All but invisible: older gay men and lesbians

The sexuality of older people, and gay and lesbian sexuality in particular, is an issue that has largely been ignored in the nursing literature. But, says Elizabeth Price, older gay men and lesbians are becoming more vociferous about the health and social care services they have a right to expect

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The sexuality of older people has been something of a neglected issue and has only recently received long-awaited attention (for example, Archibald 1998, 2001, 2002, Ehrenfeld *et al* 1999, Evans 1999, Heath 1999, Heath and White 2001, Heath and White 2002). Older people are, it seems, generally viewed as asexual or their expressions of sexuality are seen as problems to be managed or treated – ageist assumptions that are coupled with generally tacit presumptions of heterosexuality.

Unsurprisingly, therefore, the particular experiences, needs and concerns of older gay and lesbian people have been unrecognised and largely ignored from a policy, practice and research perspective. Few studies focusing on older people have addressed issues of sexual orientation despite a conservative estimate which suggests there are currently between 545,000 and 872,000 gay men and lesbians over the age of 65 in the UK. Given that it is likely many of these people will have partners, family or friends who might provide care of varying types, this represents a significant population – a population that remains, however, all but invisible. This situation may mean that professionals, from all sections of the caring spectrum, may lack an understanding of the way disability and illness impact on this group of people and that responding to them appropriately may be challenging (Manthorpe and Price 2003, Ward 2000).

Some reasons behind our lack of 'practice wisdom' rest on former and also current contexts. Older gay men and lesbians developed their sexual identity at a time that was vigorously unsympathetic towards any form of sexuality that did not adhere to the heterosexual norm (Friend 1996). As a result, they have been 'historically consigned to the margins of our culture' (Weeks *et al* 2001). Recent legislative changes suggest that the social and political context of homosexuality, in the UK at least, is changing. The repeal of Section 28, the newly minted Civil Partnership Act and the recent Employment Equality (Sexual Orientation) Regulations 2003, which outlaw discrimination on the grounds of sexual orientation, all point towards official recognition and greater acceptance of non-heterosexual lifestyles

In tandem with this, providers of health care for older people have begun to recognise more openly issues of sexual identity. The voluntary sector and gay and lesbian organisations have been particularly proactive (Age Concern 2003, Alzheimer's Society 2004, Kitchen 2003, Opening Doors in Thanet 2003, Turnbull 2001) and the work done by these groups and individuals makes a common set of points. In respect of health care, there is relatively little known about whether the needs of older gay men and lesbians are the same, or equally diverse, as those of other older people or, if not, how they differ. Older gay men and lesbians do, however, share with their heterosexual counterparts common concerns about ill health and the need for future care. But there is evidence that some healthcare providers do not view lesbian and gay lifestyles in a positive light (Bhugra and King 1989, Bond *et al* 1990, D'Augelli 1989, Golding 1997, McFarlane 1998, Platzer 1993, Rayner 2002). As a result, older gay men and lesbians may be reluctant to seek health care or advice.

Within the lesbian and gay community, stories are commonplace about the difficulty in accessing information about one's partner who may not be regarded as next of kin by professionals (see, for example, Hash 2001, Heath 2002, Rayner 2002). Though there is no statutory definition of the term 'next of kin', in practice spouses and blood relatives are generally viewed as next of kin by staff unless there are prearranged alternative arrangements. Similarly, anxiety relating to the completion of official documents that require information about relationship status is evident.

End of life issues

More general issues from recent research also highlight the ways in which older gay men and lesbians face discrimination and uncertainty, particularly around end of life issues and decision-making. For same-sex couples faced with the death of one partner, this means that the surviving partner can make no legal claim on property and, if there is no will, can make no claim under the rules of intestacy. A same-sex

partner cannot register their partner's death other than as 'a person present at the death' – there is no recognition of the partnership, whereas another family member may register the death in their familial context. From a financial point of view, many public sector pension schemes do not recognise same-sex partners as beneficiaries, and same-sex couples will be faced with tax inequities with regard to capital gains tax and the married couples' tax allowance. Furthermore, gay men and lesbians have no right to fatal accident compensation for their partners and have no legal protection or recourse when faced with discriminatory actions or attitudes, unlike those based on race or gender where race and equal opportunities legislation applies.

As stated, we now have evidence from gay men and lesbians that they share many of the same concerns as heterosexual people regarding the need for care and support as they age – concerns that include the possibility of long-term care. For same-sex couples, the potential trauma of choosing and moving into a residential or nursing home may be compounded by inequity. The disregard of jointly owned property, for example, automatically granted to married heterosexual couples when assessing financial contributions to care, is only discretionary in the case of same-sex partners. This may, therefore, vary from one local authority to another, allowing little clarity or reassurance in an already distressing situation. These, and other financial and legal issues, look set, in theory at least, to be addressed by the Civil Registration Act. This proposes joint state pension benefits, the right to register a partner's death, the right to claim a survivor pension, eligibility to bereavement benefits, recognition under the rules of inheritance and intestacy, tenancy succession rights and the obligation to financially maintain each other.

Nonetheless, despite legislative reform and a more widespread, if arguably superficial, acceptance of non-heterosexual lifestyles, for older gay men and lesbians who may have felt the necessity to maintain a superficially heteronormative lifestyle, the onset of disability in later life may be a minefield of potential 'outings'. The crises that may accompany the diagnosis of life-threatening disease or gradual development of disability mean that previously private matters can suddenly be open to public scrutiny. A person's domestic arrangements and individual living circumstances may be observed and judged in a negative light by those who provide care or treatment or who may visit the home for the purpose of assessment. The ability to manage sensitive information about oneself under these circumstances is clearly compromised and, for older gay men and lesbians who may have lived a lifetime 'passing' as heterosexual, this may compound already high levels of stress and anxiety.

Nurses should also consider the myriad ways in which being gay or lesbian might impact upon carers' everyday experiences. This may be particularly so for the gay or lesbian children of an older person who may have endured a troubled relationship with a parent because of their sexuality. Subsequently, professionals may label them distant or uncaring when the onset of disability forces them into the role of carer after what may be years in the familial wilderness. Similarly, it is necessary to be aware of the potential effects of heterosexism and homophobia on the ways in which people may react to difficult and stressful situations. Carers may have difficulty opening up to professionals working in a supportive capacity when they are uncertain of the response they may receive and, as such, may feel increasingly isolated in their caring role.

Nurses are not, by nature, insensitive, nor should it be assumed that they are all heterosexual. It would, of course, be unreasonable to suggest that all heterosexual people are wholly ignorant of the issues facing older gay and lesbian service users, as it would to assume that the opposite is true for all gay and lesbian people. Nonetheless, nurses' training or practice experiences may not have equipped them to discuss, and appropriately manage, care issues for older lesbians and gay men or lesbian and gay carers. A number of pointers, however, may assist them to develop more assurance in their health and social care interventions with gay men and lesbians generally and older gay men and lesbians in particular.

Older gay men and lesbians face discrimination and uncertainty, particularly around end of life issues and decision-making

Having all been brought up in a society that privileges heterosexuality above other forms of sexual expression, it is first necessary to recognise that the bias this necessarily introduces is not automatically lost upon professional qualification. It is up to individual practitioners, therefore, to explore and challenge heterosexist and homophobic attitudes, whether their own or those of other people or institutions (Wilton 2000).

Awareness

In a similarly reflective vein, heterosexual, gay and lesbian nurses also need to examine carefully their personal approach to ageing, as this will undoubtedly influence professional relationships with older lesbians and gay men (Arbore 1997).

One of the reasons for a lack of awareness of the needs of older gay men and lesbians is undoubtedly the scant attention paid to training in this area. Providing good quality care requires a sound knowledge-base and its lack can only be addressed if its necessity is made clear by both pre and post-registration nurses. Individual nurses also have a responsibility to ensure that they have up-to-date access to, and awareness of, developments in voluntary and statutory services and of the pace and implementation of legislative reform as it applies to lesbians and gay men, in addition

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to an understanding of the differing cultural needs of their lesbians and gay clients.

A lack of inclusive documentation may also need exploring in less enlightened localities – the heteronormative nature of assessment and recording procedures where there is often little opportunity for gay men and lesbians to make explicit the nature of their relationships, even if they were prepared to do, so can be challenged by individual nurses prepared to work outside a strict adherence to official procedure.

Documentation that relates only to married, single, divorced or widowed people has little currency for gay or lesbian men and women whose lifestyles do not necessarily fit this pattern. Assessments are, after all, an opportunity to gain a valuable insight into people's daily lives and to engage in appropriate discussion about the lifestyles they choose. This, however, is an opportunity missed if procedures effectively preclude the most important aspect of many people's lives – their partnerships with others. Professionals need not be constrained by documentation that excludes by default and should feel confident enough to enquire tactfully about people's personal circumstances.

There is a temptation, of course, to suggest that this would constitute an invasion of privacy and, while omitting or ignoring issues of sexuality may be the most comfortable option for some professionals, this approach risks denying the existence of specific health and social care issues. The concern to maintain confidentiality should not preclude tactful enquiry into patients' personal circumstances, which may have a bearing on their health and social care needs. As Wilton (2000) argues, 'respect for privacy is not the same as ignoring people's needs' and, further, that the 'respect for privacy is not a good reason for the health or social care professional failing to develop a sound knowledge base about the range of human sexualities and the skills to put this into practice with sensitivity.'

For those working in older people's services, however, the challenge may not be simply to promote increasing sensitivity of alternative lifestyles and the sexual identities of individuals. Nurses will need an understanding of the historical context of the lives of older gay men and lesbians and be able to respond to the social and health care needs appropriately from an informed perspective. As Arbore (1997) notes: 'All of us who work with older lesbians and gay men must genuinely believe that the choice of a same-sex love partner is as healthy, valid and life-giving an option as the choice of an opposite-sex partner.' At a more basic level it is perhaps first necessary for professionals simply to recognise the existence of older gay men and lesbians and to provide safe and supportive practice situations within which they may feel comfortable to disclose the nature of their personal relationships if they choose.

Above all, nurses will be expected to meet the needs of an increasingly confident and vociferous ageing gay and lesbian population – a population ageing with high expectations of, and the right to, culturally sensitive services from both health and social care practitioners. It is the responsibility of individual professionals to ensure that they are adequately equipped, both personally and professionally, to provide them ■

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