A survey of United Kingdom (UK) Bisexuals' experiences of emotional distress support
Grant Denkinson - University of Leicester & De Montfort University
Following a presentation at EuroBiReCon, the 1st European research conference on bisexuality,
Amsterdam 28-29 July 2016

Abstract

As a psychotherapist and bisexual I was concerned after reading studies showing bisexuals have worse wellbeing than others and hearing multiple anecdotes from bisexuals about poor support from mental health or counselling services.

I organised a number of gatherings to collect UK bisexuals' experiences of emotional distress support and clustered the results.

Participants wanted good therapeutic experiences and sometimes found tolerant therapists who would be with them on a sometimes confusing or distressing journey of self-understanding and acceptance. Some valued therapists who were able to work with people who could not label their sexuality.

Some experiences with Lesbian, Gay, Bisexual and Trans (LGBT) services or therapists were positive, others were not.

Bisexual clients may see multiple services over multiple episodes prompting confidentiality concerns, inappropriate psychiatric referrals, fatigue from needing to explain our sexuality multiple times and a lottery of whether a supplied therapist will be bi-friendly.

Many participants had their bisexuality treated as pathological, as a symptom of underlying pathology or as the cause of their problems. Therapists seemed overly fixated on looking for a cause for a client's bisexuality.

Therapist ignorance was often mentioned: Disclosing that they had never worked with a bi person, using an overly simplistic coming out model from straight to gay, being unaware of biphobia as a source of stress and incorrectly assuming all LGBT groups would welcome bisexuals.

Many bisexuals reported therapists focussing on sexuality rather than the client's chosen area of concern, sometimes showing excessive interest in a client's sexual activity. Alternatively, some therapists avoided the issue. Some challenged a client to justify or prove their bisexuality in ways that clients thought would not have happened for lesbian, gay or heterosexual clients.

Some reported experiences were gendered and/or sexist with women / women relationships being treated less seriously, bisexuality sometimes being seen as a defense and assumptions that all abuse was of women by men.

Some respondents raised important intersectional issues around madness, race, class, religion, age and political climate.

Some participants were also in education to provide emotional support professionally and reported a lack of course and tutor time, knowledge and interest on sexuality in general and challenges in being openly bi as a learner.

While being aware of psychological dynamics affecting reports of therapy, a number of issues were commonly reported and I recommend should be addressed: Bisexuality is not an illness or logically connected with pathology. Bisexual clients should be listened to carefully and therapists should educate themselves outside of the clinic about the complexity and diversity of human sexuality. Therapists should process their own confusion or assumptions around sexuality in order to be in the right place to accompany clients on their journeys. More bisexual visibility is likely to be helpful.

Motivation

Having worked as a counsellor / psychotherapist for about ten years and having been out as bisexual and involved with bisexual community for about twenty years my motivation for this project came from two overlapping strands:

1. Reading studies showing worse outcomes for bisexuals on various measures of wellbeing compared to the general population (Semlyen et al., 2016) or to others under the Lesbian, Gay, Bisexual and Trans (LGBT) umbrella such as lesbians (Colledge, Hickson et al., 2015).
2. Hearing many first-hand stories of bisexuals having had bad experiences with professionals they had gone to for support.

Method

My plan was simple: collect and organise experiences from bisexual service users and pass them on to improve future therapeutic practice.

1. Find bisexual service users
2. Hold accessible meetings
3. Listen to bisexual service users
4. Look for common themes
5. Inform training and community

I facilitated a workshop session at BiCon, the UK national bisexual get-together held in Nottingham in 2015. BiCon has been running since 1984 and modern BiCons run annually organised by different volunteer teams each year in different parts of UK. They tend to offer a residential experience over a few days with discussions and workshop sessions as well as entertainment and space for informal socialising (Bowes-Catton et al., 2011) I also ran focus groups with the bisexual groups in Swansea and Cardiff.

I introduced myself and the session including confidentiality ground rules and then allowed discussion to flow and took notes, occasionally facilitating by asking a few open questions or checking if people who had not spoken so much wanted to contribute. I also brought paper and pens so people could contribute more anonymously by putting handwritten notes in a bag for me to read later. A couple of people spoke to me of their experiences after the sessions.

After all of the sessions I typed up my notes and any written contributions and then organised them into thematic clusters which I report on below.

There were limitations to this work:

I did not undertake an exhaustive literature search so there may be areas of overlap with other studies that could be compared.

My sample size n of about 80 was small compared to the population of bisexuals. A larger sample would provide more robust results.

My participants were self-selected and the three sessions were in two countries, England & Wales. Different experiences might be reported from a geographically more diverse sample and this work does not purport to have recruited a representative or random sample.

While I was clear that the meetings were not for therapy, the issues we spoke about were often highly personal and so disclosure depended on participants trusting me and everyone else in the group. I felt that being a known member of bisexual community was helpful but a different researcher may well access experiences not shared with me.

I was deliberately broad when I spoke of bisexuality, not gatekeeping by self-identification, attraction or behaviour. I note that some participants identified themselves as bisexual, some used other terms such as pansexual or fluid or preferring not to pick a single

label and in most cases did not describe their sexuality. Some preferred to use one word but defaulted to bisexual or gay instead since for example pansexual always got, "what's that."

I chose not to collect demographic data to reduce paperwork in sessions and to minimize further feelings of exposure. Most but not all of the participants I saw as white and there were a mix of people I knew were identified as men, women and some of non-binary gender.

I also used a broad meaning of emotional support services to encompass counselling, psychotherapy, psychiatric services and helplines at least. I did this expecting that many of the issues would be similar across services and could be differentiated by further research. Also, in my experience clients can find the boundaries between different disciplines arbitrary and can drop between the cracks between services. I did not want to reproduce that dynamic and miss out vulnerable people.

I use the phrases mental health services, counselling, emotional support services and therapy quite interchangeably for this paper although I think there can be much useful conversation on how they are similar or differ and how each works with bisexual clients.

Results

The first thing I want to report on is that I found much hope and desire for a good therapeutic relationship. Even when people had missed out on good therapy they still held a reasonable ideal for what therapy should be like.

While I was focussing on professional services some support comes from friends and community. "We find each other," said one participant. Another said they see a professional one hour per week, their friends ten hours per week. "We look after our own. But if rural?"

Some participants spoke about LGBT specific services or counsellors who identified as gay or were situated under a gender and sexuality diversity umbrella: Some therapy experiences were good and others were not. LGBT services and people can provide good services to bisexuals but it would not be safe to assume that they all do.

Participants reported some good experiences of therapy or emotional support:

Some people were happy to have an open, tolerant therapist and being helped on a journey to understand and accept oneself. Some clients were in a state of distress and confusion over their life and sexuality and were helped by a therapist who would "be with" them at that time. A couple of people mentioned not always being able to find words to describe their situation or self. They valued a professional who could be helpful and supportive while helping them to either discover useful language or decide that words and labels did not need to be found urgently. Some choose not to label their sexuality, "If you put yourself in a box, you stunt who you are."

Clients often used multiple services and through multiple episodes: Sexual health clinics, general practice doctors, student support staff, psychiatric services, counselling or psychotherapy in private practice, National Health Service (NHS) counselling and others were mentioned.

When using services many people reported lacking choice in who they saw; Whether they saw someone good with bisexuality was a lottery, "How many before someone good?" Provision was sometimes inadequate with long waiting lists, "could be dead by then."

People had confidentiality concerns: if they came out about something to one professional would that go on their medical records and who would be able to see them? "A long-term worry"

Explaining bisexuality many times was fatiguing as bi people were met by a number of different people each time they accessed a service or were passed between services. "I was

never asked if I was Bisexual, like most people they just assumed I was straight. And when it does come up, they always assume I have issues with it."

Partners and other loved ones of bisexuals may also be distressed, "we can find no support for my wife as the spouse of a revealing bisexual."

Some bi people felt they had been inappropriately referred: for example being told that the pain they had presented with was in their head and did not have a physical cause. A woman with endometriosis was told by her doctor that it was because she was bi and therefore sleeping around and promiscuous. Being bisexual they were seen as needing psychiatric help or as crazy and untrustworthy about their own experiences.

One cluster of experiences was therapists focussing overly much on cause and effect of bisexuality or pathologising it rather than working on what the client chose to bring. These experiences could be reported in four strands:

- Bisexuality is the client's problem and should be focussed on, regardless of what the client would prefer to focus on.
- Bisexuality is a cause of a client's problems. For example, a woman was told that if she chose a single gender for partners rather than being open to people of various genders then her anxiety would go away.
- A client's problems cause their bisexuality. For example, not being able to attach to a stable object person left bisexuality as a symptom or a fear of men led to a defense of being attracted to women.
- The cause of someone's bisexuality could and should be found: A client was told she was bisexual because of having been abused. In our groups we agreed we were unlikely to see a therapist propose to look for the causes of heterosexuality. One was asked, "Why are you like this?"

Another cluster of experiences I'll boldly categorise as ignorance and led to some discussion of what basics a counsellor should know from their training before working with clients with a diverse range of sexualities and what they should do when faced with a gap in their knowledge or emotional self-regulation:

- "Staff don't know what to do."
- There were therapists reported as saying to their client that they had never met a bisexual person before after perhaps 20 years experience. This seems statistically unlikely and perhaps could be more down to creating the conditions in the therapy room and in wider society where coming out would feel safe enough to do if relevant. While there is ongoing debate about therapist self-disclosure, we noted that some bisexuals do feel isolated and do not know other bisexuals and having this "weirdness" seemingly confirmed by a therapist could be upsetting.
- Some therapists appeared to be working with a simple model of coming out from straight to gay and actualization following. Our joint experiences and knowledge of bisexual lives would suggest a more nuanced model of growth and openness might be better suited to our realities.
- Some therapists seemed unaware of biphobia as a significant stress in bi life. Homophobia in society seemed better known as a source of micro or indeed macro aggressions. Attacks specifically about bisexuality including from so-called LGBT community were known by bisexuals to hurt but were out of therapist awareness.
- Some therapists seemed to also have a simple answer to isolation in suggesting LGBT community groups to bisexuals. While some such groups are bi friendly and inclusive, others are not in our experience. This might parallel the situation of a gay person needing to check out if a mainstream group were gay friendly or not rather than assuming it would be.
- "Stop making us feel we are confused - we're not - you are."

Some ways of working with bisexuals were reported and challenged:

- Some people felt their therapist directly challenged their bisexual identity, feelings or experiences. They felt their therapist was presuming to know better than the client. A therapist, "should be there to support you."
- A client said their counsellor was the first person they had come out to and this trust and milestone was insufficiently honoured.
- While straight clients and to an increasing level gay or lesbian clients were accepted, bisexuals had to prove and justify our bisexuality.
- Some clients reported their therapists kept focussing on their sexuality and were inappropriately intrusive about what sex acts the client enjoyed and how.
- Others reported therapists taking a position too far in the opposite direction: avoiding bisexuality as a topic because the therapist was uncomfortable with it. A college counsellor on being told by a student they were bi responded with, "why tell me?"

Some reported experiences were gendered and/or sexist:

- Woman / woman relationships were treated as less serious and important than relationships with men.
- Some clients were challenged that their attractions to more than one gender were down to denial or fear of women or of gayness.
- There was an assumption that all abuse was of women by men.

Some respondents raised important intersectional issues:

- Being bi or having a mental illness makes you untrustworthy in some people's eyes and having both made you highly untrustworthy, "he's nuts, he's lying."
- Bisexuals and mad people are both figures of fun in society and so neither get their issues considered seriously. People who identified as both bi and mad felt there were clear parallels in how they were treated and the combination was particularly difficult.
- Race and class were very important to participants where they were working class, non-white or both and religious families were mentioned as problematic in ways that would be difficult to resolve.
- Age made a significant difference:
 - Society and professions were better at accepting gay people etc. now. Some older people had a history of being subjected to legally and more societally sanctioned homophobia. One man said he chose jobs which had anti-discrimination rules before they were legally required and appreciated his union.
 - Younger people might have their sexuality discounted as a phase or less serious. An older participant was told, "they're too old to have feelings of bisexuality."
 - Words have changed meaning, "I hate LGBT, we used to use queers [inclusively]", "rainbow community was softer", "all the work."
- More young people are rejecting labels in our experience and knowledge. This could be liberating or make it harder to find others with similar experiences or desires.
- The wider political environment was mentioned. Some older participants said it was, "Harder under the Tories [The UK Conservative political party]" and picked this out having lived under previous conservative administrations.

Some participants had experiences both as clients and in therapy training:

- Some theory pathologises bisexuals. We noted older Freudian theory on polymorphous perversity and ideas of normal heterosexual development and deviance.
- There was unanimous reporting from our meetings that courses spent little time on any aspect of human sexuality and bisexuality was often missed out completely.

- Some tutors seemed uninterested or uninformed about bisexuality and would shut down discussion of it.
- Being openly bisexual in class could mean one was challenged by classmates or tutors.

Conclusion

As a therapist I am aware when I hear reports of experiences in therapy that there will be interpersonal and intra and inter-psychic dynamics in play in the co-created space with therapist and client. I am aware that processes of splitting, projection, denial and the like mean that as well as reported issues there may be much going on out of awareness. I know that appropriate timing and amount of challenge or self-disclosure is a common individual professional discernment as well as a debate within schools of counselling.

That said, in the groups I convened and facilitated some issues around bisexuality came up often and could be triangulated to point to trends in professional training and practice.

I have a few suggestions:

I assert and think I have reasonable backing that: Bisexuality isn't an illness, doesn't cause illness & isn't a symptom of illness.

I want therapists to listen and accept our experiences as bisexuals, follow our language use and work on the issues we choose. "Use my language."

A professional therapists we need to deal with our own issues. "What a proper counsellor should do," as one participant said. If we have a big emotional response to parts of our work around bisexuality then we need to understand that, say, feelings of confusion are ours, not our clients, and we need to resolve them enough to work with cultural competence or make appropriate referrals. Therapists need good education on bisexuality formally or otherwise. It is unreasonable to put our clients in the place of unpaid tutors.

We should expect humans to be complex and dynamic in sexuality as we do in other areas. All humans should be supported, regardless of their sexuality or how it might change over time. "It is hard to explain, predict, any part of you including sexuality."

Once bisexuality is seen more, in general and amongst therapists, it will probably be more understood and accepted.

I hope that readers will process their own thoughts and feelings about what I report here and my opinions on the matter and then we will be able to focus more on giving good professional support for bisexual people in emotional distress as individuals within our unique environments and move past stereotypes, ignorance and confusion.

Funding

Funding from the social entrepreneurship fund UnLtd from HEFCE and University of Leicester paid for travel, enabled access for participants such as being able to secure physically accessible venues, offering to reimburse local travel costs and getting interpreters for deaf participants or those using a language I do not speak such as Welsh. Funding allowed events to be advertised more widely and will finally be used to ensure results are communicated effectively to therapists and those who help educate us.

Acknowledgments:

I would like to thank my funder: UnLtd from HEFCE and University of Leicester. I appreciate professional consultation and support from Sandra Hopkins, Senior Lecturer, Centre for Work Related Studies - Professional Development, University Of Chester.

My focus groups happened due to the volunteers who organised BiCon 2015 and the organiser of Bi Cymru/ Wales – The All-Wales network for people attracted to more than one gender and people who think they may be bi. Thank you to Bi Community News (2015) and the online resource The Bisexual Index <www.bisexualindex.org.uk/> for helping publicise this work. My supervisor Patricia Whitworth helped me refine my thoughts.

Finally and most importantly, thank you to the many people who shared their personal experiences in order to help others in the future.

About the author:

Grant Denkinson works facilitating open access to research publications and data at the David Wilson Library, University of Leicester. He also offers counseling / psychotherapy in private practice and in student support at De Montfort University.

References:

Bi Community News (BCN) (2015)

Bowes-Catton, H., Barker, M., & Richards, C. (2011). 'I didn't know that I could feel this relaxed in my body': Using visual methods to research bisexual people's embodied experiences of identity and space. In P. Reavey (Ed.) *Visual Methods in psychology: using and interpreting images in qualitative research*. pp.255-270. London: Routledge.

Colledge, L., Hickson, F., Reid, D. and Weatherburn, P. (2015) "Poorer mental health in UK bisexual women than lesbians: evidence from the UK 2007 Stonewall Women's Health Survey," *J Public Health*. Oxford University Press (OUP). doi: 10.1093/pubmed/fdu105.

Semlyen, J., King, M., Varney, J. and Hagger-Johnson, G. (2016) "Sexual orientation and symptoms of common mental disorder or low wellbeing: combined meta-analysis of 12 UK population health surveys," *BMC Psychiatry*. Springer Science + Business Media. doi: 10.1186/s12888-016-0767-z.