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Self-Reported Health Concerns and Healthcare Experiences among Diverse Bisexual Men: An Exploratory Qualitative Study

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Abstract

Bisexual individuals have disproportionately higher rates of physical and mental health concerns compared to both heterosexual and gay/lesbian individuals. Few studies have examined diverse bisexual-identified men's perceived health concerns for themselves and other bisexual men or their experiences in healthcare settings. This qualitative study explored health and healthcare experiences among cisgender and transgender bisexual men, most of whom were also men of color. Data were collected through semi-structured interviews. Participants included 31 self-identified bisexual men from the Chicago area. Participants were asked questions surrounding bisexual men's health and healthcare experiences in general and their personal experiences, drawing connections between intersecting bisexual and racial/ethnic identities. Interview transcripts were analyzed using thematic analysis. Participants reported sexual health and mental health as the top health concerns for bisexual men. Participants viewed their bisexual identity as a motivator for seeking healthcare services and adopting safer sex practices. Mental health challenges faced by respondents were connected to bisexual stereotypes and fear of disclosing bisexual and transgender identities. Furthermore, perceptions of masculinity amongst bisexual men of color were particularly salient in connecting to their mental health experiences. The intersection of participants' transgender and bisexual identities impacted their healthcare experiences in general healthcare settings, with many participants reporting a lack of cultural competence and provider knowledge concerning their identities. LGBTQ Federally Qualified Health Centers, however, were described as providing compassionate care. Our findings suggest the need for more interventions that account for bisexual men's intersecting identities. Furthermore, increased provider training is necessary for providing affirmative care to bisexual men.

Keywords

Bisexual men; healthcare experiences; health concerns; transgender men; qualitative

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Introduction

Even within the growing body of evidence on health concerns among lesbian, gay, bisexual, transgender (LGBT) and other sexual and gender minority (SGM) populations, research focusing specifically on bisexual groups remains relatively scarce. This is particularly true for diverse groups of bisexual-identified men (Bostwick & Dodge, 2019). Bisexual men of color likely face unique health concerns and challenges related to their multiple and intersecting minoritized identities (sexual minority, racial/ethnic minority, gender identity for transgender men, etc.). A range of studies has indicated that bisexual individuals, in general, demonstrate higher rates of physical, mental, and other health concerns relative to both heterosexual and gay/lesbian individuals. In aggregated national data, Gorman and colleagues show that bisexual men report the poorest self-rated health relative to both heterosexual and gay men (Gorman et al., 2015). Bisexual men are more likely to report alcohol dependence and other substance use issues relative to heterosexual and gay men (McCabe et al., 2009). Bisexual men and women are also more likely to be less educated and be in lower socioeconomic positions than their heterosexual and gay/lesbian counterparts (Gorman et al., 2015). These disparities are due, in part, to the unique stressors that bisexual people experience, including stigma and discrimination from heterosexual and gay/lesbian people (Feinstein & Dyar, 2017). Along with sexual minority-related stigma, transgender bisexual men also have distinctive health experiences related to intersecting sexual and gender minority identities that have remained relatively invisible (Rahman et al., 2019). Based on these prior findings, in this exploratory study, we aimed to examine health and healthcare experiences among a racially/ethnically diverse sample of cisgender and transgender bisexual men.

Similarly, the study of bisexual men's healthcare experiences is warranted although overall, research related to bisexual men's specific health and healthcare preferences and needs is limited (Dodge et al., 2012; Ross et al., 2016). Prior exploratory studies have indicated that bisexual men often report negative experiences when accessing health services. A Canadian assessment found that bisexual men did not receive appropriate information about safer sex with male and female partners while accessing health services (Dobinson et al., 2005). Providers often assumed these men engaged in risky behaviors with multiple partners. Additionally, participants reported inappropriate jokes implying that they were "either gay or straight" and that their bisexuality was "the problem." Similar findings emerged regarding bisexual men's negative experiences with engaging in mental health services (Page, 2004). Not only did participants describe difficult interactions with service providers relating to their sexuality, they also reported not disclosing their bisexuality to health providers due to fear of judgment or receiving substandard services. Thus, the stressors related to being a sexual, gender, and/or racial minority individual are cumulative and may accelerate poorer health outcomes, as posited by intersectionality theory (Bowleg, 2013; Crenshaw, 1991). When these stressors (e.g. negative stereotypes and social rejection) are imposed on a multiple minoritized individual, they can lead to increased experiences of stigma, higher rates of adverse health outcomes and a reluctance to search for the appropriate support services (Bowleg et al., 2016). Biphobia, homophobia, and transphobia in healthcare settings may deter sexual and gender minority individuals from publicly identifying as such because

of the real possibility of being faced with a negative reaction from healthcare providers (Dodge et al., 2012; Ross et al., 2016).

Despite these prior findings, researchers have not yet explored diverse bisexual-identified men's perceived health concerns, both for themselves and for other bisexual men, as well as their experiences in healthcare settings due to any one or all of these minoritized identities. We used in-depth interviews with 31 racially and ethnically diverse bisexual men (as part of a larger multi-method study) to gain a deeper understanding of health and healthcare experiences among cisgender and transgender bisexual men, the majority of whom were also of color.

Methods

The *Men's Daily Experiences Study (MeDES)* is a multi-method study of racially and ethnically diverse bisexual-identified men. The study gathered data, sequentially, through qualitative interviews, an electronic baseline survey, and electronic daily diaries. The daily diary arm of the study is still on-going. This paper presents data from semi-structured face-to-face interviews, all of which took place in Chicago, Illinois. Participants for the interviews were recruited from Chicago and surrounding suburbs through postings on listservs and social media platforms, through formal and informal networks of the research team and Community Advisory Board members, outreach to community-based organizations serving men of color and/or LGBTQ communities, and through flyers posted in geographically diverse locations throughout Chicago. The study was approved by the Institutional Review Boards of the University of Illinois at Chicago and Indiana University - Bloomington. Men received a \$50 cash incentive for their participation. Interested persons completed an online screening to determine if they met eligibility: self-identification as bisexual, identified as a man (cis- or transgender), were 18 years of age or older, and lived in the Chicago area. Three attempts were made to contact potential participants via their preferred method (i.e., email or phone) to schedule the interview. Those who were non-responsive after three attempts were dropped from the pool of screened eligible participants and were not contacted again. Quota sampling was used to ensure that the sample was majority men of color and that the sample was diverse in age. The sample (n=31) was comprised of 14 Black men, eight Latinx men, five multiracial, one Asian, and three White men. The majority of participants (n=24) were cisgender men. Educational attainment ranged from high school diploma (n=7) to Bachelor's degree or higher (n=14). Almost equal proportions of the participants reported a household income below \$19,999 (n=10), between \$20,000 and \$49,999 (n=11), and between \$50,000 and \$99,999 (n=9). One participant reported not knowing his income. Ages ranged from 19 to 61 years (mean age 31.3 years, sd=10.3). While all participants self-identified as bisexual, seven participants used other and/or additional non-monosexual identity labels: five participants identified as queer and two participants identified as pansexual (Table 1).

Though the screening survey was in English, potential participants were given the option of completing the interview in English or Spanish. Interviews were conducted from late April to October 2018 in a private location of the participants' choosing. They lasted an average of 34 minutes and ranged from 20 to 50 minutes. All interviews were digitally audio

recorded. After consent was obtained, participants completed a brief survey that assessed demographics, health status, and characteristics of their bisexual identity. Interviews covered the following topic areas: aspects of bisexual identity, including importance of bisexual identity; unique stressors associated with race, gender and sexual identities; experiences of microaggressions related to sexual identity, race/ethnicity and gender, separately and in combination; and access to supportive others. They also discussed inclusion/exclusion in communities; prioritized the most salient health issues affecting bisexual men, generally and specifically; and were asked how (if at all) their racial/ethnic and/or sexual identities influenced their healthcare experience (for the items on health concerns and healthcare experiences in the interview script, please see Appendix A). Here, we report on findings related specifically to health and healthcare experiences. Interviews were conducted by authors 3 and 5, and a third interviewer, who was bilingual in English and Spanish. All interviewers identified as cisgender women, as bisexual, lesbian, or queer, and two were White and one was Latina. All interviewers identify as members of the larger “LGBTQ” community.

Measures

Participants were asked a series of questions related to their health and healthcare experiences. These questions sought to distinguish between general opinions about bisexual men’s health versus the specific health issues or concerns of the participant e.g., *what do you think are the top health issues among bisexual men?* versus *how has your bisexual identity influenced your health?*. We asked similar questions related to racial/ethnic identity among racial/ethnic minority participants, and we also deliberately inquired about intersecting bisexual and racial/ethnic identities and their influence on health and healthcare, e.g., *And how do you think being a bisexual man of color has influenced your health care experiences?*.

All interviews were transcribed verbatim and participants were given pseudonyms by the study team. One interview was conducted in Spanish, transcribed, and back-translated into English. Three research team members (DW, BB, and AK) independently open-coded transcripts within Dedoose, a qualitative data organization and management software (SocioCultural Research Consultants, 2018). Coding meetings were held during the process to assess consistency in code utilization.

Data analysis

Inductive thematic analysis was utilized in the current study. According to Braun and Clarke (2006) thematic analysis allows researchers to investigate components of a phenomenon in depth. As the current paper focuses very specifically on participants’ identities in relation to health concerns and health experiences, this form of analysis was an appropriate approach. Thus, thematic analysis aided us in providing a rich and detailed account of the data (Braun & Clarke, 2006). We began by sorting codes into potential themes and combining relevant coded data extracts within these initially identified themes. Then, we examined our codes and considered how they might combine to form overarching themes. After this process, we refined our set of potential themes and examined patterns between codes. Lastly, we defined and named our themes.

We carefully considered and discussed our interpretations to ensure our findings were grounded in the data. We acknowledge that we are a part of the meaning-making processes during analysis and interpretation. Our team maintained an ongoing dialogue to consider how our perspectives, identities, and lived experiences inevitably influence the interview process, as well as the analytic and interpretive process. The authorship team was comprised of three cisgender women and two cisgender men, three of whom are white and two of whom are Black. All team members identify as members of the LGBTQ community. Author 1 (DW) has been involved in LGBTQ communities for 7 years and has been engaged in activism with these communities during this time. She identifies as a Black woman. Two of the authors (BD & WB) having been conducting bisexual health research for twenty years. Both identify as bisexual. One author has worked with LGBTQ populations in social service and research settings for over six years. One of the authors has a background in HIV/STI research and epidemiology in LGBT populations and identifies as a gay person of color.

Results

Most participants indicated that sexual health and mental health were the two top health priorities among bisexual men. Respondents who described sexual health as a top priority (n=23) primarily discussed STI/HIV risk and lack of consistent testing as the main sexual health concerns for bisexual men. Those who highlighted mental health as a primary health priority (n=13) expressed concern for bisexual men's struggles with depression, anxiety, stress, and suicidality. When asked about the main health priorities for men of color, participants gave a variety of responses. Latinx men mentioned mental health (n=1), STI risk (n=1), and lack of healthcare access (n=3) as top concerns. Black men listed mental health (n=4), heart disease (n=1), and sexual health (n=1) as primary concerns for their community. Other men of color were unsure of top health priorities for men in their communities. Additionally, transgender respondents identified health concerns for other transgender men that included lack of trans-specific health guidance (n=1), sexual health (n=1), and mental health (n=1).

When participants discussed their personal experiences with health and healthcare, five main themes emerged: *bisexual identity as a motivational factor in health-promoting behaviors, mental health challenges, perceptions of masculinity, affirming healthcare experiences, and lack of cultural competence in standard healthcare.*

Bisexual identity as a motivational factor in health-promoting behaviors

Though some participants felt their bisexual identity had little to no impact on their health, others felt that their bisexual identity positively contributed to their wellbeing. Many respondents revealed that their bisexuality served as a motivational factor to engage in health-promoting behaviors. These health-promoting behaviors included seeking healthcare services more frequently and adopting safer sexual practices.

Participants commonly framed their desire to seek healthcare services through the lens of sexual health. Accessing regular STI and HIV testing was viewed as a necessity for bisexual men. Carl provided an example of this, "Being a bisexual man, you just have to take the precautions. You have to make sure that you're up to date with all of your testing" (31,

Cisgender Man, Black). Hunter similarly viewed his bisexuality as an impetus to prioritizing STI and HIV testing, “I for sure have been very good about getting tested ... the fact is I am having sex with not only different people but different sexes and different genders. I’ve always been told that I should be getting tested, so I just made sure to always [do it]” (19, Cisgender Man, Multiracial). Though some participants felt their bisexuality contributed to increased sexual health risks, they also indicated that this positively impacted them by encouraging them to attend preventative healthcare visits. Participants described regular healthcare appointments as a source of comfort noting they felt peace of mind knowing they were taking their health seriously. Percy (36, Cisgender Man, Black) highlighted how his bisexual identity motivated him to see his healthcare provider more frequently, “I go more often just because I feel better that way. So, I go every two to three months depending on situations. But, I definitely try to engage more just because as time elapses more things can occur.”

Participants also noted their bisexual identity increased their desire to engage in safer sexual behaviors such as “using protection during sex” (David, 45, Cisgender Man, Latinx) and “[getting] on PrEP” (Devon, 25, Cisgender Man, Black). Furthermore, three interviewees mentioned their bisexuality made them more cautious when choosing sexual partners and engaging in sexual encounters:

I’m definitely more aware of who I sleep with, and I definitely cut down on promiscuity (Percy, 36, Cisgender Man, Black).

You need to be more careful about what you’re doing [sexually] when you are bisexual (Mike, 27, Cisgender Man, African American).

[Being bisexual], you have to be careful of who you’re messing around with (Carlos, 34, Cisgender Man, Latinx).

Percy associated his sexual past with “promiscuity,” which has been long used to stereotype the sexuality of bisexual individuals. Likewise, Mike and Carlos did not express the need to “be more careful” simply because they were engaging in sexual behaviors; they mentioned the need to be mindful of their sexual encounters *because* they are bisexual. Participants did not seem to interpret this association as negative; instead, they discussed their caution as a necessary part of protecting their wellbeing.

Mental health challenges

It is well documented that bisexual groups face a multitude of mental health disparities in comparison to heterosexual, gay, and lesbian groups (Bostwick et al., 2010; Dodge et al., 2016). Multiple participants described the ways their bisexual identity negatively impacted their mental health such as being “one more reason for anxiety” (James, 27, Cisgender Man, Multiracial). Many bisexual individuals experience various forms of discrimination and nonacceptance in both heterosexual and LGBTQ communities. Bobby (32, Transgender Man, Multiracial) described his mental health as “worse” due to the discrimination, biphobia, and transphobia he encounters daily.

When discussing how his bisexual identity influenced his health experiences, Clarence mentioned, “it’s a mental stress thing. The questioning if it’s real or not” (25,

Cisgender Man, African American). Bisexual individuals often face scrutiny concerning the believability of their sexual identity. Bisexual men, in particular, are oftentimes presented within of narrative of being “actually gay,” thus invalidating their bisexuality. Occurrences such as this are mentally distressing, complicating bisexual men’s feelings about the authenticity of their sexual identity. Max presented another example of bisexual invalidation and its connection to mental health:

I think a lot of bisexual and trans men have a lot of anxiety and because of the condition of the stigma. If I’m not dating other “queer people”, being a bisexual person makes you feel sort of bad because you’re being told you aren’t real or that this is a phase (25, Transgender Man, White).

Bisexual individuals commonly experience erasure based on their relationship status and relationship history. The invisibility of bisexual identities leaves individuals in heterosexual appearing relationships to be labeled “actually straight” or stereotyped as “confused.” As Max expressed, his bisexuality only appears credible to others if his queerness is visible in his relationship status. This is further complicated for transgender bisexual men who date cisgender women. When transgender bisexual men undergo gender-affirming processes, their sexual identity, which may have been more accepted as queer before, may be erased and replaced with presumptions of heterosexuality. This can produce immense anxiety in transgender bisexual men in constantly having to prove their sexual identity is real *and* defend their queerness if they are in a heterosexual appearing relationship.

As highlighted by Max, the intersections of transgender and bisexual identities present unique challenges concerning mental health in comparison to cisgender bisexual men. The process of “coming out” or disclosing a minority sexual or gender identity can lead to mental stressors such as anticipation of stigma and fear of rejection. Individuals who are both transgender and bisexual are confronted with the decision of concealing or disclosing multiple minority identities which may cause additional stress and anxiety. Vincent, who has already “come out” to his family as transgender, fears the notion of coming-out a second time as bisexual. He explained:

Mentally, it does get to me sometimes because I feel like I’m always having to hide. That’s just me not being out as bisexual, I guess. Yeah, me thinking about, “What if I do fall in love with a man and I do want to date him? How am I going to tell my family? How am I going to bring him to my house? How am I going to tell my grandma?” She’s going to be like, “What the f*ck? I don’t understand.” You know? It just makes me anxious sometimes. Just gives me anxiety just thinking about possibilities (21, Transgender Man, Latinx).

Other participants who were both transgender and bisexual experienced mental health struggles from feelings of isolation. Not having supportive social networks made it challenging for respondents to feel motivated in prioritizing their physical and mental wellbeing. Warren provided this example, “[my identities] have made me sadder which has made me a bit less keen on taking care of myself. I think I just feel an intense lack of support” (20, Transgender Man, White).

Perceptions of masculinity

Several participants of color discussed perceptions of masculinity within their communities as a salient factor that impacted attitudes toward seeking psychological services and discussions surrounding mental health. *“African American men, they never talk about anything ... they won’t [go to counseling]. We as black men need to be masculine ... slap a band aid on, keep it moving. That type of attitude”* (Kerry, 50, Cisgender Man, Black).

Relationships between masculinity and health are complex for bisexual men of color. Bisexual men of color often feel pressured to comply with heteronormative prescriptions of masculinity; deviation from these norms may result in violence, harassment, or social isolation from their racial communities. Normative or “traditional” forms of masculinity have commonly been associated with heterosexuality, homophobia, and antifemininity as well as the possession of specific traits such as strength, assertiveness, and restrictive emotionality (Mincey et al., 2014; Pleck, 1995).

Early research conceptualizes Black men’s masculinity through self-determinism and accountability, family, pride, and spirituality and humanism (Hunter & Davis, 1992). More recent research expands on these findings. Black men have additionally defined their masculinity through the ideology of having multiple female sex partners (Bowleg et al., 2016); being mature, responsible, a provider, and self-aware (Chaney, 2009); and being responsible and accountable for their actions (Hammond & Mattis, 2005). Nathan described the challenges that Black men face in discussing their mental health resulting from their perceptions of masculinity. Pressure for Black men to be strong and proud at all times prevents them from acknowledging or examining their emotions:

Mental health is [an issue among Black men]. I feel like the way that the world has set it up for African American men at this point, it’s harder for them to be vulnerable. And being vulnerable doesn’t always mean you’re soft it just means that you’re willing to take in emotion and feeling and logic and just be able to rationalize it all without sticking to just this defense mechanism. And a lot of the times the guys in our community are so prideful (26, Cisgender Man, Black).

David discussed his challenges with mental health as a Black bisexual man:

It’s mainly the stress and pressure. A lot of Black men, I would say a lot of bisexual and gay men ... are bipolar. And it’s something that’s not discussed enough. Crazy ... that’s what people used to call me. And [my fiancée] was like, “you never thought of talking to nobody about it or something like that or seeing?” I ain’t going to talk to nobody. I fought her for a good two months and I finally gave in. I said lemme go see. When I went, yeah, stuff started coming out. I found out the same symptoms were common (45, Cisgender Man, Black).

David also highlighted the lack of conversations surrounding mental health in the Black community. Many Black men express disdain and distrust of medical providers, refusing to seek necessary medical care. This, in part, stems from historical ethical atrocities Black men have faced in the name of medical advancements (Gamble, 1997; Washington, 2006). Black men are even less likely to seek psychological services due to the stigma of mental health in the Black community and perceptions of men who seek counseling as “weak”

(Barksdale & Molock, 2009; Watkins & Neighbors, 2007). Thus, because mental health discussions were not normalized for David, he delayed seeking psychological treatment. Kerry, similarly, described Black men's unwillingness to visit healthcare providers. He attributed this decision to Black men feeling the need to be "*macho, take care of [things], and have no problems*" (50, Cisgender Man, Black). Black men experience conflict between being self-sufficient and asking for "help" or guidance from doctors. This tension is often resolved through Black men avoiding healthcare altogether. Kerry questioned his defense of some of the harmful masculinity expectations held among Black men, suggesting these norms misalign with his personal beliefs. Despite this, he seemingly upholds these standards out of an unspoken obligation. "*We have the image ... that masculine image that we have to protect, and a lot of times it's conflicting with me because it's like, 'Why am I protecting this? This makes no sense'*" (50, Cisgender Man, Black).

For Latinx men, the concept of *machismo* is often used to describe standards of behavior for men. Machismo is often misunderstood as only referring to negative aspects of masculinity (Félix-Ortiz et al., 2001), however, machismo is a multidimensional construct consisting of multiple characteristics including hypermasculinity, pride, stoicism, providing, and protecting (Torres et al., 2002). *Caballerismo*, the second component of Latinx men's masculinity, is characterized through more positive internal qualities such as honor, humility, and responsibility (Walters & Valenzuela, 2020). While constructs of masculinity vary cross-culturally, some Latinx participants shared similar experiences with masculinity as Black participants. James delayed seeking mental healthcare due to cultural expectations of Latinx men as self-reliant. He explained, "*I just think that the code of silence, code of honor among Latinos in not getting mental health help when they need it ... They're so afraid to ask. I know I was. I didn't see a psychiatrist until I was in my thirties, late thirties*" (45, Cisgender Man, Latinx). In contrast to Black participants, Latinx participants discussed their family's role in promoting masculinity expectations. James' father told him as a child, "*crying is for sissies. Man up*" (45, Cisgender Man, Latinx). This instilled emotional restraint in James at a young age, likely contributing to his initial avoidance of psychological services. Hunter recalled attempting to discuss his mental health concerns with his mother:

I remember when I told my mom I was depressed when I was like probably 15 or 16. She was like, "It's okay to be sad sometimes." They just don't know that depression it's a real thing, they just attribute it to emotions and just being moody and like, "Oh you had a bad day" (19, Multiracial, Cisgender Man).

Diminishing these concerns as "a bad day" subscribes to the damaging rhetoric that presents Latinx men as impervious to mental health challenges. As James expressed, this "silencing" of conversations on mental health is pervasive among Latinx men.

Affirming healthcare experiences

In discussing their healthcare experiences, many participants noted receiving affirming, respectful care from providers. Most affirming experiences were attributed to participants intentionally seeking out care at a Chicago-area LGBTQ-focused Federally Qualified Health Center (LGBTQ FQHC). Describing his experience as "wonderful," Francis mentioned, "*I am lucky to have a doctor at [an LGBTQ FQHC]. I've had really good experiences*

(23, Transgender Man, White). Remy (27, Transgender Man, Multiracial) described his doctor at an LGBTQ FQHC as “*competent and understanding*.” For individuals who are both transgender and bisexual, finding safe spaces in healthcare to disclose their multiple identities can be difficult. In addition to concerns surrounding provider competence, transgender bisexual men frequently fear binegativity and transphobia when accessing healthcare services. Participants consequently viewed LGBTQ FQHCs as a haven from these harmful encounters:

I’ve only gone to [an LGBTQ FQHC] since I was trans. I’m very scared to go to other places. I would never go to a place unless I knew that they were LGBT friendly. But, that also sounds complicated to find those places. How positive am I that they’re going to be ... What if I’m super sick and I can’t go to [an LGBTQ FQHC]? Where do I go? What do I do? (Max, 25, Transgender Man, White).

Not only do LGBTQ FQHCs enhance primary care services for patients, they are also viewed as a *necessity* for transgender bisexual men. As Max suggests, without access to an LGBTQ FQHC, he would feel uncomfortable seeking out care through other avenues.

Cisgender bisexual participants also expressed concerns over binegativity as well as bisexual stereotypes and assumptions from providers concerning their HIV status. Participants felt they decreased their chances of receiving stigmatizing or discriminatory care when they visited LGBTQ FQHCs. Cisgender bisexual respondents were comfortable sharing their sexual identity and discussing their sexual behaviors and sexual health needs with LGBTQ FQHC providers:

My testing doctors, they’re great. The one that treated me, it was a center for the LGBTQ community ... they embraced everyone. So, it was easier to be able to explain to him that I needed treatment for this (Nathan, 26, Cisgender Man, Black).

For Roy, seeing other LGBTQ people in the clinic while waiting for his appointments eased his nerves and gave him a sense of belonging. Accordingly, LGBTQ visibility in healthcare spaces is a powerful factor that gives bisexual men an added feeling of safety when accessing healthcare:

If you can go in places [LGBTQ FQHCs], there’s a guy in drag there, there’s the trans woman and trans man, you’re like, “Okay, I feel a little more comfortable.” So I can sit down and have a seat, and not feel like I’m out of place. Not to compare, but just a sense of comfort (26, Cisgender Man, Black).

Lack of cultural competence in standard healthcare

While some participants received affirming healthcare from providers in LGBTQ FQHCs, others discussed non-affirming experiences in general health care settings, i.e., those not explicitly tailored to LGBTQ + communities. Multiple participants had negative experiences in these standard systems due to a lack of cultural competence from providers. Nearly all the respondents who described these experiences are transgender, suggesting transgender bisexual men face additional challenges in healthcare in comparison to cisgender bisexual men. Healthcare providers often lack the knowledge and training to be sufficiently informed on best practices for serving transgender patients. This coupled with misinformation

or ignorance on bisexual identities results in lower quality and inappropriate care for transgender bisexual patients. Warren explained:

I've been getting strange questions from my doctor. The first was what happened when he asked if I had any more questions after a small briefing me on what sexual health is. I was like, "Okay. How much of this applies if I'm having sex with a woman?" To which he stuttered and then said, "I don't know." He was like, "Are you having sex with a woman?" I was like, "Yes." He was like, "Well, how do you do it?" I was like, "She puts her dick in me," and at that point, I think he was ready to faint. He was like, "What?" When I explained the situation, he asked me if I was wearing a condom, and I said, "No." He asked if we'd both been tested, and I said, "Yes, but I don't understand if I can get pregnant or not." At that point, he almost had another fainting spell (20, Transgender Man, White).

Warren highlighted some of the ongoing challenges that transgender bisexual men experience with incompetent providers in standard healthcare systems. Enduring inappropriate inquiries on their sexuality such as "well how do you do it?" is humiliating and dehumanizing for transgender bisexual men. Providers who are unable to demonstrate understanding and sensitivity to transgender bisexual men's health needs miss opportunities to provide them with necessary screenings, culturally competent recommendations, and proper guidance for medication. Remy echoed another instance where a provider was unable to effectively comprehend his sexual health needs:

I went home to the gynecologist and that was a weird experience, where they were like, "Why are you on birth control if you're dating women?" I was like, "Well, you never know! You never know." Not all women have vaginas. And he was very confused (27, Transgender Man, White).

Lack of culturally competent care leads to transgender bisexual men being underserved in healthcare settings. Consequently, receiving substandard care from ill-prepared providers may contribute to health disparities such as conditions being undiagnosed or providers being unable to properly educate transgender bisexual men on critical sexual health information. There is no "single way" to be transgender; therefore, providers must ask the appropriate questions that assess transgender bisexual men's sexual health behaviors to provide a high standard of care. Vincent expressed frustration over most providers' inability to do this:

I feel that a lot of healthcare providers don't know how to deal with trans bodies because they're so varying and things like that. It does affect you if, let's say, you had bottom surgery and you're engaging in sex with men and things like that. These are questions that need to be asked, if trans-men are queer, because you're not entirely sure about what's going on with our bodies. The intersectionality of being trans and being queer is definitely not Black and white area (21, Transgender Man, Latinx).

While most participants discussed a lack of provider competence concerning intersections of their gender identity and sexual identity, a few participants also described a lack of cultural competence from providers in treating racial/ethnic minorities. Troy (26, Cisgender Man, Black) mentioned a "hesitancy" in visiting healthcare providers due to their historical

lack of cultural competence in treating Black patients. Moreover, providers in standard healthcare systems often lack the cultural understanding to integrate and address the traditions, customs, and values of racial/ethnic minority patients while delivering healthcare services. Failing to take his culture into account, Vincent discussed feeling dissatisfied by his provider's nutrition recommendations:

All the healthcare providers I've been to, [it's a problem with] them just not understanding. They're like, "Oh, eat all these fruits and vegetables." I'm like, "No, I'm going to eat beans and chicken. I'm not going to eat that. That's not what we're eating at home." I guess just not understanding my cultural background (21, Transgender Man, Latinx).

Discussion

Overall, interviewees addressed a wide variety of health concerns and personal experiences with health care systems. Participants identified sexual health and mental health as the two top areas of concern for bisexual men. This is noteworthy, given bisexual men experience health disparities extending beyond these areas of health, including disparities concerning intimate partner violence, substance use, smoking, disordered eating, lack of social support, physical violence, and access to healthcare, (Feldman & Meyer, 2007; Friedman et al., 2019; Friedman et al., 2014; Schick & Dodge, 2012; Substance Abuse and Mental Health Services Administration, 2012; Lim et al., 2014). When discussing sexual health concerns, participants most often described STIs and HIV as salient priorities. Available evidence indicates that similar to gay men, bisexual men are also at increased risk for HIV and other STIs compared to heterosexual men (Caceres et al., 2018; Friedman et al., 2014; Jeffries, 2010). However, these rates should not be interpreted in isolation. Sociocultural factors such as biphobia and societal stigma may contribute to STI and HIV risk among bisexual men (Jeffries, 2014). Respondents highlighted their bisexual identity as a motivating factor to seek regular STI and HIV testing as well as to adapt their sexual behaviors. Viewing their sexual identity as a risk factor, some participants felt prompted to carefully consider their sexual partners. A long history exists of bisexual men being stereotyped as "disease-carriers" or "promiscuous" (Burke & LaFrance, 2016; Jeffries, 2014). Consequently, participants may feel partially motivated to use "caution" during sexual encounters out of internalization of these stereotypes.

Many participants additionally discussed mental health as both a prominent challenge affecting bisexual men at large and a personal challenge, citing experiences similar to those in prior studies (Dodge et al., 2016; Bradford, 2004; Brewster et al., 2013; Ross et al., 2010; Rust, 2000). We found that transgender bisexual men have unique challenges with mental health due to the intersections of their identities. While cisgender bisexual men undoubtedly experience bisexual invisibility and erasure (Steinman, 2000; Dodge et al., 2016), transgender bisexual participants discussed added layers of erasure due to their gender identity. Transgender bisexual men may feel increased invalidity of their multiple identities due to transphobia and biphobia. Furthermore, transgender individuals who undergo gender-affirming procedures may have their bisexuality erased, ignored, or misperceived afterward.

Participants' experiences with mental health also intersected with their racial identity and gender identity. Several Black and Latinx participants discussed masculinity expectations within their communities as a factor impacting discussions on mental health and attitudes toward psychological care. Respondents underscored how men in their racial/ethnic communities often remained silent about their mental health needs for fear of being perceived as "unmanly" or "dishonorable" amongst other Black and Latinx men. Furthermore, some participants delayed seeking mental healthcare because of these masculinity norms. Intersectionality research reveals that bisexual men of color face unique challenges in maintaining a masculine identity (Bowleg, 2013; Muñoz-Laboy et al., 2009). Black and Latinx communities are more likely to have negative attitudes toward bisexual men than white communities (Dodge et al., 2016), and bisexual people of color may experience increased challenges in finding social support in comparison to white sexual minority individuals (Flanders et al., 2019). Moreover, masculine ideologies are often based on heteronormativity and femmephobia (Hoskin, 2019). Deviation from these expectations can lead bisexual men of color to lose their place of belonging among other men of color (Bowleg, 2013). Thus, for our participants, the pressure to uphold masculinity standards may be even more pronounced, leading them to reject perceivably "feminine" or "weak" behaviors such as discussing emotions and seeking assistance from mental healthcare providers. Some Latinx participants additionally emphasized the influence of their family in promoting rigid masculinity expectations. Familism, a cultural value in which the family ascends individual interests, is of critical importance for Latinx communities (Muñoz-Laboy et al., 2009). This construct might play a role in Latinx participants' struggles with discussing their mental health with family members as well as their delaying of psychological services.

We found that transgender bisexual men in our study were more likely to access healthcare at LGBTQ FQHCs than cisgender bisexual men. These results suggest transgender individuals might more frequently receive or *anticipate* they will receive incompetent and discriminatory care in general healthcare systems. While some cisgender bisexual men accessed care at LGBTQ FQHCs, most received care through standard channels. Several participants did not feel the need to mention their sexual identity to their provider unless they were specifically discussing sexual health. Thus, cisgender bisexual men may be less inclined to seek care at LGBTQ FQHCs if they rarely disclose their sexual identity during appointments.

When transgender bisexual men accessed healthcare through standard channels, they noted a severe lack of provider competence concerning the intersections of their gender identity and sexual identity. Participants' experiences with inappropriate questioning and ignorance surrounding their bodies were similar to previous studies (Chisolm-Straker et al., 2017; Heng et al., 2018; Safer et al., 2016). However, there is a dearth of research on the interconnectedness of transgender and bisexual identities, despite evidence that a substantial number of transgender people are bisexual (James et al., 2016). Our findings reveal some of the understudied challenges transgender bisexual men encounter in standard healthcare systems including providers' lack of understanding of transgender bisexual men's sexual behaviors and sexual functioning. While a few participants of color discussed providers' incompetence toward racial/ethnic minorities, we were surprised that no participants

discussed non-affirming healthcare experiences from the intersections of their bisexual identity and racial identity. This could be because racial/ethnic identity is oftentimes visible, while sexual identity is largely invisible without disclosure. Accordingly, participants may have been more likely to experience or anticipate provider incompetence concerning their racial/ethnic identity alone due to the visible nature of this identity.

Strengths, limitations, and future directions

This study presents critical findings on the health concerns and health/healthcare experiences of a racially and ethnically diverse group of cisgender and transgender bisexual men. Participants provided rich responses to questions due to the qualitative, interview-based nature of the study, contributing to a more in-depth understanding of their lived experiences. However, this study is not without limitations. As probability samples of bisexual men are difficult to obtain (Dodge et al., 2019; Jeffries & Dodge, 2007), we relied on purposeful community-based sampling techniques to acquire study participants. Further, because inclusion criteria included identity rather than behavior, the experiences described by participants may not apply to men who are behaviorally bisexual but do not self-identify as bisexual. Future research should consider including behaviorally bisexual men in addition to self-identified bisexual men to explore similarities or differences in health concerns and experiences between these groups. Additionally, as is a tenant of theoretical sampling (Coyne, 1997), representativeness was not a necessity this study; instead, we aimed to develop a diverse sample of respondents in terms of how they relate to the research questions.

We recognize that the location of the study may have impacted our findings as bisexual men in Chicago might have different health concerns and experiences and more access to affirming healthcare than bisexual men in other areas. Thus, findings here should not be extrapolated beyond Chicago. However, because this study sought to understand the aspects of health and healthcare for bisexual men in Chicago, these findings are particularly useful for developing interventions in this community, and possibly localities with similar social and demographic characteristics. We additionally encourage further studies on the unique health and healthcare experiences of transgender bisexual men as research is critically lacking.

Conclusion and implications

The present study illuminates the health concerns and health/healthcare experiences of racially and ethnically diverse cisgender and transgender bisexual men. Participants highlighted sexual health and mental health as top concerns for bisexual men while also discussing the positive impact of their bisexual identity on their sexual health behaviors and their personal challenges with mental health. For many Black and Latinx participants, perceptions of masculinity in their communities decreased their willingness to discuss mental health and created avoidance in seeking psychological services. Participants additionally discussed their experiences in healthcare, revealing the affirming nature of LGBTQ FQHCs, especially for transgender bisexual men. Transgender bisexual men shared more experiences of provider incompetence in standard healthcare systems, however,

some participants also experienced provider incompetence toward their race/ethnicity. This research can be used to better inform healthcare providers in their interactions with cisgender and transgender bisexual men.

Healthcare providers urgently need enhanced training and understanding on serving transgender bisexual patients with sensitivity and appropriateness. Medical schools and teaching hospitals should aim to include more extensive information on LGBTQ identities in their curriculum to help providers deliver high-quality care to transgender bisexual men. Furthermore, increasing racial and ethnic diversity in healthcare could help increase the quality of care received by bisexual men of color. Finally, our findings imply interventions are needed to address the stigma surrounding mental health in Black and Latinx communities. Creating safe, mediated spaces for bisexual men of color to discuss mental health challenges and masculinity expectations can increase social support for seeking psychological services.

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Appendix A

Men's Daily Experiences Study (MeDES): Interview Script Related to Perceived Health and Health Concerns

Health

- a. What do you think are the top health issues among bisexual men?
- b. How has your bisexual identity influenced your health care experiences?
- c. How has your racial/ethnic identity influenced your health care experiences?
- d. And how do you think being a bisexual man of color has influenced your health care experiences?
- e. How has your bisexual identity influenced your health? (*Probe*: This could be physical health, mental health, emotional health; however you define health)
- f. How has your racial/ethnic identity influenced your health?

- g. Is there anything else about your health that you'd like to share or that you'd like me to know?

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Wendy Bostwick, PhD, MPH, is an Associate Professor and Associate Department Head in Population Health Nursing Science, College of Nursing, at the University of Illinois Chicago. She conducts research related to health disparities among sexual and gender minority populations, with a focus on mental health and substance use among bisexual groups. Her current work, funded by two separate NIH grants, explores how microaggressions associated with race, gender, sexual orientation and their intersection may affect mental and physical health among racially and ethnically diverse bisexual women and men. Her research has been supported by the National Institute on Drug Abuse, the

National Institute on Minority Health and Health Disparities, and the American Institute of Bisexuality, among others. Her work has appeared in the *American Journal of Public Health*, *Archives of Sexual Behavior*, *Culture, Health & Sexuality*, *LGBT Health*, and *Journal of Bisexuality*. In 2019, Dr. Bostwick Co-Chaired the first-ever NIH workshop on bisexual health research, with Dr. Brian Dodge.

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Table 1.

Participant Demographics (N = 31).

	% (n=)
Race/Ethnicity	
African American/Black	45% (14)
Latino	26% (8)
Multiracial	16% (5)
Asian	3% (1)
White	10% (3)
Gender Identity	
Cisgender	77% (24)
Transgender	23% (7)
Mean age	31.3 years
Age range	19–61 years
Education	
High School Diploma	23% (7)
Some college	32% (10)
Bachelor's	35% (11)
Grad or prof school	10% (3)
Income	
<\$19,999	32% (10)
\$20,000–49,999	36% (11)
\$50,000–99,999	29% (9)
Don't know	3% (1)