Moving Forward:

Working with & for older Lesbians, Gay Men, Bisexuals & Transgendered people

training and resource pack

Steve Pugh, Willie McCartney & Julia Ryan with the
Older Lesbian, Gay Men Bisexual & Transgendered Peoples Network

Updated August 2010

in association with

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WELCOME

Who are we?

This teaching and training resource pack has been produced by members of the Older Lesbian, Gay, Bisexual and Transgendered Peoples Network based in the North West of England in association with the University of Salford.

The network seeks to ensure that older lesbians, gay men, bisexuals and transgendered (LGBT) people can influence the practice of health and social care professionals and agencies and to provide a vehicle for consultation and training on issues related to older LGBT people.

As such older LGBT people themselves are at the core of the network and this has included the following people in alphabetical order:

Alan Edwards
Allan Horsfall
Mike Taylor
Sue Morris

A number of staff from various agencies and organisations have also been involved in the network and have contributed to the production and editing of this pack for you.

These include representatives from the following organisations:

Age Concern Salford,
Age Concern Stockport.
Bolton Metropolitan Borough Council,
Manchester City Council, Housing support services for older
        LGBT people
Stockport Primary Care Trust
The Lesbian and Gay Foundation
University of Salford
Wigan Metropolitan Borough Council

Rationale for the teaching and training pack

Our aim has been to explore the position that older LGBT people are placed in when they are in contact with the health and social services recognising that such contact is not always a positive experience.

Equally we have wanted to ensure that health and social care services provide good quality services for older LGBT people which are based upon equal treatment and respect thus ensuring that contact with such organisations is positive for everyone concerned.

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What is in this pack?

We have brought together a wide range of material on different topics which will help you to explore both the current position of older LGBT people and help you improve your services and your practice.

The approach that we have taken in developing this pack is to provide material which explains the issues but does so in a non-threatening and judgemental manner. We believe that explaining and illustrating these issues and what they mean for real people will have more a positive impact on services and practice.

The pack is divided into four parts:

Part 1
Explores the exclusion of older LGBT people and looks at explanations for such exclusion. As such this part of the pack contains material for you which explores:
- Exclusion
- Ageism
- Homophobia
- Heteronormativity

Part 2
Explores the inclusion of older lesbians, gay men and bisexuals by looking at:
- What is meant by inclusion

- The law
- Government policy
- Social inclusion and citizenship
- How to include older LGBT people
- The customer response to health and social care professionals
- The implications for health and social care services and practice
- The biographical approach and inclusion

Part 3
Provides you with an overview of the existing literature related older LGBT people and can assist you with some of the background to the issues that are of concern to older LGBT people.

Part 4
Contains plans for training sessions which draw on the material in the pack which can be use in training health and social care staff.

In each part of this pack there are themed activities that can be taken on their own or as part of a series or training session.

LGBT
Through out this teaching and training resource pack the abbreviation LGBT is used to refer to lesbian, gay, bisexual and transgendered. This abbreviation is commonly used as a

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mechanism to maintain inclusive approach thereby ensuring that a 'community' is recognised for all its constituent groups. The abbreviation will be used in association with the word 'people' to ensure that we are reminded that we referring to people and not an anonymous group.

The Virtual Dining Club

We have developed a virtual dining club as a means by which we can bring to life some of the issues that are to be raised in this pack.

There are biographies of 10 fictitious people who attend the dining club and these will be developed through the pack and used in each of the themes.

Jueveillie Fine Dining Club

Our purpose in developing the dining club is as stated to bring to life some of the issues that we are referring to and also to employ a life course approach to this material.

All too often older people are seen as having no past and no future other than their inevitable death. A life course approach helps to see the life of the older person and how it has helped shape who they are today.

Such an approach employed in health and social care settings can assist staff to see older people in the context of their lives and focus on their strengths rather than as all too often on problems.

We hope that you find the material helpful whether you use the pack on your own or in teaching and training sessions.

The organisation that have been involved in the production of this pack.

University of Salford
A Greater Manchester University

AGE Concern Salford   AGE Concern STOCKPORT

Wigan COUNCIL

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Welcome to the Jueveillie Fine Dining Club

We are a group of older people who meet on a two weekly basis to enjoy good food and good company

Our meetings are very informal – more like a group of friends, but more importantly…

You are welcome to join us and be part of our club

Contact Robert on ****************

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The Jueveillie has 10 members who are:

Edna

was married to Paul but is widowed now and has been for 5 years. She has 3 children and 5 grandchildren all of whom she adores. Edna worked as a School Secretary and was very much respected in that job. Since retirement some 15 years ago and particularly since Paul's sudden death she is lonely and enjoys the club because it gives her the opportunity of going out and meet friends.

Edna misses Paul very much, they were very much as the saying goes 'two as one'. They were each others best friends and went everywhere together. They were together for 76 years and married for 66 years – childhood sweethearts. The only time they were separated was during the war when Paul was posted to the Far East. Edna lives alone in the family home which if she is honest is too big for her but there are so many memories of her and Paul and the children there that moving would be such a wrench for her. If she were to move where would she go? She has pondered this a lot. When Paul died her eldest Mark wanted her to move near him - but that is in London and Rachel and Debbie, other children live in the north.

Mark's wife is nice and they have 3 lovely children, but they have their own lives to lead and Edna is not going to spoil that. While Rachel and Debbie live closer Edna doesn't see so much of them. Rachel is busy with her two children and Debbie – well Debbie is just busy. If she sees them once a month Edna is lucky. Anyway, moving out of the area would mean moving away from her friends at the club.

Edna is 86 years old. She has £10,000 worth of savings, her own state pension and Paul's works pension. She describes herself as 'not badly off'.

Robert

lives alone and has done so for most of his life. He plays a very active role in organising the group – suggesting venues and hosts the club at his own home regularly. He is the life and soul of the group and is very flamboyant. He travelled the world through his time in the Merchant Navy and has continued to do so after his retirement 15 years ago. He enjoys the group because he has made some good friends.

Whilst Robert is the life and soul of the group, he is lonely and sometimes he thinks he is depressed. He has an extensive network of friends who he has known for decades – some are his school friends. Robert is in contact with his friends on a regular basis – primarily by telephone.

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His home has many memories of his travels – he collected furniture and pottery from around the world – particularly from Hong Kong where he visited countless times. His home is his family home and he shared this with his mother until her death 15 years ago.

Robert loved the merchant navy – he loved travelling – still does but he cant afford to do as much travelling as he likes. He does go to Spain – particularly Benidorm on a relatively frequent basis and has made friends there and from right across Europe.

He has a car and likes to travel around the country visiting his friends– although the car is an expensive luxury. Well it is becoming more than a luxury as he seems to be developing arthritis which he blames on sailing the ocean waves and the damp atmosphere.

Robert's main interests are related to his travels – he loves fine furniture and porcelain and will travel the country to go to auctions or exhibitions. He has been relatively successful in buying at auctions and selling on making a small but reasonable profit in doing so.

Robert is 76 years old. He has his state pension and good pension from the merchant navy. He feels he is comfortably off.

Karen

enjoys the company that she obtains from the group and has made friends with the other members. She describes herself as a bit of a loner following her divorce from Michael 38 years ago. She waited until her 2 children had grown up before divorcing their father. She does not have contact with her children and still misses them terribly.

She worked as a Professor at the local University and was very well respected. She retired from paid employment 18 years ago. She is well published in her field and has travelled the world extensively giving lectures and presenting at conferences.

Karen has friends from work and sees them on a regular basis but spends a lot of time on her own reading and she has continued to publish. She keeps much of this activity to herself – not telling the group for no other reason than she doesn't think that they would be interested. Her close friends in the group know that she is continuing to publish material.

Karen enjoys holidays and regularly goes away in the country and abroad. She doesn't like sitting on a beach and would prefer to visit ancient archaeological sites and investigate the cultures associated with them.

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Karen lives alone, although has had lodgers in the past and is thinking about having one or two female students from the University. She lives in a large house on the outskirts of town and uses her car to go shopping, visit friends and to go out at night.

Karen is in very good health although over the years she has had a number of very serious health scares which have shaken her confidence significantly and she often wonders whether and how she would cope if she became seriously ill now. Karen has an extremely good pension from the University and her state pension. Karen is aged 78 years.

Doreen

comes to the club for the company and the friendship that the members offer her and describes herself as looking forward to the meetings. She was married until her husband suddenly died 4 years ago. She has 2 sons who live in different parts of the country and sees them regularly. She worked as a School dinner lady until she retired 10 years ago.

Doreen has been very low in mood and depressed following the death of her husband, whom she describes as her best friend. Doreen doesn't drive and her husband took her where ever she wanted to go – so she never had the need to use public transport until her husband died. Where she lives is quite isolated and the bus service whilst frequent can be unreliable. This as well as having arthritis in her knee makes getting on the bus very difficult and she has recently resorted to using taxis or lifts from friends.

She lives in a small house which she says is just big enough for her, it is well maintained and warm in the winter. The house is too small to have members of the whole group to visit although she has had some of her friends from the group to visit over the summer and they had a very pleasant afternoon sat in the garden.

Doreen has been going to various luncheon clubs for the company and then heard about **J**ueveillie made contact with Robert and has been attending the club for the last nine months. She is newest member of the club.

Whilst the lunches are quite expensive for Doreen, she so likes the company and the other people that she makes sacrifices over the weeks so that she can go to the meetings of the group. One of the sacrifices that she makes is not having a holiday – well she never really liked being away from home when she was younger – a week was enough then.

Doreen has a state pension and a small pension from her husband's works. Doreen is 70 years old.

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Simon

was married until his divorce 35 years ago and has lived alone ever since. He has one child – a son who he sees infrequently but speaks to on the telephone almost daily.
He says that he does get lonely but enjoys the friendships that he has made at the club. He worked as an office worker for a multi-national telecommunications company and prior to that he worked in a factory. He has been retired for 8 years.

Simon lives in a one bedroom housing association flat, in what he describes as a 'lousy' part of town. The stairwell of the flats regularly has drug addicts injecting their drugs and they leave their injection kits just lying around. He used to go and pick these up until he was told by somebody from the housing association of the risks of doing so. There are also a lot of alcoholics living in the flats which on occasions can mean a lot of empty bottles lying around, vomit on the stair wells and a lot of noisy arguments.

Simon hates living there. He feels very intimidated and only goes out at night if he has to. He wishes he could move to a better part of town and has asked the housing association to move him – with no success so far.

He has a telephone but can't really afford to use it – he has it more for safety than anything else. Simon doesn't have a car anymore although he can drive. His car was vandalised outside the flats.

Simon is a very private man and he keeps himself to himself and would never invite his friends from the club to visit him where he is living. He has very few friends other than the ones that he has made at the dining club but the friends that he does have outside of the club have known him for decades and have been there when he has needed them.

He loves meeting with his friends at the club and says that this is the only time he can be truly relaxed and who he actually is. In some respects Simon is a bit of a snob and has to make many sacrifices in order to be able to afford to go to the club meetings – not that he would ever tell anybody at the club this.

Simon is aged 73 years old. Simon lives off his state pension and other benefits.

Colin

is married to his second wife Anne who has a severe dementia and is now living in a residential home. He visits his wife every day but finds Anne's illness difficult to cope with. Colin gets a great deal of support from the group and meets individuals from the group outside of the regular meetings.

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Colin was employed as a steel worker in the local factory until its closure 20 years ago. He continued to work for another 18 years at the local DIY store until he retired.

Colin lives in his wife's house – which he moved into shortly after meeting Anne, but it has left him feeling very insecure particularly at the moment. Anne has two adult children who she has not seen since they announced that they were getting married. Both children felt that it was all right for Colin and Anne to live together but they felt that their getting married was disgusting and that they should be ashamed of themselves. Colin has never said to Anne, but he feels that their reaction was about the house that Anne owns – he thinks that they were expecting to get the house when Anne died. This is partly why is he so insecure about where he is living.

The other reason he is feeling so insecure at the moment is that he has become very friendly with the partner of somebody living at the residential home where Anne is living. In fact Colin thinks he is falling in love – he didn't mean for this to happen – and whilst he is very sad about visiting Anne and seeing her as ill as she is – he is very happy about going for a coffee afterwards with his new love.

Most of Colin's time is taken up with visiting Anne and doing jobs in the house – and more recently staring into the distance with a big smile on his face and a dreamy look in his eyes. He has not told anybody at the club about his new love.

Before all of this Colin had an allotment and grew all their own vegetables. He is a very good carpenter and learnt many new skills when he was working with the DIY store.

Colin is aged 68 years. He has a small pension from his previous jobs and a state pension.

Matt

is currently being divorced by his wife who recently announced that she didn't love him, has never loved him and had been having an affair with a woman for 17 years which he knew nothing about. He is still living in the same house as his wife although this is up for sale. He has 3 children who are upset about the divorce and their mother's relationship. They are in very regular contact with their father but want nothing to do with their mother.

Matt had been coming to the group for some time before the divorce, and will admit that his confidence has been shaken by his wife's news. He has take a shine to Karen, although he is not sure what she feels about him – she hasn't said anything about what she feels about him – which is confusing him a bit.

In fact Matt has been very depressed and would not blame Karen for not finding him very interesting after the life that she has led. Matt thinks he is dull and the others put up with him.

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He doesn't have any hobbies and just sits and watches the TV – hour after hour. As you can guess Matt doesn't go out a lot.

He retired from the civil service 11 years ago and did some small part-time jobs for a bit – working in the local shop on a Sunday for example. But he has stopped this now as well.

He loves his children, 2 daughters and a son but they all live some distance away and he doesn't see them very often.

Matt is aged 71 years. He has a civil service pension, some savings and a state pension.

Shirley

is living with her boyfriend – Arthur – and has done so for 35 years – the longest engagement in history as she describes. Arthur is a bird watcher; Shirley is not interested in this so when Arthur goes bird watching she comes to the club. Shirley is a relatively recent member and enjoys the company of others who enjoy her hobby - eating. Whilst Shirley would like to get married, she feels that she would have to lose weight and can not be bothered with that – so she will remain forever engaged.

Shirley and Arthur were not able to have children and adopted twins – Rebecca and Rachel. Shirley and Arthur live very near to their adopted daughters and their families – both daughters have got married – which Shirley finds quite funny given that their mother is still engaged to their father. She has 4 grandchildren and sees them every day and quite regularly they all stay over for the weekends – Shirley is never happier then when this happens.

Shirley has a lot of energy and is always busy and always laughing – she describes herself as fat and happy. Arthur is also very busy – as well as being a bird watcher he also has a large garden and an allotment in which he grows all the vegetables that he and Shirley need and most of Rebecca and Rachel's families needs.

Shirley loves the dining club – not just because she has friends there but also because they go to some wonderful restaurants and have wonderful food. Shirley also loves Roberts cooking – she thinks he is a wonderful man.
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Shirley recently retired from the local council – a job that she really enjoyed – working with the environmental health officers. But now when she looks back, she wonders where she ever got the time from to go to work because her life is so full.

Neither Shirley nor Arthur drive and they are dependent on other people driving them around – this falls mainly on Rebecca and Rachel. This does cause a little tension but they all soon get over it.

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Shirley and Arthur do not have a great deal of money – Shirley gets a local government pension but Arthur doesn't get a works pension and they get the state pension. Shirley is 66 years old..

Muriel

Is now living alone having had 5 husbands – all of whom have died – the most recent 4 years ago. She has 6 children from the first three husbands and has different relationships with them – she sees some on a regular basis and is close to them – the others she rarely has contact with.

Muriel is seen as a bit scandalous with all these husbands dying but she is very much liked by the other members of the club.

Her second husband left her comfortably off. Each of her subsequent husbands have added to her feeling of 'comfortableness'. She describes marriage as her pension plan and much more reliable than the government.

Muriel intends to spend her money and leave nothing to her children – as she says they didn't have to marry 5 times so why should they get any benefit out of it. This is partly why she does not see some of her children – and she firmly believes that those that she sees are hoping that she will change her mind.

Whilst she says that she has a lot of money put by – she lives in a modest 3 bed roomed house in a nice part of town. The house is very well maintained although decorated in an 'eclectic' style. Muriel has two cars – she has always insisted that she should drive and have cars in order to maintain her independence. Getting up to mischief more likely husband number 4 used to say.

Muriel is 76 years old. She has never worked – marrying was her job – but receives income from her husband's occupational pensions. She has her own pension and considerable savings. She is on the look out for husband number 6 – and she wants a young man with whom she can have some fun and spend her money.

Valerie

in contrast to Muriel, Valerie is the quiet one of the group. She lived with her mother until hr mother died. She has never married and never had a boyfriend – although she has told other that she has. Valerie lives alone in her mother's house and is an only child.

She worked as a librarian – and she knows it is a cliché but she loves reading and books. She believes that these new electronic books are horrid and think the most important aspect of reading – is holding a book.

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Valerie retired about 4 years ago – she wasn't looking forward to this but is a regular visitor to the library that she worked in, although this time as a customer. Her house is like a library – as Valerie visits second hand book shops and can't seem to leave without buying a book. Her main interest is ancient culture and ancient mythology – the Greek gods and goddesses being her favourite.

In fact she loves visiting the Greek islands and will go as often as she can afford. She doesn't stay in luxury hotels, rather she back packs around the islands but always ends up on her favourite island.

She is very friendly with Karen who she admires very much and loves the rare occasions she has been able to watch Karen work. Valerie doesn't have a car and has to rely on Karen picking her up. But when she does visit Karen she does tend to stay over – which she loves.

Valerie is 69 years old. She has a good pension and a state pension. She also has some money that her mother left her.

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Part 1

The social exclusion of older lesbians, gay men, bisexuals and transgendered people

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Social exclusion of older people

What is social exclusion?

Social inclusion and combating social exclusion has become a major policy initiative of the Labour government that was elected in 1997. At the core of the policy is an understanding that some people, for a variety of reasons, live their lives on the margins of society and may be completely or partially excluded from that society. Social inclusion as a concept attempts to understand why they are not fully involved with society and seeks to ensure that they are included and involved.

There are many reasons why people may be excluded which include:

- Poverty
- Unemployment
- Disability
- Drug addiction
- Undertaking crime
- Being oppressed and discriminated against.

Older people, as a result of ageism, can experience exclusion. Older LGBT people as a consequence of ageism, homophobia and heteronormativity (these terms will be explained later) experience multiple layers of oppression and are potentially more likely to be excluded or ignored.

It is interesting that when looking at social exclusion, the emphasis tends to be placed on employment or work with the expectation that working will give people an income, make people less poor and ensure that they are included in society. However, the majority of older people are excluded from employment because of compulsory retirement.

This has meant that as Scharf et al (2001) comment

'…that current government initiatives relating to social exclusion…tend to ignore the needs of older people. The public policy emphasis of current social exclusion debates is clearly oriented to integrating younger and unemployed people into the labour market.'
Scharf et al (2001) 304

This means is that older people are again at the top of the list of those who are excluded – excluded from 'the excluded'. We will see this again when we discuss ageism as a system of oppression and explore why ageism is seen as the least important or significant form of discrimination.

Defining social exclusion

It will not surprise you to know that there are different ways of defining what social exclusion is. These differences reflect what is being measured and the emphasis that is placed on

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those who are undertaking the measurement of social exclusion.

Perri (1997) states that social exclusion

Is a useful term in societies in which there is growing geographical polarisation of access and opportunity, so that often quite small areas – a housing estate, an inner or outer urban area – are cut off from the life around them.
Perri 1997:3

Perri is here placing importance on the experience of exclusion as it impacts on a geographic area and identifying that the people living in that area experience exclusion as a result of living in that area and of other common factors.

These common factors or multi-dimensional processes are identified by Madanipour et al (1988) who link these factors into the common experience of certain neighbourhoods.

Both Madanipour and Perri are placing an emphasis on particular areas in which there are high levels of unemployment, high levels of poverty, low levels of engagement with the political system as few people vote and high levels of 'disengagement' with society.

Social exclusion is defined as a multi-dimensional process in which various forms of exclusion are combined: participation in decision making and political processes, access to employment and material resources, and integration into common cultural processes. When combined, they form acute forms of exclusion that find a spatial manifestation in particular neighbourhoods.'
Madanipour 1998:22

Whilst these definitions are looking at social exclusion in geographic areas and we know that older people can and do live in such areas, we have to ask ourselves whether such measures actually capture the nature of social exclusion experienced by older people.

The key focus of many other commentators is related to the experience of poverty and how being poor has the result that people are unable to participate in 'normal life' because they do not have the resources to do so. But as Bhalla and Lapeyre (1997) comment

'adequate levels of income are a necessary though not sufficient means of ensuring access of people to basic human needs.'
Bhalla and Lapeyre 1997

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Clearly, there are other factors beyond poverty which influence the exclusion of people. Berghman (1997) identifies

'non-realisation of citizenship rights within four key societal institutions – the democratic and legal system, the labour market, the welfare system, and the family and community system. '
Berghman 1997 cited in Scharf et al 2001:305

With a similar focus, Diane Richardson's work (see Richardson 2000) explores how lesbians and gay men may be regarded as citizens at one level but are denied equal rights with other citizens. Lesbians and gay men are for example denied the rights and status of marriage which are different from a civil partnership as defined by the Civil Partnership Act 2004.

How does the Government measure exclusion in later life?

The Government measures exclusion in later life by exploring a number of 'dimensions' which flow from asking older people what matters for their quality of life. Quality of life is defined as 'things that everyone should be able to expect' (ODPM 2006:18). The report identifies that the following factors were mentioned:

- Decent health

- Decent income
- Their home as being important
- Good relationships with family and friends
- Having a role
- Feeling useful
- Being treated with respect.

These factors have given rise to the following dimensions for measuring the social exclusion of older people

The Government's indicators of exclusion
- Social relationships (contact with family and friends)
- Cultural activities (such as going to the cinema or theatre)
- Civic activities (such as being a member of a local interest group, undertaking volunteering or voting)
- Access to basic services (such as health services and shops)
- Neighbourhood exclusion (feeling safe in your local area)
- Financial products (such as a bank account, or long term savings) and
- Material consumption (such as being able to afford household utilities and an annual holiday).
ODPM 2006: 18

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It is interesting that whilst older people themselves identified a decent income as a factor in determining their quality of life, this has not directly been included as a dimension for measuring exclusion. Although it must be acknowledged that some of the dimensions do rely on a decent income. The Government maintains that:

'The experience of exclusion in later life can be particularly acute as it is all too rare that people already excluded in mid-life are able to break the cycle of exclusion in later life and it may even worsen. Additionally, key elements in later life, such as bereavement or retirement from work, can lead people to become excluded, and age related prejudice can limit an individual's opportunity to overcome these.'
ODPM 2006:18

So, the Government acknowledges that the exclusion of older people can be an issue for the individual older person through out their life or it can be a consequence of the events the surround later life. Given that retirement and age related prejudice (ageism) affects all older people is it fair to say ALL older people are excluded?

The answer to this very much depends on how you view older people and how you define exclusion.

We have seen above that there are different ways of defining exclusion, narrow definitions (limited elements or factors that are regarded as excluding) would inevitably mean that smaller numbers of people would be counted as being excluded. However, broader definitions such as poverty (this depends on what is poverty) would potentially involve larger number of people.

In terms of older people, it might be tempting to say that as ageism and retirement from work affects all older people then all older people are excluded. However, this approach 'homogenises' older people in that it treats everybody as the same. What we do know is that the group of people that we call older are a very diverse group of people.

The group of people that we call older have ages that can span 50 years or more – think about what you have in common with someone who is 50 years older or younger than yourself.

Older people can be very wealthy
Older people can be very poor
Older people can be very isolated and lonely
Older people can be very involved with their family or their community
Older people can be very healthy
Older people can be very ill

So we can not say that all older people are socially excluded – some will be whilst others are not.

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How many older people does the Government think are excluded?

The Government believes that 7% or 1.2 million older people are excluded on three or more of their indicators of exclusion (see above). Furthermore they believe that 13% (approximately 2 million people) of older people are excluded on two indicators, leaving 80% of older people NOT experiencing multiple exclusion (being excluded on two or more indicators).

This leaves 51% of older people not experiencing exclusion on any of the indicators and 29% of older people being excluded in one of the indicators.

Whilst this is interesting there are other issues that we need to look at in order that we get a better understanding of what is happening to older people.

Who does the Government think is at risk of multiple exclusion?

The Government believes that those older people who:

- Have low income
- Are living alone and
- Are suffering from depression

are between 2 and 5 times more likely to experience multiple exclusion compared to the older population as a whole.

As an indication of some of the complexities in understanding the exclusion of older people, the Government provides us with an example

'…that only one per cent of older people have no phone. But, of these people, 35% experience multiple exclusion.' ODPM 2006:20

Age and social exclusion

There is a strong relationship between age and social exclusion such that increasing age increases the likelihood that people will be excluded in the areas of social relationships, service provision and material consumption, whilst those aged between 50 and 59 years are more likely to be excluded from civic engagement.

One in three (33%) of those people aged over 80 years were excluded from basic services in comparison to one in twenty (5%) people aged between 50 and 59 years. A similar picture exists for exclusion from social relationships as one in four (25%) of those age 80 years or over are excluded in this area whilst 9% of those aged between 50 and 59 years.

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So, age has an effect on the experience of exclusion, not only which factor older people are excluded from but also how many older people experience exclusion in that area.

Does where the older person live matter?

The Office of the Deputy Prime Minister (ODPM) in their report 'A sure start to later life' (2006) comments that excluded older people live in all the regions of England.

Some areas were found to have higher numbers of excluded older people:

- Older people living in London experienced more multiple exclusion than in other regions.

- The south east and east of England have the least risk of exclusion

- the north east and west, Yorkshire/Humber, east and west midlands and the south west were all found to have higher rates of exclusion.

In areas regarded as deprived by the Index of multiple deprivation (2004) there is a higher proportion of older people experiencing exclusion.

Where you live does matter, but where you live is also affected by a number of issues such as income, health, family and others. But remember excluded older people live everywhere including potentially next door to you.

What are the characteristics of excluded older people?

The Office of the Deputy Prime Minister (ODPM) in their report 'A sure start to later life' (2006) identify the characteristics of the typical excluded older person indicator by indicator.

Exclusion from social relationships
Typical profile – male, no partner, living alone, no children, no siblings, poor health, depression, no physical activity, low income, no car, aged 60 and over

Exclusion from cultural activities
Typical profile – female, non-white, living alone, no partner, no educational qualifications, receipt of benefits, low income, poor health, depression, no car, no physical activity

Exclusion from civic participation
Typical profile – female, white, 4 or more children, no or few educational qualifications, poor health, depression, low income, living alone, aged 50 – 69, renting

Continued

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Exclusion from basic services
Typical profile – aged 70 and over, non-white, living alone, permanently sick, poor health, depression, no telephone, no car, never use transport

Exclusion from neighbourhood
Typical profile – 4 or more children, unemployed, poor health, depression, low income, renting, deprived area

Exclusion from financial products
Typical profile – younger female, non-white, lives with children, has no partner, 2 or more children, no or few educational qualifications, not in employment, poor health, low income, renting, deprived area, no car, depression, low income, no telephone

Exclusion from material exclusion
Typical profile – aged 70 and over, male, non-white, living alone, no partner, no children, poor health, low income, renting or buying accommodation, no car, no telephone, few educational qualifications, deprived area

Source: ODPM 2006:20

As you can see, there are common elements in these typical profiles which feature in the indicators or dimensions of exclusion. These are:

- Low income
- Poor health
- Depression
- Living alone
- Living in a deprived area
- Few educational qualifications
- No car

Many of these common elements are linked such as low income which will mean that the person is unlikely to have money to run a car and is more likely to live in a deprived area. Low income also impacts on diet and health.

Activity
Using the government's 'dimensions' of exclusion – now read the profiles of the people attending the Jueveillie Fine Dining Club and answer the following questions.

How many of the members of the club are socially excluded and how many experience multiple exclusion?

- Do you think, from their profiles that they are excluded?
- Do you think that they **feel** they are excluded?
- Are there members of the club that you think are excluded but who do not fall within the Governments dimensions of exclusion?

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What does the Government say about the exclusion of older lesbians, gay men, bisexuals and transgendered people?

The report by the ODPM (2006) does not say a great deal about older LGBT people and what it does say is tucked at the back of the document - but this section is part of the main report and not an appendix to the report.

The report starts this section with a quote from Age Concern England.

'Older lesbians, gay men and bisexuals may face issues and injustices because of their sexuality, many caused by a lack of legal recognition of their relationships as well as the double discrimination of ageism and homophobia.'
ODPM 2006:103

The report then contains two short statements:

'Older LGBT people have told us about fearing negative responses on the grounds of their sexuality from institutions when life changing events occur, for example, loss of independence through hospitalisation, going into a residential home, or having home carers.
ODPM 2006:103

Lack of recognition of same sex relationships has also been raised as a problem. Many pension schemes have failed to recognise same sex partners as beneficiaries and same sex couples have no status as next of kin causing financial difficulties at a time of bereavement. The advent of the Civil Partnership Act is aimed at addressing this.
ODPM 2006:103

The report is clearly identifying that older LGBT people can be excluded as any other older person can be in terms of the measures or indicators of exclusion as a consequence of poor income, poor health living alone etc.

The report is also acknowledging that there are additional elements that affect the lives of older LGBT people which do not impact on older heterosexuals, such as:

- Homophobia – a hatred or fear of LGBT people,
- Attitude of health and social care staff being hostile to them at a time potentially when they are most in need
- A lack of recognition of their sexuality,
- A lack of recognition of their relationships
- A lack of services to meet the specific needs of older LGBT people when they need help,

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Conclusion

The social exclusion of older people is a problem and this has now been acknowledged by the Government. As we have seen, older people can be excluded on a number of measures and older LGBT people can equally be excluded on these measures.

However, older LGBT people can face additional factors of exclusion that are related to their sexuality and which are not experienced by other older people.

This additional layer of exclusion, experienced by SOME older LGBT people is the reason why we have produced this teaching and training pack. We hope that the material contained in this pack will help you as either a trainer, educator or as a health or social care worker better understand the position of older LGBT people thereby ensuring that they are responded to with respect and with equal treatment.

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Ageism

Ageism in our society is both pervasive (spread through out society) and endemic (deeply rooted). It impacts on all of us, irrespective of our age because it is a form of discrimination which is based solely upon our age.

It is reflected in:

- the decisions made by government,
- the actions of health and social care professionals,
- it is portrayed to us in newspapers and on the television every day,
- it is reflected in the birthday cards that we buy.

Ageism is similar to other forms of oppression and uniquely different to discrimination based upon gender, race, sexuality and disability.

As ageism discriminates against people solely because of their age, it discriminates against the young as well as the old. It acts against people in their mid-life as much as the young and the old.
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Definitions of ageism?

The three definitions of ageism that follow have a number of things in common – each of them identifies how ageism is experienced and the basis upon which ageism operates.

'Ageism can be seen as a process of systematic stereotyping of and discrimination against people because they are old, just as racism and sexism accomplish this for skin colour and gender.
Butler (1987:22)

'Social process through which negative images of and attitudes towards older people, based solely on the characteristics of old age itself, result in discrimination.'
Hughes and Mtezuka) – cited in N. Thompson (2001:89) Anti-discriminatory practice

'the discriminatory behaviour towards older people stemming from the socially constructed attitudes and beliefs that growing old is accompanied by loss of competence and intellectual deterioration'
Pierson, J. and Thomas, M. (2002:23)

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What are the common features of these definitions?

- **Stereotypes** – each of the definitions identifies that ageism constructs images of what it is like to be old. These stereotypical images are experienced by ALL older people and are negative in character.

- **Discrimination** – the stereotypes allow us to recognise the group – in this case older people - and on that basis treat them badly or discriminate against them.

- **Separation** – the stereotype, because it constructs an image of older people which does not belong to us, allows us to separate ourselves from older people because we do not have these characteristics and therefore we are not old.

What are the stereotypes about older people?

The stereotype constructs images of older people that we can see on television and we all recognise. Such images include the characters of Victor Meldrew or Hyacinth Bucket.

Older people are portrayed as grumpy, interfering, out-of-touch, obsessed with small issues, a bit odd, having blue rinses

These images are negative and apply to ALL older people, thus:

Ageist stereotypes

- All older people live alone
- All older people are socially isolated
- All older people are poor
- All older people live in bad housing and house that are too big for them
- All older people are ill
- All older people are dependent on younger carers
- All older people are unhappy
- All older people are withdrawn
- All older people are awaiting death

Old = useless
Old = childlike
Old = ill
Old = thick
Old = ugly

Some stereotypes are contradictory:
Old = childlike – the image of a second childhood - but what about the image of the dirty old man?

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Quite clearly many of these stereotypical images feed into each other to present a degree of consistency – however far that may be from the reality of older people's lives. So being poor and living alone inevitably means being socially isolated and withdrawn. Equally, if you are poor, isolated and alone, the likelihood is that you will be unhappy.

The responsibility for all of this rests with the older person themselves for being old is in many ways seen as a sign of individual fecklessness, of being irresponsible thus television adverts urge us to treat the signs of ageing as if ageing or becoming old is something to be avoided.

What do these stereotypes mean in practice?

Asexuality - Ageism acts to deny the sexuality of all older people. It is based upon the idea that the body young is the body beautiful. Of course the opposite of this means that the body old is the body ugly and who would want to have sex with someone who is ugly.

There are a number of consequences of this stereotype:

- older people who do have sex are viewed as odd, perverts and dirty.

  - Government advice about sexual health either completely ignores older people or says that

contraceptives are not necessary because there is no chance of becoming pregnant. This is DANGEROUS advice because of the spread of sexually transmitted diseases such as HIV and AIDS, AND it assumes that all older people are heterosexual.

Burden on younger people – this is a very powerful stereotype and can create fear and hatred of older people. It is based on the idea that late life is a burden – an unpleasant thing that we all do not want and will stop us doing the things that we want to do.

The stereotype presents itself in many different and sometimes subtle ways:

- Economic burden – this has been used a great deal over the last number of years to describe the idea that we can not afford the level and number of pensions that we are currently paying and that the economy can not sustain the number of older people who are receiving pensions.

  The Government does not portray the options fully.. The options that we are given are a reduction in the value of pensions coupled with younger people having to specifically save for their own late life rather than pay increased taxation.

- Burden of care - one image that is constructed is that we will be forced to care for our parents in late life in our own homes and that this will stop us living our

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own lives. We therefore have the idea that we can 'put our parents in a home' when they become a nuisance to us.

This idea is of course absolutely wrong – we have no rights to 'put our parents in a home' and unless the older person is subject to compulsion through an Act of Parliament, then the move in to a residential home has got to be consented to.

Old people are poor – the pensions that we as a society pay to older people as a percentage of average income (the replacement ratio) are and always have been low in comparison to other countries. So there are groups of older people, who do not have a great deal of income, but the majority do have reasonable incomes and there some very, very rich older people – the Queen at 80 years is amongst the richest people in the country.

Older people do not claim all the benefits that they are entitled to receive but also there are a large number of benefits which they can claim or are paid automatically:
- winter fuel allowance
- free television licence
- Age related benefits
-

In the absence of a comprehensive single payment – older people's income is dependent on this wide range of benefits and of course many older people do not realise that they are entitled to benefits, do not know about them or find them

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Activity 1

One evening when you are watching television, ask yourself the following questions:

1. What type of programmes are on the television?
2. What type of audience do you think that they are aimed at?
3. what type of programmes do you enjoy?
4. Are older people part of the television programmes?
5. Would the programme be more complete if older people were included?
6. If older people are being portrayed in the programme – what sort of image is being portrayed?
7. How many older people do you actually know who are like the person being portrayed on the television
8. Count the number of images of older people you see on the television
9. Are the older people central to the programme or are they bit-part players?
10. You are a visitor from another planet – based upon what you have seen what conclusion would you draw about older people?

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difficult to claim. As a result many older people are poorer than they should be.

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Activity 2

- Read the profiles of the people attending the Jueveillie Fine Dining Club and ask yourself what impact do you think is ageism having on the lives of the people in the club?

- Where, in these profiles do you think ageism has forced the members of the club to change their lives?

- Do you think that the stereotypes of older people, identified above fit into the lives of the members of the club?

- If the stereotype does fit with the lives of the members of the club – is it age that has caused this or is it another factor and if so which factor?

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Why is Ageism the same as but different from other forms of discrimination?

Steve Scrutton (1990) importantly argues that whilst ageism, racism and sexism have a lot in common, there are two differences between ageism and the other expressions of oppression.

1. Older people do not form an exclusive group and everybody will become a member, however, the white racist will not become black and the male sexist will not become a woman BUT the young ageist will become old.
2. Ageism can appear to result from the natural process of biological ageing rather than being socially constructed – therefore ageism can appear to be "natural" and thereby there is nothing wrong with ageism.

The consequence of Scrutton's first point is that the young ageist has learnt what it means to be old and knows what the negative images are and how to use them – hence in part the reason to avoid being old in the first place.

But it also means that in later life, older people themselves can be ageist drawing a distinction between themselves and other older people – sometimes people who are younger than they are. This also means that older people who have lived their lives in an ageist society may also restrict what they do in the belief that older people do not do certain things.

Like other forms of oppression and discrimination – ageism is transmitted by both language and behaviour. In the case of institutions ageism is expressed by the language and

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behaviour of the staff as well as the policies that the organisation adopts and uses to carry out its functions.

Attention to the language that we use when talking about or describing older people is very important because it is a vehicle of oppression.

Words such as 'the elderly' 'elderly' 'geriatric' homogenises (treats everybody as the same) older people. These words do not identify the differences which exist between older people – bearing in mind that older people can include people whose ages can be 50 years different.

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The term 'older people' – which is the term that we are currently using - establishes a relationship between you and the people that you are referring to by essentially saying the person or the group are older than you are. Ageism, as a system of oppression, tries to separate you from older people – but the term 'older people' by establishing a relationship between you and older people undermines this separation.

What is being done about ageism?

Ageism as a system of oppression and a vehicle of discrimination is not illegal at the moment. In October 2006 it became illegal to discriminate on the basis of age **in employment only**. The Employment Equality (age) Regulations will see changes in how employers recruit employees – dates of birth will no longer be allowed on application forms and it will be illegal to sack people because of their age.

But this regulation only offers limited protection up to a specific age and only applies to people in employment. Colin Duncan (2008) argues that age equality legislation does not address age discrimination. He says that in age equality there are 3 phases:
  • Recognition by commentators such as Butler (1987) and McEwen
  • Reaction to demographics and welfare/labour market concerns

• Application to all ages with symbolic priority given to younger people in the labour market

Duncan goes on to argue that age discrimination is much more personally focused on older people and creates negative images of older people. By focusing on age equality the Government is again denying the existence of older people as it privileges the young and in this respect age equality becomes age discrimination.

The Equality Acts - in April 2007 it became illegal through the Equality Act 2006 to discriminate in goods and services on the basis of:
  ▪ Race
  ▪ Gender
  ▪ Disability
  ▪ Sexuality
  ▪ Religion

For the first time in the United Kingdom it became illegal to discriminate against lesbians and gay men. However, discrimination based upon age was not included in the 2006 Act. The result was that ageism became the only legal form of discrimination and by its absence the Act itself became ageist further illustrating that age discrimination is both not viewed as serious as other forms of discrimination and that our society endemically ageist.

The Equality Act 2010 creates a single public sector equality duty which covers the 8 protected characteristics:

• Age,
• disability,
• gender recognition,
• pregnant or maternity,
• race, religion or belief,
• sex and sexual orientation.

The Act establishes that discrimination is about relative rather than absolute standards. Therefore it is about a person's treatment in comparison to a comparator rather than absolute standards. Direct discrimination will occur if a person is treated less favourably because of their age however, indirect discrimination will occur if a provision, criterion or practice is applied which puts a person at a particular disadvantage. The Act does not considered it discrimination if a particular policy or practice can be shown to be a proportionate means to achieving a legitimate aim – *'objective justification'*.

This Act does include age discrimination BUT allows such discrimination to continue if a public body can objectively justify it. So it remains a possibility for social services to justify unequal distribution of resources and support for older people if this can be objectively justified.

In health and social care – Standard 1 of the National Service Framework for Older People (DoH 2001) requires agencies to 'root out ageism'. The Standard requires health and social care agencies in England to:

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> '… ensure that older people are treated as individuals and that they receive appropriate and timely packages of care which meet their needs as individuals, regardless of health and social services boundaries.'
> (DoH 2001)

Is there evidence to suggest that nurses, social workers, doctors, physiotherapists or occupational therapists are ageist to warrant a whole standard to counter ageism in health and social care practice?

> 'There is a deep rooted cultural attitude to ageing, where older people are often presented as incapable and dependent – particularly in the media. As there is an increasingly ageing population, there is a need for policy makers and those who plan and deliver public services to consider the impact of ageism and to take action to address this'.
> Audit commission 2006

> 'tendency for social work with older people to be seen as routine and uninteresting, more suited to unqualified workers and social work assistants than to qualified social workers.'
> Thompson, N. 2001:110

The Forward to the National Service Framework for Older People (DoH 2001) describes the staff working in the health and social services as working within oppressive systems and structures of the agencies. However, inevitably structures and systems of both the health and social services are constructed and are implemented by the staff. But it is not wholly fair to solely blame the staff – who have grown up and work in a society which is endemically and pervasively ageist so it is inevitable that ageism is part of professional practice.

> 'Implicit vested interests which promote and sustain professional hegemony'
> Warnes, A.M. Warren, L. and Nolan, M. (2000)

Hegemony – means dominant way of thinking - of viewing the world and its power is such that other ways of looking at the world are not even thought about because it is natural.
This quote from Warnes, Warren and Nolan suggests that ageism could potentially be regarded as a vested interest which can be used to perpetuate professional power and dominance.

The joint Audit Commission, Health Care Commission and the Commission for Social Care Inspection (2006) report reviews the progress of health and social care agencies in implementing the standards within the National Service Framework for Older People (DoH 2001). The report explores implementation of Standard 1 – Rooting out age discrimination – by drawing a distinction between access to services and attitudes of health and social care staff.

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In terms of access to services, the report identifies that health and social care agencies have **'started'** to audit their policies related to access and eligibility criteria for services. They report that 76% of organisations had reviewed their policies for access to services and some 38% had implemented changes.

In terms of the attitudes of health and social care staff, the report notes some progress but acknowledges that ageist practice and behaviours were still present within service areas. The report goes on to note that:

- o Older people in some acute hospitals were receiving poor treatment because of their age,
- o There was little evidence of training to assist staff to challenge ageism
- o Many older people who were involved in the review had experienced ageism,
- o There was little coordination of policies related to fair access,
- o In mental health services, there had been an improvement but that there was more work to be done to ensure equal access to the range of mental health services.

Clearly, this report identifies that there are continuing problems of ageism within health and social care services and with the staff of these agencies. This report was undertaken as a mid point review of the progress of a 10 year plan which the National Service Framework for Older People (DoH 2001)

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Activity 4

What do you think Warnes, Warren and Nolan's statement?

Do you think that health and social care professionals do use ageism to maintain their power?

If you think health and social care professionals do – how does their behaviour reflect this – what do they do to suggest this? – please give specific examples of their behaviour

What should health and social care professionals do about these issues?

Health and social care staff are required by their training and their professional codes of conduct to treat people with respect and in the case of social work to work within an anti-discriminatory framework which in itself seeks to highlight and combat oppression and discrimination.

The emphasis therefore is that health and social care staff in their professional practice should not discriminate against older people and furthermore should seek to combat ageism

(and any other form of oppression) whenever they see it. As Thompson (1993) comments:

'As with racism and sexism, if we are not actively 'swimming against the tide' of cultural and institutional ageism, we will be carried along with it, such is the strength of ageist ideology.'
Thompson, N. (1993:94)

Thompson (1993) also argues that as a professional worker, if you are not actively seeking to combat oppression then you are part of the problem.

There are clear, professional, moral and policy imperatives which require health and social care professionals to work in an anti-ageist manner. However, as the joint commission report (2006) identifies, ageism still exists in professional practice and can manifest itself not only in differential treatment in terms of access to services based on the persons age, but

'Care givers and volunteers with older people, for instance tend to use more questions and repetitions, and to enjoy simpler syntax in the conversations with older people, arguably indicating an assessment of lower intellectual abilities.'
Andrews M (1999)

'Society tends to treat adults with mental illness as children, determining where they live, what they do, when they go to bed, when they rise, what they eat, helping them dress, making sure they are ready for the ambulance, minibus, or the next music and movement session – these are widely viewed as the prototypical features of institutional care.'
Morgan. K. (1992)

The examples of practice identified here highlight the subtle ways in which ageism presents itself in professional practice in the actual interaction between older people and health and social care professionals. Ageism, as illustrated by these examples, means that we have to talk to older people differently than we would when talking to younger people – talking slower, loudly, using simpler words. It means that we can tell people when to go to bed, what to eat and where to go – would you like to be treated in this way?

Can the 'personalisation agenda' help?

The personalisation agenda (see HM Government, 2007 and Department of Health, 1998) for adult social care in the UK has the potential to significantly change how social care is organised and delivered with the promise of much greater control being given to the users of services. This prospect of change applies to everyone who needs social care in order to

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support them, including older LGBT people. However, this potential may not be fully realised because of a number of very broad influences such as:

> ➤ The overall cost of social care to the public finances,
> ➤ Demographic changes as the absolute numbers of older people increase significantly,
> ➤ The erosion of professional power as the people who use services determine their own needs.

The objective of personalisation is to place the control of the organisation of care with the person who needs the care. In this way they can make decisions about what is best for them rather than what is available in the area in which they live. The previous Government's vision for social care in England (See DoH 2006) included maintaining the independence of people; ensuring their social inclusion; that they receive high quality services and that prevention and community based solutions are key aspects of supporting people.

The issue of community based solutions feeds very neatly into the idea of a 'gay community' with the expectation that older LGBT people will be looked after by the gay community. However, the real world is not this simple. Older LGBT people do not live in easily identifiable communities but live on your street and in your neighbourhood and therefore are part of the communities in which they and you live. Equally, there is not one idea or image of what it means to be gay, lesbian or bisexual. There is in fact a wide variety of ways of living and what would suit one gay man will not suit another. Some older LGBT people will be 'out' to their community whilst others will

not be so public about their sexuality. If personalisation is to successfully address the needs of older LGBT people then it has to be flexible enough to enable people to be who they are and not what is acceptable for services. For some this inevitably will involve additional costs as employing a lesbian or gay carer may involve greater distances to be travelled but also in helping the person to maintain existing networks may also involve travelling further. As an example, as an older gay man I might want to go to the pub but I don't feel comfortable going to the pub at the bottom of my street and would prefer to go to the local gay pub which is much further away.

The payment of care within the personalisation agenda relies on either:

> ➤ Direct payments or,
> ➤ Individualised budgets.

The actual money that the individual receives to pay for their care costs is determined by the Resource Allocation System (RAS). This is crucial as the RAS sets out what this older person will get and what that younger adult will get. The key is equality of outcome so that the individual receives money to pay for their care based upon their need and not upon ideas of what older people require. It is at this point that the potential exists for different treatment made acceptable by the 'objective justification' element of the Equality Act 2010.

The implication for older LGBT people is that the additional costs involved in employing a lesbian or gay carer or continuing to engage in their own networks would not be

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acknowledged in the calculation of the cost of their care. This is a 'sexuality blind' approach which fundamentally denies the sexuality of all older people (see below) and denies the difference in how lives have been lived based on differences in sexuality. A sexuality blind approach becomes difficult to justify for health and social care agencies and practitioners as it reflects ageist attitudes and may give rise to questions about the legality of such an approach. The Commission for Social Care Inspection, (2008) recently identified that 45% of LGB service users said that they had experienced discrimination when using social care services with the result that social care services are not presently fully accessible and appropriate to LGB people in the UK.

'It is not the prerogative of the younger professional to explore what is right. It is the obligation of the younger professional to explore what is right – or more realistically, what is best or the best possibility – in any particular situation with an older person.'

'Whilst acknowledging the impact of ageist values and discriminatory policies on older people, professionals must avoid conceptualizing older people as victims. Their status as survivors, as people with responsibility for their own actions and with a wide range of personalities as in other groups of people must be acknowledged.'
Hughes B. 1995:45 and 48

Abuse

As ageism constructs a separation of younger people and older people, it also establishes the basis of differences in treatment which although are abusive can be viewed as normal or the way that older people should be cared for.

Ageism also constructs dependency in late life as a nuisance or an irritant – as inconveniencing younger people (the burden of care argument) and thereby the seeds of abuse are sown.

The House of Commons Health Committee reported in 2004 on its investigation of abuse directed towards older people and in the summary acknowledges that child protection has a much higher profile that the abuse of older people which it says remains in the background.

'Abuse is a violation of an individual's human and civil rights by any other person or persons…Abuse may consist of a single act or repeated acts. It may be physical, verbal or psychological, it may be an act of neglect or an omission to act, or it may occur when a vulnerable person is persuaded to enter into a financial or sexual transaction to which he or she has not consented, or cannot consent. Abuse can occur in any relationship and may result in significant harm to, or exploitation of, the person subjected to it.'
No Secrets (DoH 2000:4)

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In the evidence to the Committee, Gary Fitzgerald, who was representing Action on Elder Abuse highlighted an example of the care of an older woman by her relatives in contrast to the care of Victoria Climbie, a child tortured and murdered by her relatives. In terms of Climbie, criminal prosecutions and an inquiry took place with professional workers being held to account for their actions. In the case of the older woman – Margaret Panting the inquest established an open verdict and no one was held to account for what happened to her.

'…Margaret Panting, a 78 year old woman from Sheffield who died after suffering "unbelievable cruelty" while living with relatives. After her death in 2001, a post-mortem found 49 injuries on her body including cuts probably made by a razor blade and cigarette burns. She had moved from sheltered accommodation to her son-in-law's home – five weeks later she was dead. But as the cause of Margaret Panting's death could not be established, no-one was ever charged. An inquest in 2002 recorded an open verdict.' House of Commons Health Committee (2004) Elder Abuse page 5

Diversity in late life

As ageism has sought to homogenise (treat everybody as the same) older people, increasingly the diversity of older people is being recognised although the recognition of the differences that exist amongst older people tends to be seen in groups. As result of the work of feminists writer and commentators such as Simone De Beaviour (1977) and Sara Arber and Jay Ginn (1995) we now recognise that older people can be **women** and that in fact as a result of differences in life expectancy (men die younger than women) the experience of very late life is on the whole women's experience.

As a result ageism as a system of oppression interacts with sexism to ensure that older women are oppressed as a consequence of both ageism and sexism. This means that older women are invisible in policy, in the consideration of services and are treated differently in terms of pension entitlement.

We have also begun to recognise that older people can be **black or from minority ethnic communities**. Writers and commentators such as Alison Norman (1985) and Ken Blakemore and Margaret Boneham (1993) have highlighted the position in which older black and minority ethnic people are placed in our society and how racism interacts with ageism.

Ageism, because it does not differentiate between older people ensures that all older people are considered to be white and racism acts to ensure that services that are available to assist older people are either not available or not suitable for black and minority ethnic older people. Whether the lack of appropriate services for black and minority ethnic older people is deliberate or a reflection of a lack of

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understanding will inevitably reflect your understanding of racism and the position of older people from black and minority ethnic communities.

The importance of acknowledging the aspirations and needs of black and minority ethnic older people in the United Kingdom is not only a moral equality issue but is particularly important for the people who experience racism and ageism and will be more so given that the numbers of older black and ethnic minority older people are set to rise from 175,000 people today to 1.8 million by 2026 (Social Exclusion Unit (2006).

More recently we have begun to acknowledge that older people can be **lesbian, gay, bisexual or transgendered**. However, the power of ageism seeks to deny the sexuality of all older people, thus recognising that some older people's sexuality exists AND is different from heterosexuality is a bit like trying to peel the layers of an onion. Homophobia (the fear of lesbians and gay men irrespective of age) and heteronormativity (the assumption that heterosexuality is normal irrespective of age) means that when an older person's sexuality is recognised, it is always presumed to be heterosexual.

But of course older LGBT people can be black and from minority ethnic communities. Healey's (1994) discussion of being old and a lesbian identifies the effect of the interplay between these systems of oppression individual people and their lives. She describes both what she is and what she is

not, as such she states that she is not docile, does not accept the orthodoxy's of women serving and relying upon men. She is not, in a broad sense a 'grandmother' to the world although recognises that many older lesbians do have grandchildren.

She has placed a high value on independence and her own self-reliance recognising the:

> '…meaning of being multiply oppressed. Every lesbian has paid a large price for being different because she is a woman and a lesbian. If she happens also to be a woman of color, or Jewish, or poor or disabled, she then experiences additional reprisals and discrimination. And now, finally having grown to be old (original emphasis), we experiene the compounding of all these oppressions in the insidiousness of ageism, and the total effect is most assuredly greater than the sum of the individual parts'. (Healey, 1994:111)

Healey (1994), identifies how being oppressed at different levels at different times in her life, she now is invisible from consideration based upon the reaction to her age. She identifies that she, like other lesbians has '…found the strength, the bravery and the courage not just to survive but to grow and to love as well.' (Healey, 1994:112) She now feels - at the age of 70 years - freer than ever before, less restrained by some of the conventions through which lives are lived. Interestingly, the experience of ageing and of ageism, draws

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Healey (1994) to acknowledge the links that she as an older lesbian has with all older women.

There are of course many other systems of oppression – **class and disability** for example, however, the difficulty as we have said above is that we swap one universal category of older people – all older people are the same – and construct new but smaller categories and then say that all older people who are within these groupings are the same. Thus all black and minority ethnic older people are the same, all LGBT older people are the same.

What we should do if we have to categorise older people, is to start from the position of the individual and begin to understand what things mean for that person and not assume that everybody is the same. So for an older black lesbian, we should start from her understanding of what it means to be a lesbian, to be black, to be an older person and to views these from an understanding of her life and how she has lived her life.

Hierarchy of oppression

Finally in this discussion of ageism we need to recognise that whilst we are beginning to acknowledge the differences that exist between older people, ageism and its effects are still viewed as less important than other systems of oppression. As a result we have a 'hierarchy of oppression' in which ageism is always placed at the bottom. The implication of this of course is that ageism is seen as less important, as having less of an effect on the individual than racism, sexism etc. It is interesting that in identifying systems of oppression ageism operates in this process by making the experience of discrimination on the basis of age less significant – which of course is ageist and a manifestation of the pervasive (spread through out society) and endemic (deeply rooted) nature of ageism – and that is where we started.

Activity 5

Of the ten people who are members of the Jueveillie Fine Dining Club – who do you think is most oppressed and who is least oppressed?

- Do you think this is helpful in understanding people's experience of oppression and discrimination?
- if your answer is yes – then why is it helpful?
- and if your answer is no – then why not?

Conclusion.

In this section, we have defined ageism and explored how ageism manifests itself by constructing negative stereotypes of older people, the characteristics of which all older people are thought to demonstrate.

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We have explored how ageism affects the practice of health and social care professionals and that in spite of Government policy – ageism still exists within the health and social care services.

We have also seen another example of how ageism works by denying the individuality of older people and thereby not acknowledging diversity in late life. But even in this process ageism exists because it enables older people and the experience of older people to be at the bottom of a list of other oppressions which in some way are seen to be more important.

Suggested Reading

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Thane, P. (2002) Old age in English History: past experiences, present issues. Oxford University Press, Oxford.
Walker, A. and Hagan Hennessy, C. (2004) Growing older: quality of life in old age. Open University Press, Maidenhead
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Welcome back to the Jueveillie Fine Dining Club

We would like to provide you with some more details about some of the members of the club – notably Robert, Simon, Colin and Valerie.

Robert

is a gay man and he is proud of who he is. He doesn't make a song and dance about it – he has no need to – it is obvious to those who know him that he is gay.

He describes his time in the merchant navy as an absolute dream, he was in all male company, far away from Britain and met and fell in love with many wonderful men. He also spent time in many foreign ports again in the company of men.

Whilst he loved being in the merchant navy, he was very wary of being 'caught' or at times even being thought to be gay. He could have lost the job that he loved so much and would have done nothing to jeopardise that.

For the early part of Robert's adulthood, being gay was a criminal act which could have resulted in him being imprisoned, losing his employment, losing his home, having compulsory treatment and being open to financial extortion – having to pay people to keep them quiet.

Oscar Wilde famously said that this was the love that dared not say its name; – for Robert – this was a secret, a deep deep personal secret that other people could not – must not - know anything about because the consequences were too severe.

Whilst Robert did fell in love – he describes himself as falling in love easily – he never had any long term relationships – he couldn't, if he was to be in the company of one man for too long then people would start asking questions and he could not afford that. Sex then was a matter of opportunity, enjoyed and walked away from.

Robert was in his thirties when the Sexual Offences Act 1967 was passed and began the process of liberalisation. But things didn't change over night. There was no party and suddenly men could not kiss other men in public without being arrested.

In fact he was 66 years old – or thereabout when it got noticeably easier to be a gay man. The period between 1967 and the late 1990's did see some very tough times for gay men – the police carried on their activities of entrapment and targeting gay men, the government got tough with section 28 (actually Section 2a of the Local Government Act 1988) and then there was AIDS.

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Gay men became viewed as diseased, filthy, people would not stay in the same room as us, hospital staff would not touch us unless they were wearing gloves, getting life insurance was a nightmare and friends died.

This is why Robert is proud of being gay and now feels that he has nothing to hide or be ashamed of. He is 'out' in the club and nobody just seems to be bothered.

Simon

in himself, Simon is happier now than he has ever been. Born a woman but knowing that he was a man inside, was terrible for him and caused him terrible pain and suffering.

As a child he can remember having to play with dolls when all he wanted to do was play cowboys and Indians, he had to help his mother in the house when all he wanted to do was be with his dad repairing engines. This was a terrible time – particularly as his body started to develop into something that he did not recognise or want.

He did get married – did what everybody expected him to do and he did give birth to a son – Michael – who he loves very much. But this marriage was not going to work – he so hated himself how could he love somebody else.

His husband – Frank - was not unkind – in fact he was very kind but being with somebody when he didn't know who he was, was going to lead to disaster. And it did, Simon, became very depressed and withdrawn and Frank just didn't know what to do, what was going on. Then there was the times he tried to take his own life and ended up in hospital talking to a psychiatrist who didn't understand and thought Simon was a very sick woman.

Separating from Frank and then divorcing him meant leaving Michael but better that than him growing up in a bad environment. Shortly after the divorce, Simon decided that he was going to live as a man – he told his parents who became very angry with him and threw him out of the house never wanting to see him again. So he moved away and started a new life as Simon.

Having the surgery ten years ago was a dream come true – now he was a man – but all his official documents still said that he was a woman – but this changed as well with the Sex Discrimination (gender realignment) Act 1999.

Whilst he is happier now, he remains frightened - he lives in such a rough neighbourhood and is always scared that someone will break in to his flat and find out his real identity and that will lead to real problems.

When he is out with the club he feels safe and can be who he has always dreamed of being – a real man and nobody questions this. But they don't know his secret – he has thought about telling them but is scared of ruining a good

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thing- so at least for the time being he will his secret to himself.

Colin

feels very confused at the moment – he is married to Anne – and he loves her don't get mistaken about that, but he has fallen in love with Mark.

Mark visits his partner Richard at the residential home that Anne is living in and Colin has watched Mark care for Richard. Over time they got talking and sharing some of their difficulties, they started travelling to the home together and then going out in the evening. On a couple of occasions they have ended up back at Mark's home at the end of the evening and slept together. The first couple of times they did not have sex – they just slept holding each other, but recently they have been having sex and Colin loves it.

If Colin is honest, he has had sex with men before and enjoyed it. Before he met Anne, he was going out with Matthew – they weren't living together but saw each other most evenings. Then he met Anne and fell in love with her.

At times when he was with Anne, he would stop off at a local gay cruising area and have sex with a man that he had picked up and then go home to Anne. This didn't mean that he loved her any less. Colin thinks that he is bisexual, he loves being with a man and a woman – sometimes in his fantasies he would have liked to have a man and a woman at the same time – but that never happened – well Anne would not have allowed that.

Being with Mark has made him happy again – BUT – what about Anne's children – they already want the house as soon as Anne dies – finding out that he is cheating on their mother AND with another man is going to make this situation even worse.

He so envies Robert who is so confident about being who he is but he also knows that many gay men are very antagonistic towards bisexuals so should he risk telling Robert - but how can he not – he has this stupid grin on his face all the time and somebody in the group will twig that something is going on.

Valerie

so obviously a lesbian but so obviously not. In fact Valerie presents as completely asexual and this stood her in good stead over the years as people – her colleagues at work have asked questions about her love life.

She has had affairs – not with people at work – but these have been very discreet – not even her mother knew – or at least she doesn't think so. These affairs have lasted sometimes a couple of years but have always been shrouded in secrecy.

Whilst it was illegal to be gay, there were no laws affecting lesbians but there was very severe social reaction and sanctions directed towards lesbians. Many of the women that she had affairs with were married with children and in many instances the affairs ended because her partners were afraid that they would lose their children. And this was very real for them.

So much of Valerie's life is in many respects a cliché – she loves the Greek islands – Lesbos is where she always goes to when in Greece. She reads about Sappho – the greek Queen of Sparta. But equally this is all kept a secret from the rest of the world – she has lived 69 years with this secret – so why change now.

But there is a woman who could change this – Karen. Valerie loves her independence, her strong spirit and her intellect. Valerie has long realised that she is in love with Karen but doesn't know whether Karen feels the same – she hopes she does.

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Homophobia

The word homophobia was coined by the clinical psychologist Weinberg (1972) to describe the attitude of those people who have an irrational aversion to, or discriminate against homosexuals. It can also mean hatred of and disparagement of homosexual people.

The word is made from the Greek

phobos meaning "fear" or "panic" and

homos meaning "the same", as in homosexual.

Why does homophobia exist?

To dislike or even hate someone on the basis of their sexuality is not a new phenomenon. History shows that there have always been those who have the need to identify people whom they can single out, portray in a negative way and discriminate against.

Homophobia is one such form of discrimination and it shares similar social characteristics as racism or sexism. In homophobia the target is lesbian, gay and bisexual (LGB) people. In this respect, sexuality becomes the point of difference which others can single out, portray in a negative way and discriminate against.

It also means that some people can suffer multiple levels or types of discrimination based upon expressions difference. Thus, if a person is a lesbian and black they may experience discrimination because they are black, a woman and a lesbian. This also means that the source of discrimination can come from many different directions – from men because this person is a woman, from white people because they are black and from heterosexuals because they are a lesbian.

Explanations have been offered for homophobia, some argue that it is due to a psychological dynamic. Herek (2000) has argued that homophobia as a psychological phenomenon stems from suppressed erotic desires, as a reaction-formation defence against admitting homosexual desire. Adams *et al* (1996) found that exclusively heterosexual men who admitted negative attitudes towards gay men (as measured on the Index of Homophobia) showed sexual arousal to gay male sex videos. Here the homophobic individual was either unaware of or denied their arousal. This explanation can be criticised because of its focus on the male psyche: whereas homophobia is a phenomenon which is possessed by both men and women

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Prejudice

As an alternative to the purely psychological explanation for homophobia Bernstein (2004) suggests that

" Sociocultural approaches to prejudice, negative cultural views are conceptualised as socially learned and embedded in individual psyches."
Berstein (2004)

" Psychological research on homophobia focuses predominantly on examining the demographic correlates of negative attitudes towards lesbians and gay men, including sex, age, education, race and marital status. These studies have found that those who are older, less educated, single, or male tend to be more homophobic than those who are younger, more educated, married, or female."
Berstein (2004)

Stonewall (2003) in a survey of nearly 1700 adults found that a majority of the population - 64% - were prejudiced against at least one group. They found that prejudice against lesbians and gay men is gendered in that it is related to whether you are a man or a woman. As a result of this heterosexual men fear overt gay male sexuality, which they describe as 'disgusting' and 'repulsive'. Heterosexual women do not have a level of fear of lesbian advances.

It is interesting to ask why heterosexual women don't have the fears that heterosexual men have about same sex relationships. This may be the consequence of women's sexuality being 'invisible', of not being important for consideration and thereby not feeling threatened by different expressions of sexuality. Much of this argument is located in the understanding of power and who holds power in our society and what they do with it.

Gay men's sexuality is also commonly confused or associated with paedophilia. Thus gay men and in particular older gay men are thought to seek out young boys for sex. Such assumptions are both wrong and dangerous placing many gay men at risk of violence. This attitude reflects part of the dangers of homophobia which allows one group to single out another group, portray them negatively and discriminate against them.

It was found that the people who had most respect for minority groups were women aged between 15 and 44 and with at least 'A' level educational achievement. They found that the people's learning and maintenance of prejudice was influenced by various sources throughout their life. The influences they found were:

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Influences on prejudice

Parents	32%
Television	26%
Newspapers	23%
Friends	19%
School	14%
Religious beliefs	13%

As this shows, the media – television and newspapers - is very important in forming our attitudes to issues and people.

Homophobic violence or hate crime which often captures news headlines and is clearly an issue of great concern for us all representing the worst outcome of extreme discrimination. Media headlines make unpleasant reading and sometimes reinforces the homophobia that caused the situations in the first place.

It was Cohen (1972) who discussed the notion of 'moral panics', where the mass media play an important role in creating the climate of public apprehension where groups of people considered as outsiders can be focused on and intimidated.

In the case of the portrayals of lesbians, gay men and bisexuals these are often negative. Television can have a powerful effect in shaping the ways that lesbians, gay men and bisexuals are perceived. In a 168 hour sample of BBC 1

& 2 programmes shown at prime time it was found that gay lives were represented positively for just six minutes and were five times more likely to be portrayed in negative terms than positive. Given that the media is a very powerful influence on our understanding of people, these figures are very important with very important consequences.

The researchers state

"There is almost no examples of homophobia or homophobic preconceptions being challenged in BB programming. It is far more usual to see implied gay sexuality used as an insult or as a way of undermining *someone.*"
Cowan K. & Valentine G. (2006)

However extreme, violence is not the only way that homophobic prejudice is expressed.

"The contemporary focus on hate crimes can obscure the ordinariness of everyday prejudice in terms of verbal abuse and incivility: pity and sympathy: or unwittingly derogatory language. As a result, many individuals fail to recognise their own beliefs and actions as a form of prejudice."
Valentine G. & McDonald I. (2004)

In their research, Valentine and McDonald (2004) - found that interviewees used positive or benevolent stereotypes to talk

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about lesbians, gay men and bisexuals as funny. These stereotypes are not intended to demonstrate a less positive attitude, but lesbians, gay men and bisexuals can experience these views as negative and discriminatory.

This benevolent or 'kindly' or not nasty prejudice demonstrates a lack of understanding of what being a lesbian, gay man or bisexual can mean and also represents a lack of awareness of more serious discrimination that can often be experienced. They argue that prejudice can be experienced in several ways.

- **Aggressive prejudice:** open and explicit animosity, often backed with the threat of violence

- **Banal prejudice:** mundane or implicit examples of less positive attitudes towards minority groups, which may be intentional or unintentional, that pass unnoticed.

- **Benevolent prejudice:** expressions of positive views about minority groups that are not intended to demonstrate less positive attitudes towards them, but which may still produce negative consequences.

- **Cathartic prejudice:** a release of views recognised as being less positive about minority groups, and therefore unacceptable, that is justified and therefore rendered acceptable.

- **Unintentional prejudice:** attitudes or behaviour that unwittingly demonstrate an ignorance or lack of understanding of diversity and rights issues.

What does homophobia do?

The outcome of homophobia will vary between individuals and no one cause and effect can be used to fully understand the impact of this form of discrimination.

Some people, such as Peter Tatchell and other civil rights activists, are energised through anger to challenge homophobia and campaign for change. However the outcomes of homophobia are often negative for the recipient of it and can range from the loss of their life through to fear and internalisation of hatred causing self-loathing. The internalisation is a product of the lesbian, gay man or bisexual accepting other's belief that they are less worthy of respect with a consequent feeling of inferiority. The lesbian, gay man or bisexual person can experience poor psychological and physical health, which in turn can damage social relationships and employment or education performance.

Herek et al (1999) found that lesbians and gay men who had been subject to hate crime were more likely to suffer mental distress than those who had been subject to non-bias crime. He argues

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> " In particular, lesbian and gay hate-crime survivors may perceive that their sexual orientation places them at heightened risk for all kinds of negative experiences in a dangerous world over which they have little control."

King M. & McKeown E. (2003) have pointed out that homophobia has a negative effect on the mental health of lesbians, gay men and bisexual people. Health outcomes include depression, heightened levels of anxiety and low self-esteem. Gay men are more likely to experience poor mental health due to hate crimes, rejection, discrimination and internalised homophobia.

Scott et al (2004) argue that there is clear evidence that there is widespread homophobia amongst healthcare professionals which impacts on the ability of lesbians and gay men to access healthcare. This a worrying finding when it is considered that health and social care services are often the first place that someone who is experiencing homophobia will seek support and help.

It is not only in health care where homophobia causes damage; it also occurs in schools. PACE (2003) in a survey of young lesbians, gay men and bisexual people in London showed that 47% had experienced harassment or physical abuse at school and 83% had been verbally abused. It was recently found that in Scottish schools that awareness of homophobic bullying was extremely high with 84% of those surveyed being aware of it in their schools and 52% had

experienced it themselves. Only 15% of respondents who had been homophobically bullied had reported it to school staff and none was satisfied with the outcome. (O'Loan S. & Bell A. 2006)

> ## Activity
>
> Read the additional profiles of Robert, Simon, Colin and Valerie.
>
> - How has homophobia affected the lives of these people?
> - Do you think that homophobia continues to affect their lives?
> - What role do you think prejudice has had in shaping their lives?
> - In what way has homophobia and prejudice affected the lives of the other people in the group?

Culture: 'outside' or 'inside'?

Giddens (2001) asserts that

> 'Culture consists of the values the members of a given group hold the norms they follow…. Values are abstract ideals, while norms are definite principles or rules which people are expected to observe. Norms are the do's and don'ts of social life.'

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Discriminatory attitudes such as those which are expressed in homophobia are often founded on moral ideas about 'good' and 'bad' sexuality: here to be lesbian, gay or bisexual is deemed to be 'bad'. If the sexuality and implied or expressed behaviour is 'bad', then it is permissible to treat that person in a less favourable way than one would if their sexuality was 'good'. People acquire their moral beliefs through learning as they grow up from their family and in schooling. Other socialisation takes place through exposure to the media and in employment. Each of these primary and secondary socialisation contexts will be organised around some sort of cultural belief system which creates the possibility for there to be 'outsiders' and 'insiders'.

Some people seek a sense of comfort from the idea that there are other people who are in some way morally inferior to themselves and therefore not worthy of the same rights as the perceived superior majority: this is the bedrock of homophobia and various religious ideologies can provide the rationales to permit homophobia to exist. Their argument – which allows them to maintain such attitudes - would be based on an understanding that being lesbian, gay or bisexual is sinful, is not part of God's way and is a danger to the stability and structure of society.

Words such as pansy, poof and bender amongst others are used to ensure that the person can be stereotyped and trivialised. Here the labels classify, categorise, stigmatise, segregate and alienate people who are perceived to be not sexually normal and therefore different from the rest of society. Indeed the word gay which has been widely accepted as being a positive one to identify a legitimate sexual identity has now been used as a form of derision. It is concerning that in a recent report the BBC rejected a complaint that a radio presenter who used the term ' a bit gay' to mean something was 'lame' or 'rubbish' was only reflecting the language used by some groups of young people who listened to the radio programme. The BBC's judgement is clearly helping to reinforce negative attitudes and thus fuelling homophobia.

The concept of "labelling" as a social process has come to be understood to involve the labeller i.e. homophobic people, wanting to apply a label or name which has negative connotations in order to discredit and disparage the person being labelled and the person who has been labelled - having some self awareness in relation to learnt social norms, and making judgements about the meanings attached to the label. This therefore is a process whereby one person calls another person a name or unpleasant word with the purpose of putting that person down AND that the person called the name understands how unpleasant that word is.

The critique of labelling theory is that it portrayed the recipient of the label as being passive and a victim rather than being an active participant in the process. The implication is that through individual and group action those who are being negatively labelled may reject and challenge the labeller's assumptions. (Pilgrim 2005).

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These power imbalances can be redressed by positive individual and group action. An example of this is lesbians and gay men 'reclaiming' the word 'queer' which was a word used to describe lesbians and gay men in a negative way. So lesbians and gay men who use the term queer do so to positively take the power back from those who use it unpleasantly.

Power

The process by which a majority group – surveys have demonstrated that statistically the majority of people identify as being heterosexual - seeks to vilify a minority group – in this case LGBT people - is essentially about the exercise of power. The philosopher Foucault has offered an influential and compelling analysis of power.

That which is allowed as legitimate discourse is shaped by Foucault's philosophical configuration of power-knowledge. Power for Foucault is not a given, rather it arises out of discursive practices and these in turn allow legitimate knowledge. Here he is alluding to belief systems and the ways that they occur and are maintained through systems of moral justification. Foucault states: -

'By power I do not mean a group of institutions or mechanisms that ensure the subservience of the citizens. Power must be understood as the multiplicity of force relations immanent in the sphere in which they operate'.
Foucault 1976

Power for Foucault is omnipresent – is everywhere and always - as it is produced from one moment to the next; one is always inside power and the object of it. In particular Foucault makes reference to the human body as a focus for discursive practices, especially in biomedicine with its power knowledge 'gaze'. Gaze in this context means a way of seeing and knowing through the 'eyes' of biological reductionism of medicine.

Foucault is arguing from a post-modern philosophical position. The core contention of postmodernism is that the philosophy that espouses ideas of truth, enlightenment, progress and therefore supports grandiose ideas about human achievement is obsolete (Norris 1990).

Here phenomena such as classifications of sexuality – lesbians, gay men and bisexuals - and reaction against them – homophobia, are products of sets of relationships within a particular historical context – *episteme.* An episteme is a set of relations that unite, at a given period, the discursive practices that give rise to epistemological figures (crudely an episteme has no clear line of progression from the past to the

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future and it demonstrates a distinctive structure of thought. (Smart 1985). Of homosexuality Foucault asserts:

> ' We must not forget that the psychological, psychiatric, medical category of homosexuality was constituted from the moment it was characterised…less by a type of sexual relations than a certain quality of sexual sensibility, a certain way of inverting the masculine and feminine in oneself.'
> Foucault 1976

He insists that power over all matters sexual is exerted at

All levels from the micro to the macro via simple mechanisms of law, taboo and censorship. Here the law is represented as one of transgression and punishment and such is the case with homophobia as a mechanism to exercise power. The intention is subjugation and domination; of social control and manipulation. Foucault points to institutions such as Christianity as playing an important role in the power-knowledge of sex.

If Foucault's analysis of power is used then homophobia is seen in the light of the general process of insisting that there are discreet sexualities that can be given a moral categorisation. The point is that the perceived differences are the issues for analysis and debate and the ways that those who seek to discriminate understand about what they fear. Here the power-knowledge about lesbians, gay men and bisexual people is being picked apart so that the truth can be exposed.

By so doing homophobia may lose its substance as a legitimate belief system and be replaced by positive ideas about the acceptance of difference and diversity. In particular Foucault has pointed to the degree of responsibility that the medical-psychiatric profession has had in creating the discourse to allow homophobia to exist.

Today, issues of professional power-knowledge are more widely spread across various professional groups who provide health and social care. It is these groups who have a responsibility to challenge homophobia within their own ranks and more generally with those they provide service to.

Challenging homophobia

If lesbian, gay and bisexual people's human rights for equal treatment both legally and socially is to become more than political tokenism then homophobia has to be challenged where it occurs both in the one-to-one encounter and on the national political arena. Organisations such as civil liberties groups and specific pressure groups such as Stonewall have achieved much in recent years.

The introduction of legislation such as the Equality Act (2006) - that contains specific provisions for sexuality - will help in giving people who suffer homophobic discrimination recourse to justice through the courts. The Act establishes a

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Commission for Equality and Human Rights (CEHR) which is charged with the responsibility to oversee and monitor the observance of equality and diversity in areas such as employment, public services and goods and services.

Valentine G. & McDonald I. (2004) and Scott *et al* (2004) offer actions that they argue are essential if homophobia is to be challenged effectively. These can be summarised as:

- **Work together**
  Minority groups face many of the same issues around prejudice - it is vital that government and minority groups work together. The Commission for Equality and Human Rights should take this as key issue.
- **Adopt a national approach**
  There are strong similarities in prejudice across diverse geographical locations. Here national strategies are needed as is better training for health care staff at all levels and all occupational groupings.
- **Rethink how we inform people about minority groups**
  To avoid resentment campaigns should be designed to teach the value of difference.
- **Develop workplaces that foster respect**
  Employers have a responsibility to create workplace cultures that encourage positive contact between minority and majority groups.
- **Educate young people to read media critically**

The media provides a key source of people's attitudes towards minorities. The government, schools and minority groups need to work together to help people to be more critical of given opinion. Here the emphasis should be on challenging heterosexism and heteronomativity

- **Present more positive images of minority groups**
  Journalists and broadcasters need to be influenced to improve the way that minority groups are represented.
- **More research**
  This is important to carry on the work of developing understanding of the nature of prejudice and ways of tackling it in contemporary society.

Activity

- Do you think you have a responsibility to challenge homophobia? – please explain your answer
- What can you do to ensure that your work place is homophobic free? – please provide details
- How can you make your workplace welcoming to older lesbians, gay men, bisexuals and transgendered people – please be specific

Conclusion

The evidence is clear that the effects on lesbian, gay and bisexual people of exposure to homophobia is damaging and that the forms of discrimination are sometimes more subtle

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and less obvious than others. The way that lesbian, gay and bisexual are portrayed in the media tends to use stereotypes to This section has addressed the issue of homophobia. It has been defined and explanations for it have been explored. Seen as a form of social prejudice it has been argued that discrimination in general often seeks to reinforce preconceived ideas of a dominant group.

provide easy to understand characters who do not challenge cherished often negative attitudes.

The core issue in this section has been the production of homophobia by the social process of creating perceived cultural –moral difference. The argument about the nature of power-knowledge provides an important framework for understanding how discourse about sexuality is situated historically and the context that could perpetuate negative attitudes to the 'deviant'. Essentially individual and group action to challenge homophobia has taken place and should continue at all levels in society. The issue at stake in this challenge to homophobia is human rights for lesbian, gay and bisexual people and the fostering of a society that embraces difference and diversity for the good of all.

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Heteronormativity

Heteronormativity is a relatively new expression which has replaced the term heterosexism which was used to describe the dominance of heterosexuality.

Hetero – means *'other or different'* as opposed to homo which means same or like. In the use of the terms heterosexual and homosexual the references are to the **attraction** to either the opposite sex – *heterosexual* or to the same sex - *homosexual*.

Normative – means establishing a norm, standard or natural.

So heteronormative means that heterosexuality is the norm or the standard for human beings with the implication that it is natural.

What is heteronormativity?

Cronin (2006) defines heteronormativity as:

'heteronormativity refers to the way in which the structural organisation of western societies is predicated on the belief that heterosexuality is biologically, psychologically and sociologically superior… thus heterosexuality represents an axis of power and the dominant mode for conducting intimate relationships, which in turn is linked to gender-appropriate sexual behaviour.'
Cronin (2006:110)

Cronin's (2006) definition of heteronormativity identifies that western societies not only assert that heterosexuality is normal but that it is also superior to any other expression of sexuality. The claim to superiority is located in:

- **biology** – that it is natural and normal for human beings to be heterosexual. This is based both in terms of procreation (reproducing the species) but also how God created the species.
- **psychology** – because it is normal for human beings to be heterosexual, our psychology is based upon this assumption. Therefore, to be other than heterosexual causes problems for the individual because they are behaving unnaturally.
- **sociology –** heterosexuality and heterosexual relationships are thought to be the norm or natural they are reflected by the structures of society which in turn support them.

The perceived normative nature of heterosexuality, supported by biology, psychology, sociology as well as belief systems such as religion – ensures that heterosexuality is given a great deal of power. This power is expressed in many ways which supports and reinforces the position of heterosexuality.

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This power is exercised both in the structures of society – government, religion, the media etc and at the individual or personal level.

As an example, heteronormativity means that it is seen as determining the way in which relationships should be conducted and how we should behave with each other. Heteronormativity becomes part of the culture or beliefs of a society which then determines that *'…men are sexually active and women are sexually passive'.* (Cronin 2006:110)

This Cronin argues, is not only a double standard which is supported by society but goes further to inform the broader relationships between the men and women where men are viewed as much more dynamic than women.

As a result, men are perceived to be much more valuable to society than women and their interests are protected. But of course, because men are thought to be much more dynamic than women, it is men who set up and enforce the rules and in doing so protect their own position.

A similar process happens with heterosexuality – thus the legal system – the laws – not only protects heterosexuality but also ensures that people who are not heterosexuals can be treated differently.

Cronin (2006) points out that as a result of the power of heterosexuality to protect itself by passing laws it becomes 'privileged' and hegemonic (the dominant way of thinking).

She maintains that if heterosexuality is hegemonic then marriage is the hegemonic form of heterosexuality.

Heterosexuality, as an hegemonic and privileged expression of sexuality, can be seen everywhere and in all aspects of our lives. As such it becomes, like ageism both pervasive (spread through out society) and endemic (deeply rooted).

An Example

Marriage is conceived of as a union between a man and a woman and therefore it is something that is exclusively heterosexual. This is recognised by the state which passes laws to give marriage prominence and to protect it. Marriage is also supported by the religions who maintain that it is both God's wish and the natural way.

The Civil Partnership Act 2004 allows the recognition of same sex unions and gives some legal protection to the union. However, it is not marriage – marriage is protected for heterosexuals. Lesbians and gay men can have their relationships recognised but not with the same status as marriage. Equally, it was not until December 2005 that same sex relationships were recognised by the State.

As an example of the differences between Civil partnership and marriage – the dissolution of a civil partnership can not be made on the basis of adultery whilst such act represents grounds for divorce for heterosexuals.

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Sexual identity

The ideas that are outlined below have been included in this section because they further illustrate the dominance of heterosexuality through heteronormativity to define other people. Whilst you are reading this material, note the involvement of heterosexuals in the process – a further reflection the power of heteronormativity and also that there are no models for the development of heterosexuality as a sexual expression – this is based solely on the idea that heterosexuality is natural and therefore does not have to be explained.

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Much of the interest in sexual identity is expressed through the essentialist/constructionist (nature/nurture) binary (a binary presents an either-or-option so in this case the choice is either nature **or** nurture) which seeks to:

'…identify biological or core determinants of sexual attraction and behaviours and those who emphasize the power of social naming and context to influence sexuality.' (Fowlkes,1994:165)

This binary – either-or-option has influenced the understanding and 'treatment' of same sex desire and is expressed in such terms as orientation and preference in respect of sexuality. Thus sexual orientation assumes a biological or essentialist (nature) determination whilst sexual preference assumes choice and thereby a constructionist (nurture) approach.

At the root of this is the desire to understand why lesbians and gay men are different with the unwritten assumption that heterosexuality is the species norm - heteronormativity.

Richardson describes 'a continuing search for answers to two questions: "Who is a homosexual?" and "What makes a person a homosexual?"… In such assumptions the term homosexual is used to refer to a core and enduring aspect of being a group of individuals'
Richardson, 1983:79

Our understanding of these issues has changed fundamentally; a process that began in the 19th Century with a move away from an emphasis on sexual acts to an understanding that personality informs what people do. Thus the act of sodomy produced a sodomite not a gay man but the change in understanding gave rise to a personality type called a homosexual. At the same time, heterosexuality was acknowledged as the dominant expression of sexuality – the natural. However, even the character of heterosexual relationships changed with much greater emphasis on privacy and exclusivity.

Much of this change was the result of the development of terms that were employed to categorise and describe an individual's identity which was based on their behaviour. Thus the terms homosexual and a little later heterosexual were employed within medical, judicial, psychiatric and ecclesiastical circles. The term homosexual was used to describe men and women who desire people of the same sex for intimate relationships and according to Roseneil (2002), was first employed by Kertbeny in 1868 though not used in print until 1869 and the term heterosexuality was first used in 1880. These dates for naming different forms of sexuality again reflect the power of heteronormativity and the assumption that heterosexuality is normal thus the 'abnormal' 'the problem' or the 'deviant' was defined first.

Cass (1984a) identifies that the concept of homosexual identity lacked clear definition but in a later article she

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establishes a theoretical model of how lesbian and gay identity is formed (Cass, 1984b). This model identifies a number of stages through which lesbians and gay men go through in order to establish their identity. The model is a six stage process, involving:

Stage 1	identity confusion
Stage 2	identity comparision
Stage 3	identity tolerance
Stage 4	identity acceptance
Stage 5	identity pride
Stage 6	identity synthesis.

In essence, the model describes the process the individual goes through in order to recognise a difference in sexual interest from their 'natural' identity. According to the model the person then makes contact with other like minded people which address their emotional and sexual needs; the development of a positive view of themselves from this contact resulting in a pride in themselves and a loyalty to other lesbians and gay men as a group. The final stage results from positive contacts with heterosexuals which aids the development of themselves as people with:

'many sides to their character, only one part of which is related to homosexuality.' (Cass, 1984b:152)

This last stage requires validation from heterosexuals and it is only when this happens that a homosexual identity is achieved. Yet again, heterosexuals are given the power to

confirm – or not lesbian or gay identity further reflecting the power of heteronormativity.

Fernbach (1981) seeks to outline the 'causes' for this deviation from the species norm by maintaining that gay male sexual identity arises from an effeminate gender identity. This in turn is a consequence of the individual not being separated from their mother by either the father, or in broader terms, wider heterosexual society. Fernbach (1981) is identifying the search for reasons why some men are gay and again this reflects the power of heteronormativity in that explanations need to be sought because after all it is natural to be heterosexual.

Gough (1989) argues that the inevitable conclusion from Fernbach's theory is that all gay men are effeminate and that sexual identity and gender identity are in fact one and the same thing. Of course the other issue is that in trying to find reasons for why some men are gay, Fernbach is laying blame with the mother and again this reflects the power of heteronormativity which says being gay is not natural and therefore this has to be somebody's fault.

Chapman and Brannock (1987) have developed a model, which explores lesbian identity development. Their model is a 5-stage process, involving:

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Stage 1	same sex orientation,
Stage 2	incongruence
Stage 3	self/questioning/exploration
Stage 4	self-identification
Stage 5	choice of lifestyle

In a similar way to Cass (1984b), this model identifies a process that involves self-recognition and identification and an acceptance of difference. This leads to a seeking out of and greater contact with other lesbians and finally involvement with (or not) other women as a love interest whilst maintaining a lesbian lifestyle.

Chapman and Brannock (1987) identify that there are in fact a number of models of lesbian and gay identity formulation, to which they make an additional contribution. Many of these models involve a linear (a straight line) progression from being heterosexual to being a lesbian or gay male all of which involve stages that need to be completed. Also many of the models view this process as a journey of self-discovery, of moving from state of unhappiness to a newfound state of completeness and happiness.

Esterberg (2002) comments that:

'most previous models of homosexual identity have seen identity development as occurring in one direction only: from straight to lesbian of gay'.
(Esterberg, 2002: 221/222

Equally many of the models – Fernbach (1981) and Cass (1984b) place a centrality for the involvement of heterosexuals in the process of lesbian and gay identity formation on the basis that good homosexuals can only emerge from heterosexuals and their involvement. The involvement of heterosexuals becomes quite crucial in the establishment of such identity, for without the existence of heterosexuality there would be no need to give a name to alternative expressions of sexuality. However, more fundamentally, many of the models take for granted that the original identity of the individual from which they have moved is that of heterosexuality. This represents a further expression of the dominance of heterosexuality and heteronormativity.

Foucault and post modernism

Post-modernism places a great deal of emphasis on the individual and the storey of that individual. Gibbins (1998) in reflecting on the postmodern theoretical understanding of identity, maintains that:

'…postmodernists reject metanarratives and replace them with multiple narrative disciplines, and reject methodological foundationalism and essentialism, so they also reject ideas of an essential human nature or self; structured lifestyles based upon social categorisation; and the ideas that values are merely epiphenomena of these primary structures.'
Gibbins(1998:41)

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Gibbins (1998) is arguing that this post-modern understanding of identity has moved away from sexuality being fixed and universal – which would mean that you are either heterosexual or homosexual – to an understanding of multiple personalities with many different aspects which are often conflicting. These facets find expression in individual narratives or stories and are not restricted or held together by the needs of society and the structures of society.

Gibbins (1998) illustrates this diversity of self with two examples:

'…a married mother shares her life with work friends and another at the health and sports club, and may gender bend while exploring on the internet. A redundant male miner from South Wales may have a life with young mothers around the school and may study art with the Open University, while maintaining a 'drinking-and-rugby' culture with old friends'
Gibbins. 1998:41

Unfortunately, Gibbins is falling into the trap of stereotypes of sexual identity when he assumes that studying art with the Open University is something that is unusual or odd in the culture of a miner from South Wales.

Of equal importance in this discussion of the fluidity of identity and the rejection of fixed identities, is the understanding that being a lesbian or gay man does not mean a single expression of this identity. What this means is that as much as there are many different ways of being a heterosexual so there are many different ways of being lesbian or gay. So, according to post-modernists, not only is sexuality fluid – so that a man through his live time could be in a relationship with a woman, and then another man and then another woman – but also being heterosexual, lesbian or gay is fluid as there are many ways of being each of these expressions of sexuality.

Foucault (1998) identifies the power of heteronormativity in the following terms:

'The legitimate and procreative couple laid down the law. The couple imposed itself as model, enforced the norm, safeguarded the truth, and reserved the right to speak while retaining the principle of secrecy. A single locus of sexuality was acknowledged in social space as well as at the heart of every household, but it was a utilitarian and fertile one: the parents' bedroom. The rest had only to remain vague; proper demeanour avoided contact with other bodies, and verbal decency sanitized one's speech. And sterile behaviour carried the taint of abnormality; if it insisted on making itself too visible, it would be designated accordingly and would have to pay the penalty.'
Foucault, 1998: 3/5

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In this passage Foucault is outlining how the power of heteronormativity is being expressed which is through the heterosexual couple and heterosexual marriage, but importantly he also identifies that being other than heterosexual AND being visible carries with it a cost that has to be paid by the person who is not heterosexual. The 'cost' or the consequences of being gay has varied over time from being executed, to imprisonment, to enforced 'treatment' to extortion, ridicule and harassment to being beaten up.

Foucault (1979) refers to 'the deployment of sexuality' as practices that name and regulate and construction of lesbian and gay sexuality.

> 'great surface network in which stimulation of bodies, the intensification of pleasures, the incitement to discourse, the formation of special knowledges, the strengthening of controls and resistances, are linked to one another'
> Foucault, 1979:105-6

Foucault is highlighting the common aspects of being lesbian of gay and these aspects are made by people, are constructed and are not natural. From these constructed aspects of sexual identity individuals recognise each other and are linked together.

The death of heterosexuality?

Roseneil (2002) asserts that the hetero/homosexual binary (this is a way of viewing sexuality as an either or – so you are either heterosexual or homosexual) is currently being eroded as a consequence of a number of 'tendencies' namely:

1. Queer auto-critique – in which she identifies the diversity within lesbian and gay sexuality as a challenge to the previously held view of its coherence. The existence of diversity within lesbian and gay sexuality has prompted a rethink about the relationship between gender, embodiment and sexual desire.
2. The breakdown of heterosexual dominance – the evidence for this, she suggests, comes from the changing nature of the family such that only 23% of households in Britain are traditional family structures with many people choosing to live alone and consciously choosing to have children in one parent settings. The result is that marital heterosexuality is no longer hegemonic.
3. The emergence of hetero reflexitivy – which she describes as the increasing need for heterosexuals to identify themselves as being such and as a result, heterosexuality becomes a conscious choice rather than the assumed ascription.

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4. Cultural valorization of the queer – this is a reflection of the 'queering' of popular culture as expressed in the media which is then reflected in individual behaviour. A very good example of the process is David Beckham, clearly identified as a heterosexual man who wears sarongs and hair slides and in doing so presents ambiguity in gender identification and therefore crosses boundaries. Beckham presents as a role model for other heterosexual men who are forced to have regard for him because of his position and is unlike other 'gender benders' of previous decades (such as David Bowie and Boy George) who were dismissed as the product of a reality which was not part of everyday life.

If Roseneil (2002) is correct in her comments, this of course represents a major challenge to the dominance of heteronormativity and perhaps means that our understanding of sexuality is changing.

Activity

Discuss with your colleagues Roseneil's ideas:

- Do you think that heterosexuality is dying?
- What do you think are the implications of this?
- How do you think the death of heterosexuality would affect the members of Jueveillie Fine Dining Club?

Conclusion

This section has been looking at heteronormativity – at what it is and the power that it has to dominate other expressions of sexuality in many ways. Thus heteronormativity made gay male sex illegal in Britain for 82 years and when it was legalised – heteronormativity only allowed gay male sex under very strict conditions.

Equally, the power of heteronormativity to assert that heterosexuality is normal and natural meant that explanations were sought for why some people were lesbian or gay. These reasons tried to 'blame' others because being lesbian or gay was wrong.

Whether the power of heteronormativity is reducing – as Roseneil suggests will depend on your point of view. Only time will tell whether in fact heteronormativity will no longer have power over other expressions of sexuality.

Suggested Reading

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Part 2

Social Inclusion of older lesbians, gay men, bisexuals and transgendered people

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Social Inclusion

Tackling difficult multifaceted issues such as exclusion needs multifaceted approaches to try to resolve them. Sayce (2001) draws attention to some of the approaches that need to be addressed when she defines social inclusion as:

' A virtuous circle of improved rights of access to the social and economic world, new opportunities, recovery of status and meaning, and reduced impact of disability. Key issues will be availability of a range of opportunities that people can choose to pursue, with support and adjustment where necessary.'
Sayce (2001)

If older LGBT people are to be included then the virtuous circle described by Sayce (2001) requires action by Government, health and social care agencies and of equal importance by the staff who work in such agencies who are the people that have direct contact with older LGBT people. In many respects it is these members of staff who actually make a significant difference to the experiences of older LGBT people.

Treating people equally, irrespective of their age and/or sexuality, with respect and dignity, including them in the decisions that are being made about them as individuals and about the services that are assisting them ensures that older LGBT people are more likely to feel included than to feel excluded. This of course requires that health and social care staff understand the factors that exclude older LGBT people. Those factors which lead to exclusion need to addressed in their own practice as well ensuring that the conditions are in place for older LGBT people to be included which can include not only moral and professional arguments but also the issue of rights based upon a claim to citizenship.

In the previous section the social exclusion of older people and in particular older LGBT people was discussed and it was emphasised that homophobia and ageism act to compound the negative attitudes and discrimination that some, but not all older LGBT people experience. To successfully promote social inclusion homophobia and ageism must be challenged. Core attitudes and beliefs in both social structures such as education and the media and the attitudes of health and social care professionals have to be addressed before social inclusion can be achieved. Mere tokenism is of no real value but empowerment of older LGBT people through policy and legislative change can provide the strength necessary to allow for their rights of equal access to health and social services, leisure facilities, education and many other aspects of social life to become a reality.

This section seeks to discuss issues relating to the various ways that social inclusion for older LGBT people can be achieved and by whom.

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Government Policy

On a practical level, policy and plans for social inclusion have to address local issues and needs. Older LGBT people, like their heterosexual counterparts can lose roles, suffer from poor social participation and isolation because of life course events such as loss of work, death of a partner and personal circumstances such as living alone poor transport or ongoing poor health. (Office of the Deputy Prime Minister 2006) For older LGBT people to participate, at whatever level they choose in society it is essential that general issues such as isolation and health are addressed.

Government policy on social inclusion is shaped in part by European community policy. The Nice European Council held in 2000, and the subsequent Directive of the same year launched a process that is based on four common objectives for inclusion. The European Union's social inclusion strategy requires that Member States draw up a National Action Plan on Inclusion (NAP).

However countries may choose not to act, or politically may be unwilling or unable to act, even if problems are identified. (Armstrong K.A. 2006) The United Kingdom NAP in relation to objective 1 talks about transforming the welfare system from a 'passive benefits payment machine to an active system that tackles poverty, creates opportunity and helps people become self-sufficient and independent.'

The common objectives for inclusion from the Nice European Council held in 2000

1 Facilitate participation in employment and access by all to resources, rights, goods and services.
By organising social protection systems to allow access to education, services and other public and private services, such as sport and leisure.

2 Prevent the risk of exclusion
by exploiting fully the potential of the knowledge-based society and of new information and communication technologies and ensure that no one is excluded.

3 Help the most vulnerable.
by promoting social integration of people facing persistent poverty because they are experiencing particular integration problems.

4 Mobilise all relevant bodies
by adapting administrative and social services to the needs of people suffering exclusion and ensuring that front-line staff are sensitive to these needs

European Commission (2000)

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The government asserts that older people today are healthier than in the past and around one million people are currently working past state pension age. (Department of Work and Pensions 2005) They argue that I million pensioners have been lifted out of poverty. (Cabinet Office 2006) For the government the way to meet the 'challenge of an 'ageing society' is through helping more people into work. They state that their aim is to have 1 million more older workers in the labour force, including many who will choose to work beyond the traditional retirement age. (Department of Work and Pensions 2005).

Armstrong (2006) points out that the 'language of rights tends to be absent from Labour's social policy discourse, with the emphasis instead on the responsibility of individuals to take up opportunities'. Or if rights are mentioned they are taken as a 'personal' matter rather than one of civil rights and responsibility in citizenship. This point was reinforced when the government stated that in their 'renewed' drive against social exclusion that one of the principles would be '*personal rights* and responsibilities' (Cabinet Office 2006) They assert that they want to 'build inclusive communities that meet local needs where the contribution of older people is key to their success'. (Office of the Deputy Prime Minister 2006). Here again the focus for the government is on the specific local areas rather than the broader societal issue of justice and equality. This ambitious aspiration has to be tempered by the fact that illness and disability impacts on the ability of individuals to participate fully in the life of society. (Atkinson et al 2004)

The Law

For the rights of older LGBT people to be ensured it is vital that the government provide legal support so that changes needed to allow social inclusion can be enforced. Certainly there is a moral obligation to ensure fairness and also a policy obligation via Europe and national plans for inclusion.

Employment has featured greatly in the discussion so far as a key aspect of social inclusion. Some older LGBT people may want to continue in their current work or be able to gain access to employment without being discriminated against on the grounds of either their age or their sexuality. The case of older people who identify as being LGBT can further compound negative cultural attitudes aimed at age alone. (Office of the Deputy Prime Minister 2006)

In order to ensure that discrimination in employment on the grounds of age can be challenged the Employment Equality (Age) Regulations came into force in October 2006 making it unlawful to discriminate against workers, employees, job seekers and trainees because of their age. It is now unlawful for an employer to discriminate either directly – by treating them less favourable - or indirectly – by applying criteria which disadvantage people of a particular age – unless either of these can be 'objectively justified'. As an example, if there are specific training requirements for employment then it may be justifiable to fix a maximum age. (ACAS 2006)

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The Civil Partnership Act 2004 provides legal protections for same sex couples. Here issues such as next of kin status and financial protection in pension rights are given. Not all older LGBT people will want to form a civil partnership but its existence gives those who want recognition under the law for their relationships, sometimes very long term, and gives them the same legal protection as their heterosexual counterparts as a right and not a privilege.

The incorporation of the European Convention on Human Rights (1950) in the United Kingdom took the form of the Human Rights Act 1998 and began a process of enshrining and enforcing human rights in United Kingdom domestic legislation. For older LGBT people this Act can be the basis from which they can assert their human rights and Article 8 of the Act is of particular importance. Article 8 asserts that 'everyone has the right to respect for his private and family life, his home and his correspondence.'

An example of the effective use of Article 8 of the Human Rights Act 1998 to protect the right to privacy is in the case of Goodwin v United Kingdom (2005) in which the issue was whether the United Kingdom Government failed to respect the right to a private life of a post-operative male to female transgendered person. The specific issue was the lack of recognition given to her gender reassignment. In concluding that the United Kingdom Government had breached Article 8, the court referred to the judgement made in the case of Dudgeon v United Kingdom (1982) in which it was recognised that serious interference can occur when domestic law

conflicts with an important aspect of personal identity. In both of these cases Article 8 has been used to assert the rights of individuals to a private life and rights associated with who they are.

The Equality Act (2006) sets out provisions prohibiting sexual orientation discrimination in the provision of goods, facilities and services, in education and in the execution of public functions. The act also provides that a Commission for Equality and Human Rights is established to over see the implementation and monitoring of the legislation. This is an aspect that has been welcomed by human rights organisations as it was missing from the provisions given in the Human Rights Act 1998.

Between March and June 2006 the Department of Trade and Industry (DTI) consulted on Regulations relating to the ways that the particular aspects of the Equality Act 2005 would be applied. The consultation paper sought views on specific points about the range of activities that should be covered by the regulations, and on whether any exceptions should be provided from them to ensure that the protection provided is effective and appropriately targeted. The new rules to prevent schools, companies and other agencies refusing services to people because of their sexuality that were to have taken effect in October 2006, have been delayed and the Government who now intend to bring the regulations into force on April 2007. (DTI 2006)

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The current Communities Secretary, Ruth Kelly, is responsible for delaying the new guidelines. Her stated reason is the large amount of objections the government has received. Criticism has come from religious groups, most prominent among them the Roman Catholic Church who argue that there should continue to be separate schools which are focused on particular religions. Ms Kelly is the cabinet minister charged with delivering equality but she has been a controversial appointment given that she has to refused to say whether she thinks gayness is a sin or not and is always absent when votes on issues relating to legislation such as the Civil Partnership Act (2004) have taken place. (Pink News 2006)

Of key importance for all older people will be whether the Equality Act (2005) will incorporate measures to make it illegal to discriminate on the basis of age in goods and services. If this becomes the case many aspects of current professional and organisational practice will become illegal and open to challenge, not least the differential expenditure on supporting older people in comparison to younger adult service users and patients.

Social inclusion and citizenship

Rummery and Glendinning (1999) in referring to the work of Marshall (1950) identify that citizenship involves an acceptance of equality of outcomes in the provision of resources, which are in place to meet need. They go on to identify that the judgements and behaviours of professionals who act in a 'gatekeeping' capacity restrict access to resources. Acting in this manner, they argue, the professionals

'…undermine[ed] disabled and frail older people's civil rights.'
Rummery and Glendenning 1999:342

Quite clearly, if there are variations in outcomes for older heterosexuals there will equally be similar variations for older LGBT people and between them and older heterosexuals. Necessarily there will be implications for the citizenship rights of older LGBT people.

Traditionally the concept of rights has been viewed as comprising a number of elements – political, civil and social (Marshall (1950). However, the recent enactment of the European Convention on Human Rights (1950) in to United Kingdom law via the Human Rights Act 1998 has brought the discourse on rights and citizenship in sharper focus. At the same time theoretical understanding of these issues has been influenced by postmodernist deconstruction of accepted concepts such as sexuality. This has been taken further with an examination of the emerging concept of sexual citizenship as outlined by Richardson (2000).

Richardson (2000) identifies three broad elements to the claim for sexual citizenship which are in turn divided into rights-based elements. These are:

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- Conduct based rights claims;
- Specification of what an individual can or can do,
- The right to participate in and enjoy sexual acts,
- Rights of bodily self-control,
- Identity based rights;
- Right to self determination,
- Right to self expression,
- Rights to self realization,
- Relationship based rights;
- Rights of consent to sexual practice in relationships,
- Rights to choose sexual partners,
- Right to publicly recognised sexual relationships.

Each of these rights-based claims to sexual citizenship are outlined in detail by Richardson (2000) who applies them to women in general, disabled people but also to lesbians and gay men. These claims to rights can all be applied to older LGBT people with the result that sexual relationships should be recognised, the person's right to self expression and determination – of being who they are – should be accepted and respected. The implication, therefore is that services on the whole do not acknowledge same sex relationships; do not enable the older LGBT person to express who they are and determine their outcomes thereby deny sexual citizenship.

This denial of sexual citizenship is in addition to the denial of civil rights as a result older LGBT people are subjected to a triple jeopardy, to reflect Norman's (1985**)** concept, in that their needs for services are unlikely to be fully met and that this represents a denial of their civil rights, a second jeopardy. The third jeopardy to which older LGBT people are exposed to is the denial of their sexual citizenship which is expressed in the failure to recognise and respect who they are and the relationships in which they are placed.

How to include older lesbians, gay men, bisexuals and transgendered people

The inclusion of older LGBT people reflects a key question which inclusion in what? The answer to this question is very much the opposite and reflects how are they excluded and what can we do to make sure that older LGBT people no longer experience exclusion.

To achieve inclusion and end the exclusion of older LGBT people we need to explore a wide range of issues and practices. However, absolutely central to such an approach is the older LGBT person themselves what they want and how they want to be identified.

Taking a 'person first approach' not only addresses government policy but also ensures that attitudes and arrangements are not imposed on older LGBT people that they may not want. It is important that as much as there are many ways to be heterosexual there are as many ways to be an older LGBT person with the result that what may suit one

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person may not suit another. Blanket approaches based upon an assumption that all older LGBT people are the same with the same needs and aspirations are as oppressive as being outwardly homophobic or ageist.

There are many elements to an approach which has as its starting point the inclusion of older LGBT people. Some of these reflect the nature of the physical environment in which older people in general are located and in which older LGBT people can find themselves in, whilst other elements are much more specific to individual interactions – if you want the environment in which care is provided.

The social environment

The particular difficulty in attempting to include older LGBT people is the social situation that they often find themselves. It has been argued that:

> 'The emphasis in gay spaces has always been and continues to be youth, and therefore, older gay men are excluded from a world in which being old equates to being unattractive and being attractive is a precondition for entry. As a result, there are no public spaces available for older gay men, who are thus excluded from the support of other older gay men.'
> Jones J. & Pugh S. (2005)

Many 'gay spaces' in urban centres such as London, Manchester and Birmingham cater for younger people and in particular young gay men. This does not need to be the case. Age Concern Manchester as an example organises a lunch club for older LGBT people which meets in a bar in the 'gay village'. This arrangement has the result that the club occupies a space in an area in which older LGBT people can be excluded from but it also provides business for the bar and encouragement and support to for those individuals to go elsewhere within the 'village'.

Of course there will be older LGBT people who, regardless of negative attitudes, will use gay spaces such as 'gay scene' venues but some will seek support in other ways.

Friendship

Friendship networks in particular provide support to many older LGBT people. Heaphy et al (2004) found that older LGBT people consider friendships as important or even more important than relationships with partners or relatives. Pugh (2005) points out that

> 'The reality is that older lesbians and gay men do have vibrant social lives that involve mutual support networks that enrich their lives.'
> Pugh (2005)

Heaphy et al (2004) found that older LGBT people valued 'highly' couple relationships but that with increasing age it was

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increasingly difficult to meet a partner. Here it is important that specific opportunities are provided to help older LGBT people who want to seek a relationship and develop friendships to do so.

This involves having easily accessible information available for older LGBT people about clubs, groups and networks that are both local and national/international. However, it is equally important to recognise that such information can be viewed very negatively and as creating the opportunity for older people to engage in relationships that they should not be doing and certainly not where the potential exists that these new relationships might be sexual in nature. This negative attitude also views the development of new same sex relationships equally harshly if not more so.

These negative attitudes reflect the dominance of both ageism and homophobia – the very attitudes that have excluded older LGBT people. However, the opposite to this position is pushing and insisting that older LGBT read such material or join such clubs without having regard to their current position, their wishes and their desires.

An example of self generated support and help organisation is the Care and Friendship for Men Over Sixty (Caffmos) www based organisation that started in 1998 as a social group that expanded, and has become a well-established friendship site for the older gay man, on a global platform. They organise events and social get-togethers throughout the UK. However the difficulty is that, as Caffmos point out, many older gay men

do not have access to a computer or/and have skills necessary to use one. Here the European objective 2 for social inclusion - 'communication technologies and ensure that no one is excluded' becomes highly relevant. There is a need to provide learning opportunities relating to the use of information technologies specific to older LGBT people.

In Manchester the Lesbian and Gay Foundation (LGF) offers two groups for older LBGT people -

♦ Carousel is a group offering social activities and support for self-defining older lesbians and bisexual women. The group meets on the first and third Tuesday of the month between 7pm and 9pm. The group also runs a drop in service on the first Saturday of the month between 1pm and 4pm.

♦ The Forty Plus group provides a safe and welcoming environment for gay and bisexual men aged forty and above. Activities range from talks to quizzes and watching videos.

Both groups meet in the LGF at Princess House, 105-107 Princess Street, Manchester, M1 7DA.

Other Voluntary organisations such as Age Concern and Help the Aged play an important role in encouraging social inclusion for older LGBT people. Age Concern's Opening Doors programme has provided opportunities for older LGBT

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people to gain support in participating in various social activities. They state that they are: -

‘… committed to the promotion of good practice and to taking positive initiatives to create an environment of positive acceptance and welcome for all our lesbian, gay and bisexual clients, staff and volunteers.’
Age Concern (2006)

Involvement

Polari was established in 1993 by lesbians and gay men concerned that the needs of older LGBT people were not being represented within existing housing and community care provision in London. Polari (2006) asserts that

‘We have been leaders and initiators on the social inclusion of older lesbians and gay men and the development of services more appropriate and friendly to them. ’

Hubbard & Rossington (1995) were commissioned by Polari to undertake research into the housing needs of older lesbians and gay men and found that most of the older lesbians and gay men they talked with wanted accommodation specific to them and preferably on a single sex basis. They found that existing accommodation such as

‘sheltered’ accommodation and residential care was not ‘gay/lesbian friendly’ and that there was an urgent need for training of care, health and social care staff in general. More needs to be done in relation to housing and accommodation as an aspect of social inclusion of older LGBT people outside of London.

Clearly there is an agenda here for involving older LGBT people in the design of the services that are available to them. This agenda equally applies to health and social care services.

However, involvement means different things to different people and different agencies. At one level involvement can mean a very superficial ‘consultation’ with the people concerned in which they are ‘listened too’ but which has no impact or influence on the final decision. On the other hand older LGBT people can be very involved from the start of a project to its conclusion. So to say that older LGBT people have been included very much depends on the definition of inclusion and the reality of that inclusion.

Essentially this is an issue about power in the form of money, professional expertise and/or employment position – and whether those with power - are willing to share their power or hand their power in the form of control over to the people who use the services. Arguments about ‘hard to reach’ groups are used in many cases to hide the unwillingness to share control when in reality the issue is about the organisation reaching out to the people they are charged to serve. Older LGBT

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people are frequently referred to as a 'hard to reach group' but this is in part a reflection of the absence of organised groups but more importantly it involves creative and innovative approaches in reaching out to older LGBT people.

Of course an organisation that purports to involve older LGBT people will be judged by its own approach and whether or not it is seen to be listening and responding to their needs.

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Activity

Given what you have been reading about inclusion –

- What are you going to do in your workplace to ensure that older people are including? – please be specific
- What are you going to do in your workplace to ensure that older LGBT people are included? – please be specific
- Is there a difference in your answers to these questions? – if there is please explain why there is a difference and if there is no also explain why there is not.

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The customer response to Health and Social Care professionals

Interestingly, both health and social care professionals clearly assert the centrality of the service user in the exercise of their professional role. Thus older people are valued and

respected. Care is offered in an inclusive manner reportedly focusing on the older person in routine expressions of practice. In social care, the value base of the profession is reflected in the concept of anti-oppressive practice. Dalrymple and Burke (1995) are very clear in their assertion that anti-oppressive practice is good practice because it challenges the oppression faced by some groups and aims to minimise the power differences in society. Thompson (1992**)** comments that

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'There is no middle ground: intervention either adds to oppression (or at least condones it) or goes some small way towards easing or breaking such oppression. In this respect, the political slogan "if you are not part of the solution, you must be part of the problem' is particularly accurate. An awareness of the socio-political context is necessary in order to prevent becoming (or remaining) part of the problem'
Thompson 1992:169-70

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However, the articulation of the centrality of older people with health and social care professionals is not reflected in the commentary made by service users. There is an extensive and powerful body of research covering the last thirty-five years that highlights the attitude of service users towards social care practitioners. Mayer and Timms (1970) as far back as the early 1970's highlighted that service users expected social workers to listen to their story and to reach a conclusion based on the rights and wrongs of the situation.

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The approach of the social worker was reported as a surprise and a puzzle to them leaving feelings of dissatisfaction based on the belief that social workers were not interested in them or at best displayed a lack of understanding. These are very clear criticisms of social work as a profession, which espouses a competency base that includes listening, empathy and understanding.

Allen, Hogg and Peace (1992) reviewed service provision for older people and identified a number of surprising results based on the interviews with older people who had been assessed by social workers. The research concluded that social workers acted as gatekeepers to resources by not giving older people and their carers the information about the full range of services.

Further more they concluded from their research that 33% of older people felt that not enough notice was taken of them primarily because the social worker was not interested and in fact some older people felt intimidated. This research reflects Mayer and Timms (1970) findings twenty-two years earlier of an evident and felt lack of interest on the part of social workers in the older person

Nocon and Qureshi (1996) reported that professional staff placed more emphasis on their own expertise rather than on the service user's views. As a result, the assessment process was felt to be humiliating with a focus on incapacity rather than ability. The assessment was also felt to focus on form filling and gathering information which further reinforced

feelings of dependency with a conclusion that service users got what social workers said they could have.

Harding's (1996) survey of the users of mental health services produced a series of headings that illustrated the behaviours that they identified as being desirable and that should be expressed by social workers. These included credibility, respect, honesty and reliability, concluding that there was a general wariness of social workers and their pet theories.

In each of these accounts, service users are reporting their lack of understanding of what the social care professional was doing. Equally, they felt that the professional did not have an understanding of their situation. These expressed feelings of a lack of interest and intimidation in service user's interaction with the social worker further heightens this later point. Acting as the gatekeeper to resources, the social worker, in using their professional knowledge and expertise, was seen to alienate the service user leaving feelings of being given what the social worker felt was appropriate.

There is clearly a dichotomy being expressed here as service users are unhappy about social work practice whilst practitioners are being urged to be anti-oppressive and to reflect on the impact that their value system may have on the outcomes for service users. Such dissatisfaction with professional practice does not rest solely within a social care context, as criticism of health care professionals by patients is equally forthright. Older people are articulating that the professionals who are employed to assist them at times of

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need have clear objectives of their own. These objectives can be expressed both within the technical nature of the professional task which is felt not to be fully understood by the older person and the location of the professional within organisational structures. Maintaining the centrality of older people within the professional task has to compete with other professional and personal objectives and quite clearly older people as service users are experiencing the consequences of such competing objectives.

Whilst we have highlighted considerable criticism of health and social care professionals and their practice in interaction with older people, we do feel that we have to acknowledge the tremendous pressures that such professionals are currently working within. The Community Care (delayed discharge) Act 2003 is a clear example of such pressures as health and social care agencies seek to implement the Government's agenda of high levels treatment in order to address the political imperative of reducing hospital waiting lists. However, whilst the professionals are clearly under pressure to achieve targets, the process inevitably reinforces the image that older people are problems as evidenced in the language of 'bed blockers' with the result that older people become a commodity in the exchanges between health and social care agencies.

The implications for health and social care practice

The government has asserted that the needs of groups such as those who face discrimination on the grounds of sexuality should be built into mainstream services. (Office of the Deputy Prime Minister 2006) However, Harrison (2002) has argued that LGBT people aged 65 and over are more likely to not come out publicly, nor will they necessarily identify with terms such as gay or lesbian. She argues that because of this the emphasis is on service providers to be non-homophobic and non-discriminatory and insist that their employees be trained to be such.

Training has an important role to play in assisting health and social care organisations to ensure services are inclusive for lesbian, gay and bisexual people. The government's equality and diversity agenda, supported by legislation, has insisted that issues relevant to all LGBT people be addressed in strategy for providing health and social care services.

The commitment to outlaw discrimination on the basis of sexuality in the provision of goods and services via the Equality Act 2005 has important implications, in particular, it is expected it will lead to an improvement in the level of uptake of health services by LGBT people of all ages. The Department of Health commissioned a report entitled Core training standards for sexual orientation: making the National Health Services inclusive for lesbian gay and bisexual people

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with the aim that it will assist health and social care organisations in promoting equality. (Cree & O'Corra 2006) The hope is here that service providers will be more sensitive to the needs of older LGBT people given that there is evidence that services have traditionally been less than supportive.

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Activity

Discuss with your colleagues the material related to the law and inclusion and the implications for health and social care practice.

- Do you think that you are everything that the government wants you to do? – please be specific
- If feel you are not doing this – what are you going to do to ensure that what the government wants is done? - please be specific
- What do you feel are the implications of not doing it? – please be specific and think about the affects on you, your agency and service users and patients

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Pugh (2005) asserts that the interactions of health care professionals with older lesbians and gay men should take account of:

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- The hostility felt by older lesbians and gay men towards them expressed by health and social care professionals;
- The lack of knowledge held by health and social care professionals about what it is to be lesbian or gay;
- The need to acknowledge the diversity of experience and identity amongst older lesbian and gay men;
- That such diversity should inform service provision;
- That service provision should al least be demonstrably lesbian and gay friendly if not exclusively lesbian and gay;
- That friendship networks, partner and children should be acknowledged with parity to heterosexual relationships.

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There is much work to be done to see the aspirations of policy makers and training providers in relation to equality and diversity to be translated into the 'real' world of face-to-face encounters and the motivation to cater for particular needs of minority groups such as older LGBT people.

To help ensure that accountability in health and social care becomes a reality, organisations such as the Healthcare Commission, who have a statutory duty to assess the performance of health care organisations and award annual performance ratings for the NHS, have been created. The Commission for Patient and Public Involvement in Health was set up in 2003 as an independent public body, sponsored by

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the Department of Health. They have created 572 Patient and Public Involvement (PPI) Forums which aim to ensure the public is involved in decision making about health and health services in England. The Commission for Social Care Inspection (CSCI) registers inspects and reports on social care services in England. They state that their aim is to improve social care and stamp out bad practice. In each of these bodies the views of older LGBT people should be heard and action taken.

Harrison (2002:5) conducted research with older lesbian and gay men in Australia and analysed the notion of self-determination, collective action and activism. One of the gay activists stated that

' Creating a speakers bureau of gay and lesbian seniors headed by a professional person is a powerful tool, to be a component of in-service training at every kind of senior organisation from home deliver meals, to nursing care in nursing homes, every range of services. Its an excellent way for people to see, be public, about ageing, about gay and lesbian ageing.'

Here there is a need for older LGBT people themselves, with the support for voluntary organisations and others, who provide supportive networks, to be assertive in making their needs known to health and social providers of whatever type. However, some older lesbian and gay men for various

reasons that may include disability and mental and physical ill health may not be able to engage with supportive networks and will need health and social care provision to help them lead as full and rewarding a life as possible.

Standard 2 of the National Service Framework for Older People (Dh 2001) requires that both health and social care services ensure that the services that are offered to older people are person centred. This means that the individual older person is placed at the centre of any care arrangements that are put in place to meet their needs. Standard 2 applies equally to older LGBT people as it does to older heterosexuals.

Inevitably this approach means changes in the practice of health and social care organisations as much as it does to the practice of health and social care practitioners. Busy professionals argue that they do not have time to get to know their patients or service users, however, a person first approach is based upon getting to know the person – what they need, what is important to them what they like and do not like and how best to assist them to achieve what they want to achieve. – this is essentially the biographical approach.

Biographical approach and inclusion

The purpose of linking the biographical approach with social inclusion is to ensure that appropriate service provision is offered which meets the needs of the older person in general

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and older LGBT people in particular (Gearing and Dant, 1990). This approach affords the opportunity of enabling health and social care practitioners to get to know their patients and service users and therefore to ensure that not only are they at the centre of care provision but also that services are tailored to each individual.

Whilst this approach is not new in itself, the increasing emphasis on person centred care which is reflected in Standard 2 of the National Service Framework for Older People (Dh 2001) gives an approach which helps health and social care professionals to get to know their patients or service users added impetus. In essence the approach requires the professional to understand the person in the present by understanding them in the past. This requires listening to the person and asking them about their past in order to gain that level of understanding.

However, like all things care needs to be taken about using this approach for many older people will not appreciate questions about their past and may feel this as intrusive, but equally many will and may enjoy the opportunity to reflect on their past. How the information is used is of very great importance – if for example this information sits at the back of an assessment form which nobody looks at then there is little point in having that information. If however, the information is used actively to plan services and to ensure that the right help is offered to the older LGBT person in the right manner then the approach has helped to make the person the centre of their care.

The approach explained

Biography is a specific genre that involves writing about another person or ourselves, however, within the context of the assessment of need, clearly the focus of biographical work is on the person whose needs are being assessed. The biographical approach envisages the collection of information about an individual's life through the auspices of oral testimony – the spoken word of the individual. As a result the biographical approach is a merging of biography and oral history traditions to produce a text which in turn informs the outcomes of the assessment. The sense that is made of the testimony is crucial in understanding the person and how the individual's life has influenced who they are now.

The references to the biographical approach represent an element of the assessment process which some twenty years ago was referred to as a social history. This social history contained key biographical facts and references to significant events in the person's life. On the whole social histories had become appendages to the major focus, that being the assessment of need. More latterly, this appendage has in fact been dropped as it appeared intrusive and involved confidential information sitting in a file having little relevance to the outcomes of the assessment process.

Johnson (1976) refers to this approach in terms of a person's life history being viewed as a series of interrelated careers. The term career is well known in its conventional sense, which

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is related to occupation or work history. Goffman (1961) and Becker (1963) both used the term in mental health and deviance settings. However, Johnson extended the concept to one of a life career thus a person may experience many careers in a lifetime – marriage, work, education, leisure. These careers will be of differing degrees of importance to the individual and for every individual there will be phases in their life that will be problematic because 'important careers' are not progressing satisfactorily or are in conflict with one another.

For Johnson (1976) the biographical approach involves listening to the life history of an older person and becoming aware of their life careers and the way these careers have shaped the individual's present day. By doing this, the individual's priorities for later life will emerge which will enable health and social care professionals to see older people as unique individuals.

Within the literature, the terms life history and life story are frequently used. Atkinson (1998) reports that there is very little difference between the term life history and life story, they are usually different terms for the same thing.

'A life story, is the story a person chooses to tell about the life he or she has lived, told as completely and honestly as possible, what is remembered of it, and what the teller wants others to know of it, usually as a result of a guided interview by another.'
Atkinson 1998:8

Johnson et al (1988) maintain that the biographical approach is more than a life history. The interest in an individual's past is more instrumental in terms of what it reveals about the present. Clarke (2000) believes that through listening to the life stories of older people, the circumstances and structures that have shaped their lives enable a fuller appreciation of that person's wishes and aspiration. This in turn reveals the diversity of older people's lives thus enabling common assumptions regarding later life to be challenged.

Dant and Gully (1994) identify the biographical approach as discovering the unique experiences of the individual and the part these they play in shaping people's attitudes and lifestyles. They progress further to explain that in practice this means asking people about themselves rather than making assumptions about who or what they are and what their problems are. This will result in finding out about their strengths and abilities as well as their problems and current difficulties. It will enable professionals to learn how they have coped in the past and how they feel about themselves and the people around them.

Johnson et al (1988) undertook an action research project, a collaboration between the Open University and Gloucestershire Health Authority running from 1986 to 1989. The focus of this project was the use of the biographical approach to assess the health and social care needs of older people by understanding current needs in the context of past experiences. The objective was to achieve an improvement in

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the services offered to represent a better 'fit' in terms of needs and a reduction in the take up of institutionalised care.

Given that Johnson (1976) had earlier argued that the biographical approach was an important tool in the assessment process, three principle outcomes were identified as a result of the application of the biographical interview to the assessment protocols, namely:

1. Those who listen to the life stories of older people gain markedly different pictures of the person and their needs from those who administer traditional assessment techniques,
2. The older person's self esteem can be enhanced by the skilled encouragement of reminiscence,
3. The way people cope with multiple losses is directly related to earlier life experiences

Boulton and Gully (1989) identified that in terms of the project, the past was used to inform the understanding of the person's present situation and how care could be offered that was appropriate to the older person's needs. They deduced that the approach was useful in the following areas:

- Eliciting older people's attitudes,
- Understanding family relationships,
- Finding out about relationships between carers and the older person,
- Discovering kinds of help which would be unacceptable,
- Relating to and understanding people labelled difficult,
- Learning how people coped with past difficulty and hardship,
- Assessing how people might react and be helped in some future crisis.

The key issue in the application of the biographical approach to the assessment process is the ability of the approach to move care provision from generalised, formulaic responses to one of individualised or person centred care. 'Knowing the patient' is a valued aspect of humanistic nursing care (Jenny and Logan 1992) and is essential to a patient's feeling of being cared for (Tanner et al 1993). Radwin (1996) highlights that knowing the patient becomes a process of understanding and treating the person as a unique individual

Gunaratnam (2004) provides an excellent examination of the importance of the biographical approach within race and gendered health care provision. She comments that

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'…biographical approaches to race and ethnicity can play a significant role in enabling professionals to engage with the nuances of somatic experience …[which] lies in the extent to which practioners and researchers are able to use the approaches to move beyond thinking about race and ethnicity in relation to rigid, one-dimensional categories.'
Gunaratnam, 2004:205/206

This in essence is a further reflection of the need to get to know the individual in order to more fully understand their situation and their interpretation of events and by not imposing assumptions about what an older LGBT person needs or wants. Assumptions are made about the existence of a gay culture or community and it would be relatively easy for health and social care professionals to feel that an older LGBT person should be linked into that culture. The difficulty here of course is what is that culture, where can it be found and fundamentally does the older LGBT person want to be linked to a community or not.

Williams (cited in Gray and McGuigan 1997**)** in his treatise on culture can help us begin to understand what this term can mean for older LGBT people. He identifies the ordinary nature of culture as a lived experience. William's (cited in Gray and McGuigan 1997) analysis rejects the assumption that the indicative nature of a specific culture is determined by the characteristics of the ruling class and the rich and wealthy.

Instead he ensures that the focus of attention is on individuals and how, by their lived experiences they are part of a living culture. As such, each and every one us experience culture through our own lives and in view of the infinite variety of forms of living this gives rise to an infinite variety of expressions of culture.

Given Williams' assertion of ordinariness of culture, it is essential that health and social care practitioners in their interactions with older LGBT people understand the individual in the context of their lived experience of culture. Too frequently references to culture within health and social care contexts are restricted to those service users who appear not to be part of a 'British culture'. Such a restricted view has the result that health and social care professionals fail to reflect the individual experience of culture and the multiplicity of variations in the expression of culture through a life lived.

Clearly health and social care professionals must at the very least develop competence in reflecting upon their interaction with individuals in order to ensure that expressions of culture are encapsulated in their understanding of the person. Employing such models as Schon's (1991) distinction between 'reflecting-in-action' and 'reflecting-on-action' may assist in the development of such competence. Such reflexivity inevitably requires health and social care practitioners to examine themselves in terms of their values and norms in order to review how the outcomes of the assessment were influenced by their practice. Given that most professionals will be younger than the people whose needs

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they are assessing, an additional aspect of reflexivity is required, that being an understanding of the impact of the assessor's culture on the culture of the older person.

Having accepted Williams' understanding of culture as a lived experience we can not ignore the existence of meta and micro narratives in this debate. The most obvious examples of a meta narratives affecting older LGBT people are the discourses of power which exist around the exercise of ageism and heteronormativity in a society or culture that is youth and heterosexually dominated. This is all the more powerful if we accept, as we have previously stated, that on the whole health and social care practice is imbued with ageism and heterosexism. The imperative of cultural reflexivity in terms of practice is the examination of self and one's own culture in interaction with that of an older person with particular regard to outcomes for that person.

Implementing the approach which is embedded in Standard 2 is not a option for health and social care organisations and professionals – this is an example of Government policy influencing organisational and professional behaviour with the objective of ensuring much greater levels of inclusion.

The decision of course for older LGBT people is whether to disclose their sexuality to health and social care professional. This decision inevitably will be based upon many factors not least the perception that Heaphy et al (2003) identified held by older lesbians, gay men and bisexuals of a lack of trust of health and social care professionals. Equally influencing this

decision will be the person sense of self, their confidence, their willingness to manage the potential consequences of such a disclosure and the reality of what is happening to them that brings them into contact with the health service and/or social services. As an example think of an older person who is in a great deal of pain or is very ill the issue of sexuality may be of less importance at that moment in time to that person than how they are going to get to the toilet.

> ## Activity
>
> Discuss with your colleagues the section on the biographical approach.
>
> - What do you think are the advantages and disadvantages of the approach? Please be specific
> - How would you include this in your workplace? – please be specific

Conclusion

The social inclusion of older people in general and of LGBT people in particular has not been given the degree of attention by providers of health and social care, housing, and leisure facilities that it should. The reasons for this often relate to nothing more malevolent as simply focusing attention on the needs of the more visible and audible majority: younger

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people. This requires refocusing on the needs of older LGBT people: providers of services and facilities should find out what the needs are and individuals and groups should make their views and wants known through whatever medium necessary.

However, there are other more sinister reasons for older LGBT people being excluded and therefore needing to be included. Ageism and homophobia in general have to be tackled wherever and in whatever way they manifest themselves. It is only when these twin negatives are addressed that social inclusion will become a reality as opposed to well-intentioned tokenism. The valuable contribution that many older LGBT people can make in all aspects of society should be recognised and celebrated on its own merits. The richness of experience, wisdom, knowledge and emotional understanding that many older LGBT people can share should be seen as a valuable resource in the maintenance of any healthy society.

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Including older lesbians, gay men, bisexuals and transgendered people

Physical environment

- Ensure that the environment – the ward, the care home, the day centre – has images that do not promote a particular life style – this may be interrupted as being that 'I am not welcome here'
- Ensure that the environment – gives equal prominence to images that promote diversity and the different ways that people live their lives – this is saying that difference is valued here
- Ensure that information is available and easily accessible in different formats about a wide variety of services available for people from different backgrounds
- As much as Christmas is celebrated – celebrating other festivals and key events such as Pride ensures that people from different backgrounds are seen to be welcome
- Ensure that opportunity exists for visitors to be welcomed and that their visit is private and comfortable
- Ensure that if friends and relatives want to be involved in the person's care that this can be undertaken – as long as the person wants this to happen

Professional Practice

- At all times be respectful to the person
- Remember that you are there to help
- If help is needed – offer it freely and without judgement
- Listen to the person and what they are telling you without making assumptions or being judgemental
- Create an atmosphere in which you are regarded as being trustworthy and accepting
- Do not make judgements about the person and how they have lived their life
- Do not make assumptions about relationships – a regular visitor may be a friend or a lover
- Your use of language is very important – terms which place emphasis on age in a derogatory way are both offensive and ageist
- Your use of language related to sexuality is also very important – words like poof or dyke can be offensive and homophobic and will have the result that people will not trust you
- Do not gossip about people
- include people in decisions about their care by asking them what they want – listen to the answer and try to ensure that this happens or explain why it can not
- Remember – in general terms you have no authority to make decisions on behalf of other people or force them to do things – would you like it if this was happening to you?

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The literature

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Reviewing the literature

There is a considerable amount of literature available related to older lesbians and gay men, however older LGBT people are on the whole ignored in the material and there is very little research and commentary specifically related to them. The material that does exist, whilst focused on older lesbians and gay men is not gathered within standard texts related to older people. The material is therefore not easily available and but is spread through various Journals, reports and other published material which makes searching for it very difficult and time consuming.

The absence of commentary related to older LGBT people is interesting in its own right but the nature of the material that is available is also interesting. This presents us with a critical commentary about both gerontology and sexology as disciplines and how much wider social processes are influencing their considerations. This critical commentary reflects:

1.   the influence of ageism within the very field of study that explores issues related to older people – gerontology - thus the broader influence of ageism seeks to deny the sexuality of older people and this is reflected in the issues that gerontologists study.

'…fails to mention elderly gay men and lesbians or provide little discussion of the concerns about aging. This omission reflects the systematic ignoring of and subsequent exclusion of older gay, lesbian and bisexual populations in mainstream gerontology, (Jacobs etal.1999:4).

2.   the material that is available is very diverse, however,

the majority of it refers to older gay men reflecting in part the sexism that is imbued within sexology.

3.   the material in general terms is divided into 2 forms – statistics and life story or narrative and it is no surprise that the statistical material tends to be focused on older gay men and the life story material on older lesbians and this is an interesting reflection on gender issues and the understanding of gendered sexuality.

Thus male sexuality tends to be researched in terms of the number of sexual contacts, receptions and ejaculations. This approach lends itself to an approach which relies on counting. On other hand the material related to older lesbians is much more about individual life experiences and life stories and of course is told much more as a story.

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4. this has a number of implications not least that it is easier to report statistical information than to group together very different life experiences and as a result commentaries to tend to be dominated by issues related to older gay men. Inevitably this leads to the continued invisibility of older lesbians – a further reflection of the invisibility of women in general.

5. equally, how the researchers define sexuality and sexual activity needs to be carefully explored. Men, in general terms, tend to view sexual activity as penetration whilst, in general terms women place importance on intimacy which does not necessarily include penetration. This has the consequence that when reading the material we have to be aware of the gender of the person writing it and how they are defining sexual activity.

6. In a similar way we need to be careful about some of the implicit assumptions that are contained within the material and the influences that are acting on the authors.

   Much of the material dates back to the 1970's and 80's when society's attitude to lesbians and gay men was still very negative. This negativity can be seen in some of the images that are constructed within the literature.

So we need to consider the material very carefully and be aware of the influence of:

- ageism
- homophobia
- heteronormativity
- gender
- sexism.

Older people can be gay

The change in society's attitude in the United Kingdom and in the United States towards lesbians and gay men began to occur in the 1960's and came out of lesbian and gay civil rights movements and groups such as the Campaign for Homosexual Equality - CHE. In the United Kingdom this followed the publication of the Wolfenden Report in 1957 which lead to the enactment of the Sexual offences Act 1967 some ten years later.

This Act is widely seen as legalising male same sex relationships when prior to the act it was a criminal offence for two men to have sexual contact with each other. In the United States the Stonewall Riots in New York in July 1969 had the affect of redefining and galvanising the lesbian and gay 'community' to challenge the oppression that they were experiencing. The existence of such groups as CHE became the vehicle through which people were able to organise activity to challenge the law – prior to 1967 and to change social attitudes which remained very hostile for a long period after the law had changed. The emphasis at that time was on

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the acknowledgement of human and civil rights for all lesbians and gay men.

Whilst considerable diversity (see Chauncey 1995 and Houlbrook 2005) existed then as it does now with in the lesbian and gay 'community' the acknowledgement of such diversity took second place in the face of the larger struggle for rights. However, in the late 1970's when the struggle for rights had achieved a considerable degree of success attention began to turn to the diverse nature of the lesbian and gay 'community' which included the acknowledgement that lesbians and gay age. Slowly, the absence of older lesbians and gay men in the public lesbian and gay areas was being noticed.

'This point is illustrated by the *Christopher Street* periodical which asked in November 1977 *'where do old gays go?.* In 1982 the New York Daily News, quoting a gay man stated *'you never see them (older lesbians and gay men) around; after a certain age they seem to disappear. Where do they go?* (LaRosa 1982). A poster for a Toronto gay forum *asked 'what happens to homosexuals over 50?* (GLHC,1985). The absence of older lesbians and gay men was noted although there were few answers for these questions because research in this area had either not started or was just begining.' Pugh (2002)

There is no single reason which explains why older LGBT people have on the whole not been acknowledged by academics, younger LGBT people or by society in general. We could explain this situation by looking at the effect of different systems of oppression but in doing so we also must acknowledge the effect of these systems of oppression operating in conjunction with each other. So it is not simply and solely the effect of ageism or homophobia but we can see both of these systems in operation alongside heteronormativity, sexism, disability and race.

A further explanation could rest in the ability of lesbians and gay men to 'hide' their sexuality – to become anonymous and blend in with the rest of society. This explanation needs to be placed in the context of the need to avoid detection at a time when same sex relationships were either criminalised or subject to severe social restriction and sanction. The reality is that for older lesbians and gay men, the threat of being discovered which existed through most of their adult lives informed how same sex relationships were established, how they were conducted and even how the imagery of self was formulated. Jacobs et al (1999) comment that the:

'secrecy related to sexual orientation was a common coping response to discrimination, but often resulted in individuals feeling guilty and ashamed of their gayness or lesbianism' (Jacobs etal.1999:3).

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This latter point - the effect on older lesbians and gay men of the criminalisation and severe social reaction to their sexuality earlier in their adult life and the necessity to hide their sexuality reflects on the importance of the life course approach in terms of understanding the current position of older LGBT people.

A changing world

The Sexual offences Act 1967 de-criminalised gay male relationships in England and Wales (the situation in Scotland and Northern Ireland did not change until 1980 and 1982 respectively) The Act, did not symbolise a progressive change in attitude on the part of the State which welcomed LGBT people. The general principles of the Act were proposed some ten years earlier in the Wolfenden Report and the Act itself was laid before Parliament as a private members bill and not a Government bill. The contents of the Act also did not represent equality for gay men but rather that gay male sexual contact was no longer a criminal offence within strict and narrow conditions for which there was no heterosexual equivalence.

The conditions within the Act were such that victimless, consensual crimes were constructed which again had no heterosexual equivalence and which legitimated continued surveillance and harassment from the police. The consequence of this is still being felt by many older gay men who were convicted of these crimes which are sexual in

nature and represents a criminal record. For these men employment within the health and social care sectors is dependent upon a satisfactory Criminal Records Bureau check which inevitably discloses these convictions. This does not automatically mean that they can not get employment within these sectors but it does mean that such employment is dependent on the vagaries of ad hoc decision making within agencies. This again highlights the life course approach and the reach of oppression from the past into people's current situations.

The Act, however, did begin a liberalising process which has changed the environment in which many younger lesbians and gay men currently conduct their lives. The 1967 Act passed into law when the current 80 years olds were aged in their late 40s and early 50's. The liberalisation, which is a consequence of this change in legislation, did not occur overnight, but in fact has been a gradual process which has developed and quickened in pace over the last 30 or so years. The pace of reform has in fact moved faster since 1997 driven primarily by a European equality based agenda.

Employing a life course approach – these changes have occurred within the lifetime of the current cohort of older LGBT people. The implications for older LGBT people – for this group of people who were in their 40's and 50's at the time of the change in the law – was in fact little immediate change. It was not until this group were well into their 60's and 70's before most could identify any appreciable change in society's attitude.

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Whilst it may appear that the path to equality has been in one direction from severe oppression to the current position of much greater equality, in reality this has not been entirely smooth journey and there have been considerable set backs. The continued existence and operation of discrimination – primarily in the form of homophobia but equally heteronormativity has presented many challenges for individual LGBT people but also for the civil rights of all LGBT people.

Thus such areas as the age of consent, rights to recognised relationships, the notorious Section 28 (section 2a of the Local Government Act 1988) [1] and archaic attitudes towards lesbians and gay men in respect of childcare, reflect legitimated discrimination based on sexuality. Whilst most of these issues have been addressed in equality and civil rights terms, the debates in the House of Lords in respect of Section 28 and the age of consent, clearly demonstrate that homophobia is alive and well and exists within the English legislature.

Since 1997 the situation in respect of the civil rights of LGBT people has changed considerably. The age of consent has been equalised with heterosexuals, it is now illegal to dismiss a person from their job because they are lesbian or gay, same sex relationships are now recognised in a form of 'marriage'. Many of these changes have been imposed upon the United Kingdom Government by European Union legislation leaving a sense of a reluctant government being forced to ensure the rights and equal treatment of its citizens.

However, the legacy of official, state sponsored homophobia in the 1980's and through the 1990's continues to have its impact on the lives of LGBT people. Given both the power of homophobia and heteronormativity it is not surprising that the deep rooted negative and hostile attitudes that they generate is still in existence and continues to be reflected in the ways of working of state employees such as in the health service or in social care agencies. The continued existence and manifestation of both homophobia and heteronormativity has had the results that many lesbians and gay men, irrespective of age, have hidden their sexuality when in contact with the health or social services. This is demonstrated by the work by Heaphy et al (2003) who identified the perceptions of older lesbians, gay men and bisexuals towards health and social care staff. Heaphy et al noted that many older lesbians, gay men and bisexuals felt that health and social care staff were either hostile or at best ambivalent towards them and that services did not take account of their needs.

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[1] Section 2a of the Local Government Act 1988 forbids local authorities in England and Wales (the section has recently been repealed in Scotland) from devoting resources which promote homosexuality and prevented *'the teaching in any maintained school of homosexuality as a pretend family relationship'* (Brown.1998:26).

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So what hope was there for older LGBT people who wished to maintain their respect and dignity at times when they may be dependent on the care of other people. Such care may be provided in environments such as residential or nursing homes or even in their own homes. These issues are illustrated by Brown (1998):

'...I am a woman paralysed after a stroke from the neck down, how can I ask my home carer, employed to facilitate my 'independent living' to switch on Dyke TV (Channel 4, 1995) when I do not wish to reveal my sexual-orientation because the carer has already let me know that their opinion that Beth Jordace's death on Brookside (Channel 4, 1995) was better than she deserved because she was a lesbian"

(Brown.1998:113)

Cooke-Daniels (2006) provides us with a similarly powerful example of the effect of oppressive health and social care practice in relation to an older transgendered person.

'Andrew adored Mr. Adams. Not only was he lucid…but he was charming. And so interesting! He had travelled so many places in the world and had so many wonderful stories he was will to share.

So he was very concerned when Mr. Adams came to his office one day and asked whether he could close the door. Something was clearly wrong. While Mr Adams wheeled into place, Andrew came from behind his desk…For a while Mr Adams wouldn't say anything, just hanging his head down. Then, to Andrew's horror he saw a tear drip down Mr.Adams's face and into his lap…

Slowly haltingly, his face turned away from Andrew… two of the nurse aides had begun making fun of his penis whenever they caught him alone during dressing or toileting. "they've noticed my…um, urine…doesn't come out the end of my penis like, uh, most men's," he said. Plus they make fun of his penis's small size. Gradually they had begun escalating their behaviour, trying to make him get an erection through various means and taunting him when nothing happened. Eventually, two days ago, they has anally raped him with something; he didn't know what.'
Cooke-Daniels (2006:20)

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Images of older lesbians and gay men

When we are exploring the images of older LGBT people we need to have regard to the issues discussed above related to the influences which construct these images. Many of these images are extremely negative and contain elements which are very dangerous and equally are wrong. These images were constructed in a time that is very different from our own and it is from our own perception that we need to view these images very carefully. We also need to be aware, as you will see, that older LGBT people remain invisible with the result that the material that follows concerns older gay men and older lesbians.

The received wisdom related to older gay men, creates an image of :

'…loneliness, isolation, sexlessness, poor psychological adjustment and functioning, fearful anxiousness, sadness and depression and sexual predation on the gay young who reject their company and exclude them from a 'youthist' gay culture.'
 Wahler and Gabbay 1997:9

We can see that both ageist and homophobic attitudes undoubtedly influence this stereotype. To be a gay older man pours on the misery not least because it is bad enough to be one or the other but to be both is to double the misery.

Kimmel (1977, 1978, 1980) presents us with different images from the stereotype identified above and in fact identify that older gay men have little contact with younger men – this inevitably undermines the assumption of older gay men's predatory behaviour – that they are not in general terms seeking younger men in a predatory way. This idea of older gay men seeking contact with younger men in a predatory way is a strong image and reflects ageist ideas about the young being beautiful and therefore desirable but was also used forcibly in the arguments to deny an equal age of consent. The basis of this assumption is also very dangerous because young is not defined potentially facilitating links between older gay men, promiscuity and paedophilia which are both unfounded and feed homophobic attitudes.

The image of older lesbians in contrast is very different as they are frequently portrayed as highly educated, politically liberal, middle class, professionally employed and unmarried or divorced (Jacobs et al 1999). In contrast, older heterosexual women are often stereotyped as poorly educated, politically conservative, poor, religiously active, asexual, professionally unemployed and married or widowed. The difference in the treatment – in the imagery of older lesbians and older heterosexual women is very interesting and reflects the influence of hegemonic heterosexual masculinity. This influence and the ensuing power issues suggests, as stated above that older lesbians are perceived to be of no threat to heterosexual men and therefore portraying

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them positively is of no consequence. This of course reinforces the argument about older lesbians being invisible. Healey's (1994) discussion of being old and a lesbian can provide invaluable insight into this lack of visibility experienced by older lesbians. In her narrative, she describes both what she is and what she is not, as such she states that she is not docile, does not accept the orthodoxy of women serving and relying upon men.

She is not, in a broad sense a 'grandmother' to the world although she recognises that many older lesbians do have grandchildren. Healey (1994) has placed a high value on independence and her own self-reliance acknowledging the:

> '...meaning of being multiply oppressed. Every lesbian has paid a large price for being different because she is a woman and a lesbian. If she happens also to be a woman of color, or Jewish, or poor or disabled, she then experiences additional reprisals and discrimination. And now, finally having grown to be old, we experience the compounding of all these oppressions in the insidiousness of ageism, and the total effect is most assuredly greater than the sum of the individual parts'.
> Healey, 1994:111

Healey (1994), identifies she was oppressed at different levels at different times in her life and that she now is invisible from consideration based upon the reaction to her age. She identifies that she, like other lesbians have

> '...found the strength, the bravery and the courage not just to survive but to grow and to love as well.'
> Healey, 1994:112

She felt, at the age of 70 years freer than ever before, less restrained by some of the conventions through which lives are lived. Interestingly, the experience of ageing and of ageism, draws Healey (1994) to acknowledge the links that she as an older lesbian has with all older women and represents a point of convergence in terms of experience.

In terms of transgendered older people the available literature is very limited this is in part a reflection of ageism and the denial of sexuality in later life but it is also partly the fact that the 'technology' of transition is a relatively new phenomena.

Cook-Daniels (2006) Identifies that the ability to physically complete the process of transition – by consuming hormones and undertaking surgical intervention – is still so relatively new that in fact people have been attracted to this process from all age groups with people in later life undertaking transition. Cooke-Daniels (2006) refers to this as a cohort affect with the implication that as the 'technology' of transition becomes established over time then those who wish to transition will do so at an earlier age. It is difficult to substantiate this assertion – we do know that older people do 'come out' in later life having lived in heterosexual relationships for most of their adult lives. This again may in fact be a 'cohort affect' and as we see society's attitude change and civil rights become more

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established then the environment of oppression will change making easier for people to be themselves whether this involves their sexuality or an altered gender.

Adjusting to growing older

The idea of having to adjust to ageing at one level constructs an idea that being old is unpleasant and unwanted so that the inevitability of growing old has be coped with. At this level we are clearly dealing with ageist ideas and need to be careful with the assumptions that lie beneath the research and commentary that is identified below. However, in a society that is endemically ageist, that portrays growing older as undesirable, it is inevitable that some sense of adjustment has to take place – not least because of the consequences of forced retirement from employment with the associated reduction in income, structure and social contact. What is important is how these issues linked to older lesbians and gay men and the images that are developed.

The literature identifies positive adjustments to ageing and social networks amongst older lesbians and gay men. Most researchers and commentators make an assumption that good health in later life means that the person must be with involved with the wider gay community. This link between health and involvement with the gay community is based on an idea that being involved with the gay community means that the person has 'come to terms' with their sexuality and represents a 'healthy' acceptance of sexuality. Of course this assumption has the result that if the individual has little or no contact with the wider gay community then they are inevitably 'unhealthy' as they have not accepted their sexuality which of course suggests depression and mental illness.

This issue of involvement with the gay *'community'* causes a number of problems because:

- it represents an additional test that older heterosexuals are not expected to undertake in order to demonstrate their adjustment to their sexuality.
- there is an assumption that such a gay 'community' exists and is welcoming of older lesbians and gay men
- such a community is easily accessible.

The underlying problem here is the issue of demonstrating that the individual has 'come to terms' with their sexuality by joining or being part of the gay community. The imagery is one of loss – the loss of the desired and normal condition of heterosexuality which the individual has to adjust too. This again reflects the power of heteronormativity to define what is normal and acceptable with all other states being a loss of this.

Yet again we come across life course issues because much of the research assumes that joining lesbian or gay groups indicates that the individual has accepted their sexuality but ignores the fact that some people are not joiners of groups,

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have not been through their life but are also accepting of their sexuality.

Weinberg (1969, 1970) identified that age was a determinate of engagement with the gay community as older gay men had reduced their contact with the gay community with increasing age, but importantly that they did not feel any more lonely than younger gay men. Francher and Hankin (1973) whilst equally reporting a reduction in involvement the wider gay community also noted an increase in the contact that older gay men had with their social networks, both gay and heterosexual. This suggests that private friendship networks become increasingly important for older gay men and may in turn reflect the operation of ageism in the public gay male arenas. Some researchers observed that older gay men have many gay friends but less heterosexual friends and that in general, gay men had significantly more close friends than heterosexual men (Kelly (1977) Friend (1980).

The development of private friendship networks and close relationships within those networks actually suggests that gay men are more able to adjust to their own ageing than heterosexual men. Older gay men were also reported as being less worried about their sexuality being disclosed, that they had higher levels of self-acceptance and had an improved and stable concept of self (Weinberg (1969, 1970, Kelly 1977). These images are certainly very different to the very negative images of isolation and unhappiness identified earlier.

Many older lesbians appear are reported to view their sexuality in terms of emotional intimacy and personal identification with other women (Jacobs et al 1999). The literature identifies a contradiction related to living arrangements as older lesbians are reported to be living with a partner or living alone. Most studies identify continued interest in and valuing of sex although celibacy was a feature of many older lesbians lives which, for many was not a choice. The research identifies that the relationship arrangements involved a belief in monogamy. (Minnigerode and Adelman, (1978), Raphael and Robinson, (1980) Tully, (1983) Kehoe, 1986).

Goleman Wolf (1982) in fact, on a very positive note, suggests that heterosexuals could learn and benefit from a gay model of ageing. Berger (1984) notes that the issues for older gay and non-gay people were the similar – with a major feature being self-acceptance.

In contradiction to the many stereotypes of older lesbians and gay men, a number of commentators have identified that the atmosphere of repression encountered whilst older lesbians and gay men were growing up and conducting their early adult lives, has in fact assisted them to adjust to their own ageing.

Frencher and Henkin (1973) were the first to propose the idea that 'coming out' as a life crisis assisted older gay men to cope with ageing. Kimmel (1978) also reflects this view. The assumption that is being made is that 'coming out' must be a difficult and painful process and having 'competently'

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responded to this crisis, older lesbians and gay men have the skills to cope with other life crises, in particular, the move into retirement and late life.

The idea of 'coming out' as being a very difficult process is very powerful but again there are many assumptions that lie behind this. The need to disclose difference – I am not… - reinforces the dominance of heterosexuality as the norm – as a result not being heterosexual requires this statement of difference. Having made this statement and dealt with the reaction to it the assumption remains that this in essence a one process but in reality 'coming out' is a continual process as new people are encountered. At each point a decision has to be made about disclosure and this decision is made based on confidence, the context and the perceived reaction of the people to whom the disclosure is being made. This process continues when older LGBT people engage with health and social care professionals.

Whilst the literature focuses on the issue of 'coming out' in a lesbian or gay context with its emphasis on sexuality, Cook-Daniels (2006) identifies that for many transgendered people, the issues of 'coming out' has more to do with their gendered identity than their sexuality. There is however, an inevitable association between gendered identity and accepted categories of sexuality – thus a man who transitions to become a women and who is sexually attracted to women would be described as a lesbian in terms of their sexuality.

The issue of a public declaration or coming out for transgendered people becomes very important in the process of transition as most doctors require such an acknowledgement. Of course doctors become very important in this process both in terms of access to the necessary hormones but also in terms of surgical intervention.

Cooke-Daniels (2002) identifies that a:

'A substantial proportion of transgender people do not transition until middle age or later.'
Cooke-Daniels (2006:22)

Consider the implications for a person for whom the biological body is itself is the source of such profound unhappiness and confusion. For such people the biological body may be the absolute opposite of who they feel they are in gender terms – a feeling of profound dislocation.

The felt experience of dislocation in respect of gender and the biological body inevitably involves periods of anguish, sometimes very long periods of anguish resulting for some in the decision to structurally change the body – to align the body to the gender that they feel they should be. Such a profound decision is not made lightly but is made in the expectation that the dislocation and anguish will come to end as a new identity is achieved with a new body that is in line with the gender that they feel they should be. Such expectations involve the desire to adopt a different gendered identity and with that the adoption of an image of the woman

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or man that they will become or they desire to be. Rarely in making such life changing decisions is there a consideration of ageing on the body re-aligned and the constructed gendered identity. The result is a process of transition which involves expectations of a desired body upon which ageing will act in ways probably unthought-of in terms of their desired body image.

Schrock et al (2005) from their research illustrate the constructed nature of the desired gendered identity. They provide the example of Kris who comments that:

‘with the three wives that I had, I studied them. I mean I studied them. It wasn’t just observation. I watched how they did things. How they held a cigarette, how they sat, how they walked, how they gestured…picking up a fork, the way a woman drives a car. Men don’t realize it, but everything is so different…A woman holds a cigarette out towards the end of her fingers, and a male holds a cigarette down here[near the knuckles]…When a woman drives a car, both hands are not on the sides; they’re at the top [and] the thumbs are above the steering wheel…if you start listening, when [women] end a sentence, they go up. The voice inflection will always go up. And when you do that, it softens your voice.’
Schrock et al 2005:322

A further example is provided of Karen who drew her gendered identity from watching women on television. For both Kris and Karen this process involved what Schrock et al refer to as ‘retraining the body’ but the interesting question that is not asked is why Kris chose his ex-wives to study when one was identified as ‘ultrafeminine’ and which women on television did Karen choose to study and with what expectation in constructing their new gendered identity.

Clearly, in constructing their new gendered identity both Kris and Karen choose characteristics that they felt most matched their image of the women they wanted to become. In doing so, this process of ‘retraining of the body’ becomes the expression of resolving the dislocation between the biological body and the desired gender. However, in actively deciding to realign the body to the desired gender rarely does the consequences of the ageing of the body feature in the decision.

Dozier (2005) identifies the wider structural context of transition and a constructed gender identity. She sites the example of Rogelio who comments:

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'I am a black man. I'm the suspect. I'm the one you have to be afraid of. I'm the one from whom you have to get away, so you have to cross the street, you have to lock your doors. You have to clutch whatever you've got a little closer to your body…It's very difficult to get white FTM's to understand that…[As a black person], if I go into a store, I am followed. Now I am openly followed; before it was, "oh, lets hide behind the rack of bread or something so that she wont see us," Now it's, "oh, it's a guy, he's probably got a gun; he's probably got a knife. We have to know where his hands are at all times.' Dozier(2005:310)

In the example of Rogelio, the desired gendered identity, that of being a man in interaction with a race ascription brings with it a particular societal reaction to such an identity and in this case the aspired gendered identity is reacted to negatively.

It is interesting that in the consideration and both Schrock et al (2005) and Dozier (2005) the socially constructed and biological identity variable that is ignored is that of age. Rogelio comments upon the reaction to him as a black man without pondering how potentially different the reaction would to his gendered identity as an older black man. Both Kris and Karen establish their gendered identity by retraining their bodies to mimic the characteristics of the woman they aspire to be but the aspirational gendered identity is not that of an older women. In the examples of Kris, Karen and Rogelio we

can see the function and operation of the social construct that is ageim impacting at different levels.

Initially we can see the discounting or rejection of age and ageing as a variable in terms of the constructed aspirational gendered identity. This constructed identity is located clearly in the here-and-now and reflects both the age of the person at transition and the type of man or woman they would wish to become.

It would be interesting to establish how men who are very visible in our society cope with the invisibility of being an older woman having transitioned either in later life or transitioned and aged to become an older woman.

Having 'managed' the consequences of 'coming out' – this life crisis – is viewed by the commentators as equipping the individual with skills to deal with other life events. In fact Berger (1980) refers to the term 'mastery of crisis' which was later endorsed by Jeffery Weeks (1983). Lee (1987) asks whether Berger's assumption is true or whether some puritanical idea that suffering is good for the soul is present in these comments.

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There are aspects of the homosexual experience that facilitate adjustment to aging. Social workers who work with the elderly would do well to consider these aspects for what they reveal about adjustment to aging for homosexuals and heterosexual alike... the coming- out period is a major life crisis, which, when resolved, provides the individual with a stamina unavailable to many others. Today's older homosexual had to resolve a crisis of independence at a young age and at a time less tolerant of sexual nonconformity. He knew that he could not rely on the traditional family supports that heterosexuals take for granted. Whereas older homosexuals are as likely as heterosexual to be alone in old age, they are better prepared for it, both emotionally and in terms of support networks of friends. Berger.1982:238

A competence model, or more accurately – crisis competence, has been used by Berger (1982), Francher and Henkin 1973, D'Augelli 1994 and others to maintain that older gay men are more able to cope with life crises. In reflecting upon the model, Pope and Schulz, 1990, Kooden, 1997 identify that older gay men are able to cope, in a positive sense with loss and less rigid role expectations. Friend (1980) identified that the changes in social status and role that occur with aging are less of a problem for older lesbians and gay men because of more flexible gender roles experienced through out their lives.

This is an interesting reflection on how lesbians and gay men are assumed to conduct their lives and their relationships. Such comments further reinforce the power of heterosexism as a system of oppression, in structuring how relationships should be and are conducted. Thus in same sex relationships there must be a 'man' and there must be a 'woman' to undertake the ascribed roles.

Wahler and Gabbay (1997) in their review of the literature, identify a number of themes related to the adjustment to ageing:

- The similarity between gay and non-gay older people in some of the predictors of successful ageing,

- That self acceptance can be a critical variable,

- That gay men are better prepared for the process of ageing than non-gay men,

- There are some unique challenges to the gay experience of ageing.

In fact they go on to identify positive benefits of being a lesbian or gay man in late life as they assert:

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However, they do identify a note of caution involving older lesbians and gay men who 'lack self-acceptance'. In most of the literature – lack of self-acceptance is inevitably equated to not being 'out' and or not involved with the wider gay community.

Kimmel (1977) identifies a number of other benefits of being an older lesbian and gay man. Such benefits, he argues, are a consequence of many gay male lives not being disrupted by 'life cycle' changes such as the death of a spouse; role changes of retirement and the movement of adult children away from the home. Kimmel's commentary again reflects a number of assumptions in terms of older gay men not being in relationships and not having children from relationships earlier in their adult lives. Patently, older lesbians and gay men do not lead lives separated from family and friends and many of the life-cycle changes identified by Kimmel (1977) do have an impact on people's everyday lives. Older lesbians and gay men are touched by the death of partners, parents and friends and retirement or the exclusion from work has different meanings for people.

Kimmel (1977) goes on to state that older gay men have a more self-reliant attitude in respect of their own needs which is based in part on higher levels of earned income and more disposable income in later life. In measuring both quality of life and social exclusion – income becomes a crucial variable suggesting therefore that if older gay men are reported to have higher levels of disposable income then their quality of life and levels of social inclusion should be high.

Older lesbians are reported to have adapted well to the ageing process and to have a positive self-image, equally, they do not experience the acceleration of ageing as fast as heterosexual women (Laner 1979).

What do you need to age well?

The primary condition for gay men in successful ageing is income and access to financial resources. Lee (1987) comments that this as a powerful indicator in the general population regardless of sexuality. Education is also a strong indicator and is related to income. This is again related to the whole population of older people and is not specific to older LGBT people. The presence of a life partner is the third in the correlation with happiness in old age (Berger, 1980, Lee 1987) with loneliness representing one of the major threats to happiness. Ageing, itself is the final aspect in the correlation

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with satisfaction in old age rather than being gay. This in part reflects the attitudes towards dependence and the attainment of goals such as a comfortable home and a sex life. These are again related to the whole population and not specifically related to older LGBT people.

The message is quite clearly, that happiness or satisfaction in later life is dependent on other factors rather than sexuality per se. However, unlike heterosexual older people, the literature identifies an additional factor for older LGBT people. Whilst this factor is identified differently (Wahler and Gabbay (1997) refer to it as 'self acceptance') it relates to publicly disclosing the nature of their sexuality - of being 'out'. The literature asserts that being 'out' is likened to happiness and the test is participation in the gay community by belonging to gay or lesbian organisations.

This is a substantial test which heterosexual older people do not have to pass. Whitford (1997) identifies two aspects to participation in the community. The first is a formal measure which relates to participation with gay organisations, whilst the second is informal and addresses the characteristics of the social networks or friendships which the older person maintains. This measure identifies the number of gay friends and is specific to the majority of friends being gay. The importance of this latter measure rests with the prediction of positive outcomes in terms of adjustment to ageing.

There are a number of assumptions that lie behind such ideas that have been highlighted through out this review of the literature but remain equally valid at this point. The first, as identified above is that being old is a state that has to be adjusted to and thereby unpleasant or to be avoided. The avoidance of aging has become a moral imperative. To be young and active is the state we should strive to achieve. For commentators from a political economy perspective, the world of economic activity – work – is the condition that provides meaning to our lives and thereby to be excluded from this on the basis of age is an inequity.

The second assumption is related to being 'out'. The process of coming out can be devastating for some people, for others it can be liberating. To assume that happiness is being out denies individual experiences and again establishes a moral imperative – lesbians and gay men must be out to be happy. Lee's (1989) work cited above identifies that many people maintain wholly satisfying lives whilst being very private about their sexuality.

Equally being 'out' is not a fixed and complete state, different levels of knowledge exists in various groupings. Perhaps, in order to ensure wide spread knowledge of the person's sexuality, older lesbians and gay men should be made to wear vests at all times with some form of outing statement of self declaration thus complying with the moral imperative and maximising the opportunity for happiness.

The third point rests with membership of lesbian and gay organisations as a test of the degree of 'outedness'. This again denies the individual's experience and wishes. In equity,

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we should assert that heterosexual older people have to join groups in order to satisfy a test of happiness. The theoretical underpinning with this test is *activity theory* (Havighurst, 1963)

Diversity and older lesbians and gay men

Kimmel's (1977, 1978, 1980) work actually found considerable differences between older gay men, thereby recognising diversity amongst older gay men rather than the generalisations upon which the stereotypes have been constructed. In fact Kimmel's (1977, 1978, 1980) work directs us to an important issue – that of diversity - which involves an understanding that being a LGBT person does not mean a single expression of this identity.

Thus diversity of sexuality intersects with other expressions of diversity within society, such as ethnic background and disability which creates, as Roseneil (2002) comments a:

'queer community' of lipstick lesbians, butches, femmes, FTM's s/mers, switchhitters, muscle marys, opera queens, bisexuals, transsexuals, the transgendered, those who identify as black, Asian, Irish, Jewish, latino...'
Roseneil, 2002:29

We must not assume that the current cohort of older LGBT people did not experience such diversity of the expression of their sexuality when they younger. Many older LGBT people did enter into heterosexual relationships earlier in their adult lives and married partly in order to hide their sexuality but also because this was the only model of relationship that was presented to them.

Equally, as Lee (1989) identifies many older LGBT people choose to remain single with an attitude of asexuality. Furthermore many older LGBT people lived as such with differing levels of secrecy to reflect their individual circumstances and changing patterns of social reaction. Of equal importance in this discussion of individual narratives or life histories and the development of sexual identity is the rejection of fixed identities which are shared by all or which are experienced in a similar manner over time. Thus how an older LGBT person was and is these identities will reflect their interests, their understanding of self and their circumstances.

It is interesting that age as an expression of diversity in this discussion is repeatedly rarely recognised. Such exclusion may in part reflect the dominance of ageism both within the lesbian and gay community and in broader society with its assumption that all older people do not have sex and are in fact are asexual. Here again we see issues of convergence and separation with the wider population of older people. Thus ALL older people are portrayed as being devoid of sexuality based upon ageist assumptions about what is beautiful but equally, older people's sexual identity necessarily will reflect diversity of expression.

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This issue of acknowledging diversity - of different life experiences and different ways of being LGBT is very important for health and social care practitioners in their response to older LGBT people. Assumptions can not be made about what it is to be old and a lesbian or a gay man not least because the basis upon which the stereotypes are derived are contradictory. Equally, the development of sexual identity will vary from one person to another reflecting their past and current experiences. There are many ways of being a LGBT person as much as there are many ways of being an older heterosexual.

Accelerated ageing

Much of the research on issues related to older lesbians and gay men has been conducted in the United States and Australia and has interestingly identified the issue self identification vis a vis age. The reference to accelerated ageing is purely an issue of self identification and does not imply that LGBT people experience premature ageing directly as a result of their sexuality.

The emphasis on the body young being the body beautiful, within the lesbian and gay community (in particular the gay male community) reflects the extent of ageist attitudes. The result is that people who are in mid-life are, or feel they are, disregarded and no longer attractive or sought after. This belief is reflected in a colloquialism, which asserts that *nobody loves a fairy over forty.*

The consequence of this is that some older lesbians and gay men – more notably gay men, identify themselves as old, decades before their heterosexual counterparts. It is this self identification as old that is being referred to as accelerated ageing.

Interestingly and unsurprisingly the evidence for such a phenomena is contradictory. Bennett and Thompson (1991) comment that:

'because of the gay community's emphasis on youth, homosexual men are considered middle-aged and elderly by other homosexual men at an earlier age than heterosexual men in the general community. Since these age-status norms occur earlier in the gay subculture, the homosexual man thinks of himself as middle-aged and old before his heterosexual counterpart does'.
Bennett and Thompson.1991:66

Friend (1980) undertaking research in Philadelphia advertised for older gay men with the result that over 90% of the respondents were aged under 64 years – the youngest was aged 32 years. However, Laner (1978) in her analysis of gay and heterosexual contact adverts in newspapers concluded that there was no evidence of accelerated ageing.

In terms of age related norms, Minnigerode (1976) undertook research to identify how gay men aged between 25 and 68

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years old defined themselves using chronological stages in life (young, middle-aged and old) and to place themselves within these stages. All the men in their 20's, 80% of the men in their 30's and 28% of the men in their 40's all considered themselves as young. The rest regarded themselves as middle-aged. The mean ages for middle-aged was 41.29 years and 64.78 years for old age.

Neugarten, Moore and Lowe (1965) established similar figures amongst heterosexual people with Minnigerode (1976) concluding that accelerated ageing did not exist. Kelly (1977, 1980) asked gay men who were aged between 16 and 79 when these stages in life began and ended. The conclusion was that the majority regarded youth as starting before 18 years and ending at 30, middle-age started and finished between the ages of 30 and 50 years and old age started at 50 years. The conclusion reached was that accelerated ageing did exist.

Bennett and Thompson (1991) employed a symbolic interactionist approach in their research on accelerated ageing. Their contention was that gay men live in two worlds– that of the gay community and that of the wider society, thus an examination of the duality of gay men's experience was essential in understanding the attitude to ageing. They established that there was no claim for the existence of accelerated ageing based on the gay men's self-identification. However, they did establish that gay men believe that other gay men view the stages of life as occurring earlier than with the rest of society.

This self-identification has affected some of the research undertaken on issues related to older LGBT people. However, interestingly when asked, the people who self identify as old recognise a distinction between the significance of age in the gay community and the rest of society.

Social Support

The practicalities of social support assumes greater significance for the researchers of issues related to older LGBT people particularly given the image portrayed by Kehoe (1991) of

'disapproval and distancing by their relatives, with older lesbians and gay men) left with no meaningful human contacts'
Kehoe.1991:137

Francher and Henkin (1973) also noted that whilst family support may have been withdrawn as a result of the person's sexuality this support had been replaced by friendship networks.

Kehoe's image has added to Berger's (1980) who states:

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> 'older [homosexual] men are depicted as isolated from other homosexual males, both young and old, who place great importance on the goods looks of youth. Older homosexual men are believed to have unhappy sex lives, if any, and to resort to 'tearooms', hustlers and young children for sexual gratification. They become effeminate, are socially unacceptable to other adults and are labeled as 'old queens'
> Berger.1980:163

Berger's description of the ageing process that gay men undertake involves desperation, a change in personality and eventually a change in sexual expression. It is hardly surprising based on the images that older LGBT people are thought to become socially isolated.

In respect to older people generally, an association is identified between support network and mental health, in particular depression (Phifer and Murrell 1989; Russell and Cutrona 1991). The primary sources of social support for older heterosexuals are their relatives and in particular their children. The extent and quality of the familial relationships are thought therefore to have an impact on the older persons mental health. The implications for older lesbians and gay men who stereotypically are thought to live much more isolated lives, are higher incidences of depression. However, in their research, Dorfman et al (1995) have identified:

> '…no significant differences between older homosexuals and heterosexuals with regard to depression and over all social support, despite significantly less family support in the homosexual group…Apparently a homosexual orientation among the elderly does not impede development of a socially supportive network.
> Dorfman etal.1995:39

The health related consequences of this research for 'friends based social networks' are identified by Dorfman et al (1995) as;

> • Friends are more likely to give freely and without obligations where as families have increased expectations and demands,
> • Friends are more empathic listeners than families who have vested interests in avoiding and denying difficult areas,
> • Friends provide fun.

They go on to comment that the shared experience of being gay in a heterosexual world has strengthened the relationships that exist between older lesbians and gay men. In terms of relationships, Heaphy et al (2003) reinforce previous findings related to the significance and importance of

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friendship networks and also the partners and children of older lesbians and gay men.

Older lesbian's social support is drawn from within the gay and lesbian community. In times of crisis support is obtained from lesbian friendship networks rather than heterosexual friends, siblings or other family members and in fact at such times, there was a reporting withdrawing or isolation from the general heterosexual culture. (Albro et al, 1977, Chafez et al 1974, 1976, Minnigerode and Adelman, 1978 Raphael and Robinson 1980, Tully 1983).

Jacobs et al (1999) identifies that older lesbians prefer to relate to their own age group for their social and sexual needs, however, 66% of Kehoe's (1986) survey had been involved in cross generational relationship where the age difference varied from 20 – 53 years. The vast majority of older lesbians in Raphael and Robinson's (1980) research had lost a partner at some point, with 53% reporting little support after the loss.

The implications are clear – older LGBT people – on the whole have vibrant social lives, which involve mutual support. As individuals, they gain a great deal from these support networks which may include increased enjoyment and happiness with their lives. Such conclusions would make Berger's (1980) profile of older lesbians and gay men seem irrelevant and not reflective of the reality of older lesbian and gay men's lives.

In terms of more formal support, Jacobs et al (1999) identify that older lesbians and gay men (they add bisexuals) may be hesitant in approaching and using social services, even if specific services are available. The rationale that they identified for such hesitance in service up-take, is located within older lesbian and gay man's own internalised homophobia and historical social stigma. The consequence of this internalised homophobia, defined by Kominars (1997) as *'the fear of, and hatred of one's homosexuality'* (Kominars.1997:29-30) can be low self-esteem, greater isolation and poor social interaction. Jacobs et al (1999) go on to comment that many older lesbians viewed professionals associated with the support services, as not accepting their sexuality and would wish to 'cure' them.

Whilst support may be drawn from friends, Berger (1982) notes that other institutional arrangements can impact negatively on the wishes of older lesbians and gay men and deny the existence or access of friends at critical times. Berger (1982) cites institutional policies, legal discrimination, medical oversight and social service agencies neglect for much of this negative impact. Thus, hospitals and nursing homes may deny access to a gay partner based on a failure to recognise the relationship and families can and do contest wills, which leave property to a surviving partner.

The professional practice of health and social care practitioners is clearly being highlighted in these comments with the consequence that older LGBT people are treated differently in interaction with such professionals. The

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experience of such treatment by health and social care practitioners may inform Heaphy et al's (2003) research which indicates high levels of distrust of such professionals held by older LGBT people.

Older lesbians and gay men and the gay community

Throughout this work references have been made to the existence of a gay community and the idea of a 'gay culture' and a 'gay community' has a great deal of resonance within the media and popular understanding of geographic divisions within urban areas. Such an idea conjures images of a rural idle involving a mutually supportive group of people who share a common background and present.

Of particular concern to this debate is whether such a community exists beyond instrumental expressions within urban areas and whether such a community has a culture. According to Fowlkes (1994) the existence of a community with a culture is taken for granted, as she identifies that:

' Lesbian feminism and the gay rights movement that gathered momentum after the Stonewall rebellion of 1969 converged, with the result that for the first time in western history homosexuals have designated themselves and achieved recognition as a distinct social group…homosexual persons, both gay men and lesbians, may find and claim membership in a visible, well defined community with a highly elaborated culture of its own. No longer closeted or hidden from view, those inside the community find validation and support for their minority sexual preference to a degree that has never before existed.'
(Fowlkes, 1994:164)

This celebratory comment and the strong assertion of a well-defined lesbian and gay community with a distinct culture is of course a reflection of the circumstances of the mid 1990's. Given that a community with a culture does exist its relevance becomes what can be drawn from it. Fowlkes (1994) comments that,

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> 'The homosexual lifestyle, as it has come to be called, is not merely a matter of same-sex genital activity. It is a culture with identifiable norms and values about the interrelationship of sexuality and intimacy. As a culture of same sex eroticism it appears, at first glance, to be clearly marked off and set apart from the majority heterosexual culture. In reality, though, it is a culture profoundly reactive to and conditioned by the customs and mores of present-day American heterosexuality'
> Fowlkes,1994:170

Fowlkes (1994) is clear in her assertion that a lesbian and gay culture goes beyond contact with each other for sexual purposes. This culture has 'norms' and 'values', which are related to sexuality and intimacy, however, further characteristics of such a culture were not identified by Fowlkes (1994). Harry and DeVall (1978) identify the

> '… rewards of sex, sociability, self-esteem and neutralization of stigma which are the principle benefits the community can bestow'
> Harry and DeVall, 1978: 1998

Brint (2001) provides a number of additional elements, which would include safety, support, loyalty and acceptance.

Williams (cited in Gray and McGuigan 1997) in his treatise on culture, identifies the ordinary nature of culture as a lived experience. His analysis of culture rejects the emphasis placed upon the ruling class and the rich and wealthy as being indicative of a specific culture. Instead he ensures that the focus of attention is on individuals and how, by their lived experiences they are part of a living culture.

The implications of this for older LGBT people is a reflection of the ordinariness of culture as expressed by the way that lives are lived. In essence this is a further reflection of the diversity of sexual identity in association with the diversity of ways of living. We are left with individual life stories, which show us how a particular person is a LGBT person and an understanding that such life stories differ in particular areas from those of older heterosexuals.

The assumption of a common lesbian and gay culture or community suggests a degree of homogeneity expressed in shared interests between LGBT people. However, the reality is very different in terms of the exercise of power within urban centres that style themselves as lesbian and gay. The majority of the public spaces in these centres are male dominated reflecting in part differential income based upon gendered employment patterns.

As a consequence there are very few women only public spaces with varying levels of antagonism between lesbians and gay men in the shared spaces. Equally, the lesbian and gay culture as lived by individuals in the 'community' has little regard for older people who are also excluded from the public spaces. Equally, the experience of hostility and antagonism

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between lesbians and gay men is also directed towards bisexuals and transgendered people.

If we add to this analysis the increased recognition of diversity then a community which has been based upon homogeneity – of shared experiences and common identity - becomes one of considerable heterogeneity reflecting the very differences which exist both between and amongst LGBT people.

So what does all this have to do with health and social care practice?

The assessment of need is given legal status by Section 47(1) of the National Health Service and Community Care Act 1990 however, the definition of need is not clear. If we employ Maslow's (1954) model, the current practice of need assessment with older people routinely acknowledges both physiological and safety needs with little regard being paid to belonginess and love needs; esteem needs and self actualisation. The emphasis more often than not is placed on the here and now thereby maintaining the status quo with an anticipation of further decline.

Such an approach fits very neatly into the medical model of ageing, which has been one of the dominant theoretical positions from which ageing has been viewed and understood. Andrews (1999) argues that theories that seek to understand the position of older people in society are premised on the assumption that age and ageing is a problem. Hazan (1994) comments that:

'the inaccessibility of the experience of being old, coupled with the inadequacy of available conceptual frameworks, calls for an entirely different kind of approach to the acquisition of knowledge about ageing…The main instructive value of seeking knowledge of ageing is the potential it offers for facilitating an untried and vanguard experiment in unlearning and debunking'
(Hazan 1994:94)

Maslow's hierarchy of need

Growth need

Deficit Needs

Self-actualisation needs

Esteem needs

Belongingness and love needs

Safety needs

Physiological needs
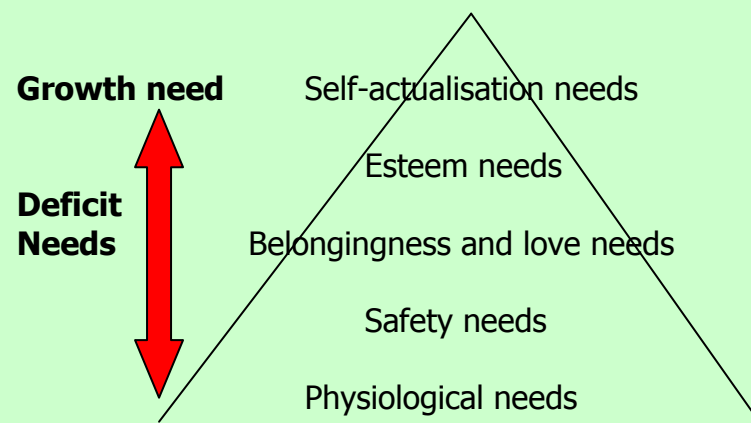
Maslow (1954)

What we begin to see is that the medical model based upon illness and deficit significantly influences current assessment

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practice with all older people. Equally, given the limited nature of the needs that such assessments routinely address, we can argue that such practice is also reductionist in approach. If we add to this a tendency for formulaic service responses – day care, meals on wheels, home care etc, we begin to see a practice area that has little regard for the individuality of its service users.

This becomes significant for older LGBT people who are having or have had their needs assessed under the provisions of the 1990 Act. Assessment practice that views the person in the here and now inevitably has little regard to their past and how this has influenced who they are now which is in turn reflected in their individuality. This is made much more problematic by the denial of the sexuality of older people in general and older lesbians and gay men in particular. Such an attitude is given credence by Government advice (DoH (1991) that singularly fails to acknowledge sexuality as an aspect of older people's lives with the result that assessments can not possibly be comprehensive and 'in the round'. This commentary reinforces the importance of getting to know the individual and of course highlights the importance of the biographical approach to assessment. Supporting this is of course Standard 2 of the National Service Framework for older people (DH 2001) – person centred care.

Social work practice in particular is required to be located within an anti-oppressive framework, however, the evidence presented below would suggest that such practice is at its worse homophobic, more often than not heterosexist and at best sexuality blind. Hicks', (1996) research in a different area of social work practice (fostering and adoption) employed here as a result of the absence of comparable research with older people, identifies examples of how social workers have conducted themselves in interaction with potential lesbian and gay foster carers who were being assessed. Hicks(1996) argues that social work maintains heterosexism in both its institutions and in practice where the later exercises 'lay beliefs' about lesbians and gay men. These beliefs exist in relation to the suitability of lesbians and gay men to look after children and include:

- transmission of lesbian and gay sexuality to the children,
- gay men are a sexual threat to children,
- children growing up in lesbian and gay households will have a distorted view of what it is to be a woman or a man,
- undue stigma will be directed towards the children as a result of their family arrangements.

These beliefs are translated in stereotypical views of lesbians and gay men with one respondent in Hicks' (1996) work commenting that he felt his social worker regarded all gay men as "Oscar Wilde types". The assessment of this gay man included the following comment:

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> "… Peter admitted to me that he was a homosexual…Despite being homosexual, Peter does not wear theatrical clothes…His flat and way of life is perfectly normal".
> Hicks 1996:18

Ricketts and Achtenberg (1990) comment that lesbians and gay men are:

> '…scrutinised more carefully and are held to a higher standard than are their heterosexual counterparts'. (Ricketts and Achtenberg 1990:104).

Hicks(1996) comments that many of his lesbian and gay respondents had to educate the social worker about lesbian and gay issues. Hardman (1997) identified that attitudes of social workers towards lesbians could be characterised as being 'liberal humanist' with the effect that:

> 'When translating these attitudes into practice, it became apparent from the case vignettes that respondents holding liberal humanist attitudes failed to acknowledge the lesbian context in their assessments, problem formulations and interventions. In short, they considered lesbian clients to be no different from non-lesbian clients'.
> Hardman 1997:561

The decision therefore for older LGBT people is whether to 'come out' to health and social care professionals. Langley (2001) employs the sociological concept of 'passing' to describe those lesbian and gay men who choose not to disclose their sexuality. In employing this concept she quotes from Sullivan (1995) stating that

> 'lesbian women and gay men are different from most other oppressed groups in that they can hide their difference and 'pass' as heterosexual. 'Passing' is the term to describe the behaviour of lesbian women and gay men which avoids them being identified as a homosexual.'
> Langley, 2001:922-923

She goes on to link 'passing' to the more colloquially used term of being 'closeted'. The difficulties with this association are related to the actual behaviour of the individual in 'passing' and the motivation for 'passing'.

This idea of 'passing' is in direct contradiction to the earlier work of Kelly (1977) and Friend (1980) who both report that older gay men were not as worried about their sexuality being known based on their high levels of self acceptance and concept of self. Given this, the assertion of 'passing' as identified by Langley (2000), may in fact be too generalised a statement in application to older lesbians and gay men.

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In terms of motivation for 'passing', we need to look much more closely at these interactions in order to establish why this was happening. Brown (1998) argues that

'One of the most difficult aspects of coming out is that it is a never-ending process, each new situation requires another telling. In the main, as sexual-orientation isn't visually obvious and the assumption is often made that people are all heterosexual, this is a fairly constant and exhausting process' Brown 1998:49

For older people, the situation is more complex in that ageism denies sexuality full stop. Therefore an older lesbian and gay man is likely to experience a denial of sexuality because this is what happens to all older people. Should sexuality be acknowledged, as Brown (1998) states the assumption will be one of heterosexuality. In 'passing' the motivation for the individual may actually not be to present as a heterosexual, but that the issue of sexuality has not become pertinent. The interaction may be characterised therefore as one of sexuality neutral, which is not a deliberate attempt to 'pass' as a heterosexual.

In terms of Brown's (1998) later comment related to continually having to come out as being an exhausting process, we must recognise that the individual who is having their needs assessed may require assistance and that this may be at a time when that person is unwell. To expect that person to engage in the 'exhausting' process of coming out at this time and having to manage the reaction is to expect a great deal. As a result rather than 'passing' the individual may well adopt a need to know approach with a subsequent neutral sexuality stance because it is easier.

The absence of older LGBT people in social care contexts may, as we have seen, may be due to a number of influences or processes, which include 'passing'. However, 'passing' as a concept is not and can not be the only explanation for the lack of visibility of older LGBT people. The atmosphere in which care is delivered is one aspect of the response to the needs of older LGBT people.

The National Service Framework for Older People (DoH 2001) in its introductory chapter identifies that:

'…there have been reports of poor, unresponsive, insensitive, and in the worst cases, discriminatory services' (DoH 2001:2

NSF Standard 1 goes on to state that the

'NHS will be provided, regardless of age, on the basis of clinical need alone. Social care services will not use age in their eligibility criteria or policies, to restrict access to available services'. DoH 2001:16

The emphasis within the NSF is on the examination of the structural policies and procedures and not professional

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practice. The evidence identified above indicates that there are problems with the professional practice of those who have contact with older LGBT people. Interestingly the NSF (DoH 2001) highlights particular minority groups within the population regarded as older however, older lesbians and gay men are excluded from this list which further highlights their invisibility in policy terms with the resultant probability that they are invisible in within practice.

Heaphy et al (2003) in their research identified a number of interesting issues that impact on the practice of health and social care professionals in their interaction with older lesbians and gay men. Specifically, they identify that 65% of their respondents felt that health professionals were either ambivalent or hostile to non-heterosexual clients with 84% not trusting health professionals to be knowledgeable about lesbian and gay lifestyles. Their respondents

> '… often recounted experiences of hostility, differential treatment and a generalised lack of understanding by health professionals.'
> Heaphy et al 2003:12

Furthermore, their respondents felt that health and social care providers maintained heterosexual assumptions and failed to meet their specific care needs. They also regarded residential accommodation as undesired and distrusted that their sexual identities and relationships would be respected in such contexts. In terms of relationships, Heaphy et al (2003) reinforce previous findings related to the significance and importance of friendship networks and also the partners and children of older lesbians and gay men.

Conclusion

This review of the literature is in no sense exhaustive such is the volume that has been published. However, the material contained in this review does provide an insight into the major themes that have been commented upon in respect to older LGBT people. As you have seen there are consistent themes contained within the material much of which is based upon assumptions which over time look increasingly out of step with the real lives of older LGBT people.

The essence of good practice with all older people is the focus on the individual and not making assumptions about their life. The same applies to older LGBT people. Assumptions about what it is to be LGBT and what it is to be older invariably function with stereotypes which in turn by their very nature are negative. Asking how an older person is LGBT provides much greater insight in to their life, how they conduct and see themselves than ever assumptions can do.

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Part 4

Training Plans

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Introduction

These training plans have been prepared for you in order that you can begin to use the material that is being presented in this teaching and learning pack.

Each plan has a set of learning objectives which can be employed not only to establish what you want to achieve by the individual sessions but can also be used to demonstrate how you are addressing corporate training objectives.

A number of plans are presented here for you to use however, you will need to prepare material for each of the sessions and there are suggestions about where the material can be located within the pack. You may feel that other material in the pack is more helpful to you rather than the suggested ideas – please feel free to use the pack in a manner that best suits your agency and the staff that you may be working with.

The training plans are set out below but are not in any order of importance – we feel that in working with staff who in turn may be working with older LGBT people all of these issues are important. In health and social care practice, ageism, homophobia, Heteronormativity, exclusion and inclusion are extremely important because they all focus on respecting older people and valuing them as individuals who are unique.

Some of the plans involve whole day sessions whilst others are only half days. This again does not reflect the importance that we are giving to one issue over another but is rather a reflection of the amount of material that may need to be covered to afford an understanding of the issues.

> **Training Plan 1 -   General awareness of issues related to older LGBT**

> **Training Plan 2 –   Ageism – general**

> **Training Plan 3 –   Ageism – more detailed**

> **Training Plan 4 –   Social exclusion of older people**

> **Training Plan 5 –   Social exclusion of older LGBT people**

> **Training Plan 6 –   Homophobia and heteronormativity**

> **Training Plan 7 –   Exclusion and inclusion of older LGBT people**

> **Training Plan 8 –   Assessment of older LGBT people**

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Training Plan 1 – General awareness of issues related to older LGBT people

Purpose:

This session aims to provide an opportunity for participants to:
- ➢ To raise awareness of older LGBT people,
- ➢ To explore the stereotypes of older LGBT people
- ➢ To explore a life course approach in order to better understand the position of older LGBT people
- ➢ To explore research which identifies the perceptions of older LGBT people towards health and social care professionals
- ➢ To explore what changes the participants will make in their workplace

Use:

This session can be used with all health and social care staff at all levels although there will need to be some individual tailoring to reflect the roles and needs of the group.

Materials needed:
- ➢ Flip Chart and OHP

Preparation:
- ➢ Read pages 86 – 113 of the Pack
- ➢ Summarise the material on pages 35, 36, and 37 and put onto acetates
- ➢ Copy the stereotypes of older LGBT people onto acetates (Pages 92 -94)
- ➢ Use the material to prepare acetates on:
    - o A changing world (pages 55 – An example and 89 - 91
    - o Ageism, Homophobia and Heteronormativity pages 24 61 (summarise the key points in this material
    - o Social support – pages 103 - 107
    - o Heaphy's research page 113
    - o Diversity of older LGBT people – pages 102 and 103
    - o So what does all this have to do with health and social care practice? Pages 109 - 113

Programme Outline

9.30	Welcome and introductions
9.40	Purpose of the session – to raise awareness of the existence of and issues related to older LGBT people,
	Present a summary of the material on pages 35, 36 and 37
9.55	Present the images of older LGBT people
10.10	In small groups – ask the participants what they think of the images and why they think they are so negative
10.25	Feedback
10.35	Present the explanations for these images contained in pages 92 -94
10.45	Present the material about a changing world – highlighting that these changes have occurred during the life time of older LGBT people include in this presentation the material from Roseneil on pages 60 – 61
11.00	Break
11.30	In small groups – ask the participants whether they feel that the world has changed – asking them to be specific by providing examples of changes – equally ask them what they think of Roseneil's comments
11.50	Feedback
12.10	Current influences on the position of older LGBT people – ageism, homophobia and Heteronormativity

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12.25   In small groups – ask the participants whether they feel ageism, homophobia and Heteronormativity exist in their workplace – ask them to be specific

12.50   Feedback

1.00   Lunch

2.00   The diversity of older LGBT people - present the material on pages 102 and 103 – emphasising the need to understand how the older LGBT person defines themselves both in terms of sexuality but also in terms of how they understand themselves.

2.20   Present the material related to social support of older LGBT people and then present Heaphy et al's work – related to the perceptions held by older LGBT people of health and social care professionals

2.40   In small groups ask how they feel health and social care practice In general should change and what they will do in their workplace
       (do not ask how their practice needs to change)

3.10   Feedback

3.20   Present the material – So what does all this have to do with health and social care practice?

3.35   In small groups – ask the participants to think again about how health and social care practice should change – asking them to be specific about what they are going to do in their workplace.

3.50   Feedback

4.00   End

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Training Plan 2 – Ageism - general

Purpose:

This session aims to provide an opportunity for participants to:

 ➢ To explore ageism as a system of oppression,
 ➢ To explore the affects of ageism on older people,
 ➢ To explore how ageism can be manifest in health and social care practice
 ➢ To explore how health and social care practice should change to become anti-ageist
 ➢ To explore what changes the participants will make in their workplace

Use:

This session can be used with all health and social care staff at all levels although there will need to be some individual tailoring to reflect the roles and needs of the group.

Materials needed:
 ➢ Flip Chart and OHP
 ➢ A number of magazines on sale in the high street

Preparation:
 ➢ Read pages 24 – 36 of the Pack
 ➢ Copy the definitions of ageism onto acetates (Page 25)
 ➢ Copy the stereotypes of older people onto acetates (Page 26)
 ➢ Use the material to prepare acetates on:
   o the stereotypes
   o asexuality,
   o burden and
   o poverty (Pages 27-29)

Programme Outline

9.30 Welcome and introductions

9.40 Purpose of the day **– Ageism – present the definitions**

9.55 Activity 3 (page 32)

10.15 Feedback – what words and phrases were identified?
Which list was longer and why?
Ask the group to provide an explanation for the difference.

10.25 Stereotypes – using the material on page 26 – identify the stereotypes
of later life – highlighting:
 ➢ how these images diverge from reality – all older people live alone – do they?
 ➢ how the stereotypes construct contradictory ideas of late life – asexuality and dirty old man and
 ➢ how they separate older people from ourselves – this idea is important because it provides a justification for treating older people differently than how younger people would want to be treated.

10.55 Break

11.25 Images of old age – in small groups - using the magazines – ask the groups to look for images of older people in the magazines and to critically review these images – what are they saying about older people.
 ➢ You could ask to the group to cut the images out and construct a
 montage – but you will need flip chart paper and glue

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11.55   Feedback – ask each group to explain what they have seen in the
        magazine – remembering that no images is significant in its own
        right

12.15   More on images – using the material on pages 27-29 explore the
        effect of the images of older people on how we view older people

1.00pm Lunch

2.00pm Feedback from the morning session – any issues raised

2.05   Working in small groups undertake Activity 2 (page 29)

2.45   Feedback

3.00pm Break

3.30   What has this got to do with health and social care practice
        Present the material on pages 30-34
        Emphasising Standard 1 of the NSF for older people and
        Anti-oppressive practice
        (Do not do Activity 4)

4.0   In small groups ask how they feel health and social care practice
        In general should change and what they will do in their workplace
        (do not ask how their practice needs to change)

4.15   Feedback

4.30   End – ask the participants to undertake Activity 1 that evening

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Training Plan 3 – Ageism – more detailed

Purpose:
This session aims to provide an opportunity for participants to:

> ➢ To explore ageism as a system of oppression in a more detailed manner,
> ➢ To explore in detail the affects of ageism on older people,
> ➢ To explore in detail how ageism can be manifest in health and social care practice
> ➢ To explore how health and social care practice should change to become anti-ageist
> ➢ To explore what changes the participants will make in their workplace

Use:
This session can be used with all health and social care staff at all levels although the session is aimed at more senior staff. There will need to be some individual tailoring to reflect the roles and needs of the group.

Materials needed:
> ➢ Flip Chart and OHP

Preparation:
> ➢ Read pages 24 – 36 of the Pack
> ➢ Copy the definitions of ageism onto acetates (Page 25)
> ➢ Copy the stereotypes of older people onto acetates (Page 26)
> ➢ Use the material to prepare acetates on:
>> o the stereotypes
>> o asexuality,
>> o burden and
>> o poverty (Pages 27-29)

Programme Outline

9.30   Welcome and introductions

9.40   Purpose of the session **– Ageism – present the definitions**

9.55   **S**tereotypes – using the material on page 26 – identify and present the stereotypes of later life – highlighting:
> ➢ how these images diverge from reality – all older people live alone – do they?
> ➢ how the stereotypes construct contradictory ideas of late life – asexuality and dirty old man and
> ➢ how they separate older people from ourselves – this idea is important because it provides a justification for treating older people differently than how younger people would want to be treated.

10.20   In small groups – ask the participants to identify and detail how each of the following issues is made manifest in health and social care practice
> o asexuality,
> o burden and
> o poverty

11.00   Break

11.30   Feedback from exercise

11.45   What has this got to do with health and social care practice
Present the material on pages 30-34
Emphasising Standard 1 of the NSF for older people and Anti-oppressive practice
(Do not do Activity 4)

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12.00pm Present the quote from Warnes, Warren and Nolan (Page 31)
        In small groups ask the participants to do Activity 4

12.10   Feedback

12.20   Present the material on Diversity in Later life (pages 35-37)

12.30   In small groups ask how they feel health and social care practice
        In general should change and what they will do in their workplace
        (do not ask how their practice needs to change)

12.50   Feedback

1.00   End – ask the participants to undertake Activity 1 that evening

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Training Plan 4 – Social exclusion of older people

Purpose:
This session aims to provide an opportunity for participants to:

- To explore social exclusion as a concept,
- To explore the affects of social exclusion on older people,
- To explore how social exclusion can be manifest in health and social care practice
- To explore how health and social care practice should change to become inclusive
- To explore what changes the participants will make in their workplace

Use:

This session can be used with all health and social care staff at all levels. There will need to be some individual tailoring to reflect the roles and needs of the group.

Materials needed:

- Flip Chart and OHP

Preparation:

- Read pages 16 – 23 of the Pack
- Copy the definitions of social exclusion on to acetates (Page 17)
- Copy the definitions of social exclusion of older people on to acetates (pages 18 + 19)
- Copy the material on pages 20, 21 and 22 on to acetates
- Make copies of the profiles of the members of the **Jueveillie Fine Dining Club** - pages 7 to 14 for each participant

Programme Outline

9.30   Welcome and introductions

9.40   Purpose of the session **– Social exclusion – present the definitions and the definitions of social exclusion in later life**

9.55   In small groups, ask the participants what they think of these definitions and whether they think that they apply to the area in which they work

10.15   Feedback

10.30   Present the material on numbers of older people excluded, who is at risk of multiple exclusion and does where the older person live matter (pages 20+21)

10.45   Break

11.15   Present the characteristics of excluded older people

11.30   In small groups – ask the participants to read the profiles of the members of the Juevillie Fine Dining Club identifying who they think are excluded, why and whether any of the members of the club experience multiple exclusion

12.00   Feedback

12.15   In small groups ask how they feel health and social care practice In general should change and what they will do in their workplace (do not ask how their practice needs to change)

12.40   Feedback
1.00   End

1.00   End

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Training Plan 5 – Social exclusion of older LGBT people

Purpose:

This session aims to provide an opportunity for participants to:
- ➢ To explore social exclusion as a concept,
- ➢ To explore the affects of social exclusion on older LGBT people,
- ➢ To explore how social exclusion of LGBT people can be manifest in health and social care practice
- ➢ To explore how health and social care practice should change to become inclusive of LGBT people
- ➢ To explore what changes the participants will make in their workplace

Use:

This session can be used with all health and social care staff at all levels. There will need to be some individual tailoring to reflect the roles and needs of the group.

Materials needed:
- ➢ Flip Chart and OHP

Preparation:
- ➢ Read pages 16 – 23 of the Pack
- ➢ Copy the definitions of social exclusion on to acetates (Page 17)
- ➢ Copy the definitions of social exclusion of older people on to acetates (pages 18 + 19)
- ➢ Copy the material on pages 20, 21 22 and 23 on to acetates
- ➢ Make copies of the profiles of the members of the **Jueveillie Fine Dining Club** - pages 7 to 14 for each participant
- ➢ Copy the definitions of Homophobia and Heteronormativity on to acetates pages 43 + 53
- ➢ Copy the additional profiles pages 39-42 for each participant
- ➢ Prepare acetates on prejudice from the material on pages 44-46

Programme Outline

9.30   Welcome and introductions

9.40   Purpose of the session – Social exclusion – present the definitions of social exclusion in later life

9.55   In small groups, ask the participants what they think of these definitions and whether they think that they apply to the area in which they work

10.15   Feedback

10.30   Present the material on numbers of older people excluded, who is at risk of multiple exclusion and does where the older person live matter (pages 20+21)

10.45   Break

11.15   Present the characteristics of excluded older people

11.30   In small groups – ask the participants to read the profiles of the members of the Juevillie Fine Dining Club identifying who they think are excluded, why and whether any of the members of the club experience multiple exclusion

12.00   Feedback

12.10   What does the Government say about the exclusion of older lesbians, gay men, bisexuals and transgendered people? Present the material on page 23 – EXCEPT the last bullet points

12.20   In small groups ask the participants why they think older LGBT people experience additional exclusion

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12.35   Feedback

12.50   Present the explanations for exclusion of older LGBT people
        which are at the end of page 23.

1.00   Lunch

2.00   Homophobia and Heteronormativity – present the definitions on
        pages 43 and 53

2.20   In small groups ask the participants to do the Activity on page 51

2.35   Feedback

2.50   In small groups distribute the additional profiles of Robert, Simon,
        Colin and Valerie pages 39 -42 and ask the participants to read
        them and undertake the Activity on page 47

3.15   Feedback

3.45   Prejudice – present the material on pages 44, 45 and 46

4.00   In small groups ask how they feel health and social care practice
        in general should change so as not to demonstrate homophobic
        and heternormative attitudes and what they will do in their
        workplace (do not ask how their practice needs to change)

4.20   Feedback

4.30   End

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Training Plan 6 – Homophobia and heteronormativity

Purpose:

This session aims to provide an opportunity for participants to:

- To explore homophobia and heteronormativity as a concepts,
- To explore the affects of homophobia and Heteronormativity,
- To explore how homophobia and heteronormativity can be manifest in health and social care practice
- To explore how health and social care practice should change to avoid homophobia and heteronormativity
- To explore what changes the participants will make in their workplace

Use:

This session can be used with all health and social care staff at all levels. There will need to be some individual tailoring to reflect the roles and needs of the group.

Materials needed:

- Flip Chart and OHP

Preparation:

- Read pages 42 – 61 of the Pack
- Copy the definitions of homophobia and heteronormativity on to acetates (Pages 43 and 53)
- Copy the material on prejudice on to acetates (pages 44, 45 and 46)
- Copy the material on pages 39-42 so that each participant has a copy

Programme Outline

9.30　Welcome and introductions

9.40　Purpose of the session **– to explore homophobia and Heteronormativity as systems of oppression – present the definitions**

10.0　In small groups ask the participants to do the Activity on page 51

10.15　Feedback

10.25　Prejudice – present the material

10.30　In small groups distribute the additional profiles of Robert, Simon, Colin and Valerie and ask the participants to read them and undertake the Activity on page 47

11.00　Break

11.30　In small groups ask how they feel health and social care practice in general should change so as not to demonstrate homophobic and heternormative attitudes and what they will do in their workplace (do not ask how their practice needs to change)

12.00　Feedback

12.15　End

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Training Plan 7 – Exclusion and inclusion of older LGBT people

Purpose:

This session aims to provide an opportunity for participants to:

➢ To explore social exclusion and inclusion as concepts,
➢ To explore why older LGBT people are excluded,
➢ To explore how older LGBT people can be included in health and social care practice
➢ To explore what changes the participants will make in their workplace

Use:

This session can be used with all health and social care staff at all levels. There will need to be some individual tailoring to reflect the roles and needs of the group.

Materials needed:

➢ Flip Chart and OHP

Preparation:
➢ Read pages 15- 23 and 64-82 of the Pack
➢ Copy the definitions of social exclusion on to acetates (Page 17)
➢ Copy the material on pages 20, 21 22 and 23 on to acetates
➢ Make copies of the profiles of the members of the **Jueveillie Fine Dining Club** - pages 7 to 14 for each participant
➢ Copy the material on pages 25, 43 and 53 on to acetates
➢ Copy the material on pages 27-29, 46+47, 53-55 and 37 on to acetates
➢ Copy the additional profiles pages 39-42 for each participant
➢ Copy the material on pages 69-73 on to acetates

Programme Outline

9.30   Welcome and introductions

9.40   The purpose of the day – to explore the exclusion of older LGBT people and how health and social care practice can be made more inclusive.
Present the definitions of social exclusion in later life

9.55   In small groups, ask the participants what they think of these definitions and whether they think that they apply to the area in which they work

10.15 Feedback

10.30 What does the Government say about the exclusion of older LGBT people?
Present the material on page 23 – EXCEPT the last bullet points

10.50 In small groups ask the participants why they think older LGBT people experience additional exclusion

11.10 Feedback

11.20 Break

11.40 Present the explanations for exclusion of older LGBT people which are at the end of page 23.

11.50 Homophobia, Heteronormativity and Ageism – present the definitions on pages 25, 43 and 53
Present the material on the effect of these systems of oppression on pages 27-29, 46+47 and 53-55
Present the material on Hierarchies of oppression on page 37

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12.10	In small groups – ask the participants to undertake the activity on page 37
12.30	Feedback
12.40	in small groups – ask the participants to undertake the Activity on page 47
1.00	Feedback
1.10	Lunch
2.10	What is social inclusion? – present the material on page 64 Present the material on policy, law and citizenship on pages 65-69
2.30	In small groups ask how they feel health and social care practice in general should change to become inclusive and end the social exclusion of older LGBT people and what they will do in their workplace (do not ask how their practice needs to change)
3.00	Feedback
3.20	Break
3.40	Present the material on how to include older LGBT people
3.50	in small groups – ask the participants what they are going to do to make their service attractive or at least responsive to Robert, Simon, Colin and Valerie
4.10	Feedback
4.30	End

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Training Plan 8 – Assessment of older LGBT people

Purpose:

This session aims to provide an opportunity for participants to:

- ➢ To explore social exclusion and inclusion as concepts,
- ➢ To explore why older LGBT people are excluded,
- ➢ To explore how older LGBT people can be included in health and social care practice
- ➢ To explore what changes the participants will make in their workplace

Use:

This session can be used with all health and social care staff at all levels who have responsibility for assessing older people in general.

Materials needed:

- ➢ Flip Chart and OHP

Preparation:
- ➢ Read pages 75-82 and 109-113
- ➢ Copy the material on pages 109-112 on to acetates
- ➢ Summarise the material on pages 77-82 on to acetates
- ➢ Copy the material on pages 112 and 113

Programme Outline

9.30   Welcome and introductions

9.40   Purpose of the session – to explore issues related to the assessment of older LGBT people
Present the material related to assessment on pages 59- 62
(but not the material on the NSF)

10.00   In small groups – ask the participants what they think are the implications of the material presented on assessment

10.20   Feedback

10.30   Biographical approach to assessment – present a summary of the material on pages 42 - 45

10.45   In small groups – ask the participants to undertake the activity on page 45

11.05   Feedback

11.15   Break

11.45   Present the material on pages 61 – 62 – the NSF and Heaphy's work

12.00   In small groups ask how they feel health and social care assessment practice in general should change to reflect the needs of older LGBT people and what they will do in their workplace (do not ask how their practice needs to change)

12.20   Feedback

12.30   End

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Contact details:

Steve Pugh,
School of Social Work, Psychology and Public
Health,
University of Salford,
Frederick Road,
Salford,
Manchester
M28 7UT

s.e.pugh@salford.ac.uk

+44 (0)161 295 2375

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