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Depression and/or Oppression? Bisexuality and Mental Health

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Perhaps the most important, and consistent, finding in existing research on bisexuality is the fact that bisexual people are more prone to mental health problems than either heterosexual, or lesbian and gay, people. This article considers bisexual mental health from an individual, and a community, perspective. It asks how we, as individuals, generally understand mental health, and what ideas might be useful in relation to this. It also asks how the bisexual and wider lesbian, gay, bisexual, transgender, queer communities that we are located in can relate to the ways in which we engage with mental health.

KEYWORDS   bisexuality, activism, bisexual erasure, biphobia

INTRODUCTION

Perhaps the most important, and consistent, finding in existing research on bisexuality is the fact that bisexual people are more prone to mental health problems than either heterosexual, or lesbian and gay, people. This finding has been replicated across many different countries and contexts, as readers of this journal are well aware (e.g., Colledge, Hickson, Reid, & Weatherburn, 2015; Jorm, Korten, Rodgers, Jacomb, & Christensen, 2002; King & McKeown, 2003; Schrimshaw, Siegel, Downing, & Parsons, 2013). Therefore, in presenting a keynote talk (see acknowledgments) on bisexuality it seemed appropriate—even essential—to focus on issues of mental health.

My interest in this topic is threefold: First I am an academic who is interested in sexuality and mental health and have written on both areas over the last decade; secondly as a therapist I work with largely lesbian, gay,

bisexual, transgender, queer (LGBTQ) clients; and finally as an individual I have—perhaps inevitably given the aforementioned findings—struggled with these matters on a personal level, and within the bisexual and other sexual and gender communities that I am a part of.

This article considers bisexual mental health from an individual, and a community, perspective. It asks how we, as individuals, generally understand mental health, and what ideas might be useful in relation to this. It also asks how the bisexual and wider LGBTQ communities that we are located in can relate to the ways in which we engage with mental health.

I begin this article by exploring the common understandings of mental health that are out there in the wider culture in which bisexual individuals and communities are embedded. I then discuss the implications of what we know about bisexual people and communities for our understandings of mental health and how we engage with it. Following this I consider some of the challenges we face when shifting perceptions of mental health within bisexual and LGBTQ communities, if indeed that is something that we think would be worthwhile. Finally, I end with my suggestions for a potential way forward: a balance between resistance and compassion. The 'resistance' part of this refers to resisting current understandings of bisexuality and mental health. The 'compassion' part refers to cultivating kindness and care for ourselves as individuals, and within communities, where it is all too easy to end up contributing to each other's distress and poor mental health, rather than ameliorating it.

Common Understandings of Mental Health

A key element in popular understandings of mental health, which I have observed in my own therapeutic work and explored in various texts over the years, is the fact that these tend to be binary and internal (see Barker, 2013a; Barker, Vossler, & Langdridge, 2010). By 'binary' I mean that is generally agreed that either you are mentally ill or that you are mentally healthy. And by 'internal' I mean that distress is widely regarded as something that is caused by internal factors relating to you as an individual. Combining these elements puts people in the following double bind, when they are reflecting on their experiences of emotional struggles.

> *Either*
> I'm ill—I need help—it's not my fault
> *Or*
> I'm not ill—I don't get help—it is my fault

In the case of the former position, distress is regarded as something that is generally biologically caused that requires medical or other expert treatment,

but which we cannot be held personally accountable for. In the latter case, distress is regarded as caused by our own bad habits or personal deficiencies that we are responsible for having put in place, and need to get out of by strengthening our willpower or 'pulling our socks up.'

Clearly this binary relates to wider current cultural tendencies around the medicalization of distress (Kutchins & Kirk, 1997), and around neoliberal individualistic understandings of atomized individuals who have a personal responsibility to make themselves happy (Ahmed, 2010). Indeed histories of the self-help industry have highlighted a very similar binary between 'victimization' self-help (that argues that people are not responsible for their distress but rather are victims of disorders that are out of their control) and 'empowerment' self-help (which suggests that anybody can make themselves successful through positive thought) (Cherry & Barker, in press).

This binary tendency to regard distress—and many other aspects of human experience—as either biologically determined or a matter of total personal choice, is deeply problematic. I touch, here on three key reasons why I think this is the case.

Binaries put people in unhelpful double binds that exacerbate distress.   The first problem with the mental health binary for individuals is that it places them—or rather us—in a double bind. We become trapped in this because accepting one side inevitably involves denying the other one. According to the commonly-held model above either something is wrong with us that needs fixing, or we are to blame for our difficulties. Neither of these is a great outcome. Those who place themselves—or are placed by others—in the 'ill' category may well feel disempowered and as if there is nothing that they can do to improve their situation. Meanwhile, those who place themselves—or are placed by others—in the 'not ill' category may feel that they cannot admit to having any problems or get any support, and that they are completely responsible for their own happiness and well-being.

In addition to this, there is also a danger that whichever side of the binary we accept, the other continues to haunt us: we have to defend against it because it is out there in the popular imagination. So, for example, if we accept that we are ill we may well worry that somebody will discover that we are not really ill and we will be 'found out' for 'faking it' in some way. Popular discourses of benefit scroungers and people cheating on their 'disability' feed into this. If we accept that we are not ill, we often fear—on some level—that there really is something 'wrong' with us, and that we'll be exposed for being 'unwell' or 'crazy.' Either we are haunted by the guilt that we are not really ill, or we are haunted by the shame that we might actually be pathological in some way. Both options exacerbate the self-criticism and distress that are key features of mental health difficulties.

Given this situation, we may end up doing a good deal of emotional work attempting to prove that we are really ill, or that we are totally fine. We

may also find it difficult to see others who are on the other side of the binary. For example, if we regard ourselves as being ill we may struggle to read all of the posts on our social networking site about everything everybody else seems to be doing without such problems (forgetting that this is likely just the version of themselves that they feel able to express). If we see ourselves as not being ill, we may struggle to hear about other people who admit to their difficulties and get support because we are not getting that. Such tensions may well play out in communities where some are positioned as ill and others as well.

Both (biology/choice) options internalize experiences that are actually biopsychosocial. Another important problem with the binary is that both sides internalize distress that is either regarded as a matter of biology or of personal agency. In this way we have no choice but to assume that our problems are internally caused. Our only option is whether to regard them as caused by some illness (perhaps a genetic vulnerability and/or brain chemistry issue) or by a personal deficiency (such as bad habits, faulty thinking, or lack of moral fiber).

Such a way of understanding things goes against all the evidence in the psychological and therapeutic literature. It is generally agreed upon by all of my colleagues right across the spectrum from biological science through to cultural theory that human experience is complexly biopsychosocial. Certainly this is the case for distress such as depression, anxiety, and psychotic experience. So, for example, research into neuroplasticity and epigenetics demonstrates that while, of course, our genetic makeup and existing neural connections are involved in how we experience the world, it is also the case that what we learn as we grow influences how our brain wires up and how our genes express themselves (Carey, 2012; Davidson & McEwen, 2012). It is not simply the case that biological factors *cause* psychosocial experience, but rather there is an ongoing complex interaction between all three elements such that they cannot be disentangled, hence the one word: 'biopsychosocial.'

To exemplify this in relation to mental health, the evidence suggests that we each have some physical, perhaps genetic, vulnerabilities to experience distress in certain ways, for example, in terms of how we respond to threat. At the same time, social experience, such as growing up in poverty, or being the victim of discrimination, write themselves on our psychology and our biology in various ways through our thought patterns and the ways in which our neurons connect, for example. Thus biological factors are inextricably interwoven with the way in which we experience the world and the way in which it treats us.

Such internalizing detracts from the vital sociocultural context of distress. The important point here is that purely internal biological or 'choice' explanations are potentially highly damaging because they internalize what is actually—to a large part—external. This means that we blame ourselves

(either our bodies and brains, or who we are as a person) for distress which has at least some—and often a very large—social component and simply would not happen in a different cultural context.

Neither of the internal explanations has much sense of the impact of social experience on mental health. Even when this is acknowledged—for example, in relation to abusive childhoods or traumatic experiences—there is very rarely an acknowledgment of the impact of the wider social norms and cultural contexts in which mental health problems emerge.

This is a major oversight given that many writers on mental health view the kind of culture that we live in to be a major factor in increasing rates of mental health problems (e.g., de Botton, 2004; James, 2007). The French philosopher Michel Foucault (1975) famously used the analogy of Jeremy Bentham's panopticon prison for contemporary society. In the panopticon, any prisoner could be seen at any time by a single guard at the top of a central tower in the middle of a circle consisting of layers of cells. The fact that they could be viewed at any time resulted in prisoners monitoring their own behavior in case they might currently be being watched. Foucault argued that culture operates in this way through admonitions to self-improve, to work on the self, to present a positive, successful self to the world, and to police oneself at all times. This is embedded in consumer culture that encourages us to fear that we are lacking, and to buy products, read books, follow fashions, and so on to allay these fears. Makeover shows, self-help books, and beauty products are some of the more obvious examples of this. The relentless self-evaluation, toxic comparison, and defensive withdrawal that we are all embroiled in disconnects us from others and from ourselves.

We know that self-criticism is a—perhaps the—major component of most mental health issues. For example, probably the most common psychotic experience is that of hearing self-critical voices; depression is frequently characterized by feeling useless and highly self-critical; and anxiety is often about not trusting oneself in the world due to an overwhelming fear of failure and a vocal inner critic. As Gergen (2009) put it:

> I must always be on my guard, lest others see the faults in my thinking, the cesspools of my emotions, and the embarrassing motives behind my actions … I must worry about how I compare to others, and whether I will be judged inferior. (pp. xiii–xiv)

So this binary view of mental health as explicable through either individual pathology (illness) or choice is problematic for the following reasons:

1. It forces people into trapped either/or positions which separates out 'us' and 'them' when, in fact, we all suffer over the course of our lives.
2. It oversimplifies the reasons for distress despite the major problems in locating emotional experience solely within atomized individuals.

3. It internalizes what are often highly social forms of suffering in ways which exacerbate distress.

I now turn to what the study of bisexuality has to offer toward a better understanding of mental health.

Bisexuality and Mental Health

This section of the article is part of a broader trend in my research to counter common mainstream psychological attempts to explain 'difference' (e.g., why people are bisexual, nonmonogamous, trans, kinky, or asexual). I try to ask, instead, what can be learnt about human sexuality, and human being more broadly, through engagement with such experience.

In this section I consider what our knowledge about bisexuality from international research—as summarized in reports like *Bisexual Invisibility* (San Francisco Human Rights Commission, 2010) and *The Bisexuality Report* (Barker, Richards, Jones, Bowes-Catton, & Plowman, 2012)—has to offer for our understandings of mental health issues and our ways of relating to them. I suggest that there are two key implications: First bisexual experience reminds us of the social element to mental health problems mentioned above. Secondly, it opens up the potential for alternative understandings.

Reminding us of the social element.   As mentioned at the start of this article, the very clear main finding of overviews of the research literature is the higher rates of mental health problems (such as self-harm, suicide, and depression) among bisexual people than among heterosexual, or lesbian and gay, people. Virtually all studies on this, whether quantitative or qualitative, and across a range of countries and contexts, replicate this finding (though it is important to note that all studies have been within minority world countries that define sexuality as an identity in this way, and in relation to gender of attraction). Indeed it is often the 'B' in LGB that raises the statistics on mental health in studies which—as most of them do—do not separate out bisexual people from LGB people. A major problem is that the statistics on LGB mental health are used as the basis for arguing for services which are then overwhelmingly provided to gay men, or to LG people, in the 'scene' or 'community' rather than reaching the bisexual people who are struggling the most (Barker, Richards, Jones, Bowes-Catton, Plowman, & Yockney, 2012). There are similar problems in relation to LGBT research which fails to separate out trans experience.

The large-scale longitudinal studies have yet to be conducted that would enable us to conclusively point to the processes through which bisexual experience relates to poor mental health. However, from other research it seems likely that this is due to marginalization in general, and to the specific marginalizations faced by bisexual people.

In relation to the former point, we know that other marginalized groups are also more likely to experience mental health difficulties compared to groups who are less marginalized. Rates of mental health problems are higher among lesbian and gay people than heterosexual people, women than men, trans and nonbinary people than cisgender people, and people of color than White people within predominantly White cultures (see Barker et al., 2010).

In relation to the latter point, bisexual erasure/invisibility seems a likely candidate to explain the higher rates of mental health problems experienced in this group (Barker & Langdridge, 2008). We know that bisexuality tends to be erased by the common popular cultural assumption that sexuality is binary (people are either gay or they are straight). For example, there is minimal media representation of bisexual people, bisexuality is often depicted as a phase, past research has questioned the existence of bisexual men, and bisexual women are often dismissed as just titillating men (Barker, Richards, Jones, Bowes-Catton, & Plowman, 2012). Recent moves toward equal marriage often termed this 'gay marriage' evidencing the erasure of bisexual people in same-gender relationships.

Such erasure means that bisexual people have to engage in additional everyday emotional work (in common with other groups who go beyond binaries, like people of mixed race or nonbinary gender; Richards & Barker, 2013). This work involves constantly having to decide whether to challenge binary assumptions (through repeated recloseting and coming out) or whether to remain hidden (that involves its own stresses). Like the microaggressions also experienced by bisexual people from straight and gay communities (Bostwick & Hequembourg, 2014), such constant everyday emotional work seems likely to take a toll on mental health.

Therefore one thing that we can learn from bisexual people and communities in relation to mental health is that we really need to question the kinds of internal understandings of mental health problems mentioned previously. Bisexual research provides further evidence to support the likely key role of social aspects such as marginalization and lack of visibility.

Opening up alternative understandings.   We ended the bisexuality report with Rostosky, Riggle, Pascale-Hague, & McCants's (2010) research on the positive aspects of bisexuality because it is important not to paint a wholly bleak picture, but rather to also include research on what bisexual people have to offer. Participants in Rostosky et al.'s research spoke about the flexibility of being bisexual, their sense of authenticity, and the importance they placed on community and on being actively involved. Shiri Eisner (2013) also helpfully pointed out our tendency in bisexual communities to go through the 'myths' around bisexuality defensively saying why they are untrue, to try to prove how 'normal' we are really. Instead we might embrace those things and challenge the underlying assumptions that, for example, it is bad to be promiscuous (greedy) or uncertain (confused). The projects

of Rostosky et al. and Eisner alert us to what bisexuality has to offer and remind us to be cautious of emphasizing purely 'victim' narratives that may perpetuate the link between bisexuality and mental health problems.

So, instead of focusing purely on how troubling it is that bisexual people are so at risk of mental health problems, we can also ask what the ways of understanding people that we have in bisexual communities might have to offer in terms of how we engage with mental health.

Given that the problem with conventional understandings of mental health is that they are binary, bisexuality potentially to have much to offer, given the challenge that it poses to binary thinking. Also, compared to some gay movements, bisexual communities are often less attached to internal (biological) explanations of sexuality, meaning that bisexual people and communities are well placed to challenge the binary and the internal, thinking underlying current understandings of mental health.

In my (Barker, 2013b) book, *Rewriting the Rules*, I suggested that the fixed view we often have of our 'self' is problematic in terms of mental health, because we monitor that self, compare it against others, worry that it is flawed, and so on. If we see ourselves in different—more plural and fluid—ways it is possible to become more accepting because we can realize that we are not one fixed thing that remains the same over time: we can feel less stuck or trapped.

Again, bisexuality has a lot to offer in these areas given the embracing of multiplicity and fluidity in many bisexual communities. The attraction to more than one gender can enable some bisexual people to experience themselves as different selves in different relationships and situations (Richards, 2010), and the experience—of some bisexual people—that their sexuality shifts over time can enable them to experience themselves as more fluid (Diamond, 2009).

Thus, learning from bisexuality communities, we might move away from the fixed, static self of common understanding to open up less rigid ways of treating ourselves. I return to this in the consideration of self-compassion toward the end of the article.

Challenges Relating to Bisexuality and Mental Health

Despite these potentials I have been struck by a lack of critical engagement with mental health within the bisexual communities that I am familiar with. Bisexual people are often critical of the binary, fixed, internal explanations that others make of their sexualities, and sometimes genders. However, many still seem to view mental health as very much something that is binary and internal in the ways described earlier in this article. There tends to be little recognition, for example, that—like sexuality - mental health might be:

- On a continuum rather than binary.
- Something that shifts over time rather than a fixed aspect of who we are.
- Biopsychosocial rather than simply internally caused.

The prevalence of more common, less critical, understandings of mental health in bisexual (and LGBTQ) communities is, of course, understandings given that none of us can ever completely step outside of culture (Barker & Gill, 2012).

   More critical engagement with psychiatry and psychotherapy would, I think, be valuable within bisexual communities. For example, Walters, Plowman, and Whitehouse (2012) analyzed the classification of borderline personality disorder (BPD) in the American Psychiatric Association's *Diagnostic and Statistical Manual*. They found an overlap between the criteria for this 'disorder' and stereotypes of bisexuality, which is highly likely to result in an overdiagnosis of BPD within this community. For example, they point to criteria such as uncertainty around self-image, impulsive behavior, chronic feelings of emptiness, and intense unstable relationships. It would be easy for a practitioner who was unfamiliar with bisexuality to read bisexual identity as 'uncertainty,' to regard sex with more than one gender as impulsive, to misread societal erasure and alienation as internal 'emptiness,' and to regard bisexual relationships as 'unstable.' Indeed, we know from the research that a concerning proportion of practitioners view a client's bisexuality as an intrinsic part of any mental health difficulty that they might experience and consider conversion therapies (to straight or gay identities) (Page, 2007).

   My concern with the lack of critical engagement around mental health in some bisexual communities is that the dividing 'us and them' lines between the 'ill' and the 'healthy' will be maintained in problematic ways (see Johnstone, 2000). This may function to disempower and fix the 'ill': It might create a sense that those of us who struggle in various ways cannot do things for ourselves and will always struggle, and a paternalistic notion that we require the help of the 'healthy.' On the flip side, it may also silence and/or overburden the supposedly 'healthy': It might lead to a sense that those of us who resist applying labels to our distress or talking about it are not legitimate when we struggle, are entitled to the same kind of help, or that we should take on the burden of responsibility for everyone else.

Potential Ways Forward: Balancing Resistance and Compassion

In this final section of the article I want to consider potential ways forward in relation to mental health, for individual bisexual people and for bisexual (and wider LGBTQ) communities. Here I am arguing for a combination of resistance and compassion. By 'resistance' I mean addressing the social

aspects of our suffering directly. By 'compassion' I mean countering the strong self-critical element that is so common in our experiences of mental health difficulties.

Resistance.   bell hooks (1990) wrote that,

> understanding marginality as position and place of resistance is crucial
> for oppressed, exploited, colonized people. If we only view the margin
> as sign marking the despair, a deep nihilism penetrates in a destructive
> way the very ground of our being. (p. 207)

I think that hooks is saying that our options, when marginalized, involve seeing marginalization as a place of resistance, or regarding it as a marker of our pain that leads to hopelessness and risks exacerbating our suffering. This seems to point to the idea that it is valuable to resist the social messages that keep us oppressed or marginalized, because failing to do so can trap us in mental health problems and exacerbate distress.

This begs the question of what we can practically do to claim marginalization as a place of resistance. Suggestions include increasing bisexual visibility, affective activism, and mindful bi-furiosity.

Increasing bisexual visibility is one obvious answer to the problem of bisexual erasure. *The Bisexual Report* (Barker, Richards, Jones, Bowes-Catton, & Plowman, 2012) drew out recommendations for various sectors including education, health, workplaces, the media, and LGBT organizations about how they might increase the visibility of bisexual people in those arenas. Engagement with government, media, and other organizations seems to be resulting in a gradual increase in bi visibility (e.g., the inclusion of 'biphobia' alongside 'homophobia and transphobia' in some policies and campaigns).

Affective activism draws on the work of theorists like Sara Ahmed (2010) who have written compellingly on the relation between affect and power. For example, Ahmed pointed out the ways in which queers, women, and people of color may not have the same access to forms of 'happiness' that are related to normativities. She also highlighted the current problematic cultural demand to be happy. Katherine Johnson (Johnson & Guzmán, 2012) coined the term 'affective activism' to mean sociopolitical practices for reconfiguring gender and sexual relationships. For example, she visually captured the everyday experiences of LGBT people living with, and managing, mental health problems and suicidal distress. Photography exhibitions based on this work challenged stigma and created a dialogue between participants, photographers, and audiences, around vulnerability and support, and their involvement in psychological well-being.

'Bi-furious' was a phrase coined in bisexual activism as a resistant alternative to 'bi curious' (a phrase that is often used to undermine bisexual experience). I suggest that we might consider 'mindful bi-furiosity' as form

of bi-furiosity that is also mindful of where it is aimed and how it may be heard.

In terms of aim we might consider the notion of punching 'up' rather than 'down.' For example, one activist (Morgan, personal communication, September 25, 2014) spoke of ensuring that he was not critical of smaller organizations than his own on twitter, but only larger ones. We might even question whether it is necessary to 'punch' anybody at all! Perhaps we could become furious with the cultural message rather than the individual expressing it, though there it is important to balance this with not allowing institutional monosexism to become an excuse for individual biphobic behavior.

In terms of how our messages are heard, this points to the necessity to balance bi-furiosity with compassion, thinking about how we express furiosity, who to, and what it is may accomplish. For example, we might create supportive spaces with each other to express our furiosity and to consider how we will engage with others in ways that they will be able to hear. This was a key feature when presenting *The Bisexuality Report* (Barker, Richards, Jones, Bowes-Catton, & Plowman, 2012) to the U.K. government and LGBT bodies, as well as when writing a book for mental health practitioners about good practice across sexual and gender diversity, including bisexuality (Richards & Barker, 2013).

Compassion. Compassion is a vital balancing feature with resistance, or bi-furiosity, so that we can consider, for example, the potential impact of our message on the audience, which directions it is most fruitful and fair to focus our furiosity, and when we have the energy for activism and when we need to retreat and to look after ourselves.

In relation to mental health specifically, much recent work, from neuroscience through to psychotherapy and critical social theory, has emphasized the importance of compassionate treatment (Gilbert, 2010; Spandler & Stickley, 2011). This is because, as we have seen, self-criticism is such a key feature of most mental health problems. We criticize ourselves and withdraw from others through fear that they will see our vulnerabilities and perceived lacks, feeling under threat, defensive and protective. In common with older humanistic traditions, Gilbert's (2010) Compassion-Focused Therapy, and many of the other mindful approaches to psychotherapy (Barker, 2013a), advocate a shift from self-criticism and defensive responses to threat into compassion and soothing. Also, importantly, compassion for others and compassion for ourselves are regarded as being mutually reinforcing. So if we are trying to cultivate self-compassions we need to cultivate compassion toward others, and vice versa.

In relation to mental health problems in bisexual communities we need to seriously engage in community compassion. This is vital on in terms of increasing solidarity in the areas where we share experience, and increasing compassion in the areas where we differ (of course we always have shared

and different areas within any community or group of people). This counters the 'us and them' approach of 'ill' and 'healthy' that I mentioned earlier because it acknowledges that everybody is deserving—and requiring—of kind treatment.

I feel that this is vital at the moment because we often actually exacerbate each other's distress or mental health problems in a very real way. We bash up against each other, in conflict, leaving everyone feeling bruised, confused and betrayed, and perhaps reinforcing the ways in which we all criticize ourselves. This leaves us with less compassion for ourselves and for others, and with less capacity to engage in the kinds of resistance we have considered here. Of course, as writers such as Serano (2013) have emphasized, the fear of fragmentation in LGBTQ communities should not mean that we avoid difficult conversations (which leads to more silencing) or pretend that everyone is the same really. However, it does mean having such conversations with compassion on all sides.

There are a few common conversations within LGBTQ movements in which I am particularly aware of the need for compassion.

First compassion is vital in the common tendency to distinguish the 'real' or 'proper' LGBTQ people from the less so (not a very compassionate practice!) I would like to see LG groups particularly thinking compassionately about what it is like for BTQ people when they only speak of gay or LG issues, or homophobia, or ask questions about BTQ people that they wouldn't ask about LG people. Compassion is also important when they say that they include BTQ people, but it clearly isn't a priority (the phrase 'B-no' helpfully refers to the common tactic of referring to bisexuality in 'name only'). However, it is also necessary to cultivate compassion to understand where such approaches are coming from (see Barker, 2014), perhaps understanding the resistance to nonbinary sexualities when previous battles have been fought on the basis of binary sexuality, and the fear of 'getting it wrong' that can underlie tokenistic gestures. Similarly, within bisexual communities, we need to compassionately challenge implicit hierarchies that place 'proper' bisexual people above those who are regarded as somehow questionable (e.g., those who are dismissed as 'bi-curious'; Eisner, 2013).

Secondly, bi activist burnout is a very common phenomenon. Just ask BiReCon, BiCon, and BECAUSE organizers whether any of them will be doing it again! Much of this is due to the large quantity of criticism that such organizers tend to receive, and the lack of compassionate dynamics within organizing teams (who are often very under-resourced and unsupported). One year I endeavored to try to counter the overwhelming tendency for community organizers to receive far more criticism than they do appreciation. I ran a 'bi appreciation' workshop at UK BiCon that people could create posters about the people they appreciated in relation to their bisexual experience. Only one person came to that workshop! This may well be a sign of how deep rooted the lack of compassion is. Alternatively I am aware that

it may have been partially due to the fact that my workshop ran in parallel with a workshop about strap-ons!

Finally, Jamie Heckert and I have written about conversations relating to privilege which continue to be highly prevalent in LGBTQ communities (Barker & Heckert, 2011). Again, we are not suggesting a move away from resistance to just 'being nice' to everyone no matter how badly they behave. Rather we are suggesting a need to balance resistance with compassion in this area.

In LGBTQ, and perhaps particularly bisexual, communities, we are virtually all in situations of being in societally more privileged positions, and in societally less privileged positions. When we find ourselves in situations of wanting or needing to point out dynamics of privilege, power imbalance, oppression, or marginalization, to others who seem to be unaware of them, we could contemplate first how it is to be on the receiving end of such messages. This may help us to tailor the message that it can be heard and make a difference. Similarly, when we find ourselves on the receiving end of such messages—that we have been perpetuating such problematic dynamics, excluding others, or stigmatizing people—we might try not to respond in a habitually defensive mode. It is very tempting to react by denying that we did anything wrong, or by saying that we didn't mean it. Instead we might try to hear the other person's pain, to accept our role in it, and to consider the potentials for reparation in this case and/or future changes in behavior. Here again it is helpful not to fix ourselves as either 'good' or 'bad' individuals, but rather to recognize our multiplicity and capacity for helping and harming.

CONCLUSIONS

In conclusion I have argued, through this article, that current cultural understandings of mental health problems do people a disservice due to their presentation of mental illness/health as binary, and their internalizing what can better be regarded as biopsychosocial experiences. I have suggested that bisexual people's experiences have a lot to offer in this area, because they highlight the sociocultural elements of mental health problems, and because they call attention to the problems of polarizing human experience into binaries, seeking biological 'explanations,' and regarding identities as fixed and singular rather than fluid and plural.

However, I have also reflected that current understandings of mental health within bisexual spaces—online and offline—often echo wider cultural understandings rather than offering this valuable kind of critique. This risks perpetuating, and trapping, bisexual people in 'us and them' categories in relation to mental health.

It seems that, in responding to the high levels of mental health problems and distress among bisexual people, it would be valuable to bring together hooks's (1990) marginality-as-resistance with the kind of compassionate ethics of care currently being advocated by many across critical mental health and LGBTQ activisms (e.g. Serano, 2013; Spandler & Stickley, 2011). Combining bi-furiosity with compassionate communication could provide us with fruitful tools moving forward as we attempt to shift wider understandings of bisexuality and mental health, and to care for ourselves and others within the current structures and systems.

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