ECOLOGICAL ANALYSIS OF BISEXUAL IDENTITY AND HEALTH ACCESS:

AN INTERPRETIVE CRITICAL INQUIRY

A Dissertation

by

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ABSTRACT

Ecological Analysis of Bisexual Identity and Health Access: An Interpretive Critical Inquiry
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This interpretive critical inquiry was aimed at coming to understand the experiences of self-identified bisexuals, and how bisexual health disparities occur due to misunderstandings of bisexual identity and institutional barriers that foster biphobia. This study was carried out in the metropolitan Atlanta area.

Purposive sampling was used to select 36 self-identified bisexuals as study participants. The data collection included participant observations ethnographic interviews, focus groups, and document analyses and occurred over a 19-month period between January 2017 and July 2018. The focus groups and interviews were audio recorded, transcribed, and analyzed using Lincoln and Guba's approach to content analysis.

Based on the themes and subthemes that emerged, the experiences of bisexual healthcare experiences seemed to yield positive self-image that is complicated by how society construes their sexuality. Overall, participants did experience different obstacles in accessing healthcare, there is a lack of bisexual social spaces to socialize, and face discrimination from both the heterosexual and homosexual communities. One key theme is how bisexual identity is often collapsed with other identities such as men who have sex with men (MSM) or women who have sex with women (WSW). Typically, within the academic literature bisexuality as an identity is synonymous with gay or lesbian identities. This folding of bisexuals into broader categories (MSM, gay, etc.) is based on sexual behavior rather than one's sexual chosen identity.

The majority of the participants appeared to be resilient and have a positive self-image of bisexuality. Many said their bisexuality is an important aspect of their social identity. Results indicate that when bisexuals seek medical care there is considerable variation in how they receive medical care. The conclusion includes implications for public health planning, community practitioners, and, state systems; recommendations for future research; and three working hypotheses.

DEDICATION

I dedicate this dissertation to my immigrant family who came from a country under military dictatorship for fifty years with four suitcases filled with hope, anticipation, eagerness and a wavering sense of how to navigate American institutions.

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First and foremost, I would like to thank my faculty advisor and committee chair, Dr. Ken McLeroy, who provided incredible guidance, support, kindness, leadership, and insight throughout my dissertation process. His intellectual curiosity is the central reason why I ask the academic questions that I do. He is my intellectual father. In the same way that I was influenced by Dr. McLeroy, I was fortunate to also be taught by Dr. Yvonna Lincoln, my intellectual mother. She taught me to see the beauty and depth of methodological inquiry. My teaching and research is highly influenced by her axiological views of the need for social justice frames within social science research. They both have truly influenced the way I look at the world and the way I approach my work. A most sincere thank you also goes to Dr. Jim Burdine and Dr. Eric Wright, my committee members, who provided their support, feedback, and unique perspective throughout the process. Dr. Burdine instilled in me hope that someone of my age and professional experience has value to contribute during an academic career. Dr. Burdine is the person I go to get advice on professional development since he can understand what it means to be older and start a new career in academia. Dr. Wright exemplifies who I hope I can become as an LGBT focused researcher, and I hope that he can be a future mentor. I see his career path and use his model for how to become a LGBT researcher.

I am exceedingly grateful for all of the family, friends, classmates, colleagues, and other faculty who have provided their support, understanding, encouragement, guidance, advice, and patience. A special thank you to Zina Age, Aniz, Inc for their continual support and encouragement over the years.

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gone through much in this country. I thank them for offering continual encouragement and giving me much needed life perspective. A special thanks to my nephew Tyler who inspires me as to why we as an immigrant family have the desire to succeed.

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This dissertation was the result of a community-based project examining health access barriers for bisexual individuals. This project, “Acknowledging the Silence: Addressing the Health Disparities Access Issues for the Bisexual Population”, was funded by the Atlanta Clinical Translational Science Institute (ACTSI) Community Engagement Research Program (CERP) 2015 Community Academic Research Partnerships Grants Program award in the amount of $10,000. The community agency that hosted the study was Aniz, Inc. I was hired as an evaluation consultant to oversee methodological approaches. In addition to Aniz, this study was a collaborative partnership with Physicians for Reproductive Health with the end goal to develop cultural competency training for medical providers to provide clinical services for bisexuals.

This study has been approved by two IRBs. One was to conduct the community project by Morehouse School of Medicine, (IRB 906342-4 IRB protocol). For the dissertation phase, a second IRB approval was secured (IRB 2018-0026M) entitled, “Resilience and Sexual Identity Construction of Bisexual Identifying Individuals: a socioecological assessment and health policy case study”.

The data analyzed for Chapter II and III was provided by the Aniz community project.

NOMENCLATURE

LGBT	Lesbian, Gay, Bisexual, Transgender
LGT	Lesbian, Gay, Transgender

National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (The National CLAS Standards)

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CHAPTER I

INTRODUCTION

After decades of empirical study of sexual behavior and desire, extant literature in this field has come to rely on a set of traditional measurement strategies (McCabe, Hughes, Bostwick, Morales, & Boyd, 2012; Cahill, & Makadon, 2017). These measurement strategies have limitations, however, especially when it comes to understanding bisexual populations. The cartographies of sexual identity have been both gendered (e.g.., the social construction of what it means to be a female or male) and polarized by a heterosexual and homosexual dichotomy of sexual orientation. The gendering of sexual identity and sexual orientation polarization has impacted how bisexuality is defined and understood.

Bisexual acts, attraction, and desire are not static (van Anders, 2015), and whom one chooses to partner with can affect many aspects of one's life, especially how delivery of health services are conducted. In the last 10 years, in the quest to better understand and examine sexual orientation, health researchers have identified a need for studies rooted in intersectionality (Bowleg, 2012; Bockting et al, 2016) as one way to understand how sexuality is constructed through different sociocultural lens. For example, health research using intersectionality as a critical lens of analysis demonstrates the potential of distilling the complexities and lived narratives of sexual orientations and gender identity-affirming care to buffer against some of these effects of stigmatization and discrimination (De Vries, 2014). Intersectionality is a promising critical lens of analysis but there are limitations. Some researchers rely either or more on the structural approach (i.e., relationship to a larger structure) as compared to the constructivist approach (i.e., understanding the untold stories or meanings) (Ferree, 2009). For this dissertation I will be using the constructivist approach to better appreciate how bisexual health is understood.

Constructivist approaches allow the researcher to disentangle stereotypes and stigmas with commonly understood social ascribed definitions. For example, Prins's 2006 case study uses a constructivist approach to explore how ethnic membership is understood by her Dutch and Moluccan classmates:

> "Belonging refers to an experience of 'fitting into' certain intersectional locations – locations that may be manufactured by hegemonic discourses of ethnicity, nation, culture and race, but also by articulatory practices around family, gender, age, religion, sexuality or class. Hence, because identities are performatively produced in and through narrative enactments, belonging is never given, but always a precarious achievement." (Prins, 2006, p. 288)

Prins's example provides a glimpse into a key insight into why bisexuality is not well explored and understood. Bisexuality as a construct has been defined by a larger LGBT identity dominated by gay male, lesbian, and transgender narratives (Callahan, Hazarian, Yarborough, & Sánchez, 2014; Summers, 2017; Krinsky, & Cahill, 2017). In the socially desirable quest to fit in, it is not uncommon for bisexuals to socially self-label as either gay or lesbian. This is an example of group pressured collectivism (to be gay or lesbian) defined by essentialist conceptions of common LGBT identity. Separating and focusing on bisexuals as a population to promote bisexual-inclusive pride may significantly improve health outcomes, reduce decisions to forgo care, and increase the likelihood of engaging in health-promoting behaviors among bisexual individuals.

In a recently edited text, *Bisexuality in Education: Erasure, Exclusion and the Absence of Intersectionality*, Elia (2016) is an example of recent researchers who question why bisexuals have traditionally been overestimated. Within research our investigative desire to cluster and quantify various forms of sexuality had misrepresented the bisexual population, reporting that "because so much research has lumped bisexuals with other sexual and gender minorities . . . [Elia] rel[ies] on the writings that focus on LGBTQI youth as a 'proxy' for discussing bisexual youth" (Elia, 2016, p. 39). In the same edited text, Sears (2016) describes "categories" as "crutches" that should be cast aside in the search for self-knowledge (p. 4). Traditionally, the bisexual population is mispresented within studies in science and social inquiry. Today, scholars who specialize in sexual orientation or identity research (Arbeit, Fisher, Macapagal, & Mustanski, 2016) are becoming more mindful of the Kuhnian notion of 'awareness of anomalies' (Kuhn 2012, p. 52) within social inquiry. In other words, for many years bisexuality was an anomaly and not considered a separate sponsored binding identity distinct from the gay, lesbian, and transgender identities. Today, these anomalies, such as what is bisexuality, are raising questions as to how we frame, measure, and understand bisexuality within conventional scientific structures.

Research across different fields has begun to shed light on the complex ways in which sexual orientation bias is reflected within the healthcare system and related institutions to produce health disparities among bisexual individuals. Statistical analysis and large-scale surveys have been crucial in demonstrating the severity of these differences in health and healthcare accessibility and in starting to assess the health needs of bisexual populations. However, to date, there is very little qualitative research focusing in-depth on the perspectives of bisexual individuals around issues related to health and healthcare. This study explores the experiences of bisexual-self identified individuals within the healthcare system to examine a deeper understanding of how sexual orientation bias manifests in health contexts and how that bias may affect one's ability to access health care. In other words, experiences of bias seem likely to directly affect one's willingness to access care, whereas bias (the fact that it exists and providers act on it) may directly affect one's ability to access care. This dissertation will explore these possible tensions.

Framing of sexual identity

The framing of sexual identity has been marred by the conventional scientific obsession with reductionism and essentialism (Galupo, Davis, Grynkiewicz, & Mitchell, 2014). Through this focus on scientific rationality and reductionism, existing knowledge of sexuality as fluid and as a social construct was forgotten (Katz, 1995; Halperin, 2004; Morandini, Blaszczynski, Costa, Godwin, & Dar-Nimrod, 2017; Semon, Hsu, Rosenthal, & Bailey, 2017). Though the quantitative revival in sexuality studies didn't start until Kinsey's examination of sexuality in the 1950s, the interest has roots in the late 1880s with the scientific quest to understand human sexual behavior and how desire became conventional. It was during this timeframe that sexuality and desire became specimens to be examined, labeled, and counted in professional academic associations (German *Society for Sexology, est. 1913*) and specially designed sexual research laboratories (Kinsey Institute, est. 1947).

In the attempt to understand sexual attractions, sexuality and desire became medicalized. Through the medicalization lens, human sexuality and gender became sexual identities (Plummer, 1998; Zijlstra, 2014) in which social categories were constructed that reinforced heteronormative images of what it means to be a man or woman (Rosario, 1997). This medicalization process, largely driven by the scientific community's obsession with the function and utility of genitalia's sexual functions (e.g., psychology as a field of study), would become a precursor to laying a foundation for a more nuanced understanding of sexuality (Minton, 1997). This fixation on genitalia later influenced Kinseyan theoretical and conceptual frameworks of how we understood surveillance of sex behavior survey strategies by challenging conventional norms of sexuality. Kinsey's scientific observations of sexuality allowed for a redefinition and social renegotiation of how sexuality is socially constructed. The obsession with enumerating sexual desire and behavior solidified how sexuality should be studied. In fact, what Kinsey brought to light is the predominance of quantitative population survey strategies and orthodox science in the race to quantify the normal (heterosexual) and the un-normal (everyone not heterosexual).

Since the Kinsey studies (1948, 1953), the field of critical sexuality studies has furthered our theories of the social construction of sex and sexual desires. As William Simon and John Gagnon (1986) argue, we are born into histories and cultures, and they influence how to behave and how we are categorized. In Kuhnian terms, this is a sociological paradigmatic shift for critically understanding sexuality away from a focus on people to societies – with an in-depth understanding of how societies socially influence sexualities. Even though Simon and Gagnon represent an influential perspective, most current research on sexual minorities is impaired by outdated latent categorical federal labels (e.g., OMB racial and ethnic categories). As a result, the preoccupation of research on LGBT populations with quantifiable static labels ignores the fluidity of sexual desires, behaviors, and identities (Plummer, 1998; Cahill & Makadon, 2014). To a lesser extent, there has also been a slow-but-growing focus on bisexual diversity as a population among LGBT populations in the United States (Bostwick & Hequembourg, 2013; Weinrich & Klein, 2002; Walton, Lykins & Bhullar, 2016). Today the research community is exploring the diversity of sexual identity classification systems (e.g., Gay, WHO's SOGI-classification system of sexual orientation and gender identity) and sociologically driven transnational identities that impact how LGBT populations categorize themselves in a global context (Grewal & Kaplan, 2001).

As an example of transnational identities, in Joseph’s book (2015), she describes how the construction of race is influenced by migration, social norms, and geographical locations. She coined the term *transnational racial optic* in which immigrants from one country will develop and assign social meaning to race in one country, while drawing conceptions of race from another. Joseph’s idea of re-categorization process is not new (Newby, & Dowling, 2007; Margolis, 2007; Tsuda, 1999). In Newby and Dowling (2007), the authors using constructivist methods demonstrated that Cuban immigrants living in Austin, Texas, were socialized and identified by the Mexican American immigrant and nonimmigrant community to be Mexican. Margolis has documented the same phenomena with Brazilians immigrants living in the U.S. to be Latino or Hispanic. Like Cuban and Brazilian immigrants, the bisexual identity has been culturally politicized, misunderstood, and depending where one lives, miscategorized (Boellstorff, 2011). This dissertation will later explore in chapter II this miscategorization process of bisexuals specifically and its impact on health outcomes. The present arguments within Queer theory, is for all this work on the categorization process, what’s missing is the work that focuses on *why they categorize* in the first place. Like bisexuals, why are Cubans and Brazilians misinterpreted as a group? This dissertation will explore these tensions as to why bisexuals are not valued as a stand-alone group.

Data collection of bisexual individuals is problematic, however, in the last five years during the Obama administration, there have been significant strides made in how to best collect data on and from bisexual individuals (Cahill & Makadon, 2014). Most notably, a recent Institute of Medicine (IOM) 2018 report on *Improving Health Research on Small Populations: Proceedings of a Workshop*, identified three groups who have historically been challenged with a lack of data: (1) LGBT, (2) Asian American, Native Hawaiian, Pacific Islander (AANHPI) health, and (2) the health of homeless populations. While there are promising survey methods provided in the IOM 2018 report as it relates to this dissertation topic there are, two recommendations provided: (1) a need to disaggregate data collection strategies for LGBT groups to explore the nuances of each population (bisexuals); (2) a need to utilize more qualitative emerging designs within research focused on small populations.

The support to collect sexual identity and orientation information was partially fueled by debates of Obama federal policies on how to collect LGBT health data (Sell & Holliday, 2014). This slight shift to collect LGBT health data within health research is not new (Bostwick & Hequembourg, 2013). HIV as a research study area along with critical social sciences (i.e., Queer Theory) has been at the forefront of advocating for LGBT health data (Minton, 1997).

Today the research community is documenting the positive experiences and self-esteem (Flanders, Tarasoff, Legge, Robinson, & Gos, 2017) of bisexual individuals. There is a growing body of literature on how healthcare services are accessed by sexual minorities (MacKay, Robinson, Pinder, & Ross, 2017; Alpert, Cichoskikelly, & Fox, 2017). Despite some progress, there still exists systemic challenges such as structural homophobia, biphobia, and transphobia (Bostwick & Hequembourg, 2014; Bonvicini, 2017). While the healthcare system is more LGBT friendly than historically (Cahill, Singal, Grasso, King, Mayer, Baker, & Makadon, 2014), as a healthcare system implicit and explicit bias still exists (Stone & Moskowitz, 2011). For example, Dodge et al. (2012) explained that bisexual individuals are not usually differentiated from gay men nor lesbians when studying health outcomes. The confusion between what is bisexual and gay/lesbian may lead to misrepresentation of the health needs of bisexual individuals (Friedman, et al, 2014).

CLAS Standards: healthcare policy implementation

One national policy has had a significant impact on how healthcare services for LGBT populations are delivered--the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (the National CLAS Standards). There are 15 National CLAS Standards which are focused on adopting, implementing and maintaining all Standards as the most effective approach to improve the health and well-being of all individuals – and these standards have been developed based on evidence-based literature (Estrada & Messias, 2015). The CLAS Standards provide end users with global strategies to improve healthcare services at the individual level. For health educators and training institutions (e.g., legal and social services professions educators) the CLAS Standards are incorporated into cultural and linguistic competence curricula. The CLAS Standards allow for the dissemination of research to practice and practice to research (Zuniga, Seol, Dadig, Guion, & Rice, 2013). The longer-term impact of the CLAS Standards has been their influences on policies and national priorities such as the Affordable Care Act, Healthy People Initiative, and the Federal Agencies strategic plans.

The National CLAS Standards are a framework for advancing health equity and constitute an implementation blueprint for healthcare accreditation and credentialing agencies. The policy muscle behind CLAS Standards is in the accreditation and credentialing branch where healthcare organizations are assessed by the extent to which culturally competent services are being provided. Within this sphere, the Joint Commission on Accreditation of Healthcare Organizations (accredit hospitals, health clinics, etc.), the National Committee on Quality

Assurance, professional organizations such as the American Medical and Nurses associations, and quality review organizations such as Peer Review Organizations are all end users of the CLAS Standards. The CLAS Standards are current Federal requirements for all recipients of Federal funds and are primarily directed at healthcare organizations. According to Office of Minority Health the standards, "culturally and linguistically appropriate services should be integrated throughout an organization and undertaken in partnership with the communities being served" (HHS OMH).

In 2013, the Office of Minority Health at the Department of Health and Human Services released new standards for the first time that are LGBT-inclusive. There are two distinct differences from the 2000 and 2013 standards. The first is how culture was defined in 2000 by racial, ethnic and linguistic group characteristics. In 2013, there was an increased focus on biological and sociological characteristics. This biological construct allowed for the first time the notion of sexual orientation and identity to be considered as a part of a cultural definition. The other subtle difference is the moving away from the definitional notion of patients/consumers to individuals/groups. This reframing allows a more critical and holistic lens in how to understand social groups and individuals.

In the case of this dissertation, the framing may help us better understand how bisexuals define themselves as individuals and how bisexuals fit within other social groupings. One typical misconception is a bisexual person is just confused and is really a lesbian, gay or heterosexual person. Under the 2013 CLAS classification a bisexual person is a group or individual. This classification is a significant move away from 2000 terminology of consumer or patient. Consumer as a term and in the traditional sense is an economic sorting term laden with a market driven doctrine. By separating individuals from groups, we can now begin to value people for who they are and begin to assess and understand social groups to be more complex and less viewed through a binary dimensional lens (straight and gay, black and white, democrat and republican). This underlying essentialist approach also allows room for sexual orientation to be more fluid and “in between” (Ding & Rule, 2012).

The 2013 revised National CLAS Standards policies, however, do not necessarily mean that the shift in how healthcare services are provided and facilitated for LGBT patients (Bilodeau & Renn, 2005) are uniformly positive. There is still a gap in knowledge in providing LGBT-inclusive healthcare (Banks, 2009; Gee, 2006). As some scholars have noted, translating policy goals into practice is a challenge, which can be messy and marred by misinterpretations (Davis & Howden-Chapman, 1996; Lindblom, 1979). This is especially the case when policy gets reinterpreted at different legislative levels and how key stakeholders and providers interpret these new standards/laws for their organization (Guba, 1984).

National LGBT health disparities priorities

In 2011, under the Obama administration, the IOM published a groundbreaking report, *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*, looking at contextual issues and health disparities of LGBT communities (IOM, 2011). Three of the seven key IOM recommendations centered around data and urged the NIH and other federal agencies to explore the development and standardization of sexual orientation and gender identity measures. One recommendation called for NIH to support methodological research related to LGBT health. However, these four recommendations were centered in conventional science definitions and beliefs that sexuality can be measured and is a relatively fixed identity. Other IOM recommendations encouraged exploration of LGBT health beyond the impact of AIDS/HIV, such as the need to examine other health topics such as eating disorders, obesity, and the role of stigma in accessing healthcare (Balsam & Mohr, 2007; Balsam et al, 2011). A second recommendation called for state and local communities to start developing systems of care for sexual minorities (IOM, 2004, 2006, & 2011). The 2011 IOM report represents a national starting point for other federal policies around LGBT health, especially the revision of the National CLAS Standards. Sadly, the Trump administration recently removed sexual orientation and gender identity questions from several national surveys (Cahill & Makadon, 2017). These actions will further marginalize the LGBT population and discount bisexual health as a priority.

Under the Obama Administration, there has been an explosion of federal policies incorporating LGBT-related language, and for the first time the recognition of bisexuals as a separate population. In March 2010, the Affordable Care Act allowed for insurance companies to no longer discriminate just because he or she is lesbian, gay, bisexual, or transgender. In 2010, there was the repeal of Don't Ask Don't Tell policy. In 2013, the Obama administration held one of two national Bisexual Leader Roundtable meetings[1]. In 2014, President Obama signed an Executive Order addressing the needs of sexual orientation and gender identity minorities from discrimination. Many of Obama's policies remain in place, however, the implementation of transgender bathroom laws and transgender inclusivity have been delayed and thwarted.

Under the Obama administration was the first time there were key national policies which include a clear distinction between gay and lesbians or transgender individuals. Oddly enough there is a consistent emphasis on laws protecting transgender populations. By contrast, while there were minor advancements in bisexual awareness, the bisexual community is often grouped with the gay and lesbian community. While the Obama administration policies are generally

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[1] One of the participants from the focus group was a member of Obama's Bisexual Leader Roundtable.

limited to the federal level, the state and local level policies are a more diverse quilt of laws, regulations, and ordinances. Slowly but surely, under the Trump administration most policies affecting LGBT communities have been rolled back.

Problem Statement

As the United States becomes more diversified, healthcare providers are looking for creative new strategies to provide culturally competent care. One hard to reach population are LGBT populations (Bonvicini, 2017), especially the bisexual communities (Friedman et al, 2014). Most of the health disparities literature conducted with LGBT populations explores the LGBT population as one unit (Summers, 2017; Ruben et al, 2017; Albuquerque, 2016) or a focus on Gay men (Race, 2015), Lesbians (Abdessamad, Yudin, Tarasoff, Radford, & Ross, 2013), and the Transgender (Reisner et al, 2015), and very little research has examined the health disparities of bisexuals (Baldwin et al, 2017; Semon, Hsu, Rosenthal, & Bailey, 2017).

The long-term impact of this research is to understand the health needs of bisexuals, who to inform regarding healthcare practices, and to provide culturally competent services for bisexuals. Today, the local communities, practicioners, and healthcare system are beginning to grapple with how to develop systems of care that embrace the diversity within sexual minorities (Mansh, Garcia, & Lunn, 2015; Lerner, & Robles, 2017). Bisexuals lack physical community spaces to socialize (Lambe, Cerezo, & O'Shaughnessy, 2017). However, with the advent of social media and online suppport groups (Lelutiu-Weinberger, 2017), there are visible platforms for social networking (McConnell et al, 2018; Karpiak, Larson, Seidel, & Brennan-Ing, 2017). While these online platforms are a form of social support and community connectedness, bisexuals still struggle to find online bi-friendly spaces due to biphobia from hetersexual and homosexual communities (Law, Mathai, Veinot, Webster, & Mylopoulos, 2015). Since there is more of awareness of LGBT populations, the lack of acceptance of bisexuals and understanding their experiences may be one approach to mitigate isolation, stigma, and health disparities affecting them.

Purpose of the Study

The purpose of this interpretive critical inquiry was to (a) understand the experiences of bisexuals and how their sexual orientation impacts health access; (b) based on the findings, offer suggestions and recommendations for community practitioners and state systems, and (c) identify the implications for public health planning in terms of addressing biphobia and a lack of understanding of the bisexual identity.

Research Questions

The purpose of this critical inquiry is to (a) understand the experiences of bisexual identity construction as it affects health access and utilization, and (b) understand how a federal policy implemented at the local healthcare organizational level has implications for bisexual healthcare needs.

The specific research questions are:

1. How is bisexuality as a social identity socioecologically understood?
2. How does bisexual identity disclosure influence health access?
3. How do local level healthcare providers interpret Federal CLAS Standards and what implications does this have for healthcare utilization and access by the bisexual population?

By using a qualitative evaluation design to assess the last question (Goodman, & Wandersman, 1994), this proposal will explore how and why bisexual self-identity impacts health access, and how and why healthcare providers understand bisexuality as part of the new enhanced 2013 CLAS Standards.

Definition of Terms

Bisexuality is traditionally defined as an sexual act with either men and women, but bisexuality is more complex when considering sexual attraction and desire (van Anders, 2015; Sears, 2016).

Biphobia is a “phenomenon distinct from homophobia, and appears to be slightly amplified when directed to bisexual men relative to women”, and this amplification manifests as prejudice, stigma, and discrimination (Friedman et al., 2014, p. 8).

Bi-erasure, according to Yoshino (1999), is a cause of bisexual invisibility and “manifests itself in the studied omission of bisexuality in discussion of sexual orientation… [and t]his elision carries over into the law” (p. 367).

Bi-inclusive is similar to bi-friendly in which policies, people, services, community spaces, and/or social groups welcome bisexuals (Barker, 2004).

Significance of the Study

This proposed study will provide contextual information on the lives of bisexuals and how they access health services, which may facilitate how healthcare providers can improve services and enhance help-seeking readiness, and thereby lead to appropriate utilization of needed care. There is little known about how to address underutilization of healthcare services among bisexuals. There is a lot of research which has focused on system and provider barriers by increasing access and availability of culturally and linguistically competent services through integration of healthcare service in primary care settings and addressing provider multicultural competence. Very little has been done to address bisexual consumer factors affecting healthcare underutilization. This proposal will add to the limited extant literature by exploring associations among health access, healthcare literacy, stigma, and related help-seeking behaviors for bisexuals.

Organization of the Dissertation

This dissertation is organized into five chapters, with a reference section, and appendices. Chapter I: Introduction, the current chapter, provides a brief overview of the problem as well as the purpose of the study, research questions, definition of terms, and significance of the study. Chapter II: Literature Review, offers a review of literature on bisexual health disparities, cultural competency models, and policy implementation strategies. These three concepts are appropriate to this study. Chapter III: Methodology, details the underlying theoretical paradigm of this study as well as the research strategies, participant and site selection, data collection and analysis, and trustworthiness of the study. Chapter IV: Data Analysis and Findings, describes the findings from the analysis. Chapter V: Conclusions, Implications, and Recommendations provides conclusions, implications of the results, and recommendations for future studies. Following the fifth chapter are the list of references and appendices.

CHAPTER II

LITERATURE REVIEW

Introduction

This chapter will provide an overview of the literature of different facets of bisexuality. This chapter is divided into three sections: (1) bisexuality defined, (2) bisexual health disparities, and (3) important ecological and policy implications for bisexual health. Part one will explore the social construction of bisexuality and how psychological measurement scales have influenced our understanding of bisexuality. In addition, the visibility of bisexuals is slowly reshaping our understanding of the fluidity of sexual orientation and identity (sexual identity and sexual orientation). This visibility is not well represented in the health care literature. Part two will explore the spectrum of LGBT inclusive healthcare in relation to bisexual health disparities. The last section, part three, will provide an ecological overview of bisexuality and how there is a lack of positive policies for bisexuals. To help frame the CLAS Standards, and overview of cultural competency models will provide a reference point to comprehend how the CLAS Standards are being implemented today. In addition, the CLAS Standards is also a helpful case example of how bisexuals are not considered within LGBT policies.

To our knowledge, this is the first study exploring bisexual health access with a predominate African American population. The literature review was conducted in two phases. The first phase explored the public health literature on bisexuality and health access. The second phase explored ecological and policy implementation studies. The literature review started with the dissertation proposal in 2016, and since then was refined to explore different aspects of bisexuality. Special emphasis was placed on studies from the Queer Theory literature and Critical Race Theory. Collectively the systematic review yielded approximately 140 studies [106 for bisexual health access; 35 CLAS Standards]. Key search terms included: bisexuality, bisexual health access, bisexual health disparities, bisexual health care, and CLAS Standards.

Part One: Bisexuality defined

Social construction of bisexuality

Reductionism within psychology (Putnam,1973; Barendregt, & van Rappard, 2004) has fostered a dichotomy of what is normal and unnormal (Ross, 2015; Belluardo-Crosby, & Lillis, 2012). For example, within the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (D.S.M. 5), there are sexual and gender diagnoses which have historically stigmatized, caused shame, and fear about a person wanting to express nonconforming gender norms. The classical example are individuals of the transgender umbrella. Individuals identifying as transgender were medically diagnosed as social oddities or as a moral affront to what is considered acceptable. Transgenderism was first medically diagnosed in 1965 by John Oliven as transsexualism, and also as a mental illness. Therefore, medically one can argue that transgenderism emerged in 1960s as a medical condition. This is not the case, transgender individuals have existed in all cultures and societies since recorded history (Stryker, 2008; Feinberg, 1996). Also, during the 1960s, transgenderism was indistinguishably interlocked with the homosexual identity (Armstrong, 2002). Today, though more thorough academic research, the transgender community has different social networks (Fassinger, & Arseneau, 2007), and has very different health outcomes from gays and lesbians (Graham, Berkowitz, Blum, Bockting, Bradford, Vries, & Makadon, 2011). It took science from the 1960s to 2013 for the notion of transgendered medicalized behaviors to be considered nonpathological. Using the transgender as an example, one can note that the commodification of knowledge can be messy.

Today, under the American Diagnostic and Statistical Manual of Mental Disorders (DSM-5), to be diagnosed as transgender are under codes 64.0, F64.1, 302.85, and 302.6 respectively and is not a mental illness but considered as gender identity disorder (GID).[2] For the transgender community, under these codes is defined what is medically normal and reinforced medical science. The notion of how medical science is understood and interpreted can vary across countries and cultures. For example, the Danish parliament in 2017 abolished the F64 Gender identity disorders. France removed gender identity disorder as a diagnosis by decree in 2010 (Atwill, 2010). Other countries such as India and Nepal have created Third Sex categories to compliment the male and female gender spectrum (Chhetri, 2017), and other international organizations such as the World Health Organization debate whether to declassify transgender identity as a mental disorder (Belluck, 2016). Regardless of whether the research community has agreed upon medical science, science will be interpreted and operationalized differently. Given how medical knowledge is gathered and used to improve population health, the bisexual community has not fared better than the transgender community when it comes to classifications.

The DSM-II, which was published in 1968, listed homosexuality as a mental disorder. This correlation between homosexuality as a mental disorder is rooted in religion, and viewed homosexuality as a sin (Drescher, 2015). Like transgenderism, the DSM followed in a long tradition in medicine and psychiatry in how bisexuality is medically classified. In 1973, D.S.M., published by the American Psychiatric Association, changed the diagnosis of "homosexuality" to "sexual orientation disturbance" and "ego-dystonic homosexuality". In 1987, "ego-dystonic homosexuality" was no longer in use. This process of classification and reclassification has created different societal meaning(s) and understanding(s) of transitional identities of what it

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[2] Transgender identity has changed in the D.S.M. too, classified under "sexual deviations" in 1968, "psychosexual disorders" in 1980 and "sexual and gender identity disorders" in 1994.

means to be bisexual. The D.S.M. medical classification process brings up an interesting notion (Wilkerson, 1994) of who has the authority to classify, categorize, or codify social groups.

The idea of who gets to define or categorize a group has a long and rich discourse within academia. For the purposes of this dissertation I will limit my discussions to sociology and the art of historiography. In a recent paper by sociologist Richard Jenkins (2000), he explores how categorization is understood in the social context and then the ways in which we as a society choose to categorize. Jenkins (2000) discusses the idea of pragmatic individualism, a social world in which it is also a world of embodied individuals. Jenkins work is inspired by Goffman and Giddens, in which "whatever-it-is-that-we-call-society" …[are] "a set of relationships within and between three orders of social phenomena" (p. 10). The first order, individual order, looks at the - "a world of embodied individuals and what goes on in their heads" (Jenkins 2000, p. 10). The second order, interaction order, examines "relationships between embodied individuals and what goes on between people" (Jenkins 2000, p. 10). The last order, institutional order, "the world of patterned, organized and symbolically templated ways of doing things" (Jenkins 2000, p. 10). Within each order the processes of categorization occur at different levels. Some categorizations, such as the institutional order, are more formal,while at the individual level, categorization is a more private and sometimes unknown to the external world process. As Jenkins argues, individual embodiment is central to the three orders. The idea of embodiment is gaining ground within qualitative methods to explore embodied experiences. In the case for this dissertation, the varying meanings of bisexuality and how the body is understood as a sexual object, and how manifestations of bisexual desires can be understood, is still a debate with many academics.

The second approach I want to explore is how the art of historiography can affect how social groups are defined in the present context and historically. The ability to fully comprehend a historical period is daunting and complex. Within any historical period, there are known facts and unknown facts. Braudel discusses how "history exists at different levels, I would even go so far as to say three levels but that would be… simplifying things too much" (p. 74). He argues that there are "ten, a hundred levels to be examined, ten, a hundred different time spans. On the surface, the history of events works itself out in the short term; it is a sort of microhistory. Halfway down, a history of conjunctures follows a broader, slower rhythm" (p. 74).

The further down you go, as Braudel argues (1982), then we are looking at historical period over a centur(ies) and some historical sites are well documented versus others. Using the LGBT history of New York State during the 1950s and 1960s, as an example, the microhistory would be the social organization of citizens living in New York City' Greenwich Village (Kissack,1995; Hanhardt, 2008) compared to the lesser known history of Buffalo's LGBT history (Kennedy, & Davis, 2014), while this "history of conjunctures follows a broader, slower rhythm" (Braudel 1982, p. 74) that Braudel (1982) discusses reflects the *longue durée* (p. 122), which looks at long-term historical structures over short term or "event history", *histoire événementielle* (p. 3). As Braudel (1982) argues, "the belief "[m]en make history. No, history also makes men and fashions their destiny" (p. 10). Braudel's insight is history is not something you can control or put in a box to fully understand. Braudel (1982) cites the examples of the alphabet, steam, numbers, fire, "all are impersonal and common in all cultures" (p. 201). Like bisexuality, there are many histories of bisexuality as it is defined by different communities, and certain communities with large LGBT populations are well documented and that knowledge commons gets generalized to the rest for all LGBT different populations/communities.

The notion of time needs to be separated from the construct of history as a field of study. To distinguish between time and the construct of history, Smail (2012) quotes how Nietzsche was amused one day, as he watched cows grazing in a pasture. He said “[t]he beast lives ahistorically.” In other words, cattle do not have a concept of time nor are they aware of their own history (Smail, 2012). Granted, humans are capable of recognizing historical events and comprehending them, while animals are aware of danger rather than being able to recognize and comprehend historical events. Braudel quotes Paul Lacombe when he states, “time is nothing in itself, objectively, it is only an idea we have” (p. 47). Braudel (1982) later distinguishes the historian from the concept of time and the practice of recording history, he states "[t]he historian can never get away from the question of time in history: time sticks to his thinking like soil to a gardener's spade" (p. 47). In Carr's work, What is History, he mentions how can you separate the "observer and the thing observed" within history facts are observed and recorded (p.158). The notion of "objectivity in history - if we are still to use the conventional term - cannot be an objectivity of the fact, but only of relation, of the relation between fact and interpretation, between past, present, and future" (p.158-9).

In Carr's chapter on 'Causation in History' (1961), he discusses how "Historians, like other people, sometimes fall into the language and speak of an occurrence as 'inevitable' when they mean merely that the conjunction of factors leading on to expect it was overwhelming strong" (p. 125). He later uses the example of how the Russian revolution of 1917, "a clash between the Bolsheviks and the Orthodox Church was inevitable" (p. 125). He suggests that the wiser words would have been "extremely probable" (p. 125). Regardless if it is "1538 or… 1958, the problem for anyone tackling the world scene is to define a hierarchy of forces, of currents, of particular movements, and then tackle them as an entire constellation" (Braudel, 1982, p. 34).

As Carr suggests, knowing causality within history is complex and multifaceted. We will never truly know all the true dynamics of how bisexuals have incorporated themselves into the LGBT community. The field of history, with the aid of archeology, sociology, anthropology, provide us with a historical idea to get an understanding of past events. The practice of history is essence "[a]ll historical work is concerned with breaking down time past, choosing among its chronological realities according to more or less conscious preferences and exclusions" (Braudel, 1982, p. 27). The quest to know the past is a process that utilizes available credible documents.

The concept of bisexuality is defined and historically operationalized differently (Smith, 1996) across cultures (Anderlini-D'Onofrio, 2003; Carrier, 1985) and nature (Roughgarden, 2004; Driscoll, 2008). Some present (Massad, 2002) and historical cultures (Sanders, 2009) look at bisexuality as an extension of homosexuality, while others look at bisexuality as a cultural import from colonization (Epprecht, 2006). For example, many African cultures believe that to be gay, lesbian, bisexual, or transgender in Africa is a result of European or Muslim colonization to Africa (Amory,1997). This histo-cultural aporia only fosters stigma, shame, and fear for sexual minorities.

Today, bisexuality is an umbrella term for "people who recognize and honor their potential for sexual and emotional attraction to more than one gender" (Bisexual Resource Center: USA). In practical terms someone is bisexual who is attracted to more than one gender. When one deconstructs the social term of bisexuality, there are several human components that need to be considered such as identity, behavior (sexual and/or romantic relationships to any sex [male, female, transgender] or gender, or two or more genders), desire, different attractions (physical, emotional, sexually), and potential to feel attracted. Bisexuality is not inherently transphobic or exclusive of non-binary genders. There are both gender binary and non-binary trans people who identify as bisexual. Bisexuality does not reinforce the gender binary stereotypes. Robyn Ochs a Bisexual Activist, “bisexuality is not half gay and half straight” (Bisexual Resource Center: USA). Bisexuality is also “not gay when dating the same gender and straight when dating a different gender” (Bisexual Resource Center: USA). Bisexuality is “not in between gay and straight” (Bisexual Resource Center: USA). According to Robyn Ochs a Bisexual Activist,

> “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” (“Selected Quotes by Robyn Ochs,” 2018).

Today, according to The Bisexual Organizing Project, the umbrella term of bisexuality has expanded to include “non-monosexual,” “persexual,” “omnisexual,” “ambisexual,” “pansexual,” or “queer” (http://www.bisexualorganizingproject.org). This expansion has caused more confusion on what bisexuality is to some. This dissertation will explore these concepts in later chapters.

Measurement scales

As noted previously**,** bisexual disclosure is marred by biphobia both from the heterosexual and homosexual communities. This biphobia is a direct result of lack of social group legitimacy of their sexual orientation from heterosexual individuals as well as lesbians and gay men (Alarie and Gaudet, 2013). This lack of acceptance is wrought by microaggressions, everyday slights and insults.

The question of what bisexuality is, how do you measure it, and how do we know bisexuality exists – are research questions pursued by several academics. The measurement is bisexual has origins with Klein’s Sexual Orientation Grid (KSOG) (Klein, 1993) (See Table 1). Klein’s seven-point model, for a total of 21 values, to assess the dimensions of sexuality at three different points in an individual's life: past, present, and ideal.

Table 1
Klein’s Sexual Orientation Gird (KSOG)

Variable	Past: early adolescence to one year ago	Present: last 12 months	Ideal: Idealized future
A. Sexual Attraction. To whom are you sexually attracted?			
B. Sexual Behavior. With whom have you had sex?			
C. Sexual Fantasies. About whom are your sexual fantasies?			
D. Emotional Preference. Who do you feel more drawn to or close to emotionally?			
E. Social Preference. Which gender do you socialize with?			
F. Lifestyle Preference. In which community do you like to spend your time? In which do you feel most comfortable?			
G. Self-Identification. How do you label or identify yourself?			

In Klein’s research, he noted that there are four types of bisexual people: transitional, historical, sequential, and, concurrent bisexuals. Transitional are people moving from a sexual orientation to another (heterosexual identity to a lesbian or gay or from lesbian or gay identity to a heterosexual). Historical bisexuals are people who in their past moved to a bisexual sexual relationship/space. Sequential bisexuals are people who have partners of different sexes at different times in their life-course. Lastly, concurrent bisexuals are sexually active with both men and women in the same time period.

Klein’s Sexual Orientation Grid is a good start to understand the geographic mappings of bisexuality. In Weinrich’s et al article (1993), the measurement of sexual orientation is classified into two camps – lumpers and splitters. The lumpers reduce sexual orientation/identity into “small number of categories”, while the splitters focus on the “differences among groups and individuals that make classification schemes increasingly difficult and/or intricate” (p. 157). This study questioned the utility of flexibility of the model. The factorial analysis concluded that both the lumpers and splitters are correct. However, outside of this study there are serious shortcomings to consider. For example, when considering sexual activity (past, present, and ideal) the number of partners or number of incidences is not clear. In regard to the ideal state, how is sexual desire differentiated from fantasy. This is also not clear. Moreover, it is possible for a person to be romantically attracted to another person (e.g., infatuation), which can include obsessive thoughts, desire, and fantasies to start or sustain a relationship to have one's feelings reciprocated. How is this complex set of feelings and emotions accounted for within the model? This is not clear. Klein’s model is lacking in its attempt to explain complex feelings and emotions.

Previous models were more gay or lesbian focused. For example, based largely on Cass’ work (1979) on gay identity development, “Fassinger and colleagues described gay and lesbian identity development” in four phases (awareness, exploration, deepening/commitment, and internalization/synthesis) “along the dimensions of individual and group membership identity” (Navarro, Savoy, & Worthington, 2013, p. 2). As Navarro, Savoy, and Worthington (2013), noted, “building upon the work of Fassinger and colleagues, Worthington, Savoy, Dillon, and Vernaglia (2002)” developed “a model of sexual identity that broadly establishes sexual orientation identity as just one of six components of individual sexual identity” (p. 2). These six components are perceived sexual needs, preferred sexual activities, preferred characteristics of sexual partners, sexual values, recognition and identification of sexual orientation, and preferred modes of sexual expression. Cass, Fassinger and colleagues, along with Worthington and colleagues did not address the sexual and personal dynamics of bisexuality.

Worthington and colleagues (2008) conceptualized the Measure of Sexual Identity Exploration and Commitment (MoSIEC) to explore the processes of sexual identity development. The MoSIEC model is influenced by Marcia's (1966) model of identity development. MoSIEC looks to measure sexual identity development by examining the processes of sexual identity development among individuals of any sexual orientation identity. MoSIEC includes four interrelated, but independent, dimensions underlying the construct of sexual identity, specifically (a) *commitment*, (b) *exploration*, (c) *sexual orientation identity uncertainty*, and (d) *synthesis/integration*. While the MoSIEC model is promising, as a model it does not capture the complexity of what it means to be bisexual.

Like Fassinger and Worthington, Mohr and colleagues (2011) developed the Lesbian, Gay, and Bisexual Identity Scale (LGBIS) is a 27-item measure designed to assess eight dimensions of lesbian, gay, and bisexual (LGB) identity. A typical question is "I am glad to be an LGB person" (Mohr & Kendra, 2011). Out of the 27 scale questions, ten refer to bisexuals as "LGB person". The other 17 questions do not refer to bisexuals in their questions. By combining bisexuals with LG convolutes bisexual identity construction.

A more promising scale, influenced by Klein's KSOG, is the Bisexual Identity Inventory (BII). Since there is only one scale that look at bisexuality, Paul and colleagues develop a 46-item assessing scale to explore facets of bisexual identity. BII was administered to a total of 422 self-identified bisexual participants. Through an exploratory factor analysis, the survey measurement concluded 4 factors: illegitimacy of bisexual identity, anticipated binegativity, internalized binegativity, and identity affirmation (Paul, Smith, Mohr, & Ross, 2014). Illegitimacy of bisexual identity, anticipated binegativity, and internalized binegativity were associated with positively depression and negatively correlated being out as bisexual (Paul, Smith, Mohr, & Ross, 2014). These findings are supported by the findings of this dissertation. On the other hand, identity affirmation (self-affirmation, pride) supported being out as bisexual. This is also supported by the findings of this dissertation.

In more recent studies there has been more of a deliberate strategy to explore bisexual sexual identity topographies in relation to stigma and bisexual disclosure. These studies are a direct challenge to the LGBT cannon on how bisexual identity has been portrayed or constructed in previous studies. In a study by Lambe and colleagues (2017), with a national sample of 203 bisexual women, binegativity was highly correlated discrimination from heterosexual individuals as well as lesbians and gay men, and internalized bisexuality negatively associated with self-esteem, depression, and being out as bisexual. Binegativity and discrimination has a direct effect on being out. If a bisexual person is not supported or feel supported within the LGT spectrum, then that will negatively affect being out. This notion of internalized binegativity is explored by other studies (Antebi-Gruszka & Schrimshaw, 2018; Dyar, Feinstein, Schick, & Davila, 2017).

A large part of the studies above explored various psychometric properties of these different scales and how these scales impact our understanding of bisexual identity construction. All of the studies above are quantitative in nature (e.g., factor analysis, regression) and only provide a limited lens of the bisexual identity. This dissertation hopes to augment existing literature and provide a different lens on bisexual disclosure influence on health access.

Bisexual Visibility

Structural inequalities in health are prevalent (Hatzenbuehler, 2014) and numerous national health strategies (McAllister, & Noonan, 2015), politico-legal (Salokar, 1997), conceptual models (Fredriksen-Goldsen, et al, 2014), and measurement scales (McCabe, Hughes, Bostwick, Morales, & Boyd, 2012) have been proposed to address them. However, the various national strategies, conceptual models, and measurement scales, while providing a layered understanding are also sometimes superficial and ignore selected subgroups or important social identities. One national strategy that has led to effective best clinical practices with LGBTQ populations, and has been adopted by most healthcare providers, are the National CLAS Standards which were adopted in 2000. Another promising conceptual model is one proposed by Fredriksen-Goldsen et al., in their (2014) Health Equity Promotion Model in which they incorporate (a) heterogeneity and intersectionality; (b) structural and environmental context; and (c) behavioral, social, psychological, and biological processes that influence health. The innovativeness of this model includes the incorporation of a life course development perspective.

Measurement scales for LGBTQ populations have matured from just looking at heterosexual behavior to exploring what was once deviant sexual behavior. Today, these measurement scales help us understand, on a continuum, what one's sexual orientation might be, but these quantitative scales do not speak to the lived experiences of LGBTQ individuals. Some of these identity measurement scales (i.e., The Lesbian, Gay, and Bisexual Identity Scale; LGBTQ Coming Out Stress Scale; Bisexual Identity Inventory; Klein sexual orientation Grid) provide a temporal lens on one's sexuality. As Ebin (2012) argued, at an individual level someone might had same sex relationships but not necessarily identity as part of the self-identified bisexual community. Behaviorally, epidemiologists would classify this person as bisexual or MSM. This could be the wrong method to classify someone. The long-term effects is that this subtle difference (individual and community) carries itself into the arena of medical care and how we provide care based on behavioral sexual patterns.

Bisexuals (men 39.3%; women 32.6%) have higher rates of nondisclosure to healthcare providers than lesbians (10%) and homosexuals (12.9%) (Durso & Meyer, 2013). This nondisclosure was linked to poorer psychological wellness at one-year follow-ups (Durso and Meyer, 2013). In a recent qualitative study, a Canadian research team interviewed 41 respondents and determined there were four principle traits which impacted medical help seeking: (a) the availability of health services, (b) the process of finding health services, (c) barriers and facilitators to accessing health services, and (d) the experience of service utilization (MacKay, Robinson, Pinder, & Ross, 2017). As discussed in the final section of this dissertation, all these factors were evident with the 36 bisexuals in this dissertation.

Also addressed in the discussion section will be how sexual orientation nondisclosure is perceived to be easier for adolescence than older populations. In a (2017) study with 383 cisgender bisexual youth, parental support did not act as a protective barrier for bisexual men and women (Pollitt, Muraco, Grossman, & Russell, 2017). In fact, the adolescents in this study experienced higher stress than their heterosexual counterparts. Coming out as bisexual is socially riskier than coming out as gay due to biphobia issues.

Sexual identity and sexual orientation (SOGI)

One of the key Obama policies was a national move to collect more data on the LGBT sexual identity and sexual orientation (SOGI) populations. Sexual identity and orientation questions were methodically included in several national health surveys (e.g., since 2105, sexual identity and orientations questions have been asked in the National Health Interview Survey, National Survey on Drug Use and Health, National Health and Nutrition Examination Survey, etc..). Both the IOM and The Joint Commission have recommended asking sexual orientation and gender identity (SOGI) questions in clinical settings. However, as the 2012 IOM report noted, while there are some national surveys that collect sexual identity and sexual orientation data, there is still little health data on LGBT populations. This lack of data makes it difficult to track progress in measure progress in addressing sexuality related health issues, to benchmark progress at both at the national, state, and local levels, and to tell a story of how certain diseases manifest in different populations. However, as many survey methodologists have noted, the smaller the population the more difficult it is to collect reliable quantitative data.

One significant Obama policy move was to collect Sexual Orientation and Gender Identity (SOGI) data using electronic health records (EHRs) (Sanders, Feit, & Alper, 2013; Haas, Lane, & Working Group for Postmortem Identification of SO/GI, 2015). While the inclusion of SOGI was without hesitation and concern by the administration, one concern that emerged among health care providers was which of the best practice standards should be used to collect SOGI data (Cahill, Singal, Grasso, King, Mayer, Baker, & Makadon, 2014). In 2015, the Centers for Medicare and Medicaid Services and the Office of the National Coordinator for Health Information Technology provided national guidance on the collection of SOGI data in clinical settings (Cahill, Baker, Deutsch, Keatley, & Makadon, 2016). Despite these significant strides in the collection of SOGI data, the 2016 Presidential election promises to change much that progress since the Trump administration in 2017, removed SOGI questions from one national aging survey (National Survey of Older Americans Act Participants - NSOAAP) and later on that same year the U.S. Census Bureau stepped back its commitment to include SOGI questions. The policy impact of these decisions has a direct effect on the allocation of federal funding to state and community services. At a personal level, LGBT groups felt ignored and discounted.

Part Two: Bisexual Health Disparities

Overview of bisexual health disparities

A growing body of evidence across disciplines has demonstrated significant disparities in health outcomes and barriers to healthcare accessibility experienced by bisexual individuals (Friedman, Dodge, Schick, Herbenick, Hubach, Bowling, ... & Reece, 2014). Negative health outcomes exist for both cisgender and transgender individuals who are on the bisexual orientation spectrum (Katz-Wise, Mereish, & Woulfe, 2016). These health disparities suggest sexual orientation may function as an axis along which bias operates, similarly to race and socioeconomic status, to produce disparities in health and ability to access healthcare. In a healthcare system characterized by “two-gender medicine” (Snelgrove et al, 2012) and “bisexual erasure” (Yoshino, 2000), bisexual individuals and communities experience informational and institutional erasure in regard to their health.

Informational erasure is the product of a number of factors. It is a result of healthcare providers’ lack of knowledge about many aspects of bisexual healthcare and of how bisexuality is socially constructed (Moleiro & Pinto, 2015; Valentine, 2003). Institutional erasure occurs through a failure to recognize and accommodate bisexual health needs (Barker & Langdridge, 2008; Bostwick & Hequembourg, 2014). Additionally, there is a shortage of healthcare providers who are knowledgeable about bisexual health and have competence addressing gender identity (IOM, 2011; ODPHP, 2010). An assessment by Stanford University of U.S. medical schools found the median combined hours dedicated to teaching LGBT health to be only five hours across the entire four-year curriculum (Obedin-Maliver et al, 2011). A vast majority of medical schools do not offer LGBT-specific clinical sites, and less than half have required curriculum dedicated to LGBT-specific health needs (Sanchez et al, 2006; Obedin-Maliver et al, 2011). Schools of public health also have limited LGBT focus within their curricula. Less than 9 percent of school of public health departments had ever offered an LGBT course extending beyond work on HIV and AIDS (Corliss, Shankle, & Moyer, 2007). Less than ten percent had a doctoral student in their department who had ever completed a dissertation on lesbian, gay, bisexual, or transgender health (Corliss, Shankle, & Moyer, 2007). In many respects like medical schools, schools of public health are still struggling to learn how to incorporate LGBT health research agendas and create an environment that is LGBT friendly (Snowdon, 2013).

Within medical schools today there is a concerted effort to separate the T (transgender) from the LGB (lesbian, gay, bisexual) (Stroumsa, 2014; Gardner & Safer, 2013). There is also an emphasis on providing transgender individuals with culturally competent healthcare (Safer & Pearce, 2013) and training (Lim, Johnson, & Eliason, 2015; Utamsingh, Kenya, Lebron, & Carrasquillo, 2017). Transgender individuals, unlike the LGB populations require more specialized healthcare such as gender reassignment transitional care. Within medical and clinical care management, out of the LGB communities, there is little to no emphasis on the bisexual culturally competent healthcare within medical schools (Sanchez, Rabatin, Sanchez, Hubbard, & Kalet, 2006). Within the medical care model, gay and lesbians have traditionally been the center of medical treatments.

Within medical schools, beyond technical competency, interpersonal competency in working with bisexual patients is a particular challenge for healthcare providers. This issue is not a new challenge for providers. For example, an assessment of LGBT health research found significant gaps in studies on bisexuality and health, particularly on healthcare inequities, and intervention research (Institute of Medicine, 2011). This gap is misleading and supported by how public health and medical professionals conduct and focus their research. For example, most of the research within schools of public health (41%) have a faculty member conducting LGBT health research (Corliss, Shankle, & Moyer, 2007). However, most of the research is related to HIV (Corliss, Shankle, & Moyer, 2007), and this research is focused on risky sexual behavior – and bisexual identity is confused with gay identity. This skewed research emphasis results in bi-erasure and contributes to our understanding of bisexual health.

Since bisexuality has been socially framed and grouped with other sexual minorities which may affect their perceptions of self-worth. For example, a higher percentage of bisexual adults (13.3%) reported being dissatisfied or very dissatisfied with their life compared to heterosexual adults (5.2%) (Vankim, Padilla, Dakota, & Pride, 2010). The dissatisfaction and stigma of being bisexual also affect other aspects of people's lives. In a 2012 study by the Williams Institute, bisexual individuals were significantly less likely than lesbians and gay men to disclose their sexual orientation to their medical provider. According to this study, 39 percent of bisexual men and 33 percent of bisexual women reported not divulging their sexual orientation to any medical provider, compared to only 13 percent of gay men and 10 percent of lesbians who chose not to disclose (Durso & Meyer, 2013).

“Bisexual women were less likely than heterosexual women to have health insurance” and more likely to have difficulty obtaining needed medical care (Diamant, Wold, Spritzer, Gelberg, 2000, p. 10). “Whether a bisexual woman or lesbian has disclosed her sexual orientation” affects “the likelihood of having or having had mental health problems” (Koh & Ross, 2006, p. 10). Bisexual women were more than twice as likely to have had an eating disorder compared to lesbians (Koh & Ross, 2006). Berg, Mimiaga, and Safren, (2008) found bisexual men seeking health services had higher rates of depression (55.1%) and anxiety (23.6%). Bisexual men have more relationship problems (20.2%) and feelings of isolation (10.0%). They also have sleep problems (12.4%), mood swings (10.0%), sexual compulsions (7.9%), and substance abuse (7.9%). Saewyc, Homma, Skay, Bearinger, Resnick, and Reis (2009) found that bisexual youth had lower levels of protective factors. For example, bisexual youth reported less family and school connectedness than heterosexual youth.

Nature of Bisexual Health

Depending from which academic discipline one draws information and conclusions about bisexuality, the knowledge quilt depicting bisexuality is ever changing and at times inconsistent. Bisexuality has largely been influenced by several academic disciplines. Psychologists explore human behavior, Sociologists spend their time looking at social and structural associations (i.e., race, social mobility), Anthropology focuses on culture, Queer theory as a multidisciplinary area of study philosophically deconstructs heteronormativity, within the English rhetorical analysis process writers explore intent and textual meanings, Histographical writings are based on available historical sources (availability of historical documents only depict known viewpoints - for example, how do we know Alexander the Great was bisexual?), Art as a field explores the margins of eroticisim, and so on… Bisexuality as a field of study has been influenced directly and indirectly by all these disciplines. Bisexuality is primarily a mixture of the act of information smuggling from other academic disciplines (i.e., Queer Theory exploration on the range of human sexual desires, while advocating that self-definition of sexual orientation is constantly in a mobile state) and is highly influenced by inferential and descriptive statistics to understand bisexual behavioral patterns. This state of information gathering has resulted in a skewed and limited view of bisexuality. In some cases, according to the academic literature (Welzer-Lang, 2008; Weiss, 2004), bisexuality is on parity with other sexual orientations (gay and lesbian). In other words, bisexuality is synonymous with either gay or lesbian identities. This has created greater confusion within the academic literature. For example, bisexuals are grouped with either gays or lesbians. In addition, for the transgender population, there is a societal assumption that when someone transitions from their own gender to another, they assume the sexual orientation of their desired new gender. This dissertation will tease the sociocultural labels of bisexuality and explore the varying degrees of how health access is managed by bisexuals. In addition, this dissertation will look at the multi-dimensionalities of bisexuality as an entity and how that influences health access.

Besides the patchwork quilt of what we know of bisexuality, the bisexual community is a disenfranchised community with significantly more health disparities than other sexual minorities. There are many research articles and some summary reports (IOM, 2011; Rust, 2002; Albuquerque et al, 2016; Blondeel, et al, 2016) that have been published on Lesbian, Gay, Bisexual, Transgender (LGBT) health. However, there is significantly more research and health data available on lesbians and gay men, than is available for transgender and bisexual communities. In 2011 the Institute of Medicine (IOM) published The Health of Lesbian, Gay, Bisexual and Transgender People, and it quickly became the national benchmark for the state of LGBT health in the United States. With this IOM report, the National Institutes of Health (NIH) formed a committee, NIH LGBT Research Coordinating Committee (RCC), which was charged with “developing and coordinating potential research and training opportunities to be undertaken at the NIH as a result of recommendations from the Institute of Medicine (IOM) report on LGBT health issues...” (NIH LGBT Research Coordinating Committee, 2013, p. 1).

The significance of the 2011 IOM Report is that it provided the first comprehensive overview of the health of LGBT populations in the United States. In addition, the report also explored what were the present scientific research needs. The 2011 IOM report noted that data and research on LGBT populations' health are quite limited. "Existing research has focused primarily on gay men and lesbian women and on certain health risks (e.g., HIV/AIDS, sexually transmitted infections, substance use/abuse, and mental illness)" (NIH LGBT Research Coordinating Committee, 2013, p. 4).

The IOM charged NIH to develop a research agenda to advance the health of LGBT populations and undertake specific actions to implement a research agenda. Table 1 in the appendix (Summary of IOM Report Recommendations and Related Issues) summarizes the IOM Committee's recommendations and specific health conditions/risks identified as particularly important for LGBT populations. The committee used McLeroy's social ecology perspective as one way to better understand the healthcare landscape of LGBT communities. This application of a social ecological model was couched within sociocultural and institutional mechanisms to frame minority stresses over the life course. Bisexuality was by definition intersectional and responsive to both heteronormative and homosexual biases.

The urgency to develop a comprehensive and coordinated LGBT research agenda is a result of the lack of historical research on LGBT populations and present health inequities. The IOM Report noted that there was more research on gay and lesbian populations and less on bisexuals and transgender persons. According to the RCC, the majority of FY 2010 funded projects focused on gay men or men-who-have-sex-with-men (MSM) as a category. Most of the funded projects dealt with sexually transmitted diseases. The RCC also noted a number of projects that included or focused on bisexual men, bisexual women, and/or men who have sex with men and women (MSMW). Again, these projects primarily focused on sexual transmitted diseases.

Today, according to the 2016 NIH's Sexual and Gender Minority (SGM) Research Strategic Plan, there is an SGM research portfolio totaling $898,656, which were awarded to nine grantees (National Institutes of Health, 2015). This strategic plan is coordinated by the Sexual and Gender Minority Research Office (SGMRO), which resides within NIH's Office of the Director (OD) and oversees programs and activities of the NIH's 27 centers. The SGM research portfolio was focused on three priority populations designated by NIH: transgender, men-who-have-sex-with- men (MSM), and at-risk populations (e.g., youth, high-risk individuals). Unfortunately, like the RCC noted in 2010, the 2016 SGM research portfolio grouped bisexuals with the MSM populations (Alexander, Parker, & Schwetz, 2016). Today under the Trump administration sexual health and sexual and gender minority research agendas are slowly being eliminated. This purging process is further isolating bisexuals as a population from the health services and social welfare research agenda (Starrs, 2017; Gonzales, & McKay, 2017; Seegert, 2018; Fenwick, 2018).

Since the 2011 IOM on LGBT health, the 2016 NIH's Sexual and Gender Minority (SGM) Research Strategic Plan is the second report (first report in 2015) in which the federal government reports on SGM research priorities. This SGM Research Strategic Plan is designed to help guide efforts to increase research and supporting activities in SGM health. These activities have four goals and 11 objectives that are based on the 2011 IOM on LGBT health.

While the 2011 IOM provides an in-depth overview of the state of LGBT health, LGB populations are clustered together with a specific emphasis to distinguish transgender from the LGB as a needed area of focus. This bundling of how to view the LGBT community is framed by a three-chapter life course analysis (Childhood/Adolescence; Early/Middle Adulthood; Later Adulthood). This framing only adds to the confusion as to how to distinguish bisexuality from the LGT domains. The number of bisexual studies are limited and often included as a subpopulation within gay or lesbians classifications. For example, while bisexual health is primarily interwoven with gay and lesbian health, within some chapters transgender health disparities are highlighted and featured as an area that needs further research. Bisexuals do not often receive this individualized focus. Part of the reason for this clustering within the 2011 IOM is a challenge to how bisexuality has been defined based on sexual behavior. This has been a past challenge for the research community to "(1) operationally defining and measuring sexual orientation and gender identity, (2) overcoming the reluctance of some LGBT individuals to identify themselves to researchers, and (3) obtaining high-quality samples of relatively small populations" (p. 89). These three conditions have led to bisexuality being viewed as an objet trouvé which has begun to receive more attention within the academic literature since the 2011 IOM report.

Ebin's (2012) article, 'Why bisexual health', argues for a foundation, a common language to understand bisexuality and how bisexuality is framed at the individual and community-level. While there is a self-identified bisexual community, there are others who have sexual attractions or behaviors and are not necessarily part of a community. This dichotomy can be a challenge to recruit and identify bisexuals within health services research, especially at Ebin's individual level. One reason for this contradiction is how self-identified members of the bisexual community struggle to gain and retain bisexual spaces. This notion of lack of spaces is well argued in a 2012 study where bisexual men in the Midwest could not identify as a visible bisexual community and expressed difficulty belonging to a community (Dodge, Schnarrs, Reece, Goncalves, Martinez, Nix, ... & Fortenberry, 2012). Even within this bisexual community concept, bisexuality faces stigma both from heterosexuals and homosexuals. While heterosexuals do not understand bisexuality, the homosexual community doubts bisexuality exists and that a person who self-defines as bisexual is really gay or lesbian. This idea that bisexuality is less valued, or a second order sexual orientation fuels a monosexist world view (Flanders, Ross, Dobinson, & Logie, 2017).

One strategy to distill how stigma can play a role in health outcomes is by using the minority stress framework to better understand the micro-agressions that are directed at bisexuals. These aggressions are in part caused by social stigma, individual prejudice (either form the heterosexuals and homosexuals), and institutional discrimination (Baptiste-Roberts, Oranuba, Werts, & Edwards, 2017; Friedman, Dodge, Schick, Herbenick, Hubach, Bowling, ... & Reece, 2014). This idea of minority stress is supported by a qualitative (2014) study which emphasized "bisexual-specific microaggressions include hostility; denial/dismissal; pressure to change; dating exclusion; and hypersexuality" (Bostwick, & Hequembourg, 2014; p. 488).

The minority stress framework has been used in numerous research studies to understand how health disparities manifests themselves within the bisexual community, especially within HIV/AIDS, substance abuse, and mental health research. Within HIV/AIDS research there is an argument of the "bisexual bridge" of HIV transmission. This bridge has been used epidemiologically to explain HIV transmission to the heterosexual community, but this explanation also fuels the notion of blaming bisexuals (Malebranche, 2008). One long-standing prospective cohort study (Multicenter AIDS Cohort Study) conflicts with this argument but with some caution. The study asked the question of do men-who-have-sex-with-men-and-women (MSMW) have higher rates of polydrug use, depression symptoms, and HIV viral load levels compared with men-who-have-sex-with-men-only (MSMO). These results indicated that MSMW were more likely to have higher depression scores, polydrug use, and viral load levels than MSMO (Friedman, Stall, Silvestre, Mustanski, Shoptaw, Surkan, ... & Plankey, 2014). Part of the explanation is how micro-aggressions manifests themselves at different levels and how bisexual men are misunderstood within the present public health interventions.

These stressors have also been well documented in substance and mental health research. Bisexuals have higher rates of concurrent substance use and HIV risk behaviors (Friedman, Kurtz, Buttram, Wei, Silvestre, & Stall, 2014). There are a large number of studies looking at the state of mental health within the bisexual community (Johnson, 2016; Persson, & Pfaus, 2015). There is a general consensus that more mental health research is needed (Taylor, 2018). While there is a need for more mental health research, it should be noted that the field of psychology historically has been more interested in quantifying bisexuality in all its forms – desire, attraction, and behavior as opposed to identifying and treating co-occurring mental health conditions. This quest has led, in part, to the mislabeling of bisexuality from a fluid sexuality spectrum to a fixed sexual orientation label.

In Taylor's 2018 article, *Bisexual Mental Health: A Call to Action*, a comprehensive literature review was conducted, and several themes emerged: invisibility and erasure; stereotypes and biphobia; identity and labels; intimate relationships and sexual behavior; coming out; community and belonging; and positive aspects. Some of these themes are not new. Some of the themes considered in this chapter are the bisexual coming out process and how more difficult it is for bisexuals than their gay and lesbian counterparts. Leonard et al (2012) noted bisexual males are the least likely to have disclosed their identity. Some studies have addressed positive aspects of bisexuality. In Rostosky et al.'s (2010) study, respondents expressed a sense of freedom to be who they are, and ability to expression without a fear of social rules and a rebuttal to binary sexual orientation scale.

LGBT inclusive care

To provide inclusive bisexual medical care is not a straight forward process. One issue is how medical staff are approachable to bisexual health needs in the midst of changing national policies. Another issue is how a person's bisexuality is recorded in medical records. Lastly, even if a person's medical clinic is bi-friendly, a question remains what outside health systems are available to be supportive to bisexuals needing specialized medical care. In part, the source of these issues lie in how medical staff are trained and schooled.

Medical school education devotes little time to educate future medical doctors on LGBT health issues (Tamas, Miller, K. H., Martin, & Greenberg, 2010; Snowdon, 2010). In a recent JAMA published study, of 176 Canadian and U.S. medical schools, 150 schools responded to a 13-item questionnaire on LGBT inclusiveness. On average, the schools that provide LGBT centered medical education devote on average 5 hours within the entire medical curriculum to LGBT health. "Of the 132 [Canadian and U.S. medical schools] respondents, 9 (6.8%) reported 0 hours taught during preclinical years and 44 (33.3%) reported 0 hours during clinical years" (Obedin-Maliver, Goldsmith, Stewart, White, Tran, Brenman... & Lunn, 2011). Additionally, this study discussed further how some medical schools that focus on LGBT related content taught students to ask patients if they "have sex with men, women, or both" when obtaining a sexual history (Obedin-Maliver, Goldsmith, Stewart, White, Tran, Brenman, ... & Lunn, 2011). Studies have shown when medical students are exposed to LGBT related content they are more likely to be responsive to the health needs of LGBT patients. Sanchez et al., (2006), noted that "medical students with greater clinical exposure to LGBT patients reported more frequent sexual history taking with LGBT patients, had more positive attitude scores, and possessed higher knowledge scores than students with little or no clinical exposure" (p. 21). However, medical students tend to better understand the lesbian and gay populations first, followed by the transgender, and are generally less tolerant of the bisexual communities.

In the last 10 years, there has been an explosion of awareness around LGBT clinical care. Much of this progress within medical schools is in part due to the Obama administration's positions on LGBT inclusivity (Byne, 2017). Within the Obama administration, there were policy directives to embrace transgender care and inclusion of LGBTQ populations in military service, a national committee on bisexual issues, the Defense of Marriage Act (DOMA) was abolished, same sex marriage was sanctioned as a federal policy, etc.. In addition, NIH designated sexual and gender minorities (SGM) as a health disparity population, and SGM health research increased 10-fold. Also, former US Secretary of HHS, Kathleen Sebelius, created the Internal LGBT Coordinating Committee to ensure that SGM health concerns would be considered in all its activities. Today, the Trump administration is rolling back many of the Obama regulations and promoting federal policy that is not LGBT friendly (Glied & Frank, 2017). Since bisexuals get lost and forgotten with the LGBT spectrum, the rolling back of many policies will have more of a negative impact on a population that has struggled to be recognized.

Part Three: Important Ecological and Policy Implications

Ecological Approach

Ecological models have a distinct historical lens in how health is understood. For example, Lewin's 1951 ecological psychology is one of the earliest ecological frameworks exploring environmental influences on health (Sallis, Owen, & Fisher, 2015). Other ecological approaches such as Moos' (1990) social ecology looked at four broad environmental factors: (1)

physical settings, (2) organizational settings, (3) human aggregate, and (4) social climate. Cohen's (2000) structural-ecological model also has four categories of structural influences. These influences range from physical to social structures and policies. Cohen also incorporates media and cultural messages within the model. One last ecological approach is Stokols (2003) social ecology model for health promotion has four assumptions. The first assumption explores some common themes in ecological models: how health behavior is influenced by one's environments; the role of settings in how people influence health behaviors; and, the importance of human-environment interactions on health. Stokols also writes that environments are multidimensional (which could be interpreted as social constructs). While all these models explain how social context interacts and influences health, all these models are heteronormative in assuming one's social identity is static.

One classical model is Bronfenbrenner's ecological model which suggested that a person's development was impacted and affected by their surrounding environment (Bronfenbrenner, 2009). Bronfenbrenner's model was developed to better understand adolescence and how certain interactions impact a child's development. In Bronfenbrenner's model there are five different levels: the microsystem, the mesosystem, the exosystem, the macrosystem, and the chronosystem. Each level is a nested system within the others. Microsystem is an individual's human relationships and/or interpersonal interactions. Mesosystem is the second layer surrounding the individual which defined by interpersonal interactions (family, friends, etc,). The third system is the exosystem, and within this layer there are interactions that do not affect the individual directly but may do so indirectly. For example, losing their job and a lack of financial stability that may impact a child's development. The macrosystem is the outer most layer and highlights the cultural and societal beliefs that influence an individual's development.

There are several public health and psychological models that can assist public health frame health over the course of one's life span, most notably how contextual factors can and do have an impact over one's health. What Bronfenbrenner's model also discusses is how time is conceptualized and how time as a phoneme can impact individual's development. In Bronfenbrenner's model, this notion of time is broadly defined as chronosystem. Chronosystem is defined as changes in family structure, residency, or employment networks. Chronosystem is based on four principles – process, person, context, and time. Process in simplistic terms is the systematic interactions between each level and what that process can differ from person to person. The second principle, person, observes how each person differs from another person in personal characteristics. In particular, within this archetype there are two nuances of social interactions and a person's developmental journey across the life span. Bronfenbrenner notes that some aspects (age, sex, gender) are more obvious and easier to measure than others (physical and mental health). Context is an interesting observation that Bronfenbrenner notes and is the framework for understanding the social ecology of behavioral interactions. More globally, Bronfenbrenner describes context as micro-, meso-, exo-, macro-, and chronosystems. Finally, the concept of time is loosely defined categorically (liberal or conservative) and continuous (height or weight) measurable products. Bronfenbrenner relies on examples of how family values are considered as part of the time principle. What he refers to is how values or morals are shared between generations. The idea is how morals can shape an individual's personal development.

Even though Bronfenbrenner's model looks at how child development occurs across multiple stages, what is missing from the model is how romantic and sexual relationships impact one's social networks and psychosocial development. More specifically, how an individual chooses to acknowledge, identify, and socially affirm their sexual preferences – and how sexual preferences and identity as a *process*, over *time*, nurtures the *person* and impacts the *context* (different levels). Sexual desires and how individuals choose to couple is not static and may change over time. Bronfenbrenner's model is heteronormative and assumes that sex and gender are fixed social constructs. As we know today, sexual desires have manifested into a kaleidoscope, from heterosexual to pansexual, of personal sexual tastes and desires. With this heteronormative assumption, there is also an underlying belief that if a woman likes a man their sexual desire is a permanent photograph. This is not that case. People's sexual desires and attractions change as they mature, and experience (that woman experiences a same sex relationship) and gain new sexual knowledge (that same woman may explore sexual bondage play as she matures). Typically, bisexuality as an identity is not fixed over one's life course. Nor are the individual's sexual desires and attractions. Understanding bisexuality presents an opportunity to explore Bronfenbrenner's model boundaries.

Queer scholars have long argued that academia is heteronormative. This heteronormative argument has roots in feminist critique in the definition and utility of gender. Feminist, along with critical race theorists, have argued how scientific-driven conceptual models or frameworks lack a racial or feminist lens. Recognizing the Feminist lens is important to re-theorizing the social-cultural relationships among individuals. Queer theorists owe much to early feminists for leading the discussion on gender inequities. Today, Queer literature has explored the tensions of how desires and sexual preferences, along with sexual identity, can change over time. From a Queer theorist perspective, one can argue that the ecological model is heteronormative and lack a queer lens.

A more adaptable approach which can reconsider queering within Bronfenbrenner's ecological model is McLeroy's socioecological model (McLeroy, Bibeau, Steckler, & Glanz, 1988). On the surface, the interrelationship of the text between the two models (Bronfenbrenner-McLeroy) differ, are related, and in many ways similar. Nonetheless, there is this notion of intertextuality linking the two models which look at the same ecological settings. While there are few studies comparing the two models directly, there are many studies examining and applying Bronfenbrenner or McLeroy models. This brief discussion of the two models hopes to honor how ideas migrated from one model to another. My hope is that this intertextual analysis is to stimulate debate on this issue between different approaches and as to why which model is best to use for this dissertation.

In McLeroy's model there are layers or levels within the social ecology, from the individual which is the core of the model to policy the outer layer. Each layer may have a direct impact on a person's health but as embedded systems, each layer or level influences the other levels in the model. For example, with the interpersonal layer there are several studies that explore the role of family or a medical provider in facilitating health (Austin, 2011). The organizational (Bagchi, 2015) and community layers (Smith, Whitehead, Sheats, Chubb, Alema-Mensah, & Ansa, 2017) explore healthcare systems and community partnerships respectively. Policy the most outer layer (Anderson, Likens, Rozzi, Gutiérrez, Armesto, & Poole, 2008), explore the complexity of how policy development and implementation affect a person's health outcomes.

Not only does each level of the ecological model have the potential to affect the health of individuals and collectives, but each level may influence other levels. In the example above, organizational context may affect the behavior of health care providers, rules and regulations may affect the behavior of individuals seeking care, and providers and patients may mutually affect each other. Again, these are complex systems with bi-directional feedback occurring across levels and across time.

Like Bronfenbrenner's model, McLeroy's socioecological model does not directly consider how one's sexual desires or preferences change over time and how these changes impact health outcomes. Unlike Bronfenbrenner's model, McLeroy's model is less rigid and more welcoming to being critiqued by Feminist and Queer traditions. In addition, within the public health field, McLeroy's model is widely used as a way to decode the influences of ecological layers. Within public health, McLeroy's model has been viewed by the Feminist lens (MacLellan-Peters, & Aston, 2009). The Feminist tradition has slowly critiqued present public health approaches (Daykin, & Naidoo, 1995; Bowleg, 2012). Some of the origins of Feminist critiques of public health are centered on sexual reproduction (Thorogood, 1999) and sexually transmitted diseases (Wilton, 1994). As Wilton notes, "the social construction of gender and sexuality has influenced the design and delivery of health promotion in the field of HIV/AIDS prevention… Educational materials on safer sex for women are scarcer, and less explicit than those available to men" (p. 64). Thorogood (1992) explored early on how sex education prevention programs have "constructed through notions of heterosexual desire" (p. 64). On the other hand, Moore (2010) argued "the body is essentially uncontrollable (yet something we should seek to control, as a matter of virtue), that it is a good in and of itself, and that it is synonymous with the self" (p. 59). For the purpose of this dissertation, McLeroy's model will be used because there are more studies looking at sexual health than Bronfenbrenner's model.

Cultural Competency: Historical Background, Definitions, and Models

The purpose and need for cultural competence is loosely connected and rooted in the civil rights movements of the 1960s and academic discipline shifts to understand different cultural groups. The legal-political foundation of cultural competence is embedded within several civil rights movements, federal laws (i.e., Civil Right Act of 1964), federal mandates (i.e., CLAS Standards), and, in turn, resulted in governmental guided cultural competence directives as part of federal and state funding requirement for social service and health programs (Kohli, Huber, & Faul, 2010). How academic departments evolved also had a significant impact in how we understand culture. The academic process to decode culture has its beginnings in large part in anthropology and sociology. Historically, anthropology focused nonwestern “cultural” systems (“the other”) to understand micro level human interactions, while sociology was preoccupied with examining Western “social” systems and how macro level social structures impact existing social problems (Kroeber, & Parsons, 1958). These two academic disciplines greatly influenced our understanding of cultural and social diversity. Both anthropology and sociology dealt with the role of culture, and both also share theoretical frameworks.

Lum (2000), discussed that to be competent implies “capability, sufficiency, and adequacy.” (p. 6) Within healthcare delivery, cultural competence, as an operational traditional definition, is centered around awareness and humility to bridge the gap between two or more cultural groups to effectively deliver health care services focused on cultural, social, and linguistic needs of patients. Another way to consider cultural competence is to view it as a patient-medical provider discourse tool for decision making. This tool is grounded in evidence based theoretical principles, and healthcare systems have devised benchmarking to assess success and challenges. This discourse process is grounded in intercultural and cross-cultural values that is a reiterative process between the one cultural person/group with another cultural person/group. In how we, in American values, conventionally respond to cultural competence, it is nestled between the notions of collectivist and individualistic positions. Individualistic outlook is when a person's motivation and behavior are determined by personal goals, rather than considering the shared group interests and values. Collectivist beliefs are group driven and typically exemplified within immigrant communities (Vandello, & Cohen, 1999). These traditional values are universal standards within many cultural competency theoretical frameworks.

Collectivist and individualistic American values have been evident with cultural competency different models. The 1950s was dominated by the melting pot with an emphasis on the treatment of clients' problems (Chau, 1990). The 1960s reflected an awareness of different cultural contexts in which treatment included consideration of clients' sociocultural contexts (Harper & McFadden, 2003). As an indirect result of the civil rights movements, the 1970s was dominated by the minority perspective that highlighted the political and economic turmoil with an emphasis was placed on minority perspectives. Thus, models included information on people of color and women (Gould, 1995; Montiel & Wong, 1983). The 1980s and 1990s was dominated cultural pluralism and multi-culturalism models respectively. Cultural pluralism models explored oppression and the importance of identity development (Harper & Lantz, 1996; Torres & Jones, 1997). Multi-culturalism models explored "not only ethnic and racial issues, but also age, sex, gender, physical and mental abilities, sexual orientation, religious affiliation, and political affiliation" (Harper & Lantz, 1996, p. 10). Thus far, many of the cultural competence models were influenced by an emphasis placed on respecting racial and linguistic differences (Kohli, Huber, & Faul, 2010; Engebretson, Mahoney, & Carlson, 2008). The multi-culturalism models of the 1980s and 90s can be considered a linguistic turn in that culture was not only defined by race, ethnicity, and language but now expended to sexual orientation and identity. This expansion provided for a more globalist re-definition and reconstruction of culture. Within the early 2000s, an ethnocultural framework emerged as a social constructionist framework to "teach.. workers to become morally active practitioners." (Kohli, Huber, & Faul, 2010; p. 256) This definitional evolution of culture is typical and indicative in how we define and redefine what is known and include what is not known in a common definition. In the case of this chapter, we will explore how bisexuality as an identity is incorporated in federal policy around LGBT populations and cultural competency.

In regard to developing cultural competency models, along with nursing, psychology (counseling), and social work are three academic fields that have pioneered in developing effective cultural competency models. These professional fields have practitioners that interact constantly with different populations. As a result, many models have been developed. For example, the Giger and Davidhizar Transcultural Assessment Model was developed in the late 1980s for nursing students[3] to assess and provide care for patients that were culturally diverse (Giger, & Davidhizar, 2002). Counseling as a profession has developed innovative models, from the stress-resistant delivery model[4] (Smith, 1985) to the adoption of the *Multicultural Counseling Competencies and Standards* by the American Psychological Association (Sue, Arredondo, & McDavis, 1992). Finally, within social work, the culturally transferable core model, within the context of neoliberal principles, acknowledges the struggles to provide responsible care due to

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[3] Other models include the Purnell Model for Cultural Competence which is an organizing framework for student nurses to use as a clinical assessment tool (Purnell, 2002). More universal models, grounded in the field of nursing, have been developed. The 3-D puzzle model of culturally congruent care is focused on the ways in which culture influences nursing care from an emic, or insider, perspective (Schim, Doorenbos, Benkert, & Miller, 2007).

[4] Explored the importance of understanding stress factors in clients' lives and how to distinguish stress from prejudice and discrimination.

lack of resources available for social service, and how these resources are defined by whom and for what purpose (Taylor, 1999).

While there was a recognition of sexual orientation (aka, linguistic turn) as a variable during the 1990s multi-culturalism models, bisexuality remains understood and not a priority population (Craft, & Mulvey 2001; Clark, Landers, Linde, & Sperber, 2001). In an half-hearted attempt to remedy the lack of bisexual representation, there are many national guidelines in how to provide culturally competent care to the LGBT as a larger community (McNair, & Hegarty, 2010; Taskforce, Harper, Finnerty, Martinez, Brace, Crethar, H.... & Kocet, 2013). In the last ten years or so, there has been a slow shift, both professionally and academically, to substitute LGBT for the term ‘sexual minority’. This shift can be confusing for individuals not familiar with the LGBT community. This sexual minority terminology has furthered diluted the bisexual identity with the LGBT spectrum, and predominately focused on the gay and lesbian populations. For example, Crisp’s (2006) gay affirmative practice scale (GAP) allows for practitioners to assess their own beliefs and assumptions of gay and lesbians. However, prioritizing and highlighting bisexuals remains of low importance. Bisexuals have to deal with biphobia both from heterosexual as well as lesbian and gay individuals. This biphobia process only marginalizes bisexuals even further. This marginalization phenomena is discussed by Scherrer (2013) social work study that recommended a closer examination of bisexual identity development in light of how biphobia influences practitioner attitudes about bisexuality. Scherrer’s study is a first step to develop a cultural competency training addressing bisexual social service needs.

Review of CLAS Standards

The National Standards for Culturally and Linguistically Appropriate Services in Health Care (National CLAS Standards) was published in 2000 by U.S. Department of Health and Human Services, Office of Minority Health. The purpose of the National CLAS Standards is a framework for healthcare services to provide appropriate cultural and linguistic needs of all individuals. Today there are fifteen standards, each guideline is an action step that benchmarks professionals and organizations in their implementation of culturally and linguistically appropriate services.

In 2013, in an effort to update the National CLAS Standards, the federal government introduced the National CLAS Standards Enhancement Initiative to expand its scope and become more reflective of the U.S. diversity spectrum. There are two significant differences between 2000 and 2013. The first key definitional difference is how culture is defined as a racial, ethnic and linguistic group in 2000 when compared to 2013. The 2013 revised definition was expanded to include biological and sociological characteristics.

According to Novins, Beals, Roberts, and Manson, culture is understood to be “customs, beliefs, values, communications, and actions, wholly partially, with racial, ethnic, or linguistic groups, as well as with religious, spiritual, biological, geographical, or sociological characteristics” (p. 10). The concept of culture (Novins, Beals, Roberts, & Manson, 1999), within the standards are largely rooted in native language (Hovey, 2000), social memberships (Hovey, 2000), health literacy (Hovey, 2000), shame and stigma (Roush, Brown, Mitchell, & Cukrowicz, 2017). Novins, Beals, Roberts, and Manson also note that “culture is dynamic in nature, and individuals may identify with multiple cultures over the course of their lifetimes” (p. 10). Moreover, this definition of culture “also attempts to reflect the complex nature of culture, as well as the various ways in which culture has been defined and studied across multiple" academic disciplines (p. 10).

This evolving modification of what is culture allowed for the first time the notion of sexual orientation and identity to be considered as a part of cultural definition. Pulling from the standards, the definition of sexual orientation which encompasses attraction, desire, identity, and behavior. Most researchers studying sexual orientation have defined it operationally in one or more of the following four classifications[5]. (Sell, 2007; Shively, Jones, & De Cecco, 1984) First, in terms of behavior, sexual orientation can be referred to a developmental array of sexual or romantic activity with men, women, or both sexes. (Bem, 1996) A second definition focuses on attraction or desire of sexual or romantic feelings for men, women, or both sexes. This identity includes both personal identity as well as social identity. (Diamond, 2003a) An increasing popular definition is how personal identity refers to a self-based pattern of sexual and romantic attractions and behaviors toward men, women, or both sexes. (Diamond, 2003b) The most widespread definition is based on a social (or collective) identity and this classification refers to a sense of association within a social group based on a shared identity of sexual orientation, and this social membership is closely connected to one's self-esteem to that group. (Weinrich, & Klein, 2002)

A second difference with the CLAS standards is the reframing from patients or consumers to individuals or groups, has allowed for a reconsideration of how complex population dynamics need to be considered when determining group dynamics. This research notion to try to understand group dynamics is not new and allows for a deeper understanding of

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[5] When considering the LGBT identity canopy, the terminology around sexual orientation and gender identity is more expansive and diverse that the LGBT acronym. LGBT as an acronym refers to a sense of a community consisted of commonalities around sexual orientation and gender identity.

how complex the sociological landscape can be. The categorization of patients or consumers is rooted in market-driven operational definitions. Patients, like consumers, are medicalized-commercial terms used to understand customer behavioral trends and health consumption patterns. Depending on what healthcare services one is seeking, healthcare patients and consumers are viewed in light of a health symptom (Schilder, Kennedy, Goldstone, Ogden, Hogg, & O'Shaughnessy, 2001). For example, if one person is being treated for suicide ideations, there are many evidence-based cognitive treatments and psychometric scales to determine the severity of the disease (Tarrier, Taylor, & Gooding, 2008). The disease largely defines, and overshadows, the person as a whole. Medical decisions are based on primarily the understanding of disease. This approach is a modern humanist approach, and according to Corliss Lamont, medical decisions are made "primarily upon reason and science". (Francoeur, 1987)

This re-definition of patient or consumer is significant for a social group, such as bisexuals, who are representative of all races, ethnicities, non-gender binary, socioeconomic status, etc.. Historically, within the healthcare industry, bisexuals have been viewed as infectious disease patients or consumers. Like a suicide survivor example, there is an underlying stigma and shame associated with certain diseases. In the case of persons who are suicide survivors or associated with risky sexual behavior, these are value laden categories that influence how approach and interact with these persons. Moving away from stigmatizing medical terminology, we can now begin to value individuals for who they are and begin to assess and understand social groups to be more complex and less viewed through a binary dimensional lens.

There are two examples that illustrate how the CLAS standards are adjusting to contemporary definitions of sexual orientation and gender identity. The first example explores how the medicalization and politicization of a patient's body can negatively impact sexual orientation and gender identity minorities when seeking healthcare. For example, in the gender discrimination case of transgender woman who was seeking breast examination and mammogram based on her sex in March 2013 exemplifies how the body is heteronormatively gendered and politically objectified. (Lombardi, & Banik, 2015) The complainant Jennifer Blair, a Colorado transgender woman, alleged that the Department of Public Health and Environment, Women's Wellness Connection Collaboration (WCC), denied her funding for her breast examination and mammogram. (Lombardi, & Banik, 2015) In the case for denying the examination, WCC referenced the Centers for Disease Control and Prevention (CDC) policy guidance stating that grant funds could only be used to cover women who are genetically female. After much lobbying from LGBT interest groups, "CDC issued guidance to its grantees stating that grant funds can now be used to provide services to transgender women (male-to-female transgender individuals) who have taken or are taking hormones to increase their screenings for mammograms and other preventative services." (Lombardi, & Banik, 2015, p. 20) Blair's discrimination case is an example of how CDC was asked to clarify policy in what gender is or is not. This policy re-interpretation accounted for how the different components of cultural norms of gender can change with time.

While Jennifer Blair's case is an example of group norms can medicalize and politicize gender, the case of *Jenny and Jessica Buntemeyer t*estify how antiquated forms collecting demographic are. Jenny and Jessica legally wed on October 8, 2010 and remain in the Army Reserves[6]. Shortly thereafter, Jessica became pregnant via in vitro fertilization through an

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[6] On April 3, 2009, the Iowa Supreme Court upheld the lower court's ruling, making Iowa the third U.S. state to legalize same-sex marriage, after Massachusetts and Connecticut.

anonymous donor. On October 21, 2011, Jessica gave birth to Brayden, who died soon after he was born. On the “death certificate form Jessica filled out the boxes for mother and Jenny filled out the boxes marked father, which were the only option on the form for a second parent” (Leonard, 2013, p. 10). On January 12, 2012, the Iowa Department of Public Health (IDPH) issued them a death certificate on which someone erased Jenny’s name and identifying information. After a high-profile legal case, Buntemeyer v. Iowa Dept. of Public Health, in 2012 the court ordered an accurate death certificate to be issued for Brayden. (Duncan, 2013; Leonard, 2013) The Buntemeyer case illustrates how having traditional policies (mother and father categories) in place is not sufficient to providing culturally and linguistically competent services. What the CLAS standards remind us is that policies must also be monitored and enforced, given how we define cultural groups.

Review of Policy Implementation

This section will provide a conceptual framework background to understand the National CLAS Standards implementation processes, both at the national and state levels. Policy development is operationally radically different from how policy implementation occurs. Policy effectiveness is not easily discernable. Given this ambiguity, policy implementation is a complicated field of study.

The field of policy implementation studies is extensive, and this section will focus on three schools of thought: top down, hybrid, and bottom up implementation theories. This section will be an overview to better understand how policy implementation is not a linear and flawless process. By examining how policies are crafted and the implementation process will gain a deeper appreciation for what constitutes a successful policy.

There are some underlying assumptions of what an ideal performing policy looks like – from execution and how to regulate the policy. A more realistic version of policy implementation involves partisan "philosophical reflection and political debate" that is based on different interest groups "expression of basic principles and aspirations." (Pressman, & Wildavsky, 1984: p. 176) Pressman and Wildavsky (1984) further noted that "[i]n between, where we live, is a set of more or less developed potentialities embedded in pieces of legislation, court decisions, and bureaucratic plans." (p. 176) What Pressman and Wildavsky reminds us is that through, in large part, both legislative and judicial feedback loops fuel an everchanging policy landscape.

Interest groups can also change and amend policies, and that can impact policy effectiveness. After a policy drafted and implemented, policy success can be determined by various interest groups, stakeholders, and individuals. What is success to some might be considered a policy shortcoming to others. Policy success is largely determined by the policy chain of causality. In other words, "the more numerous the reciprocal relationships among the links and the more complex implementation becomes," the more difficult to assess policy achievements. (Pressman and Wildavsky, 1984: p. xxiv) These numerous reciprocal relationships complicate how we execute and regulate policy. Lindblom's classic 1959 article, *The science of "muddling through,"* typifies how complex and non-linear policy execution and implementation are.

There are three schools of thought to help us organize the complexities of policy implementation. The top-down approach is a linear view consisting of a series of chains of command where policy formulation occurs at the national level and the implementation phase transpires with managers at lower levels of government. Pressman and Wildavsky are advocates of this approach. Within the top-down approach, policies contain clearly defined goals against which performance can be measured.

The bottom-down approach is the extreme version of the top-down approach. The assumption of bottom-down method depends on the success or failure of public and private actors who get involved implementing policy programs. At the local level, policy implementers may change the way of polices implemented, and often redefine policy objectives because they are closer to the problem. This local level policy implementation is an interactive process characterized by negotiation and bargaining. Lipsky is a leading theorist within the bottom-down approach. Lipsky coined the term street-level bureaucrats as leading policy protagonists (Lipsky, 2010). As Birkland characterized the "[b]ottom-up approach recognizes that [policy] goals are ambiguous rather than explicit and may conflict not only with other goals in the same policy area, but also with the norms and motivations of the street-level bureaucrats." (Birkland 2015: p. 182) Unlike the top-down approach, the bottom-up method is grass roots in nature, leaves more for protracted conflict resolution, and has the potential for stakeholder buy in. A good test of a good policy is not whether it meets objectives but whether there is agreement on the policy. As Lipsky noted, through the local level negotiation, individual decisions of street-level bureaucrats do add up and form the backbone of agency policy. The bottom-up method is not perfect and seamless process but, like the top-down approach, provides a way to conceptualize how policy implementation can occur at the local level.

The hybrid approach is a mixture of both top-down and bottom-up approaches. Majone and Wildavsky are leading figures within the hybrid approach. Within the hybrid method, policy change is an interactive and recognized as a complex process. As Majone and Wildavsky noted "when we act to implement a policy, we change it." (Dery, 1998: p. 166) The first act of policy change is the execution of a policy, and policy changes are authored by both national and street-level bureaucrats. Also, changes to a policy are natural and expected throughout its life course. Policy development and implementation is not a fixed process nor is the policy objective static. This depiction is at the heart of the hybrid model.

As Majone and Wildavsky discussed "[w]hy is it reasonable to assume that the final results will be genetically related, however indirectly, to the original policy idea?" (Majone & Wildavsky, 1984: p. 147) This causal assumption is typical and dangerous for those interpreting policies. To illustrate this point, the proposed policy exclusion of pre-existing conditions from the Affordable Care Act (ACA) would change the nature of the ACA. However, the popular common interpretation still views ACA with the same essences of when the policy was crafted. In reality when key provisions are removed from the ACA legislation really means a change under the "same name (ACA) conveys very different realities" and interpretations. (Majone & Wildavsky, 1984: p. 145) So, changes to ACA over time are just as relevant as the policy intent and measuring its success. This modification paradox exemplifies the best and shortcoming of the hybrid model.

In part, Wildavsky's work on the hybrid model was influenced by Charles Lindblom's essay, "The Science of 'Muddling Through'" (1959) which looked at policy as incremental. Or in other words, incrementalism refers to the study of "muddling through" behavior policy development (Lindblom, 1959). Incrementalism is an integrated approach, and policy development is contextual to other policies, socioeconomic-cultural contexts, and evolutionary in nature (Scott, 2010). In other words, only rarely are new policies developed which are not related to other policy objectives. Instead, policy development is built on existing policies and revised similar to an evolutionary process. The appearance of this evolutionary process is slow, frustrating, confusing, and small revisions can appear insignificant. A common public argument that often arises from this appearance is government is sluggish, antiquated, and unresponsive. That is not the case. Policy development and implementation is contextual and complicated. The small changes are just as significant when compared to original policy development. The two changes to the CLAS Standards is an example of this significance, and the basis for the chapter.

Summary of the Literature Review

This chapter reviewed three aspects of bisexuality (how bisexuality is defined, bisexual health disparities, and ecological and policy implications), at least three phenomena that appear to be pervasive in the literature today. One, bisexuality is not easily measured and understood. Second, bisexual health disparities are marred by lack of data and lack of visibility in the literature. Lastly, from an ecological perspective, bisexuality is more complex than previously thought. In addition, from a policy and cultural competency lens (The CLAS Standards), bisexuality also lacks visibility which further bisexual marginalization. These three constructs—how bisexuality is defined, bisexual health disparities, and ecological and policy implications—are germane to this dissertation study aimed at coming to understand the experience of bisexuals. The following chapter. *Chapter III,* describes the methodology used to carry out the study.

CHAPTER III

METHODOLOGY

This chapter details the methodology for this study, including the five components that comprise methodology—theoretical paradigm (Denzin & Lincoln, 2005), research strategies, participant and site selection, data collection and analysis, and trustworthiness. In addition, the specific methodological strategies (semi-structured, focus groups) for this study will be explored to understand the health access challenges of bisexuals. The following sections will also introduce the qualitative evaluation approach for FORmative Evaluation Consultation And Systems Technique (FORECAST) model used to understand the CLAS Standards.

Theoretical Paradigm

The term "paradigm" was popularized by Thomas Kuhn (1970) and later elaborated by Burrell and Morgan (1979) to "designate a shared set of ontological and epistemological assumptions that unites a community of scholars and prescribes specific guidelines for conducting research" (Prasad, 2015, p. 8-9). Along this line of reasoning, paradigms are "overarching philosophical systems" (Lincoln, 2005, p. 230) or a paradigm is "the net that contains the researcher's epistemological, ontological, and methodological premises" (Denzin & Lincoln, 2005, p. 22). As Guba (1990) noted "to put it baldly, paradigmatic assumptions determine research strategy" (p. 106). As Lincoln discussed when we adopt a paradigm, this decision impacts every aspect of the inquiry (Guba, 1990). Lincoln further notes researchers either assume that

"1. There is a real world out there that one can know more or less well and where one could explain relationships among phenomena and attempt to generalize from one situation to another, or
2. it is possible to worry about whether there is a real world so one should concentrate on reporting and clarifying people's interpretations about what is happening in specific settings" (Guba, 1990, p. 107).

The first position is positivist and the second is constructivist and as Lincoln notes "there is no middle ground" (Guba, 1990, p. 107). Within positivist and constructivist, the notion of research traditions guides the research process and are a "complex ensemble of assumptions, world views, orientations, procedures, and practices [e.g., researcher training]" (Prasad, 2015, p. 8). Within qualitative traditions (ethnography, critical theory, symbolic interaction), a researcher can pair their own intellectual inclinations and a particular field of inquiry. By becoming familiar with qualitative traditions one can maximize and match researcher skills to the different traditions.

Within research, traditions are constantly morphing and adjusting to real world realities. "Traditions can be invented, established, ransacked, corrupted and eliminated" (Prasad, 2015, p. 8). Within qualitative traditions, critical theory will be employed as an analytical lens in this chapter. Critical theorists provide a unique lens to unravel complex social phenomena. The philosophy of what embodies critical theory tradition is *ideology critique* a "systematic critique of ideological forces in every aspect of social life" (Prasad, 2015, p. 139). In particular for this study by looking at how bisexuality is defined and understood within LGBT studies, critical theorists question the production of knowledge with the hope to emancipate knowledge from conventional traditions. By examining academic driven definitional conception of bisexuality, critical theorists explore the "inconsistencies, contradictions, distortions, and asymmetries" (Prasad, 2015, p. 149).

Positivism, Interpretivism, Critical Theory, and Assumed Paradigmatic Knowns

Paradigms are organized into several schools of thought and for this chapter I will focus on two – (1) conventional inquiry is positivism; (2) interpretive or naturalistic inquiry is interpretivism or constructivism (Denzin & Lincoln, 2005; Guba & Lincoln, 2005; Guba, 1990; Lincoln & Guba, 1985). For the purposes of this study, critical inquiry (e.g., critical theory) will be approached within the ensemble of qualitative research (Prasad, 2015). This section first provides an overview of the three paradigms – positivism, interpretivism, and critical theory—that can guide an inquiry. For each paradigm the axiological approach to knowledge creation will be discussed. After a review of positivism, interpretivism, and critical theory, the rationale for using the blended genre of interpretive critical inquiry will be discussed.

Positivism

Positivism is rooted in a realist ontology. Typical phrases such as "how things really are" or "how things really work" emphasizes that there is a real world out there which can be measured (Guba, 1990, p. 19). In other words, we can only know what the world tells us through objective and tested observation (Howell, 2012). Positivism is also known as empiricism or scientific empiricism. Ontologically, positivism postulates that there is a real world to be learnt and measured. How reality is understood with positivism is sometimes called naïve (or direct) realism. Epistemologically the researcher and external world are separate and through the scientific process truth can be known. Positivism assumes that it is free from a value system (axiology) (Lincoln & Guba, 1985).

Finally, the assumed paradigmatic knowns are tasks or targets such as programs, how program implementation is conducted, or policy sponsors (both the legislative and voter driven initiatives). Academia, with the assistance of OMB racial and ethnic classifications, does play a significant role in our understanding of certain minority populations. For example, how racial and ethnic classifications evolved was through an interplay between policy makers using evidence-informed data from academia to codify racial and ethnic groups. The classic examples are US Census and how OMB developed its racial and ethnic classification system. These policies are reductionist in nature, and supported by statistical descriptive and inferential inquiry.

Interpretivism

Morehouse (2012) cites Westerman to explain the philosophical principles of interpretivism as the "lived world is always *in medias res*, or in the middle of things" (p. 2). When studying social life, interpretivism is sometimes used as a synonym for all qualitative inquiry. In essence, interpretivism acclaims there is relativist world of multiple realities that are socially constructed in which the "knower and known are interactive, inseparable" (Lincoln & Guba, 1985, p. 37). Constructivism is "an example of interpretivist thought", and one key assumption of behind this thought is "reality is a social, and, therefore multiple construction" (Guba, 1990, p. 233-4). Positivists are nestled in objective facts while the interpretivist knowledge is: (1) "grounded in knowledge, not.. armchair speculations", (2) "represents inside understanding", (3) "knowledge… not nomothetic models but holistic", (4) "identify truth with internal consistency", and, (5) is "value-bound.. [and] social inquiry is meaningful only because it does involve values" (Guba, 1990, p. 235). In other words, while positivism's ontological view is that there is one reality, external to the mind, and capable of being studied in parts – interpretivism differs from this philosophical thinking. One other striking difference in axiological terms is that while interpretivism inquiry is value laden, positivism is not.

Prasad (2015) notes that the interpretivist tradition covers several fields such as symbolic interactionism (a search for self and meaning), hermeneutics (interpretation of texts), dramaturgy (life as theater), ethnomethodology (study of ordinary life), and ethnography (cultural meaning). Within this varied fields, the methodological approaches to understand the lived experiences range from historical text analysis to participant observation. Other methods include case study, ethnography, life history, phenomenology, and ethnomethodology.

Building on what stated in the previous section, positivism on assumed paradigmatic knowns, this section expands the target definition to include sexual minority groups. While positivism responds and works with known classification systems, interpretivism through phenomenological research expands population research to explore other entities such as men who have sex with men (MSM), women who have sex with women (WSW), or sexual orientation gender identities (SOGI). These entities were created as a respond to a need. Unlike racial and ethnic entities that are codified by policy makers, MSM, WSW, and SOGI are sexually behavioral entities developed through research by academics, especially epidemiologists. These entities were in response to a need in the existing literature to address gaps how to classify a population having same sex encounters.

Critical Theory

Critical theory has a long rich tradition of providing a different analytical lens on social phenomena. This lens is disruptive and challenges the status quo. Critical theory originates from the Frankfurt school (Horkheimer, Adorno, Marcuse, Benjamin, Fromm, and Habermas) (Kincheloe, & McLaren, 2011). The critical theory tradition has been shaped by many theorists such as Michel Foucault (medicalization of sexuality), Kimberly Crenshaw (intersectionalities), and Paulo Freire (social justice). As Prasad notes that critical traditions "are best characterized as a set of intellectual positions that examine social arrangements through the lenses of power, domination, and conflict" (Prasad, 2015, p. 145). Critical theorists also share with interpretivists that the world is socially constructed (Prasad, 2015). In essence, critical traditions are committed to both critique and change. This commitment to change by critique is embedded in freeing oppressed groups from material and symbolic domination (Guba & Lincoln, 2005; Denzin, & Giardina, 2016).

In the process of freeing oppressed groups, the researcher is engaged with the researched, and in praxis, what emerges is a socially conscious action that becomes intertwined with the researcher and those researched (Denzin, & Giardina, 2009). The epistemology of the critical tradition it is subjectivist, formed between the researcher and the researched, and aims for emancipation from the oppression. For the critical tradition, the ontology is historical realism, a "virtual reality shaped by social, political, cultural, economic, ethnic, and gender values, crystallized over time" (Guba & Lincoln, 2005, p. 193). The methodology is dialogic in nature. The axiological stance of critical tradition is guided by the researcher's values and more than value laden.

By now, hopefully, one can see how the assumed paradigmatic knowns change and grow with each theoretical framework. It is within the critical theory approach that we can see bisexuality as an identity well defined. It is the critical theory approach that challenged the conventional positivist classification systems, and with the interpretivist approach we see a challenge to positivism. As a reminder, the positivist approach works with largely classifications systems such as racial, ethnic, gender, age, socioeconomic status; while interpretivism is expanded to new sexual orientation categories (MSM, WSW, SOGI).

Critical theory by its very definition is a critical lens or sociocultural critique. The critical lens can provide a voice for silent persons. In Lincoln's 1993 article, *I and thou: Method, voice, and roles in research with the silenced,* the bisexual voice(s) have been largely silent and ignored. The critical lens acknowledges the lack of understanding within sexual orientation, in this case bisexuality, to expand to new sexual orientation classifications such as pansexual, omnisexual, queer, and genderqueer. These categories will be discussed later in the Data Analysis section. Like the interpretivist approach building upon the positivism, critical theory utilizes interpretivism and positivism as a platform to react to and critic how we socially construct categories. In our data, there was a cry for new classification system to go beyond the bisexual identity. Many participants dual identified as pansexual and bisexual, or bisexual and queer, or bisexual and genderqueer.

Assumed paradigmatic knowns

One chilly wet Monday afternoon, October 15, 2018, I met with Dr. Lincoln at Blue Baker on University Avenue. I had a list of questions pertaining to the methodology section of my dissertation. She was patient and answered my questions, one by one. One nagging question stemmed from Dr. Lincoln's Constructivist Credo book where she lists out presumptions, arguments, and rationale on the nature of knowledge and inquiry. This nature and making sense of knowledge is centered on four axioms - ontological, epistemological, methodological, and axiological. To me, there was something missing and

I could not properly vocalize it.

I will not be shy to say that I struggled (yes, I was nervous) to explain to Dr. Lincoln as to why I saw something missing or not clear in limiting to these four axioms for the purpose of this dissertation. I am a practitioner at heart, and while these four axioms provide a framework on the nature of knowledge, to me something was not clear from a practitioner's viewpoint. In looking at the four axioms and the dissertation research questions on policy and how bisexuality is framed, I asked myself what axiomatic perspective needed clarification. The present four axioms did not fully address a contextual landscape that is constantly changing. More importantly, in my own words I saw that change agents/tasks can impact the outcomes for each framework (e.g., positivism, interpretivism, etc.).

I began my long question (or need for clarity) while providing examples from books, articles, and observations from life. While we struggled through this question with Blue Baker being cold (the heat was not turned on), the conversation was spirited and warm. Dr. Lincoln finally saw what I was trying to ask, even though my words and question was protracted with a sense of personal uncertainty. In her excitement she said, "I got it" and she mentioned that I explore "tasks" in her 1986 article. Then she paused with her head bowed down and said "assumed paradigmatic knowns" will be the fifth column. I said that is it, then she told me to draft our conversation while she had a cigarette outside. In essence, the addition of a fifth category, *assumed paradigmatic knowns*, recognizes while each theoretical framework compliments one another, and they are also very unique from one other in how they are "experienced by.. clients and targets" (Lincoln, & Guba, 1986, p. 36). In Lincoln and Guba's (1986) article, there is a discussion on how "some consideration of paradigmatic underpinnings of inquiry may.. suggest where choice of paradigm [or in this case the theoretical framework] might prove crucial in the outcomes of inquiry efforts" (p. 2). In other words, one can argue that each theoretical framework has mutually desired outcomes or operational knowns such as impact on a program, a certain population, etc…

According to the Constructivist Credo (2013), below operational definitions of different paradigm presumptions (1) ontology, (2) epistemology, (3) methodology, (4) axiology, and assumed paradigmatic knowns. (Lincoln & Guba, 2013, p. 37; Guba, & Lincoln, 1994, p. 109; and a conversation with Dr. Lincoln on October 15, 2018, where we brainstormed an additional category – 'assumed paradigmatic knowns').

Table 2 summary of Paradigm Presumptions

Paradigm Presumptions	Definition
Ontology	"What is there that can be known" "What is the nature of reality"
Epistemology	"what is the nature of the relationship between the knower and the knowledge"
Methodology	"How does one go about acquiring knowledge"
Axiology	"Of all the knowledge available to me, which is the most valuable, which is the most truthful, which is the most beautiful, which is the most life-enhancing"
Assumed paradigmatic knowns	What targets (e.g., consumers, interest groups, etc.) are impacted and impact each tradition

Now that the paradigm presumptions are defined, below is a summary of different three traditions – (1) positivism, (2) interpretivism, and (3) critical theory; and, assumed paradigmatic knowns (adapted from Guba and Lincoln, in Denzin, 1994, p. 109; and, Howell, 2012, p. 29; Guba, & Lincoln, 1994, p. 109; and a conversation with Dr. Lincoln on October 15, 2018, where we brainstormed an additional category – 'assumed paradigmatic knowns'). Please note that the assumed paradigmatic knowns are an exhaustive list, but a representation of possible knowns and their potential impacts on each theoretical position.

Table 3 summary of traditions and the components of positivism, interpretivism, and critical theory

Positivism				Assumed paradigmatic knowns
Ontology	Epistemology	Methodology	Axiology	
There is a single, external reality Native realism	The investigator and investigated are totally separate. Reality is studied through the senses (observation and experiment)	Scientific experiments based on hypothesis – deductive method used to quantify	Not influenced by a value system	Programs Program implementation Policy sponsors Administrative interest groups Academic knowledge production Targets: general population, OMB racial and ethnic groups, gender, age, etc..
Interpretivism				Assumed paradigmatic knowns
Ontology	Epistemology	Methodology	Axiology	
Multiple realities based on social construction.	Co-created subjectivist beliefs	Hermeneutical – understand lived experiences	Value laden	Programs Program implementation Policy sponsors Administrative interest groups Academic knowledge production Targets: general population, OMB racial and ethnic groups, gender, age, etc.. Targets (sexual minority groups): LGBT population MSM (men who have sex with men) WSW (women who have sex with women), SOGI (sexual orientation gender identity)

Table 3 summary of traditions and the components of positivism, interpretivism, and critical theory Continued

Critical Theory				Assumed paradigmatic knowns
Ontology	Epistemology	Methodology	Axiology	
Reality shaped by history – formed by values that are crystalized over time. Historical realism	The investigator and investigated linked. Subjective, emancipatory, with a leaning towards social justice	Dialogic – between the investigator and the subject of investigation	Focused on social change and more than value laden	Programs Program implementation Policy sponsors Administrative interest groups Academic knowledge production Targets: general population, OMB racial and ethnic groups, gender, age, etc.. Targets (sexual minority groups): LGBT population MSM (men who have sex with men) WSW (women who have sex with women) SOGI (sexual orientation gender identity) Targets (bisexual umbrella): Bisexual Pansexual Queer Genderqueer

Interpretive Critical Inquiry

Combining interpretivism and critical theory to form *interpretive critical inquiry*, as an approach, allows to explore the inherent and messy contradictions between those who identify as bisexual and those who get mislabeled as with gay or lesbian. To explore these contradictions rests on paradigmatic interpretive challenges, conflicts, and polarized schools of methodologies (quantitative, mixed methods, and qualitative) (Sullivan, 1996). In the wake of the paradigm wars of the 1980s, Guba's 1990 essay, *"Carrying on the Dialog"*, categorized 10 emergent themes when considering the future of qualitative inquiry. Of these themes relevant to this study, theses one calls for “greater openness to alternative paradigm critiques” (p. 370), and thesis seven acknowledged that “a change in paradigmatic postures involves a personal odyssey; that is, we each have a personal history with our preferred paradigm and this needs to be honored” (p. 374).

These two themes are foundational for this study. The merging of interpretative and critical traditions allows us a deeper understanding of social conflict and why researchers adopt certain interpretations of the researched. In regard to the second theme, my own academic and professional journey moved me from science based research (SBR) to constructivism was not an easy and overnight journey. As someone who specializes with hard to reach or hidden populations, SBR has serious limitations to understand the narratives not captured by validated scales.

As Lincoln (2013) notes, the interpretative and critical theory paradigms is “an example of Geertz’s blurred genres” (p. 89). Interpretive critical inquiry is a partial answer “to the criticism that interpretivism’s aim of coming to understand the lived experiences of the researched stops short of questioning how their world is and what can be done to address any social conflict in their world” (Lincoln, 2013, p. 89). As Lincoln notes (2013), interpretive critical inquiry consists of 5 principles: (1) the “aim of inquiry is not to generalize but to develop working hypotheses, (2) cause-effect relationship is impossible as human behavior is embedded in context and time, (3) the researcher is the human instrument, guided by the ethics of not marginalizing the researched in any way, (4) knowledge formed provides vicarious experience, and (5) trustworthiness, authenticity, and catalyst for action form the criteria for judging for quality and goodness” (p. 89-90). These five guidelines provide a general framework for interpretative and critical theory.

With any qualitative tradition, there are real world limitations, assumptions, and challenges that need to be considered. As Guba (1990) noted, "researchers are not in the business of developing and verifying (or falsifying) their own theories" (p. 112). The qualitative data will speak for itself through triangulation. While a recurrent critique noted by Thomas (1989) discusses, "[i]n many instances, empirical/analytical researchers have been rightly criticized by interpretive and critical perspective researchers for interpreting responses of individuals in terms of the researcher's meaning rather than in terms of the individuals' meanings" (p. 89) That is the value added of the interpretive critical tradition. Alvesson and Skoldberg (2000) note that "good research makes new meanings and understandings possible" (p. 368). These new meanings allow for "new understanding of relevant fragments of social reality, furnishing new alternatives to social action" (Alvesson and Skoldberg 2000, p. 396). However, as researchers, we will always deal with "one degree of uncertainty about the choices and interpretations researchers make (Alvesson and Skoldberg, 2000). In addition, "[t]he researcher's repertoire of interpretations limits the possibilities of making certain interpretations" (Alvesson and Skoldberg 2000, p. 250). As Walsham further discusses, any theoretical choice is always "a way of seeing and a way of not-seeing" (1993, p. 6). Walsham's observation is true for any methodology.

Theoretical Paradigm and Rationale for This Study

I am combing two theoretical paradigms (interpretivism and critical theory) for this study. This combined paradigm was focused on the interpretive critical. The justification for the blended genre will be primarily the lived experiences of bisexuals accessing healthcare (aka interpretative lends), and Queer studies (along with Queer theory) as a critical optical gaze of how bisexual identities are constructed.

Rationale from the Queer perspective

Since the advent of the HIV/AIDS epidemic in the 1980s, bisexual identit[ies] have been shaped by a paradoxical simultaneity of unprecedented bisexual visibility within public health (e.g., bisexual mental health, interventions acknowledging bisexuality, etc..) along with ongoing bi-phobic structural “isms” sentiments (Boucher, 2006). These isms are largely explored through a Queer lens (or LGBT studies) in order to explain how the construction of sexual identities are understood. Bisexual studies are nested within LGBT studies, and bisexual studies are not yet separate from LGBT studies (Elia & Eliason, 2012). As a discipline, Queer studies are is not a movement, philosophical analytical frame, and area of academic study. Queer studies are closely related to LGBT or Gay and Lesbian studies and can get confused with Queer theory. The next few paragraphs will provide an overview and discuss the subtle differences between Queer studies and theory, and its implications for this study.

In essence, Queer studies is not the same as Queer theory. Queer studies have its roots in Gay and Lesbian studies from the 1970s, and its academic tenets are genealogically related to Women and Ethnic studies. Classic examples of Queer studies are the works of John Boswell (e.g., Same Sex Unions in Pre-Modern Europe - 1994) or Martin Duberman (Stonewall - 1993). Also, Queer studies (aka Gay and Lesbian studies) is philosophically rooted and influenced in the Frankfurt School and critical theory.

By and large, Queer studies have looked at the structural mechanism that support the *isms*, in this study what isms support bi-phobia. For the bisexual population, the isms manifest themselves as biphobia with the assumptions that bisexual people are in a phase, cannot make up their minds, or greedy sexual beings. These isms also reinforce bi-invisibility within the heteronormative and LGT populations. These isms shape and reinforce typecasts of what a bisexual person is or is not. This labeling occurs both in the literature and society. On the other hand, Queer theory is centered on the discourse of sexuality and gender by exploring the legal-political constructions along with the medical practices of sexualizing gender and sexuality. In other words, Queer theory is an analytical position and a critical lens within Queer studies. A classic example of Queer theory is Foucault's work on sexuality (The History of Sexuality - 1978) or Eve Kosofsky Sedgwick published work, *Epistemology of the Closet* (1990). Regardless of this distinction, both Queer studies and theory question the social construction of sexuality in ways that cannot be easily separated. For the purpose of this study, I will not distinguish studies from theory. This debate between studies and theory is a larger discussion than can be a dissertation of its own.

For the time being, I do recognize and accept the disputes and debates between Queer studies and theory. A classic dispute is that Foucault focused on power relationships while failing to incorporate gender into his account of sexuality. A common critique from indigenous and non-Western societies is that Queer Theory preserves, rather than critically questions, long-standing sociocultural structures in Western culture. In addition, Queer studies are also tainted by Western viewpoints of what being Queer is or is not.

Some have argued that Queer theory is lost in a utopian schema of alternate genders and sexualities (transsexualities and gendering of material objects), and by the very nature of labeling something Queer is operating within a larger frame of heteronormative norms – or what is normal and not normal. In other words, Queer theory by its very nature operates from what is normal and not normal, just like a heteronormative frame. A more serious and intricate critique is how earlier authors in LGBT related studies are often oversimplified or overlooked for their larger philosophical contributions. For example, Foucault's work and analytical frame, while noteworthy, have become its own methodological lens (Foucauldian analysis). This Foucauldian analytical lens is not what Foucault suggested as a specified method in his writings. Foucault was operating from a critical lens not necessarily wanting to develop a new methodological lens. This migration of critical critique to methodology is not new, Crenshaw's intersectionality is now debated in feminist circles whether it is a method or not (MacKinnon, 2013; Nash, 2008). Lastly, queer studies and theory is criminal in ignoring other non-Western critical theorists such as Brazil's Joao Trevisan's work on *Perverts in Paradise* (1986) which explores sexuality as both multidimensional lust or desire(s), and rooted in Pre-Columbian, African, and European traditions.

Again, for the purposes of this study, I will draw from both Queer studies and theory as they both scientifically contribute to understand the lived lives of LGBT populations. Both Queer theory and studies have merit to be used to deconstruct how bisexuality socially constructed. Queer theory explores what is normal and not normal, while Queer studies explore sociocultural and political structural mechanisms that support bi-phobia. Queer studies and theory are approaches useful to deconstruct from a critical and structural lens different phenomenon of marginalized populations. Both have different assumptions, inclinations, and debates. In many ways, Queer studies and theory balance one another, and this balanced approach provides and is akin to… "dialectic [process] between theory [Queer theory] and practice [Queer studies or viewing Queer lives]" (Guba, 1990, p. 364).

Rationale using the FORECAST Model for five state case study perspective

As mentioned previously, a paradigm according to Guba is defined as a set of essential beliefs that guide both everyday actions and scientific measures (Guba, 1990). A paradigm is entrenched in a set of assumptions and beliefs that are "considered" true (as given). At a minimum a paradigm helps us frame, articulate, and communicate what we have learned, what problems to answer, and what methodological approaches should we follow in order to answer these problems. Some consider a paradigm to be a window or lens where the different phenomena in the outside world (or multiple contexts, realities) can be observed. In other words, the ontology is the different phenomena in the outside world, epistemic viewpoints are the knowledge references (in this case qualitative) we use to make sense of the world, and methodological tools (e.g., observation) are commonly agreed upon mechanisms in which we use to decode or make sense of the world.

In this study, we are using two different qualitative methods (interpretative critical and FORECAST an evaluation model) to answer two different research questions. The interpretative critical will explore bisexual lived experiences in accessing health. Using the FORECAST an evaluation model, the second question will the intensity (through activities) of how bi-inclusive five states are with the implementation of the National Standards for Culturally and Linguistically Appropriate Services (CLAS). While it is “possible to use a combination of various qualitative theories, methodologies and methods, there are philosophical differences within these two approaches that cannot” always easily resolved (Guba, 1990, p. 35). The key to account for possible philosophical differences is to account for any epistemological, ontological, or even axiological incongruencies between the two approaches. Similar to the preview examination of the examination of the ontological, epistemological, and axiological positions, this study will also explore the assumed paradigmatic knowns for each methodological framework: fourth generation evaluation, policy Analysis, and FORECAST Model.

As a general rule as Lincoln noted (2013), “consensus can be achieved within [a] paradigm… but not between incommensurable paradigms” (p. 60). Germane to the second question on implementation of the CLAS Standards, both policy analysis and evaluation are intrinsic to decoding the policy implementation process, and need to be disentangled. Below is a brief summary of theory fourth generation evaluation, evaluation, and policy analysis (adapted from Lincoln, & Guba, 1986, p. 8-29; Guba and Lincoln, 2001; and, Goodman, & Wandersman, 1994; Guba, 1984; and a conversation with Dr. Lincoln on October 15, 2018, where we brainstormed an additional category – ‘assumed paradigmatic knowns’). Again, please note that the assumed paradigmatic knowns are an exhaustive list, but a representation of possible knowns and their potential impacts on each theoretical position.

Table 4 summarizes key components of fourth generation evaluation, evaluation, and policy analysis

Fourth generation evaluation				Assumed paradigmatic knowns
Ontology	Epistemology	Methodology	Axiology	
Relativism – organize experiences into explainable form	Transactional subjectivism – reality or truth rest on individuals and audiences crafting reality or truth	Hermeneutic-dialecticism – related on discovery and assimilation phases	Value laden	Program goals/outcomes Policy makers Key stakeholders Federal funding priorities Community readiness *Focus on social justice*
Policy Analysis				Assumed paradigmatic knowns
Ontology	Epistemology	Methodology	Axiology	
All policy definitions are constructions, and none claim definite reality	Co-created subjectivist beliefs	Mix and multimethod: different data sources imply different methodologies	Influenced by different value systems	Program goals/outcomes Policy makers Key stakeholders Federal funding priorities Community readiness *Social justice is a policy intent but often lost in policy implementation* *How policy is developed greatly impacts how social issues are mediated*
FORECAST Model				Assumed paradigmatic knowns
Ontology	Epistemology	Methodology	Axiology	
Relativism – reality is determined by our language or conceptual schemes	Transactional subjectivism – reality or truth rest on individuals and audiences crafting reality or truth	Hermeneutic-dialecticism – related on discovery and assimilation phases	Focused on program change and value laden	Program goals/outcomes Policy makers Key stakeholders Federal funding priorities Community readiness *Focus on social justice* *How policy is developed and implemented at the federal level greatly impacts how local implementation* *Prospective analysis of how programs are measured/success*

Evaluation: fourth generation evaluation

Guba and Lincoln (1981) notes that “naturalistic inquiry attempts to present ‘slide of life’ episodes documented through natural language and representing as closely as possible how people feel, what they know, and what their concerns, beliefs, perceptions, and understanding are” (p. 78). Through naturalistic inquiry attests that the social world experiences, specific to action of people and groups, can be observed and interpreted. Lincoln (2013) goes on to argue that “evaluation is a form of inquiry whose focus is some evaluand (the program, process, organization, person, and so forth being evaluated) and which is aimed at the development of merit and worth constructions” (p. 61). The ontological stance rests on how certain experiences are organized into understandable categories. The epistemological viewpoint is a ‘reality’ or ‘truth’ is dependent on individuals and audiences (stakeholders) who craft the asserted reality or truth. The methodological approach is centered in discovery and assimilation. The discovery is “what’s going on here.. the ‘here’ is the evaluand and its context”, while the assimilation “represents the evaluator’s effort to incorporate new discoveries into the existing construction or constructions” (Guba, & Lincoln, 2001, p. 2). There is no ordered manner in how discovery and assimilation should be done and may overlap or be a parallel process. Axiologically fourth generation evaluation is value laden.

Lastly, assumed paradigmatic knowns are centered on how key stakeholders conduct program development, goals, and measure desired outcomes. Policy makers are instrumental in developing and directing federal funding priorities. More importantly, the notion of community readiness needs to be accounted for since if a community is not ready to implement a program, the programmatic impact could have limited short- and long-term effects. Finally, fourth generation evaluation redresses how social justice should be an integral part of social inquiry.

Policy analysis

Guba (1984) listed eight different definitions of policy: (1) goals or intents, (2) standing decisions, (3) guide to discretionary action, (4) problem solving strategy, (5) sanctioned behavior, (6) norms of conduct, (7) outputs of the policy making system, (8) constructions based on experience (p. 65). These eight definitions provide a backdrop to understand the complexities between policy design, intent, implementation, and outcomes. In essence policy analysis is a "form of inquiry whose focus is on some proposed or existing policy (guide to discretionary action, mandated practical action, legislation, or legal/juridical decision) and which is aimed at the extension or revision of that policy construction and/or the development of new policy constructions" (Lincoln, 2013, p. 60). In support of Lincoln's point, Guba has argued, "different [policy] definitions will produce policies of different complexities" (Guba, 1984, p. 65). What we can take from this depiction is that policy is a process, and a can be a complicated practice consisting of many stakeholders, agendas, and intended and unexpected outcomes.

As discussed in fourth generation evaluation, qualitative evaluation "provides the opportunity for groups whose values may not represent those of program managers and funders to achieve voice, agency, and efficacy. This is especially critical when those who legislate and those who design implementation policies and procedures for target groups may be quite far removed from those groups" (Lincoln, 2003, p. 78).

What Lincoln denotes is that there is more than a difference between those who direct from the implementers, and this difference can impact the success of policy design and implementation. By utilizing evaluation one can perform a corrective plan to ascertain how the process works and if the intended outcomes met the intended program goals. This corrective plan is a constant rebalancing of many competing contextual and programmatic interests. As Lincoln discusses the “rebalancing evaluation efforts to include recipient voices has the corrective effect …. to create awareness of how policies are actually experienced” (Lincoln, 2003, p. 78). From an ontological stance, the different definitions of policy analysis are constructions, and none are rooted in a fixed reality. As the noted political scientist scholar Roderick Rhodes (2014) argues in his article, *Genre blurring’ and public administration: what can we learn from ethnography?*, that policy analysts need to expand their “toolkit” by combining different approaches that can serve as a “social technology we can use in the search for applied, practical solutions” (p. 24). Like the interpretivism, the epistemological viewpoint is co-created subjectivist beliefs. The methodological approach is a multimethod approach that relies on different data sources which imply different methodologies. *Axiologically policy analysis is* influenced by different value systems which shape policy development.

Finally, in addressing the assumed paradigmatic knowns we are building on fourth generation evaluation but adding one component on policy development and modifying the social justice intent within policy development. There are two central issues to consider with social justice within policy development. One key addition is how policy is developed can impact how social issues are mediated. For example, with development of the Affordable Care Act (ACA), there were many interest groups (elected officials, lobbyists, community stakeholder, professional organizations [e.g., American Medical Association or the American Insurance Association], etc..) that helped shape ACA legislation. Just because ACA was passed by Congress, how ACA was implemented at the state level greatly impacted each state’s social and health disparities outcomes. Some states (e.g., Massachusetts, California, etc..) embraced ACA while other states (e.g., Georgia, Florida, etc..) did not. Lastly, another key issue is how social justice is a policy intent but often lost in policy implementation. This last point is reinforced by the previous ACA example. ACA’s intent was to increase insurance coverage and manage healthcare costs, thus, promote social and health equity. The tension between managing healthcare costs and increase insurance coverage helped diminish and limit social and health equity impacts.

FORECAST Model

The FORECAST approach draws its principles from the empowerment evaluation tradition, and is a prospective evaluation model to evaluate complex initiatives. The acronym FORECAST means “formative” within the evaluation tradition that explores ongoing programs, especially with a focus on how federal policy development and implementation impacts program effectiveness. (Goodman, & Wandersman, 1994) The FORECAST model has shown to be a good approach to assess ongoing initiatives such as national cancer initiative, national substance abuse program effectiveness, and violence prevention programs. (Katz, Wandersman, Goodman, Griffin, Wilson, & Schillaci, 2013; Goodman, 2000a; Goodman, 2000b) Since the CLAS Standards are still in implementation and dissemination phase at the state level, the FORECAST approach suits the research question on CLAS implementation impacts.

Since the FORECAST approach means formative, the E, for “evaluation,” implies evaluation. The C stands for how the evaluator is a consultative role, and the process is reflective and interactive. FORECAST, as a whole, investigates all implementation stages, in our case from policy formation to outcomes in real time. The AST within the FORECAST acronym allows or continual improvement as the CLAS Standards are still being implemented. On the surface, the model best suits the CLAS implementation because it accounts for complexities with implementation. FORECAST allows for flexibility, beyond the controlled randomized design paradigm, and room for how multiple viewpoints to be considered. As Green and Mercer (2001) argued sensibly, within conventional research there is an expectation that communities are readied to engage in research, but in real time this is a false expectation and can cause some communities to shy away from research. The FORECAST model, as a new empowerment strategy, allows flexibility and addresses the shortcomings of experimental design in the evaluation research of community programs.

One noteworthy aspect to the FORECAST model is its social ecological stance. The social ecological perspective allows for program or even a policy to be "understood from a social context that includes family and social network influences, community conditions, organizational supports or lack thereof, and social policy." (Goodman, & Noonan, 2009; p. 14-5). Goodman and Noonan (2009) characterized community, culture, and even policy as "complex and interact in unique ways at any given time." (Goodman, & Noonan, 2009; p. 12) These interactions need to be considered when doping community research, and not considering these interactions can complicate how a program can be evaluated. For example, in our case with the CLAS Standards, not acknowledging these complex policy exchanges will portray a limited world view or one-sided lens of how policy is implemented. The FORECAST approach will allow us to consider contextual elements of policy implementation.

As Guba and Lincoln (1989) discussed these interactions or complexities in program and policy implementation are "mutual simultaneous shaping;" meaning in the case for the CLAS Standards, at least culture, demographics, street level bureaucrats, interest groups, and program elements interacting continuously to impact all levels of policy implementation. (p. 37) It is even possible that some of these interactions may occur at different times, reoccur, or be difficult to observe. When viewing multiple occurrences or sites of policy implementation we cannot be certain a program or policy is duplicated and disseminated in multiple locales in the same way. Understanding these different interacting layers, then, is important and the FORECAST approach allows us to observe the variations that may occur.

What Goodman, Guba and Lincoln remind us is that community interventions are not a controlled and prescriptive process. Context matters in evaluation, especially how policy is deliberated. At its pure elements, evaluation allows us to understand what is working, why it is working, and why and how the program was not effective (Trickett, Beehler, Deutsch, Green, Hawe, McLeroy, K., ... & Trimble, 2011). The beauty of the FORECAST approach is that community setting, and even policy, are not variables in a controlled laboratory setting subject to controls for external conditions. The FORECAST model allows for new innovative methods to build capacity and explore possible solutions for why certain programmatic or policy phenomena are occurring (Goodman, & Noonan, 2009). In other words, using the FORECAST approach can impact future policy development and implementation in the case of the CLAS Standards.

In exploring the five states, we will use the FORECAST as an evaluation framework to better understand the CLAS policy implementation processes and outcomes. In reviewing state and community documents, the FORECAST model will be composed of four sections: markers, measures, sources, and meaning. Given the complexity of policy implementation activities, I have added a separate section a fifth section– “sexual orientation references,” to specifically detail LGBT and bisexual activities.

From an ontological position, reality is determined by our language or conceptual schemes. The epistemological viewpoint, reality or truth rest on individuals and audiences crafting reality or truth. The methodological approach is a grounded in discovery and assimilation phases. The ontological, epistemological, and methodological is philosophically located within fourth generation evaluation approach. Lastly, *axiologically the FORECAST approach is on assessing* program change and value laden.

The assumed paradigmatic knowns build on fourth generation evaluation and policy analysis, and the FORECAST model recognizes that how policy is developed and implemented at the federal level greatly impacts how local implementation. The FORECAST model is a prospective evaluation approach to assess program or policy effectiveness. In Goodman's ideal of the FORECAST model, there is an acknowledgement how social justice is considered.

Research Strategies

There are two research strategies employed for this study. The first is ethnography, followed by qualitative evaluation. Ethnography connects process and product through fieldwork and written text. Fieldwork employs *participant observation*, where the researcher, over time, becomes acquainted with the cultural nuances (Sanjek, 1990; Spradley, 2016), in this case the lived lives of bisexuals and how they access health care. The ethnographic *written text* is how culture is described, as part of a larger process of cultural translation (Emerson, Fretz, & Shaw, 2011). Qualitative evaluation is entrenched in exploring worth, merit, and the meaning and potential impact of the evaluation on what is being evaluated. Qualitative evaluation is influenced by several intellectual movements of phenomenology, existentialism, hermeneutics, and critical theory (Schwandt, &

Burgon, 2006; Schwandt, 1994). A key aspect of qualitative evaluation is "in general, hold that understanding and interpreting lived experience is fundamental to the activity of evaluation as social inquiry" (Schwandt, & Burgon, 2006, p. 100). It is understanding and interpreting mechanisms within qualitative evaluation that forms an essential lens to decode, depict, and understand the processes of what is being evaluated.

Site Selection

There are two sites used in this study Aniz recruited bisexuals from Metropolitan Atlanta. The second site includes five states (California, Massachusetts, Nevada, Delaware, and Georgia) who are in the process of implementing CLAS Standards.

Aniz, Inc.

The research site for recruiting bisexual participants is Aniz, Inc., located in downtown Atlanta, Georgia. Aniz was established in 1996 by Zina Age, who is a regional leader in social services for marginalized populations. Zina is openly bisexual and connected to several regional bisexual networks. According to Aniz's website, its "mission is to provide comprehensive health awareness, education and prevention services through therapeutic" interventions "for disadvantaged multicultural children, adults, and families, who are infected with or affected by HIV/AIDS" (Aniz.org). "The organization's vision is to empower children and adults with the knowledge and skills to prevent the spread of HIV/AIDS to the next generation" (Aniz.org). Aniz has over 16 years of experience in providing culturally competent mental health, substance abuse and peer-lead support groups to individuals infected with and/or affected by HIV/AIDS in metropolitan Atlanta as well as rural areas in Georgia and other Southern states.

According to Aniz's website, Aniz is the only minority serving agency in metropolitan Atlanta that provides comprehensive mental health, substance abuse and HIV services. The organization fulfills its mission through five main service components: (1) Prevention education, offering HIV/AIDS, STI, Hepatitis C and pregnancy prevention programs to increase the knowledge regarding these issues and reduce the likelihood of engaging in risky behaviors; (2) Awareness, working with community partners to raise awareness of the impact of HIV/AIDS within the community and to provide HIV testing and condom negotiation skills to reduce transmission of HIV/AIDS; (3) Advocacy, through a program designed for HIV+ women to become change agents within the community and reduce the factors that result in the high rates of HIV among women in Atlanta; (4) Therapeutic Interventions, offering individual and group counseling sessions for LGBT youth and those with histories of mental illness and/or substance abuse that are at high risk for HIV or HIV+; and (5) Support Groups, offering weekly peer-led support to LGBT youth to address mental health, substance abuse, and/or PTSD as well as for persons living with HIV/AIDS in order to share commonalities of living with this disease and increase self-efficacy to improve their quality of life living with HIV/AIDS (Aniz.org).

Bisexual Participant Selection Process

Originally the study goal was to have 3 focus groups (6 to 10 in each focus group) of self-identified bisexual individuals over the age of 21, with a total of 30 participants. The rationale for having 3 separate focus groups is to allow participants from the same age group to share thoughts and ideas as its relates to their sexual orientation and health access. The recruitment strategy was snowball sampling and recruitment marketing to specialized bisexual support groups through various social media networks (e.g.,[7] Atlanta Bisexual

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[7] Bisexual Meetups in Atlanta (2018, April 20). Retrieved from https://www.meetup.com/topics/bisexual-friends/us/ga/atlanta/?_cookie-check=LkxX85CIm-oPs_Cq

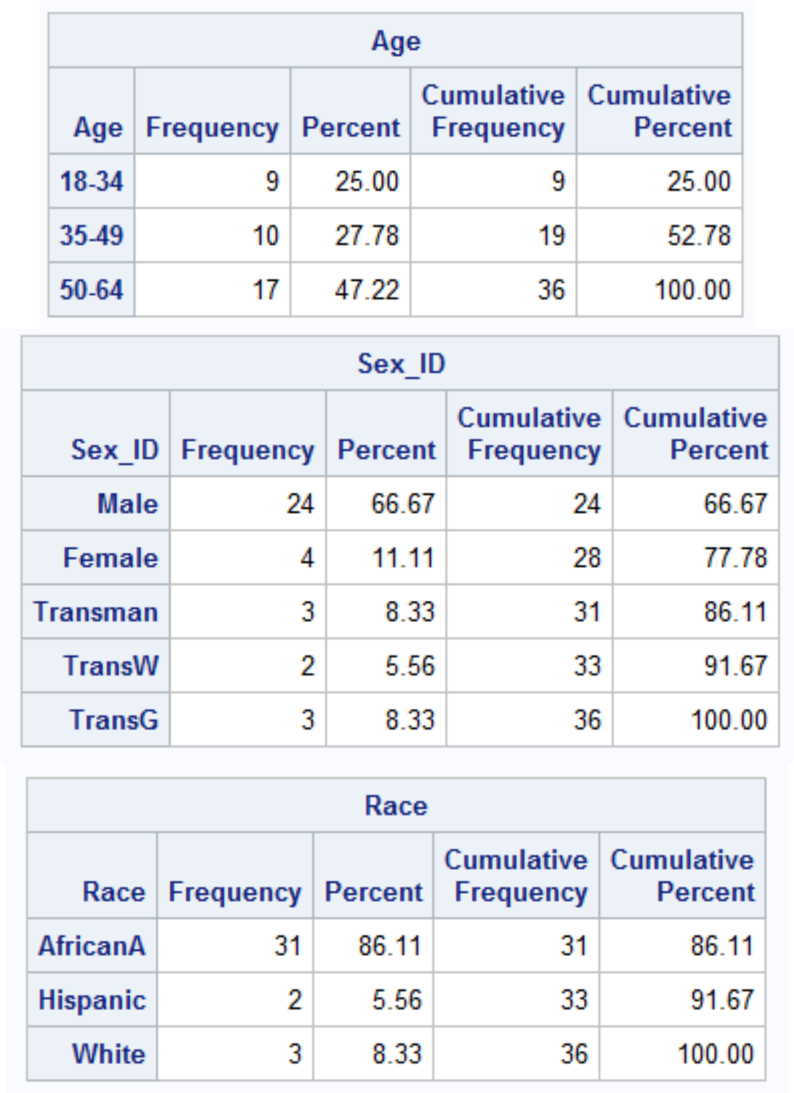
Femme Meetup, Bi Curious Meetups, The Rainbow Mixes LGBT Social Mixers - Network vents -Parties, Gay Pride, Gay and Lesbian Bars, etc..). In addition, the agency, Aniz, Inc., that hosted the focus groups is led by a regionally known bisexual African American woman. Aniz is known for its LGBT inclusive atmosphere and serves marginalized LGBT populations.

Despite the sponsorship of Aniz, Inc., a community recognized provider of services, participant recruitment for 3 focus groups became a challenge. One ongoing challenge was recruiting bisexual identified women. The 2 focus groups were men only. In consultation with my dissertation committee and community members (key informants within the bisexual community), a revised strategy was to redesign market materials for the focus groups to have the CEO of Aniz, Zina Age, as the lead to community members to contact. A more significant shift was to eliminate the last focus group and scheduling one-on-one semi-structured interviews. With this re-marketing effort, 11 face-to-face interviews were held, including recruiting and consenting 9 women, 25% (4 cisgender women and 5 transgender women).

Participant Demographic Data

A total of 36 participants who identify as part of the bisexual spectrum were interviewed. Of the 36 participants, 47.22% were in the 50-64-year age group, and 86.11% were Africans Americans followed by 8.33% that were White. The majority of the participants were Male (66.67% Male compared to 4% Female; 22.22% identify as part of the Transgender sexual identity umbrella (8.33% Transmale; 5.56% Transfemale; Transgender [Male to Female] 8.33%). The study population had some level of higher education 50%, followed by 50% that had some high school degree or GED. The majority of the participants (58.82%) were in a stable housing, followed by 38.89% that were in a transitional state (US HUD guidelines). The majority (56%) are originally from Atlanta, while others are Atlanta transplants originally from Tennessee, Ohio, New Jersey, Alabama, Mississippi, Florida, and South Carolina.

Table: 5 Demographic distribution of study participants



Age

Age	Frequency	Percent	Cumulative Frequency	Cumulative Percent
18-34	9	25.00	9	25.00
35-49	10	27.78	19	52.78
50-64	17	47.22	36	100.00

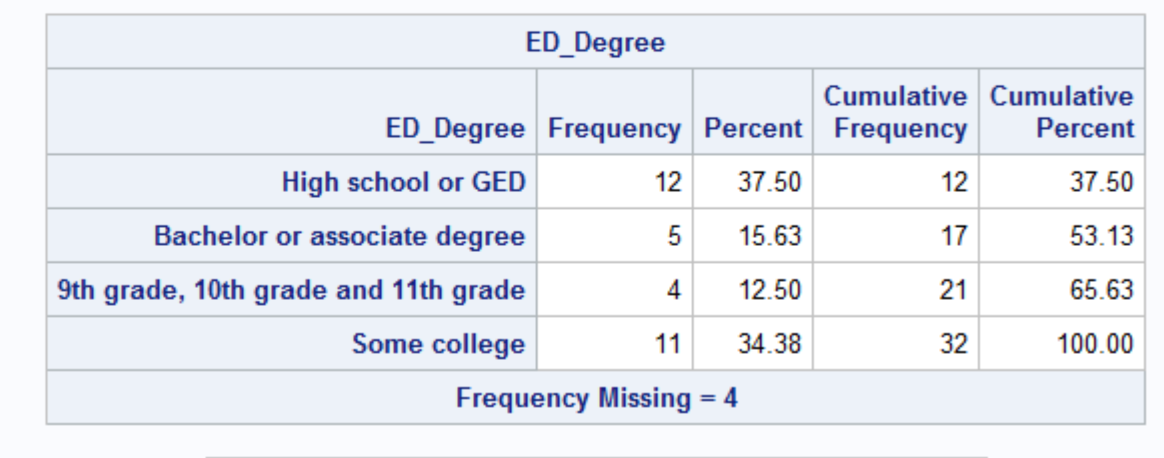
Sex_ID

Sex_ID	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Male	24	66.67	24	66.67
Female	4	11.11	28	77.78
Transman	3	8.33	31	86.11
TransW	2	5.56	33	91.67
TransG	3	8.33	36	100.00

Race

Race	Frequency	Percent	Cumulative Frequency	Cumulative Percent
AfricanA	31	86.11	31	86.11
Hispanic	2	5.56	33	91.67
White	3	8.33	36	100.00

Table: 5 Demographic distribution of study participants Continued



ED_Degree				
ED_Degree	Frequency	Percent	Cumulative Frequency	Cumulative Percent
High school or GED	12	37.50	12	37.50
Bachelor or associate degree	5	15.63	17	53.13
9th grade, 10th grade and 11th grade	4	12.50	21	65.63
Some college	11	34.38	32	100.00
Frequency Missing = 4				

All the participants live in the Atlanta metropolitan counties (Fulton 73.33%, DeKalb 23.33%, Cherokee 3.33%). At[8] least 3 participants (n=12) lived in one of the following zip code areas: 30303 [downtown Atlanta, including Sweet Auburn area which is historically African American business district], 30308 [Midtown Atlanta, north of Sweet Auburn], 30310 [Southwest Atlanta, geographically below several historical black colleges and near the airport], and 30318 [West Atlanta, geographically above several historical black colleges, set of Georgia Institute of Technology]. The area codes 30308 [median household income $51,584; median home value $252,300] and 30318 [median household income $39,421; median home value $174,800] has experienced rapid mixed-use redevelopment with high rise condominiums and shopping. In the last five years area code 30303 [median household income $19,000; median home value $200,700], has been undergoing a mixed-use redevelopment phase. Certain parts of area code 30310 remains [median household

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[8] Average Income per Household by Income Source
https://www.unitedstateszipcodes.org

income $22,681; median home value $89,300] in economical blight. At least two participants (n=8) reside in the following zip codes[9]:

- 30030 - incorporated and some unincorporated Decatur, parts of Avondale Estates - median home value $307,800 -median household income $66,134
- 30032 - unincorporated Decatur - median home value $100,900 - median household income $33,475
- 30324 - Northeast Atlanta Piedmont-Lindbergh areas - median home value $313,300 - median household income $63,810
- 30344 - City of East Point - median home value $104,300 - median household income $36,830

Bisexual Participant Selection Limitations

This section will provide a general discussion about possible limitations for this study. The question of knowing if a researcher has participant sample saturation, or if the sample is representative of the general population are critical and contentious issues within the quantitative and qualitative debate (Gelo, Braakmann, & Benetka, 2008). Like the quantitative paradigm, qualitative approaches have mechanisms equivalent to quantitative methods to ensure participants are representative of the general population or, for example,

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[9] The remaining - one each
30088 - Stone Mountain
30189 - Woodstock
30302 - Castleberry Hill, Atlanta
30311 - Southwest Atlanta
30315 - Grant Park, South Atlanta
30317 - East Lake, Atlanta
30331 - Greenbriar, Atlanta, between 285 and Fulton Industrial Parkway
30342 - North Buckhead, Atlanta
30345 - Northlake, Atlanta

if a sample size of eight is sufficient to carry out a study. Miles and Huberman (1994, pp. 27-28), citing Firestone (1993) argue that the case or participant selection process within qualitative inquiry can serve as a platform, or an inter-paradigm discussion, to understand new or existing theory about the phenomenon being studied. In other words, theory drives the selection of cases, and careful review of the cases can either illuminate existing theory or argue for a reformulation of theory, or even question the methodical approaches.

In the case of this study, the bisexuals are mainly African American with some transgenders who identify as bisexuals. Their lens on bisexuality is unique and influenced by their race, sexual identity, religion, and social networks. The question of whether African Americans who are bisexual and transgenders who are also bisexual are representative of the larger bisexual community needs further study. That is a limitation to this study. To date, this is the only study looking at bisexuality with a moderate size African American population. While there is some overlap in shared bisexual experiences, being a person of color and bisexual allows for unique experiences.

Five State Site Description

California, Massachusetts, Nevada, Delaware, and Georgia are diverse from one another, but they also have similarities. According to the US Census data, state populations vary wildly. Four out of five individuals in those states (75%+) speak English. The median household income of families in those states can be grouped into two cohorts: (1) California and Massachusetts, (2) Nevada, Delaware, and Georgia. The racial and ethnic diversity varies from Massachusetts with a majority Caucasian population to California being a minority majority population. The other three states, Nevada and Delaware, and to a lesser extent Georgia are within the 50th percentile with a Caucasian population. The table below, illustrate the level of diversity according to population, language, income, and racial and ethnic diversity.

Table 5: Diversity of Five States

	POPULATION	**LANGUAGE – ENGLISH %**	**MEDIAN HOUSEHOLD INCOME**	**RACIAL & ETHNIC DIVERSITY %**[10]
CA	35,536,653	58.1	$66,636	W 37 AA 7 H 39 API 15 AI 1.5
MA	6,859,819	77.4	$67,861	W 73 AA 8 H 11 API 6 AI 0.5 OR 2 MR 3
NE	2,998,039	80.4	$55,431	W 54 AA 8 H 13 API 7 AI 1 OR 12 MR 5
DE	961,939	91	$57,756	W 53 AA 26 H 13 API 6 AI 0.1
GA	10,439,379	87.4	$50,768	W 58 AA 31 H 9 API 3 AI 0.3 OR 4 MR 2

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[10] W is White (Non-Hispanic White), AA is African American, H is Hispanic (of any Race), API is Asian Pacific Islander, AI is American Indian, OR is Other Race, and MR is Multiracial.

Five State Site Selection Process

In selecting which states, territories, or jurisdictions to highlight in this study was daunting given the different levels of CLAS implementation intensity. To address the intensity issue, this study used the Office of Minority Health at U.S. Department of Health and Human Services five CLAS implementation classification system: (1) currently under review, (2) no activities, (3) legislative activity for CLAS training, (4) state-sponsored implementation activities, and, (5) CLAS training legislation (activity or enacted) AND state-sponsored implementation activities. We were able to eliminate states that have no activities (n=16), and all the U.S. territories (n=8) that are still considering adopting CLAS Standard guidelines. It should be noted that CLAS Standards are recommendations, (in)directly supported by other federal laws such as ACA or Title VI Civil Rights Act, and no state, territory, nor jurisdiction have enacted comprehensive CLAS Standards legislation

The states of California and Massachusetts are representative of other states for the category - CLAS training legislation (activity or enacted) AND state-sponsored (n=21). These are states that have fully embraced CLAS Standards (enacted laws or developed state level CLAS implementation plan) and serve as a model for other states wanting to implement the CLAS Standards. A second category, state-sponsored implementation activities (n=11), can be characterized as states who have done some level of CLAS Standards implementation (such as having a comprehensive strategic plan and minimal legislation activity). Delaware and Nevada are representative of the second category. The less intensive implementation group are states who have had some legislative activity for CLAS training (n=3). The state of Georgia is typical of this category. California, Massachusetts, Nevada, Delaware, and Georgia are examples of instrumental cases that are diverse in geography, demographics, political climates, and commitment to legislative implementation of cultural competency activities.

To help guide the selection process of identifying which states to highlight for the 3 categories, we used Stake's (1995) criterion in which cases to select need to answer the question, "what we can learn" from the case. (p. 4) Stake further mentions that there needs to be a "balance and variety are important; opportunity to learn is primary importance." (1995; p. 5) As Stake mentioned, certain generalizations can be drawn from a limited number of cases. Stake calls this "petite generalizations" acknowledging the real implications of being able to fully characterize multiple realities. (1995; p. 7).

Of the 35 states that could be possible case studies within three levels of CLAS implementation, five states emerge as possible case study candidates. Both California and Massachusetts (CLAS training legislation activity or enacted AND state-sponsored) are considered model for not only implementing CLAS Standards but also leading on several LGBT policies. Same sex marriage was first pass in Massachusetts and California has led the nation on transgender rights. Nevada and Delaware (state-sponsored implementation activities) are considered middle of the road states with minimal impact on LGBT national policy. These states are not both liberal nor conservative states. Lastly, Georgia (legislative activity for CLAS training) is largely indicative of Southern values, that have a long history of both racial and LGBT civil rights concerns. These five states provide an opportunity to learn how the CLAS Standards were implemented, and they provide a balance of how states considered LGBT, specifically bisexuality, when they implemented the CLAS Standards.

Five State Site Selection Possible Limitations

In considering the possible 35 states to choose from, there are also two considerations/assumptions that need to be acknowledged. The first is with ascertaining the accurate LGBT population per state. LGBT census data is a challenge due to individuals not disclosing their sexual orientation on census forms or assuming all LGBT populations are coupled in same sex relationships. The U.S. Census has been doing ground breaking work on collection data from same sex couple and has concluded 95%+ of counties in the U.S. have same sex couples.) Baumle and Poston (Baumle, & Poston, 2009) acknowledge upfront there are serious challenges to data collection in work with sexual minority populations due to social stigma and shame. It is more difficult to know an accurate number of bisexuals. Table 7 (LGBT Demographics) below indicates per CLAS activity level some of the highest percentages of LGBT populations.

Table 7 LGBT Demographics

CLAS training legislation (activity or enacted) AND state-sponsored implementation activities			
State	2015-2016 LGBT Adult Percentage Estimate[11]	2000 to 2010 % Increase of Same Sex Couple Households[12]	Growth 2016 Transgender Adult Percentage Estimate[13]
CA	4.8%	6.53%	0.76%
MA	4.9%	18.46%	0.57%
State-sponsored implementation activities			
State	2015-2016 LGBT Adult Percentage Estimate	2000 to 2010 Same Sex Couple Households	Growth 2016 Transgender Adult Percentage Estimate
DE	4.7%	41.65%	0.64%
NV	4.8%	43.60%	0.61%

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[11] Gates, G J (15 February 2017). “Vermont Leads States in LGBT Identification”. State of the States. Gallup Politics. Retrieved 25 June 2018.

[12] “Decennial Census Data on Same Sex Couples”. Same Sex Couples. U.S. Census Bureau. Retrieved 30 June, 2018.

[13] Flores, Andrew (June 2016). "How Many Adults Identify as Transgender in the United States". Williams Institute UCLA School of Law.

Table 7 LGBT Demographics Continued

Legislative activity for CLAS training			
State	2015-2016 LGBT Adult Percentage Estimate	2000 to 2010 Same Sex Couple Households	Growth 2016 Transgender Adult Percentage Estimate
GA	4.0%	10.52%	0.75%

A second consideration is assuming states with large LGBT populations, largely located in metropolitan areas, have LGBT friendly state level policies. That is not always the case. For example, Texas and Florida are classic examples of states with a significant LGBT population[14] that allow employment discrimination based on sexual orientation and gender identity.

Examining CLAS standards and considering LGBT friendly policies as a primary selection criterion for states is a problematic approach. Some states and jurisdictions are LGBT friendly, such as Vermont, District of Columbia, or New Hampshire but have no CLAS state level activities. Some states located in the deep south such as Louisiana, Georgia, Texas, Kentucky, and Florida have embraced state level CLAS implementation. However, these states remain less friendly for LGBT policies.

In considering the states in Table 7, California, Massachusetts, Delaware, and Nevada have many policies that protect LGBT populations. For example, these states prohibit employment, housing, and public accommodations discrimination based on sexual orientation and gender identity. These states have anti-bullying laws that provide specific protection based on sexual orientation and gender identity. There are laws that addresses

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[14] Texas and Florida are populous states with high percentage of LGBT populations (3.6% and 4.2%). (Gates, 2017) Texan cities such as Dallas (7%), Austin (4.8%), and Houston (4.4%) are major urban centers with LGBT communities. (Gates, 2006) Likewise, Floridian cities such as Miami (5.5%), Tampa (6.1%), and Orlando (7.7%) are American cities with some of the highest LGBT populations. (Gates, 2006)

hate or bias crimes based on sexual orientation and gender identity. Finally, these four states have bans on insurance exclusions for transgender health care.

Excluding the state of Delaware, the states of California, Massachusetts, and Nevada also prohibit discrimination in education on the basis of sexual orientation and gender identity and have transgender-inclusive health benefits for state employees. Only California and Massachusetts have second-parent adoption as an option for same-sex couples statewide. Therefore, state case selection was based on two factors: states with high concentrations of LGBT populations, and states with some LGBT friendly leaning policies. The case selection of California, Massachusetts, Delaware, and Nevada fit within two criteria of high concentrations of LGBT populations and LGBT friendly policies.

The state of Georgia is located in the deep south, and is considered a purple state, with less friendly LGBT policies such as transgender coverage exclusions in Medicaid and state laws that criminalize behaviors that carry a low or negligible risk of HIV transmission. (Warbelow, & Diaz, 2015) We are including the state of Georgia in our analysis for two reasons. One, Georgia is only one of three states (Indiana and Missouri) in which there is legislative activity for CLAS training; and two, the state of Georgia has one of the highest concentration of LGBT communities (Metropolitan Atlanta is the gay mecca of the south). Another consideration is the state of Georgia will provide a benchmark for the other states with some CLAS activity.

Data Collection

The data collection occurred over a 17-month period between December 2016, and July 2018. This study utilized two methods of data collection, (a) ethnographic interviews/focus groups, and (b) document analyses for the five states. The ethnographic interviews/focus groups took place between January 2017, to March 2017, and the document analyses took place between April and July 2018.

IRB approval process

This dissertation is unique in regard to IRB approval process. There are two distinct aspects to this dissertation that required two IRB approvals. One, the bisexual health access project was awarded a $10,000 grant in November 2015. Aniz, the community site, was awarded a Community Academic Research Partnerships Grants Program by the Atlanta Clinical Translational Science Institute (ACTSI) Community Engagement Research Program (CERP). I was hired as the evaluator consultant for this project. Morehouse School of Medicine (MSM) IRB (IRB# 906342-3) approved the project in August 2016 with an approval for continual review in September 2017. Since the bisexual health access project was IRB approved, I conducted the analysis and final report for this project to be submitted to the funder in May 2017. Part of the initial analysis overlapped with the bisexual health access research questions (questions 1 and 2) for this dissertation. The second, and the lengthiest part, was IRB approval by Texas A&M University (TAMU) to conduct the dissertation, especially the state level document analysis. The TAMU IRB was approved in March 2018 (IRB# 070273).

Ethnographic Interviewing

Once I received MSM IRB approval I started my data collection process, Aniz recruited and scheduled the interview/focus groups, and provided the participants with the IRB approved information sheet/consent form. The interview lengths ranged between 40 minutes to 60 minutes; and the focus group length ranged from 1.5 hours to two hours. A total of 36 participants who identify as part of the bisexual spectrum were interviewed;

two focus groups and 11 interviews were held at Aniz's conference room.

Table 8. Study Participants for Interviews

Pseudonym	Gender	Race / Ethnicity	Age cohort
Chocolate	MtF	African American	50-64
Debbie	MtF	African American	35-49
Lykee & Dez	MtF & FtM	White & Puerto Rican	35-49
Jazz	MtF	African American	18-34
Katrina	Female	African American	35-49
Lala	Female	African American	18-34
Lamar	Male	African American	50-64
Queen B	Female	African American	50-64
Shawn	Male	African American	35-49
Sisterhood	Female	African American	50-64
Walter	Male	African American	35-49

Table 9. Study Participants for Focus Groups

	FG1	FG1
Sexual Identity	11 males 1 Transgender	10 males 2 Transgender
Race	1 Hispanic 10 African American	2 White 11 African American
Age	3 in 18-34 3 in 35-49 6 in 50-64	4 in 18-34 2 in 35-49 7 in 50-64

Recording the Interviews

The focus groups and interviews were audio recorded on two devices, an Olympus digital voice recorder and a MAC Laptop One-Note recording application that allows one to write notes as the focus groups are being recorded. As a backup to the audio recordings for the focus groups, I had two observers (one an MPH trained person, and an MSW) handwrite the interview conversations. After each focus group, the two observers compared notes and reconciled any discrepancies. For the individual interviews, I handwrote the interview conversations in my interview journal.

Interview Protocol

What surprised me most was that the interviews yielded richer stories than the focus groups. With the focus groups, I found participants talk over one another, and some participants knew each other socially and this may have hindered some conversations. Being the human instrument in the interviews, I was able to ask, probe, ask for clarification, and tailor the interviews in a manner appropriate for each participant as well as my research questions. For both the focus groups and interviews, I followed the interview protocol with predetermined questions. For both, focus groups and interviews, I allowed for an organic conversation to set the stage to allow me to sequence the order in which the questions were asked. See Appendix B for the interview protocol.

Transcribing the Interviews

The focus groups and one interview with a bisexual couple were transcribed by Rev.com, a transcription consulting service. Three audio files were uploaded to Rev.com to be transcribed. The transcriptions were completed within a few days at average cost of $1,000, that is 30% of the grant budget. Due to unforeseen transcription costs, under my supervision ten interviews were transcribed by hand by an Aniz staff MPH trained staff person. The transcription process for these interviews took ten weeks, on average one transcription per week. The focus groups and 11 semi-structured interview transcripts resulted in a total of 274 pages of transcribed texts. All transcripts were in a Word document format.

Since these interview files were in a proprietary format, all audio recorded files were securely kept on password protected file at Aniz, for the staff person to transcribe with an audio headset to ensure participant privacy. I also created a copy of the audio files that were locked in a key protected file cabinet, located in a locked data room at Aniz.

Phases in Transcribing the Interviews

For all completed transcripts, I conducted a 4-phase process to ensure transcription quality. The data analysis starts by getting to know the data by reading and re-reading the transcriptions (Krueger, 1997). In addition to getting to know the focus group transcription data, we compiled and reconciled the data by developing a memo on all meeting notes. This allowed us to consider respondent's tone, reluctance, and enthusiasm when answering questions. The first phase was dedicated to ensuring high quality of the audio recording to ensure faint conversations were clear, if not, I would hand write the conversation for the transcribers to verify. The second phase, once the transcriptions were completed, I would edit for words that needed clarification, edit out *um* or *uh* or any awkward pauses (Bertrand, Brown, & Ward, 1992). I also checked for misspelled words. The third phase, I would read the transcripts to ensure there were no mistakes such as one participant naming another participant by their real name. Instead of the person's real identity, I would edit in place of the person's name the person's pseudonym. At this point, the transcript was a *pure file*. The last phase was dedicated to obvious grammatical errors and deleting extra empty spaces between each conversation. I did this to condense the pages as much as possible. I considered this fourth phase file the *final transcript* for conducting member-checking and for analyzing the interview data.

Document Analysis

Bowen (2009, p. 27), citing Corbin & Strauss (2008) and Rapley (2007) define document analysis as a "systematic procedure for reviewing or evaluating documents—both printed and electronic (computer-based and Internet-transmitted) material… [and] requires that data be examined and interpreted in order to elicit meaning, gain understanding, and develop empirical knowledge." Schwandt (2001) also view document analysis as obtaining documents and records appropriate for a study (or research questions) and examining and deciphering the data obtained from them. As Denzin (1970) noted, one key rationale for document analysis is that it is "often used in combination with other qualitative research methods as a means of triangulation—the combination of methodologies in the study of the same phenomenon" (p. 291). Qualitative researchers frequently rely on multiple (at least two) sources of evidence; that seek convergence and corroboration (Yin, 2009), and ultimately enhance the quality and credibility of the study (Patton, 1999).

Specific uses of documents vary from the context within which research participants operate to how documents can shed new light on unthought some questions that need to be asked (Bowen, 2009). As mentioned above, document analysis is a form of corroboration to verify findings and a way to track program/policy change and development. The advantages and limitations of document analysis need to be mentioned – see Table 9 Advantages and limitations of document analysis (largely adapted from Yin, 2009; Bowen, 2009).

Table 9 Advantages and limitations of document analysis

Advantages	Limitations
Efficient	Insufficient detail
Document availability (esp. online documents)	Bias selectivity
Cost effective	Low retrievability
Localized and specific (contextual)	
Unveil hidden voices	
Documents are not limited to time periods	
Exactness (names, references)	
Stability: researchers do alter what is being studied	

For this study there are several important advantages and limitations. Since the main approach for document procurement for the CLAS standards was through online sources (state agency websites), it is important to note that some states have more developed state agency websites than others. Moreover, many state systems have been moving to documents of public significance to be made available online (Cabellero, 2005). Even, if I were to visit each state agency, they might have me examine their publicly available documents that are located online. As a result, I relied on available CLAS Standard related strategic plans, needs assessments, meeting agendas and minutes, committee structure and memberships, online videos, trainings provided, and training curricula. For the five states being considered, all the documents were sourced and examined from federal, state, and local perspectives.

The document analysis process is grounded in an iterative process of content analysis and thematic analysis. Using your research question as a conceptual guide, content analysis is the process of organizing information into categories. “Thematic analysis is a form of pattern recognition within the data, with emerging themes becoming the categories for analysis” (Fereday & Muir-Cochrane, 2006, p. 20). There are some qualitative researchers who may object to content analysis (Silverman, 2000), they argue content analysis obscures the interpretive processes that turn talk into text. For this study, I am not using document analysis as a stand-alone approach but with the goal to illuminate and as a way to verify questions one (bisexual identity) and two (bisexual health access).

Evaluating the evidence of documents is grounded in ensuring the documents fits the conceptual and methodological frameworks of the study. Document relevance is intimately connected to document/content accuracy, authenticity, credibility, and representativeness of the selected documents. To achieve this requires a balanced approach from the researcher to ask several questions; what the original intent of the document was, target audience, authorship credibility, ensure data cited is within the scope and context of the study, and what does dissent look like (Bowen, 2009).

Data Analysis

For research questions one and two, I analyzed the interview/focus group data using the content analysis technique as described in Lincoln and Guba (1985). For question three, I also used the same approach documents related to the implementation of CLAS Standards within five states. There are five general steps used in the analytical process: (a) unitizing the interview/focus group data; (b) coding the units; (c) identifying the categories of similar units; (d) noting the emerging themes; and (e) subdividing the themes into subthemes. The following paragraphs detail the processes used for analyzing data for research questions one and two (bisexual identity and bisexual health access) and question three (how bisexuals are depicted within the CLAS Standards).

Unitizing the Data for Interviews, Focus Groups, and CLAS Standard Documents

The final transcripts from the eleven interviews and two focus groups, along with the CLAS Standard documents, were the sources for the unitizing process. As a result, the focus groups and eleven semi-structured interview transcripts, resulted in a total of 274 pages of transcribed texts. I reviewed over 100 documents (strategic plans, assessment forms, needs assessment, other state reports, state level laws, committee membership., etc…) to learn how sexual orientation (bisexuality) was incorporated into state level CLAS related documents in five states that are LGBT friendly. The processes used in the analysis will be discussed in the following paragraphs. Finally, details on member-checking are provided in the *Trustworthiness* section later in this chapter.

Initially to get familiar with the data, I relied on 5" x 8" index cards to organize and combine units of data. The 5" x 8" index cards were created from a letter size (8.5" x 11"). All units of data on the index cards were printed in large font (14 Times Roman) for easier legibility and also increased the top for any note taking. I also made sure to have space on the margins to write notes to remind myself later in the analysis or as a reminder of questions I had. Located in the header, I included the interview pseudonym, whether it was a focus group (FG) or interview (I), date of interview or focus group was held, and the index card number. The process I used to segment the units of data from the final transcript to the index cards, was reading the transcripts, copying and pasting the unit of data of interest to an index cards, and printing the cards on my home printer. Once a unit was copied I would color code the unit of data in the final transcript to correspond to the emerging theme. This allowed me to see the direct connection between unit of data and emergent theme. This process took me about a month to complete.

Once I was comfortable with this phase of data analysis, to ensure there were no mistakes in the coding process I developed an excel file to reinforce how well I know the data. The excel file demarcated columns entitled by theme as a header, and I reused the final transcript (with color coded unites of data already made) and copied the units of data under each theme. Each unit of data was designated to the final transcript page number where the data is located with the transcript, followed by the participant pseudonym and the question that was being addressed at the time of the interview. Within the excel file, I developed an excel sheet for each interview and focus groups. This process allowed me to visually see on a large computer screen how the themes, and even the units of data, are related, and whether I made an initial mistake and coded the same unit twice under one theme. Through sorting of the data in each column, I was able to identify duplication of codes which were documented and resolved.

For the units of data for the CLAS Standards, using the FORECAST approach I relied on organizing the units of data in an excel file, using the similar process as the interviews. Instead of participant pseudonym I used the document name/title. Each unit of data was linked to a page number where the data is located. This process allowed me to, again, see how the units of data and themes are connected.

Coding the Units

My initial plan was to code the data using large post it notes on my empty wall located in my home office. Since I am a visual person, I am comfortable in seeing connections across themes and collapsing units of data within a theme. To me, doing this on a large wall is logical and easy to revisit areas of conflict and question. However, I know that this process would never work for a number of reasons, from my cats playing with the post it notes to the wall not being a mobile platform. Instead, as part of my first process, I printed each transcript and printed the 5” x 8” index cards. For the excel file organization process, I also bought two large computer screens connected to one computer for my home to code and organize the data.

Identifying the Themes for Interview and Focus Groups

Because of the amount of data, every third interview transcript (average of 10 pages), I paused to identify the emerging themes by grouping the index cards with similar codes or meanings. The only deviance from this step are the focus group transcripts that were between 70 to 91 pages in length. With the focus group transcripts, every 20 pages I would pause to identify the emerging themes.

Data analysis was started by organizing the data by identifying concepts, trends, themes, behaviors, terminology, or phrases and assigning them as significant statements (506 significant statements). For example, if the focus group topic was barriers to health access, I might identify common themes in responses such as stigma, lack of health resources, and so on. All coding was done using a spreadsheet with distinct color coding of notes in excel (Sim, 1998).

During this process of data coding, I took note of patterns, connections, relationships, and themes that were developed into open codes (Gibbs, 1997). There were 645 open codes identified, which were organized into 27 axial/intermidiant codes organized around each level of the socioecological model [individual 11; interpersonal 8; community 6; organization 1; policy 1]. These axial/intermidiant codes range from *disclosure of bisexuality* at the individual level to there are *no policies* protecting bisexuals at the policy level. Each axial code is connected to quotes from the transcripts (Kitzinger, 1994; Krueger, & Casey, 2009). Finally, during the interpretation of the data phase, several iterations of memoing will take place to organize the 27 axial/intermiitant codes that each question 1 and 2 of this dissertation (Krueger, & Casey, 2009).

Identifying the Themes for CLAS Standard Documents

The FORECAST approach was used to organize the 'themes' into markers, measures, sources, and meaning. The markers were influenced by the National CLAS Standards evaluation study. The "markers," "measures," and "meaning" will be based on the national CLAS Standards evaluation report. The "sources" will be a combination of what has already been identified by the CLAS Standards evaluation report, and available documents to conduct a real time deeper dive into existing CLAS activities focused on LGBT populations, specifically bisexuals. In developing the model, we deemed it necessary to include a fifth section, "sexual orientation references" to document detailed LGBT and bisexual examples that are set apart from describing the meaning of each measure.

Since calendar year 2000, states, territories, tribes, and jurisdictions have implemented the CLAS standards with varying degrees of intensity. This has led to a kaleidoscope of state centered policies, from minimal implementation to embracing the CLAS standards at various levels of state government. There are also states that have no activities[15] to states that have CLAS training legislation (activity or enacted) AND state-

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[15] There are sixteen states and jurisdictions with no activities: Alabama, Alaska, Arkansas, District of Columbia, Idaho, Maine, Mississippi, Montana, New Hampshire, North Carolina, North Dakota, South Carolina, South Dakota, Tennessee, Vermont, and West Virginia.

sponsored implementation activities[16]. Similar to no activities, there are jurisdictions that have activities such as strategic plan development currently under review[17]. Finally, there are states with state-sponsored implementation activities[18], and to a lesser extend states with some legislative activity for CLAS training[19].

In 2015-16, the Office of Minority Health at U.S. Department of Health and Human Services conducted a national evaluation of all CLAS related activities, entitled National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care: Compendium of State-Sponsored National CLAS Standards Implementation Activities (aka the Compendium) (U.S. Department of Health and Human Services, Office of Minority Health, 2016). The Office of Minority Health at the U.S. Department of Health and Human Services keeps track of all CLAS related activities. The state activities are also reported to HHS.

The Compendium is a national evaluation report of state level CLAS Standards implementation. The review of the states was broad and lacked local level activities. The Compendium used state governmental reports, websites, and online publications as a central method to assess the level of intensity of CLAS standards implementation activities. The evaluation results were organized into three different themes: Planning,

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[16] There are 21 states that have CLAS training legislation (activity or enacted) AND state-sponsored implementation activities: Arizona, **California**, Colorado, Connecticut, Florida, Hawaii, Illinois, Iowa, Kentucky, Maryland, **Massachusetts**, Minnesota, New Jersey, New Mexico, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Texas, and Washington.

[17] There are eight jurisdictions that have activities currently under review: American Samoa, Commonwealth of the Northern Mariana Islands, Federated States of Micronesia, Guam, Palau, Puerto Rico, Republic of the Marshall Islands, and U.S. Virgin Islands.

[18] There are elven states with state-sponsored implementation activities: **Delaware**, Kansas, Louisiana, Michigan, Nebraska, **Nevada**, Rhode Island, Utah, Virginia, Wisconsin, and Wyoming.

[19] There are three states with legislative activity for CLAS training:
Georgia, Indiana, and Missouri.

Policies, Collaboration; Training and Technical Assistance; and Dissemination (see Table 10 Summary of Findings Planning, Policies, Collaboration).

The table below is a summary of all CLAS activities for the 50 states, one jurisdiction, and five territories. The Compendium reviewed a total of 172 activities from 32 states. The most common number of activities focused on three themes, one, planning, policies, and collaboration. These activities were centered around state level strategic plans. Dissemination was the second most popular approach with a concentration on website development to promote CLAS related activities. The third largest category focused on training and technical assistance, specifically focused on state wide online and face to face trainings. These three themes are broad categories where evaluation markers are housed (i.e., strategic plans).

Table 11 Summary of Findings Planning, Policies, Collaboration

Categories (in bold) and Markers	# of Activities	Number of states
Planning, Policies, Collaboration	**87**	**29**
Markers		
Strategic Plans	38	20
Partnerships/Task Forces	22	18
Needs Assessments	16	14
Policies, Procedures, and Regulations	11	9
Training and Technical Assistance	**40**	**24**
Markers		
Training	26	22
Technical Assistance	7	7
Provides grant funding	7	5
Dissemination	**45**	**24**
Markers		
Web development	19	17
Reports/toolkits	13	13
Newsletters/short pubs	10	9
Conferences/presentations	2	1

Table 11 Summary of Findings Planning, Policies, Collaboration Continued

Videos/Non-print media	1	1
Total	172	32

Source: U.S. Department of Health and Human Services, Office of Minority Health, 2016

Trustworthiness and Rigor

Bisexual Participant Data Trustworthiness and Rigor

According to Guba and Lincoln (1981) there are three major aspects to consider in analytic induction including "bounding, focusing, and rigor" (p.86). Bounding decisions were defined by the parameters set for the study. Focusing provided for the ongoing process of converging on concerns and issues from various perspectives, which were used as a lens to diverge and gather additional information that helped clarify or resolve matters. Rigor was the other methodological concern identified by Guba and Lincoln (1981). To ensure validity and reliability, certain procedures needed to be maintained during the critical process. The method of triangulation proved useful and involved comparing sources of information and identifying recurrent themes.

Trustworthiness is intended to ensure data rigor. To a certain extent, data rigor speaks to possible truths. Within trustworthiness there is the underlining notion of uncovering truth(s), or as Todorov noted the French ideal of *vraisemblance* as a “construction of truth” (Ellis, & Bochner, 1996: p. 257). To attain truth is a process that requires sound methodological strategies. In other words, for data to be true, especially collecting data from hard to reach populations and interpreting that data requires a confidence the research design and methods are sound. To ensure data integrity within qualitative inquiry, data credibility needs to be considered. In other words, the confidence that the research findings are true. Within this project, data credibility was ensured through verification of existing literature on the lived lives of bisexuals along with study participant confirmation.

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In qualitative inquiry, trustworthiness is "intended to parallel the rigor criteria that have been used within the conventional" (scientific) research (Guba & Lincoln, 1989; p. 233). Within qualitative inquiry trustworthiness is the larger framework for determining credibility, transferability, dependability, and confirmability. Given the amount of data within this study, a second reviewer (James Doster) examined transcript data from each focus groups and semi structured interviews. From the initial data transcription review process, James reconstructed from 506 significant statements to 645 open codes. Then from the 645 open codes, 26 axial/intermediate codes emerged.

Credibility assesses whether the research findings are believable, examines how the realities constructed by interviewees, and realities represented by the investigator (Guba & Lincoln, 1989). Data/document triangulation was utilized to strength credibility by having a second party review data analysis process (Guba & Lincoln, 1989). Also, by ensuring credibility in a socially just manner is to share the data findings with the study participants through the community site Aniz.

Transferability was assessed by comparing the data findings to existing literature not only from public health but also from critical methodologies (queer, critical race, etc..). The dependability of the data was triangulated and is consistent and data from focus groups were aligned with semi structured interviews. The confirmability of the data was supported by a confirmability audit to ensure the study findings are shaped by respondents and not researcher bias or interest.

Like quantitative data, within qualitative inquiry, generalizable knowledge has limitations. This issue of limitations, and others such as *dependability and confirmability*, will be discussed later in the limitations and delimitations section of this chapter. In essence *dependability* parallels reliability and its purpose, it to provide guidance at how the regularity and stability of data over time (Guba & Lincoln, 1989). *Confirmability* parallels objectivity and provides a way of looking at the extent, to which data, and data interpretation (Guba & Lincoln, 1989) is internally consistent and consistent with information from other known sources (e.g., published literature). More importantly, what this study addresses are how bisexual experiences are embedded and understood through different levels of community contexts and how context impacts self-disclosure and health access.

Trustworthiness and Rigor for FORECAST MODEL

Data integrity is always a concern that needs addressed in any study. Selected data collection, maintenance, and analysis methods were used to judge the adequacy of the study. With *trustworthiness*, we need to consider credibility, transferability, dependability, and confirmability. *Credibilit*y was supported by triangulation, by using different data collection methods and sources. The data was cross referenced with other national and state reports. In addition, since the implementation of the CLAS Standards are located with State Department of Public Health, the accuracy of the conclusions drawn were verified by other state and local level data reports.

As Stake discussed (cite) with case selection that they need to answer the question of what can be learn. One issue with selecting cases is generalization of the information learnt. In considering how to select the cases to give us the best information, the issue of "balance and variety are important" consideration. (Stake, 1995; p. 5) This balance and variety will allow us to make petite generalizations to give us a window how the CLAS Standards are impacting LGBT populations, specifically with bisexuals. Our cases are not necessarily meant to be generalizable to a broader population, but to aid transferability, we selected a range of five states to provide a range of contrasting cases and help understand findings in multiple contexts. Purposive sampling was also used to strengthen transferability. (Guba & Lincoln, 1989)

To enhance dependability and confirmability, we created an excel database to organize and document sources, data, and interpretations of data. (Guba & Lincoln, 1989) A content analysis was performed on existing documents (over 70 documents). Data sources included, state strategic plans, committee agendas and minutes, other relevant state and local level reports, national and state quality improvement reports, website content, trainings, legislative laws and bills. Through a content analysis process, it helped to reveal themes that were common across programs and identify emerging best practices. The data was counted combined and summed across all five sites to indicate which codes were repeated most often. The codes were most thematic for the evaluation. In addition, the number of sites that mentioned a code were summed to indicate to what extent a code could be generalized across the five study sites. Therefore, the numbers that appear in Table 11 are the number of times each code was mentioned.

Summary of trustworthiness criteria for my study

The trustworthiness criteria for my study is centered on Lincoln and Guba's parallel methodologic criteria and authenticity/ethical criteria. Credibility was anchored by triangulation of sources, methods, and theories; and member checks. Transferability is grounded by thick descriptions. Dependability and confirmability's audit trail was provided by James Doster and reflexive journal.

According to Lincoln's (2013) *Constructivist Credo*, the quality or rigor of the data rests on several principles or authenticity criteria [*italicized*]. The *ontological authenticity* is my journey, through my interviewing process, to learn more about bisexuality and applying qualitative methods to explore epistemic contradictions of how bisexuality is constructed, unveiling phenomena how health access is mediated by bisexuals, and how policy design is limited by the conception is skewed by traditional gay and lesbian identities, and largely neglects bisexuals. Sometimes during the interview process, participants had aha moments in regard to their self-refection about their sexuality and personal experiences. *Educative authenticity* in this study is buttressed by my educational journey (academic training), community work with LGBT populations, and the dissertation research questions, is supported by the triangulation of sources (interviews and documents). This support of triangulation of sources is also known as *fairness*. This study is located along the arch of social justice and action (*catalytic* *authenticity*), and my hope (as a public health practitioner) is that the findings can impact some key stakeholders in rethinking the complexities of sexual orientation. After the completion of this dissertation, my short-term goal is to publish these findings in peer reviewed journals (*tactical authenticity*).

Limitations and Delimitations

The choice of qualitative methodology for this study involved both limitations and delimitations. To mitigate the limitations, procedures were incorporated to address credibility, confirmability, and dependability. An obvious limitation is this study was conducted in Metro Atlanta with a majority population that identify as African American and bisexual. Views on bisexuality could be limited or enhances by using a critical race lens to understand the lived experiences of a racial population that is accustomed to what racial marginalization. The reconstructed perspectives by the study participants may be subject to recall bias and Christian religiosity within the African American population.

Since Trump's election, another limitation could be federal and state policies that have negatively impacted the LGBT community. Since the new presidential administration, there have been several targeted policies affecting the transgender community and local states have a new synergy to challenge existing federal laws and regulations impacting the LGBT community. For example, in South Carolina[20] some state representatives are advocating reclassifying same sex marriage as 'parody marriage'. Other states have rigorously enacted new initiatives for limitations on transgender access to cisgender bathrooms. Some states are now having rigorous debates on religious

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[20] South Carolina Lawmakers Want to Define Same-Sex Marriage as 'Parody Marriage' (2018, April 22). Retrieved from http://fortune.com/2018/02/20/south-carolina-same-sex-marriage-gay-marriage/

freedom bills to allow merchants to discriminate against LGBT populations. While this cultural backlash is developing, we have seen a rise in LGBT persons seeking political office and political elected candidates; Oregon’s Governor Kate Brown, openly bisexual, is seeking re-election; Representative Kyrsten Sinema, also openly bisexual, is running for the U.S. Senate seat in Arizona being vacated by retiring Sen. Jeff Flake; Dana Beyer, a transgender activist from Maryland, is seeking a state Senate seat; Nelson Araujo, openly gay person of color, is running to become Nevada secretary of state.

Triangulation of Sources, Methods, and Theories

Triangulation is centered on using multiple sources. Asking the semi-structured interviews and focus groups the same questions is a form of triangulation of sources. As Patton (1990) noted, triangulation is “seldom a straightforward process in analysis [and by] using multiple methods to study a program.. [and by] using different perspectives (or theories) to interpret a set of data” can narrow down to a common understanding (p. 161). For this study, I would check one participant’s response with another by asking the second participant a question about that piece of data, or by verifying how one state conducted a primary activity through other state activities that support the primary activity.

The triangulation of methods as a technique refers to using various forms of data collection to confirm exactness of the data (Lincoln & Guba, 1985). In this research study, two forms of data collection methods were utilized - interviews and document analyses. Finally, the triangulation of theories refers to verifying units of data with implicit and explicit theories (Donaldson, & Scriven, 2003; Cairney, 2013). I relied on several implicit and explicit theories. For the implicit theory, or implicit knowledge, I leaned on (a) the level of sexual orientation diversity with the LGBT population is more complex than just gay and lesbian (e.g., bisexuals are often mislabeled or understood to be either gay or lesbian); (b) how bisexuality is measured through psychometric tools is lacking; and, (c) when policies that are LGBT focused or addressing are LGBT populations, bisexuals are ignored. In regards, to explicit theory, or explicit knowledge, were (a) patient medical provider communication strategies – there are evidence based methods used that enhance these communication strategies to make it easy to disclose health information (Dorsen, & Van Devanter, 2016; Fuzzell, Fedesco, Alexander, Fortenberry, & Shields, 2016; Rullo, et al , 2018; Coleman, et al, 2017) (b) policy implementation and effectiveness – as Guba (1984) noted, defining a policy, now it gets implementation, and assessing policy outcomes are very different processes.

Negative Case Analysis

With any research project there is a continuous dialogue and process of adjusting the working hypothesis to account for outlying situations can be substantiated in the working hypothesis (Lincoln & Guba, 1985). One key example is that my findings appear to suggest that regardless if one is transgender or cisgender male or female, one who is bisexual is still discriminated based on their sexual orientation. For cisgender bisexuals, they are confused and really gay or straight. They are pressured to socially perform as either straight or gay to meet society’s expectations of what is sexual orientation. For transgenders who are bisexuals, they are treated like pink unicorns or as an oddity. The question that bisexual transgender’s get are, you really exist. This issue of how bisexuality is understood, or does it matter, when interviewing the participants - I asked direct questions on their views of bisexuality, the participants strongly reinforced the idea you cannot separate my sexuality from my sexual identity (e.g., transgender), nor can society successfully suppress my bisexuality to conform to either the gay or straight identity typologies.

Member Checks

Lincoln (1985) noted that member checking is both “informal and formal, and it occurs continuously” (p. 314). Member checking is defined as “data, analytic categories, interpretations, and conclusions are tested with members of those stakeholding groups from whom the data were originally collected”, and it is essential to stabling credibility (Lincoln & Guba, 1985, p. 314). Given the population was hard to reach, during the intake process to assess if a person met the inclusion criteria Aniz Inc collected email addresses from the participants. When dealing with hard to reach populations, there is always a level of hesitancy to provide detailed personal information. Out of the 36 participants, seven did not either have an email address nor their email addresses were no longer functional – 29 had working email addresses.

For each interview and focus group final transcript, it was emailed to the participants for verification from an email secure Aniz email address. Within the email, it was stated that if there is no response, then the assumption will be that the final transcript was approved by them. The participants were given three weeks and were asked to review the deidentified transcripts for accuracy; and each participant was reminded and provided with their pseudonym. Of the 29 participants with working email addresses, only two (transgender bisexual couple) requested to make changes. Their clarification focused on medical access and experiences of being labeled bisexual.

Thick Description

During the interview process, the set up was between an interviewer and interviewee. This dialectical exchange occurs within a one on one interview and within a group setting with many individuals. As Kvale (1996) notes, an interview really means "*inter view* is an inter exchange of views between persons conversing about a theme of mutual interest" (p. 2). The interview or dialogue forms the basis of a thick description which rests on "conversation-methodology, epistemology [nature of knowledge], and ontology [subject of existance]" (p. 37). Within these interviews, the notion of meanings take shape and guide the conversational tone. Diley (2004, p. 128), citing Seidman (1998) writes that meaning is not "just the facts," but rather "what was said" to "what is the relation between what was said, how it was said, what the listener was attempting to ask or hear, what the speaker was attempting to convey or say". Interviews are a methodological tool that "allow us to investigate, in critical ways, our respondents' comprehensions of their experiences and beliefs—as well as our own" (Diley, 2004, p. 128). These comprehensions, experiences, and beliefs coalesce into meanings. These meanings are transcribed and form the basis of a thick description, that is supported by observational notes, and other supporting documents.

Thick description is an in-depth, detailed, and technically exhaustive (for this study - interviewer notes, participant narratives, and other supporting documentation) approach to obtain enough details of the social context to assist the study in answering the question of whether or not the findings are transferable to the reader's context (Lincoln & Guba, 1985). The question that needs to be addressed is. what do we mean by thick? For the purposes of this study, thick refers describes recording the contextual meanings, intentions, strategies, motivations, and unique circumstances; that sometimes need to be done by working through difficult conversations. In our study, during the focus groups, in a social group format, there was some sadness expressed not being recognized for being bisexual. Please see the next chapter, Chapter IV: Data Analysis and Findings, for thick descriptions analysis.

Dependability and Confirmability Audits with Audit Trails

Since I was working remotely from College Station, my primary auditor was James Doster who has advance training in Qualitative Methods from the University of Georgia. The primary tools that were used were field memos and an observational memo. The memos detailed the data collection process and data analysis, which detailed how the results for the study. In addition, to ensure dependability and confirmability, two EQUATOR (Enhancing the QUAlity and Transparency Of health Research) guidelines were employed. EQUATOR seeks to improve the value and reliability of published health research literature through a checklist process to ensure transparent and accurate reporting. The first checklist was COREQ (Consolidated criteria for reporting qualitative research) specifically addressing the bisexual study (dissertation questions one and two) (Tong, Sainsbury, & Craig, 2007). COREQ checklist is a 32-item list. COREQ explores the standards for reporting qualitative research with an emphasis on qualitative data collection methods (e.g., interviews). All COREQ checklist items were addressed fully. From my observation, the only limitations to COREQ are; (1) sexual orientation was not asked for but is an important factor in reflexivity, (2) when gender was asked, transgender identity was not recognized – only Cisgender was acknowledged. COREQ is not transgender inclusive. The second EQUATOR checklist is Standards for Reporting

Qualitative Research (SRQR) which aims to improve the transparency of all aspects of qualitative research by providing clear standards for reporting qualitative research (aka, for the whole study) (O'brien, Harris, Beckman, Reed, & Cook, 2014). All SRQR checklist items were addressed fully. (See Appendix E: COREQ & SRQR standards for reporting qualitative research)

Reflexive Journal

Using a reflexive journal allows the researcher to track ongoing research issues, personal reactions to the development of the research project, and as a tool to flag potential issues and conflicts within the project (Lincoln & Guba, 1985). The researcher is the human instrument and a reflexive journal is a tool to expose in a thoughtful manner ongoing issues and how to mitigate them. For me, I started my journal when the project was initially funded in 2015. One unforeseen issue, since the study was funded, while I was a student I used my class qualitative journal – where I wrote questions about research design, philosophical issues, class progress notes, or even notes form conferences (International Conference on Qualitative Inquiry) I attended as the journal for this study. At first, I found it helpful to keep since I was learning to encapsulate all my thoughts in one place. The drawback of doing this is going back and findings key statements that I wrote. These statements were enmeshed with conference proceedings, notes from books/articles I read, dissertation study questions, ideas for future funding/publications, etc.. Midway through the study, I changed course. I now have a journal dedicated for this study, one for rambling ideas/future funding ideas, and one for that I kept notes on key articles and books.

Publications Resulting from This Research Study

This dissertation has been a journey, from the IRB hostage holding process to collecting primary data while at the same time dealing with staff dynamics of Aniz (there was one staff department in the midst of data collection which required training and to include the new staff in the Morehouse School of Medicine IRB protocol). At first, I was focused on a three-article format as opposed to a traditional dissertation format. The struggle I had with the three-paper format is the limited space to depict, in a very detailed manner, the methodological approach and how the different theories were combined to form one lens of analysis. After completing four chapters (Introduction, Paper 1, 2, and 3), Dr. McLeroy suggested that the traditional format would be best. At first, I was taken aback, but when I started to copy and paste from the three-paper format to the traditional format – I really saw the wisdom in his advice. I was actually pleased, while to some my chapter two – literature review, looks like a literature review on steroids, to me it embodies an in-depth review how bisexuality is defined, the nature of bisexual health disparities, and an overview of both ecological and policy implementation – centered on the CLAS Standards. These three sections of the literature review set the stage to explore bisexual health access and policy implications of how bisexuals are depicted in the CLAS Standards in five states.

In plain English, I went to town, rewriting Chapter three – the methodological section. While I was rereading old articles and books, I found a path to reformat Chapter three in Lincoln's *Constructivist Credo* dissertation example. What I struggled with initially is how to combine critical theory with a qualitative approach that makes sense. I also struggled with how to incorporate the FORECAST Model within the qualitative theoretical paradigm. What I wanted to show was a step by step process in how the methodological analytical lens were derived.

As part of the educative, catalytic, and tactical authenticities – based on the three dissertation questions I will publish three papers from the study. My short-term goal is to add to the small but growing body of literature on bisexual health access studies by publishing dissertation questions one and two. Another goal is nostalgic in nature, in which I want to put to use my Master’s academic training in public administration/policy analysis by publishing in a public administration journal on question three, using the FORECAST Model (Goodman, & Wandersman, 1994).

Summary of Methodology

This dissertation study was guided by the blurred genres - interpretivism and critical theory into interpretive critical inquiry (Geertz, 1973; Schwandt, 1994). This study explored bisexual health access issues along what does it mean to be bisexual. The community site, Aniz, has a long history of serving the LGBT population in the south, and has strong community connections with the LGBT community. Originally, the funded study’s goal was to recruit 20 bisexuals. Instead, through a purposive sampling, the study was able to recruit 36 bisexual participants. Technically, the project started in 2015. Through the initial IRB approval by Morehouse School of Medicine in August 2016, study participants recruitment started in the Fall of 2016. To meet OGAPS dissertation requirements, a second IRB approval was sought from Texas A&M, and finally approved in 2018. In addition to interview data on bisexuals, five states were selected to assess how the CLAS Standards are being implemented and how bisexual inclusive they are. This dissertation relied mainly on interview data and document analysis. The interviews were transcribed and analyzed using Lincoln and Guba's (1985), and the document analysis was performed using Goodman and Wandersman (1994). The trustworthiness criteria were grounded in Lincoln and Guba's parallel methodological criteria and authenticity/ethical criteria (Guba & Lincoln, 2005; Guba & Lincoln, 2013). The data results are located in the next chapter - *Chapter IV: Data Analysis and Findings*. *(For a detailed memo for focus group and individual interviews – see Appendix A)*

Subthemes Identified
Six subtheme clusters
(1) Health Affects
(2) Emotional/Religious Support
(3) Pink Unicorn
(4) Ghost Echoes
(5) Delusional Identity
(6) Textual Contradictions.

CHAPTER IV

DATA ANALYSIS AND FINDINGS

This chapter is a result of a labor of love, mixed with some anguish and at times frustrations. Personally, this dissertation allowed me to begin to understand why, at times, bisexuals identify as gay or lesbian or straight. Since college, I have had friends who self-identified and publicly socialized as gay or lesbian, but they are really bisexual. Two stories come to mind that directly or indirectly inspire my intellectual curiosity for this dissertation. First, one of my earliest public health mentors (Jack) in Massachusetts is married to a man (I was his best man), socializes and identifies as a gay man, but is bisexual. Jack started Gay Dads in Massachusetts, and he was at one time married to a woman who knew about his sexual inclination for men. His life always puzzled me, and he did not talk about his sexuality.

This reluctance within the gay male community to talk about bisexuality, is also extended to lesbians I knew who shied away from bisexual women. Many years ago, I was in a five-year relationship with a man (Jose) who socializes and identifies as a gay man, but he too is bisexual. He was from the Azores, and for the first time in my life there was something magical to be with a man who got me culturally. There were just some unspoken social norms that we accepted, whereas, what we called the "Americans" (folks who were not Portuguese speaking) would never understand. The troubling issue is, the reason I broke up with him, besides the psychological abuse, negativity that impacted my self-worth, and manipulation, was when I found out he is bisexual – five years into the relationship. When I found out, I felt betrayed and confused as to why he denied his bisexual identity and why he said he was gay. This was a turning point for me, for in my teens and early twenties I would hide my sexuality from others, and here I discovered bisexuals doing the same within the gay community.

With the help of a therapist, I have worked through these emotions many years ago and my feelings of betrayal and why I was being controlled by Jose. Yes, I will admit, I broke up with Jose because he is bisexual and admitted to me that he was bisexual in the last few months of our relationships. Even when Jose, I was never aware that I dated a bisexual man. However, my intellectual curiosity still nagged at me as to why bisexual people cloak their identities as something else, even in gay friendly social circles, and the possible public health implications from hiding. These two stories are written in my reflective journal and as I indicated I have worked through the notion that as a gay man, I was – and I still am operating in a gay culture that is bi-phobic. Bi-inclusivity, as some of the study participants noted, is a fleeting notion of trying to be culturally competent with a lack of understanding of the sexual identity spectrum and its complexities around social norms. I need to be clear that this intellectual journey is not as Westbrook (2009) noted a "romantic obsession", trying to capture a lost memory, but an intellectual one (p. 142). Therefore, to me the findings are much anticipated.

The participant narratives provide a window into the human condition, and these views allow us to learn (and generate) new knowledge. The question of how that new knowledge is utilized is beyond this dissertation. For me, what is relevant is through the coding process I began to see emerging patterns and themes. I also began to see new viewpoints, new ideas, new controversies, etc.. The process of generating new knowledge, in large part, is reflected in the memoing process which allowed me to conceptually and practically see how a bevy of data points coalesce into a cogent story(ies). As I am reminded by a quote from Westbrook (2009), in regards to the process of knowledge gathering and analytical interpretations, that it is “neither.. an effort at revolution nor counterrevolution, but instead as a response to the conflict, not exactly a synthesis, more an intellectually belated answer to the question, what do we do afterward?” (p. 80). It is this afterward, the next phase of my professional career, as I see myself as a human instrument to unveil and analyze subaltern dialogues, that excites me.

The following sections detail the data analysis and findings for both the bisexual participants and FORECAST approach. In this section there will be a series of tables in the appendix describing the data and how the analyses and results evolved from the data.

Data Analysis Process for Questions 1 and 2

Below in table 12 is a list of interview questions that was used for both the focus groups and interviews. These questions were pretested with four bisexual persons before they were used with the actual focus groups and interviews. Zina Age, CEO of Aniz, vetted the questions. Zina, who is bisexual, is trained as an MSW and has experience in providing healthcare services for marginalized persons. The other three bisexuals’ persons were Aniz staff members (Del, “Bud”, and JJ) who provided feedback. The feedback consensus was on being open to the idea that there might be bisexual persons who are also transgendered – see question 3, sub-question b. Their feedback was both strategic and correct since the study had eight transgenders included among the respondents. (*For a detailed individual protocol – see Appendix B)*

Table 12 – sample of interview questions

SOCIOECOLOGICAL MODEL
This first question is about your identity or who you are.
Do you often feel that people do or do not fully understand what it means to be bisexual? Please Explain
What does bisexual mean to you as an identity?
Do you use any other identities such as pansexual, straight, genderqueer, etc?
How much does the bisexual identity matter in your social networks?
How does race and ethnicity factor into your bisexual identity?
What comes first as the most important part of your identity, race or bisexual identity? Explain
Is there a difference between old and young bisexual people in how they self-identify?
If you have been in other bisexual communities (outside of Atlanta), how do the bisexual community typically identify themselves?
For questions 3 to 7 – Based on the socioecological model:
Individual level:
How does your bisexual identity impact your personal belief system (self-esteem)?
Do you feel the bisexual community is more at risk for healthy behaviors?
Intrapersonal level:
Is there a difference between family and friends in how they perceive your identity? Explain
Do you have an online identity profile? If so, how reflective does it mirror your personal identity? (e.g., you are pre op but online you are biological female or male) Why do you do this?
How do your family and friends perceive your identity?
Community level:
How important are your social networks?
How do you think that organizations perceive your identity? Explain
How connected do you feel with the non-bisexual community? Explain
Institutional level:
Do you seek out organizations that are bisexual friendly? Explain
Policy level:
How do you perceive the present national polices around bisexual identity? Are things getting better?
HEALTHCARE NEEDS
Has anyone had any negative issues in accessing health care services?
<u>Probe:</u> Please explain with whom did you have a negative experience? Was the medical front line staff, the questions being asked on medical intake forms, or the medical provider (e.g., doctor)?
In what ways do you feel that the health services fell short in helping you?

At this point we'd like to hear about the positive health services you have received.
Please share where you all get the best health services?
In what ways were the health services helpful to you?

Table 12 – sample of interview questions Continued

In what ways were these experiences negative or positive to you?

Now imagine that you are part of a committee of people designing a training for health care providers to promote and/or facilitate health access.
What are the aspects do you feel clinicians need to know to make health access a positive experience for you?
What do you think that clinicians should be aware of the bisexual population?
What are the training learning objectives would you to ensure the clinicians would walk away with?
. Is there anything else we haven't discussed yet that you think is important for healthcare providers to know about the bisexual population in accessing health services?

From the two focus groups and 11 semi-structured interview transcripts a total of 274 pages of text were transcribed. The data from two focus groups and 11 semi-structured were used to answer two research questions: (1) how is bisexuality as a social identity constructed and understood?, and (2) how does bisexual identity disclosure influence health access? There were 645 open codes identified, which were organized into 27 axial/intermitent codes organized around each level of the socioecological model [individual 11; interpersonal 8; community 6; organization 1; policy 1]. Please see Appendix A, Research memo #2: Questions 1 & 2 Reflective memo – study participant focus groups & semi structured interviews

Individual

1. Substance abuse
2. Sexually abused
3. Race and bisexuality
4. Feelings
5. Self-esteem
6. Disclosure of bisexuality
7. Religion
8. Self-conception of bisexuality
9. Resilience

10. Accepting my bisexuality
11. Blame & shame bisexuals

Interpersonal

1. HIV and bisexuality
2. Support
3. Bisexuality does not exist
4. Confusion on what bisexuality is or is not
5. Bisexual means GAY
6. Transgender and bisexual
7. The issue of Class
8. The "OTHER"

Community

1. Generational divide
2. Bisexual sex
3. Media & Social Media
4. Communication with medical provider
5. Bisexual community
6. What society expects about bisexuality

Organizational

1. Organizations not bi-friendly

Policy

1. No policies

I used qualitative thematic analysis to analyze data from focus groups and semi-structured interviews of self-identified bisexual adults (Boyatzis, 1998; Aronson, 1995). Thematic analysis allows to locate broader themes that are collapsed to sub-categories of meaningful knowledge statements. This is an inductive process which allows the data to emerge from a lager data set, and the categorization of the data is not predetermined by the researcher.

The data coding process was limited to two or three lines of text to identify key concepts, emotions, and imagery statements. The coding procedure is an explicit and iterative process that allows for clear and concise boundaries. From a code themes emerge. The criteria for a good code captures the qualitative richness of the phenomenon.

To ensure code validation, there was a two-part process (1) read and re-read the data with an intent of double-checking for consistency and validation, and (2) a second reviewer was utilized. From the codes, a centralized codebook was developed to identify themes and sub-themes. At this point patterns emerged from the coded data. A last step was the finalization of the name of each theme with a descriptive analysis.

Data analysis was guided and influenced by the interpretative tradition. The interpretative tradition is grounded in Fouculdian medical gaze. Foucault's medical gaze (Foucault, 2012) is a useful way to understand the different definitions of how bisexuality is operationalized within medical discourse. Using the medical gaze is a way to appreciate how medical institutions separate the body from the person, and how the biological categorization process occurs. In other words, the separation of the body from the person, and the way we compartmentalize, categorize, and objectify the body and sexuality is complex and value laden.

The medicalization of the person is a form of hermeneutical injustice (Wardrope, 2015), in which a person who visits a medical provider might proclaim their bisexuality but not be understood by the medical provider due to institutional/medical prejudicial assumptions. This concept is embedded within medical practice and has been observed in medicine. For example, Davenport (2000) examined the tension between objectification and subject-making between medical students with homeless populations seeking medical care. The objectification of a person (e.g., assumptions of homelessness) impacts patient and medical provider communication that can impede a trust building relationship. The subject-making in the medical diagnosis process divorces the person from medical environment. In other words, the person and their body become medical products to be recorded and labeled is such a way that is lacking a sense of humanity.

Davenport (2000) further argues that an important component of medicalization is "medical gaze, and he sees it as a given of the scientific epistemology that informs medical practice" (p. 313). Davenport cited one example of how a patient was "talked over, despite [the patient's] attempts to participate in [doctor's] presentation of what is, after all, [the patient's] story" (p.320). What Davenport reminds us is the body, and the appearance of sexuality, become a temporal instrument for analysis that is guided by "medico-legal aspects of record keeping" (p. 321). How bisexuality is recorded in medical records and how medical providers ask questions about sexuality impact the comfort level of patients. Also, the objectification of the medical body extends also to the objectification of sexuality. This objectification and subject-making results in epistemic medical injustice.

The Bisexual Participants

All study participants consented prior to participating in a focus group or interview (See appendix for *Consent To Participate In A Research Study*). The next few sentences is a demographic overview of the study participants. In total there were 36 study participants. The majority are African American (n=31), male (n=24). In addition, there are eight transgender individuals who also identify as bisexual. Tables 13 and 14 are a reminder of participant diversity.

Table 13. Study Participants for Interviews

Pseudonym	Gender	Race / Ethnicity	Age cohort
. Chocolate	MtF	African American	50-64
. Debbie	MtF	African American	35-49
. Maria & Phil	MtF & FtM	White & Puerto Rican	35-49
. Jazz	MtF	African American	18-34
. Katrina	Female	African American	35-49
. Lala	Female	African American	18-34
. Lamar	Male	African American	50-64
. Queen B	Female	African American	50-64
. Shawn	Male	African American	35-49
. Sisterhood	Female	African American	50-64
. Walter	Male	African American	35-49

Table 14. Study Participants for Focus Groups

	FG1	FG2
Sexual Identity	11 males 1 Transgender	10 males 2 Transgender
Race	1 Hispanic 10 African American	2 White 11 African American
Age	3 in 18-34 3 in 35-49 6 in 50-64	4 in 18-34 2 in 35-49 7 in 50-64
Note: The democratic consensus within each group was not to have pseudonym like 'Mary', 'John' etc .. but rather be designated a number (participant 1, participant 2, 3, 4, 5, etc.) for anonymity purposes.		

The participants all live in metro Atlanta. While the study participants appear to be similar, they are very diverse. The educational attainment for study participant pool ranged from have a Master's degree to obtaining a GED. The study population ranged from being homeless to stable housing, in recovery from using substances to never having used, those who were sexually abused to not, and HIV positive to not being positive. One note to consider was during one of the one on one interviews, one interviewee was under the influence and that resulted in a partial interview. After that interview, I debriefed with Dr. Lincoln as she suggested that this partial interview not to be used. Right after the interview, in consultation with Aniz, the interviewee was referred to an MSW counselor for an patient intake to be assessed for future social services. The next section, I will address the findings for questions one and two.

The Findings

Using the interpretive critical inquiry allowed me (a) to better understand the overall experiences of bisexual persons; (b) based on the findings, to better understand the different meanings of how bisexuality is defined by bisexuals; (c) get a clearer picture of how bisexual disclosure occurs with a medical provider, and (d) to explore health care access experiences from a bisexual perspective. Again, to remind the readers, the two questions explored in this section are (1) how is bisexuality as a social identity constructed and understood?; and, (2) how does bisexual identity disclosure influence health access?

Question 1. How is bisexuality as a social identity constructed and understood?

This section is organized by how bisexuals see themselves in relation to their social context. Using the socioecological model as a conceptual map, I had the interviewees, through a series of questions, reflect on their bisexuality at the individual, interpersonal, organizational, community, and public policy domains.

For the purpose of this question, I will rely on the 27 axial codes organized by each of the levels of the socioecological model because they depict the contradictions, tensions, joy, and ambivalence of how bisexuality is understood. If I were to use the six subthemes (health effects, emotional / religious support, pink unicorn, ghost echoes, delusional identity, and textual contradictions) much of what it means to be bisexual at the socioecological level would have been lost.

Table 15 are 27 axial codes organized by each of the levels of the socioecological model.

Table 15 Axial codes per socioecological level

Socioecological Level	**Axial Code Labels**
Individual	1. Substance abuse 2. Sexually abused 3. Race and bisexuality 4. Feelings 5. Self esteem 6. Disclosure of bisexuality 7. Religion 8. Self-conception of bisexuality 9. Resilience 10. Accepting my bisexuality 11. Blame & shame bisexuals
Interpersonal	1. HIV and bisexuality 2. Support 3. bisexuality does not exist 4. confusion on what bisexuality is or is not 5. Bisexual means GAY 6. Transgender and bisexual 7. The issue of Class 8. The "OTHER" [erotification; exotification]
Community	1. Generational divide 2. Bisexual sex 3. Media 4. Communication with medical provider 5. Bisexual community 6. What society expects about bisexuality
Organizational	1. Organizations not bi-friendly
Policy	1. No policies

At the *individual level* there are 11 codes which can be organized into 3 broad constellations - *general emotions* around being bisexual (self-esteem, shame, acceptance, stress of disclosure, resilience), *emotions on being victimized and addiction* (substance and sexual abuse), and e*motional responses on how race and religion* (race, religion, self-conception of bisexuality) impact one's conceptualization of bisexuality. At the *interpersonal level* there are 8 codes that form a broader universe of how bisexuals interact with family, friends, co-workers, and others. These codes are broad but loosely connected in how society and communities understand, support, or stigmatize bisexuality. At a more personal level, participants in this study acknowledged that there are varying degrees of social support. However, bisexuals in their study believe they are more accepted within higher income socio-economic status groups.

In the *community level*, there are four distinct categories in how bisexuality is socially framed: (1) generational divide; (2) how bisexuality is socially framed (bisexual community, what society expects about bisexuality, bisexual sex); (3) media; and (4) medical-provider communication. In the midst of biphobia and social confusion, today many more individuals are self-disclosing as bisexual (Scherrer, Kazyak, & Schmitz, 2015; Buxton, 2000; Rust, 1993) because there is more visibility of bisexual individuals who are a part of the LGT spectrum. This bi-visibility challenges social norms of what it means to be a part of the LGT spectrum (Firestein, 2007; Esterberg, 2016). However, within the community lens, we can see how bisexuals are socially accepted, but there are stark generational differences in how bisexuality is understood within and outside LGT groups (McLean, 2008). To generation Y 'aka' Millenials (Born: 1977-1994), bisexuality as a sexual identity has morphed into borderland sexualities than are more fluid that the LGBT sexual orientation arch. Today, the most common sexualities are pansexual (are gender blind and can be a sexual or romantic or emotional attraction regardless of sex or gender identity), omnisexual (are attracted to all genders), queer (rejection of traditional gender and sexual orientation identities), and genderqueer (typically genderqueer is a challenge to gender binary masculinity and femininity social roles). The morphing has not stopped. How sexual identity is being understood is being challenged by a number of critical queer theorists (Callis, 2009; Young, 1997; Erickson-Schroth, & Mitchell, 2009). These frontiers are not as drastic with Boomers (Born: before 1965) and Generation X (Born: 1966-1976), who still abide by the traditional LGBT identities.

How bisexuality is socially framed has changed. Since Stonewalls' 1968 social uprising, the social construction and meaning of bisexuality has evolved. Gay and lesbian identities was largely defined by the quest for sexual liberation (Epstein, 1998) and health movements (Batza, 2018). During the age of Stonewall's sexual liberation movement, gays, lesbians, and transgender communities wanted to have a space to be themselves and have sex without the fear of being arrested. During the HIV epidemic, there are several arguments made that HIV activists wanted to understand the transmission of the HIV virus so that the fear of HIV would not be used as a political strategy to criminalize gay spaces. In other words, the process of 'identity formation' politics, either based on the HIV epidemic (Weiss, 2004) or ability to be in gay spaces without persecution (Bérubé, 2003), has inadvertently defined bisexuality as part of the sexual deviance of homosexuality - gay, lesbian, transgender. For example, your sexual identity (gay or bisexual) when one becomes HIV positive was defined by who one had sex with (Young, & Meyer, 2005). On the hand, when one is having sex with the same sex, in that moment of having sex, no one is going to ask you for your gay or lesbian credentials.

Bisexuals have always existed within GLT culture, but bisexuality has been less socially accepted. According to Gammon and Isgro (2006) bisexuality had three significant popular media exposures. The first was two major publications (Time and Newsweek) in 1974 which featured news articles on bisexuality.[21] During the 1970s, David Bowie and Elton John blurred the lines of "bisexuality chic" (Gammon, & Isgro, 2006). In the second as already mentioned with the HIV epidemic, bisexual behavior was socially marred by the recognition of men-who-engaged-in-sex-with-other-men (MSM) term in the 1990s by epidemiologists to better understand the nature of how HIV could spread.[22] The last popular media news cover story (Newsweek) was 1995, and explored how bisexuality does not mean gay[23]. The common theme of these news articles is how bisexuality threatens one of the core values of heteronormative society (Pitt Jr, 2007).

One area where disclosure of bisexuality can become a health hazard is during the interactions of patient and medical providers. If shame, fear, stigma exist in disclosing one sexuality to a medical provider, then certain health risk factors could negatively impact one's health. As Smith, et al, (1985) notes "60 percent of the entire group [LGBT] in [their] study would be more likely to disclose if the information were not written in the medical record and suggests that confidentiality may also affect disclosure" (p. 1087). In a more recent study, Durso and Meyer (2013) documented that bisexual men (39.3%) and bisexual women (32.6%) compared with gay men (10%) and lesbians (12.9%) had higher

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[21] The new bisexuals. (1974, May 13). *Time*, 79-80; Bisexual chic: Anyone goes. (1974, May 27). *Newsweek*, 90

[22] Gelman, D. (1987, July 13). A perilous double love life (Bisexuals and AIDS), *Newsweek*, 44-46; Nordheimer, J. (1987, April 3). AIDS spector for women: The bisexual man, *New York Times*, pp. A1, D18; Randolph, L. B. (1988, January). The hidden fear: Black women, bisexuals and the AIDS risk. *Ebony*, 120, 122-123, 126.

[23] Leland, J. (1995) "Bisexuality: Not gay. Not straight. A new sexual identity emerges," *Newsweek,* July 17, 44-50. Unlike the 1974 articles that were far from front page news, the 1995 *Newsweek* article was the cover story.

rates of nondisclosure to healthcare providers (p. 11). Durso and Meyer, (2013) also acknowledged that health outcomes with a one year follow up resulted in poorer psychological wellbeing. This nondisclosure also extends to youth who are less likely than gay and lesbian youth to disclose their sexuality (Meckler, Elliott, Kanouse, Beals, & Schuster, 2006). This hesitancy to disclose one's bisexuality is not an isolated (Klitzman, & Greenberg, 2002; Jones, 2010).

Bisexuals face social stigma and confusion on who or what they are as a sexual orientation. A strong premise within this fog of confusion is the belief that bisexuality does not exist outside of the bisexual community. Both heterosexual and homosexual communities doubt the existence of bisexuality. Many outside of the bisexual community believe that if one is bisexual, in reality, that means that they are perceived as gay. Bisexual disclosure is marred by social stigma (McLean, 2008b; McLean, 2007) and often times society confuses bisexuality with being gay or lesbian (McLean, 2008a).

That bisexuals are really gay and lesbian, is a shame-blame link between the spread of HIV and bisexuality. In other words, outside the bisexual community bisexuals are viewed as gay and are to be blamed for the spread of HIV. From the bisexual perspective they are often exoticized as immoral, sexually confused beings. This erotification is a key basis for how bisexuals are socially mis-categorized as a sexual minority group within the homosexual and heterosexual communities. The notion of one being bisexual (sexual orientation) and transgender (gender identity) is a typical of the *othering process* when transgender individuals who are bisexual are an extreme of exotification process. These transgender individuals who also identify as bisexual are treated as the mythical pink and purple polka dotted unicorns by both the homosexual and heterosexual communities. The classic response is *how can you be both, and how does your equipment work at that point*. The basis of this thinking is that we as a society are obsessed by defining human beings into gendered categories based on sexual organs. This obsession has been reinforced by an intertwined moral authority and academic inquiry (Herman, & Mandell, 1996).

Within the *organizational level*, bisexuals feel like organizations can do more to be bisexual friendly. Some of the participants noted that in addition to having a rainbow flag to also include a bisexual flag. Other recommendations are in how medical providers conduct a medical intake history to include demographic data categories that are bisexual inclusive, such as sexual orientation, bisexual, and to conduct bisexual awareness cultural sensitivity classes. Halperin (2009) noted “in an age in which *queer* has lost its sense of unassimilable and irredeemable sexual deviance and subsided into a mere synonym of *gay* - that is why queer theory, and bisexual theory in particular, may still have something critical lens to teach us” (p. 454). Bisexual needs to be considered through a queer/bisexual critical especially in organizational policy and procedures. Sexuality is not static. Sexuality does not fit neatly into a fixed category. Sexuality is fluid and sexual desires/attractions/behaviors can change over time and socially interpreted differently from the individual to the organizational levels. A noteworthy study by Köllen, (2013), reported that bisexual employees are “an unstable and therefore illegitimate phenomenon. Such questioning of bisexuality as a legitimate and stable sexual orientation is widespread among homosexuals and heterosexuals” p. 126. Anteby and Anderson, (2014), argue “concealment also made it more likely that gay, lesbian, bisexual, and queer workers would witness sexual prejudice among colleagues, which was shown to cause psychological damage and that they would experience stress and depressive symptoms" (p. 32). Anteby and Anderson, (2014), also utilizes Armstrong's cultural-institutional analysis (Armstrong, 2002) which embraces distinctiveness and internal diversity as strategy to organize in the face of structural and institutional discrimination. Armstrong (2002) also explores why certain LGBT organizations flourished especially when there was internal fighting in how to organize. She notes a peculiar phenomenon "Gay + 1" organization - the Gay/Lesbian Quilters or the Safe Sex Leather Sluts as examples (Armstrong, 2002). Combining the sexual identity and identity building (the "Gay" part) along with specific vision and organizational activities (the "+1" part) allowed for LGBT organizations to flourish (Armstrong, 2002). Sadly, bisexual focused organizations have been largely dominated by the HIV epidemic: The Bisexual Resource Center, 1985; Bay Area Bisexual Network, 1987; BiNet 1987; International Conference on Bisexuality 1991; American Institute of Bisexuality 1998. Before the mid 1980s, there were very few bisexual organizations and those that existed were located in LGT friendly cities[24].

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[24] 1972 – The National Bisexual Liberation Group forms in New York. Within three years, more than 5,500 members in 10 US chapters receive what is probably the earliest bisexual newsletter, The Bisexual Expression.
1975 – Bi Forum, a social, educational, and support group, forms in New York "to encourage awareness of bisexual issues in a non-threatening and non-judgmental environment." At its peak in 1980, BiForum has more than 200 active members and a mailing list of several thousand.
1977 – The San Francisco Bisexual Center, in coalition with members of the gay and lesbian community, sponsor a press conference with lesbian activists Del Martin and Phyllis Lyon, and pediatrician Dr. Benjamin Spock to protest Anita Bryant's "Save Our Children" campaign.
1978-79 – Grassroots bisexual communities grow with the formation of Midwestern groups such as One To Five and BI Women Welcome in Minneapolis, The BI Married Men's Group in the Detroit suburbs, and BI Ways in Chicago.
In the 1980s, bisexual groups mushroomed around the country and the world. Throughout the 1980s bisexuals organized significantly in the US, Canada, Europe, New Zealand, and the UK. In addition to the various social and support groups arising locally across the nation, by the mid-1980s umbrella groups formed to consolidate resources and facilitate regional organizing.
1983 – The Boston Bisexual Women's Network (f. 1983), the oldest extant bisexual women's group, begins publishing their bi-monthly newsletter, BI Women. The longest-lived bisexual newsletter in the US, more than 600

The last outer layer of the socioecological model examines *policies*. The consensus among the study participants are that there are no state and federal policies focused on bisexuals and to protect bisexuals. Federal, state, and local laws protecting LGBT populations are inconsistent and form a complex patchwork of policies protecting gender identity and sexual orientation. While there are local municipalities (San Francisco, New York City) which have led the way to protect sexual minorities, many states still lack consistency in policy language and implementation on how to protect sexual minorities. As of today, there are twenty states, two territories, and jurisdictions[25] which have statutes that protect against both sexual orientation and gender identity discrimination in employment in the public and private sector. Most of these states are located in the upper Mid-West, Southwest, West and Northeast coasts. Eight states[26] have either an executive order, administrative order, or personnel regulation protecting sexual minorities either on sexual orientation or gender identity. Finally, there are four states[27] with executive orders prohibiting discrimination in public employment based on sexual orientation only. The only states in the Southern United States with such restrictions are Missouri, Virginia, and North Carolina. Statutes are laws enacted by a legislative body of

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people currently receive BI Women.

1983 – BiPOL, the first and oldest bisexual political organization, forms in San Francisco. Founded on progressive feminist principles, BiPOL "educates, advocates, and agitates for bisexual rights, visibility and inclusion."

1984 – The Boston Bisexual Men's Network (BBMN) forms to address the social and support needs of bisexual men in the greater Boston area. At its peak in 1988, about 150 people are receiving their newsletter, Boston Bisexual Men's Network News.

1985 – The Bisexual Connection, a social and support organization serving the greater Twin Cities Area forms in Minneapolis. Currently 350 people receive their newsletter, BI Focal.

[25] District of Columbia, Guam, Puerto Rico, California, Colorado, Connecticut, Delaware, Hawaii, Illinois, Iowa, Maine, Maryland, Massachusetts, Minnesota, Nevada, New Jersey, New Mexico, New York, Oregon, Rhode Island, Utah, Vermont, and Washington

[26] Indiana, Kentucky, Michigan, Montana, New Hampshire, North Carolina, Pennsylvania and Virginia

[27] Alaska, Arizona, Missouri, and Ohio

a government, whether federal or state. Executive order, administrative order, or personnel regulation are either enacted by a state agency and/or by the governor's office. Twenty states out of 50 have precautions for gender identity and sexual orientation. Three territories out of sixteen and one jurisdiction have comprehensive local policies protecting gender identity and sexual orientation. Within the sexual orientation discrimination policies, bisexuals are an assumed protected population.

Internationally, bisexuals do not fare any better. As Rehaag (2009) argues "[b]isexuality tends to be invisible in [international] human rights practice and discourse, even in areas that are otherwise comparatively sensitive to sexual minority issues" (p. 415). As an example, at the international level Rehaag (2009) further argues "bisexuals are significantly less successful than other sexual minority groups in obtaining refugee status" (p. 415). As study participants struggled with the policy question, many referred to the passage of gay marriage as a potential policy that impacts bisexuals who are in a same sex relationship. Otherwise, the participants did not have an answer on what policies protect bisexuals.

Below in table 16 is a summarization of the key quotes for each level of the socioecological model.

Table 16 is a summarization of the key quotes for each level of the socioecological model

Socioecological Model with axial code
Corresponding Findings

Individual
Substance abuse
Sexually abused
Race and bisexuality
Feelings
Self-esteem

Table 16 is a summarization of the key quotes for each level of the socioecological model Continued

Disclosure of bisexuality
Religion
Self-conception of bisexuality
. Resilience
. Accepting my bisexuality
. Blame & shame bisexuals
Substance abuse: Several participants mentioned that they struggled with “substance abuse” and/or are “in recovery”. Substances were used to cope with the “coming out process”.
Sexually abused: Several (between 3 and 8) discussed how they were “sexually abused by a relative”. This abuse resulted in personal conflictions. While some “acknowledged that they enjoy the sex as pleasurable” the fact that they were “non-consensual” and they were minors “created mistrust within relationships”.
Race and bisexuality: The question of how their racial or ethnic identity factored into their sexuality was minimal. The only significance was the African American community, “bisexuality is not talked” about “nor seen in a positive light”.
Feelings: The feelings that emerged from the data is participants have a lot of “hope” but are wanting “respect”, a need for more “trust”, and “compassion”. There was also feeling of “not being heard” and “suicide ideation”.
Self-esteem: The overwhelming majority (nearly all) of participants had “high self-esteem”.

Disclosure of bisexuality: This emotional abstraction is more complicated than what it seems. Disclosure is highly influenced by the reaction of others. Some noted that the “*bisexual closet”* existed both in the gay and straight communities, and there is a message to not advertise bisexuality. Along the same lines, the idea of how you can tell someone is bisexual was discussed. This idea of how you can tell.... also has an impact on how bisexuals talk to a medical provider about their sexuality. Lastly, there is experimentation with sexuality, and more importantly bisexuals are not confused about their bisexuality.
Religion: Many of the participants “held on” to their “religious beliefs”. This religiosity was also a source of “guilt”, “shame”, and “stigma” for being bisexual.
Self-conception of bisexuality: When it comes to society “people like categories.” Bisexuality is about “experimenting at a mental level or connection level.” Bisexuals “know who” they are “as a bisexual person” and “watch YouTube to see other bisexuals doing well.” “The roll of desire in bisexuality” is more than “having a penis or vagina” which “does not matter for some bisexuals.” Bisexuals feel that they are “not valued and well understood.” There are also “no space for bisexual people” and “not sure if one is bisexual when socializing.”
Resilience: Bisexuals see themselves as resilient on “being who you are.” Resilience is also about being an “out bisexual.”
. **Accepting my bisexuality**: The self-acceptance arch, ranges from bisexual experiences in prison or the belief that bisexuality is not a choice. The underlying tone is the complexities of acceptance: “uncertainty”; “comfortable”; “connections”; “being out,” and “God makes no mistakes.”

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Table 16 is a summarization of the key quotes for each level of the socioecological model Continued

Blame & shame bisexuals: Shame, guilt, and stigma are drivers for why bisexuals struggle with their sexuality. From a social perspective, family and friends are the influences that promote and instill shame, guilt, and stigma. “Dispelling myths on bisexuals passing on the HIV virus.”

Socioecological Model with axial code
Corresponding Findings

Interpersonal
HIV and bisexuality
Support
Bisexuality does not exist
Confusion on what bisexuality is or is not
Bisexual means GAY
Transgender and bisexual
The issue of Class
The "OTHER"

HIV and bisexuality: There is “blaming bisexuals for spreading HIV” along with the “refuting from bisexuals for blaming bisexual for spreading HIV.” The idea of getting all bisexuals to be tested for HIV, just because they are bisexual.

Support: The idea of support comes from several places: family, friends, church, and social networks. The quote that illustrates this support is: “You're my son. I love you regardless.”

Bisexuality does not exist: Bisexuality is not real as it has been told by the straight and gay communities. For example, here are some key participant passages: “ain't no bisexual, you gay”; “do not understand what bisexuality is”; “who looks gay … nobody looks bisexual”; “people deny that you can be bisexual”; and “label them as she's dating a woman so she's a lesbian, or she's dating a man therefore she's straight.”

Confusion on what bisexuality is or is not: What bisexuality is or is not is interpreted differently by straight and gay communities. For example, here are some key participant passages: “they were bisexual that whole time, and they ended up choosing a man in the end”; “I hate to use the word phase, but some people I think actually do go through this little experimental phase where they just don't really know what they want, or they want to explore”; or “it is OK for women to be bisexual”; and, “you're probably with a bisexual and don't even know it.” A key issue with bisexuality is “identity politics,” as some of the participants noted - “straight people do not categorize themselves the way (chuckles) queer people do” and this social misunderstanding of bisexual categorization leads to “confusion between sexual orientation and sexual identity.” As many of the participants noted bisexuals cannot be easily identified with “little necklaces that tell you what [sex] you're into” nor do bisexuals act like “sims [*another word for avatar*] where you have little diamonds over your head labeling who you are.” All this social confusion on what bisexuality is or is not is also impacting “confusion on what pansexual [demi sexual, sapiosexual] is or is not” or as “bisexuality as [seen as a] down low” [act].

Table 16 is a summarization of the key quotes for each level of the socioecological model Continued

Bisexual means GAY: The resounding sentiment that the word “gay is a catch all category that swallows bisexuality.” As one participant noted, “well I think that most people think that if a man is bisexual they are really gay,” and this notion of misunderstanding is an emotional issue for some. For example, “as much as I get frustrated with their labels sometimes, I have a responsibility to the community to accept [that this is how it is].” This statement resonates with many participants who feel that “it's like all these other little sub-categories… because a minority has to fit in this little box, always has to fit in this little box.” This little box (the gay category) overshadows the bisexuality identity.

Transgender and bisexual: For the transgender who are bisexual, they feel that “being transgender and bisexual is rare.” Many believe that their “trans identity is first and then my bisexual identity” or that “BI’ness falls as a subsidiary underneath the trans identity.” Many believe that their “bisexuality gets more complicated when one is trans and bisexual.” For example, “someone who's bisexual will not necessarily date someone or be interested in someone who's transgender.”

The issue of Class: The issue of class/race is connected to how society perceives bisexuals. For example, “white people do not care about bisexuality.” Another supporting quote states, “seem[s] like more middle class and upper class [one] is [the] more accepting [they are] than the lower class and I think that, a lot of that had to deal with a lot of people deal with their situations by dictating or oppressing other people.”

The "OTHER" is also known as erotification and exotification. For example, “someone's who's pansexual says, I don't care if you're male, or you're female. I don't care what parts you have. I truly just care that you're a human being and I like you as a human being.” Many question “what defines a woman,” the role of “bisexuality and parenthood.” One remarked that “I'm watching all of these other people perform gender. I don't feel like I fit in because I'm not a performing gender.”

Socioecological Model with axial code
Corresponding Findings

Community

Generational divide
Bisexual sex
Media & Social Media
Communication with medical provider
Bisexual community
What society expects about bisexuality

Generational divide: The participants acknowledged there is a generation divide on how bisexuality is acknowledged as an identity. For example, “today [younger bisexuals are] bolder about their sexuality.”

Bisexual sex: Bisexual perceptions about sexuality are “sex positive about sex” and “having sex is fun.” Some were more graphic and emotional such as one participant stated, “we going to be smashing these hoes together’. And he was like ‘wait what?’ And I was like ‘oh I didn’t tell you that I like girls too.” Society’s perceptions of bisexuality are that “bisexuality [only exist in] sex clubs” and “bisexuality manifests in those spaces - swinger clubs.” One

Table 16 is a summarization of the key quotes for each level of the socioecological model Continued

participant remarked that “having sex with a woman was not like a guy with penetration but it was good.” Others also added that “how the porn industry normalizes what is sex and show should be having sex with whom.”

Media & Social Media is a medium to meet people and portray bisexuals. For example, one participant used online social media to “meet other bisexuals” and another stated that “when you go online you are looking for someone who is interested in sex and not into labels of who you are.” Media is also a venue to see “who is bisexual in the movies” or “celebrities that have come out recently as bisexual.” An example that was cited was the “20/20 episode on bisexual people.” Several participants mentioned that “people watch porn, for example, and someone who's heterosexual might watch bisexual porn, or they might watch lesbian porn, or gay men being a female. It's very common.”

Communication with medical provider: On one spectrum, one participant stated that “I am not shy in talking to my doctor about my sexuality medical - your sexual orientation should not matter.” Two participants stated that “gay men are more likely to seek care than an open bi man” while another questioned “closeted bisexual person and what it means to seek healthcare.” Many of the participants agreed on the medical “clinical body” and how a “medical provider lists bisexual as a high-risk category positive view of medical ownership.” This “type of questions doctors ask informs risk and also informs stigma.” On the other spectrum, a “medical provider was afraid of my bisexuality” and there “there is a need for more respect.” Many agreed that “we do these trainings, show the reality of our lives and it is not just about sex doctor's office. Like, he said, where like they're using my sexual experience to try and categorize risk factors for me”; “medical providers need to focus on the importance of like validating people's lived experiences, and not like questioning it”; and, “medical providers need to be bi competent as soon as you, um, say that you are sleeping with a man who identifies as gay or bisexual, and medical providers just clump it as gay.”

Bisexual community: All agreed that “bisexual[s] are invisible in GLBT spaces” or “the bisexual population is hidden” but, “the bisexual community is so large.” Many also agreed that “LGBT spaces are divided.” When the conversation turned to where do bisexuals hang out, many said: “bisexual community [are] tied to sex clubs” or “bisexuals hang out at strip clubs” and “find other bisexuals in gay or straight clubs” or “bisexual hang out at gay & straight clubs.”

What society expects about bisexuality: Many agreed that the “community views of bisexuality as a bad thing” and that “bisexual people look too normal looking – heteronormative.” Many of the sentiments reinforced this notion: “a lot of the times, sadly, they choose a man in the end because that's easier by society's eye”; “when I was married,.., I just knew I was bisexual”; no, you can't do that. You supposed to only fuck a woman”; and, “oh, you messin' around ... you messin' around with a tranny? But as long as you still fuckin' some women, you cool with me.”

Socioecological Model with axial code
Corresponding Findings

Organizational

1. Organizations not bi-friendly

Table 16 is a summarization of the key quotes for each level of the socioecological model Continued

Organizations not bi-friendly: The typical organizations that are bi-friendly are “AIDS Service Organizations are more welcoming.” Geography also plays a role in fostering bi-friendly environments. For example, “when I moved to Atlanta, I became free around my sexuality” and that there are “great LGBT services in Atlanta.” Many agreed for the most part, “organizations are not bisexual friendly” and many “shy [away from] new organizations.”

Socioecological Model with axial code	Corresponding Findings
Policy	
No policies	No policies: Overall all the participants agreed that they are “not sure if there are any policies [superficially for bisexuals].” At first many participants responded by questioning “what it means to be black around policies.” Other sentiments were “no polic[ies] in place” and “there are no national policies geared for bisexual community.” Many cited “adoption might be another policy affecting bisexuals” or “Gay marriage is the main policy issue for bisexuals.” Many “lost of hope around policies” and there is a “fear of Trump.” Many also agreed that “bi-erasure in the medical and policy context [exists].”

Limitations

When working with hard-to-reach populations, there are always data limitations to consider. One issue is to ensure recruitment of a sufficient number of participants to have data saturation. This study was able to recruit 36 bisexuals. The demographics of the study were primarily African American. While this was originally considered a data limitation, upon closer examination of the literature there are very few studies that focus on African American bisexuals and health access issues.

Question 2. How does bisexual identity disclosure influence health access?

To assist in the data analysis and to better understand how bisexuality is understood over time, the data were stratified by age groups (Generation Y ‘aka’ Millennials - Born: 1977-1994; Generation X - Born: 1966-1976; and, Boomers Born: before 1965). Data from the focus groups and semi structured interviews are mixed gender to capture the essence and experiences of what it means to be bisexual within a certain age category. See below table 15 detailing the ages of participants within the study. The reason for age stratification is disclosure of one's sexuality varies greatly by age and is defined and socially understood differently at each level of the social ecological model. Someone who is 22 years of age will have a very different experience than someone who is 58 years of age when disclosing about their bisexuality. Generationally, bisexuality is more accepted and understood by Generation X than Boomers. Also, these generational societal norms can affect health outcomes.

The rationale for stratifying by age is entrenched in Bronfenbrenner's notion that people travel through time in age cohorts (chronosystem: process, person, context, and time). As people age and change their social networks, people's desires influence their behaviors. This rationale is also buttressed by focus group research design (Carey, 2005). In addition, from a Queer lens, each generation has a different experience in how they self-identify as part of the LGBT community. For example, while someone in Generation *Y* might identify as genderqueer, bisexual, and/or queer while Boomer would be more comfortable with bisexual. The advantages of segmenting into age cohorts helps to better understand how identity construction is understood generationally. However, it is also important to note that age cohorts are often misunderstood within the literature, and definitions and uses vary throughout different academic disciplines (Markert, 2004).

Table 17. Study Participant Age Distribution

Boomers	**Generation X**	**Generation Y**
1954	1966	1983
1957	1966	1988
1961	1968	1989
1961	1970	1990
1963	1970	1994
1965	1971	1994

Boomers Born: before 1965)

Generation X - Born: 1966-1976

Generation Y 'aka' Millennials - Born: 1977-1994

Responding to calls for more research on bisexual health that situates the understanding of the complexities of sexuality as central to bisexual lives (Roberts, Horne, & Hoyt, 2015; Friedman, Dodge, Schick, Herbenick, Hubach, Bowling,... & Reece, 2014; Zivony & Lobel, 2014), this study question explored the lived lives of bisexual in accessing healthcare, and how bisexual disclosure occurs. The findings illustrated that medical providers of bisexuality were intimately intertwined with the quality of care of bisexuals receive.

Related to this study question, three themes emerged from the interviews and focus groups, including: how bisexual disclosure occurs in medical setting, the process of medical care, how bisexual health care is medically operationalized in the clinical setting, and the need for medical training. From these diverse axial codes, I organized the data into six clusters (subtemes) (Please refer to memo #1). The following are the six clusters:

(1) Health effects, (2) Emotional/religious support, (3) Pink unicorn, (4) Ghost echoes, (5) Delusional identity, and (6) Textual contradictions. Questions two will be answered by using a combination of these six subthemes.

Cluster: Pink unicorn and emotional/religious support- *How bisexual disclosure occurs in medical settings?*

There were seven primary categories (see Abbreviated summatiion of themes from the memoing process for question 2) that emerged from interviews and focus groups organized into five emergent clusters: need to disclose bisexuality, positive interactions with medical providers, proactive in seeking healthcare (self-assured, healthcare advocate), hesitant to disclose (hesitant to disclose, hesitant to disclose but supportive clinical staff), medical staff unaware of intertwining transgender and bisexual identities, and bisexual identity as a social stigma. At a personal level by having a medical provider needing to know one's sexuality was seen as universally important by all seeking care. However, this wanting to share was overshadowed by a sense of hesitancy driven by stigma and fear of rejection. One participant stated "I feel that some things are just not for everyone." Participant two from focus group two also echoes this sentiment: "I mean, if I go to a doctor, I'm going to tell doc what's wrong with me. My sexuality ain't got nothing to do with what's wrong with me."

These two ideas of not sharing was supported by Debbie based on interactions with a "(medical doctor) was an older gentleman…and not to say that he judged me, but I just felt distance where that wouldn't be cool as far as me coming out and just saying anything." This dread and fear are well supported within the literature (Durso & Meyer, 2013). In part, the fear to disclose one's sexuality is impacted by the societal social stigma of disclosing bisexuality. For example, Lala, transgender (male to female) biracial bisexual participant, stated

> "had one doctor that was afraid to even take blood from me. He freaked out and then just like walked out of the room. So, another doctor had to come in and take blood from me. And I was like…what? He must be new or something.' Or he was just afraid. Because I was a transgender. I think he freaked out because I was a transgender AND [emphasis on and] I was bi."

Lala's experience is speaking to the complexities of when sexual identity can overshadow sexual orientation. There has been an increase in the cultural acceptance of transgender health healthcare and treatments. For example, TransECHO (Extension for Community Healthcare Outcomes) is a network of health centers and content experts aimed to increase medical provider knowledge around transgender patients (Lower, 2016). At this point, this is no national network that provides culturally-responsive, comprehensive, primary care for bisexual patients. Being transgender and bisexual is a unicorn within the traditional medical paradigm, in which medical students are not given case studies of transgender and bisexual patients seeking to be treated for the flu. This lack of awareness shapes social stigma and marginalization.

This marginalization occurs not only at the societal level with interactions between bisexuals and non-bisexuals; the stigma is also internalized within bisexual community. During an interview with Maria and Phil, a bisexual transgender couple [Maria is male to female, and Phil a female to male], they stated that "Right, and there's some truth to it, but it's also because of stigma. Like, it's not inherent with a bisexual relationship is going to inherently be risky, but we [bisexual community] encourage riskiness with the stigma around it. So, you know, you ... Instead of openness around bisexuality, it's all closed up. And then once it's closed up, it, you know, things [sexual acts] behind closed doors, people are just more ... I don't know what wording to say. There's no pressure on them (bisexuals) to use condoms and be on PrEP and to ask, you know, enlightened questions about, um, like, safer sex when you're hooking up. You know? Um ... And so that stigma encourages behavior which fuels the stereotyping which drives the stigma, right?”

When Maria and Phil were answering several questions on bisexual health access, they depicted internalized biphobia as a perpetual cycle of shame, stigma, and fear. Maria and Phil also associated closeted bisexual sexual behavior with the fear of asking, or advocating, for better health care such as using PrEP as a preventative measure to reduce HIV transmission. The conversations with Maria and Phil, two advocates for transgender health, also touched on a theme throughout all interviews and focus groups as to why bisexuals need to be more proactive and open in personal healthcare management.

Advocating for better health is a shift from existing literature on bisexual health disparities that depicts as to why health disparities exist and possible recommendations to remedy this disparity (Zivony & Lobel, 2014; MacKay, Robinson, Pinder, & Ross, 2017; Johnson, 2016; Flanders, Ross, Dobinson, & Logie, 2017; Friedman, Dodge, Schick, Herbenick, Hubach, Bowling,... & Reece, 2014). Several study participants discussed how they promote personal healthcare management through direct communication with medical providers. Shawn, an African American bisexual male, was very direct and self-assured. He stated, “When I meet a new doctor the first thing…you know I don’t come in [doctor’s] office timid anymore. I come in and say, ‘this is who I am, how are you?’ and at some point, we get to the point where I disclose who I am. And if I feel that that doctor is uncomfortable, I go to another doctor. Because I’m here for your help so I need to be comfortable and confident that you’re going to give me the best treatment you can give me.”

This level of self-confidence is not unusual. Participant 3 from focus group 2, stated similar feelings with “[I] feel like I'm in charge of my own. Not my own healthcare, but I'm in charge of my body. When I go into the doctor's, my doctor, I ask him, tell him what's going on with me. ‘Give me your opinion. What should I do? And what's causing it and what can we do to prevent it?’ So, it's up to me to explain what's going on with my body. And give me his professional opinion. It's up to me to accept it, you know.”

Participant 3 is aware of what he is in control of and what he is not. While he is not in control of healthcare, he is in control of self-advocating for himself by having open and direct conversations with his medical provider. This positive patient and provider communication can lead to an encouraging relationship with medical providers. Debbie noted that she would go to a woman doctor and “the nurses knew me as far as coming out and saying I’m bisexual and this is what I do in my life. And they were like ‘be yourself, be yourself, go ahead.’” Participant three, Shawn, and Debbie have fostered relationships with medical providers to ease the transition of how to disclose one’s sexual orientation. This level of confidence is rooted in resiliency, and the belief that bisexuality should not be in the shadows lurking on the margins of deviance. Most of the study participants were self-confident, grounded in a religious faith, and have a small community of bisexuals with whom they interact.

Shawn best exemplifies this sense of resiliency. In answering study questions about interactions with his medical provider, he considers a global view as to why he is out and proud as a bisexual man. He says, “Um, I am totally 100% comfortable being me and being in my lifestyle. I talk openly with my family now. My doctor, other professional people that I meet. It’s necessary for me to disclose that information. The closer I get to people the more comfortable I am letting them know who I am. Because if I don’t then you’ll never really get to know who I am…if I don’t tell you who I am. Well. Let me say this, my doctor and I, we’re both ex-military. He’s army and I’m Navy so you know that bonded us automatically. Um, I had no issue telling my doctor about my sexuality. I think it actually came out when he sent me for a colonoscopy and I was like you really don’t want to do that, can you refer me out. He asked why, and I said well I’m not only gay but I am a bisexual black man and he said ‘oh, I didn’t know’. And he said ‘okay, I’ll send you out if you’re more comfortable’. So, you know, we talk frequently and he’s more than my doctor. He’s a personal friend.”

Cluster: Ghost echoes and Textual contradictions - *How bisexual health care is medically operationalized in the clinical setting?*

One challenge bisexuals face with is “people just automatically assume that you're straight.” (Maria & Phil) During an interview with Maria and Phil, they discussed how assumptions operate at a subliminal level. For example, they discussed how a “cis-gendered female who is presumed as straight, no one ever thinks about, you know, uh, asking you are you sleeping with a man who identifies as bi. Um, they [medical staff] just assuming that you're sleeping with a man who identifies as straight, whereas if they [medical staff] thought that that man you were sleeping with was gay or bi they treat you totally differently."

Assumptions made by health care providers can be disheartening and may cause some to regress back into the bisexual closet. These assumptions are filtered through a heteronormative lens, this lens is a variation of what Foucault called the "medical gaze". Foucault's medical gaze unpacked our understanding of medical discourses, while also arguing for a counter-practice as to how medical practice to be understood. In other words, stepping outside of the heteronormative lens allows counter-discourses to occur and challenge conventional medical practices which gives a legitimate space for bisexuals to contest how bisexuals are medically treated.

Without the critical lens of the medical gaze, the medical mistreatment of bisexuals will persist. For example, Phil, a bisexual pre-op transman recalled one incident he had with a medical provider. Phil said, "I'm not straight, so no, I do not need condoms, thank you. Um, no I do not need birth control. Thank you. I'm with a woman. They're like, oh, no, no, you should still take this birth control anyway. I'm like, no really, I'm good." This is not an isolated case. Others have cited similar examples.

When one visits a medical provider, there are a series of healthcare questions asked. The content of these questions and how they are asked can be a form of marginalization. Healthcare questions are designed to assess risk and triage appropriate medical care. In this particular case with Phil, the questions were asked before an HIV test was performed. In medical practice, these questions are grounded in a evidence-based deductive process to determine risk. However, how the questions are asked, and the tone can make a difference of interpretation. The questions that were asked of Phil are:

“how many sexual partners have you had in the last six months and how many
times have you engaged in anal sex in the last six months? How many different
partners did you have? How many times have you engaged in oral sex? Did you
use a condom when you had oral sex? Did you engage in vaginal sex?”

When these questions were asked, Phil expressed frustration as to why so many questions, and the level of detail required. Phil argued that “if they didn't make it so personal about that and just ... I'm a sexual being. I need to be tested. Why can't it just be that?” It is interesting from a humanistic perspective that Phil argues we all are “sexual beings,” and why bog the process of asking too many questions. Phil has a point on being sexual beings, but a public health argument of population disease management outweighs the needs and inconvenience of all these questions.

The counterfactual to Phil’s idea is if medical providers do not ask detailed medical questions, then how do we assess risk? How will we control disease outbreaks? These are not ethical questions that impede one’s civil liberties, but a ‘social good’ argument. Phil’s predicament is not new but rooted in the Tragedy of the Commons by Garrett Hardin. Lloyd argued that individual rights need to be balanced with a greater good, in this case the protection of the general population from spreading diseases (Feeny, Berkes, McCay, & Acheson, 1990). While there is a sense of frustration from Phil, it is important to understand the significance as to why these detailed sexual behavior questions were asked. One possible explanation for Phil’s frustration with the questions is that he is a Puerto Rican pre-op (meaning he has not fully transitioned to male) bisexual transman who often gets asked more questions than the average patient. In part the reason for the detailed questions and the nature of the questions asked of Phil is rooted in venereal disease management, especially with at risk populations for HIV/AIDS - gay and bisexual men, along with transgenders.

Within the health disparities literature, bisexual male health is framed and loosely connected to sexually transmitted diseases, especially with HIV/AIDS (Montgomery, Mokotoff, Gentry, & Blair, 2003; Parker, 2001). Health disparities for bisexual women is partially focused on mental health, cancer, and substance abuse. Given this discontinuity between bisexual men and women, the stereotyping and stigma process does discriminate by gender. In other words, according to popular misconceptions of how HIV is spread, bisexual males are to blame. This illustrates how popular misconceptions creep, in part, into how assumptions are operationalized within healthcare.

In further talking to Phil, he noted how gendered medical questions can be. Maria, his partner, agreed. Phil’s perspective is unique as someone before his transition to male, he lived as a lesbian, and now he is a bisexual transman in a relationship with a White transwoman, Maria, who was once married to a cisgender woman but secretively lived as a bisexual man. Maria and Phil discussed how “bisexual women are a little bit more at risk than, or at the same risk level of a gay man, because they're not getting the access to the healthcare that they need because they're not getting asked the questions that the need to be asked.” This is an interesting argument that supports how not being aware of the fluidity of sexuality, along with how assumptions operationalize, can negatively impact healthcare.

One way that assumptions become codified within healthcare is through the medical record keeping process. For example, if one is a heart attack survivor, that person's medical charts will note this but also label this person at risk for heart disease. Maria and Phil told a story of how, as bisexual persons, how they are recorded within their medical charts. They noted, "I'll take the doctor's office, for example. Um, on my electronic file they have me labeled as bisexual. Whatever. And then right under that it's listed as high-risk behavior, and I'm just like, why is bisexuality listed as a high-risk sexual behavior? Like, why is that listed as such? Just because I'm bisexual, or just because I am attracted to both genders does not necessarily mean that I'm partaking in high risk sexual behavior. I am in a monogamous relationship. That's not a high-risk sexual behavior, but that's what they have, like that coincided with bisexual."

High-risk behavior coupled with our understanding of sexual orientation, can get confused by persons who are not familiar with that population. For example, Phil explained this interaction between high risk sexual behavior and how medical providers can mislabel a person. They explained,

> "say that you are sleeping with a man who identifies as gay or bisexual, and they just clump it as gay, to them in the health world, you know. If it's a man that sleeps with other men in any way, and the key there is anal sex. It's anal sex. That's the bottom line. But, you know, they don't ask you that, so instead of getting really particular and asking, so, you know, are you having anal sex, it's like, are you sleeping with a man? You know?"

Maria agreed with Phil and further explained "it's when I'm in the doctor's office. Like, he said, where like they're using my sexual experience to try and categorize risk factors for me. Um, so I, I have that experience a lot.” The association of bisexuality with high risk has, in part, been explain from venereal disease model. This is a plausible explanation and supported in literature. It should be noted that bisexuality is labeled as high-risk behavior due to possible exposure to venereal diseases. However, to distinguish between bisexual identity and disease exposure gets messy. Thus, at a personal level, assumptions privately emerge and are unchecked. It is when labeling becomes stigmatizing due in part to a medical provider’s negative assumptions. Participant five from focus group illustrates how stigmatizing a label can become when he was in the hospital for a fractured knee bone. He noted, “you can get funneled even if you tell them [medical providers] you're bisexual. Because I said, uh, one day, I was in the hospital, and one day, uh, they were asking questions about my health and stuff, asking questions about health….. the next day, the lady that was with the other lady came back in asking questions and one of the questions were, ‘What do you consider yourself, um, you know, heterosexual or what ...’ Um, you know that question. I said bisexual. When I said bisexual, she went out the room. 'Bout 45, 'bout 45 minute later, a lady rolled up takin' my blood like, like she said rolled up takin' my blood. I said, ‘What's this they wanna do a HIV test on me?’”

This funneling process occurs in everyday life. For example, recently released persons from prison will have a label of criminal, regardless whether of the crime was minor. Another example is how we respond to person’s in substance abuse recovery, subconsciously we judge that maybe the person at any moment could get addicted back to alcohol or drugs, regardless of the time the person in recovery. A more complicated and hard to understand medical condition is suicide attempts. If one attempts suicide and is hospitalized, then that person’s medical chart will reflect potential future suicide ideation. Stereotyping around medical issues occurs because we fear that past behavior could be repeated. We also question privately, is this person telling me the whole truth. Medical provider interactions with bisexuals are not that different from heart attack survivor, a person released from prison, a person in recovery, nor a suicide attempt survivor. As discussed earlier, bisexual sexual behavior gets categorized as high risk because of historical implications of HIV/AIDS. Bisexual identity and sexual behavior also get questioned because we view bisexuals as confused, or bisexuality a phase. It can be argued bisexual identity and sexual behavior are misunderstood and get demonized similar to people infected by HIV in the early 1980s. At the time, as a society, homosexuals were misunderstood, and institutionally there were arguments to quarantine gay persons infected by HIV.

Clusters: Delusional identity and Health effects - The need for medical training.

Participant five from focus group one, said he has received “probably the most culturally competent care, um, that I've ever had in my life.” His viewpoint is a minority viewpoint. Others strove to attain good and workable patient-medical provider relationship. For example, participant three, Shawn, and Debbie have good patient-medical provider relationships. Overwhelming the study participants agreed that medical providers need training to provide culturally-responsible, comprehensive, primary care for cisgender bisexuals and transgenders who are bisexual patients. Some of the reasons as to why more training is needed was noted by Lala, in which she stated “if you [medical provider] touch me, that doesn’t mean that you’re going to be bi. That doesn’t mean that I’m going to like you.” Maria & Phil reiterated Lala’s feelings with “a lot of people in society feel that way about people that are bisexual, ‘You're confused. You don't know what you want. You're just promiscuous. You'll sleep with whoever.’ It's not a matter of you'll sleep with whoever, it just means that you're not closed minded to I'm only going to pick from this gender or this gender. You're open to whomever that is available to you.”

Lala, Maria, and Phil touched on how bisexuals are misunderstood by society, especially medical providers. Shawn mentioned while there has been some educational awareness of bisexuality in the clinical setting, there is a discrepancy in how medical providers are trained, and how personal/societal thoughts might cause implicit bias.

“You know I think a lot of those in the medical profession are more aware but there are some that aren’t as educated as others and there’s just a certain level of respect that I think, not only all patients need, but being in this community I need to feel at ease. And a lot of doctors they aren’t at ease.”

Many of the study participants struggled to explain as to why there is this awareness discrepancy. Many participants cited biphobia, structural discrimination, lack of awareness, misconceptions of bisexuality, and internalized biphobia with the bisexual community. One participant, Walter, an African American middle-aged bisexual, thought deeply about this issue and noted an ethical dilemma with medical training curricula and clinical settings providing healthcare. He stated, “I would assume that the agency/therapist/doctor/nurse practitioner... I would assume that they took an oath in their field of profession and that they shouldn’t at any point or time discriminate against any human being whether they are a bisexual man or women, transgender or anything else otherwise. I also think the point in fact is they are providing a service and the mere fact that they are providing a service means there is no room for personal attack or personal views. Because I don't believe agency or entity, or any group or doctor's office would allow that."

Walter Insightly noted two observations. One, how medical providers subscribe to an ethical code of conduct, the Hippocratic Oath. The Hippocratic Oath is grounded in universal principles of human rights (Hulkower, 2016). While this oath is an ideal, it is complicated by the professionalization of medicine (Jotterand, 2005), the corporatization and quantification (detailed record keeping and categorization of diseases) of medicine (Meghani, 2011), and the intellectualization of medicine (philosophy of medicine) (Lockwood, 1985). The present day medical-moral philosophical discourse has resulted in the medicalization of the body, and deductivist reasoning (connecting a premise to a conclusion) which resulted in the casuistic definition of sexuality as defined and rigid binary categories (normal and unnormal).

A second observation Walter noted is the agency aspect of how medical practice is standardized. Like medical professionals and professional associations, institutions have a code of conduct, better known as organizational mission and vision. Regardless if it is the Hippocratic Oath or agency, there is a supposition that we operate and live in a world that is not bi-friendly nor in a world in which there are positive reflections and depictions of bisexuality. This is what is called bi-erasure (Yoshino, 1999).

How we organize knowledge and information is by clumping complex ideas and abstractions into palatable and data chunks. This reductionist approach values scientific realist strategies grounded in heuristic and analytical tools. This line of reasoning (school of thought) is why medical school training is limited on content focused LGBT health issues, with little to none on the complexities of bisexual health.

While there is a need for a bicentric cultural competency training, study participants suggested six concepts to be added to yet to be developed culturally-responsive training. According to the study participants, besides being aware of the complexities of bisexuality, the training modules should entail: “be sensitive to all”, “not to pass judgement how people live their lives”, “the importance of validating people's lived experiences”, “validating their relationships”, “validating their identities”, and “compassion.”

Finally, in regard to developing a culturally-responsive bisexual tailored training, study participants also discussed how bisexuality as an identity label is slowly being replaced, from bisexual to pansexual. At its essence, bisexuals are sexually attracted (romantically, desire, etc..) to both men and women. Today, those who choose pansexuality as a label over bisexuality feel pansexuality is more relevant and inclusive of today’s recognition of gender non-binary persons, also known as transgender. Pansexuals are persons who have the ability to be attracted to all genders (male, female, gender non-binary). This is not a subtle shift, and has been occurring for some time (Galupo, Ramirez, & Pulice-Farrow, 2017; Galupo, Ramirez, & Pulice-Farrow, 2017; Flanders, LeBreton, Robinson, Bian, & Caravaca-Morera, 2017).

Maria and Phil, who are both transgender and bisexual, typify this shift and explain “I think that a lot of people that, before, would've used the term bisexual use the word pansexual. I feel more comfortable using the word pansexual, even though technically speaking if we're just going on GLBT, I guess I fit the box of Bisexual and

Transgender, now. Um ... But a lot of people that I talk to, they, they tend to just say pansexual now. That's like the new buzzword. That's like the new label. It does not yet have, like, this, this negative connotation to it."

With this latest directional change from bisexuality to pansexuality, there is a greater need for healthcare providers to be trained on the complexities of bisexual identity spectrum and what this means for accessing competent healthcare. Similar to bisexuality difficulty in finding a position of acceptance within the societal view of LGBT description, those who choose to adopt the pansexual identity over bisexual will, hopefully, have bisexuality as a community to learn from. Pansexuals might be faced with internal panphobia, like biphobia. Pansexuality as an identity might also face questions of validity, like bisexuals. A question that will be asked is - why do we need pansexuality as a label? There will be arguments made from the LGBT community that bisexuality can serve as the umbrella bridge for individuals who are attracted to others beyond the normal sexual coupling process. The question will remain, will this suffice as an argument. Finally, discrimination from those outside the LGBT spectrum might be the harshest critics as to why we have another label. It is the fierce criticism that begs the need for more culturally competent training.

Limitations

One issue to consider is how biphobia can manifest itself and result in taken for granted biases of a gay man towards bisexuals. Not being bisexual and fully aware of biphoba that exists within the LGT spectrum, I utilized two strategies to redress assumptions. One was writing in a reflective journal that allowed me to write study observations along with my emotional responses. A second strategy was to use several disinterested peer debriefers[28] (local bisexual leaders, and bisexual researchers) to assess emergent hypotheses to see if they seemed reasonable and plausible.

Data Analysis for Question 3

This section will explore the third research question of how the federal National Standards for Culturally and Linguistically Appropriate Services in Health Care (aka CLAS Standards) first published in 2000 have been implemented and incorporated with reference to LGBT populations, specifically bisexuals. The federal government has conducted a national evaluation of all CLAS Standard implementation activities in 2016. However, this evaluation project specifically addresses state level activities and not local level activities. In addition, the evaluation project did not explore the implementation of LGBT activities nor address how states were incorporating LGBT populations. Using Goodman's FORmative Evaluation Consultation And Systems Technique (FORECAST), this question explores CLAS implementation activities for five states (CA, MA, NV, DE, and GA) and highlight how LGBT and bisexual populations are surveyed.

The FORECAST Approach

FORECAST is a formative evaluation approach, in essence a mapping process, that can be used across settings while acknowledging local adaptations and innovations. The emerging results provided an interesting perspective on how the CLAS Standards are being implemented. While the CLAS Standards provide guidelines, reinforced through grant funding mechanisms and the healthcare accreditation, the Standards are just

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[28] Peer debriefing "is a process of exposing oneself to a disinterested peer in a manner paralleling an analytical sessions and for the purpose of exploring aspects of the inquiry that might otherwise remain only implicit within the inquirer's mind" (Lincoln & Guba, 1985, p. 308).

guidelines directed from the federal level. However, the innovation is occurring at the local level with the support of state legislative systems. These incubators of innovation are moving the discussion beyond the medicalization and politicization of LGBT bodies.

This section used a qualitative evaluation methodology to explore how the CLAS standards incorporate sexual orientation, bisexuality, into their state strategic plans. We reviewed over 100 documents (strategic plans, assessment forms, needs assessment, other state reports, state level laws, committee membership., etc…) to learn how sexual orientation (bisexuality) was incorporated into state level CLAS related documents in five states that are LGBT friendly. An overview of qualitative evaluation methods is provided below. We received approval for this study from the Texas A&M University Office of Research Compliance Human Subjects Protection Program.

Before we begin an in-depth discussion on the results, it is usual to get an overview of the data materials. Table 18 provides an overview of CLAS related activities. (See Appendix, TABLE 17: Summary of FORECAST Model for CLAS Standards Inclusivity of Bisexuality for CA, MA, NV, DE, and GA) Both Massachusetts and California have sixteen measures met, followed by Georgia (n=12), Delaware (n=10), and Nevada (n=9). For the marker, "strategic plan," all states have strategic plans with designated mission and goals, addressing sustainability and evaluation and coordinated by a central planning committee. For all the states, the strategic plan has produced CLAS trainings. These activities are organized by state coordinated CLAS websites.

TABLE 18: Summary of FORECAST Model for CLAS Standards Inclusivity of Bisexuality for CA, MA, NV, DE, and GA

CLAS Activities & Markers	States / # of Activities				
	CLAS training legislation AND state-sponsored implementation activities		State-sponsored implementation activities		Legislative activity for CLAS training
	CA	**MA**	**NV**	**DE**	**GA**
Planning, Policies, Collaboration					
Marker: Development of planning committees					
Measure: CLAS coordinating committee	X	X	X	X	X
Measure: Specialized committees	X	X		X	X
Marker: Needs Assessments					
Measure: Statewide assessment	X	X			
Measure: LGBT focused – district level	X	X			
Marker: Strategic plan					
Measure: Mission and Goals	X	X	X	X	X
Measure: State Level Support	X	X	X	X	X
Measure: Charge to Develop Committees	X	X	X	X	X
Measure: Develop Performance Measures and Sustainability	X	X	X	X	X
Measure: Develop other state level strategic plan	X	X	X	X	X
Marker: Policies, Procedures, and Regulations (laws)					
Measure: Passed laws	X				
Measure: Pending bills	X				
Measure: Failed bills					X
Measure: Referred to readers		X			X
Training and Technical Assistance					
Marker: Workforce development (training and technical assistance)					
Measure: Training	X	X	X	X	X
Marker: Technical Assistance					
Measure: Technical Assistance	X	X			X
Dissemination					
Marker: CLAS dissemination / Dissemination tools					
Measure: Web development	X	X	X	X	X
Measure: Reports (Quality Control focus)	X	X			
Measure: Toolkits	X	X		X	
Measure: Other: Videos/ Non-print media, Newsletters		X	X		

In addition, there is state level support, meaning the CLAS initiatives are housed at a state agency with administrative support, typically Department of Public Health. The strategic plan is not the only document but there are other documents (i.e., cultural competency plans). Both Massachusetts and California have state level needs assessments and have charged local health districts to conduct LGBT needs assessments. Sadly, none of these needs assessments are focused solely on bisexuals. Also, both Massachusetts and California are states that have enacted either CLAS training legislation or has comprehensive state level infrastructures.

On appearance, Massachusetts and California are innovators and early adopters of the CLAS Standards. However, when we take a closer look we can see that while Massachusetts and California are national CLAS leaders, Delaware and Georgia have made significant strides in attempting to implement the CLAS Standards. See Appendix, Table 18: Inventory of state level CLAS related activities

Table 19: Inventory of state level CLAS related activities

Activities	States / # of Activities				
	CLAS training legislation AND state-sponsored implementation activities		State-sponsored implementation activities		Legislative activity for CLAS training
	CA	**MA**	**NV**	**DE**	**GA**
Planning, Policies, Collaboration					
Strategic Plans	4	2	1	2	2
Partnerships/Task Forces	4	9		2	
Needs Assessments	3	2			
Policies, Procedures, and Regulations (*laws*)	4	1			4
Training and Technical Assistance					
Training	1	1	2	5	1
Technical Assistance	1	1			
Provides grant funding					
Dissemination					
Web development	1	1	1	1	1
Reports/toolkits	4	2		2	5
Newsletters/short pubs			1		
Conferences/presentations					1
Videos/Non-print media		1			
Total	22	20	5	12	14

Delaware, a state with state sponsored implementation activities, has embraced the CLAS Standards with a focus on specialized training on maternal and child health. While Delaware has not implemented CLAS related laws, the planning committee is chartered by the legislature. Georgia, classified with minimal CLAS implementation, has been active in attempting to pass state legislation to enforce the CLAS implementation process, has produced several quality improvement reports, and has a CLAS related training center. The final state Nevada, a state with state sponsored implementation activities, should have more infrastructure activities (i.e., training, passage of laws, etc.) but it falls short.

The Findings

For question three, *how do local level healthcare providers interpret Federal CLAS Standards and what implications does this have for health care utilization and access by the bisexual population?*, we found a wide-range of interpretations and approaches based on the CLAS Standards implementation activities. Table 19 allows us to see by state a descriptive inventory of CLAS related activities. (See Appendix C: Table 19: Detailed Inventory of Activities for State Level CLAS Standards)

This table above provided a platform to organize different CLAS activities within the FORECAST model by markers, measures, sources, and meaning. (See Appendix D: Table 20: FORECAST Model for CLAS Standards Inclusivity of Bisexuality) An added section, sexual orientation references, allows for a detailed description of how LGBT and bisexual populations are represented within CLAS initiatives. By separating the sexual orientation references section from meaning, allows us to see at a granular level what is occurring around LGBT and bisexual populations.

In mapping the evaluation of CLAS materials, there is an overwhelming number of measures that reach 100% saturation. For example, all five states have a centralized state sponsored website with state Department of Public Health, planning committee, well developed strategic plans with goals, and mission statements. These state level strategic plans mirror the fifteen national CLAS Standards. These strategic plans guide how training objectives are deliberated within states. Since 100% of the states have planning committees, all of the states have direct relationships with LGBT community-based agencies. However, the overwhelming majority of these agencies are AIDS service organizations. Thus, the LGBT focus is closely connected to HIV/AIDS. When exploring how LGBT and bisexual populations are represented the results are mixed. While the state of California has LGBT representation on their advisory planning committee, the other four highlight how LGBT data is a challenge and what data available is focused on adult mental health and anti-bullying for youth. Sadly, only California mentions bisexual data comparing discrimination with bisexuals to gay, lesbian and heterosexuals. This leaves an interesting issue of how states, like the federal government, struggles with LGBT data and prioritizing health benchmarks for the LGBT population.

Massachusetts, Georgia, California, and Delaware, excluding Nevada, have innovation occurring at the local levels through specialized planning committees (i.e., cultural competency committees). This innovation looks different in each state. For example, in Massachusetts 27 Community Health Network Areas (CHNA), have conducted LGBT focused needs assessments. California's 78 health districts have also conducted LGBT needs assessments. What makes Massachusetts and California unique is their centralized state funded training and technical assistance centers (Fenway Community Health Center, Massachusetts Technical Assistance Partnership for Prevention, UC San Francisco, UC Davis). This integrated state funded support allows for communities to innovate and address the needs of marginalized populations. Sadly, bisexuals are lumped with the LGT and we are not aware of any bisexual specific CLAS related training(s). On the other extreme, the state of Georgia has an ACA funded LGBT focused training, but this center is independent of state agencies. This disconnect limits the ability to innovate and disseminate LGBT educational materials at the local level.

Since the state of Delaware's planning committee is legislatively mandated and focused on child and maternal health, training activities for LGBT are minimal.

One central theme that emerged is how cultural competency, defined within the CLAS Standards, contrasts drastically with proposed or passed state legislation. States have adopted the CLAS Standards definition of cultural competency, which includes sexual orientation and identity. However, within state passed laws, proposed, pending, and bills referred to committee the definition of cultural competency is limited primarily to language, race, ethnicity, sex, and age. This classification disconnect is problematic when states want to implement policy that reflects national priorities. Another issue to consider is this lack of common definition can create confusion for local communities to prioritize the health needs of sexual minorities, specifically exploring the needs of bisexuals.

One can argue that the CLAS Standards guidelines are more symbolic than a road map with significant legislative substance. The CLAS Standards are by and large national recommendations for states, and the CLAS Standards are adopted and reinforced by the Commission (The Joint Commission), and indirectly supported by national civil rights legislation. As we have seen with the five states, how the CLAS Standards objectives get implemented varies by state. Some states adopt the 15 standards while others embrace certain standards. There is this notion within public policy studies, that objectives can reframe from slippage from original intent of they are clear. Sabatier and Mazmanian (1995) noted that "[w]hile some *slippage* is almost inevitable… , it is our contention that such slippage can be minimized if the *statute stipulates unambiguous objectives*." (p.168)

It should be noted that the CLAS Standards are guidelines and not law. However, Sabatier and Mazmanian's message reinforce that policy objectives need to be clear.

The varying patchwork of how the CLAS Standards are implemented at the state level complicates how the CLAS Standards get implemented. One possible reason why this patchwork exists and gets complicated is the possible insufficient resources to implement policy (Hill, 2003). Another possible reason is that CLAS implementers don't have the know-how to make the policy work at the state level, possibly due to vying interests of different stakeholders. (May, & Winter, 2007)

Cline (2000) noted the channels of how policy communication is mapped gets thorny rather fast. As Cline (2000) noted, "state-level implementers receive policy messages from the national, state, and local levels. National-level inducements and constraints are used to incorporate top-down influences. The bottom-up influence of state and local actors is represented in the model by state and local inducements and constraints. Thus, state implementers are at the nexus of communication in the federal system." (p. 558)

Cline's sentiments explain how the three policy approaches mentioned above intermix at varying implementation phases. Cline's characterization is nested in the hybrid model, and he also noted that there are natural tensions with implementation of policies. More importantly, how policy gets communicated and introduced to states is key to any policy implementation. If the policy communication roll out is ambiguous, this will cause much confusion and resistance to implement the proposed policy.

Communication of policy roll out is bidirectional and everchanging. Supporting this idea of policy communication is reinforced by Salamon's depiction of the relationship between the federal and state. Salamon (1981) noted, “[i]nstead of a hierarchical relationship between the federal government and its agents… what frequently exists in practice is a far *more complex bargaining relationship* in which the federal agency often has the weaker hand…” (p. 260) This idea of a bargaining relationship is what is occurring with the CLAS Standards. States are listening for the intent of the CLAS Standards but local innovation (local LGBT needs assessments and state sponsored training centers) impact the vision of the CLAS Standards. One of the key mechanisms for this local innovation is the significant influence street level bureaucrats have in policy implementation. Sadly, while there are local LGBT initiatives, this paper calls (call to action) for more deliberate focus on separating the bisexual from the LGBT in order to develop more culturally sensitive healthcare.

This call to action is not odd nor on the fringes of public policy implementation. Queer theory is already being used as an analytical frame to analyze policy data. (Lee, Learmonth, & Harding, 2008) One key aspect to this analytical frame is exploring how norms govern identity, while another is a measured exploration of the unspeakable such as the bisexual population. This paper attempted to use an evaluation approach while separating the queerness on the CLAS materials. One key observation of the evaluation results is that there is this constant tension for more Queer visibility (i.e., LGBT focused needs assessments or Virginia’s Transgender needs assessment). However, today what is needed is for bisexual political subjectivity, meaning that there is a need for local level bisexual needs assessments, CLAS trainings highlighting bisexual lives, and visible bisexuals on state planning committees. Having separate bisexual spaces would avoid a clustering of queer embodiments (Queer identity or LGBT) and foster critical disciplinary and interdisciplinary engagements with emerging identity spectrum of bi-sexualities.

Limitations

Findings should be interpreted with caution due to how policy can change both at the state and local levels. This study is representative of the five states with some of the highest LGBT demographics and some states with some of the friendliest LGBT policies. These five states represent 14% of the 25 states that have embraced the CLAS Standards. While limited to the five states, we think these results are applicable to nonprofit hospitals in other states.

A possible next analysis step, from the 35 states, is to expand the sample size from 5 states (14%) by including five new states (28%). Increasing the sample size will allow a deeper analysis and the opportunity to answer some of remaining questions. In addition, the original intention of this study was to interview the CLAS Standards Coordinators to get a better understanding of the implementation process, but some states have a designated Coordinator and others do not. Within our sample size of five, only two have a CLAS Standards Coordinator. This was problematic. When the CLAS Standards Coordinators were contacted, they declined to be interviewed due to concerns of going on the record due to a national climate not being so friendly to diversity. By increasing the states sample size would possibly mitigate this concern of very few states being interviewed.

Some of the concerns I heard were the tension of advocating for religious freedom and LGBT rights. The Trump administration has affirmed that transgender people aren’t covered under Title VII of the Civil Rights Act of 1964, which bars sex discrimination in the workplace. The Trump administration has undermined the Obamacare rule barring health care providers from denying treatment to transgender people, specifically pertaining to including gender reassignment surgery. Trump's Small Business Administration removed LGBT references from its website, and even the White House website has conducted the same. These are just some of the examples of anti-LGBT policies that impact how states conduct assessments and frame vulnerable populations needs. This reframing also impacts how states want to share information of what they are doing.

Summary of findings

For this dissertation, there were three research questions, (1) How is bisexuality as a social identity constructed and understood? (2) How does bisexual identity disclosure influence health access? (3) How do local level healthcare providers interpret Federal CLAS Standards and what implications does this have for health care utilization and access by the bisexual population? Using an interpretive critical inquiry for questions one and two allowed for a deeper understanding of bisexual lives. Using the FORECAST Model, the last question analyzed policy implementation of the CLAS Standards. This chapter explored the themes and subthemes that emerged from interview data, and document analysis. The following table 20 summarizes key findings from the three dissertation questions.

Table 20 Key findings from the three dissertation questions

Question	**Corresponding Findings**
(1) How is bisexuality as a social identity constructed and understood?	nobody looks bisexual high self-esteem bisexuals are not confused about their bisexuality in regards to religion, “guilt”, “shame”, and “stigma “having a penis or vagina” which “does not matter for some bisexuals being transgender and bisexual is rare
(2) How does bisexual identity disclosure influence health access?	the type of questions doctors ask informs risk and also informs stigma “*bisexual closet”* existed both in the gay and straight communities dispelling myths on bisexuals passing on the HIV virus generation divide on bisexuality not sure if there are any policies fear of Trump
(3) How do local level healthcare providers interpret Federal CLAS Standards and what implications does this have for health care utilization and access by the bisexual population?	There are no bi-inclusive policies, programs with the 5 states

This chapter explored the findings pertaining to the three research questions. The next chapter offers conclusions of the study; implications for bisexual health, public health, and policy makers; recommendations for future research; and three working hypotheses.

CHAPTER V

CONCLUSIONS, IMPLICATIONS, AND RECOMMENDATIONS

Summary of the Study

This interpretive critical inquiry attempted to understand the lived experiences of bisexuals who access health services, and how they identify themselves. This portion of the study was conducted in Atlanta, Georgia. In addition, using the FORECAST model, this study evaluated how five states (CA, MA, DE, NV, and GA) incorporated bisexuality into their CLAS Standards activities. The 36 bisexual participants were selected based on purposive sampling. Dissertation data was collected using ethnographic interviews and document analyses. The interviews were audio recorded, transcribed, and analyzed using Lincoln and Guba's (1985) approach to content analysis. Significant themes and subthemes emerged, and these findings attempted to answer the research questions.

Conclusions

Question 1. How is bisexuality as a social identity constructed and understood?

There are 27 axial codes organized by a socioecological model. Table 16 details the axial codes per socioecological level. Within the *individual level*, there are 11 codes which can be organized into 3 broad constellations - *general emotions* being bisexual, *emotions on being victimized and addiction*, and e*motional responses at how race and religion* impact one's conceptualization of bisexuality. At the *interpersonal level* there are 8 codes that form a broader universe of how bisexuals interact with family, friends, co-workers, etc. In the *community level*, there are four distinct categories in how bisexuality is socially framed, (1) generational divide; (2) how bisexuality is socially framed (bisexual community, what society expects about bisexuality, bisexual sex); (3) media; and (4) medical-provider communication. Within the *organizational level*, bisexuals feel like organizations can do more to be bisexual friendly. Finally, in the *policy* level, there are no policies known to the participants that protect them for being bisexual.

At the *individual* level, participants have high self-esteem, have a lot of hope, but want to be respected. The bisexual closet is real, and participants selectively disclose their bisexuality to others. Bisexuals also feel constrained by social categories of what it means to be part of the LGBT community, and bisexuals lack social spaces to socialize. At the *interpersonal* level, bisexuals feel the sting of being blamed for spreading HIV, that they are also confused and not really bisexual but rather straight or gay/lesbian. Bisexuals also get eroticized and exotified by non-bisexuals. This is especially the case for transgenders who also identified as bisexual. At the *community* level, there is a generational divide between older bisexuals and younger bisexuals. Where bisexuals find other bisexuals are in sex clubs. How bisexuals communicate with their medical providers is troublesome – bisexual participants called for more medical provider sensitivity training. At the *organizational* and *policy* levels, organizations are not bisexual friendly and there are no policies known to the study participants that protect them.

Question 2. How does bisexual identity disclosure influence health access?

In answering the question of how bisexual identity influences health access, there are sub six thematic clusters which emerged: 1) Health affects, (2) Emotional/religious support, (3) Pink unicorn, (4) Ghost echoes, (5) Delusional identity, and (6) Textual contradictions. There are three central cross over themes. First, from these themes indicates that there is confusion on what bisexuality is and the intensity of identity politics [Delusional Identity, Textual Contradictions, Ghost Echoes, Pink Unicorn]. The secondary crossover themes can be classified as a cause and effect. While there is personal social support [Emotional/Religious Support] for bisexuals, the social position of religion can be both supportive and instill stigma and shame. The last cluster is centered on how stigma and shame can lead adverse health effects [Health Affects].

Question 3: How do local level healthcare providers interpret Federal CLAS Standards and what implications does this have for health care utilization and access by the bisexual population?

There are no bi-inclusive policies, programs with the 5 states (CA, MA, DE, NV, and GA). Massachusetts and California are innovators and early adopters of the CLAS Standards. What makes Massachusetts and California unique is their centralized state funded training and technical assistance centers (Fenway Community Health Center, Massachusetts Technical Assistance Partnership for Prevention, UC San Francisco, UC Davis). Only California mentions bisexual data comparing discrimination with bisexuals to gay, lesbian and heterosexuals. Only California mentions bisexual data comparing discrimination with bisexuals to gay, lesbian and heterosexuals. Nevada, Delaware, and Georgia have made significant strides in attempting to implement the CLAS Standards, but they are still lacking far behind other states.

Implications for public health planning, community practitioners, and, state systems

The implications of this study could be many, but I decided to narrow to three: public health planning, community practitioners, and state systems. The importance of public health planning at the local level has the potential to influence policy from a bottom up perspective (Lipsky, 2010). Community practitioners have the potential to be the innovators for change and redefine social norms. Lastly, state systems can be incubators for innovation and policy agenda setting.

Implications for public health planning

One can argue from a critical lens that public health planning processes overlook bisexual health needs by clumping bisexuals with gay or lesbian identities. For transgender individuals who are also bisexual, there is an emphasis on their trans identity and their sexual orientation is often overlooked. The overlooking of transgender sexual orientation is grounded in our binary assumption of when a person transitions from one sex to another, naturally, that person will be attracted to the opposite sex. This is false (Mulé, et al, 2009; Rankin & Beemyn, 2012).

While there have been advances in cultural competency trainings for the public health workforce, bisexuals are still clumped with the gay, lesbian, and transgender identities. There needs to be a concretive effort to expand culturally competent curricula to examine the fluidity of sexual orientation. Public health as made some serious strides with the transgender population (Safer & Pearce, 2013; Snelgrove, 2012, Lower, 2016), but the bisexual population remains a marginalized group.

Implications for community practitioners

Some local level municipal entities (e.g., San Francisco, New York City) have led the way with LGBT rights and health issues. A classic example is how some municipal governments, in the early 1980s, reacted and planned prevention and treatment activities for the gay male community due to the HIV virus. These cities led the way in not only addressing the spread of HIV but also developed culturally responsive healthcare.

Today, some community practitioners are exploring and developing community health needs assessments with a deliberate emphasis on bisexual health needs. For example, the state of Minnesota developed the Bisexual Community Needs Assessment 2012. This assessment was led by a nonprofit, Bisexual Organizing Project, which also leads one of the few annual national conferences on bisexuals (Bisexual Empowerment Conference, A Uniting Supportive Experience). Community practitioners in California are an example of how some local needs assessments are incorporating bisexuals into their public health planning. Sadly, as far as I know, to date, there are numerous LGBT needs assessments completed by very few focused on bisexual health needs. Community practitioners are poised to ask questions at the local level to encourage more emphasis on bisexual health needs.

Implications for state systems

Like community practitioners, state systems are, and have been, poised to be public health innovators. In the case of this dissertation, state systems are the public agency entities that are responsible for enforcing and implementation public health programs. Examples of public agency entities are the Georgia or California Departments of Public Health. State public agency entities are in a precarious situation, they have to implement and direct federal policies and grants with their state, while at the same time trying to adapt or tailor these policies and grants to their state cultures. In addition, state resources, agency capacity, workforce development, local politics, state bond rating, vulnerability to natural disasters, state agency leadership, etc., play a significant role in how systems change can occur. State systems are in a unique place because they have a national network platform from which to draw best practices. There are also professional state health associations that can foster this exchange of ideas, and in some states, there are research universities that can assist in the cultivating of new ideas to be implemented. Nevertheless, state systems have resources but change is slow and difficult at the state level. I am reminded by Braudel's view on assessing historical change, *longue durée*, or Sorokin's idea on assessing sociocultural changes over periods of time. Taking Braudel and Sorokin's perspectives in which systems change is measured by examining cycles, it is from understanding these broad periods of time that we can get perspective on how change can occur.

Recommendations for Future Research

In thinking of recommendations for future research, based on the findings, conclusions, and implications of this study, there are two recommendations rise to the surface. In my attempt to identify these recommendations, I want to be both practical and solution focused. First, when developing public health interventions that focus on LGBT populations, the bisexual population needs to be separated from the LG and T. In many respects, transgender studies have provided a blue print for how to do this separation. CDC's compendium on HIV/AIDs interventions have a growing list of transgender focused interventions. How this separation came about for the transgender population is twofold. One, the epidemiological data noted transgenders are are risk for several health issues, and two, more significantly social awareness about transgender culture slowly became mainstream. Given the acceptance of bisexuality by younger generations, separating bisexuals from the LG and T appears to be more realistic today than 10 years ago.

A second recommendation focuses on how researchers should approach bisexual focused studies. One argument from the LGBT community is to have LGBT researchers lead LGBT studies. While this is logical at one level, the assumption is that there are enough LGBT researchers working on LGBT related topics. That is not the case. One can be LGBT and not an LGBT researcher.

A second argument which is historically couched in the educative and instrumentalist schools of thought (Hammersley, 2003), is to recognize that hard to reach populations do not respond well to instrumentalist investigations. The educative appeals to the "nature of the 'interest' which should guide educational, and perhaps all social, inquiry" (Hammersley, 2003, p. 10). In other words, this is the 'why' of qualitative inquiry. The why is what this dissertation explored in the lived experiences of bisexuals. Whereas, the instrumentalist is entrenched in positivist tradition in that social sciences are controlled by an "instrumentalist concern [which is focused on]…. prediction as symmetrical with explanation and emphasized the role of experimental testing in validating knowledge" (Hammersley, 2003, p. 15). The instrumentalist approach, or quantitative analysis, explains the how, and does not fully explore the why. This dissertation does not attempt to reconcile the commensurability between qualitative and quantitative inquiries. Instead, softly encourage, what Westbrook (2008) noted ethnographic research "can help clarify the frames employed by [socio-cultural] law[s or truths] - that is what it means to articulate the imaginary" (p. 79). In a quest to appreciate ethnographical research, Westbrook (2008) described how hard to reach populations can now claim their cultural entities and spaces, while also acknowledging places are "becoming less isolated" (p. 10). In this dissertation, ethnographic methods allowed for bisexuals to be more visible.

Working Hypotheses

In Reason and Rowan's 1981 work, John Heron discussed how the "researcher.. interact[s] with the subjects, so that they do contribute directly both to hypothesis-making, to formulating the final conclusions, and to what goes on in between" (p. 19). This notion of hypothesis-making is based on a collective converging of the study data to consider and formulate reasonable conclusions. The emerging themes that resulted from subject interviews and analysis of CLAS Standards documents yielded interesting questions and ways forward on bisexual health. These hypotheses are described below.

Hypothesis #1

When society's definition of bisexuality is marred in vagueness and contradictions, for example, does bisexuality exist, this question raises doubt and inconclusiveness which can affect policy development for the LGBT community, sexual education evidence-based interventions, and public health evidence informed patient-provider communication strategies for the LGBT community. Does bisexuality exist is a lively debate which exists in today's academic literature. From a psychological perspective, the question of whether current psychometric scales measure bisexuality is an open discussion with conflicting conclusions. Within the critical studies camp, there are compelling qualitative studies arguing for a complex depiction of bisexuality, and bisexuality does exist. As referenced in this dissertation, there are structural mechanisms encouraging bisexual erasure. In Yoshino's 1999 Sandford Law Review article, *The epistemic contract of bisexual erasure,* he listed three reasons to explain why bi erasure exists: "(1) an investment in stabilizing sexual orientation; (2) an investment in retaining the primacy of sex; and (3) an investment in preserving norms of monogamy" (p. 428). Yoshino argues that there is "studied omission of bisexuality in discussions of sexual orientation" (p. 367). More provocatively, he argues that "[g]ays, as well as straights, have distinctive investments in stabilizing their sexual orientation (p 404*)*. Gays and lesbians have proactively advocated for socio-legal recognition of their sexual orientation and entertaining the fluidity of bisexuality jars this notion. At a more intimate level, “bisexuals are seen to destabilize the primacy of sex as a diacritical axis. Straights and gays have a shared investment in the primacy of sex because their orientation identities rely on it” (p. 410). Bisexuality by its common understood definition exudes choice between a, or both, female and male sexual partners. These choices destabilize the norms of monogamy and are unsettling for some.

Hypothesis #2

When public health evidence-based strategies do not account for bisexuality, such as patient-provider communication strategies or within evidence-based interventions when bisexuals are clumped with LGBT, then bisexual health access and education is thwarted, contributing to bisexual health disparities. By recognizing bisexuality within public health evidence-based strategies we are one step closer to understand how stigma, shame, and secrecy drive bisexual invisibility.

Hypothesis #3

When public policy development and implementation only focus on LGBT as one group, such as the CLAS Standards with their limited definition of sexual orientation, then bisexuals are not a presented group with identifiable needs. This lack of bisexual recognition is, in large part, supported by current the socio-legal limitations of how bisexuality is defined and understood. Thus, hypothesis 1, 2, and 3 are intricately connected.

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APPENDIX A

MEMOS

Research memo #1: Questions 1 & 2 Reflective memo –

study participant focus groups & semi structured interviews

Background:

Study Research Questions

There were three study questions:

(1) *How is bisexuality as a social identity constructed and understood?*

(2) *How does bisexual identity disclosure influence health access?*

(3) How do local level healthcare providers interpret Federal CLAS Standards and what implications does this have for health care utilization and access by the bisexual population?

This memo examines and explores study questions 1 and 2. For study question 3, there is separate memo (Memo #3) detailing the data gathering and analysis.

Participant Recruitment

Participant recruitment was driven by snowball sampling approach, along with targeted marketing approach to bisexual social networks. The recruitment process was managed by Aniz, Inc., which a community-based agency is located in Atlanta, Georgia.

Originally the study goal was to have 3 focus groups (6 to 10 in each focus group) of self-identified bisexual individuals over the age of 21, with a total of 30 participants. The rationale for having 3 separate focus groups is to allow participants from the same age group to share thoughts and ideas as its relates to their sexual orientation and health access. As will be discussed in the challenges section, there were some serious unknown participant recruitment difficulties. The research design was amended to only have 2 focus groups and the 3rd focus group became semi-structured interviews.

Participant Demographics

A total of 36 participants who identify as part of the bisexual spectrum were interviewed from metro Atlanta (Fulton 73.33%, DeKalb 23.33%, Cherokee 3.33%). Of the 36 participants, 47.22% were in the 50-64-year age group, and 86.11% were Africans Americans followed by 8.33% that were White. The majority of the participants were Male (66.67% Male compared to 4% Female; 22.22% identify as part of the Transgender sexual identity umbrella (8.33% Transmale; 5.56% Transfemale; Transgender [Male to Female] 8.33%). The study population had some level of higher education 50%, followed by 50% that had some high school degree or GED. The majority of the participants (58.82%) were in a stable housing, followed by 38.89% that were in a transitional state (see US HUD guidelines). The majority (56%) are originally from Atlanta, while others are Atlanta transplants originally from Tennessee, Ohio, New Jersey, Alabama, Mississippi, Florida, and South Carolina.

Interview Structure

There were 2 focus groups and 11 semi-structured interviews. All interviews were conducted at Aniz located 236 Forsyth Street, SW #300, Atlanta, GA 30303.

Data Cleaning

For focus group and semi-structured interview transcripts, both entailed a clean-up of transcript text to eliminate nonessential words and double check the meaning of words that were transcribed as unintelligible. After the data cleaning process, the next step is to get to know the data by read and re-read the transcriptions to understand tone and global ideas from the study participants. An extra step initial step was taken to compare these global ideas with existing knowledge within the critical queer theory and literature review on bisexual accessing health services. The aim for this last step was to better understand how this data might be understood within existing literatures.

As stated, the focus group and semi-structured interview transcripts resulted in 274 transcription pages. Data analysis process began by organizing the data by identifying concepts, trends, themes, behaviors, terminology, or phrases and assigning them as significant statements (506 significant statements). From these significant statements, 645 open codes identified, which were organized into 27 axial/intermediate codes organized around each level of the socioecological model [individual 11; interpersonal 8; community 6; organization 1; policy 1]. These axial/intermediate codes range from *disclosure of bisexuality* at the individual level to there are *no policies* protecting bisexuals at the policy level. Each axial code is connected to quotes from the transcripts with an excel file document.

Challenges

Participant recruitment for 3 focus groups became a challenge. One ongoing challenge was recruiting bisexual identified women. We managed for the 2 focus groups to recruit men only. In consultation with my dissertation committee and community members (key informants within the bisexual community), a revised strategy was to redesign market materials for bisexual women. In addition, the contact person became the CEO of Aniz, Zina Age, as she is a leader to community members to contact. A more significant shift was to eliminate the last focus group and instead of it schedule one-on-one semi-structured interviews. This re-marketing effort, 11 interviews were held. Through some participant marketing modifications, the study was able to recruit and consent 9 women, 25% (4 cisgender women and 5 transgender women).

Trustworthiness and Rigor

In qualitative inquiry, trustworthiness ensures rigor. Within qualitative inquiry trustworthiness is the larger framework for determining credibility, transferability, dependability, and confirmability. Given the amount of data within this study, a second reviewer (James Doster) examined transcript data from each focus groups and semi structured interviews. From the initial data transcription review process, James reconstructed from 506 significant statements to 645 open codes. Then from the 645 open codes, 26 axial/intermediate codes emerged and were organized around each level of the socioecological model.

Below is a result of two unitization and categorization rounds for the 2 focus groups and 11 semi-structured interviews.

Individual

1. **Substance abuse**: Several participants mentioned that they struggled with “substance abuse” and/or are “in recovery”. Substances were used to cope with the “coming out process”.
2. **Sexually abused**: Several (between 3 to 8) discussed how they were “sexually abused by a relative”. This abuse resulted in personal conflictions. While some “acknowledged that they enjoy the sex as pleasurable” the fact that they were “non-consensual” and they were minors “created mistrust within relationships”.
3. **Race and bisexuality**: The question of how their racial or ethnic identity factored into their sexuality was minimal. The only significance was the African American community, “bisexuality is not talked” about “nor seen in a positive light”.
4. **Feelings**: The feelings that emerged from the data is participants have allot of “hope” but are wanting “respect”, a need for more “trust”, and “compassion”. There was also feeling of “not being heard” and “suicide ideation”.
5. **Self-esteem**: The overwhelming majority (nearly all) of participants had “high self-esteem”.

6. **Disclosure of bisexuality**: This emotional abstraction is more complicated than what it seems. Disclosure is highly influenced by the reaction of others. Some noted that the “*bisexual closet”*

existed both in the gay and straight communities, and there is a message to not advertise bisexuality. Along the same lines, the idea of how you can tell someone is bisexual was discussed. This idea of how you can tell…. also has an impact on how bisexuals talk to a medical provider about their sexuality. Lastly, there is experimentation with sexuality, and more importantly bisexuals are not confused about their bisexuality.

7. **Religion**: Many of the participants "held on" to their "religious beliefs". This religiosity was also a source of "guilt", "shame", and "stigma" for being bisexual.
8. **Self-conception of bisexuality**: When it comes to society "people like categories." Bisexuality is about "experimenting at a mental level or connection level." Bisexuals "know who" they are "as a bisexual person" and "watch YouTube to see other bisexuals doing well." "The roll of desire in bisexuality" is more than "having a penis or vagina" which "does not matter for some bisexuals." Bisexuals feel that they are "not valued and well understood." There are also "no space for bisexual people" and "not sure if one is bisexual when socializing."
9. **Resilience**: Bisexuals see themselves as resilient on being who you" and "are resilience about being an out bisexual."
10. **Accepting my bisexuality**: The self-acceptance arch, ranges from bisexual experiences in prison or the belief that bisexuality is not a choice. The underlying tone is the complexities of acceptance: "uncertainty"; "comfortable"; "connections"; "being out," and "God makes no mistakes."
11. **Blame & shame bisexuals**: Shame, guilt, and stigma are drivers for why bisexuals struggle with their sexuality. From a social perspective, family and friends are the influences that promote and instill shame, guilt, and stigma. "Dispelling myths on bisexuals passing on the HIV virus."

Interpersonal

12. **HIV and bisexuality**: There is “blaming bisexual for spreading HIV” along with the “refuting from bisexuals for blaming bisexual for spreading HIV.” The idea of getting all bisexuals to be tested for HIV, just because they are bisexual.
13. **Support**: The idea of support comes from several places: family, friends, church, and social networks. The quote that illustrates this support is: “You're my son. I love you regardless.”
14. **Bisexuality does not exist**: Bisexuality is not real as it has been told by the straight and gay communities: “ain't no bisexual, you gay”; “do not understand what bisexuality is”; “who looks gay … nobody looks bisexual”; “people deny that you can be bisexual”; and “label them as she's dating a woman so she's a lesbian, or she's dating a man therefore she's straight.”
15. **Confusion on what bisexuality is or is not**: What bisexuality is or is not is interpreted differently by straight and gay communities: “they were bisexual that whole time, and they ended up choosing a man in the end”; “sims where you have little diamonds over your head labeling who you are”; “straight people do not categorize themselves the way (chuckles) queer people do”; “little necklaces that tell you what you're into”; “I hate to use the word phase, but some people I think actually do go through this little experimental phase where they just don't really know what they want, or they want to explore”; “identity politics”; “it is OK for women to be bisexual”; “demi sexual, the sapiosexual”; “confusion on what pansexual is or is not”; “being an out bisexual and married to a woman”; “bisexuality as down low”; “you're probably with a bisexual and don't even know it”; “confusion between sexual orientation and sexual identity.”
16. **Bisexual means GAY**: “gay is a catch all category that swallows bisexuality”; “well I think that most people think that if a man is bisexual they are really gay”; “it's like all these other little sub-categories because a minority has to fit in this little box, always has to fit in this little box”; “as

much as I get frustrated with their labels sometimes, I have a responsibility to the community to accept."

17. **Transgender and bisexual**: "being transgender and bisexual is rare"; "BI'ness falls as a subsidiary underneath the trans identity"; "my trans identity is first and then my bisexual identity"; "bisexuality gets more complicated when one is trans and bisexual"; "someone who's bisexual will not necessarily date someone or be interested in someone who's transgender."
18. **The issue of Class**: "seem like more middle class and upper class is more accepting than the lower class and I think that, a lot of that had to deal with a lot of people deal with their situations by dictating or oppressing other people"; "white people do not care about bisexuality."
19. **The "OTHER"** [erotification; exotification]: "someone's who's pansexual says, "I don't care if you're male, or you're female. I don't care what parts you have. I truly just care that you're a human being and I like you as a human being"; "what defines a woman"; "bisexuality and parenthood"; "I'm watching all of these other people perform gender. I don't feel like I fit in because I'm not a performing gender."

Community

20. **Generational divide**: "generation divide on bisexuality"; "today is bolder and youth on their sexuality."
21. **Bisexual sex**: "sex positive about sex"; "how the porn industry normalizes what is sex and show should be having sex with whom"; "bisexual community tied to sex clubs"; "sex clubs"; "bisexuality manifests in those spaces - swinger clubs"; "clubs – swinger"; "having sex is fun"; "having sex with a woman was not like a guy with penetration but it was good"; "we going to be

smashing these hoes together'. And he was like 'wait what?' And I was like 'oh I didn't tell you that I like girls too."

22. **Media & Social Media**: "who is bisexual in the movies"; "meeting other bisexuals – online"; "20/20 episode on bisexual people"; "celebrities that have come out recently as bisexual"; "people watch porn, for example, and someone who's heterosexual might watch bisexual porn, or they might watch lesbian porn, or gay men being a female. It's very common"; "when you go online you are looking for someone who is interested in sex and not into labels of who you are."
23. **Communication with medical provider**: "clinical body"; "gay men are more likey to seek care than an open bi man"; "closeted bisexual person and what it means to seek healthcare"; "the type of questions doctors ask informs risk and also informs stigma"; "we do these trainings, show the reality of our lives and it is not just about sex doctor's office. Like, he said, where like they're using my sexual experience to try and categorize risk factors for me"; "medical providers need to focus on the importance of like validating people's lived experiences, and not like questioning it": "medical providers need to be bi competent as soon as you say that you are sleeping with a man who identifies as gay or bisexual, and medical providers just clump it as gay"; "medical provider lists bisexual as a high risk category positive view of medical ownership"; "I am not shy in talking to my doctor about my sexuality medical - your sexual orientation should not matter"; "medical provider was afraid of my bisexuality"; "there is a need for more respect".
24. **Bisexual community**: "bisexuals hang out at strip clubs"; "bisexual[s] are invisible in GLBT spaces"; "LGBT spaces are divided"; "the bisexual population is hidden"; "the bisexual community is so large"; "bisexual community tied to sex clubs"; "find other bisexuals in gay or straight clubs'; "bisexual hang out at gay & straight clubs"; "bisexuals hang out at strip clubs."

25. **What society expects about bisexuality**: “social perceptions of being bisexual”; “community views of bisexuality as a bad thing”; “a lot of the times, sadly, they choose a man in the end because that's easier by society's eye”; “bisexual people look too normal looking – heteronormative”; “when I was married,.., I just knew I was bisexual”; no, you can't do that. You supposed to only fuck a woman”; “oh, you messin' around ... you messin' around with a tranny? But as long as you still fuckin' some women, you cool with me.”

Organizational

26. Organizations not bi-friendly: “how organizations are bi friendly – AIDS Service Organizations are more welcoming”; “great LGBT services in Atlanta”; “when I moved to Atlanta, I became free around my sexuality”; “organizations are not bisexual friendly”; “shy of new organizations.”

Policy

27. No policies: “what it means to be black around policies”; “adoption might be another policy affecting bisexuals”; “Gay marriage is the main policy issue for bisexuals”; “no policy in place”; “not sure if there are any policies”; “bi-erasure in the medical and policy context”; “lost of hope around policies”; “fear of Trump”; “there are no national policies geared for bisexual community.”

It should be noted further interviews should be conducted to evaluate how the boundaries of each category will expand or merge with another category. At the juncture of the research and data unit analysis, the 27 categories below have several crossover thematic areas.

Substance abuse
Sexually abused
Race and bisexuality
Confusion on what bisexuality is or is not
Bisexual means GAY
Transgender and bisexual

Feelings
Self-esteem
Disclosure of bisexuality
Religion
Self-conception of bisexuality
Resilience
Accepting my bisexuality
Blame & shame bisexuals
HIV and bisexuality
Support
Bisexuality does not exist
The issue of Class
The "OTHER"
Generational divide
Bisexual sex
Media & Social Media
Communication with medical provider
Bisexual community
What society expects about bisexuality
Organizations not bi-friendly
No policies

Taking these 27 different constructs (themes), when one collapses these categories there are 6 possible clusters (subthemes).

CLUSTER 1

Substance abuse

Sexually abused

HIV and bisexuality

Disclosure of bisexuality

CLUSTER 2

Bisexual community

What society expects about bisexuality

Bisexual sex

Race and bisexuality

Media & Social Media

Accepting my bisexuality

Self-conception of bisexuality

The issue of Class

CLUSTER 3

Religion

Support

Resilience

Feelings

CLUSTER 4

Confusion on what bisexuality is or is not

Bisexuality does not exist

Bisexual means GAY

Blame & shame bisexuals

Self-esteem

CLUSTER 5	CLUSTER 6
Transgender and bisexual	Communication with medical provider
The "OTHER"	Organizations not bi-friendly:
Generational divide	No policies

1. At a meta level, one constellation (under "*HEALTH AFFECTS*") could look like the following:

- Substance abuse + Sexually ~~abused~~ + HIV ~~and bisexuality~~ + Disclosure of bisexuality = HEALTH AFFECTS
- HEALTH AFFECTS: in struggling with one's sexuality, bisexuals can experience addiction, could have been sexually abused, and/or are at risk for HIV. Note, the risk classification of HIV is largely society assigning to bisexuals.

2. Another possible combination grouped under "*EMOTIONAL/RELIGIOUS SUPPORT*" could look like the following:

- Religion + Support + Resilience + Feelings + Self-esteem = EMOTIONAL/RELIGOUS SUPPORT
- EMOTIONAL/RELIGIOUS SUPPORT: bisexuals do have significant emotional support from family, friends, and social networks. Note, religion has a duel role of instilling shame and stigma but also providing a base for self-esteem and resilience.

3. A third arrangement under the concept of "*PINK UNICORN*" could look like the following:

- ~~Transgender and bisexual~~ + ~~The~~ "OTHER" + ~~Generational divide~~ = PINK UNICORN
- PINK UNICORN: bisexuality as experienced by bisexuals, they feel like the odd grouping either in the LGT or heterosexual communities. Bisexuals are eroticized in sexual fantasies, as the third person in a heterosexual sexual encounter. Bisexuality is a sub category to sexual identity. For example, transgenders are first part of the trans community and bisexuality is a second category that they embrace.

4. A fourth grouping under the concept of "*GHOST ECHOES*" could look like the following:

- Communication with medical provider + Organizations ~~not bi-friendly~~ + No policies = GHOST ECHOES
- GHOST ECHOES: bisexuals do not have policies to protect them, they are invisible. They also feel lost and often act like chameleons to adapt to circumstantial social norms that either accepts their biness or not. There are two types of medical providers: those who are bi-friendly and those who are not. Those who are not bi-friendly further push bisexuals into the bi-closet. The medical providers who always assume heterosexual couples are not having same sex desires or romantic relations, also expand the stigma of the bi-closet population by the lack of their bi awareness.

5. A fifth collection under the concept of "*DELUSIONAL IDENTITY*" could look like the following:

- Confusion on what bisexuality is or is not + ~~Bisexuality~~ does not exist + ~~Bisexual means~~ GAY + Blame & shame ~~bisexuals~~ = DELUSIONAL IDENTITY

- DELUSIONAL IDENTITY: on the one hand bisexuals are somehow to blame for spreading HIV… and using the same casuistically reasoning bisexuality is not real or exist. Then which is it, bisexuals spread HIV, or they do not exist? This contradiction only disenfranchises a population. How can you blame something and 'it' does not exist?

6. A sixth compilation under the concept of "*TEXTUAL CONTRADICTIONS*" could look like the following:

- Bisexual community + ~~What society expects about bisexuality~~ + ~~Bisexua~~l sex + Race and ~~bisexuality~~ + Media & Social Media + Accepting ~~my bisexuality~~ + Self-conception of ~~bisexuality +~~ The issue of Class = CONTEXTUAL CONTRADICTIONS
- TEXTUAL CONTRADICTIONS: while a bisexual exists for bisexuals through social networks (could be a social support group or small network of friends), there are no bisexual physical spaces to socialize. The physical spaces that do exist are sex clubs (i.e., swinger clubs). While society stratifies by race, gender, age, etc.. race is not an important factor for bisexual identity. Given this status, bisexuals struggle with the intellectualizing at a social level what bisexuality means and how bisexuality can be understood. The role of media is one way that bisexuality has socially materialized as something tangible. However, bisexuality struggles to separate itself from the gay and lesbian identity as its own sexual orientation.

<u>Summary of possible six constellations:</u>

1. HEALTH AFFECTS: in struggling with one's sexuality, bisexuals can experience addiction, could have been sexually abused, and/or are at risk for HIV. Note, the risk classification of HIV is largely society assigning to bisexuals.

2. EMOTIONAL/RELIGOUS SUPPORT: bisexuals do have significant emotional support from family, friends, and social networks. Note, religion has a duel role of instilling shame and stigma but also providing a base for self-esteem and resilience.
3. PINK UNICORN: bisexuality as experienced by bisexuals, they feel like the odd grouping either in the LGT or heterosexual communities. Bisexuals are eroticized in sexual fantasies, as the third person in a heterosexual sexual encounter. Bisexuality is a sub category to sexual identity. For example, transgenders are first part of the trans community and bisexuality is a second category that they embrace.
4. GHOST ECHOES: bisexuals do not have policies to protect them, they are invisible. They also feel lost and often act like chameleons to adapt to circumstantial social norms that either accepts their biness or not. There are two types of medical providers: those who are bi-friendly and those who are not. Those who are not bi-friendly further push bisexuals into the bi-closet. The medical providers who always assume heterosexual couples are not having same sex desires or romantic relations, also expand the stigma of the bi-closet population by the lack of their bi awareness.
5. DELUSIONAL IDENTITY: on the one hand bisexuals are somehow to blame for spreading HIV… and using the same casuistically reasoning bisexuality is not real or exist. Then which is it, bisexuals spread HIV, or they do not exist? This contradiction only disenfranchises a population. How can you blame something and ‘it’ does not exist?
6. TEXTUAL CONTRADICTIONS: while a bisexual exists for bisexuals through social networks (could be a social support group or small network of friends), there are no bisexual physical spaces to socialize. The physical spaces that do exist are sex clubs (i.e., swinger clubs). While society stratifies by race, gender, age, etc.. race is not an important factor for bisexual identity. Given this status, bisexuals struggle with the intellectualizing at a social level what bisexuality

means and how bisexuality can be understood. The role of media is one way that bisexuality has socially materialized as something tangible. However, bisexuality struggles to separate itself from the gay and lesbian identity as its own sexual orientation.

Discussion

The central crossover italicized themes above how there is confusion on what bisexuality is and the intensity of identity politics [Delusional Identity, Textual Contradictions**,** Ghost Echoes, Pink Unicorn]. Secondary crossover themes can be classified as a cause and effect. While there is personal social support [Emotional/Religious Support] for bisexuals, the social position of religion can be both supportive and instill stigma and shame. This stigma and shame can lead adverse health effects [Health Affects]. These universal themes provide a reference point to separate bisexual health from LGT health.

Granted the study population are mostly African American and Southern. Possible topical areas that need to be further exploration are how religion is connected to identity formation. Another research question is whether Queer identity politics differs from new sexualities such as pansexual, genderqueer, queer, etc.. The meaning of spatial belonging for bisexuals should be explored at a deeper level – to assess contextual [beyond the piece of rhetoric], textual [piece of rhetoric], *hermeneutical analysis of historical texts,* and explore how radical critical queer theories [i.e., does a relationship have to coupled? Or, is queer theory moving toward polyamorous relationships?].

Research memo #2: Observational notes – *focus groups*

Process:

During the two focus group sessions, there was a focus group facilitator along with an audio recorder device to document the session conversations. In addition, there were there to staff members, sitting on opposites sides of the room, taking notes as the focus group conversation evolved to capture human interactions (e.g., being comfortable with the questions, any uneasiness, etc..). One staff has a Master of Social Work (MSW) to be available in case focus group participants wanted to discuss one on one difficult issues. The second person was a graduate intern from the School of Public Health, Georgia State University. As mentioned before, each person sat on opposite ends of the meeting room in order to capture any facial expression, comments, interactions between study participants, and emotional responses of interest.

For part one, using Lincoln's data analysis process, the unitization of the data will be first structured by focus group (FG 1; FG 2). Then in Part Two I will use Clarke's Situational Analysis (2016) process I combined different constructs to understand emerging subthemes and how they are related to one another.

Part One: Unitization of the Data

FG 1:

Data unit	Supporting evidence
Bi-confusion / greedy (n=4)	• You can't make a decision "you are being sexually greedy." • Conflict between heteronormative lifestyle expectations (having children) and being bisexual. • Also feels that gay men call those who identify as Bi-sexual "sexually greedy" (Note: allot of agreement from the group).

	• Group consensus- gay community does not understand bisexuality. Sees them as confused. Hard to integrate oneself into the community.
Avoid conflict (n=1)	• Avoidance to declare bisexuality to avoid combative issue.
Bi-closet (n=5)	• Note: Loves women. Loves men. Doesn't share this with family. • Expressed that people behave one way while incarcerated then different and ashamed outside. • His church would not accept him when he came out. • Hangs out with mostly straight friends or those who can keep their bisexuality a secret. • No not so much. Doctors don't need to know about sexual lifestyle. (not HIV positive?)
Blame: Bi & HIV (n=2)	• Interconnectedness between contraction of HIV and blaming bisexuality as the cause Note: focus group participant is "visibly upset." • Felt like his health care provider "grilled him" regarding how he got infected. It was like an interrogation. Didn't see a doctor again for 3 years even after discovering HIV positive because experience was so bad.
Bi-Confidence (n=4)	• The older you get the stronger you get and more comfortable you are with yourself and your sexuality. • Feels that the affirmation of his mother (as with most men in black community) is extremely important • Tells everything [to his doctor]. Doesn't care. • Seeing private therapist. Feels comfortable opening up.
Social exclusion / unawareness (n=1)	• Sometimes feels excluded from the LBTQ community as a bi sexual man by other gay men and lesbian women.
Bi-inclusive Policy (n=1)	• Observation is that group [as bisexuals] doesn't comprehend or worry about the impact of the pending administration.

FG 2:

Data unit	Supporting evidence
Bi-Confidence (n=2)	• As he gets older he doesn't feel that identity is an issue. Doesn't need a label. When he views himself he doesn't see sexuality? "I am ME" • Doesn't use labels either. It is society that likes to label. Is not ashamed. Does what make him happy.
Social bias (n=1)	• Being bisexual has made him realize that the world is very "biased, prejudiced and judgmental". You'll always find somebody who will look down on you regardless of your lifestyle choices.
Being boxed by categories (n=3)	• Society puts everybody into distinctive boxes. They don't see bisexual. They see that you are either straight OR gay. Black or white. Many people assume it's impossible to have both ways.

	• *Double standard*- straight men are allowed to be *secretly* “curious”. But once you identify as bisexual you are permanently placed into the homosexual category even if you still like women. • “Why can’t people just be people? Why do we have to label by sexuality? It’s nobody’s business what goes on behind closed doors.” Everybody should just be nice to everybody. Hates labels.
Bi-disclosure with healthcare providers (n=2)	• Most of group admits that they do not reveal that they are bisexual to healthcare providers. Finds it to be irrelevant. • The group agrees that you would need to disclose more to your healthcare provided due to your sexual experiences.
New category (n=5)	• Finds that people have begun calling themselves pansexual in recent years because bisexual has a negative connotation even though they essential have the same meaning. • Believes that there is no such thing as straight. Everybody is at least a little bit curious which in her opinion makes them secretly bi-sexual even if they don’t act upon. • Within the walls of the prison system anything can happen. • The group agrees that when it comes to bisexuals the definitions are thrown out. • Referred to sexuality as ying/yang. A little masculinity in every woman and a little femininity in every man?
Bi-shame (n=9)	• Thinks bisexuality and homosexuality is wrong. • One group member stated that he will not be bisexual forever. He will eventually give it up. • White people don’t care but Black People view it as Demonizing. • Harder to be bisexual and Black. • Bible belt black people just don’t want to deal with it. • Feels a lot of shame and pain. Prays every day to be accepted. • Visibly upset. Feels it [bisexuality] is wrong and seems very sad. “The bible says it’s wrong” (Puts head down in shame). Says his mom and grandma said it’s wrong. • The older [focus group] participants often (but not always) feel the less comfortable in their sexuality? • Understands the feeling of shame [of bisexuality] but feels like it is an addiction just like a drug. Hard to quit as much as you might want to.
Bi-resilience (n=5)	• God does not make mistakes. If this is who you are than it is who you were always meant to be. • Group seems to have very high resilience over all. “Who cares what the world thinks” but are also thankful that society as a whole is more accepting of nontraditional sexualities nowadays. • Self-esteem on being bisexual and or gay and society is high. • If you’re comfortable with yourself who cares what anybody else thinks. • “Follow your heart and do what makes you happy”.

Bi-identity (n=5)	• Bisexuality doesn’t have a look. • Bisexuality has no set image. Scares people because it is impossible to identify. “Often times people will meet a gay individual and think they can tell. But bisexuality is different.” You could have friends that are bisexual and not even know it which it is why makes some people nervous. • Acceptable: Women being bisexual. Viewed as sexy. • Unacceptable: Men being bisexual. • Feels deeply uncomfortable with his sexuality. Bible says NO
Community connectedness (n=4)	• Group agrees that true bisexual clubs do not exist as they do for the straight and gay communities. • Many agree to have frequented swinger’s clubs as the best way to meet other bi-sexual friendly people. • Meets new friends at swinger’s club. • Richer people have more freedom to explore their sexuality - to explore swingers clubs etc. Poor people don’t even have the freedom or means to find clubs. “If you live down in the hood how are you supposed to get up to Buckhead/Midtown where all the gay clubs are?”
Social acceptance (n=3)	• There is a generational gap because people are much more accepting now. • Feels that the upper/middle class is more accepting because the lower class is historically and still more oppressed so feels the need to oppress others – i.e. LGBT community. • The younger generation it’s more acceptable to be bisexual.
Bi-inclusive Policy (n=3)	• Hard to implement policy changes to help bisexual community because most people who are bi do not self-identify. • Finds that the bisexual gets lumped in [into policies] as a small part of the LGBT and is largely neglected. • Most bisexuals don’t want you to know. As [former participant] says above… hard to implement change when people don’t self-identify.

Observational Summary: Below is a summary of the unitization of the data from the actual observational notes taken during each focus group. The unitization of the data was based on Lincoln’s data analysis process. 11 unique data units emerged from the observational notes with a total of 60 significant statements (FG1 18, FG2 42). Here is a brief summary:

◆ The supporting evidence text below illustrates that there is conflict on how society views bisexuality. There is an inherent social conflict and tension to understand how coupled and gendered relationships should occur. Bisexuals just view people as people. Some think that bisexuality is immoral and wrong. These feelings are driven in part by religious beliefs and how bisexuals cannot make to their minds about who they are.

- At times participants expressed emotional responses in how shame and secrecy for not being open about their sexuality affects their self-esteem.
- There is a level of an intertwined identity merger between HIV and bisexuality. Once there is bisexual disclosure to medical providers, then there is a "procedural" step to have individuals tested for HIV.
- Bisexuality is swallowed into a larger LGT identity. There is some resentment about this.
- Some participants are not afraid to share with their medical provider that they are bisexual. Some armor hesitant, while other never disclose.
- Where bisexuals meet other bisexuals are in sex clubs. There was a sentiment that there are no bisexual social spaces.

Part Two: Situational Analysis – subtheme exploration

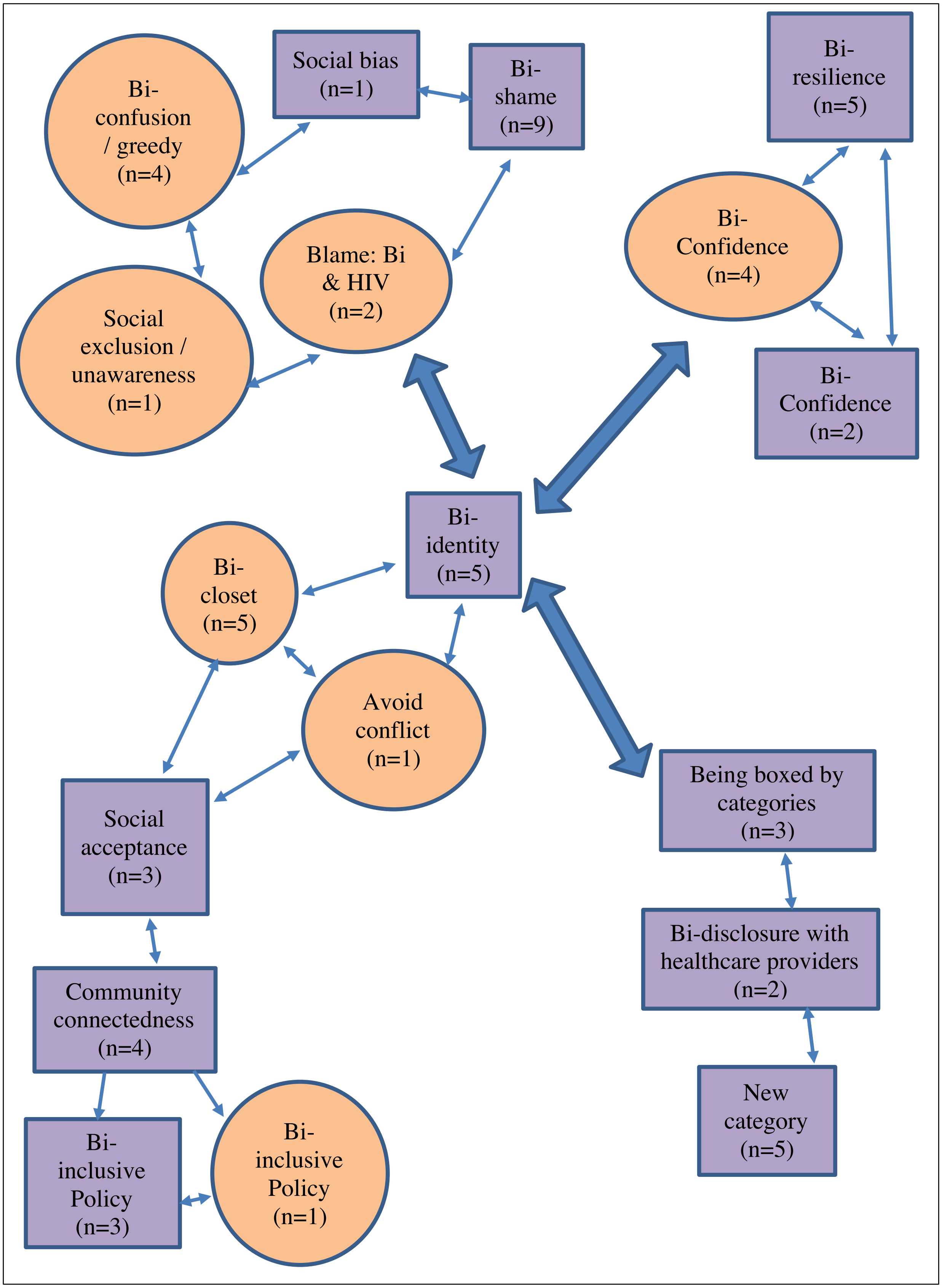
On the following page, is a cartographical depiction of how the 11 data units. With situational analysis, the analyst constructs the situation (or visual map) of inquiry empirically. This visual map is a way to understand the elements (11 data units) and their relations to one another.

Situational Analysis Summary:

- Data elements for FG1 are denoted by circular objects. The rectangular boxes are data units for FG2. The data is centered on bisexual identity.
- There are two clusters located in the upper left and right corners describe positive and negative consequences (Bi-confusion compared to confidence, etc..) of being bisexual. There is a heavy leaning on negative impacts of being bisexual.

- Being bisexual can result in the Bi-closet or Avoid conflict by not disclosing one's sexual orientation – which can impact social acceptance, community connectedness, and policies that are bisexual inclusive.
- The conflict of the bisexual label was tested among the focus group participants. Participants felt that they were restricted to one label. This label constraint is manifested in how healthcare limit sexual identity to LGBT only. The focus group participants call for new categories.
- This situational analysis is aligned with data from the two focus groups.

Data visual map: Circular objects are FG1, and rectangular boxes are FG2



Research memo #3: FORECAST planning memo

Background:

This memo documents the process in how Question 3 was analyzed - How do local level healthcare providers interpret Federal CLAS Standards and what implications does this have for health care utilization and access by the bisexual population? This memo will

State adoption process of CLAS Standards: Massachusetts, Delaware, Georgia, California, and Nevada are diverse not only in population but also how the CLAS Standards have been implemented. Using Roger's Diffusion of Innovation (DOI) model, the chart below details how each state has attempted to adopt or implement activities related to bisexuality.

DOI Stage	DOI Description	States	Example of Justification
Innovators	The first states to try the innovation.	CA	Inclusion of bisexual data gathering at the local level (community assessments)
Early Adopters	States who represent opinion leaders. CLAS materials include how-to manuals and information sheets on implementation.	MA	State level training programs exploring sexual orientation data collection (Fenway)
Early Majority	States who adopt new ideas before the "average" states. States in this stage typically need to see evidence that the innovation works before they are willing to adopt it.	DE	Incorporated LGBT into both legislative and state level strategic plan focused on the CLAS Standards
Late Majority	States are skeptical of change and will only adopt an innovation after it has been tried by the majority.	GA	While there have been several failed legislative attempts, there is a state training program
Laggards	States are bound by tradition and very conservative.	NV	Besides incorporation of a state level strategic plan on the CLAS Standards, very little has been accomplished.

Justification to utilize the FORCAST model: Appendices C and D detail the outcomes of the FORECAST model. The FORECAST model allows to assess or evaluate prospectively activities or policies to better understand the impact at the local, state, and federal levels.

The chart located in Appendix C: *Detailed Inventory of Activities for State Level CLAS Standards*, details how the data was organized per state. The chart is detailing that data under three central categories: Planning, Policies, Collaboration; Training and Technical Assistance, and Dissemination. The CLAS Standards have been evaluated by the U.S. Department of Health and Human Services, Office of Minority Health. In 2016, HHS published the - *National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care: Compendium of State-Sponsored National CLAS Standards Implementation Activities*. This report was organized in three levels - Planning, Policies, Collaboration, Training and Technical Assistance, and Dissemination. Each category explores different sub-categories as noted below. Below is a list of categories and the activities recorded under each group:

- Planning, Policies, Collaboration
    - Strategic Plans
    - Partnerships/Task Forces
    - Needs Assessments
    - Policies, Procedures, and Regulations (specifically, laws)
- Training and Technical Assistance
    - Training
    - Technical Assistance
    - Provides grant funding
- Dissemination
    - Web development
    - Reports/toolkits
    - Newsletters/short pubs
    - Conferences/presentations
    - Videos/Non-print media

Appendix D: *FORECAST Model for CLAS Standards Inclusivity of Bisexuality*, details how the data was collected using the FORECAST model as a framework. It should be noted, the "Markers" are based on the HHS 2016 report - *National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care: Compendium of State-Sponsored National CLAS Standards Implementation Activities*. The "markers: utilized in the FORECAST model are based on these sub-categories (Strategic Plans, Partnerships/Task Forces, etc..). An abbreviated framework for the FORECAST model is: Marker, Measures, Source(S), and Meaning. In addition, I included a section (sexual orientation references each task) on bisexual references to assess the level of detail paid to bisexuality.

Utilizing the 2016 HHS evaluation report, the activities are the following:

- Development of planning committees
- Needs assessment
- Strategic plan
- State laws initiated
- Workforce development (training and technical assistance)
- CLAS dissemination / Dissemination tools

These 6 activities are a truncation of the 12 activities detailed in the 2016 HHS evaluation report. The activities listed under the category, Planning, Policies, Collaboration, remained unchanged. Training and technical assistance was combined into one activity: Workforce development (training and technical assistance). All the activities listed under the dissemination were collapsed to LAS dissemination/Dissemination tools. The truncation of these activities made it easier to evaluate the five states since not all activities were applicable to all the states.

APPENDIX B
CONSENT CONTAINING INTERVIEW PROTOCOL

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Title of the Research Study: Bisexual Acknowledging the Silence: Addressing the Health Disparities Access Issues for the Bisexual Population

Sponsor(s) of the Research Study: Atlanta Clinical Translational Science Institute (ACTSI), Community Engagement Research Program (CERP)

Principal Investigator(s) of the Research Study:
Carlos Pavao – data collection (co PI); Aniz Research and Evaluation, 404-918-4850
Zina Age – facilitator (co PI); Aniz, Inc., 404-521-2410
Faculty Advisor at Morehouse School of Medicine, Dr. David Levine, 404-756-1386

Invitation to Participate:
Please carefully read all parts of this consent form. Ask us about any parts or words that are not clear to you.

We invite you to take part in this research study because of your community expertise within the bisexual community. *We want to be a part of an Advisory Council to review and provide feedback on the development of a cultural competency training on bisexual health issues*. This Advisory Council will be a part of an interview process, and will cease to exist (and will not be reconvened) after this study is complete.

The purpose of this study is to build the capacity of medical and public health professionals to address health disparities in the bisexual community. With your feedback we will develop a training curriculum for medical providers. Once this curriculum is finalized it will be shared with Physicians for Reproductive Health's Adolescent Reproductive and Sexual Health Education Program (ARSHEP). ARSHEP has created open source a comprehensive, evidence-based curriculum for residency programs, providers, and other professionals who serve adolescents on critical reproductive and sexual health topics. ARSHEP works with a select group of physicians to give free educational sessions to other providers about the best practices for adolescent reproductive and sexual health.

Your feedback will ensure that culturally competent medical services can be provided to the bisexual community. This form is to help you decide if you want to take part. We will tell you about any special needs for you to be in the study. We expect about 30 people across metro Atlanta will be in the study for a series of interviews.

Information on the Research Project:
The purpose of this research is to examine the health disparities access issues for the bisexual population. With your assistance we hope to develop a training materials for healthcare professionals to provide culturally competent, bisexual-sensitive health access services. We have two aims for our study: (1) establish a Consumer Advisory Board to adapt and tailor an existing generic LGBT training materials designed for primary care professionals to be trained to become inclusive more bisexual health related issues; and (2): pilot test the bisexual health training with

Georgia primary care professionals and share the final bisexual health training with Physicians for Reproductive Health and Sexual Health Education to be disseminated to other states.

Explanation of Procedures*:* What we will ask you to do if you decide to take part in the study
To be eligible for the study, participants need to self-identify as bisexual and live within metro Atlanta.

During the interview, hand written field notes will be conducted, a recording device to record interview information. The facilitator will read from IRB approved questions to help guide the conversation. There will be two electronic recording devices (with extra batteries) in the event of a malfunction with the first during the interview. All electronic recordings along with any identifiable electronic participant information will be stored on a memory device that is password-protected external hard drive. This memory device will be stored along with the hand-written field notes in a locked drawer in my office desk at Aniz. All identifiable participant information and will be destroyed 7 years after completion of this study.

The interview process will be conducted at Aniz. If you need transportation costs please inform Carlos Pavao - data collection (co PI); Aniz Research and Evaluation, 404-918-4850 or Zina Age – facilitator (co PI); Aniz Prevention Programs, 404-521-2410. Carlos can also be reached at research@aniz.cm and Dina Delva, Facilitator, can be reached at prevention2@aniz.org or at 404-521-2410

To give you an idea of how the interview process will structured, there will be the following open-ended questions. The interviews are expected to last an hour. Additional probing questions will be asked at the researcher's discretion (with questions that have been approved by the IRB).
Introduction: Warm-up Questions & Background Question:

Can each of you tell the me your name (or what you would like to be called for today), what do you do for a living, and, and where you do live?

Main Interview Questions:

SOCIOECOLOGICAL MODEL

11. This first question is about your identity or who you are.
    i. Do you often feel that people do or do not fully understand what it means to be bisexual? Please Explain
    ii. What does bisexual mean to you as an identity?
        1. Do you use any other identities such as pansexual, straight, genderqueer, etc?
        2. How much does the bisexual identity matter in your social networks?
    iii. How does race and ethnicity factor into your bisexual identity?
        1. What comes first as the most important part of your identity, race or bisexual identity? Explain
    iv. Is there a difference between old and young bisexual people in how they self-identify?
    v. If you have been in other bisexual communities (outside of Atlanta), how do the bisexual community typically identify themselves?

For questions 3 to 7 – Based on the socioecological model:

12. Individual level:
    a. How does your bisexual identity impact your personal belief system (self esteem)?
    b. Do you feel the bisexual community is more at risk for healthy behaviors?
13. Intrapersonal level:
    a. Is there a difference between family and friends in how they perceive your identity? Explain
    b. Do you have an online identity profile? If so, how reflective does it mirror your personal identity? (e.g., you are pre op but online you are biological female or male) Why do you do this?
    c. How do your family and friends perceive your identity?
14. Community level:
    a. How important are your social networks?
    b. How do you think that organizations perceive your identity? Explain
    c. How connected do you feel with the non-bisexual community? Explain
15. Institutional level:
    a. Do you seek out organizations that are bisexual friendly? Explain
16. Policy level:
    a. How do you perceive the present national polices around bisexual identity? Are things getting better?

HEALTHCARE NEEDS

17. Has anyone had any negative issues in accessing health care services?
    a. <u>Probe:</u> Please explain with whom did you have a negative experience? Was the medical front line staff, the questions being asked on medical intake forms, or the medical provider (e.g., doctor)?
    b. In what ways do you feel that the health services fell short in helping you?

18. At this point we'd like to hear about the positive health services you have received.
    a. Please share where you all get the best health services?
    b. In what ways were the health services helpful to you?
    c. In what ways were these experiences negative or positive to you?

19. Now imagine that you are part of a committee of people designing a training for health care providers to promote and/or facilitate health access.
    a. What are the aspects do you feel clinicians need to know to make health access a positive experience for you?
    b. What do you think that clinicians should be aware of the bisexual population?
    c. What are the training learning objectives would you to ensure the clinicians would walk away with?
20. Is there anything else we haven't discussed yet that you think is important for healthcare providers to know about the bisexual population in accessing health services?

Potential Risks and Discomforts:

You may have some risks or discomforts while you are a part of this study. The risks to the subjects might include anxiety or emotional distress as a result of discussions of barriers to health access. The organization will be able to provide additional mental health and emotional support without costs to participants.

Potential Benefits: What you can expect from being a part of the study.
The benefits of the research would be to identify areas of support and culturally competent health access for the bisexual population. Your input will enable future health and medical care will be bisexual friendly. Upon completion of this this study, Aniz will provide a listing of bisexual friendly health and medical providers.

Financial Obligations: What you are responsible to pay.
There are no expected financial obligations from the participants. All visits used in this study will be provided to you free of charge.

Compensation for Participation: What you will receive for being in the study.
We will give you $20 for the interview. This is to repay you for the time you spend in the study, any inconvenience, and costs to you such as for travel and parking.

Assurance of Confidentiality: How research records and information about you are kept.
We cannot guarantee absolute confidentiality of information about you. We will not give out information about you to anyone without your written consent unless the law says that we must. We respect your privacy. We understand that the bisexual community is a small network with metro Atlanta. We will not tell anyone facts about you that might reveal you are in this study. We will do that in the following way.

At the beginning of the interview, we will reiterate that importance of creating a safe space to share ideas and thoughts that could enhance existing health and medical services. The interview will be recorded, we will ask you to create a pseudo name so that the no one outside of the interview can link your real name to your ideas and thoughts. We will not identify you in any way as being in this research in any papers in scientific or other journals. We will not identify you in any reports made on this research at scientific meetings.

The information from the interview will be recorded through note taking of direct responses and recorded for transcription for accuracy of verbal responses. Other than demographic data, no other information will be recorded. Responses will be shredded and audio recordings securely erased at the conclusion of the project. All audio recordings will be kept in triple-locked storage (Locked office, locked door, locked file draw/cabinet)

Emergency Care and Compensation for Injury: What happens if you should be hurt or become ill from being in the study.
We will provide care for you if you are harmed as a direct result of taking part in this study. Morehouse School of Medicine and/or sponsors of the study will pay for the cost of this care, if your health insurance doesn't cover it. However, Grady Health System has not set aside funds to pay for this care or to compensate you if a mishap occurs. Care for research-related injuries may include reasonable costs for hospitalization and treatment. We will not bill public programs like Medicaid for treating a research injury, unless the law allows it. No funds have been set aside to

pay for lost wages, pain or suffering that might result from research injuries. You do not give up any of your legal rights by being in this study. If feel you have been harmed, contact Carlos Pavao- data collection (co PI); Aniz Research and Evaluation, 404-918-4850 or Zina Age – (co PI); CEO of Aniz, 404-521-2410

Persons to Contact:
If you have any questions about the research project or in the event of a research related injury or emergency, contact Carlos Pavao- data collection (co PI); Aniz Research and Evaluation, 404-918-4850.

If you have any questions about your rights as a participant in this research study you may contact the Morehouse School of Medicine's Institutional Review Board. The Director is John Smith. He can be reached at 404-752-1973. The Chairperson is Rhonda Holliday, PhD. She can be reached at 404-756-5042.

If you have any questions, complaints, or suggestions about the research study, you may contact the Research Subject Advocate (RSA). The RSA is a representative for research participants. The MSM RSA is Jacquelyn Ali, MSA. She can be reached at 404-752-1140 or jali@msm.edu.

Voluntary Participation and Right to Withdraw from the Research Study:
You are free to join the study or not. You are also free to join the study and later decide to leave for any reason. If you decide not to take part in the research, you still keep all health care services that you would expect to get from the Morehouse School of Medicine. The same is true if you join and then later choose to leave. If you start in the study and later choose to leave, we will tell you about any other places where you can get the services you got through the study. We will also give you any information that may be important to your health. The same is true if the study staff needs to ask you to drop out of the study for any reason. You may be taking medicine(s) as part of this study. If so and you decide to leave, please do not stop taking your medicine before you tell the study doctors that you plan to withdraw.

New Research Findings: Information that may be important to you while taking part in this research.
We will tell you about any new information that we discover during this research so that you can decide if you want to stay in the research.

VOLUNTEER CONSENT STATEMENT

I know that taking part in this research study is my choice. I may choose to leave this study at any time, for any reason, or for no reason. If I decide not to stay in the study, I shall tell the doctor of this decision. I freely consent to take part in this research study conducted under the supervision of ________________________________. I know there may be some risks or discomforts to me. I have read about these risks in this form and they have been carefully explained to me. My participation in this research has been clearly explained to me. I have had the opportunity to ask questions about the study and have had time to decide to participate. My questions have been answered to my satisfaction. I know I am free to ask further questions about the study at any time. I have been told about the materials and procedures used in this study. I know what I am supposed to do in this research study. I understand I will receive a copy of this consent form.

I certify that I am at least 18 years of age (and, if female, I am neither pregnant nor breast feeding -- if applicable).

Name of Volunteer Printed

____

Date

____

Date

My signature as witness certifies that the research study has been explained to the patient/volunteer in my presence, that he/she appears to understand the information conveyed and that he/she signed this form by his/her own free will.

____

Date

or Authorized Personnel

In my judgment the patient/volunteer, having been fully informed of the research project described herein, has requisite capacity and is knowingly and willingly giving informed consent to participate in this research project.

<u>PLEASE KEEP THIS FORM IN A HANDY PLACE AND REFER TO IT FROM TIME TO TIME WHILE YOU ARE IN THE STUDY.</u>

LEGALLY AUTHORIZED REPRESENTATIVE CONSENT STATEMENT

I have read and understand the above informed consent document concerning this research study. I know that ___________________ who is my ___________________ does not have the ability to communicate or make decisions, at this time, regarding medical care and treatment and that I am making an informed substitute judgment in these matters. The experimental procedures and treatment have been explained to me and any questions I have asked have been satisfactorily answered. I understand that I am free to ask any further questions at any time. I understand that my signature acknowledges my good faith and belief that my ___________________ would want to participate in this research study and would voluntarily consent to do so if he/she were capable of understanding and communicating. I understand that in the event he/she regains the capability of communicating, that the research doctors will seek informed consent from him/her to continue his/her participation in this research. I am at least 18 years of age and bear the relationship to the patient so indicated on this form.

____
Date

____
Date

My signature as witness certifies that the research study has been explained to the patient/volunteer in my presence, that he/she appears to understand the information conveyed and that he/she signed this form by his/her own free will.

____
Date

In my judgment and belief, the legally authorized representative of the patient enrolled in this study, having been fully informed of the research project described herein, has the legal capacity and authority to authorize substitute consent and is knowingly and willingly giving this informed consent on behalf of the patient to be enrolled in this research project.

APPENDIX C

DETAILED INVENTORY OF ACTIVITIES FOR STATE LEVEL CLAS STANDARDS

Table 19 Detailed Inventory of Activities for State Level CLAS Standards

California Activities	**CLAS training legislation AND state-sponsored implementation activities** **State agency lead:** California Department of Public Health, Office of Health Equity CLAS initiative coordinator
Planning, Policies, Collaboration	
Strategic Plans	In 2014, California’s Statewide Plan to Promote Health and Mental Health Equity to outline priorities and goals targeted for implementation through 2019 In 2014, California Wellness Plan’s objectives to incorporate the National CLAS Standards in chronic disease prevention programs, processes, and publications (by 2018); increasing the percentage of persons who report that their health care provider always listens carefully and explains things so they can understand them (by 2020); and creating a statewide training and certification program for patient navigators (by 2020). DPH mandates that each county’s mental health department develop and annually update a Cultural Competence Plan to facilitate cultural competency at the county level, in accordance with the California Code of Regulations, Title 9 §1810.410 (9 CCR §1810.410). The Plan’s goal is to ensure the reduction of mental health service disparities 2010–2012 Cultural Competency Quality Improvement Strategic Plan, the Department of Alcohol and Drug Programs adopted a series of cultural competency goals and strategies
Partnerships/Task Forces	Cultural Competence Committee The Advisory Committee of the Office of Health Equity is integral in advancing the goals of the office and advises on the development and implementation of the office’s strategic plan and the National CLAS Standards. The Mental Health Services Oversight and Accountability Commission’s Cultural and Linguistic Competence Committee organizes and participates in activities to assess cultural and linguistic competency.
Needs Assessments	Group Needs Assessment (GNA) is conducted every 5 years 2016 Community Health Needs Assessment Kaiser Foundation

	Example: Perspectives on the Mental Health of LGBTQ Communities in Santa Clara County Needs Assessment Findings
Policies, Procedures, and Regulations (*specifically, laws*)	#SB 131 Pending: As of May 2016 Assembly Bill No. 496 Chapter 630 Passed: 2014 #AB 1195 Passed: 2005 #AB 801 Chapter 510 Passed: 2003
Training and Technical Assistance	
Training	Annual cultural competency training available.
Technical Assistance	UC Davis Center for Reducing Health Disparities *“Providing Quality Health and Health Care with CLAS* curriculum is an innovative program designed to help leaders in the health care industry develop comprehensive strategies to meet accreditation requirements and improve their quality of culturally and linguistically appropriate services.
Provides grant funding	
Dissemination	
Web development	Statewide website
Reports/toolkits	2011–2012 County Monitoring Annual Report DPH assessed to what extent each Standard had been implemented by counties and service providers In 2011, the California Department of Public Health’s Office of Multicultural Health created the “Providing Quality Health Care with CLAS Curriculum Tool Kit.” The toolkit includes both a Participant Workbook and Facilitator’s Manual designed to help organization leaders and program managers implement the National CLAS Standards by building upon existing infrastructure and mission values The toolkit program has three parts. The first part involves an anonymous survey to assess participants’ familiarity and comfort with the National CLAS Standards. In the second part of the program, participants attend four workshop sessions, each lasting 4 hours, in order to develop a quality improvement plan that incorporates one or more of the National CLAS Standards. After each session, participants are given assignments to complete before the next session. The third part of the program involves attending six monthly 1-hour follow-up sessions that help

	participants implement and maintain the CLAS quality improvement plan.
Newsletters/short pubs	
Conferences/presentations	
Videos/Non-print media	
Total	22

Massachusetts Activities	**CLAS training legislation AND state-sponsored implementation activities** **State agency lead:** Massachusetts Department of Public Health, Office of Health Equity CLAS initiative coordinator
Planning, Policies, Collaboration	
Strategic Plans	Making CLAS Happen: Six Areas for Action, a manual on providing culturally and linguistically appropriate services in public health settings Massachusetts Department of Public Health's Language Access Plan
Partnerships/Task Forces	Office of Health Equity established eight CLAS Initiative Committees (n=8) CLAS Coordinating Committee, working groups have been established as needed to carry out specific tasks and projects
Needs Assessments	Epidemiologic Trends in drug Abuse: Proceedings of the Community Epidemiology Work Group Community Health Needs Assessment Report and Implementation Plan 201416- Cape Cod Hospital and Falmouth Hospital
Policies, Procedures, and Regulations (*specifically, laws*)	#HB1948 Referred to committee
Training and Technical Assistance	
Training	CLAS trainings and presentations for internal and external groups and organizations. The CLAS Training Series provides information

	to various audiences (department staff, contracted vendors, community groups) on how to improve the quality of the services they provide to diverse members of the community.
Technical Assistance	
Provides grant funding	
Dissemination	
Web development	The Office of Health Equity also established a CLAS Initiative website to disseminate the National CLAS Standards and promote activities related to the CLAS initiative.
Reports/toolkits	Completed an internal CLAS Standards self-assessment in 2008 and 2011 Agency self-assessment
Newsletters/short pubs	
Conferences/ presentations	
Videos/Non-print media	The video, "Culturally and Linguistically Appropriate Services Standards: An Overview," is available on the Office of Health Equity website.
Total	20

Nevada Activities	**State-sponsored implementation activities** **State agency lead:** Nevada Office of Minority Health
Planning, Policies, Collaboration	
Strategic Plans	2011 biennial report the Nevada Office of Minority Health reported coordinating a 2009 cultural and linguistic competency strategic planning session in conjunction with the Southern Nevada Area Health Education Center
Partnerships/Task Forces	
Needs Assessments	
Policies, Procedures, and Regulations (*specifically, laws*)	
Training and Technical Assistance	
Training	The Nevada Office of Minority Health reported providing four National CLAS Standards trainings to 97 medical and social service providers in 2008 Conducted National CLAS Standards and cultural competency trainings with 125 providers in 2009
Technical Assistance	
Provides grant funding	
Dissemination	
Web development	Statewide website https://med.unr.edu/statewide/ahec
Reports/toolkits	
Newsletters/short pubs	The Nevada Office of Minority Health reported developing a National CLAS Standards and Civil Rights pamphlet in English and Spanish for distribution throughout all Women, Infants and Children (WIC) clinics in the state
Conferences/ presentations	
Videos/Non-print media	
Total	5

Delaware Activities	**State-sponsored implementation activities** **State agency lead:** Delaware Department of Health and Social Services, Division of Public Health
Planning, Policies, Collaboration	
Strategic Plans	2005 Infant Mortality Task Force (IMTF) Report recommended implementation of the National CLAS Standards as a necessary step to ensure equal access to care and improved patient participation in clinical decision-making In June 2010, the Healthy Mother and Infant Consortium presented the key findings in the Delaware Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS) Initiative Final Report.
Partnerships/Task Forces	Healthy Mother and Infant Consortium The Delaware Division of Public Health convened an internal committee to design a culturally competent public education campaign for health care providers in Delaware
Needs Assessments	
Policies, Procedures, and Regulations (*specifically, laws*)	
Training and Technical Assistance	
Training	In 2009-2010, the Healthy Mother and Infant Consortium held five cultural competency trainings as well as a series of focus groups with providers to determine the best way to implement the National CLAS Standards (n=5)
Technical Assistance	
Provides grant funding	
Dissemination	
Web development	The Delaware Office of Minority Health disseminates information about the National CLAS Standards on the Bureau of Health Equity website

Reports/toolkits	Tools are focused on medical provider education Oral Health Tool Kit. PEDS toolkit - DE Chapter of the American Academy of Pediatrics. Training and technical assistance was provided on multiple occasions to over 30 pediatric and family practices
Newsletters/short pubs	
Conferences/ presentations	
Videos/Non-print media	
Total	12

Georgia Activities	**Legislative activity for CLAS training** **State agency lead:** Delaware Department of Health and Social Services, Division of Public Health
Planning, Policies, Collaboration	
Strategic Plans	Peach State Health Plan Cultural Competency Strategic Plan 2017 (PDF) Peach State Health Plan Cultural Competency Strategic Plan 2016 (PDF)
Partnerships/Task Forces	
Needs Assessments	
Policies, Procedures, and Regulations (*specifically, laws*)	#HR 758 Failed: 2012 #HB 844 Failed (House Second Readers): 2010 #HB 943 Referred to House Second Readers: 2008 #HB 1401 Referred to House Second Readers: 2006
Training and Technical Assistance	
Training	The Health Initiative is a statewide CLAS focus training provider. Their funder is from ACA and fee for service trainings.
Technical Assistance	
Provides grant funding	
Dissemination	
Web development	Statewide website https://www.pshpgeorgia.com/providers/quality-improvement.html
Reports/toolkits	Cultural Competency Program 2017 Annual Evaluation (PDF) Cultural Competency Program 2016 Annual Evaluation (PDF)

	Cultural Competency Program 2015 Annual Evaluation (PDF) Cultural Competence Checklist (PDF) Interpreter & Translation Services PDF (PDF)
Newsletters/short pubs	
Conferences/ presentations	*Lessons Learned: Implementation of the National CLAS Standards In Behavioral Health* PPT *https://dbhdd.georgia.gov/sites/dbhdd.georgia.gov/files/related_files/site_page/Embracing%20Change%20and%20Opportunity.pdf*
Videos/Non-print media	
Total	14

APPENDIX D

FORECAST Model for CLAS Standards Inclusivity of Bisexuality

TABLE 20: FORECAST Model for CLAS Standards Inclusivity of Bisexuality

CLAS Planning, Policies, Collaboration		
MARKER[29]		
Development of planning committees		
MEASURES	**SOURCE(S)**	**MEANING**
CLAS coordinating committee	Agendas Meeting Minutes Attendance Records Membership Lists Committee reports	100% of the 5 states have a centralized planning committee. The typical committee names are Advisory, CLAS Coordination, or Consortium. 100% of the 5 states are located within Department of Public Health, typically Office of Health Equity (CA & MA).
Specialized committees	Committee descriptions Websites Strategic plans.	80% (CA, MA, DE, GA) have a centralized planning sub-committee. The typical committee specializations are mental health, substance abuse, or healthy mothers.
Sexual orientation references within the development of planning committees		

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[29] The "Markers" are based on the U.S. Department of Health and Human Services, Office of Minority Health 2016 report - *National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care: Compendium of State-Sponsored National CLAS Standards Implementation Activities*. There are three levels - Planning, Policies, Collaboration, Training and Technical Assistance, and Dissemination. Each category explores different sub-categories. The Markers above are based on these sub-categories.

<table>
<tr><td colspan="3">State committee:
CA: Several LGBT representations on Advisory Committee. LGBT topical focus: data gathering, homeless youth, housing, or discrimination. No bisexuals identified/activities within (sub)committee(s) documents.
MA: A focus on the need for LGBT data collection. DPH has a LGBT Workgroup.
DE: The Delaware Healthy Mother and Infant Consortium (DHMIC) was established as successor to the Infant Mortality Task Force (IMTF). Only mention was anti-bullying programs for LGBT youth. No bisexuals identified/activities within (sub)committee(s) documents.
NV: Charted an advisory committee of experts.
GA: A cultural competency committee is established.
Subcommittees:
CA: This state has the most sophisticated committee infrastructure. Besides the CLAS planning committee, there is a statewide Cultural Competence Committee, and the department of Mental Health has its own CLAS related activities. The Cultural Competence Committee addresses sexual minorities.
MA: there are 8 CLAS related subcommittees to implement CLAS activities with some mention of LGBT populations.
DE, NV & GA: there are no CLAS specified subcommittees established.</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td colspan="3">CLAS Planning, Policies, Collaboration</td></tr>
<tr><td colspan="3">MARKER</td></tr>
<tr><td colspan="3"><i>Needs assessment</i></td></tr>
<tr><td>MEASURES</td><td>SOURCE(S)</td><td>MEANING</td></tr>
<tr><td>Statewide assessment</td><td>State level needs assessment reports</td><td>40% (CA & MA) of the 5 states have a robust needs assessment process.
CA: The statewide needs assessment is general in nature. The reports focus on racial and ethnic communities, from Hispanics to Russian language.
MA: utilizes various DPH needs assessments to formulate a CLAS wider needed assessment process.</td></tr>
</table>

LGBT focused – district level	District level needs assessment reports	40% (CA & MA) of the 5 states have a detailed district level needs assessment process focused specifically on LGBT health. CA: there are 78 health districts. The district needs assessment either focus on LGBT or highlight LGBT health disparities communities. The 2 highlighted here are just an example. There are transgender-specific highlights, but bisexual is included in the LGBT identity. MA: there are 27 Community Health Network Areas and many highlight LGBT health disparities. The 2 highlighted here are just an example - Epidemiologic Trends in drug Abuse: Proceedings of the Community Epidemiology Work Group and Community Health Needs Assessment Report and Implementation Plan 201416- Cape Cod Hospital and Falmouth Hospital.
Bisexual references within needs assessment		
No bisexuals identified/activities were mentioned in the reports. Bisexuals were included within the LGBT identity construct. NV, DE & GA: did not have state level needs assessments available.		
CLAS Planning, Policies, Collaboration		
MARKER		
Strategic plan		
MEASURES	**SOURCE(S)**	**MEANING**
Mission and Goals	State level strategic plan mission and goals statement	All 5 states (100%) have a strategic plan that includes measurable objectives, mission, and goals. The mission and goals reflect national CLAS standards. The mission and goals are state specific modified CLAS goals.

State Level Support	Strategic plan	100% (CA, MA, NV, & DE) have a documented state level support. CA: The California Statewide Plan to Promote Health and Mental Health Equity is the first biennial report of the new Office of Health Equity (OHE), established in 2012 under the California Health and Safety Code Section 131019.5. California Health in All Policies (HiAP) Task Force, which is made up of 22 state agencies, departments, and offices and is charged with identifying priority programs, policies, and strategies to improve the health of Californians while advancing the goals of the Strategic Growth Council (SGC). Local level grants were developed to address environmental health. CA would cite MA as an example of CLAS implementation. MA: The plan is largely based on the CLAS 15 Standards. There are 6 priority areas for MA: (1) Foster cultural competence; (2) Build community partnerships; (3) Collect and share diversity data; (4) Benchmark: plan and evaluate; (5) Reflect and respect diversity; and, (6) Ensure language access. The plan focuses on LGBT safe spaces. Local level grants were developed and integrated with local level Community Health Network Areas. NV: The Nevada State Legislature created the Nevada Office of Minority Health (NOMH) in 2005. The duties of the Office are established in NRS 232.467-484. Local level grants were developed to implement and evaluate evidence-based interventions that will decrease the risk of developing diabetes. DE: In 2005, the state legislature created the Delaware Healthy Mother and Infant Consortium (DHMIC) to narrow and/or eliminate racial and ethnic prenatal care differences. DE looked at MA to CLAS guidance. GA: The plan is not clear on state level support. The plan cites federal policies.
Charge to Develop Committees	Strategic plan Agendas Minutes	All 5 states (100%) have a planning or an advisory committee. CLAS Advisory Committees membership consists of health experts, advocates, clinicians, and consumers representing diverse vulnerable communities.

Develop Performance Measures and Sustainability	Strategic plan Agendas Minutes	All 5 states (100%) have a planning or an advisory committee. CA: The Healthy Community Framework, developed with input from the Task Force, has been incorporated into programs and reports such as the *2010 California Regional Progress Report*, which provides a framework for measuring sustainability using place-based and quality-of-life regional indicators. MA: Chapter 4 is a detailed plan for evaluation and sustainability. NV: The state is seeking additional federal money to sustain CLAS activities. GA & DE: Uses epidemiologic data as performance and evaluation measures.
Develop other state level reports and plans	Other reports	All 5 states (100%) have state level reports and plans CA is the example of numerous other plans developed. For example, Cultural Competency Plan mentioned that a cultural competence training focused on LGBTQ is available. MA, DE, NV, & GA cite other federal or other state CLAS reports.
Bisexual references within the strategic plans		
CA: focuses on LGBT youth and suicide. CA has data on anti-bisexual discrimination. The data reports, anti-gay (48.6%), anti-homosexual (36.3%), anti-lesbian (12.4%), anti-heterosexual (1.6%), and anti-bisexual (1.2%). The strategic plan cites possible measurement error, small sample size, and social stigma for the low anti-bisexual data. Rates of bisexual suicidal thoughts among adults (bisexual 28.4%, Gay/Lesbian 22%, Other 9.5%, Straight 8.7%). Bisexual as an identity construct is defined as "persons who experience sexual attraction toward and responsiveness to both males and females" (p.94) This definition was provided by the CA Department of Justice. MA: There is no specific bisexual data / activities. The plan focuses on safe spaces, re-enforcing federal laws that protect LGBT persons. NV: There is no LGBT nor bisexual mentioned within the report. For example, Nevada defines health disparities focused on racial and ethnic minority populations. DE: Only mention was anti-bullying programs for LGBT youth. No bisexuals identified/activities within (sub)committee(s) documents. GA: There is a general plan for LGBT cultural competency training activities.		
CLAS Planning, Policies, Collaboration		
MARKER		

State laws initiated		
MEASURES	**SOURCE(S)**	**MEANING**
Passed laws	State laws/statutes	20% (CA) have passed laws. CA: (3) AB 496: Year 2014. Physician and surgeon is required to demonstrate satisfaction of continuing education requirements. This bill allows would authorize the accrediting associations to update cultural competency compliance standards. AB 1195: Year 2005. Continuing medical education courses include curriculum in the subjects of cultural and linguistic competency in the practice of medicine. AB 801: Year 2003. This bill is focused on licensed Physicians and Dentists from Mexico Pilot Program, which would allow licensed physicians and dentists from Mexico to practice medicine or dentistry in California for a period not to exceed 3 years. This bill would also allow for a cultural competency training for this program.
Pending bills	State bill	20% (CA) have pending laws. CA: (1) SB 131: Year 2016. The San Joaquin Valley is disproportionately affected by the state's physician shortage. This bill would allow for the University of California system to support expansion of the San Joaquin Valley Program in Medical Education.
Failed bills	State bill	20% (GA) have failed bills. GA: (2) HR 758: Year 2012. 758 contains in essence the language of previous bills. HB 844: Year 2010. Building on the 943 and 1401bills, the revised bill is a mirror image of 1401.

<table>
<tr><td>Referred to readers</td><td>State bill</td><td>40% (GA & MA) have bills referred to reader or committee review.
GA: (2)
HB 943: Year 2008. Require continuing education in cultural competency for licensure of health care professionals every two years. This revised bill focused on how professional licensing boards may at its discretion require cultural competency training, while 1401 only referred to the licensing boards.
HB 1401: Year 2006. Require continuing education in cultural competency for licensure of health care professionals.
MA: (1)
HB 1948: Year 2015. Training and implementing health literacy in all Healthcare facilities, Pharmacies, and Health Centers, possible look at the one organization (western MA) that is actively doing health literacy in MA and develop on it.</td></tr>
<tr><td colspan="3"><i>Bisexual references within the state laws initiated</i></td></tr>
<tr><td colspan="3">MA: There is no mention on LGBT.
CA: All bills refer to culture and cultural competency.
GA: All bills only refer to race, ethnicity and gender. There is no mention of LGBT populations.
NV & DE have no CLAS related bills or laws. CA seems to be the more proactive legislative system to reinforce existing state agency policies and activities related to cultural competency. GA attempts to pass CLAS related legislation is stagnant while MA recently attempted to pass a bill to disseminate community based best practice. The narrow definition of cultural competency is limited to race, ethnicity, gender, and language (health literacy). This constricted view is not reflective of diversity’s definition that incorporate sexual orientation and identity.</td></tr>
<tr><td colspan="3">CLAS Training and Technical Assistance</td></tr>
<tr><td colspan="3">MARKER</td></tr>
<tr><td colspan="3"><i>Workforce development (training and technical assistance)</i></td></tr>
<tr><td>MEASURES</td><td>SOURCE(S)</td><td>MEANING</td></tr>
</table>

Training	Strategic plan Agendas Minutes	All 5 states (100%) have some different levels of training available. CA offers annual cultural competency training available – online and face to face. CA has several training centers of innovation focused on LGBT communities (UCLA's Williams Institute, UCSF, etc..). MA offer a CLAS Training Series on how to improve the quality of the services they provide to diverse members of the community. An example of a training center is Fenway Community Health Center, an ACA funded center. NV provided four National CLAS Standards trainings to 97 medical and social service providers in 2008. In 2009, 125 providers received CLAS related trainings. DE conducted five cultural competency trainings. GA's The Health Initiative is a statewide CLAS focused LGBT training provider.
Technical Assistance	Strategic plan Agendas Minutes	40% of the 5 states have funded technical assistance centers related to the CLAS standards. CA: UC Davis Center for Reducing Health Disparities *"Providing Quality Health and Health Care with CLAS* curriculum is an innovative program designed to help leaders in the health care industry develop comprehensive strategies to meet accreditation requirements and improve their quality of culturally and linguistically appropriate services GA: The Health Initiative is a statewide CLAS focus training provider. Their funder is from ACA and fee for service trainings and technical assistance.
Bisexual references within workforce development		
60% - 3 out of the 5 states (CA, MA, GA) have CLAS trainings related to LGBT populations. The limitation of this study is not able to assess the training fidelity, accurate participation rates and number of providers participating in training activities.		
CLAS Dissemination		
MARKER		
CLAS dissemination / Dissemination tools		
MEASURES	**SOURCE(S)**	**MEANING**

Website development	Website	All 5 states (100%) have state sponsored CLAS website.
Reports (Quality Control focus)	Agendas Minutes Reports	40% of states (CA & MA) have completed quality control reports MA: completed evaluation reports Cultural Competency Program 2017 Annual Evaluation (PDF) Cultural Competency Program 2016 Annual Evaluation (PDF) Cultural Competency Program 2015 Annual Evaluation (PDF) Cultural Competence Checklist (PDF) Interpreter & Translation Services PDF (PDF) CA: evaluation reports 2011–2012 County Monitoring Annual Report DPH assessed to what extent each Standard had been implemented by counties and service providers
Toolkits	Agendas Minutes	60% of states (CA, MA, & DE) have various state centered toolkits CA: the toolkits are training focus on systems capacity building, health literacy, and cultural awareness 2011, "Providing Quality Health Care with CLAS Curriculum Tool Kit" In 2011, created by California Department of Public Health's Office of Multicultural Health. The toolkit includes both a Participant Workbook and Facilitator's Manual designed to help organization leaders and program managers implement the National CLAS Standards by building upon existing infrastructure and mission values. MA: the assessment tool kits are designed to build capacity Completed an internal CLAS Standards self-assessment in 2008 and 2011 Agency self-assessment DE: tools are focused on medical provider education Oral Health Tool Kit. PEDS toolkit - DE Chapter of the American Academy of Pediatrics. Training and technical assistance was provided on multiple occasions to over 30 pediatric and family practices

Other: Videos/ Non-print media, Newsletters	Website	40% (NV & MA) have developed CLAS related educational print material. The Nevada Office of Minority Health developed a bilingual (English and Spanish) pamphlet for distribution throughout all Women, Infants and Children (WIC) clinics in the state. Massachusetts developed a video, “Culturally and Linguistically Appropriate Services Standards: An Overview.”
Bisexual references related to CLAS dissemination / dissemination tools		
It is difficult to assess level of participation with the toolkits. It is more difficult to capture the network of collaborators. 100% of the states have formalized relationships with community level LGBT organizations. It should be noted that many of these organizations are AIDS Service Organizations. Some states are more explicit (CA & MA) than other states (GA, NV, & DE) with their formalized LGBT collaborations at the community level.		

APPENDIX E

(COREQ) & STANDARDS FOR REPORTING QUALITATIVE RESEARCH (SRQR)

Checklist aim: reporting of qualitative studies (in depth interviews and focus groups).

32-item COREQ checklist for bisexual study
(aka, for only for focus and interview data)

No. Item	**Guide questions/description**	**Response to questions/description**	**Justification/Supporting material(s)…**
Domain 1: Research team and reflexivity			
Personal Characteristics			
Interviewer / facilitator	Which author/s conducted the interview or focus group?	Interviews were conducted by PI, author of dissertation	IRB application
Credentials	What were the researcher's credentials? *e.g., PhD, MD*	Researcher is a doctoral candidate	OGAPS submitted dissertation proposal
Occupation	What was their occupation at the time of the study?	Doctoral student and community consultant	Pavao CV
Gender	Was the researcher male or female?	Cis-gender male	N/A
Experience and training	What experience or training did the researcher have?	25+ years public health practitioner, doctoral training, specialized training in Gender and Women's Studies	Pavao CV
Relationship with participants			
Relationship established	Was a relationship established prior to study commencement?	The bisexual grant was awarded to a nonprofit with the CEO being an African American bisexual woman with strong connections to the LGBT communities. I was hired as an evaluation consultant.	Grant proposal
Participant knowledge of the interviewer	What did the participants know about the researcher? *e.g., personal goals, reasons for doing the research*	As part of the IRB interview guide instrument, the study goal was introduced.	Focus group and interview transcripts

		In addition, I disclosed my sexual orientation. I mentioned I have bisexual friends who had difficulty in disclosing their own sexuality. I also mentioned I know bisexuals who lived as gay or lesbians rather than disclosing their bisexuality.	
Interviewer characteristics	What characteristics were reported about the interviewer/facilitator? *e.g., Bias, assumptions, reasons and interests in the research topic*	Biases disclosed: • I am not bisexual. • I have a gay male view of bisexuality. • My understanding of bisexuality has evolved to be more bi-inclusive. • My interest in bisexuality is to explore bi-phobia, both from gay and straight lens, and how biphobia impacts health access.	• Grant proposal • OGAPS submitted dissertation proposal • IRB application • Reflexive journal
Domain 2: study design			
Theoretical framework			
Methodological orientation and Theory	What methodological orientation was stated to underpin the study? *e.g., grounded theory, discourse analysis, ethnography, phenomenology, content analysis*	Focus group and interview approaches were utilized, using constructivist epistemology to analyze the data. The structuralist interactionist tradition was used to explore the different meaningfulness of bisexual lives in everyday situations, such as work, family, and neighborhood.	Dissertation methods section

		This tradition was supported by critical race and sexuality theories.	
Participant selection			
Sampling	How were participants selected? *e.g., purposive, convenience, consecutive, snowball*	A combination of snowball and purposive sampling approaches were utilized.	Dissertation methods section
Method of approach	**How** were participants approached? *e.g., face to face, telephone, mail, email*	Participant recruitment strategies were: Online social support groups (Facebook, MeetUp) Gay pride Craigslist Client referral process from several nonprofits	Dissertation methods section
Sample size	How many participants were in the study?	36 participants	Dissertation methods section
Non-participation	How many people refused to participate or dropped out? Reasons?	2 were excluded due to being under the influence of a substance	Dissertation methods section
Setting			
Setting of data collection	Where was the data collected? *e.g., home, clinic, workplace*	At a nonprofit, Aniz, Inc. Aniz is located in downtown Atlanta, GA.	Dissertation methods section
Presence of non-participants	Was anyone else present besides the participants and researchers?	During the focus groups, a social worker was present. In addition, one note taker was present.	Dissertation methods section

Description of sample	What are the important characteristics of the sample? *e.g., demographic data, date*	Of the 36 participants, 47.22% were in the 50-64-year age group, and 86.11% were Africans Americans followed by 8.33% that were White. The majority of the participants were Male (66.67% Male compared to 4% Female; 22.22% identify as part of the Transgender sexual identity umbrella (8.33% Transmale; 5.56% Transfemale; Transgender [Male to Female] 8.33%).	Dissertation methods section
Data collection			
Interview guide	Were questions, prompts, guides provided by the authors? Was it pilot tested?	Along with a copy of the consent form, a copy of the survey instrument was shared with the participants. The survey instrument was piloted internally at the nonprofit with bisexual clients.	Dissertation methods section
Repeat interviews	Were repeat interviews carried out? If yes, how many?	There was no need to conduct repeat interviews.	Dissertation methods section
Audio/visual recording	Did the research use audio or visual recording to collect the data?	All interviews were audio recorded.	Dissertation methods section
Held notes	Were field notes made during and/or after the interview or focus group?	Field notes were collected from 2 individuals who observed the focus groups. In addition, the interviewer kept a reflective journal – focus group and	Dissertation methods section

		interview notes were documented.	
Duration	What was the duration of the interviews or focus group?	Focus groups were between 1.5 to 2 hours. Interviews were 1 hour in length.	Dissertation methods section
Data saturation	Was data saturation discussed?	Data saturation was achieved.	Dissertation methods section
Transcripts returned	Were transcripts returned to participants for comment and/or correction?	A hard copy of the transcripts was emailed to the participants for comment and/or correction.	Dissertation methods section
***Domain 3:* analysis and findings**			
Data analysis			
Number of data coders	How many data coders coded the data?	There were 2 data coders. Carlos Pavao conducted the initial coding. James Doster, conducted verified the initial coding. Any discrepancies were deliberated.	Dissertation methods section
Description of the coding tree	Did authors provide a description of the coding tree?	The coding tree is provided in the focus group and interview reflective memos.	Dissertation appendix section
Derivation of themes	Were themes identified in advance or derived from the data?	Themes were derived from the data	Dissertation methods section
Software	What software, if applicable, was used	No. The data was analyzed through traditional sorting methods.	Dissertation methods section

	to manage the data?		
Participant checking	Did participants provide feedback on the findings?	Once the interviews were completed, the evaluation results (themes) [reflective memos] were shared with the nonprofit to share with the participants. There was no feedback nor clarifications needed.	Dissertation methods section
	Reporting		
Quotations presented	Were participant quotations presented to illustrate the themes / findings? Was each quotation identified? e.g., participant number	For the focus groups, participants had a random number assigned to them. For the interviews, the participants prefer to identify a pseudo name for themselves.	Dissertation methods section
Data and findings consistent	Was there consistency between the data presented and the findings?	Yes, there was consistency across all focus groups and interviews. The reflective memos detail how the data was analyzed.	Dissertation methods section Dissertation appendix section
Clarity of major themes	Were major themes clearly presented in the findings?	The reflective memos detail how the data was analyzed and depicting how the themes emerged from the data.	Dissertation appendix section
Clarity of minor themes	Is there a description of diverse eases or discussion of minor themes?	The reflective memos explore minor themes. Typically, minor themes were categorized as “other”.	Dissertation appendix section

Summary: COREQ checklist is a 32-item list. All items were addressed fully. The COREQ checklist has 2 limitations: (1) sexual orientation was not asked for but it is important factor in reflexivity, (2) when gender was asked for, transgender identity was not recognized – only Cisgender was acknowledged. Not transgender inclusive.

Citation: Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International journal for quality in health care*, *19*(6), 349-357.

Checklist aim: the standards for reporting qualitative research focus on a subset of qualitative data collection methods (e.g., interviews), but fail to explain how the author(s) developed the reporting criteria, narrowly construe qualitative research (e.g., thematic analysis) and in ways that may exclude other possible approaches.

Standards for Reporting Qualitative Research (SRQR): SRQR aims to improve the transparency of all aspects of qualitative research by providing clear standards for reporting qualitative research.
(aka, for the whole study)

No.	Marker	Marker description	Justification/Supporting material(s)…
Title and abstract			
S1	Title	Concise description of the nature and topic of the study Identifying the study as qualitative or indicating the approach (e.g., ethnography, grounded theory) or data collection methods (e.g., interview, focus group) is recommended	Justification: the title incorporates the population (bisexuals), the levels of analysis are based on and ecological framework to assess how the populations deals with health access issues (resiliency) Supporting material(s): Title page
S2	Abstract	Summary of key elements of the study using the abstract format of the intended publication; typically includes background, purpose, methods, results, and conclusions	Justification: The abstract is complete. Supporting material(s): Dissertation Abstract section
Introduction			
S3	Problem formulation	Description and significance of the problem/phenomenon studied; review of relevant theory and empirical work; problem statement	Justification: The phenomenon studied in context of relevant theory and supported by a literature review. Supporting material(s): Dissertation Chapter One
S4	Purpose or research question	Purpose of the study and specific objectives or questions	Justification: The 3 research questions are addressed. Supporting material(s): Dissertation Chapter One
Methods			
S5	Qualitative approach and research paradigm	Qualitative approach (e.g., ethnography, grounded theory, case study, phenomenology, narrative research) and guiding theory if appropriate; identifying the research paradigm (e.g., postpositivist, constructivist/ interpretivist) is also recommended; rationale	Justification: This study is an ethnographical approach with a case study looking at policy issues. Supporting material(s): Dissertation Chapters One, Two, Three, and Four

S6	Researcher characteristics and reflexivity	Researchers’ characteristics that may influence the research, including personal attributes, qualifications/experience, relationship with participants, assumptions, and/or presuppositions; potential or actual interaction between researchers’ characteristics and the research questions, approach, methods, results, and/or transferability	Justification: There were 3 reflexive memos: (1) focus groups, (2) interviews, (3) note take observations. In addition, a journal was kept throughout the life course of this project. Supporting material(s): Dissertation Appendix; reflexive journal
S7	Context	Setting/site and salient contextual factors; rationale	Justification: The general setting was Atlanta, Georgia. Atlanta has the highest concentration of LGBT population. Supporting material(s): Dissertation Chapters One, Two, and Three
S8	Sampling strategy	How and why research participants, documents, or events were selected; criteria for deciding when no further sampling was necessary (e.g., sampling saturation); rationale	Justification: The population was bisexuals. They are a hard to reach population, and often misunderstood as gay, lesbian or straight. The recruitment criteria: adults who are self-identified as bisexual. The criteria for further participant selection (sampling saturation) was to ensure gender parity. Initially mostly men were recruited. The research team developed targeted strategies to increase female representation. Supporting material(s): Dissertation Chapters One, Two, and Three
S9	Ethical issues pertaining to human subjects	Documentation of approval by an appropriate ethics review board and participant consent, or explanation for lack thereof; other confidentiality and data security issues	Justification: There were 2 IBS that have approved this study: Texas A&M University and Morehouse School of Medicine. Supporting material(s): IRB applications.

S10	Data collection methods	Types of data collected; details of data collection procedures including (as appropriate) start and stop dates of data collection and analysis, iterative process, triangulation of sources/methods, and modification of procedures in response to evolving study findings; rationale	Justification: Data collection procedures are detailed in the methods chapter. Supporting material(s): Dissertation Chapter One
S11	Data collection instruments and technologies	Description of instruments (e.g., interview guides, questionnaires) and devices (e.g., audio recorders) used for data collection; if/how the instrument(s) changed over the course of the study	Justification: Data collection instruments and technologies are detailed in the methods chapter. Supporting material(s): Dissertation Chapter Three
S12	Units of study	Number and relevant characteristics of participants, documents, or events included in the study; level of participation (could be reported in results)	Justification: Participant demographic data was detailed in the methods chapter. Supporting material(s): Dissertation Chapter Three
S13	Data processing	Methods for processing data prior to and during analysis, including transcription, data entry, data management and security, verification of data integrity, data coding, and anonymization/deidentification of excerpts	Justification: Data processes and procedures (transcription, data management and security, verification of data integrity, data coding, and anonymization/deidentification) was detailed in the methods chapter. Supporting material(s): Dissertation Chapter Three
S14	Data analysis	Process by which inferences, themes, etc., were identified and developed, including the researchers involved in data analysis; usually references a specific paradigm or approach; rationale	Justification: Data analysis) was detailed in the methods chapter. Supporting material(s): Dissertation Chapter Three
S15	Techniques to enhance trustworthiness	Techniques to enhance trustworthiness and credibility of data analysis (e.g., member checking, audit trail, triangulation); rationale	Justification: Trustworthiness and credibility was discussed at the end of methods chapter. Supporting material(s): Dissertation Chapter Three

Results/findings			
S16	Synthesis and interpretation	Main findings (e.g., interpretations, inferences, and themes); might include development of a theory or model, or integration with prior research or theory	Justification: Synthesis and interpretation was discussed in the methods chapter and supported by 3 reflexive memos and state CLAS data. Supporting material(s): Dissertation Chapter Three
S17	Links to empirical data	Evidence (e.g., quotes, field notes, text excerpts, photographs) to substantiate analytic findings	Justification: Thematic data is linked to evidence in the methods chapter and supported by 3 reflexive memos and state CLAS data. Supporting material(s): Dissertation Chapter Three
Discussion			
S18	Integration with prior work, implications, transferability, and contribution(s) to the field	Short summary of main findings; explanation of how findings and conclusions connect to, support, elaborate on, or challenge conclusions of earlier scholarship; discussion of scope of application/ generalizability; identification of unique contribution(s) to scholarship in a discipline or field	Justification: The implications, transferability, and contribution(s) to the public health field were addressed. Supporting material(s): Dissertation Chapter Three and Five
S19	Limitations	Trustworthiness and limitations of findings	Justification: The limitations of findings was discussed in the discussion chapter. Supporting material(s): Dissertation Chapter Five
Other			
S20	Conflicts of interest	Potential sources of influence or perceived influence on study conduct and conclusions; how these were managed	Justification: Potential conflicts were addressed. There were no conflicts of interests. Any biases towards bisexuals, or misconceptions, were addressed in the reflexive journal. Supporting material(s): Dissertation Chapter Three and Five; reflexive journal

S21	Funding	Sources of funding and other support; role of funders in data collection, interpretation, and reporting	Justification: Funding sources was address in the dissertation. Supporting material(s): Dissertation section - Contributors And Funding Sources

Summary: SRQR checklist is a 21-item list. All items were addressed.

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