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# **Older bisexual people: Implications for social work from the ‘Looking Both Ways’ study**

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## **Older bisexual people: Implications for social work from the *Looking Both Ways* study**

### **Abstract**

There is a growing social work literature about lesbian, gay, bisexual and transgender (LGBT) older people. However, research and guidance are predominantly based on the experiences of older gay men and, to a lesser extent, older lesbians. There is little to help practitioners work with older bisexual people. The *Looking Both Ways* study aimed to contribute to this gap in knowledge. We undertook in-depth purposely-sampled qualitative interviews with 12 people aged over 50, all of whom have bisexual relationship histories and half of whom also currently identify as bisexual. There were three main findings. Firstly, biphobia (prejudice against bisexual people) impacts on older people with bisexual histories in ways that may affect their wellbeing in later life. Secondly, concerns around receiving care are similar in some ways and different in others from the concerns of lesbians and gay men. Thirdly, people with bisexual relationship histories may have developed strong support networks and resilience, factors that may be very beneficial in later life. Three recommendations for social work professionals were identified: 1) understand biphobia, 2) recognise the legitimacy of concerns about receiving care, and 3) ask about support networks rather than assuming family support.

### **Introduction**

Population ageing in Western societies has been accompanied by increased visibility of older people with lesbian, gay, bisexual and transgender (LGBT) histories (SAGE, 2010; Stonewall, 2012). This means that social workers are more likely to encounter older service users who disclose non-heterosexual life histories and/or gender dysphoria and gender dissidence. They are also likely to encounter older people with those histories who do not disclose them (Hughes, 2009a).

There is a growing social work literature on the experiences of older LGBT people (Hughes, 2009a; Hughes 2009b; Jenkins, Walker, Cohen, & Curry, 2010; Lee & Quam, 2013; McGovern, 2014; Quam, Whitford, Dziengel, & Knochel, 2010; Rowan & Giunta, 2014; Van Sluytman & Torres, 2014; Ward, Rivers, & Sutherland, 2012) as well as literature aimed at enabling social work practitioners to work more holistically with older LGBT service users (Erdley, Anklam, & Reardon, 2014; Fredriksen-Goldsen, Hoy-Ellis, Goldsen, Emler, & Hooymann, 2014; Gratwick, Jihanian, Holloway, Sanchez, & Sullivan, 2014; Portz et al., 2014; Stonewall, 2012; Westwood, King, Almack, & Suen, 2015). However both bodies of literature are predominantly based on the experiences of older gay men and, to a lesser extent, older lesbians, meaning that little can be deduced about the distinctive experiences of transgender and bisexual people (Barker et al., 2012). Transgender people's later life experiences are beginning to be addressed empirically (Fredriksen-Goldsen, Cook-Daniels, et al., 2014; Siverskog, 2014; Witten, 2016) but much is still not known.

There is a small speculative literature on the issues older bisexually-identified people are likely to face when encountering support services (Dworkin, 2006; Rodriguez Rust, 2012; Scherrer, 2017) and some evidence that bisexually-identified women are at increased risk of negative health outcomes across the life course compared to lesbians (Colledge, Hickson, Reid, & Weatherburn, 2015; Fredriksen-Goldsen, Kim, Barkan, Balsam, & Mincer, 2010). Studies of LGBT populations in later life very rarely separate out the responses of bisexual people from those of lesbians and gay men, often analysing data by gender (bisexual women with lesbians, bisexual men with gay men) rather than by sexual identity. One of the few empirical publications to separate out the ageing experiences of bisexual people is Fredriksen-Goldsen et al.'s comparison of 174 bisexually-identified cisgender survey respondents within their wider sample of 2,560 LGBT-identified older people living in the USA (Fredriksen-Goldsen, Shiu, Bryan, Goldsen, & Kim, 2017). They found that, compared

to older lesbians and gay men and controlling for other factors, bisexual participants were in poorer mental and physical health. They argue that the mechanisms for this poorer health are 1) lower socio-economic status 2) higher internalised stigma 3) lower identity disclosure (being 'out' as bisexual to others) and 4) less social support.

The *Looking Both Ways* study aimed to contribute to this knowledge gap by gathering some of the first empirical qualitative data to focus on ageing and bisexuality. Given the lack of previous enquiry into the specific issues around bisexuality and later life, the focus of the study was broad. This paper summarises the findings that are particularly salient to social workers and develops recommendations to support holistic care for older people with bisexual relationship histories.

### **Methods, recruitment and analysis**

The researchers (all authors) undertook in-depth qualitative interviews with 12 people aged over 50, all of whom had significant histories of sexual relationships with more than one gender<sup>i</sup> and half of whom also currently identified as bisexual. A representative sample of respondents was not possible because too little is known about the characteristics of sexual minority older people to model this. Sexual orientation or sexual preference does not map neatly on to the sexual identities that people claim, and sexual behaviours do not always map onto sexual identities – we know that many more people have same-sex sexual behaviours than claim lesbian, gay or bisexual identities and that the mismatch between behaviour and identity is particularly high for bisexual people (Rodriguez-Rust, 2000). Many studies of LGBT ageing rely on sexual identity as a proxy for sexual orientation/preference but this may mean that findings are not valid for those with the same behaviours but heterosexual or other identities. *Looking Both Ways* therefore recruited both people who did identify as bisexual and those who did not but felt that bisexuality had some salience to them. The age range of

participants was 51-83; the majority were in their 50s and 60s and the mean age was 64. The lower-age limit of 50 was adopted in common with many studies of LGBT ageing (Guasp, 2011; King, 2016; Knocker, 2012) due to the difficulties of recruiting participants in this population, and on the rationale that this is the age at which later life often comes in to view for individuals.

Each participant was interviewed on a single occasion for between 45 minutes and 3 hours by one of the three authors. The interview schedule combined, firstly, a narrative life-history (Wengraf, 2001) and, secondly, discussion of issues to do with ageing. With permission, interviews were audio-recorded and transcribed. Each member of the research team initially read through a selection of interviews separately to identify emerging themes. Emerging themes were discussed and thematic analysis continued through readings and discussion of further interview transcripts. A coding framework of fifteen nodes was developed and applied to all transcripts, using NVivo software. Summary case studies about sexual identity and about ageing were written by the interviewer and sent back to the interviewee to check and agree. Comparing the nodes and the case studies generated three themes that were of particular relevance to social work practice.

The study was granted ethical approval by The Open University (UK) Human Research Ethics Committee and followed the research ethics guidance of the British Society of Gerontology. The small sample size means that the findings can only be indicative and suggestive. However, the in-depth exploration of experiences and meanings enabled by a life-history approach, and the fact that this is such an under-researched population, make this study a significant addition to knowledge. Relating the findings to the existing literature on LGBT ageing more generally, and to Fredriksen-Goldsen et al.'s quantitative study (Fredriksen-Goldsen, Shiu, et al., 2017), makes it possible to make some recommendations based on the diversity found within this small dataset.

## Findings

Table 1 shows participants' own written descriptions of their sexuality, gender and age.

**Table 1: Participants' descriptions of age, sexual identity and gender identity**

Age	Stage of Life	Sexual Identity	Past Sexual Identities	Gender Identity	Past Gender Identity
60	Actively retired, still caring for family, young senior?	Bisexual, polyamorous, submissive	Straight assumed	Female with some masculine tendencies	Tried presenting butch/male when partner was transitioning, but it wasn't me
51	Middle age, parent, elder	Bisexual, with queer as a secondary one	None	Male	None
65	Exploring the riches of my God-given identity	Pan-sexual	Straight and bisexual	Pan-gendered	Male/trans
57	Busy	Bi	Bi	Female	Male
64	Recently retired	Bisexual	None	Female	Uncertain
67	Retired, old queer	Queer	Lesbian, heterosexual	Female	Only female
53	Middle aged	Pansexual	Gay, Bisexual, Lesbian	Queer Femme	Transgender Gay (which was a way of identifying my gender difference before I had any useful trans vocabulary)
65	Pre-retirement	Gay	Gay, Bisexual, Heterosexual	Male	None
51	Working full time; still moving up the career ladder. Parent	Heterosexual	Not sure though significant relationship in past with	Male	Male

			man		
70	Forced by sudden health conditions to retire but hoping fervently to return to work ASAP!!	Bi	None	Male	None
82	Transgender woman (post-op). Active, healthy, very involved volunteer on ageing research and policy development.	Bisexual with preference towards females. Currently not sexually active.	Male, heterosexual	Female	Male
56	Middle aged	Bisexual	Always bi	Female	Female

Other demographic characteristics of the participants are shown in Table 2.

**Table 2: Participants' descriptions of their other demographic characteristics:**

<b>Ethnicity</b>	<b>Location</b>	<b>Relationship Status</b>	<b>Disability</b>	<b>Employment</b>	<b>Class</b>
British	Essex	long-term separated	No	Retired ex-draughtsman/ engineer Anglican and R.C priest Army Chaplain Prison Chaplain	
White British	London Borough	Polyamorous triad, legally civil partnered to my ex-husband	Cancer diagnosis less than 5 years ago, but not otherwise	Chartered professional librarian	Lower middle
White British	East Midlands	In long-term open relationship with a woman	No but I am aware that I am not 'NT' [neuro-typical]	Most of the stuff I do/have done is not paid	I have a middle class background



White English	East London	Single	Arthritis and heart condition	Manager in voluntary sector	Middle class
White British	London	Divorced	No	Part-time	
Anglo-Jewish	London		No	Operational Researcher/ Economic Analyst	Middle class
White British	London	Single	No	Charity worker	Student
White British	West Yorkshire	Single	No	Academic	
White, British, Anglo Saxon	Coastal Port, SE England	Divorced, unattached, live alone	No	Professional, Financial Consultant, Self-employed, now retired	
White European	London	Single	No	Urban Designer/ Town Planner Municipal Engineer (Chartered) BC1	
White British	London	With partner	No	Journalist	Middle class
White British	Manchester	Live alone but in a monogamous heterosexual relationship	No	Academic.	Middle class

The order of participants in the two tables is not the same and the two tables are not connected to pseudonyms or quoted words, in order to ensure anonymity given the relatively distinctive life histories of some participants. All participants lived in England in mainstream housing or sheltered housing.

### *Lifelong experiences of biphobia may affect health and wellbeing in later life*

Evidence suggests that older lesbians, gay men and bisexual people continue to have many worse health outcomes than heterosexual older people, leading to increased need for social work support (Fredriksen-Goldsen et al., 2013; Fredriksen-Goldsen, Kim, Bryan, Shiu, & Emler, 2017). Evidence that midlife and young bisexual (and transgender) people have worse mental health outcomes than lesbian and gay people is building (Colledge et al., 2015; Jorm, Korten, Rodgers, Jacomb, & Christensen, 2002) but is little studied in relation to older people. One common explanation for these worse outcomes is minority stress – long term chronic stress stemming from experiences of stigma, marginalisation or discrimination, and functioning as a social determinant of health (Fredriksen-Goldsen, Kim, et al., 2017; Meyer, 2003). While negative attitudes towards non-heterosexuality have decreased significantly in recent years, there is evidence that attitudes to bisexual people remain more negative than those towards lesbians and gay men (Monro, 2015).

The term ‘biphobia’ refers to the specific stigma and disadvantage affecting those who are attracted to more than one gender (Ochs, 1996); bisexual people may also experience homophobia (in relation to their same sex attractions) and transphobia (if their gender presentation is unusual). Common manifestations of biphobia that have been identified in the research literature include negative stereotypical views of bisexual people as promiscuous, greedy and incapable of fidelity (Alarie & Gaudet, 2013; Klein, 1993) and conceptualising bisexuality as always a transitional or inauthentic sexuality on the way to a ‘mature’ heterosexual, lesbian or gay identity (Barker & Langdrige, 2008) – the evidence is clear that, while for some people bisexuality may be a phase, for others it is a settled lifelong sexual orientation (Klein, 1993).

This is the case for Janet, one of the study participants who has identified as bisexual from her late teens onwards and who had many friends who also identified as bisexual in her mid-

20s. However her own inner certainty was challenged by wider societal changes in views of bisexuality. From the early 1980s in the feminist groups in which she worked and socialised, she felt increasing pressure to identify as a lesbian. She recalls vividly an occasion when a colleague saw 'bisexual' ticked on a survey and said 'Yuck!' She describes these pressures as very painful and as having a lasting legacy. For example, she said that she would never go to a general LGBT group for older people if she was feeling in need of support because she would expect to encounter discriminatory attitudes from older lesbians and gay men. Groups for older LGBT people offer social support, advice and guidance and there is evidence that attending such groups can bring significant benefits to health and wellbeing (Scicluna, 2017). Janet may or may not be correct in her assumption that she would encounter discrimination but her fear that she would do so has the material effect of making such support groups inaccessible to her.

Dan summarised his own life so far by saying "I've led my life in a very messy way, which has had a huge toll on my mental and physical health." He had a sense of lost potential for relationships with men, saying in relation to one early same-sex relationship "Had I met the right man, not a nasty fucked-up man, things might have been different". Having been in heterosexual relationships since then, he feels that there is little space for him to explore other sexual identities at this stage of his life. He commented that if he now started a relationship with a man he risks being ridiculed and people would say "He was gay all along, wasn't he!" Dan is not sure that he wants a relationship with a man at this stage of his life but the fact that he feels that bisexuality is not seen as a valid sexual identity (one aspect of biphobia) contributes to him closing down possibilities for himself that might support his wellbeing.

Not all participants had encountered biphobia. However, these examples suggest potential explanations for the higher levels of sexual identity disadvantage that Fredriksen-Goldsen et al. (Fredriksen-Goldsen, Shiu, et al., 2017) found. They suggest that biphobia may affect

some people with bisexual relationship histories in ways that affect their health and wellbeing.

### *Concerns about care services*

It is known that many older LGBT people fear encountering discriminatory responses from care staff at times when they are particularly vulnerable (Almack et al., 2015). When contemplating a move into residential care, older LGBT people also commonly fear discrimination from other residents and expect to be forced 'back in the closet' (Westwood et al., 2015), with negative effects on their health and wellbeing (Fredriksen-Goldsen, Kim, et al., 2017). While there are pockets of good practice, many care homes do little to train and support staff to work with LGBT older people (Simpson, Almack, & Walthery, 2016).

*Looking Both Ways* participants talked about wanting to feel free to be their whole selves when receiving care services, which included being 'out' as bisexual, but they also talked about the particular difficulty of being read by others as bisexual. Megan remarked:

*As a bisexual it's incredibly difficult to be out. Because unless you tell them there is no way they're going to guess. You know, if you're seen with a same sex partner you're judged to be a lesbian; if you're seen with the opposite sex partner you're judged to be straight. You're constantly passing for what you're not, and it's really frustrating.*

This led to quite pragmatic and situationally-determined views on the importance of being out to carers. Janet gave an example of how it might not be important to her to 'come out' as bisexual to someone coming in to do relatively impersonal support work such as cleaning the house – although it would be important that the cleaner was comfortable with all her 'queer stuff' around the house.

Imogen's worries about future care relate to what choices there might be for people like her who are committed to several non-mainstream life choices:

*It is a whole package, you know, I'm a queer pagan vegan, and that is going to be difficult in mainstream settings.*

She wants to continue to live independently for as long as possible but is aware that living alone and having some health issues and disabilities makes this difficult to maintain in the long term. Ian identified that if he went into a care home, it would be really important to him to still be able to access the internet without LGBT materials or pornography being blocked, and to have privacy to masturbate.

Many bisexual people are monogamous but rates of 'polyamory' and other forms of consensual non-monogamy are higher among some groups of bisexual people than the general population (Barker et al., 2008). Rosemary lives with two partners and, at the time of the interview, had just retired and was trying to move out of London into a new shared home. She pointed out that sheltered housing is never big enough for three adults to live together.

Ola is more concerned about encountering transphobia as she grows older than biphobia, echoing the findings of the only study focusing on ageing transgender bisexuals (Witten, 2016). A particular worry she identified was that care professionals might not have an awareness of issues important to her, such as the fact that she might be susceptible to prostate cancer. Ruth expects some carers to feel aversion towards her because of her gender transition but hopes to overcome hostility through 'personal charm'. She describes the idea of being in a care home as 'semi-imprisonment'.

This dataset suggests that, in addition to the issues commonly identified in studies of LGBT ageing, additional issues for older people with bisexual histories may include the increased complexity of 'coming out' as bisexual, lack of recognition of polyamorous relationships and,

for transgender people, problems with transphobia and lack of knowledge about the impacts of ageing after transition.

### ***Alternative support systems and resilience***

We know that, while some older LGBT people have difficult relationships with their families of origin, others have close and supportive relationships (Almack et al., 2015). Older LGBT people may also have adult children and partners who offer practical and emotional support in times of need, although both childlessness and being single in later life are more common among homosexual populations. However, it is clear that many older LGBT people have mutually supportive relationships with former partners and friends and that these relationships can play a major part in coping and resilience in later life (Almack et al., 2015). There is some evidence that coping mechanisms developed by LGBT people in earlier life to resist discrimination may help them to be more resilient in later life (de Vries, 2015; Fredriksen-Goldsen, Kim, et al., 2017). Little is known about the distinctive support systems and resilience of older people with bisexual histories but one international study of younger people who identified as bisexual reported increased feelings of independence, self-awareness and authentic living (Rostosky, Riggle, Pascale-Hague, & McCants, 2010).

Participants in *Looking Both Ways* had a wide variety of informal support systems which they drew on to face life challenges, and anticipated drawing on further as they grew older. This included birth families and adult children as well as ‘families of choice’. For instance, Imogen has a friend who has spare keys to her house and always puts down her ex-partner as her next-of-kin when filling out forms. She also gains practical and emotional support from her nieces.

Several participants had concrete plans for when they became more frail that did not depend on birth families or partners. Ruth had taught a friend to drive on the agreement

that the friend would then drive her around once she could no longer drive herself. After major heart surgery, Roger gave serious thought to his own future needs and is planning to move from a one bedroom flat to a two bedroom one so that he has more options for friends to stay and also for future care.

Megan lives with her two main partners and an adult child with disabilities. She sees their living arrangement as a significant advantage in later life because care does not fall on one person. Megan has already experienced this when she was diagnosed with bowel cancer. She said,

*So I was very ill for about a year or so. And my two partners had each other for support, and they had their secondary partners for support, and then they were still able to support me, and everything I think was so much smoother because of being poly. There was so many more people around to support [...] I know that people when there's just two people and there's a cancer diagnosis, it can fracture things so badly that you never get it back. And I was so pleased that we had more than that. I always think in terms of a relationship with two people, it's kind of like a ladder. If it hadn't got something secure to lean on, it's going to fall over. If you've got three or more, it's more like a little stool, it's stable; it's got three points to stand on.*

The experiences of the study participants are similar to those discussed in other studies of LGBT ageing more generally. Participants drew on both traditional family-based support and on networks of friends, including former partners. The distinctive features seem to be those connected to polyamory, which may be more common among some groups of bisexually-identified people (Barker, Bowes-Catton, Iantaffi, Cassidy, & Brewer, 2008).

## **Findings and limitations**

The *Looking Both Ways* study thus has three findings that are of particular relevance to social work practice. Firstly, biphobia may impact on older people with bisexual histories in ways that affect their health and wellbeing, increasing their need for social work services while simultaneously making it more difficult for them to access these support services. This extends even to services which are inclusive of lesbian and gay older people if support workers and service users subscribe to views of bisexuality as equating to promiscuity, lack of commitment or 'sitting on the fence'. Secondly, concerns around receiving care are similar in some ways and different in others from the concerns of lesbians and gay men. Thirdly, people with bisexual relationship histories may have developed strong support networks and resilience, which may be very beneficial in later life.

The *Looking Both Ways* study had a small sample size due to the difficulties of recruiting older bisexual people, who are widely recognised to be a hard-to-reach group (Westwood, 2016) and due to very limited funding for the study. The study aimed to recruit a diverse set of older people with bisexual histories and was partially successful - they were diverse in terms of sexual and gender identity, health and wealth. However, they were predominantly well-educated, at the younger end of the older age group, and all had white ethnicities – these limitations are common to most studies of LGBT ageing and it is important to address them in future studies. The experiences of bisexual older people who live in a care home or who regularly encounter racism are likely to be very different and understanding, for example, the intersections of race and minority sexualities in later life is a priority for future research.

## **Recommendations**

Combining the findings from this study with previous empirical research into LGBT ageing, Fredriksen-Goldsen et al.'s quantitative findings about older bisexually-identified people



(Fredriksen-Goldsen, Shiu, et al., 2017), and the speculative literature on bisexual ageing leads to the following four recommendations to social workers.

***1: Understand biphobia***

Experiences of biphobia and internalised biphobia, as well as homophobia and transphobia, may mean that service users are reluctant to disclose a bisexual identity or history and this can lead to delays in help-seeking. Social workers can facilitate safe environments for disclosure by asking open questions and not assuming heterosexuality or cisgender when encountering an older person (Croghan, Moone, & Olson, 2015). Social workers can also improve care for older people with bisexual histories by educating themselves about bisexuality (a list of further resource may be found in a report presenting case studies from *Looking Both Ways*: <https://bisexualresearch.files.wordpress.com/2016/07/looking-both-ways-report-online-version.pdf> ) and reflecting on their own experiences and understandings of bisexuality. They can remain alert to the heterogeneity to be found within the LGBT umbrella to ensure that any referrals they make to support services are appropriate and acceptable to the individual.

***2: Recognise the legitimacy of concerns about receiving care***

While many heterosexual people have concerns about receiving personal care, and especially fear going into a care home, LGBT older people may have additional fears. People with bisexual histories may fear and encounter additional discrimination due to biphobia. Bisexual people who are also transgender are perhaps most likely to fear and encounter discrimination in care settings. Recognising the legitimacy of concerns is an important part of offering holistic care – attempting to make health and social care services more LGBT-inclusive is, of course, its corollary (Croghan et al., 2015; Erdley et al., 2014; Fredriksen-Goldsen, Hoy-Ellis, et al., 2014).

### ***3: Ask about support networks rather than assuming family support***

LGBT people, including bisexual people, often have support networks that extend beyond family of origin, partners and adult children – friends and former partners may be providers and recipients of care to an extent that is very unusual among heterosexual and cisgender people. Social workers should not assume that someone who discloses a bisexual history is non-monogamous but should be alert to the possibility that they might be, and that this may offer additional sources of support.

These recommendations are also applicable to encounters with lesbian, gay and transgender older people, and indeed to older people in general. Being alert to the possibility of bisexual histories can thus be beneficial to people of all sexualities and genders by enabling more holistic and person-centred care.

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<sup>i</sup> We use the term ‘more than one gender’ rather than ‘both genders’ in order to be inclusive of those participants and their partners who did not identify as either male or female.