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Troubles with bisexuality in health and social care

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How to cite:

Jones, Rebecca L. (2010). Troubles with bisexuality in health and social care. In: Jones, Rebecca L. and Ward, Richard eds. LGBT Issues: Looking beyond Categories. Policy and Practice in Health and Social Care (10). Edinburgh: Dunedin Academic Press, pp. 42–55.

For guidance on citations see [FAQs](#).

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Version: Accepted Manuscript

Link(s) to article on publisher's website:

http://www.dunedinacademicpress.co.uk/search/category/Health_and_Social_Care

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Chapter 4. Troubles with bisexuality in health and social care

Rebecca L. Jones

Bisexual people use and work in health and social care services but are often even less visible than lesbian and gay people⁽¹⁾. In this chapter, I examine some of the reasons for this lack of visibility and argue that it is partly to do with the ways in which bisexuality is a particularly complicated and fluid sexual orientation category. I also illustrate some of the ways in which bisexuality matters and can be relevant in health and social care settings.

The category 'bisexual' frequently appears in the term 'LGBT'. This chapter begins by considering some of the effects of this inclusion in the wider category. I then move on to examine some of the different ways in which bisexuality has been theorised, before introducing some of the ways in which common features of bisexual identities trouble both health and social care practices and notions of the nature of sexual identities. These issues are examined through five case studies involving people who either identify as bisexual or who might be categorised by other people as bisexual.

The disappearing B in LGBT

These days, most organisations, campaigns and publications dealing with non-heterosexual people use the term 'LGBT' ('lesbian, gay, bisexual and trans' or sometimes 'transsexual'⁽²⁾). The use of this term would seem to indicate an awareness that non-heterosexual people are not just lesbian or gay, but also bisexual and trans.

However, the 'B' and 'T' in 'LGBT' often disappear in practice⁽³⁾, leaving the focus still on lesbian and gay people (Angelides, 2001).

For example, Stonewall, the campaigning organisation which works for 'equality and justice for lesbians, gay men and bisexuals' (www.stonewall.org.uk/) published a major report in 2008 titled 'Serves you right' (Hunt and Dick, 2008). This was the first national survey of LGB experiences of discrimination and 1,658 lesbian, gay and bisexual people in Britain took part. It undoubtedly constitutes an important piece of research. However, bisexual people keep dropping out of the picture. Although the authors state that lesbian, gay and bisexual people were surveyed, the report's subtitle is 'lesbian and gay people's expectations of discrimination' and the word 'bisexual' hardly features in the report. Similarly, another report from Stonewall, about lesbian and bisexual women's experiences of healthcare (Hunt and Fish, 2008) surveyed both lesbians and bisexual women. 16% of their more than 6,000 respondents said they were bisexual. The report talks about both lesbians and bisexual women throughout, but the recommendations at the end are things like 'understand lesbian health needs' and 'tell lesbians what they need to know'. Where did the bisexual people go?

Another way in which bisexuality 'disappears' is when famous 'gay' people who have also had significant relationships with people of another sex are cited. For example, Lord Byron and Oscar Wilde are frequently claimed to be gay, despite the fact that both also had significant relationships with women. Liberal Democrat MP, Simon Hughes, was described as 'secretly gay' and characterised as denying that he was gay by the *Sun* newspaper (Kavanagh, 2006) despite the fact that he consistently said he had had relationships with both men and women. While it is undoubtedly politically

important to say that famous people have same sex relationships, simplifying that to 'they are gay' ends up erasing the other-sex relationships, some of which seem to have been long-lasting, happy, sexual and important.

Why does this keep happening? There are several possible explanations, ranging from the relative political immaturity and hence invisibility of the Bisexual movement, to the history of the sometimes troubled relationships between bisexual people and gay people (Udis-Kessler, 1995), and especially between bisexual women and lesbians in the context of feminism (Armstrong, 1995; Hartman, 2005; Rust, 1992; Rust, 1995). 'The disappearing bisexual' has also been attributed to a wider pattern of fear and misunderstanding of bisexual people (Dobinson et al., 2005; Shokeid, 2001) which is often described as 'biphobia' (Mulick and Wright, 2002; Ochs, 1996; Ochs, 2007). An additional reason for the phenomenon of the disappearing bisexual, I want to suggest, is to do with the ways in which 'bisexual' is particularly complicated and troublesome as an identity category.

Different theorisations of bisexuality

Sexual orientation is commonly theorised in many different, often incompatible, ways and these different theorisations have major implications about how sexuality is researched and what conclusions are drawn (Kauth, 2005). Bisexuality, in particular, has been theorised in a range of ways. There is space here to give only a brief overview of the most important of these, in order to indicate how these theorisations have implications in the world of health and social care practice. (For more nuanced and sophisticated accounts of different theorisations of bisexuality and their

implications, see Angelides, 2001; Bowes-Catton, 2007; Carr, 2006; Kauth, 2005; Rodriguez-Rust, 2000). My intention is not to suggest that any of these theorisations is 'correct' or to be preferred, simply to indicate that they have different implications for what people mean when they talk about bisexuality.

Kinsey's famous studies in the 1940s and 50s (Kinsey et al., 1948; Kinsey et al., 1953) categorised people's sexual history according to a seven point scale:

Figure 4.1:

The Kinsey Scale

Rating	Description
0	Exclusively heterosexual
1	Predominantly heterosexual, only incidentally homosexual
2	Predominantly heterosexual, but more than incidentally homosexual
3	Equally heterosexual and homosexual
4	Predominantly homosexual, but more than incidentally heterosexual
5	Predominantly homosexual, only incidentally heterosexual
6	Exclusively homosexual
X	Asexual

Kinsey did not focus on questions of sexual identity but on how people behave and on their feelings and desires. As will become apparent, this can be a crucial distinction in relation to bisexuality. His scale has been used by later commentators to complicate the notion that people are either heterosexual, homosexual or bisexual, by using the scale to differentiate between degrees of bisexuality (points 1-5) and to argue that people do not have to be equally attracted to both same-sex and opposite-sex partners (point 3) to count as bisexual.

More recently, Fritz Klein developed Kinsey's work in his Sexual Orientation Grid (Klein, 1993). To fill it in, you put a Kinsey-type number into each box in the grid shown in Figure 2.

Figure 4.2:

The Klein Grid

		Past	Present	Ideal
A	Sexual attraction			
B	Sexual behaviour			
C	Sexual fantasies			
D	Emotional preference			
E	Social preference			
F	Lifestyle			
G	Self-identification			

This grid provides a way of looking at more aspects of sexual identity than Kinsey's original scale. It also distinguishes between past, present and ideal aspects. (For further discussion of the implications of using this sort of grid, see Klein, 1993). As Klein himself acknowledges, any measurement is unlikely to be exact because sexuality is complex (Petford, 2003). However, for our purposes here, the important thing to note is that the Klein grid complicates the question of what makes up a person's sexual identity and explicitly includes the person's self identification, as well as their behaviours and desires.

Klein also identified four main different types of bisexual people (Klein, 1993):

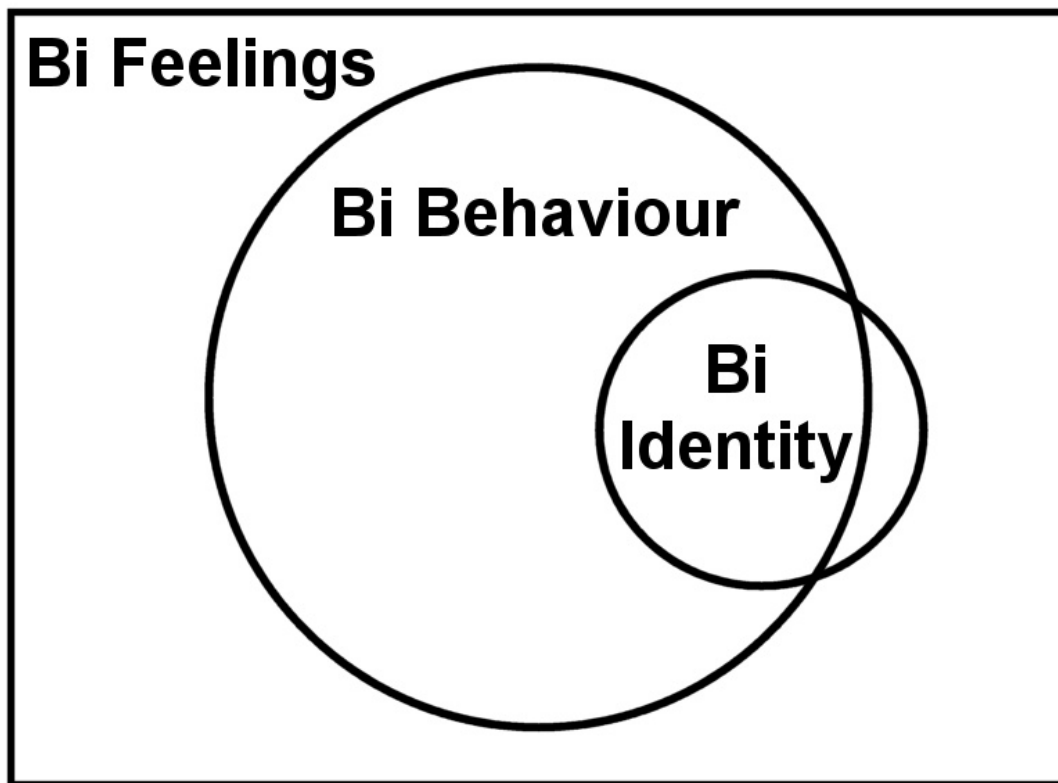
- transitional bisexuals – who are moving from a heterosexual identity to a lesbian or gay one, or, less commonly, from a lesbian or gay identity to a heterosexual one;
- historical bisexuals – who are now either homosexual or heterosexual but whose pasts include bisexual relationships;
- sequential bisexuals – who have had partners of different sexes at different times in their lifecourse;
- concurrent bisexuals – who are sexually active with both men and women in the same time period.

This typology makes it clear that people's sexual identities may change over the course of their lives. This means that a snapshot at a particular moment in someone's life may not yield the same identity as a lifecourse perspective.

Some theorists argue that 'coming out' is not a linear process that concludes when a person discovers their true and essential identity. They find that sexual identity change is much more common than is generally thought, both among bisexual people (Weinberg et al., 2001) and among the wider population (Diamond, 1998; Rust, 1993). Researchers such as Rodriguez-Rust argue that bisexual identity in particular can be a 'mature state of identity flux' rather than a fixed identity (Rodriguez-Rust, 2007: p. 4).

A final way of theorising bisexual identities is to draw a distinction between bisexual feelings, behaviours and identities, as in the following figure:

Figure 4.3:



It is a consistent research finding that many more people are attracted to people of different genders than behave bisexually, and that more people behave bisexually than identify as bisexual (Rodriguez-Rust, 2000). There is also a small group of people who identify as bisexual, perhaps for reasons of political or personal commitment, but do not behave bisexually. This diagram suggests the importance of distinguishing between which sort of bisexuality is in play in any particular situation, as will become apparent in the later part of this chapter.

Troubles with the category 'Bisexual'

Many commentators have noted that the category 'bisexual' is inherently troublesome in a number of ways. The word 'bisexual' implies that there are only two genders,

whereas some people who are attracted to people of more than one gender think of gender as a continuum, not an absolute (Barker et al., 2006; Ochs, 2007). Ochs found that as many as a third of her respondents (people who are attracted to both men and women but don't describe themselves as bisexual) said that they rejected the label 'bisexual' because it implied that there are only two genders (Ochs, 2007). The word 'bisexual' also implies that the division between men and women is the most important factor in sexual choice. Some people say that the gender of their sexual partners is irrelevant and that calling themselves 'bisexual' is therefore misleading (Barker et al., 2008).

Some of Ochs' respondents also rejected the label 'bisexual' because they felt it emphasised sex, not relationships, by having the word 'sexual' within it. They pointed out that the categories 'gay' or 'lesbian' do not emphasise sex in this manner (Ochs, 2007: p. 80). Other people argue that the term 'bisexual' leads to a binary understanding of sexuality where bisexuality is partly homosexuality and partly heterosexuality (Rodriguez-Rust, 2000: p. xvi), and would prefer to theorise it as a discrete sexual identity. However, while acknowledging these difficulties and complexities, I continue to use the category 'bisexual' as a useful umbrella term for people who experience attraction to people of both the same and other genders than themselves⁽⁴⁾ (Firestein, 2007: p. xx)

Case studies

In the case studies that follow, I focus on three ways in which common features of bisexuality can complicate notions of the nature of sexual identities, and how this can

have implications for health and social care. These are that, firstly, bisexuality is a particularly ‘invisible’ sexual identity – it is often overlooked as a possible sexual orientation and people are assumed to be really homosexual or heterosexual.

Secondly, people who have attractions to or relationships with people of the same and different genders than themselves, either at the same time or over the course of their lives, may not describe themselves as bisexual. Thirdly, non-mainstream relationship patterns are more common among bisexual people and this can have implications when they use health and social care services.

First, a word about the provenance of these case studies. They are not based on particular individuals who took part in research studies. Rather, they are composites, based on the findings of a variety of research studies and also on real life situations known to members of the UK bisexual community. All the case studies have been reviewed by at least 25 people who are active in the UK bisexual community and by UK academics doing research into bisexuality. This review process took place partly online and partly during a workshop at BiReCon 2008 - a conference for academics and practitioners held as part of the annual national bisexual gathering, BiCon 2008 (www.bicon.org.uk/). These reviewers helped refine the case studies and agreed that they are plausible, authentic, realistic and, in some instances, common.

Mel works in a care home for adults with severe physical and learning difficulties. She likes her job even though it is often extremely challenging and very tiring. She gets on well with most of her colleagues and they help each other to cope with the difficult bits of the work. She has been living with her partner, Cleo, since before she started this job. Her colleagues seem to deal okay with her having a female partner

and Cleo even went along to a few work socials with some of the other partners. After a difficult few months, Cleo and Mel split up and Cleo moved out. Mel was quite upset but some of her colleagues were supportive and helped her to come to terms with the break up. Mel's colleagues had assumed that she is a lesbian but she actually identifies as bisexual. She has never mentioned this because it didn't seem immediately relevant when she was seeing Cleo, and she was worried about how they would react. After a few months she started seeing someone else, Martin. Eventually her colleagues find out about her new partner. She picks up that there is a lot of gossip about her going around and a few people make jokey comments to her about her 'coming back to join us' and that all she needed was the love of a good man. One colleague says that she always thought Mel was really straight and it must have just been a phase she was going through. Mel starts to feel really uncomfortable at work and no longer feels supported by her colleagues when service users behave challengingly. In the end this leads to her leaving the job because she can't cope with its stresses when she is not feeling supported by her colleagues.

This case study exemplifies how people's lack of awareness of the possibility that someone might be bisexual can create difficulties for individuals. Bisexuality could be described as an invisible identity, in this sense. Mel's colleagues have assumed that she is a lesbian because she had a female partner and, when this relationship ends and her new partner is a man, they assume that she is now, or indeed always really was, heterosexual. Such assumptions are perhaps not surprising, given the prevalence of the idea that people are either heterosexual or homosexual and the consequent tendency to equate someone's sexual identity with their current relationship, if they are monogamous. As Ochs argues:

A quiet bisexual will be assumed to be either heterosexual or homosexual. To avoid being mislabelled, a bisexual woman must declare her bisexuality and risk being seen as aggressively and inappropriately flaunting her orientation. (Ochs, 2007: p. 76)

It is perhaps because she does not want to be seen to be making an unnecessary fuss about her sexual identity that Mel has let her colleagues assume that she is a lesbian. The comments her colleagues make about Mel 'coming back to join *us*', just needing to meet the right man, and positioning same-sex relationships as a phase, also highlight the latent homophobia of even workplaces that are apparently accepting of non-heterosexual relationships. The nature of Mel's work means that supportive and friendly relationships with colleagues are particularly important. These comments contribute to Mel's feeling that she is not accepted by her colleagues and her subsequent inability to cope with the challenges of her demanding job.

Greg has been seriously depressed on and off for years. He has tried various medical treatments with limited success. One time when he visited his GP, she suggested he try talking therapies and referred him on to a counsellor. Initially, Greg found the sessions quite useful. He felt he was discovering new things about himself and learning new ways of thinking about old problems. One time he mentioned that, although he has only ever had relationships with women, he has always been attracted to men too and sometimes looks at gay porn on the Internet. His counsellor seemed to consider this really significant but from this point on, Greg found their sessions much less useful. He felt as if the counsellor had decided that he is really gay and was trying

to get him to admit it to himself. Greg is quite comfortable with the fact that he is attracted to men but doesn't want to do anything more about it at the moment. He really likes women too and hopes to form another relationship with a woman in the future. He has never really labelled his own sexuality. Greg started to wonder whether his counsellor was right and he is 'really' gay and just not admitting it to himself. This made his depression get worse and he stopped going to see the counsellor, telling his GP that counselling just wasn't right for him.

However, a couple of years later, Greg made a new friend, Angus, who described himself as bisexual. Angus had also seen a counsellor for some years and said that this particular person was really good and had helped him to understand what it meant to him to be bi. Greg decided to give counselling another try and made an appointment to see her. This time it worked much better for him. He concluded that perhaps he was bisexual but that his bisexuality still wasn't an issue to him, and they didn't talk about it very much once he had decided that. However, this left him feeling free to talk about the issues that did underlie his depression. After some months, Greg found he was feeling considerably less depressed.

In this case, lack of awareness of bisexuality as a possible sexual orientation meant that something which was neither problematic nor particularly important to Greg was given an unhelpful significance by his first counsellor. His counsellor didn't seem to consider the possibility of bisexuality and certainly didn't mention it to Greg.

Research suggests that this is all too common (Page, 2007; Petford, 2003; Smiley, 1997). This lack of awareness of bisexuality as a possible sexual orientation is particularly significant given that there is some evidence of worse mental health for

bisexual adults than homosexual adults (Dodge and Sandfort, 2007; Jorm et al., 2002) and than the general population (Balsam et al., 2005).

Once he had found a counsellor who seemed to be more aware of bisexuality, and to accept Greg's own assessment that this wasn't the issue that underlay his depression, he was able to benefit from talking therapies. It should be noted that Greg's access to a counsellor with a better understanding of bisexuality did not come from health and social care services, like his first referral via his G.P., but from informal contact with someone who had an identity as bisexual.

Muriel is 78. When she was a girl she had a series of intense 'crushes' on older girls but she met her husband-to-be when she was 18 and quickly fell in love with him. They got married and had three children. When Muriel was in her early-30s, her husband divorced her.

When she was in her late-30s Muriel joined a women's consciousness-raising group. In the group she came across the idea of lesbianism, which she had never heard discussed before and she met a woman, Pat, who already identified as a lesbian. Muriel was strongly attracted to her and before long they had started a relationship. After Muriel's children had left home, they lived together for several years, and became a familiar couple on the local lesbian scene. Pat developed breast cancer and, after many difficult months, she died. Muriel got a lot of support from her circle of lesbian friends and from a local voluntary organisation which supported lesbians and gay men who had been bereaved.

Some months later, to her astonishment, she fell in love with a man, Colin. Her friends were very disapproving of her new relationship and gradually cut contact with her. The new relationship flourished, although Muriel recognised that she was still attracted to women too and missed her old circle of friends, especially as she was still grieving for Pat. She didn't feel able to keep using the bereavement service because she no longer seemed to count as a lesbian.

In the mid 1980s, Muriel came across the idea of 'bisexuality' and started calling herself bisexual. After some years, the relationship with Colin ended amicably and Muriel met another woman, Joan, and went back to thinking of herself as lesbian because that was Joan's identity and she expected this to be the final relationship of her life.

Last year Joan died and Muriel experienced some major health problems. She started receiving home care. She gets on well with one of her regular carers who asked her about the photos she had up around the house of her former partners. Muriel answers honestly but is horrified to discover later that her carer has spread malicious gossip among her colleagues about her past, saying that Muriel had been sexually predatory and promiscuous.

Over the course of a relatively long life, Muriel had relationships with both men and women. She identified variously as heterosexual, lesbian and bisexual. Such movements between identity labels are relatively common among women who have been sexually attracted to people of more than one gender (George, 1993; Ochs, 2007; Rust, 1995). Which identity she drew on at a particular time depended not only on

who she was in a relationship with, but also on the social circles she was moving in, the wider political climate and the ideas about sexuality to which she had access. Like Mel, Muriel found that the support available to her to help her cope with traumatic life events depended on her displaying an 'acceptable' sexual identity. When Pat died she needed a bereavement support service that understood the additional issues of having lost a same-sex partner, but she did not feel able to continue to use the lesbian and gay bereavement service because she was now in a relationship with a man. Since she did not have a social group who identified as bisexual or who were sympathetic to her bisexual identity, she only experienced support when she identified as lesbian or heterosexual.

Once Muriel started receiving health and social care services in her own home, her past relationships with both men and women became the source of unpleasant gossip among her carers, a problem also experienced by some of the participants in Dobinson, MacDonnell et al.'s (2005) study. People who behave bisexually are often seen as greedy, promiscuous and predatory, a phenomenon which is claimed to be part of a wider biphobia (George, 1993; Mulick and Wright, 2002; Ochs, 1996; Ochs, 2007).

Anne's first child, Luca, has been born six weeks early. Luca is in Special Care because of breathing difficulties and low birth weight. Anne has three partners, all of whom think of themselves as having a parental role – she is married to Jonti, Mark is the baby's biological father and Lara is also going to be extensively involved in bringing up the child. Lara was present at the birth but Mark and Jonti were not because the labour was very quick and they could not get to the hospital in time. The

Special Care Baby Unit has a policy that only parents can visit their children while they are on the Unit. The hospital has assumed that Jonti is Luca's father because he is Anne's husband. Anne is terrified about whether Luca is going to be alright and wants all her partners to see him so they will feel involved in his care and she will feel supported by their involvement. Lara was very moved by the experience of supporting Anne in labour and seeing Luca being born. She is now feeling bereft at him being taken away to somewhere she cannot see him. Mark is feeling angry about not being allowed to see his son, and is thinking of storming up to a nurse and shouting 'I am the father', but doesn't want to upset Anne by creating a scene. Jonti is longing to see Luca too, but feels a bit guilty that he should be the one allowed to visit when he is neither the biological father nor the person who was present at the birth.

Anne is in what is often described as a 'polyamorous' or 'poly' relationship – negotiated, consensual non-monogamy. Many bisexual people are monogamous, but poly relationships are more often found among people who identify as bisexual than among other groups (for further discussion, see Anderlini D Onofrio, 2004; Weitzman, 2007 and the special issue of the journal *Sexualities* (Haritaworn et al., 2006), so it can be an important issue for bisexual people using health and social care services. In this case, the hospital's definitions of who counts as a parent does not map onto the family's ideas and this creates unnecessary distress at what is already a stressful time.

Using case studies to explore bisexuality

In this chapter I have illustrated some of the ways in which bisexuality matters in health and social care settings. The case studies I have presented have emphasised some of the difficulties that may be experienced by bisexual service users and care workers due to others' lack of knowledge or unhelpful conceptualisations of what is meant by bisexuality. Change is needed at many different levels, from the strategic and organisational to the personal and emotional, if health and social care services are to be made accessible and acceptable to all people who have some relationship to the identity 'bisexual'. One important way in which care can be improved is by providing training and education to front-line care workers and their managers. Within a training and education programme, case studies such as these can provide a useful resource.

Summaries of people's experiences, based on real life, and presented in the form of a story can be a particularly effective way of presenting unfamiliar issues (Northedge, 2002). They can introduce a complex topic in a way that is unthreatening because it appears to be 'just about people'. They can provide concrete examples of apparently abstract issues which are grounded in everyday practice. They can provide a way of moving beyond fixed categories and thinking critically about them.

Case studies such as these can form the basis of discussion by asking participants to relate the stories to their personal experience and practice. Participants could address such questions as:

- Do you think the person in this case study would describe themselves as bisexual?
 - In what circumstances might it be helpful to use the word 'bisexual' to describe their identity?

- In what circumstances might it be unhelpful to use the word 'bisexual' to describe their identity?
- How could things have worked out better for the person in the case study?
 - What could the care worker involved have done to help?
 - What could the care organisation do to make a better outcome more likely?
- Have you ever met someone like the person in this case study?
 - In what ways was their situation similar or different to the case study?
 - What happened for them?
 - What did you do?
 - Is there anything you wish you could have done?
 - Are there any ways you could help there to be a better outcome next time you meet someone in this situation?

Conclusions

There are, of course, many situations in which bisexuality is non-problematic or beneficial in health and social care. In particular, care workers who identify as bisexual, such as Mel, may constitute a valuable resource within organisations, since they may have the skills and experience both to raise awareness generally of bisexual issues and to work sensitively with bisexual service users. They may also be well placed to work with both heterosexual and homosexual service users, since they may have a good understanding of a range of different social networks.

There are, nonetheless, situations in which bisexual practitioners experience problems in health and care settings due to a lack of understanding of bisexuality. Given the relative invisibility of bisexual identities, colleagues are likely to have wrongly assumed that an individual is either heterosexual or lesbian/gay, on the basis of a current partner. Such an assumption may be especially problematic given the emotional demands made on many front-line care workers in the course of their day-to-day work, which makes the support of colleagues particularly important.

Bisexuality is also relevant when service users either identify as bisexual (like Anne and her partners, and Muriel at some points of her life) or have some relationship to bisexuality without so identifying (like Greg, and Muriel at other points in her life). Service providers' lack of understanding of bisexuality can create real difficulties in making services accessible and appropriate for bisexual people.

While some of these difficulties can be at least partially addressed by training and general awareness-raising activities (for specific suggestions in relation to health, see Dobinson et al., 2005), I have also argued in this chapter that the relative complexity of bisexuality as an identity category makes this a more challenging task. How bisexuality is theorised affects how the categories work – at the most straightforward level, practitioners need to ask: are we talking about behaviour, identity or feelings here? The difference between these different theorisations of bisexuality can have major implications for service users and care providers. Someone who behaves bisexually but does not use that label to describe themselves is unlikely to use a service aimed at LGBT people, for example.

However, the relative complexity of the category 'bisexual' also carries benefits for care providers aiming to improve the accessibility and effectiveness of services. Since many bisexual people have changed the sexual identity label they use, and since bisexuality carries such various meanings, remembering the 'B' in LGBT can help care providers to remain aware of the provisional and fluid nature of all sexual identity categories.

Endnotes:

1. The issue for Trans people is less often one of invisibility: see Firestein, B. (Ed.) (2007) for a discussion of bisexual invisibility
2. See the chapter by Alleyn and Jones in this book for discussion of some of the differences between 'transsexual' and 'transgender', which create the need for the more inclusive abbreviation 'trans'. Other terms, such as 'LGBTQI' – lesbian, gay, bisexual, trans, queer and intersex – are also used but much less commonly in the UK
3. In this chapter I focus specifically on the disappearance of bisexuality within the category LGBT because some of the issues are distinctive to bisexual people. Similar, but also distinctive, issues are involved in the disappearance of trans from the category, but they are beyond the scope of this chapter. It should also be noted that there is significant overlap between the two categories – about 20% of people attending BiCon, the main national gathering for UK bisexuals, do not identify straightforwardly as male or female (Barker et al., 2008).
4. This definition is intended to be inclusive of trans people by not implying that there are only two genders.

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