p. 42).

The data for this study came from the STRIDE project, which included an LGB sample from New York City. Participants were drawn from settings chosen to represent various cultural, political, ethnic, and sexual representations. Bars, non-bar business enterprises, outdoor settings, gatherings, and festivals were all used as recruitment sites (La Roi et al., 2019, p. 42). The total number of participants included (baseline) $N = 396$ and $N = 371$ at wave 2 (data collected 12 months later with a 94% retention rate of respondents), ranging from 18–59 years old. The participants did not include transgender participants; thus, all participants identified with their gender assigned at birth (male or female). Data were collected from a diverse population of races and ethnic backgrounds (p. 42). The authors measured sexual orientation, sexual identity dimensions, minority stressors (e.g., outness to family, chronic strain, everyday discrimination, internalized homophobia, stigma), prejudiced events, and mental health indicators (e.g., depression, psychological well-being, social well-being). These variables were measured and analyzed using descriptive data questionnaires, inventories, software analysis measures, and scales (La Roi et al., 2019, pp. 43–45).

The results that La Roi et al. (2019) found were the following: Bisexual people were less likely to have "come out" to family, and bisexual people experienced higher levels of internalized homophobia (p. 46). These results demonstrate that bisexual people are more likely to experience internalized homophobia and, therefore, less likely to accept or feel pride in their bisexual identity. Also, suppose a person is less likely to accept or feel pride in their sexual identity. In that case, coming out to others likely impacts the ability to feel connected with one's community, such as connecting with other bisexual people. Therefore, based on these data (La Roi et al., 2019, p. 46), it could be inferred that bisexual people are less likely to come out and more likely to experience internalized homophobia; therefore, the likelihood that increased experienced biphobia will weaken the development of bisexual identity among bisexual people is higher when compared to other sexual minorities. Other results found in this study were that in wave one, bisexual people reported lower social well-being. However, in wave two, they reported lower social wellness and psychological well-being and reported experiencing more depressive symptoms than other gay, lesbian, homosexual, queer, or other self-identified sexual minorities (La Roi et al., 2019, p. 46). These results show that in both waves, bisexual people reported lower social well-being (connection to others, integration, acceptance, contribution, and actualization, p. 45) than other sexual minority participants. Suppose bisexual people are less likely to connect to others in LGBTQ+ heteronormative spaces. In that case, they would be less integrated into society, and feelings of rejection would increase, most likely resulting in a hostile formation of one's sexual identity. The same concept can be applied to the results that bisexual people reported less psychological well-being and more depressive symptoms when compared to other sexual minorities (La Roi et al., 2019, pp. 45–46); more negative experiences in social

settings, poor relationships with others, and low self-acceptance, lead to more depressive symptoms experienced and less likelihood that a positive sexual identity will be formed.

The authors found that bisexual people reported less discrimination and fewer experiences with prejudiced events than other sexual minorities. These results could be attributed to the fact that some bisexual people may present as *straight passing*, a term used to describe gender expression that matches one's sex at birth (a cis bisexual woman who presents as female or a cis bisexual man who presents as male). Additionally, outness to family was reported less from the bisexual participants per the results found by La Roi et al. (2019). In that case, it is likely that bisexuals are not coming out to friends, co-workers, and others. Thus, bisexual people are less likely to experience discrimination and prejudice if they present themselves socially as straight.

Regarding the differences between bisexual people and other sexual minorities' identity dimensions, the following results were gathered by La Roi et al. (2019): All participants rated their sexual identities as important (meaning no differences between the two groups). In both waves, bisexual participants reported lower identity valence and lower identity integration; in wave two, bisexual participants reported high identity complexity (La Roi et al., 2019, p. 46). Essentially, what the authors found is that bisexual people (in both waves of data collection) reported viewing their bisexual identity as unfavorable, having challenges integrating their bisexual identity with their other personal or social identities (e.g., religious identity, professional role) and noted less integrated "identity hierarchy structures" (complex self-concept resulting from difficulty integrating all identities into one social identity; La Roi et al., 2019, p. 46). These results reinforce published data that continue to indicate that bisexual people face more negative stereotypes than other sexual minorities and that these negative experiences frequently result in

sexual orientation instability and bisexual invisibility on a societal level, including erasure within other identities (intersectionality of identities; Barnes & Meyer, 2012; Brewster & Moradi, 2010; Dyar et al., 2015; Garelick et al., 2017; La Roi et al., 2019; Rodriguez et al., 2013; Sarno et al., 2020; Shilo et al., 2016; Zelle & Arms, 2015). Thus, La Roi et al. (2019) showed that bisexual people reported higher internalized homophobia and negative experiences and that bisexual people reported viewing their bisexual identity as unfavorable, having difficulties integrating their bisexual identity with other identities, and having a more complex self-concept when compared to other sexual minorities, supports the hypothesis that increased experienced biphobia weakens the development of bisexual identity.

Positive and Negative Identity Experiences Among Bisexual and Non-monosexual People

Two studies explored positive identity experiences (Flanders et al., 2017) and negative experiences (Flanders et al., 2016) among bisexual and non-monosexual people. Both studies utilized a daily diary system of cataloging experiences across 28 days related to their sexual identity. These studies employed constructivist grounded theory (an approach that creates hypotheses and theories from emerging data) to analyze participants' experiences and categorize them through a social-ecological framework. By reviewing participant's experiences (both positive and negative), this framework categorized those experiences into intrapersonal (micro), interpersonal (meso), and institutional (macro) levels of their social systems.

After reviewing positive bisexual and non-monosexual identity experiences, Flanders et al. (2017) highlighted the impact of a strong community and peer support when affirming bisexual identity and fostering bisexual existence. Social support was apparent at different levels of the social-ecological system. The authors discussed that at the institutional level, social support is regularly manifested via feelings of bisexuality being recognized. At the interpersonal

level, social support from friends was associated with feelings of safety and being loved. The researchers determined that social interactions constitute opportunities for the bisexual identity to be met with microaffirmations and positivity. Flanders et al. (2017) theorized that bisexual community building may provide a critical opportunity to nurture positive health outcomes for the bisexual community. Because the majority of positive experiences were found at the interpersonal (meso) level, it is possible that future interventions targeting social support could be invaluable for bisexual youth. Another key finding in this study was that the absence of damaging or neutral responses toward the participant's bisexual identity was interpreted as a positive experience for some participants. These experiences toward bisexual people might display the frequency of experiencing biphobia and monosexism within the community, so much so that freedom from such experiences is interpreted as positive.

Although the study did not investigate the impact of reduced experience of biphobia, prejudice, and harmful stereotypes on sexual orientation identity development among bisexual people, the current research provides thought-provoking questions regarding bisexual identity development. Specifically, the protective factors of community support can be critically important for developing and flourishing a bisexual identity.

By investigating bisexual and non-monosexual people's experiences with negative identity experiences, Flanders et al. (2016) contributed to the minority stress literature (Meyer, 2003). A specific stressor and negative experience they discovered among their participants were microinvalidations in the form of attempts to erase or redefine bisexuality. For example, bisexuality was deemed either immature or transphobic. These microinvalidations included social pressure on bisexual individuals to identify as lesbian, gay, heterosexual, or pansexual. The researchers highlighted how the negative impact of microaggressions on sexual minority

populations could shed light on how biphobic microaggressions, which encompass microinvalidations, could introduce challenges to bisexual identity development. Specifically, it is theorized that microaggressions may interrupt the development of their bisexual identity or may pressure people into embracing an identity that is different from their sexual practices (as cited in Flanders et al., 2016). Intriguingly, in the study sample, several participants shared their reservations about whether their feelings, doubts, and experiences were normal. Moreover, participants communicated a desire for concrete criteria regarding identity development.

Flanders et al. (2016) highlighted that building a community for bisexual people could be critical in nurturing potentially positive outcomes regarding health and identity while reducing the negative influence of interpersonal microaggressions. By studying bisexual and non-monosexual identity development and negative identity experiences, Flanders et al. (2016) touched directly upon the current study's hypothesis. Both articles (Flanders et al., 2016, 2017) highlighted the importance of a bisexual community for bisexual people's identity development; thus, a strong sense of community and belonging reduced experienced biphobia prejudice and harmful stereotypes, strengthening the sexual orientation identity development among bisexual people.

Biphobia, Self-stigma, and Sense of Belonging

People who are subjected to biphobia are more prone to have unfavorable thoughts toward themselves, leading to higher self-stigma. As a result, many bisexual people experience a diminished sense of belonging as they suffer hostility from gay, lesbian, and heterosexual populations (McInnis et al., 2022). Building a community for bisexual people, according to Flanders et al. (2016), could be crucial in nurturing potentially beneficial outcomes regarding health and sexual identity while lowering the negative influence of biphobic experiences.

McInnis et al. (2022) investigated how biphobia impacts a sense of belonging and whether self-stigma affects the relationship between biphobia and a sense of belonging in the bisexual population.

The authors introduced three variables: biphobia, self-stigma, and a sense of belonging. Again, biphobia is discrimination against bisexual people that can be external (social discrimination) or internal (internalized biphobia). Self-stigma was discussed as a negative view of one's bisexual identity that often results from experienced biphobia. A sense of belonging was defined as a need to belong, often resulting in positive psychological well-being (McInnis et al., 2022, pp. 357–360).

McInnis et al. (2022) collected data by recruiting participants via Facebook, Twitter, Reddit, and emails. The survey contained two parts; the second part was optional when participating in the study. All of the participants ($N = 529$) identified themselves as being attracted to more than one gender (bisexual spectrum). The participants included a diverse gender identity sample but did not include a diverse ethnicity sample. In addition, the sample included romantic status, with almost 75% of those indicating being in a monogamous relationship. The mean age of the participants was about 30 years old, with a standard deviation of 10.04 years (McInnis et al., 2022, p. 367).

The authors measured the following variables (antibisexual experiences, self-stigma, and sense of belonging) using the Antibisexual Experiences Scales (ABES; Brewster & Moradi, 2010), the Self-Stigma Questionnaire (Bostwick, 2012, as cited in McInnis et al., 2022), and the Psychological State Scale of the Sense of Belonging Inventory (SOBI-P; Hagerty & Patusky, 1995, as cited in McInnis et al., 2022).

Regarding how biphobia subjected from LG and heterosexual people impacts a sense of belonging among bisexual people, McInnis et al. (2022) found that experiencing biphobia from both groups did not directly affect the sense of belonging, a thought-provoking finding. Although the authors did not directly discuss this finding, Flanders et al. (2017) highlighted the impact of a strong community (indicating being part of a community, hence a place where one belongs) and peer support affirms bisexual identity and fosters bisexual existence. In addition, this result (experiencing biphobia from both groups did not directly affect the sense of belonging) could also be attributed to the fact that bisexuals did not differ from other sexual minorities when they reported their sexual identities as important (La Roi et al., 2019, p. 46). Hence, it could be inferred that because bisexual people view their identity as important, they might find a sense of belonging in other personal and social identities as they may not look for external validation to find importance in their identity.

Also, although McInnis et al. (2022) did not find a direct link between biphobia and a sense of belonging, they found that biphobia experienced by both LG and heterosexual people increased a negative self-view concerning one’s bisexual identity, ultimately reducing a sense of belonging among the participants. Therefore, as internalized biphobia increased (self-stigma) due to biphobia, a sense of belonging in either community was low (LG vs. heterosexual spaces; McInnis et al., 2022, pp. 370–371). Despite that McInnis et al. (2022) did not directly discuss how self-stigma increased and how this stigma is linked to a decreased sense of belonging, potentially impacting sexual identity, the results provided insight that bisexual people who experience biphobia are likely to internalize antibisexual attitudes and behaviors (i.e., self-stigma), supporting that biphobia and negative identity experiences are likely to reduce the

shaping of a solid sexual identity foundation; these are findings supported in La Roi et al. (2019) and Flanders et al. (2017).

CHAPTER IV: BIPHOBIA AND ITS IMPACT ON INTERSECTIONALITY BETWEEN SEXUAL IDENTITY AND RELIGIOUS IDENTITIES

Ritter and O'Neill (1989) found that sexual minorities who identified with a specific religion were likely to negotiate their identities as mutually exclusive, thus resulting in people believing they must choose between their sexual orientation or religion/beliefs. Lease et al. (2005) and Rodriguez et al. (2013) found that sexual minorities who attended religious affiliations that provided support for same-sex relationships were less likely to experience homonegativity and were more likely to identify with their affiliation, serving as a protective factor for reduction of mental health concerns. Additionally, Yip (2008) found that positive negotiations of multiple identities were influenced by analyses against homonegative sentiments and affirming religious organizations, also noting that affirming religiosity affiliations may serve as protective factors for sexual minorities to help negotiate the intersectionality of identities. Barnes and Meyer (2012) noted that due to the history of homophobia and biphobia among religious organizations, research has shown that LGBT people are less likely to participate in organized religion and mentioned that sexual minorities are also more likely to abandon their religion or beliefs (Barnes & Meyer, 2012).

The research completed in this chapter explores how biphobia and discrimination within religious affiliations impact the intersectionality between one's bisexuality and religious identity. This chapter proposes that biphobia and religious identity are positively correlated. In clinical practice, minority stressors (e.g., biphobia, rejection, discrimination) are more likely to affect a bi-identifying client's cohesive relationship between their bisexual and religious identities if they experience cognitive dissonance between their identities. Three studies reviewed in this chapter discuss the relationship between internalized homophobia in non-affirming religious settings and

sexual minorities' mental health (Barnes & Meyer, 2012), the role of religiosity between discrimination of sexual orientation and meaning in the life of bisexual people (Moscardini et al., 2018), and how mediating variables, moderators, and conditional indirect effects impact the associations between encounters with the religious-based stigma of non-heteronormative people and psychological health (Szymanski & Carretta, 2019).

Attendance in Non-affirming Institutions and Internalized Homophobia

Barnes and Meyer (2012) explored the associations between internalized homophobia and mental health in a sample of New York City lesbian, gay, and bisexual participants who attended non-affirming religious environments. The authors hypothesized that sexual minorities participating in non-affirming institutions are more likely to experience internalized homophobia. The authors also explored whether LGB folks attending affirming institutions were less likely to experience internalized homophobia. In this study, the researchers collected data from Project Stride with a diverse sample ($N = 396$) of LGBs in New York City. Their sample was equally represented among Blacks, Whites, Latinos, and men and women within each race/ethnic identity from the entire sample (Barnes & Meyer, 2012).

The MST was examined to explore whether internalized homophobia—which eventually affects LGB's attitudes toward the self—is related to prejudice and discrimination experienced in non-affirming religious affiliations (Barnes & Meyer, 2012). Various published articles have found that internalized homophobia has been associated with adverse effects such as anxiety, sadness, suicidal thoughts, relationship issues, reduced well-being, and general self-esteem (Frost & Meyer, 2009; Herek et al., 2009; Herek & Glunt, 1995; Meyer, 1995; Meyer & Dean, 1998; Rowen & Malcolm, 2002; Williamson, 2000, as cited in Barnes & Meyer, 2012). Barnes and Meyer (2012) completed the study to determine if attendance of LGB people in non-affirming

religious settings would lead to higher internalized homophobia, more depressive symptoms, and diminished psychological well-being.

The authors tested their hypothesis using a linear regression with multiple independent variables. The authors found that non-affirming affiliations were associated with higher internalized homophobia. Their findings also showed that sexual minorities did not differ in feelings of internalized homophobia based on the frequency of attendance in a non-affirming religious affiliation. Thus, whether the person attended services in a non-affirming center more or less than the other participants, levels of internalized homophobia did not differ. These results demonstrate a significant positive relationship between attending a non-affirming religious affiliation and increased internalized homophobia among sexual minorities.

Another thought-provoking finding that Barnes and Meyer (2012) made was that participants who attend non-affirming religious settings (comparisons made of the authors' sample of those affiliated with non-affirming religious settings against those who never attend religious services) did not predict higher depressive symptoms and worse psychological well-being. Although their hypothesis (Barnes & Meyer, 2012) was based on the premise that attendance in non-affirming religious contexts within sexual minorities leads to lower mental health was not supported, the authors further investigated how the effect of non-affirming religion on mental health outcomes varied when internalized homophobia was taken into account. Interestingly, the authors found that when internalized homophobia was controlled, non-affirming religion became a stronger predictor of both mental health factors in the positive direction (Barnes & Meyer, 2012, p. 9).

Despite the authors not discussing how experienced biphobia/homophobia and harmful stereotypes within a religious affiliation impact a cohesive relationship between intersectionality

of identities, the current research provides interesting questions on sexual minorities' attendance in nonsupportive religious houses of worship and the likelihood of increased cognitive dissonance that might influence (e.g., same-sex relationships not aligning with the values of the religious affiliation) risk factors, such as anxiety, sadness, suicidal thoughts, relationship issues, reduced well-being, and general self-esteem. In addition, these results help understand how these minority stressors experienced in non-affirming religious affiliations increased internalized homophobia among sexual minorities (taking into account the results after the authors controlled for internalized homophobia), ultimately resulting in what research has shown, such that LGBT people are less likely to participate in organized religion and are more likely to abandon their religion or beliefs (Barnes & Meyer, 2012).

Furthermore, Barnes and Meyer (2012) specifically highlighted how there is a likelihood that internalized homophobia will likely suppress the positive effects religion may have on mental health and illustrate how the negative effects (p. 9) of religion may influence internalized homophobia (possibly as a result of cognitive dissonance) resulting in sexual minorities being more susceptible to abandoning their religious beliefs or finding an LGTBQ+ affirming affiliation to reduce internalized homophobia and improving overall mental health. Thus, Barnes and Meyer's (2012) results support the hypothesis of this study as their results (i.e., non-affirming affiliations were associated with higher internalized homophobia) help infer that one possible reason why LGTBQ+ people abandon their religious beliefs or seek an affirming affiliation is probably that LGTBQ+ people are seeking a safe space that will decrease internalized homophobia and experiences with other minority stressors. Thus, as religious-based sexual stigma (RSS) decreases, psychological distress decreases, and well-being improves (Szymanski & Carretta, 2019). Also, it will likely strengthen the intersectionality of identities

(i.e., sexual identity and religious identity), as previous literature demonstrated that sexual minorities who attended religious affiliations that provided support for same-sex relationships were less likely to experience homonegativity and were more likely to identify with their affiliation (Lease et al., 2005; Rodriguez et al., 2013).

Internalized Biphobia, Rejection, Discrimination, and Role of Religiosity in Life Meaning

Moscardini et al. (2018, p. 196) explored the potential moderating impact of religiosity in the interaction between discrimination from nonsexual minorities, internalized biphobia, and expectations of rejection concerning life meaning in a sample of bisexual adults. The authors used the MST (Meyer, 2003) framework and applied the theory to the bisexual population. As mentioned previously throughout this document, the MST discusses that sexual minorities experience ongoing stressors related to their sexual orientation. In addition, previous literature has found that bisexual people experience more stress (bisexual stress) compared to other sexual minorities (Balsam & Mohr, 2007; Kertzner et al., 2009; Kuyper & Fokkema, 2011, as cited in Moscardini et al., 2018, p. 194).

Moscardini et al. (2018) applied the MST framework to their study as it relates solely to bisexual experiences with minority stressors. Additionally, Moscardini et al. (2018) stated they were interested in exploring the concept of stress-related growth (SRG), which refers to finding meaning through adversity and growing as an individual through hardships (p. 194) since previous literature has discussed how religion is associated with SRG. The authors also stated that bisexual people are more likely to rely on religious coping when compared to gay and lesbian folks (McCarthy, 2008, as cited in Moscardini et al., 2018). However, the authors noted that bisexual people attend “non-affirming religious denominations” (p. 194), a paradox since non-affirming religious affiliations are more likely to increase feelings of internalized

homophobia (Barnes & Meyer, 2012). Thus, Moscardini et al. (2018, p. 194) focused their research questions to help shed light on the function of religion in the relationship between bisexual stress and well-being. Moscardini et al. (2018) hypothesized that as bisexual people experienced more bisexual stressors, life meaning would decrease—in particular, internalized biphobia and expectations of rejection would mediate discrimination. They also hypothesized that religiosity would moderate bisexual stressors to life meaning; therefore, exploring if bisexual people who identified with higher forms of religiosity experience more discrimination, the meaning of life is ultimately reduced.

The authors collected online data using Amazon's Mechanical Turk (MTurk). The total sample in their study consisted of $N = 365$ bisexual people aged 18 to 67 years. The study included participants living in the United States with diverse demographics. To gather results from the data collected, Moscardini et al. (2018) used a structural equation model (SEM; a multivariate statistical analysis to analyze structural relationships) to test their hypotheses (Moscardini et al., 2018, p. 196). The following variables were explored and measured: religiosity (Duke University Religion Index; Koenig & Büssing, 2010, as cited in Moscardini et al., 2018); internalized biphobia (Internalized Homophobia Scale modified to address biphobia [IHP]; Martin & Dean, 1987, as cited in Moscardini et al., 2018); discrimination (Heterosexist Harassment, Rejection, and Discrimination Scale [HHRDS]; Szymanski, 2006, as cited in Moscardini et al., 2018); expectations of rejection (Stigma et al. [SCQ]; Pinel, 1999, as cited in Moscardini et al., 2018); meaning of life (subscale from the Meaning in Life Questionnaire [MLQ]; Steger et al., 2006, as cited in Moscardini et al., 2018).

The authors found that discrimination was directly associated with rejection and internalized biphobia, but discrimination did not directly affect life meaning (Moscardini et al.,

2018, p. 198). However, expectations of rejection and internalized biphobia were significantly associated with life meaning. In addition, experiences with high levels of discrimination contribute to strong expectations of rejection and internalized biphobia, and as these two variables increased, levels of life meaning decreased (p. 198). Although these results found in the Moscardini et al. (2018) study do not directly explain how increased biphobia within a religious affiliation weakens a cohesive relationship between both identities, these data can help infer that if life meaning (usually a variable linked as a protective factor among religious people and religion playing a significant role in helping cope with stressful and traumatic events as cited in Park [2005] and Cowchock et al. [2011, as cited in Moscardini et al., 2018, p. 195]) is decreased as a result of internalized biphobia and perceived feelings of rejection, these folks are more likely to either abandon their beliefs (as these beliefs are now a risk factor against life meaning; Barnes & Meyer, 2012) or attend an affirming religious affiliation that will help improve life meaning (potentially a protective factor against minority stressors).

Another finding that Moscardini et al. (2018) made was that religiosity (moderator variable) had a significant direct effect on life meaning. This means that people who reported high levels of religiosity endorsed higher levels of life meaning despite experiencing discrimination, a contradictory result. This result could be attributed to previous research that has mentioned that religious membership, despite attendance in non-affirming affiliation (Barnes & Meyer, 2012), may offer bisexuals the support they need to cope (such as the meaning of life) with stressful situations (Moscardini et al., 2018, p. 195).

The writers also found that religiosity and discrimination levels had a significant direct effect on life meaning; the participants who reported high religiosity reported decreased life meaning when they reported experiencing more biphobia; the authors suggested that results

demonstrated that religiosity did not act as a protector between the interaction of sexual minority stress and meaning of life (Moscardini et al., 2018, p. 200).

Continued results demonstrated that those participants who reported low levels of religiosity but noted strong experiences with discrimination reported increased life meaning (another noteworthy finding), which could be explained by the fact that if a person is bisexual and reports low levels of religiosity, they likely have coping strategies built into other settings (e.g., therapy). These coping skills may act as a buffer against discrimination; as a result, these folks report higher levels of life meaning. The authors elaborated that not only did the level of religiosity not act as a barrier between sexual minorities and life meaning, but the sample that reported higher levels of religiosity and experiences with high exposure to discrimination was detrimental in the results of reported reduced life meaning.

To conclude this section of the literature review in this chapter, Moscardini et al.'s (2018) results do not directly address that increased biphobia likely results in a non-cohesive relationship between sexual identity and religious identity. Results from various articles are used to infer that since bisexual people reported high religiosity, resulting in declined life meaning because of experienced discrimination, then the supporting findings that LGBT people are less likely to participate in organized religion and are more likely to abandon their religion or beliefs (Barnes & Meyer, 2012; Moscardini et al., 2018) is evidence to support that biphobia results in a non-cohesive relationship between the intersectionality of sexual identity and religious identity among bisexual people.

Religious-Based Sexual Stigma and Psychological Health

Szymanski and Carretta (2019) explored the impact of RSS (i.e., sexual bias and discrimination perpetrated by religious/faith-based leaders and members [p. 1068]) on both

psychological distress and well-being. The authors also investigated how internalized heterosexism (internalized and externalized homophobia as a byproduct of living in a heteronormative society [p. 1063]) and religious struggle mediated the relationship between RSS and outcomes (psychological distress and well-being). Finally, the writers incorporated analyses to understand the moderation effects of religiosity better. Specifically, they examined how religiosity potentially moderates both the impact of RSS on outcomes directly and the potential mediation via internalized heterosexism and religious struggle.

The authors hypothesized that more intense experiences of RSS would be related to greater internalized heterosexism and spiritual struggle, resulting in higher levels of psychological distress and reduced well-being. They also suggested a strong relationship between RSS and psychological distress and well-being would result when people hold high religiosity beliefs. Szymanski and Carretta (2019) also theorized that a more elevated experience with religiosity would moderate direct associations between RSS and internalized heterosexism and religious struggle. Furthermore, Szymanski and Carretta (2019) postulated that when religiosity is high, the impact of religious-based sex stigma on psychological outcomes through internalized heterosexism and religious struggle is more robust than when religiosity is low. Thus, ultimately, they predicted that religiosity would likely moderate the relationship between religious-based sex stigma and psychological outcomes indirectly through the mediator variables (internalized heterosexism and religious struggle).

Szymanski and Carretta (2019) analyzed data from 193 participants, ages 18 to 75. Sixty-one percent of the participants identified as female and 39% as male. Seventy-one percent of the participants identified as lesbian or gay, and 29% identified as bisexual. The participants identified with the following religious/faith affiliations: Christian (69%), Jewish (9%), Unitarian

(7%), Buddhist (3%), Pagan (3%), and 9% of the participants identified as other (e.g., Hindu, Islam, Mormon, Baha'i). The participants were recruited through various platforms such as email, organizations, and other internet resources such as Facebook. The authors utilized the following scales: RSS, Internalized Homophobia Scale-Revised, Religious Struggle Scale, Religious Commitment Inventory short form, Hopkins Symptom Checklist-21 (HSCL-21) to measure psychological distress, and the Satisfaction with Life Scale to measure well-being (Astin et al., 2011; Diener et al., 1985, as cited in Szymanski & Carretta, 2019; Green et al., 1988; Herek et al., 1998; Worthington et al., 2003, p. 85).

The following results were found: At the bivariate level, RSS was positively related to psychological distress and negatively related to well-being (Szymanski & Carretta, 2019). These data essentially mean that psychological distress increased and overall well-being decreased when RSS increased. They also found that people who identified as bisexual reported lower levels of well-being (descriptive data results). These results could be attributable to the experience of sexual stigma exhibited toward bisexual people by heterosexuals and gay and lesbian people (data that continue to be found throughout the literature).

Results of the Mediation Analyses

The data resulted in a significant mean indirect effect between RSS and psychological distress through internalized heterosexism and religious struggle (Szymanski & Carretta, 2019, p. 1073). Essentially, these data show that higher levels of experienced internalized heterosexism and religious struggle indirectly impacted RSS, thus increasing psychological distress. Moreover, significant indirect effects emerged between RRS and well-being via religious struggle and internalized heterosexism. These data showed that higher levels of experienced internalized

heterosexism and religious struggle indirectly impacted RSS, thus decreasing well-being. These results outline the minor indirect effects of religious struggle and internalized heterosexism.

Continued data analyses showed inconsistent results with the authors' second hypothesis: Religiosity did not moderate the relationships between religious-based sex stigma and psychological distress and between religious-based sex stigma and well-being, which means that the level of religiosity did not influence RSS (Szymanski & Carretta, 2019). However, Szymanski and Carretta (2019) found that religiosity moderated the relationship between RSS and internalized heterosexism. Further analyses showed that religious-based sex stigma was significantly and positively associated with internalized heterosexism for sexual minorities with high levels of religiosity; however, religious-based sex stigma was not significantly associated with internalized heterosexism for participants with low religiosity (Szymanski & Carretta, 2019). Thus, individuals who are not as religious may not suffer from internalized sexism brought upon by religiously rooted sexual stigma as much as their more religious peers.

Additionally, inconsistent with Szymanski and Carretta's (2019) third hypothesis, results indicated that religiosity did not influence the direct relationship between religious-based sex stigma and religious struggle. This information suggests that regardless of an individual's religiosity, the relationship between religious-based sex stigma and struggle with religion was broadly consistent among participants. The data partially supported the fourth hypothesis; results supporting the hypothesis were that significant moderation found via religiosity influenced the indirect effect of RSS on psychological distress via internalized heterosexism (Szymanski & Carretta, 2019). Practically speaking, RSS's impact on psychological distress was mediated by internalized heterosexism for individuals with high and medium levels of religiosity but not for individuals with low religiosity.

Similarly, the indirect effect of RSS on well-being through internalized heterosexism was moderated by religiosity, meaning that RSS's impact on well-being was also able to be mediated by internalized heterosexism for individuals with high and medium levels of religiosity, but not for individuals with low religiosity (Szymanski & Carretta, 2019). The authors noted that some of their data opposed the fourth hypothesis. Specifically, religiosity did not moderate the indirect relationship between religious-based sex stigma and psychological distress. Essentially, data showed that relationships between RSS with both psychological distress and well-being did not significantly vary for participants with different levels of endorsed religiosity (Szymanski & Carretta, 2019).

It is important to note that although the data in Szymanski and Carretta's (2019) findings do not directly address how biphobia, rejection, and discrimination impact the intersectionality of bisexuality and religious identity, their findings demonstrated that greater religious struggle (felt anger or conflict with ideals and beliefs) mediated RSS's, which in turn indirectly associated to higher psychological distress and lower well-being. Also, Szymanski and Carretta's (2019) findings revealed that moderate and higher levels of religiosity play a role in the indirect effects of RSS via internalized heterosexism, impacting psychological distress and well-being. Essentially, these results show that if a sexual minority identifies strongly with their religious identity, the person experiences greater internalized heterosexism, increasing biases of same-sex relationships, and in turn, the sexual minority person becomes more likely to experience more significant psychological distress and report lower levels of overall well-being as they experience dissonance between the two identities (i.e., the contradiction between one's beliefs from a religious standpoint and one's sexual identity).

CHAPTER V: BIPHOBIA AND ITS IMPACT ON MENTAL HEALTH AND OTHER CONDITIONS FOR CLINICAL ATTENTION

Biphobia and bisexual invisibility lead to stresses that harm the mental health of bisexual people. The rejection of their bisexual identity, difficulty accepting their sexual orientation, disapproval from romantic partners, and exclusion from heterosexual, gay, and lesbian groups are a few of these factors. In various research, bisexual people reported less positive family support and less peer support than people of other sexual orientations. Available research has provided results that indicate bisexual people are more likely to experience marginalization from both heterosexual and LGBTQ+ communities (Bostwick & Hequembourg, 2014; Brewster & Moradi, 2010; Dyar & Feinstein, 2018; Hequembourg & Brallier, 2009; Ross et al., 2010). Bisexual people have experienced adverse effects from the idea that being bisexual is just a temporary phase and that they will ultimately identify with the gay or lesbian group or as heterosexual (Brewster & Moradi, 2010; Garelick et al., 2017; Wandrey et al., 2015).

Additionally, bisexual people report being in worse physical and mental health, experiencing more poverty rates, and being more likely to be sexually assaulted than heterosexual people (Israel, 2018). Per Copen et al. (2016), although they constitute the largest sexual minority in the United States, bisexual people report higher rates of sexual violence than heterosexual and gay or lesbian individuals. Also, compared to lesbian and heterosexual women, bisexual women have a significantly higher lifetime prevalence of sexual violence by any perpetrator, physical violence, and/or stalking by an intimate partner (mostly males), as reported by Israel (2018, as cited in Walters et al., 2013).

A significant gap in the current literature is that bisexual people in most studies are grouped into the LGTBQ+ experience per Barker (2015), making it challenging to determine

how biphobia explicitly impacts the psychological well-being of bisexual people. Numerous articles have stated that bisexual people are more prone to mood disorders, anxiety disorders, risk of suicide, and increased challenges with other conditions for clinical attention (Feinstein & Dyar., 2017; Ross et al., 2018; Taliaferro et al., 2018). The research completed in this chapter explores how biphobia impacts psychological well-being and other conditions for clinical attention among bisexual people. The hypothesis inspected in this chapter is that bisexual people have a higher prevalence of mental health challenges, increased exposure to risk factors, and other conditions for clinical attention (e.g., domestic abuse and substance misuse) than other sexual minorities because of greater exposure to biphobia from heterosexual and LG people.

Biphobia and its Impact on Mental Health—A Systematic Review and Meta-Analysis

Ross et al. (2018) completed a systematic review and meta-analysis of published literature to explore the prevalence of depression and anxiety among bisexual people compared to GL and heterosexual individuals (p. 435). The authors collected various literature, analyzed a thorough summary of all the available research within the last decade, and completed a meta-analysis to merge all literature findings utilized in their study (Ross et al., 2018, p. 435).

Ross et al. (2018) selected their studies using databases such as MEDLINE, PsycINFO, EBSCO, and other databases. The dates chosen for this study included information from 1995 to December 15, 2016 (p. 437). Keywords to find this study included words such as “bisexual*,” “major depression,” “mood disorder,” and many other words related to mental health disorders and bisexuality. The authors selected the studies if the articles met the following criteria: peer-reviewed, English, French, and Spanish (some of the authors were French-English bilingual or Spanish-English bilingual) and access to original quantitative data. The exclusion of articles included the following criteria: studies from clinical settings and studies that included group

samples with already increased risk for mental health issues (Ross et al., 2018, p. 437). The researchers also completed data extraction based on sexual minorities, gender, sex, or age, sample, size, year of data collection, sample type (p. 438), and outcomes of depression or anxiety.

Ross et al. (2018) completed a statistical analysis of continuous outcomes (for bisexual participants only) and binary outcomes and calculated the odd ratio, which measures the association between two variables. A value greater than one indicates an increased likelihood of an event occurring, whereas a value less than one indicates a decreased possibility of an event occurring (Szumilas, 2010). Ross et al. (2018) also calculated pooled estimates for the following subgroups: gender and sex, age, and sample type. Then, population-based samples were randomly selected to include sexual identity, behavior, or attraction (Ross et al., 2018, pp. 438–439). The researchers included 331 studies that passed a full-text screening, and 109 of those articles discussed the prevalence of depression and anxiety disorders among bisexual people. Altogether, $N = 52$ articles were included in the data analyses.

In all, Ross et al. (2018) found that bisexual people reported current symptoms as well as a lifetime diagnosis of depression and anxiety at a higher or the same rate when compared to gay and lesbian people. Also, bisexual individuals were at an elevated risk for poorer mental health when compared to the heterosexual group and the gay and lesbian group. These data are discussed in more depth below.

Mood Disorders—A Systematic Review and Meta-Analysis Discussion

For continuous measure of current depressive symptoms scores, results (a small effect size) demonstrated a statistically significant difference in higher depression scores among bisexual people when compared to LG people. A medium effect size was noted for continuous

depression scores between bisexual and heterosexual people, concluding that, on average, bisexual people reported depression 0.42 standard deviations higher than the heterosexual groups (Ross et al., 2018, p. 440).

The following results were gathered for depressive symptoms reported within the past 12 months and lifetime major depression or mood disorders among bisexual people. Bisexual people reported depressive symptoms within the past 12 months at a higher rate when compared to gay, lesbian, and heterosexual participants. The same findings were made when the authors examined data specific to bisexual people who reported criteria for a lifetime of significant depression (Ross et al., 2018, pp. 442-443).

These results suggest that because bisexual people are likely to experience biphobia, bi-erasure, and stereotypes within the LG+ group, communal support is less likely to be provided to bisexual people, thus increasing depressive symptoms. Now, when comparing data between bisexual people and heterosexual people, these data demonstrate that because we live in a heteronormative society, heterosexual people are less likely to experience discrimination and experience community belonging and familial support from their opposite-sex partners and can express their sexuality openly. Data continually demonstrates that heterosexual people are less likely to experience depression than LG+ people, particularly bisexual people, because of their privileged status in a heteronormative society. These data support that the more likely bisexual people are to experience biphobia in the LG and heterosexual community, the more likely they are at risk of suffering symptoms associated with depression or other mood disorders.

Anxiety Disorders—A Systematic Review and Meta-Analysis Discussion

Ross et al. (2018) determined from their data collection that bisexual people reported current symptoms associated with anxiety, symptoms of any anxiety disorder within 12 months,

and a lifetime diagnosis of generalized anxiety disorders at a higher rate when compared to LG and heterosexual people. The meta-analysis evaluated data from studies that measured anxiety either as a continuous variable or as a binary variable, in which participants were divided depending on their score against a cut-off mark indicating clinical significance. The results of this meta-analysis suggest that bisexual people experience higher chances of endorsing symptoms of anxiety as measured by continuous variables of anxiety, binary indicators of anxiety, a diagnosis of any anxiety disorder in the past 12 months, and a lifetime diagnosis of a generalized anxiety disorder when compared to their LG and heterosexual counterparts, respectively (Ross et al., 2018, p. 443).

These results are likely to be attributed to bisexual individuals reporting more prejudice from individuals who identify as gay or lesbian and heterosexual, experiencing more internalized biphobia, stigma, and discrimination, and encountering other bisexual invisibility at a societal level when compared to other sexual minorities (Dyar et al., 2015; Galupo et al., 2015). Thus, these findings support that because bisexual people are more likely to experience biphobia in the LG and heterosexual community, they are more likely to be at risk of suffering symptoms associated with anxiety disorders.

Conclusion—A Systematic Review and Meta-analysis Discussion

The authors' findings in this study are consistent with other meta-analytic studies completed by Plöderl and Tremblay (2015) and Semlyen et al. (2016, as cited in Ross et al., 2018). Results in all three studies found that bisexual people are more likely to be at risk of struggling with mental health challenges (p. 450). However, it is essential to note that the authors reported that an "absence" of research solely focused on the bisexual population continues to impact access to literature to help address bisexual health. The authors mentioned that they had

to reject more than 500 articles because those researchers did not report data separately for bisexual participants (Ross et al., 2018, p. 450), even though bisexual people in America make up more than 55% of the sexual minority group (Jones, 2022).

Biphobia, Mental Health, and Substance Use

Smout and Benotsch (2022) studied whether biphobia was associated with symptoms of anxiety and depression and the use of substances. An article by Lee et al. (2016) was discussed in Smout and Benotsch's (2022) study. Lee et al. (2016, as cited in Smout & Benotsch, 2022) reported that almost all 577 participants who identified as gay, lesbian, or bisexual indicated experiencing discrimination related to their sexual identity. In addition, Lee et al. (2016, as cited in Smout & Benotsch, 2022) found that sexual minority men who experienced sexual-orientation-based discrimination were more likely to meet the criteria for a lifetime drug use disorder when compared to sexual minority men who did not report sexual-orientation discrimination. Sexual minority women who reported sexual orientation discrimination had higher odds of receiving any lifetime diagnoses of mood or anxiety disorders than LGTBQ+ women who did not indicate experiencing sexuality-based discrimination (Smout & Benotsch, 2022, p. 540).

Smout and Benotsch (2022) collected data from $N = 226$ bisexual people aged 21 to 35 years. This specific age range was implemented in their study to account for generational differences in definitions of sexual identity. They utilized Amazon's MTurk to recruit people who only identified as bisexual (to exclude other non-monosexual identities, including pansexual). In the sample, more than half self-identified women, 40.7% self-identified as men, and 6.2% as non-binary. The samples' race and ethnicity were not as diverse, with about 80% identifying as White or non-Hispanic (Smout & Benotsch, 2022, pp. 544–545). The following

measures were implemented in their study: demographics; antibisexual events (The Anti-Bisexuality Events Scale; Brewster & Moradi, 2010, as cited in Smout & Benotsch, 2022); anxiety (The Generalized Anxiety Disorder Screener; Spitzer et al., 2006, as cited in Smout & Benotsch, 2022); depression (The Center for Epidemiological Studies Depression Scale-Revised [CES-D-R-10]; Andresen et al., 1994, as cited in Smout & Benotsch, 2022); substance use (alcohol, nicotine [cigarettes, vapes, cigars], cannabis, non-prescribed pain medication, sedatives, anti-anxiety medication, and stimulants). The substance use section was assessed by asking participants about their use of substances within the past 3 months and whether they used non-prescribed medication within the last 3 months (Smout & Benotsch, 2022, pp. 545–546).

Smout and Benotsch's (2022) descriptive results were the following: 38.5% of the participants scored at or above the criteria for moderate to severe anxiety; 58.0% of the participants scored at or above the criteria for depression; 78.7% of the people reported using alcohol, 42.9% reported nicotine use, and 45.6% reported cannabis use within the past 3 months. In the past 3 months, 18.1% of the participants agreed to use prescription drugs without a doctor's prescription. The following non-prescribed medications were misused in the past 3 months: pain medications, stimulants, anti-anxiety medications, and sedatives (Smout & Benotsch, 2022, p. 547). The authors also discussed the following findings: Biphobia was positively related to most of the mental health and drug use concerns; as experiences with biphobia progressed, symptoms of anxiety and depression rose. Biphobia was associated with a higher risk of using alcohol, nicotine, and non-medical-prescription medications across all drug types in the previous 3 months (Smout & Benotsch, 2022, p. 551). The following data support this author's hypothesis that biphobia could result in poor psychological and drug usage in bisexual young adults.

Biphobia, Suicidal Ideation, and Protective Factors

Previous researchers have stated that biphobia has been linked with suicidal ideation among bisexual people (Jhe et al., 2021; Mereish et al., 2017a, 2017b, as cited in Katz et al., 2023, p. 314). An article published by Salway et al. (2019) found that 21% of bisexual people indicated experiencing suicidal ideation, and 18% of those participants reported plans of attempting to end their life within the past year before data collection. The numbers were disproportional; when the bisexual sample was compared with heterosexual people and lesbian and gay participants, results indicated that only 7% of heterosexual people and 16% of gay and lesbian folks indicated experiencing suicidal ideation and only 6% of heterosexual participants and 11% of the lesbian and gay sample reported attempting to end their life within the past year before data collection (Salway et al., 2019). Katz et al.'s (2023) objective for their research was to find the protective factors against biphobia linked to increased suicidal ideation among bisexual people and to study the relationships between biphobia and resilience factors (i.e., community, authenticity, and intimacy) and their impact on suicidal ideation at the 1- and 2-month follow-up sessions.

The methods for completing their study included the following parts: 396 bisexual people participated from 18 to 29 years old. The sex assigned at birth for the participants was almost equally distributed between cisgender females and cisgender males, with about 15.4% identified as gender diverse. Most participants identified as White non-Latinx, while about 40% identified with minority groups. The authors utilized a longitudinal internet-based design (p. 315). and participants were found using the platform "Prolific." The study included three sections: first contact, second contact (1 month after first contact), and third contact (2 months after first contact). In the first contact, participants completed the battery of self-report questionnaires

within 30 minutes. The second, 1-month follow-up contact required participants to complete a 15-minute version of the survey, and for the third contact (2 months), participants completed a 5-minute version. In the second point of contact, 80.6% of the participants completed the survey at the 1-month follow-up assessment, while 75.5% completed the survey at the 2-month follow-up session (Katz et al., 2023, p. 315).

Katz et al. (2023) used the following measures to collect data: Brief Antibisexual Experiences Scale (Brewster & Moradi, 2010; Dyar et al., 2019, as cited in Katz et al., 2023); the Lesbian, Gay, and Bisexual Positive Identity Measure (Riggle et al., 2014, as cited in Katz et al., 2023); the brief Resilience Scale (Smith et al., 2008, as cited in Katz et al., 2023); and the Beck Scale for Suicide Ideation (Beck at al., 1988, as cited in Katz et al., 2023). The authors used bivariate correlations to examine the relationships between variables (Katz et al., 2023, p. 316).

The findings of this research were the following: Participants did not report significant experiences with discrimination and noted experiencing relatively low levels of experienced biphobia. In turn, most participants noted moderate to high levels of reporting a strong bisexual identity and possessing more forms of resiliency (Katz et al., 2023, p. 316). Because the participants reported possessing a positive bisexual identity and high levels of resilience that fell above average, it might help explain why the participants reported fewer experiences with biphobia, meaning that this sample of participants included those who likely had established protective factors in place. Although participants, on average, reported experiencing biphobia below the mean, the authors' results showed a significant positive relationship between biphobia and suicide ideation at the 1-month follow-up session (p. 317). Those results are consistent with this author's research purpose, demonstrating data supporting a positive relationship between

biphobia and increased mental health challenges and other areas of clinical concern (e.g., suicide).

Additionally, data showed that when biphobia increased, suicidal ideation increased when participants reported low community support at the 1-month assessment. Likewise, when participants reported higher experiences with biphobia, suicidal ideation increased at low levels of perceived authenticity in both follow-ups (the first- and second-month check-ins). In addition, Katz et al. (2023) also noted that when participants experienced higher levels of antibisexual discrimination, suicidal ideation was exacerbated when participants reported low levels of intimacy at the 1-month follow-up. These results highlight the importance of intimacy for bisexual people as a buffer against biphobia, ultimately reducing the risk of suicidal ideation.

A thought-provoking finding the authors mentioned was that data did not show significant relationships between experienced biphobia and its impact on suicidal ideation when considering levels of resiliency, which means that despite reports on low, average, or high levels of resiliency, this agent did not act as a buffer against discrimination that could eventually result in suicidal ideation (Katz et al., 2023, pp. 317–318). These findings are also consistent with previous data showing that “dispositional resiliency” is not enough to protect against biphobia (Breslow et al., 2015; Scandurra et al., 2020; Watson et al., 2018; Woodford et al., 2018, as cited in Katz et al., 2023, p. 318). However, protective factors unique to sexual minorities (e.g., a solid and positive view of one’s bisexual identity, pride, community, and belonging) might likely increase unique aspects of resiliency, which can potentially protect bisexual people against suicidal ideation despite experiencing biphobia (Katz et al., 2023, pp. 318-319).

Biphobia and Intimate Partner Violence Prevalence

The prevalence of sexual violence is higher among bisexual men and women. Compared to lesbian and heterosexual women, bisexual women have a significantly higher lifetime prevalence of sexual violence by any perpetrator, physical violence, and/or stalking by an intimate partner, primarily males being the perpetrators (Walters et al., 2013, as cited in Israel, 2018). Dyar and Feinstein (2018) and Swan and Habibi (2015) noted that current data also illustrate that a common misconception about bisexual people is that they are sexually irresponsible or overly sexual, as bisexuals are primarily associated with sexual behaviors rather than relating their sexual orientation to their emotional, romantic, and sexual attraction to people of both sexes and genders or different genders. This association with bisexuality and sexual behaviors results in minimal support from partners that might not validate their partner's bisexual identity, thus increasing the risk of bisexual people being victims of various types of domestic abuse.

Turell et al. (2018) wanted to study the relationship between intimate partner violence (IPV) and stereotypes commonly associated with bisexual people. In particular, the authors wanted to review promiscuity stereotypes and whether there is a specific association between IPV and perceived infidelity. The researchers included bisexual participants in monogamous or open relationships (p. 117). Turell et al. (2018) collected data from $N = 439$ bisexual people; the participants included 47% self-identified women and 42% self-identified males, with 8% self-identified queer people, 2% trans folks, and 2% undecided participants (p. 117). The ages of the participants ranged from 18 to 64 years old. Most of them identified as White/Caucasian (79.3%), and the rest of the people identified with the following racial/ethnic identities:

Black/African American (5.9%), Asian/Asian American (4.6%), Latinx/Hispanic (4.6%), bi-or multiracial (4.6%), and Native-America/Indigenous (1%) per Turell et al. (2018, p. 118).

Turell et al. (2018) used electronic programs such as Facebook and MTurk to recruit people. Participants were randomly assigned to either one of the following conditions: history of experiences in their longest relationship or experiences in their current relationship. The following measures were utilized to collect data: the Antibisexual Experiences Scale (ABES; Brewster & Moradi, 2010, as cited in Turell et al., 2018, p. 118); the Composite Abuse Scale (CAS; Hegarty et al., 2005, as cited in Turell et al., 2018, p. 119); the Abusive Behavior Inventory (Shepard & Campbell, 1992, as cited in Turell et al., 2018, p. 119) and the socio-demographic survey (Turell et al., 2018, pp. 118–119). It is important to note that the authors found significant differences between the samples via the Facebook vs. MTurk participants, and they noted it could be attributed to the disproportionate number of male and female participants in the samples. Thus, the researchers controlled the sample variable to obtain results.

Turell et al.'s (2018) findings from the one-way ANOVA analyses included the following results: The male participants reported higher rates of IPV when compared to females. These results support current literature that mentions that men who engage in the same relationships are subjected to IPV at rates comparable to or higher than those observed in women (Blosnich & Bossarte, 2009; Messinger, 2011, as cited in Finneran & Stephenson, 2014). Factors that contributed to this disparity included triggers such as power and negotiation characteristics, such as HIV status or differences in income for example, relationship characteristics, such as disagreement about sex or lack of trust, and other factors such as substance use or being under the influence, dishonesty, and threat to masculinity (Finneran & Stephenson, 2014).

Regarding race/ethnic differences, all of the minority samples reported higher rates of IPV when compared to the White/Caucasian sample. Also, Black/African American participants reported more experiences with abusive behaviors when compared to Whites and other minority groups (Turell et al., 2018, p. 120) analyzed in this study. These results could be attributed to existing data showing that people with many stigmatized social identities are especially vulnerable to negative experiences, including IPV (Whitton et al., 2021). Additionally, there was a significant association between IPV among participants who reported cheating behaviors in their relationships vs. those who denied infidelity. Again, these results could be attributed to the current data that have found a relationship between bi-specific stereotypes, such as the inability to be monogamous or bisexual people being promiscuous, increasing mistrust in the relationship (Turell et al., 2018, p. 115). However, there were no significant differences in IPV behaviors in participants who reported being in an open relationship vs. those in a monogamous relationship.

Concerning this study's hypothesis that biphobia increases the risk of mental health challenges and other areas of concern (e.g., IPV), Turell et al.'s (2018) findings of the effects (e.g., bisexual orientation, biphobia, infidelity, other variables discussed in this study) on the total composite abuse scores support the hypothesis. The authors found that participants in which both parties identified as bisexual, experiences with biphobia and infidelity (actual behavior, not the stereotype) were associated with higher composite abuse scores, which means that experiences with increased biphobia and infidelity in the relationship resulted in higher rates of IPV.

CHAPTER VI: EVIDENCE-BASED PRACTICES AND PROTECTIVE FACTORS TO STRENGTHEN BISEXUAL IDENTITY AND OVERALL WELLNESS

The current literature on bisexuality confirms that the invisibility of bisexual people in society likely results in adverse mental health challenges, unfavorable views of their sexual identity, and greater stigmatization from both LG and heterosexual individuals (Dyar et al., 2015). Much of the existing data also demonstrate that bisexual people experience unique minority stressors that lesbian and gay people are not likely to encounter. Per Dyar et al. (2015), binegativity consists of three primary components; two of these components are unique to bisexual people when compared to lesbian and gay individuals. The first component is that bisexuality is not a legitimate sexual orientation or a sustainable sexual identity. The second component of binegativity is that bisexual people are associated with sexually deviant behaviors or being sexually irresponsible. The authors discussed the third component of binegativity, hostility toward bisexual people (Dyar et al., 2015).

This chapter explores the following question: How can understanding bisexuality and the adverse outcomes of biphobia (e.g., impact on bisexual identity, religious identity, mental health, and other clinical conditions) guide clinical treatment to increase protective factors to help improve mental health disparities among bisexuals in clinical practice? This chapter confirmed that implementing evidence-based clinical interventions to increase protective factors positively correlates with strengthening bisexual identity and overall mental health improvement/wellness.

Culturally Competent Practice with Bisexual Individuals

Scherrer (2013) wanted to explore the most common themes bisexual clients report in clinical practice. She analyzed qualitative interviews with 45 bisexual people. Scherrer (2013) discussed the five themes from her study results and mentioned that biphobia, practitioner

attitudes about bisexuality, identity development, interpersonal relationships, and sexual health topics are commonly discussed in a clinical setting (p. 239).

Data were gathered from qualitative, "semi-structured interviews collected from 45 bisexual people. Participants were found to participate in this study through email accounts of LGBTQ+ groups, flyers, announcements in university classes, and "snowball sampling" (Scherrer, 2013, pp. 239–240). The data were then collected through two methods. In the first method, 20 bisexual people were asked to discuss their bisexual experiences across different social venues" (p. 240), and in the second method, 45 bisexual folks were asked how their bisexual identity was influenced in family systems (p. 240).

Most participants identified ethnically/racially as Caucasian; the rest identified as African American, Latinx/Hispanic, Asian, and multiracial. The ages of the participants ranged from 18 to 64 years old. The interviews were semi-structured and audio recorded; interviews averaged about 83 minutes and were transcribed to be analyzed in this study. Scherrer (2013) utilized NVivo, a software used for data collection. After completing analyses, the data were presented as qualitative research and formatted into case examples that discuss the experiences of bisexual people but from a clinical stance. It is important to note that the author deducted the five themes discussed in previous theoretical or empirical studies (Hesse-Bieber & Levy, 2011, as cited in Scherrer, 2013, p. 240). As noted, the author's findings (Scherrer, 2013) are relevant to clinical practice as each theme includes literature that discusses the theme (biphobia, interpersonal interactions, attitudes on bisexuality from a clinician perspective, identity development, and sexual health) includes a case example that was part of the data collection and reveals the implications of that theme in a therapeutic setting.

The first theme Scherrer (2013) discussed is biphobia. This document noted that biphobia includes behaviors and negative perceptions toward bisexual people. The participants in this study discussed their experiences with biphobia and how internalized biphobia impacts their sense of belonging. A case example that Scherrer (2013) provided included the experience of Anna, a 19-year-old Asian woman. During her coming out process, she was encouraged to come out as a lesbian. As she navigated interactions in the lesbian community, Anna became aware of the stereotypes that the lesbian community held against bisexual people, most often commenting that bisexual people were not committed, bisexual people were confused about their identity, and that bisexual people were untrustworthy (p. 241). Anna also discussed how she heard similar stereotypes in her family system. Anna reported how those experiences made her question her sexuality and that "eventually, [she would] discover her real lesbian or heterosexual identity" (Scherrer, 2013, p. 241). These data collected can help clinicians understand the impact that biphobia and negative stereotypes can have on one's sexual orientation. As clinicians understand these stereotypes, discussion of these opposing views can help in understanding the marginalization of bisexual people and, in turn, improve support and alliance between the client and the clinician (Scherrer, 2013, p. 241).

The second theme analyzed in Scherrer's (2013) study was clinicians' attitudes toward bisexuality. The writer found other studies that determined, in clinical practice, some clinicians engage in biphobic stereotypes, further invalidating the identity of bisexual clients (Eliason & Hughes, 2004; Mohr et al., 2001, 2009; Page, 2007, as cited by Scherrer, 2013). The author presented the case of Norm, a 35-year-old Caucasian bisexual man. He sought therapy to address challenges with drinking. When the counselor learned that Norm was bisexual and not gay, she suddenly asked clinical questions about his sexual orientation, something she had not done

before until she had new data about his identity. Norm did not find those clinical questions about his sexual orientation relevant and prematurely ended therapy (Scherrer, 2013, p. 242). The practice implication Scherrer (2013) discussed is that clinicians' assumptions about bisexuality can rupture the therapeutic alliance and shift clinical treatment toward irrelevant topics that unconscious biases may have influenced.

Identity development was the third theme that Scherrer (2013) analyzed. She introduced the case of Mark, a 29-year-old bisexual male. Mark noted that in high school, he came out as bisexual when he realized he was "attracted to people." He had a group of girlfriends who identified as bisexual, making him feel comfortable and secure in his identity. When he started college, Mark struggled with his identity because most of his friends identified as gay, and he felt external pressure to conform to identifying as gay because some of his peers believed that identifying as bisexual was "fence-sitting" (p. 243). Mark never felt comfortable identifying as gay. A few years later, he married a woman and wondered if his bisexual identity was still a significant part of his life. He questioned if he should identify as straight considering his current relationship, yet expressed he would be "disrespectful" to previous same-sex partners as it would come across that he did not really mean to have a same-sex relationship. He finally reclaimed his bisexual identity. Scherrer (2013) discussed literature highlighting models or trajectories of identity development that are frequently utilized to assist clients in better understanding their sexual identities. However, these models likely see bisexuality as transitionary or an experimental stage (Rodriguez-Rust, 2007, as cited in Scherrer, 2013). Thus, the implications for identity development, discussion around external pressures to conform to either the LG or heterosexual identity, can guide any confusion a client may be experiencing about their bisexual

identity. Clinicians can utilize affirming and authentic tools to help develop a strong and healthy sense of one's bisexual identity.

The fourth theme identified from the data collection of bisexual people discussed in Scherrer's (2013) study was social relationships. The author identified literature showing that "positive social relationships" improve overall well-being for LGBTQ+ people (Kertzner et al., 2009, as cited in Scherrer, 2013). However, due to the stigma and biphobia experienced by bisexual people, they are less likely than other sexual minorities to disclose their sexual identity. Data also noted that when bisexual people come out, they are more likely not to be supported by family members or other LGBTQ+ members (McLean, 2007, 2008, as cited in Scherrer, 2013). A participant described her social relationships or lack thereof, "when asked how she felt about her bisexuality, she said: 'It makes me feel very lonely'" (p. 224). Maria also noted that because of the stereotypes and the hostility experienced in the lesbian and gay communities toward the bisexual community, Maria could not find a romantic partner who could understand or appreciate her bisexuality. Scherrer (2013) proceeded to discuss practice implications (accounting for Maria's and other participants' experiences regarding social relationships), noting that clinicians understanding social relationships and the particular challenges in these interactions for bisexual people guides the clinicians in helping their clients in navigating their identities in various social situations, to "mitigate potential negative repercussions" to help reduce conflict in specific social networks that may not provide a safe space for bisexual people (Scherrer, 2013, p. 244).

Sexual health was the fifth theme that Scherrer (2013) analyzed. She noted that sexual health was raised in the study by participants who were in non-monogamous relationships. Therefore, it was emphasized that clinicians be able to discuss topics around safe sex, sexually transmitted infections, trust, and communication in polyamorous relationships, which is salient in

clinical work with bisexual people (Scherrer, 2013, p. 244). A case study from one of the participants, a 45-year-old bisexual married man named Marty, was explored in this study. He and his wife agreed to a monogamous relationship. Marty engaged in sexual relationships with other men outside of his marriage and, unfortunately, contracted HIV. At the same time, he spread the virus to his wife. He expressed guilt about his infidelity and did not know how he would have these discussions with family and friends about his bisexuality and infidelity as he and his wife had to navigate changes in their health. Marty was already in counseling and working toward ways to talk to his friends and family about his HIV-positive status. During his participation in the study, the authors noted his "eye filled with tears" as Marty discussed his bisexual identity, infidelity in his marriage, and his health status with his 19-year-old daughter (pp. 244–245). Scherrer (2013) mentioned that Marty's case guides clinicians in understanding clinical implications regarding safe sex, health complications from sexually transmitted infections, polyamorous relationships, infidelity, and verbal agreements about what is expected when honoring a monogamous relationship. Scherrer (2013) highlighted that in Marty's case, both he and his wife could have benefited from having explicit conversations about their sexual activities and expectations with same-sex or opposite-sex sexual activities as Marty stated "he decided not to tell her [his wife] about this because: I never had sex with women, so I always thought to myself: 'It's okay. [Men are] different. So, it's okay'" (Scherrer, 2013, p. 245). The writer discussed the limitations of her study, such as mentioning that the purpose of the study was not geared toward the mental health experiences of bisexual participants but that the themes essentially directed the discussions toward mental health experiences. These themes allow for future research of themes that are likely to be areas of concern in therapy and equipping clinicians with the ability to provide culturally competent practices with bisexual clients.

Although this study did not include empirical data on evidence-based practices to implement protective factors to strengthen bisexual identity and overall mental health improvement/wellness, the five themes Scherrer (2013) analyzed apply to treating bisexual people. For example, understanding these negative assumptions of bisexuality as a result of social norms may allow bisexual clients to assess bisexual stereotypes rather than internalize these discriminatory attitudes critically. As noted throughout this document, experiences in biphobia often result in bisexual people being marginalized, increasing the risk for mental health challenges, interpersonal challenges, and possible exclusion in other areas of functioning. Thus, clinical discussions around biphobia, sexual health, interpersonal relationships, professionals' attitudes and views on bisexuality, and identity development are essential to maintaining cultural competency with bisexual clients in clinical practice.

Bicultural Self-Efficacy, Outness, and Cognitive Flexibility in the Mental Health of Bisexuals

Brewster et al. (2013) examined minority stressors and mental health buffers and their impact on psychological distress and well-being. Substantial published literature continues to link the adverse effects of minority stressors to mental health challenges among LGTBQ+ people (Selvidge et al., 2008; Szymanski et al., 2008, as cited in Brewster et al., 2013). However, limited data indicate how minority stressors impact bisexual people in particular (Brewster & Moradi, 2010, as cited in Brewster et al., 2013). Researchers continue to discuss future research recommendations for professionals to investigate how positive mental health buffers affect the adverse effects of minority stressors to promote psychological well-being (Brewster et al., 2013, p. 543).

Previous literature has mentioned two factors as potential buffers and mental health promoters that may be salient in the mental health care treatment of bisexual people: bicultural self-efficacy and cognitive flexibility (Brewster et al., 2013, p. 544). *Bicultural self-efficacy* is defined as "a sense of competence in navigating multiple cultures, including the ability to foster relationships and to function satisfactorily in the cultures" (David et al., 2009, as cited in Brewster et al., 2013, p. 544). Research conducted by David et al. (2009, Brewster et al., 2013) found that as bicultural efficacy increased, life satisfaction increased, and depressive symptomology decreased in a sample of racial/ethnic minority people. In another study by Wei et al. (2010, as cited in Brewster et al., 2013, p. 545), in a sample of racial/ethnic minority people, bicultural self-efficacy mitigated the association between race-related minority stress and depressive symptoms.

Cognitive flexibility is also studied in the research and is essential in treating people who identify as sexual minorities, especially among bisexual people (Ben-Zeev et al., 2012, as cited in Brewster et al., 2013, p. 546; Brown, 1989; Riggle et al., 2008). Cognitive flexibility is the understanding that options and alternatives are available in any scenario, increasing the ability to be flexible and adapt to conditions (Kim & Omizo, 2006, as cited in Brewster et al., 2013, p. 545). Before 2013, cognitive flexibility had not been specifically researched in sexual minorities. However, various authors identified that cognitive flexibility was reported as a strength among LGTBQ+ people, and bisexual people perceived this trait in their "empowerment, freedom, and self-acceptance in the face of societal oppression" (Dworkin, 2002; Rosotsky et al., 2010, as cited in Brewster et al., 2013, p. 546). Thus, a call to conduct a study on cognitive flexibility among bisexual people was a topic of choice to examine for Brewster et al. (2013).

The study discussed in this section examined the association of minority stressors, bicultural efficacy, and cognitive flexibility and these variables' roles in psychological distress and well-being among bisexual participants (p. 546). Brewster et al. (2013) investigated the following three hypotheses: There will be a direct association between minority stressors and psychological distress and well-being among bisexual people. Bicultural efficacy and cognitive flexibility will be negatively associated with psychological distress and possibly correlated to well-being. Also examined in this study conducted by Brewster et al. (2013) was how bicultural self-efficacy and cognitive flexibility buffer experiences of antibisexual prejudice (expectation of stigma, internalized biphobia, and concealment) on psychological distress and psychological well-being. Also, although not applicable to this author's project, Brewster et al. (2013) hypothesized "proximal minority stressors" mediated the relationship between antibisexual prejudice and psychological distress and well-being (p. 546). It is important to note that this author did not discuss in depth the relationships of proximal stressors, antibisexual prejudice, and impact on psychological distress and well-being because the purpose of Chapter VI is to discuss literature that directly examines protective factors (mental health promoters) that strengthen bisexual identity and improve overall well-being in bisexual people.

Brewster et al.'s (2013) methods for their study included the following procedures: Participants were recruited through emails, discussion boards, and bisexual or other sexual minority online groups from Facebook, Yahoo groups, and "AfterElton.com" (p. 547). A total of 762 participant responses were received, but after elimination procedures (e.g., incorrect answers in the validity questions, missing 20% of data, and other elimination procedures) were implemented, 411 participants were included in the final analyses. The instruments utilized for their study included the following:

- The Public CSE subscale of the Collective Self-Esteem Scale (Luhtanen & Crocker, 1992, as cited in Brewster et al., 2013).
- The perceived antibisexual prejudice (ABES; Brewster & Moradi, 2010, as cited in Brewster et al., 2013),
    - ABES-LG subscales, and
    - ABES-H subscales to assess experiences of prejudice from lesbian or gay people and heterosexual people.
- Outness Inventory (Mohr & Fassinger, 2000, as cited in Brewster et al., 2013).
- The Lesbian, Gay, and Bisexual Identity Scale (LGBIS, a revision by Sheets & Mohr, 2009, as cited in Brewster et al., 2013) was used to measure internalized biphobia from the internalized homonegativity subscale of the LGBIS.
- The Bicultural Self-Efficacy Scale (David et al., 2009, as cited in Brewster et al., 2013).
- The Cognitive Flexibility Scale (Martin & Rubin, 1995, as cited in Brewster et al., 2013).
- To measure psychological distress: the Hopkins Symptom Checklist-21 (HSCL-21; Green et al., 1988, as cited in Brewster et al., 2013).
- To measure psychological well-being, the Satisfaction with Life Scale (Diener et al., 1985, as cited in Brewster et al., 2013) was used, and the Rosenberg Self-Esteem Scale (Rosenberg, 1965, as cited in Brewster et al., 2013) was used to measure perceived self-worth and self-acceptance.
- The demographic questionnaire.

Data collected from $N = 411$ participants were gathered and analyzed. The ages of the participants ranged from 18 to 80 years old. Most participants identified as White (79%), while only 21% identified as people of color (i.e., Hispanic/Latinx, multiracial, African

American/Black, Asian American/Pacific Islander, Native American, or other races or ethnicities). The gender of the participants included 53% self-identified as women, 37% self-identified as men, 2% self-identified as trans men and 1% as trans women, and 7% noted to identify as other genders. Regarding sexual orientation, data were collected from 75% of bisexual people. Eighteen percent of the participants identified as "mostly" lesbian or gay, 8% as "mostly" heterosexual, and 7% of the participants identified as "nonexclusive sexual orientation labels" (p. 546); however, all the participants affirmed they identified as bisexual despite reporting as mostly lesbian, gay, heterosexual, or no label. Education, socioeconomic status, and location (only 1% of these participants lived in Canada or Mexico) were also measured (Brewster et al., 2013, p. 546).

Brewster et al.'s (2013) correlation findings are discussed below. Internalized biphobia, perceived antibisexual prejudice, and the expectation of stigma were significantly associated with psychological discomfort and significantly negatively correlated with psychological well-being (Brewster et al., 2013, p. 548). Outness as bisexual was also significantly and positively associated with psychological well-being. Essentially, "out and proud" participants reported good psychological health. Bicultural efficacy and cognitive flexibility are significantly related to the positive direction of psychological well-being. Likewise, both bicultural efficacy and cognitive flexibility significantly negatively correlated with reported psychological distress (Brewster et al., 2013, p. 548). These results support this author's fourth hypothesis; the prediction was that implementing protective factors (e.g., outness, bicultural self-efficacy, cognitive flexibility [the variables in Brewster et al.'s 2013 study]) would positively correlate to strengthening bisexual identity and overall mental health (e.g., psychological distress and psychological well-being [the variables in Brewster et al.'s 2013 study]). These data provide

attention and awareness to clinicians when implementing interventions with bisexual clients, such as creating goals to increase the comfort of clients coming out in safe spaces, strengthening the views and beliefs of dual identities, or implementing problem-solving skills or reframing skills to increase cognitive flexibility. Implementing these interventions likely results in increased psychological well-being and decreased psychological distress, based on tangible findings that Brewster et al. (2013) highlighted.

Findings on the mediation analyses are irrelevant to this author's project for this chapter, but they are briefly mentioned. Brewster et al. (2013) used the PROCESS SPSS macro (Hayes, 2012, as cited in Brewster et al., 2013) to test direct and indirect associations with the mediating roles of expectations of stigma, internalized biphobia, and outness between antibisexual prejudice and psychological distress and with the mediating roles of expectations of stigma, internalized biphobia, and outness between antibisexual prejudice and psychological well-being. Antibisexual prejudice resulted in significant positive links with expectations of stigma and outness; there was no link between antibisexual prejudice. Likewise, there was a negative relationship between expectations of stigma and internalized biphobia with psychological well-being; there was no significant relationship between outness and psychological well-being. The results did not directly link perceived antibisexual prejudice and psychological well-being. The indirect link findings were the following: As expectations of stigma increased, perceived antibisexual prejudice increased, resulting in psychological distress (significantly, positively linked). There was a direct relationship in the positive direction (significantly) between antibisexual prejudice and psychological distress. Participants who reported perceived experiences with antibisexual distress also reported increased psychological distress. There were no significant indirect connections between internalized biphobia or outness with antibisexual

prejudice and psychological distress. To add, participants who reported experiencing increased expectations of stigma reported increased antibisexual prejudice and noted experiencing decreased psychological well-being. Moreover, as participants reported increased outness, although experiencing antibisexual prejudice, psychological well-being increased (essentially, outness acts as a buffer against antibisexual prejudice regarding psychological well-being; Brewster et al., 2013, pp. 549–550). Again, it is essential to note that these findings were not further analyzed (except for outness) as this chapter discusses buffers to strengthen bisexual identity and overall well-being.

Brewster et al. (2013) used the PROCESS SPSS macro (Hayes, 2012, as cited in Brewster et al., 2013) to test how bicultural self-efficacy indirectly impacts antibisexual prejudice in the overall outcome of psychological distress and psychological well-being. The same analyses were completed to test how cognitive flexibility indirectly impacts antibisexual prejudice in the overall outcome of psychological distress and well-being.

The findings from Brewster et al. (2013) are discussed. Bicultural self-efficacy was positively associated with outness and negatively associated with expectations of stigma and internalized biphobia. These data showed that being out moderated increasing bicultural self-efficacy. Previous literature has linked similar results, such as linking outness to positive wellness and social support (Tabaac et al., 2015). Bicultural self-efficacy had a positive relationship with psychological well-being and a negative relationship with psychological distress. Essentially, having a solid sense of identities that intersect helps improve psychological well-being and buffer against psychological distress, supporting this author’s hypothesis discussed in Chapter III of this project (intersectionality of sexual identity and religious identity).

The bicultural efficacy links to the predictor-mediator, mediator-criterion, or predictor-criterion were not found in the study by Brewster et al. (2013, p. 550).

Concerning cognitive flexibility, the following results were discussed by Brewster et al. (2013, p. 550). Cognitive flexibility was positively related to outness and negatively related to expectations of stigma and internalized biphobia. Also, when participants reported high cognitive flexibility, they reported improved psychological well-being and decreased psychological distress. A closer analysis of the relationship between antibisexual prejudice and well-being is also explored when including the cognitive flexibility variable (predictor-criterion link).

A direct, negative, significant link between antibisexual prejudice and well-being was reported at low levels of cognitive flexibility. Suppose a person has challenges with cognitive reframing abilities. In that case, antibisexual prejudice directly impacts their well-being, such as the person will report that experience with biphobia decreased their well-being when cognitive flexibility skills are low. Additionally, people who reported utilizing cognitive flexibility reported higher well-being than those participants with low cognitive flexibility (across all levels of antibisexual prejudice). Findings also showed that high cognitive flexibility acted as a protective factor against the impact of antibisexual prejudice on well-being (Brewster et al., 2013, p. 550).

There was no similar trend (significant relationships) when exploring links of cognitive flexibility with antibisexual prejudice on psychological distress (Brewster et al., 2013, p. 550). Thus, despite any reports on high or low cognitive flexibility utilization, no links between antibisexual prejudice and psychological distress were reported.

Results on the moderation of the predictor-mediator path (e.g., antibisexual prejudice x cognitive flexibility links to the expectation of stigma, internalized biphobia, or outness) are

analyzed in this section. At low or high utilization of cognitive flexibility, a significant and positive relationship between antibisexual prejudice and expectations of stigma was noted (Brewster et al., 2013, p. 551). Thus, if a person has low cognitive flexibility skills, antibisexual discrimination increases the expectation of stigma. On the contrary, if a person has high cognitive flexibility, experiences with antibisexual discrimination still increase expectations of stigma. Ultimately, cognitive flexibility makes no difference in the interaction between antibisexual discrimination and expectations of stigma. However, the authors mentioned that "in the context of low antibisexual prejudice, those with high cognitive flexibility had a lower expectation of stigma than those with low cognitive flexibility" (Brewster et al., 2013, p. 551). In addition, a link between antibisexual discrimination and cognitive flexibility was found in predicting expectations of stigma on the impact on psychological distress and well-being. More in-depth analyses showed that those with strong cognitive flexibility had better mental health (lower distress and higher well-being) than those with low cognitive flexibility in the context of low antibisexual prejudice. For individuals with great cognitive flexibility, however, the setting of elevated prejudice was related to faster increases in stigma expectancies, which were connected to poorer mental health (i.e., more distress and lower well-being; Brewster et al., 2013, p. 551).

Although these results partially support this writer's hypothesis, substantial utilization of cognitive flexibility did help buffer experiences with stigma at low levels of experiences with antibisexual discrimination in the outcomes of improved well-being and decreased psychological distress. However, people who reported greater experiences of antibisexual discrimination were participants who, despite utilizing high cognitive flexibility, expected stigma to increase, linked with poorer mental health. Thus, for future researchers, a recommendation for continued

exploration of protective factors will be essential when treating clients who experience significant amounts of biphobia to help improve their well-being since cognitive flexibility is not a sole protective factor against high levels of biphobia (but clinicians can still rely on cognitive flexibility interventions to aid against some experiences of biphobia).

CHAPTER VII: OVERVIEW AND FUTURE RESEARCH

Bisexuality is a sexual orientation, sometimes known as "bi," encompassing a range of sexualities in which certain persons are attracted to more than one sex and gender. The bisexual experience differs from the gay, lesbian, transgender, and other sexual and non-conforming gender experiences (McInnis et al., 2022). However, Paul et al. (2014) mentioned that current literature demonstrates a gap regarding the bisexual experience, as many investigators that study LGTBQ+ experiences incorporate bisexuality within the same-sex setting (gay and lesbian community) without distinction as a separate sexual orientation. Paul et al. (2014) also emphasized that gay and lesbian individuals have been examined "both theoretically and empirically" (p. 452), increasing clinical knowledge and improving client care. Nevertheless, bisexuality is continually referred to as an invisible sexual orientation (Ross et al., 2018), and only within the past two decades has research on biphobia and bisexuality increased (McInnis et al., 2022).

Minority stress refers to the additional stress members of stigmatized social groups may face due to their social status (Meyer, 2003). The MST is a practical conceptual framework for evaluating how stressful experiences, such as prejudice, microaggressions, and discrimination against LGBTQ+ individuals, and the relationship between these stressors affect overall health outcomes for sexual minorities. Other data suggest that bisexual people face pressures unique to their sexual orientation and mention that bisexual people face daily challenges such as internalized biphobia, stigma, and prejudice (Galupo et al., 2015). Other articles have mentioned that bisexuals are more likely to be ostracized from the homosexual and lesbian community, therefore heightening emotions of internalized biphobia (Bostwick et al., 2014). Furthermore, data also have noted that bisexual people are more prone to have sexual orientation instability,

which may result from bisexual prejudice or preconceptions (Brewster & Moradi, 2010; Garelick et al., 2017). Unique stereotypes of bisexual people are that bisexuals are promiscuous, bisexuals cannot maintain monogamous relationships, and bisexuals are experimenting with their sexuality (Brownfield et al., 2018; Wandrey et al., 2015).

In this study, biphobia is explained and thoroughly discussed. biphobia leads to remarks based on misinformation and preconceptions that call the bisexual identity into question, such as "bisexuality is a phase" or "bi people are confused." Biphobia exists within and outside the LGBTQ community (HRC, n.d.). Throughout this document, various literature highlighted that bisexual people are more likely to experience hostility from gay and lesbian people than those who identify as pansexual, queer, or fluid (Galupo et al., 2015). Various articles also discussed that bisexual folks who are victims of biphobia experience sexual orientation instability, such as confusion about identity and invalidation from others regarding their identity. As a result of biphobia, bisexuals are also likely to encounter bisexual invisibility at a societal level (Dyar et al., 2015), including erasure within other identities (intersectionality of identities) such as religious affiliation, political associations, gender, ethnicity, race, age, disability, and other groups (Barnes & Meyer, 2012; Rodriguez et al., 2013; Sarno et al., 2020; Shilo et al., 2016; Zelle & Arms, 2015).

Summary of Findings

This literature review provided information on the significance of understanding bisexuality and biphobia, as well as the impact of biphobia on sexual identity, the intersectionality between bisexuality and religious identities, and the effects of biphobia on mental health and other areas of clinical concern. This study also examined how integrating evidence-based clinical therapies to boost protective variables could help mitigate the negative

effects of biphobia. This literature review sought to educate professionals on bisexuality and biphobia. The following research questions were explored and analyzed throughout this paper to provide information for clinicians and discuss future directions in research: What effect does biphobia have on bisexual identity? What is the influence of biphobia on the intersectionality of bisexuality and religious identity? How do biphobia and minority stressors affect mental health and other clinical conditions? Moreover, in clinical practice, how can understanding bisexuality and the adverse effects of biphobia enhance clinical guidelines to promote protective factors and help address mental health inequalities among bisexuals?

Chapters III through VI included a research question, and each chapter contained this author's hypotheses. The following hypotheses were construed from available scientific data for this literature review: reduced experiences with biphobia, prejudice, and damaging preconceptions of bisexual individuals promote bisexual people's sexual orientation identity development. Minority pressures, such as biphobia, are more likely to disrupt a bisexual and religious identity's coherent relationship. Bisexual people who are victims of biphobia are more likely to have mental health problems and experience more negative life pressures than non-bisexual people. Finally, integrating and strengthening protective variables in therapeutic practice positively correlates with bisexual identity affirmation and overall mental health improvement and wellness.

An overview of each chapter and the literature reviews analyzed are discussed to finalize this author's findings. Chapter III examined the impact of experiences with biphobia on sexual identity. The first hypothesis was supported by various literature reviewed for this study. La Roi et al. (2019) noted that bisexual people reported more internalized homophobia and viewed their sexual identity as "unfavorable." This negative view of their sexual identity resulted in the

participants reporting difficulties integrating their bisexual identity with other identities and noting a more complex self-concept of their identity. Likewise, Flanders et al. (2016) found that participants who experienced microinvalidations to erase or redefine their bisexuality reported doubts and questioned if their negative feelings toward their identity were "normal." Also, results from McInnis et al. (2022) suggested that bisexual people who experience biphobia are more likely to internalize antibisexual attitudes, implying that biphobia and negative identity experiences are more likely to hinder the formation of a solid sexual identity foundation. Two articles discussed in this chapter implemented findings to highlight the importance of a bisexual community for bisexual people's identity development, implying that a strong sense of community and belonging reduces experienced biphobia, strengthening bisexual people's sexual orientation identity development (Flanders et al., 2016, 2017).

Chapter IV discusses how biphobia and discrimination within religious affiliations impact the intersectionality between one's bisexuality and religious identity. Different literature was reviewed to inspect how experienced biphobia/homophobia and harmful stereotypes within a religious affiliation weakened a cohesive relationship between sexual and religious identities. Barnes and Meyer (2012) found that participants who attended non-affirming affiliations were associated with higher internalized homophobia, and they also found that when internalized homophobia was controlled in their analysis, attendance in non-affirming religion became a stronger predictor of both mental health factors in the positive direction. Although these findings did not explicitly address this author's research question, Barnes and Meyer (2012) supported that attending non-affirming religious affiliations increased internalized homophobia in sexual minority participants. These results imply a possible reason why LGBTQ+ people participate in organized religion less and are likely to abandon their religion or beliefs (Barnes & Meyer, 2012)

since the results from their study specifically highlight how there is a likelihood that internalized homophobia will likely suppress the “positive effects” religion may have on mental health and illustrate how the “negative effects” (p. 9) of religion may result in increased internalized homophobia based on their participants’ responses.

Likewise, Moscardini et al. (2018) showed that expectations of rejection and internalized biphobia were significantly associated with life meaning (a protective factor commonly linked to religious values and belief systems), and the participants who reported high religiosity reported decreased life meaning when they reported experiencing more biphobia. Again, although Moscardini et al. (2018) did not directly address that increased biphobia likely results in a non-cohesive relationship between sexual identity and religious identity, their findings help infer that because bisexual people who reported high levels of religiosity and experienced biphobia in their house of worship, resulting in a declined life meaning (converted into a risk factor instead of a protective factor), is another possible reason why LGBTQ+ people abandon their belief systems.

Szymanski and Carretta (2019) supported this author’s hypothesis. Findings such as psychological distress increased, and overall well-being decreased when religious sexual stigma increased. Thus, sexual minority participants who reported a strong religious identity reported increased internalized heterosexism, significant psychological distress, and lower overall well-being. Szymanski and Carretta (2019) essentially demonstrated how cognitive dissonance theory functions when beliefs and behaviors do not align. Although cognitive dissonance was not measured in their study, participants likely experienced dissonance between the two identities (contradiction between one’s beliefs from a religious standpoint and one’s sexual identity), thus explaining how their results interacted with the variables measured, such as participants who reported a strong religious background, reported increased internalized heterosexism and, in turn,

reported significant psychological distress and lower levels of overall well-being as they probably experienced dissonance between their religious identity and sexual identity.

Chapter V searched how biphobia impacts mental health and other areas of concern. This chapter hypothesizes that bisexual people who are victims of biphobia are more likely to have mental health problems and experience more negative life pressures than non-bisexual people. When compared to gay and lesbian people, Ross et al. (2018) discovered that bisexual people reported current symptoms as well as a lifetime diagnosis of depression and anxiety at a greater or equal proportion. Furthermore, compared to the heterosexual and gay and lesbian groups, bisexual people have a higher risk of poor mental health; findings support this author's hypothesis. Likewise, biphobia was positively related to a higher prevalence of mental health and drug use concerns; as experiences with biphobia progressed, symptoms of anxiety and depression rose. Biphobia was associated with a higher risk of using alcohol, nicotine, and non-medical prescription medications across all drug types in the previous 3 months (Smout & Benotsch, 2022). Other findings include Katz et al. (2023), which showed a significant positive relationship between biphobia and suicide ideation at the 1-month follow-up session. Katz et al. (2023) also noted that experienced biphobia and low protective factors increase the risk of suicide among bisexual people. Last, Turell et al. (2018) discovered that bisexuals who reported experiences with biphobia and infidelity (actual behavior, not the stereotype) reported higher composite abuse scores, implying that increased biphobia and infidelity in the relationship resulted in higher rates of IPV.

The sixth chapter identifies protective variables and evidence-based treatment therapies intended to reduce the negative consequences of biphobia. This chapter confirmed that incorporating protective factors positively correlates with enhancing bisexual identity and

general mental health improvement and wellness. In sum, Scherrer (2013) examined the types of themes that are useful in treating bisexual clients who identify challenges with biphobia as a concern of treatment. For example, understanding stereotypes about bisexuality as a product of societal norms may assist bisexual clients to evaluate bisexual stereotypes rather than accept these discriminatory views critically. As stated throughout this project, biphobia experiences frequently result in bisexual persons being marginalized, increasing the likelihood of mental health issues, interpersonal challenges, and possibly exclusion in other areas of functioning. Thus, therapeutic talks about biphobia, sexual health, interpersonal connections, professionals' attitudes and perspectives on bisexuality, and identity development are critical for maintaining cultural competency with bisexual clients in clinical practice.

Last, Brewster et al. (2013) examined the relationships between minority stressors and mental health agents (i.e., bicultural self-efficacy cognitive flexibility) on psychological distress and well-being outcomes, specifically, findings regarding cognitive flexibility and how it facilitated the interaction of antibisexual prejudice with psychological well-being, the linkage of antibisexual prejudice with stigma beliefs, and the indirect connection of antibisexual prejudice with distress and well-being via the mediated impact of stigma expectations. With limitations, these moderation results found in the study were consistent with cognitive flexibility's suggested protecting role. A primary limitation Brewster et al. (2013) discussed is that findings demonstrated that some of this buffering impact of cognitive flexibility is depleted in the context of significant experiences with antibisexual prejudice. Although these findings only partially support the author's hypothesis, significant use of cognitive flexibility did significantly buffer encounters with stigma at low levels of antibisexual discrimination in terms of enhanced well-being and lower psychological distress.

Limitations

This study focused on understanding bisexuality and discussing the negative consequences of experiencing biphobia on sexual identity, its impact on the intersectionality of sexual identity and religious identity, and the adverse outcomes on psychological well-being and other areas of clinical concern. In addition, this study addressed how implementing evidence-based clinical therapies to promote protective variables buffers the adverse outcomes of experienced biphobia. One of the main limitations of this study is that although within the last 20 years, research on biphobia and bisexuality has increased (McInnis et al., 2022), there is a continued gap in the literature on bisexuality because many researchers who examine LGTBQ+ experiences include bisexuality within the same-sex setting without distinction that bisexuality is a distinct sexual orientation (Paul et al., 2014). The authors (Paul et al., 2014) also underlined that gay and lesbian people have been studied “both theoretically and empirically” (p. 452), hence boosting clinical understanding and improving client treatment. However, bisexuality is sometimes described as an undetectable sexual orientation (Ross et al., 2018). Thus, more research on bisexuality is needed to improve the understanding of bisexuality and biphobia to improve clinical treatment with this population. Moreover, although cognitive flexibility did significantly buffer encounters with stigma at low levels of antibisexual discrimination in terms of enhanced well-being and lower psychological distress, results were limited when considering cognitive flexibility when high levels of antibisexual discrimination are significant. Because cognitive flexibility is not the only protective factor against high levels of biphobia (though clinicians can still rely on cognitive flexibility interventions to aid against some experiences of biphobia), future researchers should continue to explore protective factors when treating clients with significant amounts of biphobia to improve their well-being.

Another limitation of this study is that specific literature did not directly address this author's research questions due to the variables being closely related but not directly addressing the variables being explored in this study, such as direct links between biphobia and sexual identity and biphobia and impact on sexual identity and religious identity. Some of the articles reviewed discussed homophobia and its impact on sexual identity instead of biphobia and its impact on sexual identity. Although homophobia encompasses minority stressors experienced in all sexual minority groups, biphobia is the variable that this author wanted to research as it is the experience solely unique to bisexual people. As mentioned before, the exploration of homophobia is grouping the bisexual experience with other sexual minority experiences, not encompassing the minority stressors unique to bisexuality. In addition, although still important to include for scientific knowledge, variables such as life meaning, RSS, and themes to increase competency when working with bisexual people were not factors researched for this project. Nonetheless, these variables that were not specific to this study did explore links between biphobia and its impact on sexual identity and religious identity indirectly. In addition, the themes discussed in Chapter VI bring attention to the themes that can aid in the improvement of multicultural competency among clinicians when working with bisexual clients.

Also, the existing sexual identity models, including D'Augelli's model of lesbian, gay, and bisexual identity development and the Cass identity model, combine bisexual experiences into gay and lesbian experiences, which, again, are entirely different experiences that ongoing research continues to demonstrate. Thus, when sexual identity is discussed in the literature, the current identity models continue to consolidate the identity of bisexual folks into stages of sexual identity development that may not always apply to bisexual people, not providing an accurate

description of how unique challenges among bisexual folks truly impacts their sexual identity development.

Clinical Implications and Recommendations for Future Research

This project investigated a gap in the literature, showing the need for additional research and study in this area. Continued research on biphobia and its adverse impact on the intersectionality of identities, sexual identity, mental health, and other areas of clinical attention is essential because it is likely that in clinical settings, clinicians are probably not utilizing the competency skills needed to treat bisexual people. Also, clinicians are probably not addressing the unique challenges that bisexual people experience, such as sexual orientation instability, doubt over identity, and rejection from others, or exploring how biphobia from the heterosexual, gay, and lesbian communities impacts bisexual folks. Clinicians may also not discuss with their bisexual clients their experiences with systemic bisexual invisibility, including erasure within other identities such as religious affiliation, political associations, gender, ethnicity, race, age, disability, and other groups and impacts on their psychological and overall well-being. Therefore, clinicians are probably not assessing or considering multicultural factors and challenges, including systemic bisexual invisibility, when conceptualizing or providing diagnostic skills to implement proper treatment plans with their bisexual clients.

A recommendation for trainees and current clinicians is engaging in broaching approaches to set the stage for competency on bisexuality and biphobia. Broaching is the clinician's effort and ability to discuss racial, ethnic, cultural, and identity issues relevant to the client's presenting concerns (Day-Vines et al., 2021). Broaching aids the following developmental domains: 1). Examine our (therapist) attitudes, biases, and assumptions of the world and people. 2). Understand our client's worldview. 3). Consider our differences (therapist

and client) and how these differences influence the therapeutic relationship. 4). Allow therapists to develop individual and/or community advocacy interventions. The stages of broaching would consist of the following steps: Joining, assessment, preparation, delivery, and collection of additional information to guide treatment (Day-Vines et al., 2021). Questions or phrases that clinicians can use to their clients could include the following:

1. What messages did you grow up with regarding sexual orientation?
2. What messages did you hear regarding bisexuality?
3. How do you define your bisexual identity?
4. I was hoping you could share with me some of your strengths or allies that help you navigate challenging experiences with biphobia.
5. What experiences with biases or stereotypes about bisexuality have you been exposed to? With family? Friends? Partners? With medical and mental health providers?
6. Have you experienced challenges navigating other identities that may not align with others? For example, what are your experiences as a bisexual man, transperson, or woman? How do you navigate a religious identity or spirituality as a bisexual person? How do you navigate being a BIPOC bisexual person?
7. What has been your experience within the LGTBQ+ community? In the heterosexual community?
8. Do you think some of your presenting concerns (i.e., symptoms associated with anxiety, depression, eating problems, suicidal ideation, interpersonal conflict, substance use, or other concerns) are related to experiences with biphobia? A

sense of not belonging? Or different experiences with the invalidation of your bisexuality?

9. Have you experienced any traumatic events, such as unwanted sexual contact, intimate partner abuse, or verbal or emotional abuse, because of your identity as a bisexual person?
10. How do you feel working with a clinician who identifies as (i.e., any identity that may be relevant to a reparative experience, such as an affirming self-identifying Christian clinician)?
11. I want to acknowledge that I have the privilege of being a heterosexual person living in a heteronormative society. Please feel comfortable with correcting me if I ever make you feel invalidated or make any statements that may sound insensitive, as I am trying to learn and understand your experiences with oppression, biphobia, or other challenges with the current sociopolitical climate in the states.

Another proposal from this author is that researchers could include the creation of a survey to measure competency and assess the assumptions or misconceptions that clinicians or trainees are utilizing in clinical practice when working with bisexual clients. In addition to this recommendation, continued advocacy for the development of a bisexual identity model would benefit the guidance, conceptualization, and provision of competent care to bisexual clients. Clinicians could start implementing the Bisexual Identity Inventory (BII), as data provided by Paul et al. (2014) noted that this inventory provides preliminary evidence supporting the use of the BII to measure facets of bisexual identity.

This project brings together research on bisexuality and biphobia among the bisexual population to consider how minority stressors specific to bisexual people impact sexual identity and highlight the importance of implementing sexual-identity-affirming practices into clinical treatment plans. Also, the data in this project intend to help professionals evaluate the prevalence of mental health concerns and other areas of clinical attention among bisexual clients, to implement clinical modalities, and to increase and include cultural competencies that might help reduce the stigma surrounding bisexuality. In addition, this author hopes that professionals will understand how cognitive dissonance plays a role in the intersectionality between bisexuality and religious affiliations, such as clinicians knowing that cognitive dissonance is likely to occur for self-identified religious bisexual people because their religious beliefs and church community views on same-sex relationships do not align with their sexual identity. Therefore, clinical treatment can include interventions that reduce cognitive dissonance experienced in bisexual people by helping minimize or eliminate dissonant cognitions, introducing congruent cognitions, or minimizing the significance of dissonant cognitions (Festinger, 1957). Also, the discussion on evidence-based practices and protective factors to strengthen bisexual identity and overall wellness may help clinicians analyze and treat their clients, mainly by emphasizing client strengths and creating skills and supports that help them overcome obstacles. Also, data suggested by this author intended to increase options that professionals can use or implement other treatment alternatives with their clients effectively.

Furthermore, emphasizing evidence-based treatments while emphasizing multicultural competent care may assist clinicians in exploring how they include cultural and minority stress theories in their conceptualization and treatment planning. Increasing the need for multicultural competencies in clinical work also indicates the need to use clinical judgment with clients to

include cultural values, belief systems, family dynamics, and other external factors essential in the treatment of diverse clients. The emphasis on multicultural care and competence in this initiative intends to enhance communication among professionals and clients about preventative care against minority stressors, such as increasing community work and societal strategies that can assist individuals in directing their advocacy activities and how they get active in their community. This project and other research data can enlighten physicians and researchers, as well as the community, on the types of collaborations or integration of clinical work with other professionals that can impact and make a difference in how clinicians approach their work with bisexual clients.

Last, future research needs to include bisexual people of color. Most of the articles reviewed had disparities in racial and ethnic backgrounds among participants; most participants were identified as White/Caucasian. This disparity does not provide an accurate experience of bisexual people of color, in particular, how biphobia and experiences with other minority stressors related to racism and discrimination impact sexual identity, the intersection of identities (e.g., bisexual and religious identity), and the prevalence of mental health and other areas of clinical concern. In addition, how can clinicians tailor treatment to increase protective factors, such as boosting validation and implementing bi+ attitude and affirmations of one's sexual identity and various intersecting identities in therapy and increasing psychoeducation on biphobia and correct stereotypes on bisexuality in racial and ethnic minority communities to increase social support for bisexual people of color?

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