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Abstract

This paper examines older lesbian and gay people's experiences of and expectations for the delivery of health and aged care services. In-depth narrative interviews were conducted with older gays and lesbians in the Blue Mountains, west of Sydney. Data were analysed by identifying evaluative statements within specific narratives and

grouping these statements into themes. Participants reflected on the meaning of their sexual identity and how they would like it to be acknowledged when in contact with health and aged care service providers. In addition to direct discrimination, participants reported a more indirect form of discrimination in providers' assumption of heterosexuality among clients and their failure to provide lesbian- or gay-friendly services. The findings highlight the need for health and aged care services to better understand and acknowledge older gay and lesbian people's sexual identities to enable improved access to services in the future.

Key words lesbian and gay ageing, access to services, heteronormativity

Introduction

Australian research on the ageing experiences of lesbians and gays is in the early stages of development and there are just a few studies examining their experiences accessing health and aged care (Waite 1995; Chamberlain & Robinson 2002) This lack of research is compounded by the largely heteronormative nature of Australian gerontology (Harrison 2004). That is, in the main, gerontology assumes heterosexual identities, relationships and family types and rarely acknowledges diversity apart from ethnicity, disability or geographical location. These problems are further exacerbated by the fact that research on sexuality and sexual health has failed to incorporate older people into its samples (Minichiello, Plummer & Loxton 2004).

One factor that may affect older lesbian and gay people's experiences accessing health and aged care is discrimination and, in particular, homophobia. Johnson, Jackson, Arnette and Koffman (2005) surveyed perceptions of discrimination in retirement facilities from a sample comprising 60 lesbians, 56 gay men, nine bisexuals and two transgender people. Of these 127 adults, 60% believed they would not have equal access to health and social services in older age, 73% believed discrimination occurs in retirement facilities, and 34% said they would hide their sexuality in such a facility. Past experiences of discrimination, a fear of future discrimination and the failure to provide gay- and lesbian-friendly services are also identified as barriers to health care access in non-age specific research (McNair, Anderson & Mitchell 2001). Additionally there are indications that health providers find it difficult discussing sexual health issues with lesbian and gay patients and may make treatment decisions based on personal prejudices (Hinchliff, Gott & Galena 2005; Saulnier 2002).

A further issue that may affect the engagement of older lesbian and gay people with the health and aged care sectors is a possible lack of understanding among service providers of the complexity of sexual identity expression and variations in community affiliation. For example, Rosenfeld (1999) points to differences between two 'identity cohorts' among older lesbian and gay generations. Those who came out as lesbian or gay before gay liberation – in the late 1960s, early 1970s – tend to pass as heterosexual and express their homosexuality in private, whereas those who came out after gay liberation generally support public recognition of lesbian and gay sexualities and lifestyles. In one of the

largest studies of older gay, lesbian and bisexual people, D'Augelli and Grossman (2001) identified that while 92% of the 416 people in the sample identified as either lesbian or gay, 32% had children, many had previously been married, and many remained closeted. Both local and non-heterosexual communities are identified in UK research as being important in determining older gay and lesbian people's experiences of support (Heaphy, Yip & Thompson 2004). However, the authors also identify challenges, such as dealing with ageism in non-heterosexual communities, and concealing one's sexuality in local communities.

The study reported on in this paper was framed as an initial Australian exploration of older lesbian and gay people's experiences accessing health and aged care services, including the impact of past experiences of discrimination and homophobia. A focus of the research was on the expression of older lesbian and gay people's sexual identities and how they might or might not want these identities to be acknowledged when in contact with health and aged care services, including social workers. The study was conducted in a particular geographical location. As noted, Heaphy *et al.* (2004) highlight the importance of local community experiences, including geography, in determining experiences of support among older lesbians and gays.

Method

The present study was exploratory and comprised in-depth interviews with older self-identifying gay and lesbian people. The aim was to facilitate narratives relating to sexual

identity and its expression when in contact with health and aged care providers. The point of narrative research is not so much to get at an absolute truth, but to understand what is important for a particular person: their own personal 'truth' (Heaphy, Weeks & Donovan 1998; Riessman 1993). Narratives are particularly suited to understanding identities (Biggs 2004; Sarup 1996): in telling stories about ourselves we present ourselves to others in a way that we would like to be recognised and appreciated. Typically people convey narratives about specific past events, habitual behaviours and hypothetical situations (Riessman 1993).

The research was carried out in the Blue Mountains, on the western fringe of Sydney. The City of the Blue Mountains comprises 28 towns and villages. In the 2001 Census, 12.2% of the Blue Mountains population was reported to be aged 65 and over, slightly higher than the rate for Sydney (11.8%), but lower than the 13.2% rate for all New South Wales. The area was selected as a site for the research because it has identifiable lesbian and gay communities and is claimed by members of these communities to be a site for lesbian and gay retirement migration.

The sample was mainly recruited by distributing flyers about the research to health and aged care service providers, gay and lesbian community groups, and businesses in the Blue Mountains area. Part of the sample was also recruited through media releases published in local newspapers or community newsletters. The flyers and the media releases identified the topic of the research as 'sexual identity in health and aged care'. Fourteen people were recruited to participate in the study: nine men and five women aged

58 to 72, with an average age of 66. Two people in the sample had migrated to Australia from Northern European countries and one person identified as being part Aboriginal. Five participants (all men) had moved to the Blue Mountains in later life to retire.

Interviews ranged in length from one to two hours and in all cases were carried out in the participant's own home. Participants were given the choice of a male or female interviewer. If they were in a relationship they were also given the choice of an interview with their partner: three gay male couples chose to do this. Thus, 11 interviews were conducted in total. Feedback on the results of the research was provided to participants. However, member checking or respondent validation was not carried out as narrative analysis typically focuses on narratives that are performed at a single point in time. Post-interview clarification of the intended message of the narratives may have compromised this analysis.

As appropriate with narrative research (Hollway & Jefferson 1997), the interview format was unstructured. It focused on:

- sexual identity, including experiences identifying as gay, lesbian or bisexual across the lifespan;
- past experiences with health and aged care services, particularly where there were difficulties or dilemmas in disclosing sexual identity; and
- hopes and expectations for how health and aged care services will be provided in the future.

Data analysis was in line with the principles of narrative research, which seeks to elicit and interpret stories about people's lives. While narrative analysis frequently seeks to locate narratives within wider narrative contexts – such as the story of a particular interview encounter, the story of a community or the life story of an individual – the focus of the present paper is on specific narratives conveyed during the interview. The linguistic structure of specific narratives can assist in determining the message that the narrator wishes to convey to the audience. Following Labov's (1972) structure, narratives can be seen to comprise:

- abstract: summary of the narrative;
- orientation: setting the scene in terms of time, place, situation, characters;
- complicating action: what happened and then what happened;
- evaluation: meaning of the narrative according to the narrator;
- resolution: what happened in the end;
- coda: returning to the present.

Thus, narratives usually comprise – among these other, often overlapping, features – an evaluative statement in which the significance of the story and its desired interpretation are explained (Labov 1972). For the purposes of the present paper, the evaluative statements identified from specific narratives were grouped in overarching themes and sub-themes. The value of basing a thematic analysis on evaluative statements is that the themes identified reflect a particular message that the narrator (the interviewee) wishes to

convey to the audience (the interviewer as well as arguably a wider community that might hear the results of the research). Thus the themes are based on something more substantial than a passing comment or a specific answer to a direct question. These are key messages that the interviewees wanted to be heard.

Findings

Sexual identities

In conveying narratives relating to their sexual identity, all but one person was happy to use the words 'lesbian' or 'gay' to describe themselves. While many linked their personal sexual identity to a wider lesbian or gay community identity, most acknowledged that they sometimes felt on the margins of these communities. In particular, the men in the study expressed concerns in their evaluative statements about ageism within the commercial gay scene. William said: 'What's the point of going up Oxford Street? ... They're all scene people. I'm not a scene person. What would I do? Nah, come on. I'm too old. I'm too old. Too ugly.'

Some participants conveyed in their narratives that they understand their sexual identity mainly in terms of their sexual behaviour. Others experienced their sexual identity primarily through their relationship with a same-sex partner and emphasised the relationship as the vehicle for disclosing their identity to others. Rosemary said that 'Rather than saying, "I'm a lesbian" I say, "My partner is a woman".'

In their sexual identity narratives, each participant referred unprompted to the concepts of the 'closet' and 'coming out' to indicate how open they were about their sexuality in different contexts and at different times of their life. Two men identified themselves as almost completely closeted. Other identities were also referred to: William attached as much if not more importance to his coming out as a 'rice queen' – a Caucasian man attracted to Asian men – as he did to his acceptance of being gay. Others identified their identity as a parent as important and, while no one identified as bisexual, a number of people related to having had a heterosexual identity during their life. Five of the 14 people in the study had been married or had had a long-term heterosexual partnership.

As mentioned, one woman – Jane – dismissed the notion of sexual identity. In her narratives, she rejected the idea that she should feel any particular affinity or sense of community with lesbians, although at times during her life she had attended lesbian bars and gatherings. In a habitual narrative, Jane said:

I always liked the company of girls you know, and I always sort of had stronger feelings towards the girls than what I did towards the boys. ... Well, I still never ever thought of it as being anything specific, even then. I still don't. You know the fact, the business of saying that you're a lesbian or something or other, it doesn't have any credence with me at all. For me, the whole thing is just a matter of sexual preference.

Broadly these findings point to the complexity of sexual identity expression among the older people involved in this study and, while based on a small sample, the findings do reflect those of previous research (Rosenfeld 1999; Heaphy *et al.* 1998).

Disclosing identities to service providers

There was also some diversity conveyed by the narratives on the disclosure of sexual identity when in contact with health and aged care services. Evan and James emphasised that they try to be open in all contexts. Others said that they frequently disclose being gay or lesbian to avoid being misrecognised as heterosexual. For Rosemary having previously been married and having children means that people often make this mistake. Two people indicated that they would never disclose being homosexual to any service provider, that it is a private matter. According to William: ‘There is not the necessity for me to go shouting to everyone, “I’m gay, I’m gay.” Or waving my wrists like that.’

For most participants, however, the need to disclose their identity when in contact with health and aged care providers is determined by its relevance to the context and purpose of the encounter. In their evaluative statements, some stressed the importance of disclosing to a general practitioner, when receiving sexual health services or when being provided personal or body care. Other participants felt that they should disclose if the services related to psychological or relationship issues, or if a same-sex partner needed to be recorded (e.g. in medical files) as the person to notify or ‘next of kin’. According to Dorothy, in a hypothetical narrative:

I am about to have my hip replaced in October. The relevance is: what sort of supports do I have? ... With say, personal carers in my own home, of course. It's part of my territory and it's part of my territory to be lesbian. If I'm in a nursing home, I mean, am I going to tell the cleaners? Am I going to tell the administrator in charge? ... It'd be on the same scale of to what extent one would discuss other personal issues.

Some participants emphasised in their narratives how stressful disclosing one's sexuality can be, especially in a predominately heterosexual environment. Many noted the importance of staff providing a context to facilitate disclosure. This included, as identified in some social work literature (Bayliss 2000; Langley 2001; Hughes 2003; Pugh 2005), using forms appropriate to people's lives, asking questions sensitively, building trust, using inclusive terminology and having gay and lesbian issues or images visible in the setting. However, there were mixed feelings about recording people's sexual identity on files and forms, as gender and ethnicity might be recorded: some felt strongly in favour of this, others opposed.

Discrimination in accessing services

There were reports of specific homophobic and/or sexist incidents, which in some evaluative statements were identified as impacting on their willingness to access services in the future. Margaret underwent a gynaecological examination in a large Sydney

hospital while in her 50s. The investigation was carried out by a male professor – who knew she was a lesbian – in front of what she described as a ‘proverbial swarm’ of male medical students.

He just took me aside, like I was property. And so I said, ‘Look, I do not wish these students to be here.’ ‘You can’t do anything about it, you’re a part of the research and they’re learning.’ So, and he said some outrageous things about my vagina, about my clitoris, about my, you know, just unbelievable. And so insensitive, you know. ... And, and they felt uncomfortable because I’d said I didn’t want them there. They felt more uncomfortable than he did. He was just rolling through it, you know. [I] never went back.

Three participants had been sent to doctors when they were young to try to cure them of their homosexuality. In one of Margaret’s narratives she conveyed that an ingrained sense of homosexuality as a medical disorder led her to hide her sexuality throughout her nursing career. William was concerned about his safety traveling to Sydney on a Saturday night to attend a gay social group. He expressed a fear that if he is unable to travel to Sydney he may become isolated as he is not known to be gay in his local area. And when Sid had cancer and was in hospital the surgeon refused to acknowledge his partner’s right to information about his condition and would only speak to Sid’s parents.

For other participants their narratives reflected concerns not so much of direct discrimination or homophobia, but more of an indirect discrimination in the form of

heteronormativity; that is, the assumption of heterosexuality and failure to provide lesbian- or gay-friendly services. There were reports of insensitivity in documentation, a lack of understanding of same-sex partners as persons to notify or 'next of kin' and a trivializing of lesbian and gay relationships. Two male couples were concerned about how health and aged care workers who migrate to Australia from more restrictive societies may approach gay or lesbian relationships. Dave and Stephen recounted a situation where a hospital social worker, who had emigrated from India, assumed that Stephen – who was having a hip replacement – was married and a grandfather. He found explaining his circumstances to be uncomfortable and stressful.

Local experiences

Some important issues were raised in participants' narratives of their experiences accessing local health and aged care services. As noted, some in the study had moved from Sydney to the Blue Mountains to retire. Most of these people retained contact with services in Sydney, including sexual health services, general practitioners, dentists, and gay and lesbian community organisations. For William this acts as a protective device: it keeps his Sydney-based gay life separate from his local closeted life. For other participants it was because they wanted to maintain contact with particular health practitioners or because they doubted the quality of local services. Nonetheless some people countered that the quality of care is probably not much better in Sydney. For those who use Sydney services regularly there was a sense that they might need to use more

local services in future as they get older and as traveling down to Sydney becomes more difficult. In this blended habitual and hypothetical narrative, Reg said:

I haven't had any bad experiences with anything local. But then I choose to go somewhere else, as a lot of people do. But if the day came when I was ill, I would have no choice but to look at what is local to me and what I see is not bad. It's very minimal. It's not like it's there immediately. One day a week something happens up here and you've got to be there on the day. And I don't think that's going to change. ... While I'm well, things are wonderful, but for people that I know that are in their 80s and 70s and late 60s they're becoming very concerned about how they're going to manage their future.

Reg particularly stressed the poor public transport system in the Blue Mountains and concerns about what people will do when they can no longer drive.

All of those involved in the study were aware of, if not actually involved in, the local gay and lesbian communities. These communities appear quite distinct, although do overlap particularly in relation to the long-standing artistic community in the Blue Mountains. For those who chose not to be involved in the gay or lesbian communities their evaluative statements pointed to various explanations. Some did not want to identify as gay or lesbian locally, some were not interested, some felt they had previously given enough to the gay or lesbian communities and now wanted to lead a quieter life. Others felt that they didn't want to become involved in the politics of the local groups. From some

participants – such as Dorothy – there was a sense that less organised lesbian or gay friendship networks was what they would prefer to be involved in as they get older, rather than being involved in more formal community organisations.

Hopes and expectations for service delivery

Many in the study said that in the future they would like to receive services from openly gay or lesbian staff or from gay and/or lesbian community organizations. Some narratives pointed to the benefits of having previously sought out lesbian or gay general practitioners. Other narratives expressed the sense that receiving personal care from openly gay or lesbian workers would make people feel more comfortable.

Most participants raised of their own volition the idea of a lesbian and/or gay residential or retirement facility. In hypothetical narratives, some supported this idea, while others expressed reservations. Dave and Stephen expressed concerns about a gay-specific facility becoming a ‘gay ghetto’, although they would also hate being the only gay couple in a facility dominated by heterosexuals: ‘Even worse than hostility [would be] where you were ... treated like the resident clown[s].’ They also expressed a fear that lesbian- or gay-specific services run by the private sector could try to charge more than mainstream services and might exploit lesbian and gay people.

Finally, while many in this study said that services should become more lesbian- and gay-friendly, some narratives conveyed the view that they did not expect preferential

treatment. Some emphasised the importance of being treated equally, but, at the same time, also being treated with sensitivity and respect for their difference. For Shirley, all health and aged care consumers – particularly in residential care – have fundamentally the same needs and rights:

As long as you can be yourself and access the same sorts of rights and privileges as the heterosexual inmates. You know, by and large, you're all still wanting to be fed, taken care of, provided with medical care, kept safe. All the things are the same, aren't they? You want good care. You want people who care about your welfare, kindness and respect.

Discussion

Implications for service delivery

From the present study it was apparent that past experiences in accessing health care services, in particular, affected expectations for future receipt of health and aged care, including anxieties about accessing mainstream services. Attitudes towards identity disclosure in later life were influenced by earlier experiences and perceptions about the risks of disclosure and possible consequences. While the small sample size limits the extent to which implications can be drawn from this study, these findings point to the relevance of a lifespan perspective in understanding older gay and lesbian people's experiences of ageing and accessing health and aged care services. Service delivery may

benefit from assessments that locate older lesbian and gay people's current experiences within the context of their unique life experiences, as well as within the context of their generational and – as suggested by Rosenfeld (1999) – identity cohorts.

In the present study and in previous research (Chamberlain & Robinson 2002) there have been calls for gay- and lesbian-specific aged care services. Gay and lesbian community organisations in Australia, which have worked effectively with social care organisations in delivering services to people living with HIV/AIDS, need to continue to examine the possibility of developing services targeting older people. A notable success has been the longstanding Mature Age Gays (MAG) group, which is auspiced by the AIDS Council of NSW (ACON). In Victoria, the ALSO Foundation have raised the possibility of developing a demonstration project aimed at providing sensitive home care to gay, lesbian, bisexual and transgender seniors, as well as examining a range of alternative housing options (Birch 2004). Similarly in Western Australia, a newly incorporated organisation, the Gay, Lesbian, Bisexual, Trans and Intersex Retirement Association (GRAI), is examining the development of a range of retirement and accommodation options for older people (GRAI 2005).

Specifically in terms of developing lesbian- and/or gay-specific residential or retirement facilities there were mixed feelings about this strategy in the present study. Although such facilities have been developed in the United States, as yet it is unclear if there is a market for such a facility in Australia and if this is a desired option of lesbian and gay people. Nonetheless in the narratives relating to an 'old dykes' home' or 'old gays'

home' both in the present study, in other research (Waite 1995; Chamberlain & Robinson 2002) and in the media (Laurie 2005) there appears some reflection of an imagined community (Anderson 1983). The 'old dykes' home', for example, emerges as a haven: a safe place in which one's private identities can be made public, and be recognised and honoured.

In this research there was a sense from some participants that their experience of discrimination does not solely arise from homophobia or heteronormativity. Factors such as ageism, sexism and, as Chamberlain and Robinson (2002) suggest, access to material resources may also affect the ageing experiences of older lesbian and gay people. For some in the study, particularly gay men, the experience of ageism in the gay community – especially that revolving around commercial venues – suggests the need to promote a more positive ageing experience and to take steps against ageism within gay and lesbian communities. Strategies could involve ensuring that lesbian and gay community programs effectively target older people, developing projects to enable intergenerational support and promoting anti-ageism in bars and sex venues. Some current and recent examples of successful strategies include the Older Wiser Lesbians (OWLS) group, MAG, and an initiative that involved young people (Generation Youth) and some of the marchers from the first Mardi Gras in 1978 (the '78ers') collaborating on a lead float for the 25th anniversary of the Sydney Gay and Lesbian Mardi Gras in 2003.

For social workers and other professionals there is a need to provide opportunities for older people (for example, during assessment interviews) to disclose their sexual identity

in their own way. As illustrated in this research and in previous studies (Heaphy *et al.* 2004) some older lesbians and gays may have had mixed experiences with lesbian and gay communities and some may reject these constructs. Others may require careful and sensitive questioning to enable them to disclose their identities. For others, the critical aspect of their identity – especially as it relates to discrimination – may be their gender, age, ethnicity, disability or health status. Facilitation of narratives in practitioner-service user contacts may enable older service users to articulate the identities and relationships that are meaningful to them and that require attention in the assessment for and delivery of services (Hughes 2003).

Implications for future research

While small exploratory research projects – such as the present study – are valuable, there is also a clear need for a larger and better funded research program on lesbian and gay ageing. Given the current government emphasis (e.g. Healthy Ageing Taskforce 2000), probably the most strategic way of doing this would be to frame the research priorities in terms of healthy ageing for lesbian and gay people, although it would be important to be mindful of some of the limitations of this and associated constructs (Holstein & Minkler 2003). One area for investigation would be the impact of past experiences of discrimination, fears of future discrimination and the failure to provide lesbian- or gay-friendly services on older lesbians' and gays' preparedness to access health and aged care services. A second area for research would be the development and evaluation of targeted health promotion programs aimed at reducing the incidence of

conditions to which lesbians and gay men are more susceptible. For example, lesbians have disproportionately high levels of obesity, smoking and drug and alcohol use, which are reported to increase risk of cancer (Burgard, Cochran & Mays 2005). A third area of research would be the experiences and consequences of social isolation and their impact on healthy ageing. In the past older lesbians and gays have expressed concerns about being isolated in older age, especially given that many lack the intergenerational supports (i.e. children) that heterosexuals commonly rely on in their older age (Waite 1995).

In terms of research methodologies, much can be gained from a diversity of approaches ranging from large-scale surveys to small-scale ethnographic research. Inevitably there will be difficulties recruiting large representative samples and this will limit the extent to which the question – how many older lesbians and gays are there in Australia? – can be satisfactorily answered. It is crucial that there is further Australian research that actively involves older gays and lesbians. While the present study drew on the perspectives of those ranging from their late 50s to their early 70s – arguably the ‘third age’ (Laslett 1989) – it seems important that the views of those in their 80s and 90s – the ‘fourth age’ – are also canvassed. This is especially important for a more comprehensive understanding of how aged care service delivery is experienced. There is also the potential for older lesbians and gays to be involved in participatory action research that aims to develop ‘locally appropriate’ responses (Harrison 2004, p.186). As Harrison argues, such a process should move the concerns of older gay, lesbian, bisexual, transgender and intersex (GLBTI) people ‘from the margins to the centre of attention, both within gerontology and the GLBTI community’ (p.186).

Conclusion

In Australia, as in the UK (Pugh 2005), the major obstacle service providers and researchers face in identifying the needs of the older lesbian and gay population is the invisibility of this population in health and aged care settings. As participants in this project identified, it is critical for these provider and research organisations to develop lesbian- and gay-friendly environments and projects so that older lesbian and gay people are able to disclose and express their identities – and thus become visible – where they feel it is appropriate. While based on a small sample, the findings from this qualitative study point to the complexity of older gay and lesbian people's sexual identities, obstacles to their expression when in contact with health and aged care providers, and opportunities for better take-up of services in the future.

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