The Bisexual Client: Trauma-Focused Care

HOW TO RECEIVE CREDIT

- Read the enclosed course.
- Complete the questions at the end of the course.
- Return your completed Answer Sheet to NetCE by mail or fax, or complete online at www.NetCE.com. Your postmark or facsimile date will be used as your completion date.
- Receive your Certificate(s) of Completion by mail, fax, or email.

Faculty

Jamie Marich, PhD, LPCC-S, REAT, RYT-500, RMT, (she/they) travels internationally speaking on topics related to EMDR therapy, trauma, addiction, expressive arts, and mindfulness while maintaining a private practice and online education operation, the Institute for Creative Mindfulness, in her home base of northeast Ohio. She is the developer of the Dancing Mindfulness approach to expressive arts therapy and the developer of Yoga for Clinicians. Dr. Marich is the author of numerous books, including *EMDR Made Simple*, *Trauma Made Simple*, and *EMDR Therapy and Mindfulness for Trauma Focused Care* (written in collaboration with Dr. Stephen Dansiger). She is also the author of *Process Not Perfection: Expressive Arts Solutions for Trauma Recovery*. In 2020, a revised and expanded edition of *Trauma and the 12 Steps* was released. In 2022 and 2023, Dr. Marich published two additional books: *The Healing Power of Jiu-Jitsu: A Guide to Transforming Trauma and Facilitating Recovery and Dissociation Made Simple*. Dr. Marich is a woman living with a dissociative disorder, and this forms the basis of her award-winning passion for advocacy in the mental health field.

Faculty Disclosure

Contributing faculty, Jamie Marich, PhD, LPCC-S, REAT, RYT-500, RMT, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

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The division planners and director have disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Audience

This course is designed for behavioral and mental health professionals of any kind who work with clients on a regular basis or who teach/supervise those working with clients who identify as bisexual or non-binary.

Accreditations & Approvals

As a Jointly Accredited Organization, NetCE is approved to offer social work continuing education by the Association of Social Work Boards (ASWB) Approved Continuing Education (ACE) program. Organizations, not individual courses, are approved under this program. Regulatory boards are the final authority on courses accepted for continuing education credit.

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A complete Works Cited list begins on page 31.

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Designations of Credit

Social workers completing this intermediate-to-advanced course receive 5 Clinical continuing education credits.

NetCE designates this continuing education activity for 2.5 NBCC clock hours.

NetCE designates this continuing education activity for 5 continuing education hours for addiction professionals.

Individual State Behavioral Health Approvals

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About the Sponsor

The purpose of NetCE is to provide challenging curricula to assist healthcare professionals to raise their levels of expertise while fulfilling their continuing education requirements, thereby improving the quality of healthcare.

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Course Objective

The purpose of this course is to provide members of the interdisciplinary healthcare team with the knowledge and resources necessary to improve the care provided to bisexual or sexually fluid individuals.

Learning Objectives

Upon completion of this course, you should be able to:

1. Define bisexuality using several well-accepted definitions in the LGBT+ literature.
2. List and briefly define other identifiers generally described as non-binary that often get discussed alongside bisexuality.
3. Identify concerns unique to bisexual clients.
4. Discuss the concept of trauma and oppressive cognitions in LGBT+ clients and explain how such cognitions can complicate recovery for bisexual clients.
5. Articulate a basic trauma-focused treatment strategy for working with bisexual clients.
6. Evaluate one's own personal biases surrounding bisexuality and working with bisexual clients.

Sections marked with this symbol include evidence-based practice recommendations. The level of evidence and/or strength of recommendation, as provided by the evidence-based source, are also included so you may determine the validity or relevance of the information. These sections may be used in conjunction with the course material for better application to your daily practice.

INTRODUCTION

There is an increasing interest in the health and human services professions to better serve lesbian, gay, bisexual, transgender, and other gender/sexual minority (LGBT+) individuals. At conferences, sessions on serving LGBT+ populations are more commonplace, usually justified under the conference's commitment to meet multicultural and diversity competencies. Organizations dedicated to promoting awareness of LGBT+ issues within clinical and public health settings are more visible than they were a generation ago. Yet two significant problems remain. First, many clinical organizations, from treatment settings to private practices, will declare that they specialize in working with LGBT+ clients because there is someone who identifies as LGBT+ on staff. Even worse, they may declare this competency because one or more staff members describe themselves as tolerant or liberal. A second major problem is that, despite the visibility, many courses and advocacy activities described as LGBT+ only focus on the gay or lesbian experience.

The LGBT abbreviation first came into use in the 1980s, and since then, criticism abounds that both the B (bisexual) and T (transgender) perspectives have been widely silenced. Although some general patterns connected to health care, mental health, and addiction recovery needs are ubiquitous throughout the larger LGBT+ community, the people represented by each individual "letter" have their own unique needs and perspectives that should be considered. In newer usage of the term, the plus (+) symbol has been added to include even more sexual or gender identity minorities who are seeking to find community and recognition in a heteronormative world. Intersex (formerly called androgynous or hermaphroditism), questioning, queer, and asexual individuals can all now be included under the growing scope of the LGBT+ community.

The purpose of this course is to give specific voice to the bisexual experience and to highlight the needs of bisexual clients presenting for clinical services. While there have been a variety of informal polls describing how Americans identify, some of the reputable polling organizations (e.g., Gallup) have measured the LGBT+ identifier as one population and the percentage of bisexual individuals in that group. Data from 2021 indicate that 7.1% of Americans identify as part of the LGBT+ community and that 57% of those identify as bisexual [1]. A 2011 report published by the Williams Institute at the UCLA School of Law indicated that, of the total U.S. adult population, 1.7% identified as either gay or lesbian and an additional 1.8% of the total U.S. adult population identified as bisexual (with women comprising the vast majority of bisexuals) [2]. While these percentages have increased in the past decade, the ratio of gay or lesbian to bisexual has remained similar. When taking this reported data into account, one can assert that the population of bisexuals in America is slightly greater than the number of gay men and lesbian women combined.

The chances are very high that, as a clinical professional, you have worked with a bisexual client. If you have not yet, you very likely will encounter such a client in the future. The goal of this course is to provide a basic knowledge and appreciation of bisexual clients' experiences and needs. At best, this article may empower you to further your competence in working with bisexual clients and providing them with the appropriate clinical services that they need while linking them with other resources available in the larger community.

FOUNDATIONS: IDENTIFYING BISEXUALITY AND RELATED DEFINITIONS

DEFINING BISEXUALITY

The American Institute for Bisexuality, formerly called the Klein Institute, was founded by Dr. Fritz Klein, a pioneer of bisexual visibility, in 1998. The Institute's mission is to educate the public, including human service professionals, about the needs of those who identify as bisexual. The Institute also seeks to promote and fund research on bisexuality and to engage in public discourse on bisexuality and issues of sexual identity. In his book, *The Bisexual Option*, Dr. Klein offers a set of concepts to describe bisexual identity and the bisexual experience [3]. In essence, a bisexual person has the capacity for romantic and/or sexual attraction to more than one gender. For most people, this means they can be attracted to both men and women. If one honestly feels he or she meets this criterion, then he or she is bisexual.

It is important to remember that bisexual persons are not required to feel the same kind or intensity of attraction to all genders. There is nothing for bisexual persons to prove, nothing to consummate, and no requirement to "maintain" their bisexuality. Understanding and acknowledging one's sexuality is a personal process and is about living with integrity and being true to oneself.

Bisexual and other non-binary sexual identity advocates have long embraced the Klein definition for its inclusivity and lack of emphasis on labels, categories, or boxes. The well-known Kinsey Scale was a step in the right direction, offering a continuum (on a scale of 0 to 6) as a measure for describing sexual identity (0 being exclusively heterosexual and 6 being exclusively homosexual, with various degrees expressed in between). However, Klein found the Kinsey scale too limiting and developed his own alternative—the Klein Sexuality Orientation Grid (KSOG), a more nuanced measure of the fluidity and complexity of sexual orientation (***Table 1***). The KSOG takes seven key variables into account—sexual attraction, sexual behavior, sexual fantasies, emotional preferences, social preferences, heterosexual/homosexual lifestyle, and self-identification (which can include sexual identity and political identity)—and recognizes that a person's preferences may change over time. According to Klein, recognizing that sexual orientation is an ongoing dynamic process is necessary in order to understand a person's orientation properly in its entirety [3]. After completion of the KSOG, a point score is issued that gives some insight into where an individual falls on the continuum (21 being exclusively heterosexual and 147 being exclusively homosexual), with more specific findings than the Kinsey Scale.

Professionals and bisexual advocates also cite the definition of activist Robin Ochs. Ochs was one of the first individuals to declare herself a bisexual advocate in response to the little attention she witnessed being paid to the unique needs of bisexuals in LGBT+ discussions in the 1980s. The Ochs definition of bisexuality reads as follows [4]:

> I call myself bisexual because I acknowledge that I have in myself 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.

In educating clients and clinicians about the bisexual experience, offering this definition is often a solid place to start.

KLEIN SEXUALITY ORIENTATION GRID			
Variable	**Past**	**Present[a]**	**Ideal**
A: Sexual attraction			
B: Sexual behavior			
C: Sexual fantasies			
D: Emotional preference			
E: Social preference			
F: Heterosexual/homosexual lifestyle			
G: Self-identification			

The following points are assigned for each variable for the past, present, and ideal:
1 = Other sex or heterosexual only
2 = Other sex or heterosexual mostly
3 = Other sex or heterosexual somewhat more
4 = Both sexes, or heterosexual and gay/lesbian equally
5 = Same sex or gay/lesbian somewhat more
6 = Same sex or gay/lesbian mostly
7 = Same sex or gay/lesbian only
[a]The present is defined as the most recent 12 months.

Source: [3] *Table 1*

The National Gay and Lesbian Task Force definition of bisexuality can be especially helpful for professionals new to learning about bisexuality. The Task Force notes that bisexuality is not an extension of homosexuality, and bisexuality does not require both male and female partners [5]. Behavior and identity can be, and often are, very different; a person can have a bisexual identity even if he or she is celibate or involved in a monogamous relationship with a person who identifies as gay, lesbian, heterosexual, or bisexual. Knowing whether a person identifies as heterosexual, gay, lesbian, or bisexual is not an accurate method of predicting sexual behavior.

THE GROWING LGBT+ SPECTRUM AND OTHER NON-BINARY IDENTIFIERS

Many bisexuals embrace a bisexual identity because, especially if one adheres to the Klein definition, it defies the concept of a binary. Being bisexual challenges larger societal messaging that everything must fit nicely into predetermined categories or labels. Klein commented on this phenomenon in *The Bisexual Option* [3]:

> No matter what sexual orientation a person has, he or she lives on a continuum. Despite the certainty of eventual death, the life of an individual goes on until that time. During the course of a lifetime each individual plays a number of roles: father, mother, soldier, teacher, heterosexual, homosexual, and so on. We take comfort in the labels; they help define our relationship with one another and with the world at large. Yet with each label we acquire, we limit our infinite possibilities, our uniqueness. It is our insistence on labels that creates the "either-or" syndrome.

Oregon governor Kate Brown, America's first openly identified bisexual governor, described her experience of being bisexual as such: "Some days I feel like I have a foot in both worlds, yet never really belonging to either" [6]. Brown's experience resonates with many bisexual-identified individuals. Marich explained that such an identity and life experience poses a major problem when bisexuals seek clinical treatment services [7]:

> Most mainstream treatment cultures rely on labeling; some, I would argue, are even obsessed with it. Making sure that clients are described by manualized, precise diagnostic categories is a form of labeling. Adopting pre-defined treatment curriculums for our programs and requiring our clients to respond to that curriculum (instead of modifying curriculum to respond to the needs of individual clients) is a form of labeling. When a recovery culture, especially formal treatment, relies on people fitting into neat boxes, I contend that a bisexual-identified client will have a more difficult time being validated by those who are there to help them.

Part of rejecting the damaging effects of labeling and categorizing is to also recognize that people who have traditionally been described as or have identified as bisexual may no longer find that term to fully embrace their identity and their experience. A growing momentum to change the traditional LGBT abbreviation to a more inclusive LGBT+ is one way this sea change is manifesting in larger discourse. As discussed, LGBT+ is an alternative to the traditional LGBT abbreviation that has come into popular use in the 2010s as a gesture of optimal inclusion to all individuals who may identify as being part of a sexual or gender minority group; this recognizes that the abbreviation could continue to expand indefinitely as understanding about the diversity of sexual identity and gender expression evolves. A running commentary is that if the LGBT community continued to embrace all sexual identity, gender identity, or lifestyle identity minorities into the abbreviation, it would be an excessively long acronym. LGBT+ is a growing alternative to be inclusive for all persons who do not feel like they belong in the sexual identity or gender identity mainstream. Heteronormative refers to traditional norms and mores for sexual identity and expressions being assessed by the heterosexual ideal of how things should be; people who reject heteronormativity often identify with one or more descriptors embraced by the LGBT+ abbreviation.

There is also a growing movement of individuals who are rejecting the term or the label of bisexual as being too limiting. Because the nature of sexual identity is ever-evolving, many, particularly members of younger generations in the LGBT+ community, may choose less restrictive identities to challenge what it means to label and to identify. It is important that some of these identifiers be explored, as they may be more comfortable for clients. Queer is a term that has come into wider use in recent years as an umbrella term for sexual, gender, or lifestyle identity that defies heterosexual or mainstream norms. Originally used as an insult, many members of younger generations have reclaimed it as an empowering word, although those outside the community should be careful using it widely, as members of many older generations, especially gay men, still associate it as a term of insult and shaming.

Fluid is another term coming into wider use in recent years. In an open forum posed for readers, the American Institute for Bisexuality offers this useful description [8]:

> The term fluid expresses the fact that the balance of a person's homosexual and heterosexual attractions exists in a state of flux and changes over time. Usually, but not always, people who describe their sexuality as fluid are bi people whose attractions skew very heavily toward one gender. The terms heteroflexible and homoflexible add a further level of specificity, by indicating whether the bisexual person's attractions skew almost exclusively toward same-sex or different-sex individuals.

The Institute explains that the term bisexual remains the more scientific identifier for describing sexual fluidity, especially when the intricacies of Klein's work are embraced [8].

In discussing the concept of heteroflexibility, the concept of straight men who have sex with men also arises. Several research studies have been conducted on this construct of men who identify as straight and have also disclosed encounters with men that are purely recreational in nature or in response to intoxication. As with many identifiers, it is important to refrain from judgment when men disclose such behaviors (e.g., do not assume that a client is a closeted or "in denial" gay man).

The American Institute for Bisexuality also explains that newer terms such as pansexual, polysexual, omnisexual, and ambisexual are now preferred by individuals who may have traditionally identified as bisexual. They offer this very succinct explanation [8]:

> By replacing the prefix bi- (two, both) with pan- (all), poly- (many), omni- (all), ambi- (both, and implying ambiguity in this case), people who adopt these self-identities seek to clearly express the fact that gender does not factor into their own sexuality, or that they are specifically attracted to trans, genderqueer, and other people who may or may not fit into the mainstream gender categories of male and female. This does not mean, however, that people who identify as bisexual are fixated on traditional notions of gender.

The editors make an interesting link to the shifts that the larger community is making around gender identity.

Belous and Bauman conducted an academically rigorous content analysis of online content referencing pansexuality, attempting to make comparisons and contrasts between bisexual identity and pansexual identity [9]. They explore themes such as whether or not the term pansexual carries less stigma than the term bisexual (which may explain why many young people are opting for this identifier) and whether people are opting for the term pansexual because it is fundamentally more inclusive and not as binary. In an era in which wider acceptance is growing for gender fluidity and transition, such a term may be more relevant to certain experiences. Belous and Bauman challenge a long-held notion that pansexuality falls under the bisexual umbrella, suggesting that bisexuality may better be examined as a subset of the pansexual identity, and not the other way around [9].

Working with the needs of transgender clients is beyond the scope of this specific course, but it is worthy to note the similarities between the bisexual struggle and the problems with discrimination and alienation that many trans-identified individuals have experienced within the larger LGBT+ community. While bisexual individuals have often referred to themselves as the "silent B," transgender or other gender non-binary individuals have referred to themselves as the "silent T." The LGBTQIA Resource Center at the University of California, Davis, provides a succinct definition of transgender/trans/trans* [10]:

> Adjective used most often as an umbrella term, and frequently abbreviated to "trans" or "trans*" (the asterisk indicates the option to fill in the appropriate label, e.g., trans man). It describes a wide range of identities and experiences of people whose gender identity and/or expression differs from conventional expectations based on their assigned sex at birth. Not all trans people undergo medical transition (surgery or hormones). Some commonly held definitions: (1) Someone whose determination of their sex and/or gender is not universally considered valid; someone whose behavior or expression does not "match" their assigned sex according to society, (2) A gender outside of the man/woman binary, (3) Having no gender or multiple genders.

Scholarship and advocacy around trans issues have brought an additional term—non-binary—into wider use. As it relates to gender, non-binary (often stylized as ENBY) is a gender identity and experience that embraces the full universe of expressions and ways of being that resonate for an individual. It may be an active resistance to binary gender expectations and/or an intentional creation of new unbounded ideas of self within the world. For some people who identify as non-binary, there may be overlap with other concepts and identities, like gender expansive and gender non-conforming [10]. While discussions around the fluidity of gender have shaped the terminology around experiences traditionally described as bisexual by ushering in the new terminology (e.g., pansexual, polysexual, omnisexual, ambisexual), many bisexual and sexually fluid individuals are choosing to adopt the term non-binary to describe their sexual identities as well. Non-monosexual is another option being utilized, a contrast to monosexual, or having sexual attractions/feelings to only one gender.

For professionals, it is important to respect the terminology that clients choose to embrace, if they choose any terminology at all. Professionals can get overly enthusiastic about getting clients to label themselves, but part of what the bisexual movement has always been about is embracing the nuances and fluidity of human experience. Other professionals, either implicitly or explicitly, are dismissive when a client, especially a young client, comes into session using a newly evolving term in identifying themselves. For instance, many individuals who historically identified as bisexual began using the term pansexual when it came into wider use, resonating with an increasingly popular axiom that "I am attracted to hearts, not parts." When this change in terminology became more noticeable, there was commentary (from both heteronormative people and others in the LGBT+ community) about how this term was another trend or a cry for attention. As a clinician, it is paramount, in the spirit of doing no harm, to educate oneself on the evolving terminology and to respect how clients describe themselves or identify. Many reputable websites are available for the purposes of educating oneself on evolving terminology (***Resources***).

Seeking to understand the perspectives of the younger generation, Flanders, LeBreton, Robinson, Bian, and Caravaca-Morera conducted an extensive, mixed-methods study of 60 identified bisexuals and pansexuals between 18 and 30 years of age [11]. The content analyses led them to overwhelmingly conclude that, for this sample, sexual behavior is not part of the comprehensive definition. Rather, identifying as either bisexual or pansexual has more to do with attraction and recognizing the fluidity of attraction over time. They also conclude, "The data do not support the stereotype that all bisexual people conceptualize gender as binary, or view their own sexuality as binary" [11].

For the sake of continuity and editorial clarity, the term bisexual or bisexual umbrella will be primarily used throughout this course. The bisexual umbrella is a term that has been in popular use for many years, although it is now gaining more ground in the academic literature to encompass all the related identities explained in this section [11; 12; 13]. Bisexuality still being the most widely recognized, scientifically validated term is the main reason for this decision. However, it is important to honor and recognize new identifiers as being valid paths of identity that clients may use to describe themselves, and also to acknowledge each person's right not to identify or label themselves.

CONCERNS UNIQUE TO BISEXUAL CLIENTS

A significant barrier for many bisexual individuals presenting for health care or clinical care is the fear of being truthful when asked certain questions. There can be a significant fear of being judged or further marginalized, especially when questions are asked about sexual history. Many individuals withhold truthful information that, in an ideal world in which the spectrum of sexuality is largely understood, may help professionals to better serve them. Biphobia (i.e., others' fear of bisexuality and misunderstanding about bisexuals) pushes many bisexuals further into the closet. This self-imposed isolation is generally to avoid ridicule and rejection, affecting well-being and sense of identity.

A 2015 study done in Scotland found that 48% of 518 individuals surveyed described receiving biphobic comments from healthcare professionals within the National Health Service (the United Kingdom's national healthcare network). Unwanted sexual advances by healthcare professionals were reported by 38% of the respondents. What is further compelling is that 66% of the respondents felt pressure to identify as straight and 42% of the participants found that it was easier just to identify as gay when presenting for healthcare services [14].

Discriminatory messages that bisexuals are likely to receive can be further damaging when a helping professional makes them. While this will be explored later in this course, at this juncture, it is important to understand that barriers exist about being truthful with any healthcare or clinical professionals, originating from this fear of judgment, ridicule, or misunderstanding.

Bisexual individuals can have even greater struggles with depression, mental health symptoms, and suicidal ideas than individuals who identify solely as gay or lesbian. According to a 2016 study from Drexel University that included responses of 2,500 LGBT+-identified individuals between 14 and 24 years of age, bisexual and questioning girls/women endorsed significantly higher scores on the depression, anxiety, and traumatic distress subscales than heterosexual girls/women. Lesbians, bisexual females, and questioning females all exhibited significantly higher lifetime suicide scores than heterosexual females. Interestingly, bisexual females exhibited the highest current suicide scores. Gay and bisexual males endorsed significantly higher scores on the depression and traumatic distress subscales than heterosexual males. Gay males also exhibited higher scores on the anxiety subscale than heterosexual males, with bisexual males exhibiting a nonsignificant trend toward higher scores as well. The research conclusion is that LGBT+ mental health needs should be individualized, calling for specific attention to be paid to bisexual clients [15].

The findings of this article likely come as no surprise to those who have been researching bisexual mental health and social conditions for years. Research has consistently found poorer health outcomes, mental health outcomes, and poverty levels/income inequality among bisexuals when compared with monosexual peers [16; 17; 18; 19; 20].

THE TRAUMA OF THE BISEXUAL EXPERIENCE

DEFINING TRAUMA

Trauma derives from the Greek work *traumatikos* meaning "wound." Professionals and diagnosticians continue to develop labels and technical rubrics for studying trauma and its clinical manifestations. Many are well-acquainted with diagnoses like post-traumatic stress disorder (PTSD), acute stress disorder, reactive attachment disorder, and other clinical labels from the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) that generally suggest the presence of trauma. While many individuals who fall under the bisexual umbrella carry such diagnoses due to adverse life experiences, the problem with DSM-5 conceptualizations of trauma is that they are event-centric. In other words, trauma is only recognized if a traumatic incident that meets DSM-5 standards for an established condition occurred. This has created a barrier in recognizing and addressing adverse life

events that may not meet the criteria for a formal diagnosis of a trauma-related disorder but that have had a serious impact on a client's life, mental health, and well-being.

From a humanitarian standpoint, trauma may be simply defined as a wound—physical, emotional, verbal, sexual, or spiritual—whether or not a precise DSM-5 definition is met for the suffering due to unhealed trauma. In the case of physical injury, there is often an initial wound, which may appear innocuous. However, if proper treatment is not received or if that wound continues to get agitated, further problems and complications can result. With physical injury, one large wound that gets treated properly may be less of an issue for a person in the long-run than a series of cuts or scrapes that continue to fester and infect.

According to the adaptive information processing model developed by Dr. Francine Shapiro, the creator of eye movement desensitization and reprocessing (EMDR) therapy, people learn things about themselves and the world as a result of adverse life experiences and wounding. The messages that come with these learnings are internalized and can result in either an enhanced ability to adapt (e.g., "I'm a survivor") or a paralyzing belief structure (e.g., "I am defective," "I am weak," or "I am permanently damaged"). Shapiro offers an interesting definition of trauma in the 2015 update to her adaptive information processing model [21]:

> Trauma can include DSM-5 Criterion A events and/or the experience of neglect or abuse that undermines an individual's sense of self-worth, safety, ability to assume appropriate responsibility for self or other, or limits one's sense of control or choices.

In light of this definition, consider how the life experiences that LGBT+ people, specifically bisexual individuals, may qualify as traumatic, especially when the messaging that accompanies the experiences happens at developmentally vulnerable periods of life.

For many bisexuals, the messages themselves may cause the wounding, further crystallizing negative core beliefs in the limbic brain, the center of emotions and learning. These negative beliefs are also referred to as oppressive cognitions.

TRAUMA AND THE LGBT+ COMMUNITY

Any minority group, especially those traditionally discriminated against by family members, the community, faith organizations, and society at large, is extremely vulnerable to being traumatized or wounded. In some cases, these traumatic experiences are public and large, such as in the case of hate crimes, physical violence, or pointed vandalism. For each of these public experiences, there are hundreds more that have remained uncovered. Moreover, much of the wounding faced by LGBT+ persons is experienced in the form of bullying, snide comments, and spiritually abusive messages by religious leaders or parents. For members of the LGBT+ community, dismissals and invalidation of personal identity and selfhood make up a large part of their trauma histories. Many individuals who identify as LGBT+ have also been forced into "reparative therapy," or variations thereof. These damaging religious programs are used to try to force change upon the individuals and how they love and express themselves in the world. It is essential that clinicians validate these subtler, yet equally insidious, experiences as traumatic.

Two concepts that are widely discussed in the trauma scholarship over the last decade—complex trauma and developmental trauma—may further help in the process of working with any LGBT+ client.

Complex and Developmental Trauma

Complex trauma, first coined by Dr. Judith Hermann in 1992, refers to conditions of prolonged trauma or trauma that occurs at developmentally vulnerable times for an individual. Courtis and Ford describe complex traumas as having the following characteristics [22]:

- Repetitive or prolonged actions or inaction
- Involving direct harm and/or neglect or abandonment by caregivers or ostensibly responsible adults
- Occurring during developmentally vulnerable times in the victim's life, such as early childhood
- Great potential to severely compromise a child's development

Other scholars have made use of the term developmental trauma to specifically describe the role that trauma and adverse life experiences during early childhood development can play in personality development, behavior, and affect [23].

Complex trauma/PTSD and developmental trauma have emerged as constructs seeking to fill the gap between the event-centric diagnoses that appear in the DSM-5 (and previous versions) and the reality of how many survivors experience trauma. Developmental trauma is often compared to the slow drip or water torture experience of little bits of insult, degradation, and dismissal that happen each day, accumulating over time. This includes experiences like constantly being insulted by people close to you for something that cannot be helped—like who one is attracted to, how one loves, and how one sees oneself in the world. The impact of these experiences, and the messages that accompany them, can toxically accumulate over time. If left unhealed or unprocessed, mental health and various other social problems (e.g., unemployment, instability in relationships, disconnection from community/society, spiritual identity crisis) can result.

The Human Rights Campaign (HRC) conducts extensive surveys and data collections on the experiences of LGBT+ individuals in America. Their project, Growing Up LGBT in America, surveyed 10,000 LGBT+-identified youth 13 to 17 years of age [24]. According to this survey, 42% of LGBT+ adolescents say that the community in which they live is not accepting of LGBT+ individuals, and 92% of LGBT+ youth say that they hear negative messages about being LGBT+ from school, the Internet, and peers. LGBT+ youth are twice as likely as heterosexual youth to have been kicked, shoved, or physically assaulted [24].

OPPRESSIVE COGNITIONS AND THE UNIQUE CONCERNS OF BISEXUALS

The HRC conducted a follow-up survey of nearly 5,000 youth who identified as part of the bisexual umbrella [25]. According to this survey, 10% of bisexual youth report that they "fit in" in their community, with 58% believing that they will need to move away at some point to experience fulfillment. In addition, bisexual youth report having experimented with drugs and alcohol at a slightly higher rate (56%) than gay or lesbian youth (50%) and at a significantly higher rate than straight youth (22%) [25].

Bisexual youth who participated in this survey reported the following experiences of how their sexuality is misunderstood by others, as expressed in messages that are very common to the bisexual experience overall [25]:

- "I wish that more people inside the gay community itself would support my decision to call myself bisexual. I am not being selfish. I am not a liar. I am not gay. I am not straight. I am bisexual."
- "As a bisexual, I feel shunned by the gay and lesbian community."
- "I came out to my family, and they didn't believe me."
- "Being gay is understood in my family, but being bisexual is not."

- "The one time I brought up the issue with my mom she said that I would grow out of it. And then she ignored it."
- "I feel like if I were to come out as bisexual people would just think I am a slut."
- "My parents aren't homophobic, but when it comes to me they aren't accepting at all. They say I can't be bi. I have to be gay or straight."
- "When I tell males about my sexuality I get remarks like 'that's so hot,' which I feel fetishizes my sexual orientation."
- "I'm tired of being told it's a phase."
- "I've had people tell me that my life is worthless because I'm bisexual. That I am nothing."
- "Bisexuality isn't real."
- "They just think I'm confused."
- "I would like the pressure to 'pick a side' to stop. It's very frustrating."

These statements gleaned from the HRC survey reflect many of the struggles that bisexual clients presenting for services have voiced over the years. These and similar messages reflect a reality that bisexuality is misunderstood by the public, in the context of a larger society that has traditionally been discriminatory against any sexual minority in the first place. To understand how these wounding messages can crystallize for clients who identify as being part of the bisexual umbrella, it is important to explore a newer concept in the trauma literature: oppressive cognitions.

Levis and Siniego first published the concept of oppressive cognitions in 2016. This term emerged from Levis' work as a trauma specialist/EMDR therapist and as a specialist in multicultural issues and providing culturally attuned psychotherapy. In EMDR therapy, the construct of negative cognitions, or the maladaptive messages that people receive about themselves or how they are in the world because of traumatic experiences, is critical. Levis took this a step further to suggest that when these negative cognitions or messages are received due to oppression, cultural trauma, or bias, they can crystallize more insidiously. Oppressive cognitions may be relevant to both the individual and to the specific minority group [26]. Furthermore, oppressive cognitions are sociopolitically influenced and culturally reinforced in an ongoing and insidious manner by the dominant majority and the media.

Levis and Siniego contend that treatment of oppressive cognitions requires a broadening of therapeutic focus [26]. Successful resolution depends on an acknowledgment of the impact that historic and ongoing social oppression have upon the presenting problem. For clinicians working with bisexual clients, recognizing the damaging messages that have traditionally been received by individuals identifying as part of the bisexual umbrella is paramount. While all of the messages reported from the HRC survey could apply, in this course, four specific messages are isolated for further exploration as oppressive cognitions:

- There is no such thing as bisexuality.
- Bisexual people are just confused and have not figured things out yet.
- Bisexual people use their sexuality in deviant or manipulative ways.
- Bisexual people are not really a part of the LGBT+ community.

There is no such thing as bisexuality.

The wounding inherent in this message can be received in a variety of ways. Many bisexuals and others under the bisexual umbrella hear this comment expressed by family or friends who identify as straight, but it can feel even more hurtful coming from individuals who identify as gay or lesbian. The suggestion that comes with this message, either implicit or explicit, is that identifying as bisexual is simply a step on the way to identifying as fully gay or fully lesbian. Bisexual boys/men are particularly susceptible to receiving such commentary from others. Another message that seems more tolerant on

the surface is, "Well, I just assume that everyone is bisexual. Sexuality is a spectrum, right?" The sting of invisibility can still accompany such a statement, as it suggests that how one legitimately identifies as loving in the world is "normalized" to the point of minimization.

For any of the messages that fall under the general theme of bisexuality being less than authentic, a core negative or oppressive cognition that can become installed is "I do not exist." While some bisexuals fully receive this message with power and intensity, others may also hear and internalize messages such as "How I love isn't valid," "Who I am isn't valid," and "I am invisible." Consider how many of these themes may come out in clinical work related to presenting issues like depression, anxiety, or other diagnoses in the trauma and stress disorders classification. With bisexual clients, it is imperative that professionals pause and consider how such themes may be best explained by the accumulated stress and wounding of hearing such messages about the self.

Bisexual people are just confused and have not figured things out yet.

The assumption that bisexual people are inherently confused or are simply on some path of discovery is prevalent in popular and clinical culture. While some people's sexual behavior, especially during points of developmental transition, may be described as experimental or bi-curious, it is very important that clinicians never shame individuals who are seeking to find their sexual voice or identity. While it is true that some people transition into and out of bisexual attractions and behaviors, it is vital not to assume that it is a phase for everyone who identifies as bisexual.

The oppressive cognition of bisexual confusion helps to perpetuate the myth that bisexuals are somehow the most "abnormal" of the sexual minorities and can drive home oppressive messaging such as "I am defective," "I am disgusting," "I am a disappointment," and "I am confused" as core beliefs, not just passing feelings.

In working with clients, it is useful to help them sort through how they may feel versus whether or not they have internalized negative or distressing feelings about the self. In many forms of trauma-focused therapy, such as EMDR therapy, feelings are identified as important although fundamentally transient. A client can feel like he or she is worthless, for instance, without believing at the core that he or she is worthless, especially if the feelings come and go. With oppressive cognitions, especially several of the major ones experienced by bisexuals, the belief is ingrained and impactful.

Bisexual people use their sexuality in deviant or manipulative ways.

The portrayal of bisexual characters in film and television as manipulative, deviant, or villainous is well-known. Two particular tropes recur. The first is the "emotional wrecking ball" trope, almost exclusively a woman, whose emotional instability wreaks havoc in the lives of all her monosexual (and therefore emotionally stable) friends [27]. This usually includes cheating, contributing to the social myth that bisexuals are sexually "greedy."

The second trope is of the criminally deviant bisexual. This bisexual is corrupt and morally irredeemable—often a femme fatale. At the root of these tropes is a belief that bisexuality is an event in itself; it drives the bisexual person's behaviors instead of being just one feature in a complex and multifaceted human.

The implications here for working with oppressive cognitions are clear. Negative messaging such as "I am deviant," "I am (inherently) a villain, and I will hurt people," and "I am damaged" are all examples of what bisexual clients may be carrying into their clinical work.

Bisexuals are not really a part of the LGBT+ community.

Many bisexuals describe feeling excluded from the gay and lesbian communities. Various reasons can exist for this exclusion, including fear of dating bisexuals because of perceptions that they are sexually greedy/more likely to cheat and the belief that bisexuals are really "closeted" gays/lesbians who are practicing internalized homophobia by identifying as bisexual. Bisexuals and others under the bisexual umbrella are often accused of wanting to present as sexually progressive and maybe even reaping the benefits of the fashionable aspects of gay culture without fully participating in the daily trials and social struggles of being out. These messages can internalize as oppressive cognitions (e.g., "I am defective/sexually deviant," "I am an attention monger," "I am a poser/inauthentic") and may be a part of many clients' experiences. The message that can create the biggest sting is the accusation that because bisexuals have passing privilege, they are not fully part of the LGBT+ community.

Passing privilege is a pejorative phrase suggesting that it is easier for bisexuals to "hide" in straight relationships and ultimately in mainstream society, especially compared with gay and lesbian individuals. Bisexual advocates respond to this criticism by highlighting that many people who eventually come out as gay or lesbian have also been in heterosexual marriages while they were closeted. Some marriages are a form of self-preservation to appear integrated in communities that are not fully accepting of LGBT+ people, regardless of how they may identify. To claim that it is easier for bisexuals to "hide out" in the mainstream simply reflects bias, fear, and judgment against bisexuals, part of insidious biphobia.

Clinical and human services professionals are on the front lines of being able to fight biphobia. The wounding of oppressive cognitions can be reversed simply by validating the legitimacy of bisexuality and embracing clients who identify as being part of the bisexual umbrella without trying to change them. In trauma-informed and trauma-focused care, the oppressive cognitions of minority groups, including bisexuals, may need to be evaluated through client history and addressed as treatment issues before memories related to other traumas can be processed. Clinicians should look for the links between presenting issues for treatment and possible oppressive cognitions.

Three aspects have been identified as a minimum of affirmative practice with LGBT+ clients [28]:

- Have a working knowledge of LGBT+ individuals
- Understand heterosexism and work to dispel it
- Acknowledge the possibility of one's own heterosexism

While principles of affirmative treatment will be further discussed in a later section that focuses on treatment strategies, this is a simple, evaluative starting point for clinicians wanting to improve their efficacy in working with bisexual clients. The focus on heterosexism, or the biased assumption that heterosexual identities and behaviors are the "norm" and everything else is deviant, merits attention. Oppression and thus the impact of oppressive cognitions exist because of such heterosexism in mainstream society.

THE COMING-OUT PROCESS

The concept of coming out is more widely recognized as a phrase and a concept in modern society. However, it is rarely simple to define. Coming out is typically described as the process of revealing one's non-heteronormative sexual or gender identity to others. While coming out is often portrayed as a rite of passage or a dramatic event in the lives of LGBT+ people, the reality is that people who identify as LGBT+ are "coming out" their entire life in a society that is still largely heteronormative: to new friends, in new relationships, and in new work settings. When an individual decides to come out, it is generally a multi-layered process that usually begins with "coming out" to one's self first. People may then choose to come out to those closest to them, such as family, or may need to first come out to people they feel are safer than family, such as friends/a peer group, a school counselor, a clinical professional, or another ally. An ally is generally described in the LGBT+ community as someone who is affirmative, supporting, and accepting of diversity in sexuality and gender identity and does not attempt to change or steer the individual away from being who they are. Some people are outed without their consent or permission due to others in the community making assumptions about them or their behaviors. Such forced coming-out experiences generally qualify as traumatic or wounding for the individuals affected by this invasion of personal privacy.

EVIDENCE-BASED PRACTICE RECOMMENDATION

The Joint Commission recommends facilitating disclosure of sexual orientation and gender identity, but practitioners should be aware that disclosure or "coming out" is an individual process.

(https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/health-equity/lgbtfieldguide_web_linked_verpdf.pdf. Last accessed April 8, 2022.)

Level of Evidence: Expert Opinion/Consensus Statement

It is important for medical, human services, and other clinical professionals to understand several key concepts about coming out. First, an individual identifying as LGBT+ must decide when and how to come out in health and mental health settings. In some cases, the coming-out process is unintentional and awkward, like when the provider asks about sexual preference and activity during the intake process. Clients may stammer with uncertainty about how to answer as they decide whether they feel safe enough to disclose important aspects of themselves, such as sexual orientation and gender identity. A client may also be uncertain about who they are and how they identify. In LGBT+ circles, the term questioning is often used to describe such individuals. Many questioning individuals present for clinical services to sort out their thoughts and feelings about how they identify and if/how to come out to others. Thus, being received by an affirmative (at minimum) and LGBT+-competent professional is imperative to making sure that therapy does not become a retraumatizing experience.

The coming-out process, even under positive and affirmative conditions offered by friends, family, and a faith community, can still be traumatic on some level, particularly when mainstream society is heteronormative and many people carry biases and hateful opinions. Realizing this second truth is a vital step for professionals. In working with bisexual clients, it is important to recognize how the previously discussed myths and biases against bisexuals can complicate the coming-out process. Many bisexuals choose to stay in the closet, fearing judgment from those in the mainstream while believing that they will find inadequate support among other LGBT+ people.

There is still a widespread assumption by many professionals and those in society at large that coming out as bisexual is just a step on the way to coming out as "fully" gay or lesbian, and some research suggests that coming out as bisexual may be a stepping stone for some, a construct referred to as transitional bisexuality [29]. However, professionals can do a great deal of damage by assuming that bisexuality is

just a transition for everyone identifying as part of the bisexual umbrella. For many, being attracted to both or many genders and in various degrees is an accurate reflection of who they are and how they love in the world. It can be retraumatizing if a bisexual person seeking help encounters a professional who either minimizes or fails to appropriately validate their experience of coming out.

While a discussion of all of the issues connected to the coming-out process is beyond the scope of this course, there is one more vital issue to cover related to coming out for bisexual clients: the prospect of coming out again. Professionals who work in LGBT+-specific treatment routinely report the experience of educating their clients on bisexuality and hearing traditionally identified gay men or women state that they chose to be out as gay, rather than their actual bisexual identity, because everyone assumes they are gay. In particular, bisexual men are vulnerable to a great deal of prejudice and spiteful commenting, in some cases from gay men, about not being brave enough to admit that they are gay and come out of the closet fully [7].

For bisexuals across the gender spectrum, coming out to friends and their community as bisexual after initially coming out as gay or lesbian can be difficult. Consider the case of Client A, who initially came out as bisexual and was told by her family, "There is no such thing as bisexuality." Affected by this judgment, Client A chose to come out as a lesbian and ultimately to marry a woman. After her marriage ended, in exploring her relational dynamics in her own therapeutic process, Client A reclaimed her bisexual identity. Coming out as bisexual proved challenging, as she was still met with comments about "picking a side" and "switching teams." Yet, describing her sexuality authentically as a bisexual woman ushered in a new era of growth for her. Mental health professionals can help guide clients on this journey instead of keeping them stuck in those patterns of shame by practicing from a place of bias, assumption, or misinformation.

CULTURALLY RESPONSIVE TRAUMA TREATMENT PLANNING FOR BISEXUAL CLIENTS

While a great amount of research literature has gone into enlightening the evidence-based practice movement in recent years, it is worth noting that treatment research specific to LGBT+ populations has been minimal. A 2006 task force of the American Psychological Association concluded that "an evidence-based practice in psychology is the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" [30]. Choosing a line of intervention for treatment never comes down to research alone. Other variables are important, and in working with minority groups such as bisexuals, contextual factors can take on even greater importance.

In his text on treating substance use disorders in LGBT+ populations, Michael Shelton emphasizes that treatment of LGBT+ individuals must be trauma-informed [5]. The phrase trauma-informed can be confusing to many professionals who assume that trauma-informed care is only for individuals with a PTSD diagnosis. As described, the impact of trauma can manifest in a variety of ways, not just in clinically obvious diagnoses. Shelton writes [5]:

> Some LGBT individuals enter behavioral health treatment with insidious traumatization. Since childhood they may have been bombarded with messages that same-sex attraction and gender nonconforming behaviors are disgusting, sinful, or indicative of mental problems; these microaggressions are sufficiently traumatizing in themselves.

In addition to being affirming, being trauma-informed is an imperative bare minimum in working with bisexual clients and other sexual minorities. This imperative applies to all professionals, regardless of the setting in which they may work (e.g., treatment centers, private practices, hospitals, school settings, correctional settings, medical offices).

The Substance Abuse and Mental Health Services Administration (SAMHSA) provides guidelines on trauma-informed care in their Treatment Improvement Protocol. The trauma-informed movement can be characterized as embracing the paradigm shift of asking what happened to clients as opposed to what is wrong with clients. The SAMHSA defines a trauma-informed approach to the delivery of behavioral health services as including an understanding of trauma and an awareness of the impact it can have across settings, services, and populations. It involves viewing trauma through an ecologic and cultural lens and recognizing that context plays a significant role in how individuals perceive and process traumatic events, whether acute or chronic [31]. For providers working with bisexual clients, recognizing the inherently traumatic nature of being bisexual/part of the bisexual umbrella in a heteronormative mainstream is part of viewing clients through an ecologic and culturally informed lens.

The SAMHSA Treatment Improvement Protocol emphasizes specific ways that individuals working in human services can practice trauma-informed care, including [31]:

- Promote trauma awareness and understanding
- Recognize that trauma-related symptoms and behaviors originate from adapting to traumatic experiences
- View trauma in the context of individuals' environments
- Minimize the risk of retraumatization or replicating prior trauma dynamics
- Create a safe environment
- Identify recovery from trauma as a primary goal
- Support control, choice, and autonomy
- Create collaborative relationships and participation opportunities
- Familiarize the client with trauma-informed services
- Incorporate universal routine screenings for trauma
- View trauma through a sociocultural lens
- Use a strengths-based perspective and promote resilience
- Foster trauma-resistant skills
- Demonstrate organizational and administrative commitment to trauma-informed care
- Develop strategies to address secondary trauma and promote self-care
- Provide hope—recovery is possible

The Treatment Improvement Protocol, which expands upon each actionable point in more detail, is available for free online (***Resources***). All professionals are encouraged to obtain this document, at least as a means of personal or practice-wide evaluation to determine how well they are practicing trauma-informed principles in medical and behavioral health care.

BEST PRACTICES FOR TRAUMA-INFORMED CLINICAL INTERACTIONS WITH BISEXUAL UMBRELLA CLIENTS

Do not re-traumatize—clinicians most often do this by prodding for too many details too soon or coming across as interrogatory. This relates to both the general biopsychosocial history as well as gathering information about sexual orientation or identity. Do not ask questions out of morbid curiosity or simply with the urgency to fill out clinical forms.

Do consider that getting an exact, chronologic trauma history may be unsafe or impractical because of how the memories are stored. Instead, determining presenting issues and corresponding themes is of utmost importance. If the topic of sexuality comes up in an initial session, exploring issues related to the coming-out process as a theme (as an example) may be more useful than getting a detailed history around sexual development.

Do ask open-ended questions. Questions that start with the words "what" and "how" generally allow clients to provide as much or as little detail as they are ready to give. Questions such as, "What are you willing to share today about your sexual orientation or sexual identity?," or "How has coming out as bisexual impacted your life?" are examples of how to avoid limiting clients to yes/no answers.

Do be non-judgmental. This does not mean endorsing maladaptive or unhealthy behaviors, but it does mean respecting the dignity of the person at all times. For LGBT+-affirmative therapists, it is imperative not to explore a person's sexual identity or orientation as a "problem" or the maladaptive response. However, a person may disclose engaging in problematic or addictive behaviors to cope with internalized shame and homophobia. If these phenomena are explored in the treatment plan, take care not to make sexual identity/orientation the problem—the heterosexist mainstream is the problem. With bisexual clients, discrimination from the larger LGBT+ community may also be part of the problem, although identifying as bisexual and claiming a bisexual identity is not. If one finds that their own biases are getting in the way of practicing non-judgment, seek further supervision, consultation, or training.

Do be genuine and build rapport from the first greeting. Forging a solid therapeutic relationship is essential for clinical success, especially in trauma-informed clinical services. Again, internal biases about LGBT+, specifically bisexuality, impede this process and should be addressed through supervision, consultation, or training.

Do consider the role of shame in bisexual clients presenting for treatment of addiction, trauma, and/or grief. Most clients identifying as LGBT+ carry some type of internalized shame about who they are and/or what they may have done to deal with the pressure of being who they are in a heterosexist society (e.g., substance use, acting out, hurting others while closeted). Recognizing this reality is an important competency for professionals who are in positions of power to further shame clients by making assumptions and judgments about being bisexual. Instead, professionals should help clients to see new, healthier truths about themselves and their capacity to love.

Do make use of the "stop sign" when appropriate. Let clients know that they can opt out of answering questions in the history, with the possible exception of questions related to suicidality/harm to others. Some of the greatest harm that clinicians can do with all clients, especially clients who identify as LGBT+, is to prod for too many details out of curiosity or because it is believed to be required to meet all the standards with paperwork. Those working for a highly regulated agency should determine how often statements like "client chose not to disclose" or "defer to further assessment" may be used in paperwork. Much of the detail that certain assessment tools require from clients about sex and sexuality should only be obtained in the context of established trust and rapport; this can be very difficult to do in a first session. Assess how medically and psychologically necessary a piece of information is to address the issue at hand. Although the answer may be "yes," in certain contexts (e.g., in diagnosing and treating a sexually transmitted infection [STI]), in many contexts it is not. If the latter, avoid prying.

Do assure clients that they may not be alone in their experiences, but be mindful not to minimize. Examples of minimizing with a bisexual client include using statements like, "I think everyone is bisexual to a certain degree," or "Sexuality is a continuum after all; it is not black and white." While such statements can be delivered with good intention as a gesture

of normalization, consider how they are inherently minimizing. In contrast, sharing with clients that one has worked with bisexual clients before and has learned from such clients about their experiences may be a better way to normalize or help new clients to see that they are not alone.

Do have closure strategies ready. Allow at least 10 minutes to close down and consider teaching a brief coping skill at the end of a first intake session. For all clients, it is important not to run any session to the last minute with questioning and content, especially about sexuality. If a client does have a big reveal that may have even taken them by surprise during an initial intake session, be sure to check in about how they are feeling for disclosing such information about their sexuality or sexual behavior before they leave and develop a plan for self-care between sessions. One can also preview for the client how treatment will help them and address any goals they may have around sexuality. The essential lesson here is to avoid ending the session immediately after the client has unloaded. The term "vulnerability hangover" has been coined to describe the feelings of shame and remorse that people may feel after a big reveal [32]. If clients are ill-equipped to handle the feelings that may come up, they may resort to default coping mechanisms that are self-destructive (e.g., substance use, acting out).

Do be mindful of how screening tools or devices are administered to clients. Be careful to adequately orient the client to the rationale for why the tool is being used. Also, avoid simply placing people in a crowded waiting room or small confined office if those environments may be too triggering/activating. If a tool like the KSOG is determined to be useful, it is imperative to fully explain the survey and to provide privacy. How answering these questions may serve the client and the overall treatment plan should be explained.

Consider that assessment is an ongoing process. Clinicians will not (and should not) obtain all the information that they need in the first session, especially about sex and sexuality. Information about sex and sexuality can be deeply personal and sacred to clients and is best shared when they feel sufficiently safe to disclose such information. Although some client-clinician interactions have that quality of rapport developing instantly, for most clients identifying as LGBT+, the process takes time. For bisexual clients, especially if they have been told unkind or untrue things about their sexuality by professionals before, this process may take even longer.

One final item to note is that another, deeper paradigm shift is happening with those who take the role of trauma and its impact on the human experience seriously. Although being trauma-informed is a good first step and should be a minimum of care for anyone who works with the public, being trauma-focused is required to bring about deeper healing, especially for those discriminated against by a heteronormative mainstream in their development.

Trauma-informed care recognizes the role that unhealed trauma plays in human behavior, provides a template for minimizing harm in the delivery of human services, and offers an education framework for human services systems [33]. In contrast, trauma-focused care assumes that unhealed trauma plays a major role in presenting issues, denotes greater action in the delivery of treatment services, and promotes proactive treatment planning to heal the legacy of trauma [33].

Professionals who believe that human suffering is caused or exacerbated by trauma will gravitate toward a trauma-focused approach. In working with bisexual clients, it is important to understand that trauma is insidious and plays a major role in causing or exacerbating the problems that LGBT+ clients report in presenting for services [5]. For bisexual clients, the inherent traumatization of being affected by oppressive cognitions can be salient, so adopting a trauma-focused treatment strategy for healing is imperative.

APPLYING THE THREE-STAGE CONSENSUS MODEL OF TRAUMA TREATMENT TO BISEXUAL CLIENTS

There are many theories, modalities, and approaches available for the treatment of mental health issues, substance use disorders, and psychopathology/problems of daily living specifically linked to traumatic stress. Approaches can include traditional modalities, like psychodynamic psychotherapy, Gestalt therapy, existential therapy, and cognitive-behavioral therapy (CBT), to newer interventions, like EMDR therapy and dialectical behavior therapy, both of which are listed as evidence-based practices by major clinical organizations like SAMHSA [31]. In addiction counseling, interventions like 12-step facilitation and motivational interviewing are still popularly used; when applied in the context of cultural considerations, both approaches are effective. Social justice counseling and therapy based on feminist theory are appealing choices for many LGBT+ clients. Newer wave, more somatically informed interventions for resolving trauma, like body-centered psychotherapy, sensorimotor psychotherapy, or somatic experiencing, are also viable options for engaging in trauma-focused care with bisexual clients.

The aim of this section is not to make a case that any one approach works best for bisexual clients. There has not been enough research done specific to bisexual populations to begin making a case for any one modality as the best. In addition, a culturally responsive approach to treatment dictates that clinicians should never force a preferred mode of intervention on a client. Rather, clinicians should blend their expertise and knowledge of effective practices with the cultural needs and preferences of the client. A culturally competent and proficient clinician is "aware of the importance of integrating services that are congruent with diverse populations and capable of meeting their needs. Diversity is valued. There is a willingness to be more transparent in evaluating current services and practices and in developing policies and practices that meet the diverse needs of the treatment population and community at large" [5]. This is in contrast to a culturally destructive clinician or organization that imposes attitudes from mainstream culture, including inflexible beliefs about "what works" for a client.

Clinical flexibility that honors clients' goals and preferences for treatment is critical, and much of this means not imposing rigidity about the method for treatment. Eclectic or integrated clinicians trained in several different modalities may be in a better position to work with LGBT+ clients. In trauma-focused treatment, practitioners can still be flexible and have a framework from which to operate: Pierre Janet's Stage Model for the Treatment of Traumatic Stress [34]. Tracing back to the late 19th century, this model is still relevant in the modern era because it carries a great deal of timeless common sense. Janet's original model goes by different names in the field today, including the three-stage model, the triphasic model, and the three-stage consensus model. In the century since Janet published his ideas, nearly every major scholar writing on post-traumatic stress, regardless of their clinical orientation, can agree on the three-tiered structure. Places of consensus in a field that can be divided are valuable sources of content and clinical applicability.

Janet's original stages were [34]:

- Stage 1: Stabilization, symptom-oriented treatment, and preparation for liquidation of traumatic memories
- Stage 2: Identification, exploration, and modification of traumatic memories
- Stage 3: Relapse prevention, relief of residual symptomatology, personality reintegration, and rehabilitation

Aristotelian simplicity dictates that there should be a beginning, a middle, and an end (even if this "ending" is better conceptualized as maintenance) to the healing structure of therapy. Of course, there is room for practitioners to add a personal spin and to focus on one stage more than the others based on client readiness and need. For instance, many clients present for services reasonably stabilized and ready to dive into the deeper work of stage 2. Other clients may need to engage in some stage 2 work relatively early in the treatment process before they can come close to stabilizing, a function typically described as part of stage 1 [35]. Although exceptions exist and stage 2 treatment may need to occur sooner than usual, an attuned clinician committed to affirming the client and ensuring safety before engaging in deeper clinical work can work with the client to build an individualized treatment plan [35]. Working with client context has always been vital to understanding the consensus model. In the case of bisexual clients, their presenting problems, where they are in the coming-out process, how they have been impacted by oppressive cognitions, and the nature of the developing practitioner-client relationship should all be evaluated within clinical context to determine how to apply the consensus model for treatment.

One of the greatest misconceptions about trauma-focused therapy is that catharsis, or the second component of Janet's structure (i.e., identification, exploration, and modification of traumatic memories), is paramount. However, if an individual engages in catharsis and is actively working on trauma without having a foundation of skills for tolerating emotion or affect, further damage can result. Part of this foundation and groundwork includes a solidly forged therapeutic alliance with an affirming practitioner.

Another misconception about trauma-focused care is that after something is processed or cleared, then it is fixed and gone. This mindset promotes a misconception that trauma can be cured, but a healthier approach is to look at trauma as something that can be healed. Even after a person has a breakthrough in treatment, the process of reintegrating or adjusting to regular life after healing can be another source of trauma and/or adjustment. If a person undergoes successful major surgery but no postoperative follow-up or rehabilitation is provided, he or she could be seriously harmed. The same logic applies to healing emotional trauma, especially in working with LGBT+ individuals who are likely returning to a mainstream that is still less than friendly or affirming as a whole.

Consider how the consensus model fits with the wound metaphor addressed earlier in this course. Stabilization is the immediate attention to a wound. For example, stabilization might mean cleaning out the wound and disinfecting the area. Then, a dressing is generally applied to stop the bleeding and prevent infection or contamination. However, the wound needs to be exposed to the light and air in order to fully heal. Healing occurs from the inside and can take a great deal of time. This process is stage 2. After a wound heals, it generally leaves a scar. In cases of relatively benign wounding, that scar may resolve completely. With more significant injuries, a person may live with a scar or whatever aftermath is left after the wound heals [36].

In 2012, an expert consensus panel of the International Society for Traumatic Stress Studies issued their recommendations for addressing complex post-traumatic stress. The panel still recommends the general sequence of the three-stage consensus model as the standard for trauma care [37]. The 2013 World Health Organization report on treating trauma also makes reference to similar themes, particularly the importance of psychologic first aid (or stabilization) as a standard of care for PTSD [38].

Trauma, grief, and how wounds manifest are not linear, especially for bisexual umbrella clients whose state of being can be qualified as traumatic experience. One concern with models for clinical intervention is that the more "steps," "numbers," or "components" they contain, the more likely clinicians are to be confused about how to deal with unpredictability. No model can capture the truly messy nature of unresolved trauma or grief, let alone offer the perfect solution for healing it. A simpler model allows for flexibility and the ebb and flow that characterizes human healing. As such, the consensus model is a framework. It is common sense to stabilize first—to make sure a person can deal with what may come up in the stage of deeper identification or exploration [36]. Affirmative practices and teaching basic skills for managing affect, feelings, and unpredictability (especially if a coming-out process happens during treatment) are imperative in stage 1 work with bisexual umbrella clients. However, if the exploration stage begins and it is evident that the client is not adequately prepared to engage in deeper work around oppressive cognitions or other traumatic causes of presenting symptoms, the treatment can steer back to a stabilization focus at any time. Even when actively working with clients doing stage 2 processing with any appropriate modality, it is wise to use skills acquired during stabilization (stage 1) to close sessions safely or to remind the client how to use these skills to stay as safe and as regulated as possible between sessions.

SAMPLE TREATMENT PLANNING STRATEGIES

As discussed, no single theory or modality is recommended for working with bisexual umbrella clients. Professionals should apply their chosen modality in a trauma-focused and culturally responsive manner; any modality or series of modalities can work well with bisexual clients in the context of the three-stage consensus model. In this section, a sample outline for tasks that could happen in each phase of treatment with bisexual umbrella clients is presented to aid in clinical decision making, with specific commentary on how to carry out these treatment tasks. The case of Client A, a bisexual woman, will be used as an example of how a clinician can work through each stage.

Stage 1: Stabilization and Laying the Foundation

In the first stage of treatment with bisexual clients, it is important to establish and cultivate therapeutic rapport, with special attention paid to affirming the client's bisexual umbrella identity, questioning identity, and (if applicable) coming-out process in a way that serves the client's goals. Professionals should not push an agenda or assumptions about coming out (e.g., "Coming out will be good for you right now") on the client. Work with their goals, needs, and preferences for treatment.

Clients should be linked with appropriate support in the community or, via virtual platforms, online. Having appropriate support is especially important if a bisexual client is choosing to come out during his/her treatment or therapy process. Some clients may be "out" in some aspects of their lives (e.g., with family and friends) but not in all areas of their lives (e.g., work, faith community). Obtaining support to take this next step in the journey can be critical. In working with minor clients or clients with active family ties, encouraging support for the family can be critical as well. Although parents of children are often presumed to be most affected by a coming-out process, spouses can also be profoundly affected by a partner's public coming out (especially if they did not know about the client's bisexual identity at the beginning of their relationship). Professionals should be prepared to make referrals for family members if they are open and willing to seeking this help for themselves.

Bisexual umbrella clients may be encouraged to talk with others who have also come out. This can normalize clients' experiences and set them up for greater success both in therapy and in other parts of their coming-out journey and living a meaningful life. Advocacy websites can also be useful stops for clients to see other people thriving as bisexuals.

If a client has a substance use disorder or other addiction issue, referral to a 12-step group or other mutual help group in the community can be important. Whenever possible, seek out LGBT+-specific meetings, often called "rainbow" meetings, in the area. Healthy meetings of this nature can be a good place for bisexual umbrella clients to meet sober role models and support figures in the community. In general, not all 12-step meetings are high quality and many are not a good fit for LGBT+ clients who can feel further marginalized, especially in religiously charged areas. As with many areas of human services work, asking around, networking, and searching online collaboratively with clients can be good places to start.

For many LGBT+ clients, getting involved as an advocate or with political work connected to an LGBT+ or specifically bisexual umbrella organization can be a helpful adjunct to the healing process. Promoting such involvement is a critical component of an approach called social justice counseling. While this engagement can be helpful for some clients who are working to find their voice as healthy bisexuals, be careful to avoid making assumptions that such advocacy work is helpful for every client.

Psychoeducation is a critical part of stage 1 work with all clients. Trauma-focused clinicians can do this by finding out if clients are lacking information in a certain area or if they may be operating on misinformation and assumptions given by others. Many clients who grew up in religious institutions that discriminated against LGBT+ persons are still seriously affected by this shame-based messaging. While clinicians are not expected to practice pastoral counseling if this is outside their scope of practice or comfort, pointing the client in the direction of LGBT+-accepting spiritual resources may be necessary. It can be helpful to identify which churches, spiritual communities, or other places of worship are LGBT+ affirming; many socially progressive churches promote this on their websites and in their literature. If a client is comfortable speaking with a leader at such a church, supportive religious teachings can supplement the therapy process.

Another aspect of psychoeducation for bisexual umbrella clients can involve sharing information on healthy sexuality and lifestyle. This can include the basics, like education on safer sex and STI screening for clients who are sexually active. Working with clients to determine what feels like healthy sexuality for them and developing a plan to achieve it is crucial. For bisexual clients, this generally involves connecting with and/or reading about how other bisexuals have managed to thrive and live healthy lives that honor the full expression of their sexuality. This task may include addressing the misconception that to fully claim bisexual identity, one must become polyamorous. Polyamory, literally "many loves" and sometimes referred to as ethical non-monogamy, is a lifestyle path in which multiple relationships or sexual connections are made, with the full knowledge and consent of all parties involved. Some bisexual umbrella clients find polyamory appealing, and others do not.

When conducting stage 1 treatment, it is important to evaluate whether basic needs, like food, water, shelter, and clothing, are being met. If there are deficits in these areas, be prepared to link clients with resources available in the community. This task can take on special importance when working with LGBT+ clients, many of whom have been shunned from their homes and families. Some clients may have lost jobs or financial security after coming out. All of these contingencies should be addressed, and clients should be assisted in developing a plan of action for getting these basic needs met, especially if they are running into barriers.

Coping skills and other approaches to work with heavy, intense, or unpredictable affect and feeling states should be taught, bolstered, or reviewed in stage 1 work. Clients who desire to do the deep digging of stage 2, especially if their goal is to heal the legacy of trauma created by oppressive cognitions and other stressors of the LGBT+ experience, should be prepared to reasonably handle what might surface emotionally. In stage 1, a variety of clinical methods and approaches may be used to help clients widen their affective window of tolerance, or the amount of emotional intensity and/or distress they can safely withstand and continue to adaptively and effectively function. Approaches like grounding, mindfulness strategies, breath work, guided visualizations, and expressive arts practices (e.g., writing, visual art making, engaging with music) are all dynamic ways to work with clients in stage 1.

Embodied practices like yoga/Pilates, dance, martial arts, or other safe forms of exercise can be especially fruitful in a client's trauma recovery process, as can receiving bodywork (e.g., massage) or energy work (e.g., Reiki). Such practices should be introduced on a case-by-case basis, depending on client willingness and access in the community. With all clients, it is important to brainstorm ways to build a healthier relationship with the body on some level, even if that starts as simply as taking a walk in the evening or engaging in a popular mindfulness meditation practice called body scan. Unhealed trauma manifests in the body and can be expressed as hypoarousal or shutting-down responses or as hyperarousal or anxious/"jumpy" responses. Trauma survivors often engage in addictive or other unhealthy behaviors, including avoidance and disconnecting from others, to either feel better or feel numb. Learning to live in one's body, adapt to stressors in a healthy way, and listen to the signals of the body are important in trauma-focused care. Many clients may not be able to fully engage with the body until some stage 2 work is done, but it is vital to begin teaching about listening to and working with the body in stage 1, no matter how slowly.

Client A: Stage 1

Client A presents for clinical services to address two primary life concerns: her escalating drinking/drug use (prescription pills) and her recent divorce. Client A had been prescribed a benzodiazepine medication (lorazepam) by a psychiatrist for years to deal with what she describes as chronic anxiety stemming from early childhood sexual abuse. The client was never properly evaluated for PTSD. Client A has grown concerned by how her drinking is starting to affect her work performance and seeks counseling to obtain further guidance on the matter. Client A's clinician begins by educating her on trauma and how her symptoms seem to meet the criteria for PTSD based on her early child sexual abuse experiences. In talking about trauma, Client A starts to connect the dots with other aspects of her life that also seem traumatic or wounding for her, including her sexuality.

Client A relays to her therapist, a trauma-focused eclectic, that she first knew she was bisexual around 14 years of age, when she became cognizant of the fact that she was attracted to both boys and girls. At the time, a therapist prodded Client A to come out to her conservative, Catholic parents. When Client A would not do it, her therapist outed her to her parents, justifying it as a safety measure. This premature disclosure ushered in several years of discord at home. Although Client A's parents never considered sending her for any kind of religious intervention (e.g., reparative therapy), they thought it was a phase she would outgrow. At 18 years of age, Client A's siblings told her that they would support her in coming out, but that there was no such thing as bisexuality. One sibling even encouraged her, "It's okay to come out as fully gay; I'm here for you."

While this support meant the world to her at the time and eventually helped her to live her life openly and publicly as a lesbian, now Client A is recognizing how invalidating and misinformed her sibling's statement was. Client A identifies that the stressors of her six-year marriage to a woman impacted her alcohol consumption, although by the time she presents for services she does not need to be convinced that she has a substance use problem and is open to a referral to attend a local 12-step group. Client A finds a sponsor at a local meeting that affirms her bisexual identity, and as she grows to trust that her therapist is not going to try to talk her out of being bisexual, the quality of her work begins to deepen. Client A also accepts a recommendation to attend a local "recovery yoga" class and begins working to develop a set of coping skills, like breathing and meditation. Client A is encouraged by her therapist's suggestion to begin exploring some stories of other bisexuals published online on advocacy websites. Every time Client A reads stories of people who were originally out as gay or lesbian and began to own the truth of their bisexual identity, she finds herself nodding her head in agreement.

Stage 2: Going Deeper and Modifying Traumatic Memories

As discussed, there are a variety of therapeutic modalities that can work to identify traumatic memories and other stressful issues that keep people stuck and to move them through to a more adaptive resolution. The approach collaboratively chosen for deeper work should be one with which the counselor/therapist feels confident and competent to guide a bisexual client in the work. For many clinicians, this is not a matter of just being trained technically; rather, it is about maintaining a calming presence if the client's affective output intensifies. Naturally, this also requires that clinicians working with bisexual umbrella clients be fully affirming and aware of their own biases at all times.

After a general modality or approach has been selected to work on the core wounds connected to the client's presenting issues, it is important to inventory the negative messages about the self that the client has internalized as true statements. The oppressive cognitions previously discussed can provide a solid framework from which to work on this task. Clients may also carry other negative cognitions from instances of abuse that are not specific to the bisexual experience, and clinicians should be prepared to work with this material as well. If a bisexual client has internalized an oppressive cognition like "I do not exist" connected to a society message like "There is no such thing as bisexuality," the identified approach or series of approaches may be used to help the client move/transform that belief to a more adaptive one, such as "I am valid and I exist."

Be mindful that there are a variety of grief issues that may arise for bisexual clients as they begin fully unpacking and exploring their experiences, especially experiences with oppressive cognitions. Many clients find themselves grieving the lives that they could have had and often feel the heavy emotions and sensations connected to deep regret had they come out at earlier points in their lives. Another reality for many LGBT+ clients who come out later in life is the gap in time that exists between the time they "knew" or identified the nature of their feelings and attractions and the age when they actually came out. If a client suspected at 11 years of age that she was bisexual but does not come out until 36 years of age, there is a 25-year gap in psychosexual development that should be explored to feel fully present in her identity and in herself. A variety of therapeutic approaches designed to help clients work through grief and loss can be beneficial in this process. Additionally, many bisexual umbrella clients are grieving the loss of family connections, spouses/past relationships, their faith community, or other connections that they lost because of coming out or coming out more fully. It should not be assumed that the coming-out process will immediately make bisexual clients feel better because they have chosen

to live a more authentic life. A great deal of loss is part of many individuals' coming-out journeys, and therapy should provide a safe place for clients to grieve these losses.

In working with clients who are closely bound to family members (e.g., parents, spouses), advise the close individuals that engaging in stage 2 work can be emotionally exhausting for the client. As suggested in stage 1, making appropriate referrals for family members and educating them on the coming-out and working-through processes (if the client is open to this collaboration) can be helpful. When working with children and adolescents, it can be challenging to navigate the desired preferences and identity issues of the children alongside the parents' desired outcomes for treatment. Parents or guardians may pressure a counselor or therapist to convince the minor client that bisexual desires are "just a phase," or that they are "too young" to be sure of their sexuality. Using available data and resources, parents should be educated that a younger a child can be affirmed in their sexual identity, and that acceptance at this stage can result in a healthier and happier adulthood.

Client A: Stage 2

Client A's therapist is certified in EMDR in addition to being a registered expressive arts therapist, and she works with Client A in both modalities to help her target the oppressive cognition of "I do not exist." This oppressive cognition is connected to her siblings' comments invalidating her bisexual identity and her parents' treatment of her coming out as "a passing phase."

According to the World Health Organization [38]:

> EMDR therapy is based on the idea that negative thoughts, feelings, and behaviors are the result of unprocessed memories. The treatment involves standardized procedures that include focusing simultaneously on (a) spontaneous associations of traumatic images, thoughts, emotions, and bodily sensations and (b) bilateral stimulation that is most commonly in the form of repeated eye movements. Like CBT with a trauma focus, EMDR aims to reduce subjective distress and strengthen adaptive beliefs related to the traumatic event. Unlike CBT with a trauma focus, EMDR does not involve (a) detailed descriptions of the event, (b) direct challenging of beliefs, (c) extended exposure, or (d) homework.

The EMDR process allows clients like Client A to make connections between memories that they did not consciously realize had an impact. In targeting the memories related to the cognition "I do not exist," and her siblings' invalidating comments, Client A also recognizes that her therapist outing her to her parents made her feel like she did not exist and that her feelings did not matter.

Through her engagement with EMDR therapy and visual art making, Client A fully embraces the beliefs of "I do exist, and I matter." She accepts these beliefs as they relate to her sexuality, and she translates them to other scenarios in her life as well. Client A also finds that making music playlists helps her reclaim her sexual identity, and sharing music that meaningfully expresses her journey of sexual development eventually helps her to share what it means for her to be bisexual with her mother.

Stage 3: Reintegrating to Society

Reintegration suggests that those who suffer from unhealed trauma traditionally feel cut off from mainstream society. While this truth can apply to all trauma survivors, it applies to LGBT+ clients almost universally. As discussed, bisexual clients may feel even more alienated when they encounter hurtful comments and lack of support from gay and/or lesbian communities.

Reintegration is not a perfect "step 3" in this framework. Clients in outpatient settings require some level of reintegration throughout the process in order to function as members of mainstream society. For many clients working collaboratively with therapists, the art of engaging in productive stage 3 work is to see the links between stage 1 resources and the necessity of carrying these resources into everyday life.

For many bisexual clients, the most difficult part of treatment can be learning to live as an out and proud LGBT+ person after they have engaged in deep work from the past. The client may be left with a sense of uncertainty about the future as they navigate what it means to date, to be in relationships, or to interact with family or work contacts in an authentic way. Bisexual clients who are still thwarted with stigma may find the hardest work comes in stage 3 and learning to adapt to change. The bisexual umbrella client may be fully out and more comfortable with his/her internal identity, but hatred, bigotry, and misunderstanding will continue to occur. As these problems are faced, clients will generally need to continue seeking support, especially if they are coping with a potentially chronic condition like substance use or PTSD. This may be more communal and support group in nature, or bisexual clients may need to continue accessing professional mental health care on a more long-term basis.

Continued work with embodiment and expression is highly recommended. If clients began exploring some of these resources in stage 1, their development and exploration should continue in stage 3.

Client A: Stage 3

After two years, Client A is two years sober, is working in a job that she loves, and is in a relationship situation that makes her happy. However, she has no plans to stop seeing her therapist. Their work together is largely maintenance at this point, but Client A finds it helpful to be able to work through the petty, spiteful comments she hears from others (especially old friends who knew her and her ex-wife) with professional assistance.

Another issue of navigation for Client A is being in a polyamorous relationship. Client A reports that engaging in this lifestyle is helpful and meaningful to her at this point in her journey of sexual development. She has a boyfriend, the first major relationship with a man she has enjoyed in her life, although he is open to her having relationships with other people.

While Client A is happy with this open and polyamorous arrangement for now, there are logistical issues and some jealousy to navigate, which she does with the help and support of her therapist. Moreover, Client A does not envision herself being polyamorous long-term, as she would like to settle down with a primary/exclusive partner (of any gender) and raise a family at some point. Client A is enjoying the journey of exploration for the moment and finds it very helpful to be guided by a non-judgmental, affirming therapist in the journey.

CLINICAL COMPETENCE IN WORKING WITH BISEXUAL UMBRELLA CLIENTS

One of the simplest things a professional of any kind can do when working with a bisexual client is to affirm their existence. This may sound like a given, but when how one identifies or loves in the world has been invalidated, teased, or mistrusted, simple attitudes like validation, acceptance, and non-judgment can be essential. Telling bisexual umbrella clients they are in a safe place is non-trauma-focused, because it tells them what they should be feeling. Instead, clients should be allowed to decide and to evaluate for themselves whether they feel adequately safe.

As with many skills in the behavioral and mental health professions, these approaches sound simple but may not be easy in practice. This section will explore the qualities of bisexual- and LGBT+-affirming professionals. Consider which qualities you possess and which qualities you may like to adopt. Is it an issue of improved training or understanding, or might it be better explained as a bias or blind spot?

Several qualities have been used to describe a bisexually aware professional:

- Believes that bisexuality is a valid lifestyle and is welcoming toward bisexual people
- Is aware of ways in which bisexuals' concerns differ from gays' and lesbians' concerns, and ways in which bisexuals' concerns differ from heterosexual peoples' concerns
- Actively participates in bisexual community events or forums
- Has read professional books or journal articles on bisexuality
- Attends professional workshops on the concerns of bisexual people
- Has worked professionally with several bisexual clients in the past
- Organizes bisexually oriented support or social groups or workshops

Shelton widens the scope slightly in describing the characteristics of LGBT+-affirming clinicians and treatment programs in general [5]. He states that practitioners should be aware of historical context and remain informed about sociocultural changes, both positive and negative. Training programs should increase LGBT+-specific knowledge in terms of theories and identity formation, minority stress, and the current state of the literature (which changes rapidly) about LGBT+-specific concerns and health disparities. On both training and independent practice levels, the awareness and application of LGBT+-specific culturally sensitive language across all forms of communication (e.g., call screening, forms used, assessment) should become standard practice. Clinicians should expand the discussion of confidentiality and documentation issues during their initial contact with LGBT+ clients, who may be concerned about being permanently labeled as LGBT+ within medical records and thus potentially "outed" to medical providers and others. Clinicians should attempt to understand whether a presenting problem is LGBT+-specific or whether it is one of several individual-difference factors that contributes to understanding a case and formulating a treatment plan, but is not central to treatment. Across training levels and throughout practice settings, clinicians should include appropriate assessment(s) of sexual orientation and gender identity that may better facilitate alliance and possibly improve response to treatment in their work with LGBT+ clients [5].

These qualities should form the basis of a bisexually aware and responsive practice. However, clinicians should continue educating themselves on how bisexual umbrella clients may experience trauma in the world and struggle when presenting for services.

EXPLORING AND ADDRESSING BIASES AROUND SEXUAL IDENTITY, SEXUAL EXPRESSION, AND GENDER

Those struggling with any of the concepts covered in this course may benefit from directly talking to a person who identifies as bisexual or as part of the bisexual umbrella. Many will be happy to discuss their experiences and to answer questions. Reputable organizations and websites (***Resources***) can be helpful for further exploration, particularly if other options are scarce in your community. It is important not to rely on popular films and television as a sole source of cultural information, as the overall portrayal of bisexuals in popular culture is flawed and potentially damaging.

Seeking supervision or consultation around issues that are clear blind spots in working with LGBT+ clients, specifically with bisexual clients, should be considered. Such supervision may be a necessary requirement if one is blocked from effectively working with a bisexual umbrella or other LGBT+ client because of one's personal beliefs. The ethical guidelines of the major clinical organizations that guide practice in the United States assert that professionals cannot discriminate against clients based on sexual orientation or gender identity [39; 40; 41]. If referral is not available, the duty falls on the professional to work with the client in as ethical a manner as possible.

CONCLUSION

This course has covered a variety of topics to support behavioral and mental health professionals, however they may serve the public, to work with clients who identify as bisexual or as part of the bisexual umbrella. The first section provided foundational material on defining bisexuality, identifying biases around bisexuality, expanding the scope of identities under the bisexual umbrella, and reviewing concerns that are unique to bisexual clients. The course then discussed and defined trauma and explored how LGBT+ individuals are especially susceptible to being affected by trauma. Specific attention was paid to the trauma of the bisexual experience as explained by the construct of oppressive cognitions and negative messages that bisexuals are likely to receive. Issues connected to the coming-out process were also discussed.

The course then transitioned to explaining the importance of trauma-informed and trauma-focused treatment for all LGBT+ clients, especially those identifying as part of the bisexual umbrella. The three-stage consensus model was used to provide a framework for explaining how professionals can best care for bisexual clients, especially in a clinical setting. A sample treatment plan and a sample case were offered to fully illustrate these points. The course then concluded with a challenge to self-assess one's own competency and awareness for working with bisexual clients. The most essential take-away message is not to let a client suffer or be retraumatized because of one's own biases or misunderstandings about the spectrum of sexual identity and expression.

RESOURCES

The American Institute of Bisexuality
https://bi.org

BiNet USA
https://www.binetusa.org

Bisexual Organizing Project
http://www.bisexualorganizingproject.org

Bisexual Resource Center
https://biresource.org

UCLA LBGTQ Campus Resource Center
https://www.lgbt.ucla.edu

Human Rights Campaign
https://www.hrc.org

Human Rights Campaign Report: Supporting and Caring for Our Bisexual Youth
https://www.hrc.org/supporting-and-caring-for-our-bisexual-youth

The LGBTQIA Resource Center at the University of California, Davis
https://lgbtqia.ucdavis.edu

More Than Two: Polyamory Resources
https://www.morethantwo.com

The Association of Lesbian, Gay, Bisexual, Transgender Addiction Professionals and Their Allies (NALGAP)
https://nalgap.org

PFLAG
https://pflag.org

Substance Abuse and Mental Health Services Administration (SAMHSA) A Treatment Improvement Protocol: Trauma-Informed Care in Behavioral Health Services
https://www.ncbi.nlm.nih.gov/books/NBK207201

The Trevor Project
https://www.thetrevorproject.org

Wellness Identity Sexuality Health (WISH) Research Lab
https://www.wishresearch.com

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