Categories and their consequences: Understanding and supporting the caring relationships of older lesbian, gay and bisexual people

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Abstract

This article advocates incorporating biographical narratives into social work practice involving older lesbian, gay and bisexual service users. Offering a critique of 'sexuality-blind' conditions in current policy and practice, the discussion draws on qualitative data to illustrate the potential benefits of narrative approaches for both practitioners and service users.

Introduction

This paper is written at a time of significant legislative change in the United Kingdom (UK) with a consequence that lesbian, gay and bisexual (LGB) people are increasingly protected in private and public life by an evolving statutory framework. The impact of these changes extend far beyond the UK, however, being mirrored in related shifts in social and political attitudes to LGB people that are evident in Europe-wide initiatives, the new Equalities Framework being a case in point. Evidence of the impact of the Framework is becoming increasingly apparent – for example, the European Commission recently (July 2008) proposed a Europe-wide directive that would provide protection from discrimination on grounds of sexual orientation, age, religion, belief or disability. This aims to ensure equal treatment for LGB people, which has been previously absent in the European policy agenda. LGB people are, therefore, becoming both an increasingly accepted and visible part of the fabric of contemporary European life.

As such, both policy makers and health and social care practitioners should carefully consider the ways in which they engage with LGB populations. As this article will argue, however, ostensibly anti-oppressive policy and practice may actually have limited application for LGB people who may, by default, fall outside its remit. Ageing populations across Europe and the fact that older people are high users of health and social

care services means, we will argue, that older LGB people are particularly vulnerable to the vicissitudes of both policy makers and practitioners in the health and social care arena. This article addresses one aspect of the lives of older LGB people – the reciprocal, fluid and negotiated caring relationships and the ways in which these are understood by health and social care policy makers and practitioners.

We first address the ways in which policy is shaping the living situations of older LGB people, before going on to explore the ways in which the categories 'lesbian', 'gay' and 'bisexual' shape, in turn, practitioners' responses to them. The article then presents findings from research that demonstrates how using narrative approaches in engagement with LGB people may allow practitioners to develop appropriate assessment and intervention strategies.

Policy-shaping provision

The personalization agenda (see HM Government, 2007; Department of Health, 1998) for adult social care in the UK promises significant change in the arrangements for responding to the care and support needs of older LGB people. However, the prospect of change is mitigated by the wider political context in which it is situated.

The central focus of personalization rests in placing the control of the organization of care with the individual for whom care is required, thereby enabling her/him to make informed choices about the nature of the care arrangements that best suit her/his individual circumstances. These new arrangements are articulated in the White Paper 'Our Health, Our Care, Our Say' (Department of Health, 2006), which demonstrates admirable expectations and ambitions asserting that having choice and control over the arrangements for care will transform the lives of people in need. Within the Government's vision there are additional ambitions that include the maintenance of independence, social inclusion, high-quality services, prevention and community-based solutions. Implicit in the assertion of community-based solutions is a conceptual understanding of community that rests in the idea of communities of place, with an associated assumption that within such communities there exist the resources that can support and look after people who are in need and that people in need would actually want their neighbours to undertake personal care tasks on their behalf.

For older LGB people the divergence of policy and lived experience becomes crucial. The biographies of older LGB people do not reflect one

idea or image of what it means to be gay, lesbian or bisexual. Rather they suggest a multiplicity of ways of living, reflecting individual circumstances and life experiences. This means that some older LGB people will be 'out' in their dealings with their communities, whilst others will not and, in both instances, their individual perceptions of the communities in which they live may include the anticipation or experience of negative reactions of their neighbours to their sexual identities. For older LGB people issues of sexual identity, considerations of safety and shared experiences may have the result that the community with whom they identify is not the community of place but rather a dispersed LGB 'community'. The issue of drawing support from a dispersed community of interest brings with it additional financial costs, not least travelling greater distances in order to undertake care and support and to maintain networks.

In the Government's vision for adult social care, the individual's choice and control of care arrangements is enhanced through the dual devices of direct payments and individualized budgets. The actual monetary value that is allocated to individual care needs is based on a locally determined resource allocation system (RAS). The RAS and the precepts upon which it is based are, therefore, crucial, a point reflected in Parvaneh et al.'s (2009) assertion that the transparency of the system enables service users to '... know(s) exactly what resources are included in her/his IB [individualized budget]' (p. 920). Transparency of the RAS is almost always expressed in linear or vertical terms; however, what is almost completely ignored is the issue of horizontal transparency – of equity across service user groups which, in turn, would ensure that similar levels of assessed need generate similar levels of money to support care arrangements irrespective of age. In general, older people in social care contexts will experience much lower financial settlements for their care arrangements than younger people. This differential reflects many influences, not least ageist assumptions about how older people should conduct their lives and the associated cost of support for care.

For older LGB people any additional costs incurred in making arrangements for their care – such as the travel costs associated with employing a lesbian or gay man from outside their geographic area, or the transport costs involved in accessing LGB community resources – will not be taken into account. This 'sexuality blind' approach is presented within the context of responding to the needs of the individual and treating all older people in the same manner. However, health and social care agencies that respond to older people can, and do, acknowledge issues of diversity as they are expressed through gender, 'race' and culture. This leaves a 'sexuality blind' approach, although reasoned by service providers as equal

treatment, somewhat difficult to justify and, equally, it raises questions about the legality of health and social care agencies' interactions with older LGB people in terms of legislative requirements such as the Human Rights Act 1998 and the Equality Acts 2006 and 2010. Such arrangements amount to a demand that the rights of older LGB people are both acknowledged and respected, which cannot be achieved through practices that deny the sexuality and self-construct of older LGB people.

'Sexuality blind' conditions have important consequences in terms of outcomes for older LGB people. For example, the Commission for Social Care Inspection (2008) recently identified that 45 percent of LGB service users said that they had experienced discrimination when using social care services. In addition, their past experiences of exclusion and abuse often mean that LGB people expect to experience discrimination (Hunt and Dick, 2008), and this expectation is itself a barrier to accessing services. Social care services are presently, therefore, far from being fully accessible and appropriate to LGB people in the UK.

Thinking beyond sexual categories

One of the ways in which 'sexuality blind' practice occurs is, as stated above, the tendency to treat older LGB people as simply an extension of older persons generally; that is, that they are assessed and treated 'just the same' as all other older people, a dubious approach to 'equality' that takes no account of difference and may, in fact, exacerbate inequity. It is important for policy makers and practitioners, therefore, to develop an understanding of what it means to be an older LGB person in a social system that not only disregards their sexuality, but also ignores the ways in which their sexualities may intersect with the ageing process. Similarly important, however, is the need to recognize that LGB people do not simply constitute one easily defined, homogenous social group whose needs are similar simply by virtue of membership. We would suggest that using arbitrary categories to define, or group together, diverse populations is problematic in both practice and policy contexts, as there is a tendency to presume that these categories are both fixed and immutable and that tenure of such an identity presupposes a similarly fixed range of health and social care 'needs'. The danger is that 'generalities' may replace 'complexities' in the assessment of, and intervention in, LGB people's lives (Meyer, 2001).

These presumptions of fixed need and attributes require, however, a pre- ceding presumption to allow them to operate. Before we are able to denote 'needs' to LGB people, these persons must first label themselves as lesbian, gay or bisexual. For some, especially older people, these labels

may have limited resonance and they may choose not to identify themselves thus. Services provided for LGB people, or with their supposed needs in mind, may thus be rendered inaccessible, or at least inappropriate, for those who choose not, or feel unable, to identify with these terms.

Similarly, a tendency to uncritically conflate sexual minority identities into convenient groupings may have little currency for people's lived experience. When we refer to LGB people as one seemingly homogenous group, we risk missing important differences that should inform practice and the formation of policy. Treating groups of people as if they have unitary and fixed needs is also contrary to the contemporary 'person-centred' focus of health and social care policy. It is these issues, rather than the fact that the person may identify with a particular social grouping, that may actually determine what their needs may be in any given context.

Ward and Jones (2010) warn, however, that focusing only on individual contexts may mean that wider social inequities are not addressed. It is, therefore, equally important to identify the wider social processes that shape LGB people's experiences, particularly, in the context of this article, in the health and social care arena. Whilst it is important to recognize diversity it is also necessary to acknowledge the ways in which identification with a sexual minority may colour people's experiences in similar ways. As noted in the preceding policy section, there are elements of LGB people's lives that serve to forge a sense of community with others – 'stigma, prejudice, legal inequality, a history of oppression, and the like' (Weeks, 2000: 183). Thus LGB people share a history of oppression that may invalidate more obvious social divisions (Coon, 2003). In the context of health and social care, these social conditions are particularly telling, as they impact upon access to, and standards of, care, the potential for culturally sensitive care and the selection of research priorities (Meyer, 2001). As Eaglesham (2010) notes, however, health and social care services should not perceive LGB categories as prescriptive; rather, these categories are connected in only loose ways and may or, more importantly, may not, be the starting point for considering an individual's needs.

One means by which it may be possible to consider individual difference, whilst acknowledging how this difference may intersect with the ways in which oppressive social systems impact upon individuals, is to work within a paradigm that recognizes that a 'caring encounter', be this in formal or informal contexts, constitutes part of a *life-story*, constructed by the individuals

concerned. The following section illustrates this, drawing on the integrated findings from two qualitative studies of older LGB adults conducted by two of the authors (Cronin, 2004; Cronin and King, 2010; King and Cronin, 2010) that explore the implications of LGB people's narratives of care.

Caring narratives and ageing sexualities. The first study focused on older lesbian-identified women and was exploratory in nature. The second study, funded by an inner city local authority, investigated the experiences and needs of its older LGB residents. A total of 36 adults – 12 men and 24 women, aged between 50 and 78 years, were interviewed across the two studies. Twelve men and 13 women lived in the South-East of England; the remaining 11 women lived in the USA. Data from the US interviews does not appear in this paper. All participants identified as White, apart from one man who identified as Mixed White/Black African-Caribbean. Participants represented a range of socio-economic statuses. Twelve of the women and two of the men had been married, but were now divorced. Of these, all had children except one man and one woman. In both studies snowball sampling was used to recruit participants. Initial contact was made with individuals, relevant organizations and, in the case of the second study, organizations working specifically with older people, as well as health centres and other public organizations in our chosen location.

A narrative analysis approach was used to both collect and analyse participants' biographical stories. Writing about narrative analysis, Riessman (1994: 114) notes that story telling is a universal practice that enables the teller to construct and identify significant events in their everyday lives, and in doing so link 'the past and present, self and society' as part of a story of someone's life: what has happened, what is happening and what may happen. Instead of regarding an individual account as representative of 'real life', it is posited that such an account is the outcome of a process in which people engage in 'story telling' (Plummer, 1995), and in doing so produce narrative-like accounts of their lives.

Existing research suggests that older LGB adults' experiences of caring will be shaped by the heteronormative nature of social relations (Cronin and King, 2010). Certainly care giving and receiving amongst the older LGB population differs from the general population, in relation to both gender and care practices (Kurdek, 2005; MetLife, 2006). Studies of caring amongst older LGB adults also highlights the importance of non-familial relationships – 'families of choice' (Weeks et al., 2001) or 'friendship families' (Dorfman et al., 1995) – and the suggestion that the roles of care givers and care receivers may be fluid, interchangeable and context-dependent (Manthorpe and Price, 2005; Northmore et al., 2005).

Caring for others – parents. A number of participants told stories of caring for their parents. These narratives emphasized not only how caring for parents was framed in accordance with heteronormative social relations, but also how these experiences had significantly impacted on their own experiences of ageing and their sexuality. Sandy, a 64-year-old lesbian, for example, explained that her relationship with her mother had been difficult for most of her adult life, largely because her mother could not accept that she was a lesbian. Sandy was now in a situation where she was expected by other members of her family to care for her mother, to the detriment of her own happiness and lifestyle:

I feel tied by her at the moment. I do have a brother but it's all change really. His family have moved over to [country] so he's spending more and more time there so I've got sole care of my mother now really. She [her mother] lives in [town in Eastern England]. And she's in sheltered housing but she needs quite a lot of care. I have to go up there twice a month and all over Christmas because the carers aren't working . . . I think I've spent all my life trying to stay as free as I could and not tied down and I come to my old age and I'm really feeling tied down by my mother. (Sandy, 64)

Whilst Sandy's narrative makes clear that she was unhappy about her current situation, others who had embraced the role of carer still noted its restrictions on their lives. Peter, a 58-year-old bisexual man, had been the principle carer for his mother until her death, three years prior to the interview. Peter explained that this had impacted on his possibilities for finding a partner, both at the time and subsequently:

Terribly selfish I know, but for years I cared for my elderly mother who was in a wheelchair and while that was going on, obviously, I couldn't have a partner so I just got out of the habit as it were. (Peter, 58)

Caring for his mother also fitted into a more general narrative Peter provided about care: he was a volunteer for several charities that provided support and care to people with mental health problems and for older people with disabilities. Peter indicated that these experiences had affected his decision to care for his mother. Therefore, despite the implications for his own life, his care practices 'made sense' within his biography and the place of care in that context.

The importance of biographical context was made especially relevant by William, a 56-year-old gay man, who made regular trips to visit and

care for his father, who lived some 50 miles away. Like Sandy, William explained that his siblings expected him to care for his father because he had fewer 'responsibilities', i.e. he did not have children and was not, at the time, working full-time. The stress of travelling and caring for his father had a significant impact on William's mental and physical health, particularly his HIV status. William became depressed and stopped taking his own anti-retroviral medication. He also withdrew from his wider network of friends and stopped participating in the gay community, something that William regarded as central to his identity. The turning point in William's story was the deterioration of his father's health to a point where he was admitted to residential care. This enabled William to 'get back to [his] old life' and reconstruct his sense of self. We recognize that many of these issues are not specific to older LGB adults; older heterosexuals experience mental and physical health problems, as well as emotional tumult as a result of caring for their elderly parents. However, older LGB adults, as we have shown, have to fit their experiences into biographies that are shaped by a heteronormative framework. This is particularly evident in the way in which some of our participants talked about their concerns about receiving care either in their own homes or in residential settings.

Receiving care. George was a 74-year-old gay man who led a very active life. When asked about the possibility of receiving care at home he spoke for many of our participants in that, while not relishing the thought, he accepted it with a degree of inevitability:

It's a thought that would scare me; I don't like the idea of other people visiting where I live . . . I think the thought is something I wouldn't be happy with but on the other hand, if it had to happen I think I'd probably be very philosophical about it. I wouldn't like it. (George, 74)

Peter, who we noted above, had experience of caring for others, emphasized how thoughts about receiving care are yet again framed in a biographical context, whilst referring to culturally dominant understandings of sexuality:

Hopefully, I will just be a client to any professional carers, as far as they're concerned, when it happens. I am just a person who needed care regardless of my sexuality. (Peter, 58)

A particular concern for some of our participants related to a fear that receiving care, either in the community or in a residential setting, would result in their having to go 'back into the closet' as they grew older. For

example, Donna, who talked about the possibility of ending up in residential care, voiced concerns about being unable to maintain friendships with other gay adults or to maintain a relationship with a partner. This, coupled with generalized feelings of social isolation due to having either little in common with residents or a fear of hostility from others, made the prospect of ending up in residential care a very bleak one:

What happens if you need assisted living or long-term care? Unless you're in a lesbian or lesbian-gay centre, you're stuck with listening to other hets talk about their spouse – dead or alive – and their lives together, but you cannot do the same with a feeling of safety and without a fear of repercussion (such as being totally shunned, which would be a horror, since you're stuck there and have no other options). Worse yet, if you were lucky enough to room with your partner in an assisted living centre there would be NO privacy such as the het partners have and that part of your life would be regulated. In other words, NO SEX LIFE!!! (Donna, 65)

Previous studies (e.g. Fannin et al., 2008) have suggested that one coping strategy adopted by LGB people is to desexualize their home environment.

Several of our participants made reference to this, particularly in reference to certain signifiers of sexuality such as magazines and 'smutty fridge mag- nets' (William, 56). William held a strong sense of belonging to the LGB community, and suggested that becoming housebound could have a significant effect on his self-identity, in terms of becoming isolated from the gay community. He suggested that having a gay carer could be beneficial here:

Even someone to come round and have a camp chat. [. . .] I don't know that you could specify when you need someone to come round that it would be a gay man rather than anybody else, or whether you should even be able to, but actually that's probably one of the things that would be missing from your life if you are in your own home and can't get out, you know, gay company. (William, 56)

Indeed, this raises interesting questions about the personalization agenda, discussed earlier, that is currently being promoted by the Department of Health and the importance of tailoring services to the needs of individuals rather than a general model of care. It suggests that taking narratives of ageing and sexuality into account could have significant policy implications.

Untold stories: Making sexuality visible in social work with older people, incorporating caring narratives into social work practice

In this section we turn to consider how caring narratives, such as those out-lined above, might be used to enhance social work practice with older LGB service users. We outline why a focus upon such narratives, rather than an orientation toward categories of identity, might better support practitioners to respond appropriately to the needs of older LGB people. Our argument here is that narrative work has particular benefits and significance to policy, research and practice.

In advocating the use of caring narratives in social work we do so from a critical perspective on how sexuality is currently made visible in social work with older people. For instance, in dementia care sexuality is considered largely under the banner of 'behaviour' (and not as an identity), consequently any form of sexual expression by the person with dementia is treated as problematic in care settings (Ward et al., 2005). There are no spaces within dementia care for sexuality to be expressed positively, let alone embraced as a viable social identity, and this has specific implications for LGB service users who may be ostracized and vilified (Archibald, 2006) and for carers who find their support needs poorly met (Price, 2008; Ward, 2000). The use of narratives means taking into account the 'social worlds' of older LGB service users and, in particular, how caring relationships provide a context in which ageing sexualities are articulated and practised. They can support a shift away from treating sexuality as an 'already-given', whereby LGB service users 'come packaged as fixed types' (Hicks, 2008).

In a helpful review of narrative approaches in social work, Riessman and Quinney (2005) note there is a dearth of published accounts of their use by practitioners. This is especially so in relation to working with older LGB service users (Cronin and King, 2009b). Nonetheless, the benefits of taking into account a biographical context when working with older LGB individuals are well supported in the existing literature in health and social care. Pugh (2005) highlights the importance of past experiences to the way older LGB individuals negotiate access to care services, given the key role played by the State in policing homosexuality throughout much of the last century. Similarly, Bayliss (2000) has argued that life story work with older lesbians supports an understanding of a life history of oppression. Quam (1997) and Manthorpe (2003) both recommend using case studies drawn from biographical material in order to raise awareness with practitioners and share good practice; while Jones (2010) has developed fictional

narratives of bisexual characters in order to support a better understanding of the nature of bisexual identities over time. We would add that eliciting narratives from older LGB service users promotes a situated understanding of their lives and identities showing how different constraints and life events are responded to, often creatively within caring relationships, and this can support a 'strengths' model of assessment.

Incorporating caring narratives into social work practice

No formula exists for how or when to elicit and incorporate biographical narratives in the social work relationship. Indeed, the value of narrative approaches is their flexibility and adaptability. In a discussion of narrative methods in social work research Larsson and Sjoblom (2010) point out that as well as holding a therapeutic potential, narratives methods can be used as a tool in the investigation and evaluation of social work practice as well as in research. Our argument here centres on the potential benefits to both service users and practitioners in the context of working with older LGB people, whose lives and personal histories may have been hidden and so little understood by practitioners.

Hicks (2008) argues that sexuality should be approached not as a personal attribute but a discursive production in social work encounters and warns practitioners to be mindful of social and narrative conventions that may shape the way biographical information is recounted, highlighting the 'coming out narrative' as one discursive form that may constrain the telling of an individual's experience. Equally, it should not be assumed that service users will be able to articulate a view of their own identity in a coherent fashion. Hicks (2008) further cautions social workers to critically examine the accounts they construct of the stories told to them and the need to avoid heteronormative judgements, as they draw upon biographical material in their practice.

Often, it is the case at present that biographical insights and information accumulate over time and in an informal way in social work practice. There is an inherent danger that such insights may be lost due to staff turnover or when service users transfer from one service to another. A more structured approach to gathering narratives may help avoid this and at the same time provides greater control for the service user concerned over the type and level of knowledge that is shared and with whom. In certain instances practitioners may suggest using life story work as a particular intervention that captures biographical detail before it becomes less accessible, for instance in working with people in the early stages of dementia. In other contexts, biographical narratives may be used to support collaborative and co-productive working providing a context in

which to tailor support in a person-centred fashion, featuring at an earlier stage of the working relationship. Jointly elicited narratives may also support a better understanding of the interdependent nature of caring relationships when working with older LGB caring dyads (Cronin and King, 2010).

There will however be certain situations in which working with caring narratives is less appropriate. For instance, in her discussion of practice issues in dementia care Mackenzie (2009) argues that biographical work can 'feel intimidating [for LGB couples] as it exposes details of loving relationships which may have been concealed for many years' (p. 19). The author's advice is to ensure that the individual or couple concerned are given the lead in constructing their autobiography, maintaining control over the level of detail shared.

Narratives of care allow us to ask how both sexuality and age, and the status they are accorded, operate in particular 'theatres of life' (Gubrium, 2005). This helps us to avoid falling back upon assumptions that identity categories continuously mediate the lives and relationships of older LGB people in ways that are stable, and which cross-cut all domains of everyday living. In this way they underline the inadequacy of such categories as organizing 'tools' in the context of social work practice. It is our view that using biographical narratives with older LGB service users is therefore an important addition to the 'portfolio' of relationship-based social work approaches available to practitioners. Ultimately, they promote personalized and person-centred forms of practice in ways that help to address, rather than downplay, the broader social and historical context of inequality and oppression through which such individuals have lived.

Conclusion

This article has demonstrated the ways in which policy relating to, and practised with, older LGB people is mediated by a range of sometimes competing social and political imperatives that impact upon them in varied, but often oppressive and disabling, ways. Identity categories may be central to some of these issues in that, first, LGB people's experiences, needs and rights tend to be subsumed beneath practice and policy that presumes an asexual old age within which there is little space for an acknowledgement of older people's sexualities more generally – in this context it is perhaps not surprising that LGB people's sexualities tend to be invisible. Secondly, when there *is* recognition that older people's sexualities remain vital constituents of their lives and that not all older people are heterosexual, LGB people tend to be amalgamated into a catch-all sexual category that does little to acknowledge their personal

biographies and life experiences. Further, there is little recognition of the fact that they may not choose to be categorized at all. For those working with older LGB people who may receive or provide care in various contexts, then, we suggest a model for social work practice that takes LGB people's lived experience as a starting point for assessment and intervention. The narrative approach we propose stems from an appreciation of the importance of biography and life trajectory, thus enabling service user and practitioner to engage from a perspective that both acknowledges and respects both the macro and micro contexts of individual lives. In so doing, we suggest, the variety of older LGB people's lives may be appreciated and acknowledged for what they are – unique and individual experiences that may or may not resonate and intersect with others sharing some, but not all, similar social identities. Engaging with service users in this way, we would argue, generates a true expression of the concept of 'personalization' and 'person-centred' social work.

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