

Queering Care in Later Life: The Lived Experiences and Intimacies of older lesbian, gay and bisexual adults

Andrew King, University of Surrey and Ann Cronin, formerly University of Surrey

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Introduction

Much has been written about transformations in intimacy and changes in people's personal relationships over the past few decades. Giddens' seminal book (Giddens 1992) together with the works of Beck and Beck Gernsheim (Beck 1992; Beck and Beck-Gernsheim 1995) have suggested that these changes are part of wider social processes that include the individualization of the life course and the lessening of traditional forms of social structure and constraint. Critical appraisals by others (e.g Jamieson 1999; Pahl and Spencer 2004; Weeks, et al. 2001) suggest that the association between intimacy, sexuality and relations of trust, reciprocity and care is complex but a significant feature of contemporary relationships. In this chapter, we hope to shed new light on this debate by drawing on empirical research about the experiences of giving and receiving care among older lesbian, gay and bisexual (hereafter LGB) adults¹. We do so to illustrate that the models of care, ageing and

¹ Although the experiences of older transgender adults are likely to overlap in some ways with the experiences of older LGB adults, there will also be many differences; differences that we are unable to do justice to in a chapter of this size. Therefore, whilst not dismissing the need to look at the experience of older transgender adults, our discussion here is limited to the experience of older LGB adults. For a good

sexuality currently used by policy makers and service providers are largely heteronormative, which can have profound consequences for the lived experiences of older LGB adults.

Traditionally, researchers and policy makers have assumed that all older people experienced later life in a similar way, something that can be characterised as the 'normal model of ageing' (Calasanti 1996; Cronin 2004). However, there has been a growing awareness that this is not the case and that individual and social diversity, for example gender, economic status and ethnicity, may result in older people experiencing later life in very different ways. In recent years, sexual diversity has been included in this list with the realisation that although older LGB adults will have much in common with older heterosexual adults, the way in which sexuality is organised in society means that this group may experience later life differently from their heterosexual counterparts.

We begin this chapter with a brief discussion of the literature related to transformations in intimate personal relationships, the place of sexual minorities in this debate and the significance of care in their lives. Subsequently, we consider what studies about older LGB adults tell us about later life and explain both how and why we need to 'queer' care. We then draw on a case study of two older gay men to illustrate the complexity of care practices in later life, before we draw some general

overview of ageing and transpeople see **Cook-Daniels, L.** 2006 'Trans Aging', in D. C. Kimmel, T. Rose and S. David (eds) *Lesbian, Gay, Bisexual and Transgender Aging: Research and Clinical Perspectives*, New York: Columbia University Press.

conclusions and point to issues policy makers and service providers, amongst others, may wish to consider.

Intimacy transformed/who cares?

A number of authors have asserted that personal relationships, especially intimate, loving relationships have been transformed by social processes associated with the lessening of traditional constraints and the rise of individual choice (Beck and Beck-Gernsheim 1995; Beck and Beck-Gernsheim 2002; Giddens 1992). The suggestion postulated by these authors is that individuals are increasingly charged with creating their own life course, what Giddens terms 'life experiments'. Such experiments are open to risk, in that individuals are held accountable, by themselves and indeed others, if their choices prove problematic or unsuccessful.

In discussing where the impetus for changes in intimate relationships arises from, Giddens (1992) in particular suggests that the life experiences of sexual minorities have played an important part. As he notes,

“Gay women and men have preceded most heterosexuals in developing relationships, in the sense that the term has come to assume today when applied to personal life. For they have had to ‘get along’ without traditionally established frameworks of marriage, in conditions of relative equality between partners” (Giddens, 1992: 15)

Hence, Giddens argues that because lesbian, gay and bisexual people have had to live their lives outside of the heteronormative institutions of society, against a background of social stigma and discrimination, they have forged new forms of intimate relationships that heterosexuals have subsequently copied. Unsurprisingly, this argument has been both influential and subject to critique.

In their study of ninety-six non-heterosexual people, Weeks, Heaphy and Donovan (2001) demonstrate broad support for Giddens' view, pointing to the importance of 'families of choice' in LGB communities. By this, Weeks et al are referring to networks of friends and partners who form alternatives to the heterosexual nuclear family as an organising principle in LGB relationships and lives. Central to the notion of 'families of choice' is the need to find ways of living outside a heteronormative mainstream and to take account of the complexity of relationships beyond the dyadic couple. It is important to note, however, that they also discuss limits on choice such as inequalities associated with gender, socio-economic status and power dynamics within relationships. Indeed, other studies suggest that gay relationships may not be as egalitarian or negotiated as Giddens believed; amongst gay men, in particular, studies indicate that extra-relational sexual encounters may be tolerated if not exactly accepted (Bonello and Cross 2009; Worth, et al. 2002). However, as Bonello and Cross (2010) note, viewing homosexual and bisexual relationships through the prism of heterosexual norms is itself be heteronormative.

One of the factors that is said to have affected the development of 'families of choice' and forms of intimacy beyond heteronorms has been the need to care for those affected by the HIV/AIDS pandemic (Adam 2004; Cant 2004; Weeks, et al. 2001; White and Cant 2003). Adam (2004) suggests that new forms of care, particularly between gay men, have become more visible and helped to problematise a more hypersexual representation. Indeed, these and other studies (e.g Roseneil 2004; Roseneil and Budgeon 2004) suggest that caring relationships are at the centre of such changes in intimacy amongst lesbian, gay and/or bisexual communities; thus, changes in intimacy are not simply about sexual relationships between couples, but are part of

wider changes in how people care and relate to one another. Roseneil (2004) suggests that an ethics of care between friends could queer or trouble many social and political policies that have been framed around the heterosexual heterosexual couple or nuclear family. It is worth noting, however, that the UK Civil Partnership Act (2004), which legally recognised same-sex unions, did so in traditional dyadic form; a process that Richardson (2004) notes incorporates non-heterosexuals into a heteronormative citizenship that is simultaneously inclusive and exclusive.

Whilst the aforementioned studies point to important debates about the relationship between sexuality, intimacy and indeed care, there is, we believe, a need to address the intersection of age. As we explain below, an examination of these issues without considering age is remiss and overlooks the complex experiences of older LGB people.

Sexuality, Care and Later Life

In order to understand the relationship between sexuality, care and later life we need to start by understanding what is meant by later life and particularly old age. Far from being commonsense terms, their meanings are socially, culturally and historically dependent (Jamieson 2002; Posner 1995). It is for this reason that, as indicated above, traditional models of 'normal ageing' have been challenged by a growing awareness of individual and social diversity. The importance of this awareness should not be underestimated because as Featherstone and Hepworth (1991) have pointed out traditional models of old-age serve to 'mask' differential experiences. It is for this reason that both Calasanti (1996) and Latimer (1997) have suggested that greater attention needs to be paid to the practices of categorising older people and how these

categorisations impact on the delivery of health and social care to older adults as much as any objective understanding of later life. As the following discussion suggests, this may be particularly significant when it comes to considering sexual identity categories.

The growing focus on the many different realities of ageing (Dannefer 1996) has increased our understanding of gender, class, race/ethnicity and cultural diversity; nevertheless, there has been little mainstream focus on sexual diversity (Cronin 2004; Heaphy 2007; Hudspith 1999). However, it is important to put this absence in a wider context, namely the traditional social policy silence on matters relating to sexuality, for example sexual health promotion material is in general aimed at young people, the assumption being that older people are not sexually active. While practitioners and academics alike do not necessarily actively endorse such cultural myths surrounding sexuality in later life (cultural myths that both desexualise older people and subject them to ridicule when they are sexual), their silence on the subject has done little to challenge these damaging and inaccurate stereotypes.

While sexuality is important in later life, it is an issue that is too often overlooked by policy makers and service providers (Ward, et al. 2005). Although this position is slowly beginning to change, an over emphasis on the physiological aspects of sexuality all too often results in dismissal of the psychological or the sociological. Furthermore, research on service provision (for example Aizenberg, et al. 2002; Langley 2001; Ward, et al. 2005) suggests that care workers routinely engage in the control and regulation of sexuality and sexual behaviour among older adults in residential care, with interesting gender differences being apparent. Reinforcing

dominant cultural beliefs about gender and sexuality, older men's sexuality is to be controlled through strategies of prevention and regulation, while women's sexuality either remains invisible or is actively protected, presumably from the advances of deviant old men! Such research findings suggest that many practitioners and care workers, albeit unwittingly, contribute to reinforcing the dominant cultural myths surrounding sexuality in later life. As Ward et al (2005) note, despite recent reforms to care practice in the UK, which came about as a result of the Care Standards Act (2000), sexuality and ageing are rarely considered, particularly in institutionalised forms of care.

The lack of attention to sexuality is further compounded when it comes to considering the experiences of older lesbian, gay and/or bisexual adults, whose experiences have been relegated to the margins of both policy and service provision (Cronin 2004; Heaphy 2007; Price 2005). Whilst not dismissing the problems associated with measuring populations of sexual minorities, a problem which in this case is further complicated by age (for a discussion see Rosenfeld 2002 below), Age Concern (2002) estimates that 1 in 15 of its service users will be LGB, thus representing a significant minority. Meanwhile, Almack et al (2010) cite other sources (e.g Department of Trade and Industry Women and Equality Unit 2003; Price 2005) that suggest respectively that 5-7 per cent of the UK population are lesbian, gay and/or bisexual and that 545,000 to 872,000 of those over sixty-five. Yet as Ward, et al (2005: 51) stated "neither in policy nor practice does the older lesbian or gay man exist as a category or a client".

Whilst this representation is slowly beginning to change, with policy makers and service providers gradually taking into account older LGB service users, there is, we contend, a conundrum involved in this new recognition. While at one level we would argue there is a need to raise awareness amongst service providers through the introduction of identity categories such as lesbian, gay man or indeed bisexual man or woman, we would caution against their use in an unproblematic manner, which does not take account of the diversity and intersecting identifications that are contained within them (Cronin and King 2010).

As recognised by many commentators in this area, older LGB adults will in part share a common reality with older people, yet the heteronormative organisation of sexuality means that this group may experience later life differently from their heterosexual counterparts (Cronin 2004; Fredriksen-Goldsen and Muraco 2010; Heaphy 2007). We only need to consider the socio-historical context in which current cohorts of older LGB adults reached sexual maturity to realise that this is so, a point clearly elucidated in Rosenfeld's (2002) study of older LGB adults. Rosenfeld identifies two 'identity cohorts', which she suggests will frame later life experiences.

The first cohort primarily consisting of the 'old-old', are adults who became aware of their sexuality prior to the Gay Liberation Movement (GLM). Lacking an alternative meaning many LGB adults internalised the dominant cultural understanding of homosexuality as pathological and deviant, leading to the development of poor self image and low self esteem. In the 1960s homosexuality was routinely treated with aversion therapy and it was not until 1992 that WHO declassified homosexuality as a mental disorder. In the UK male homosexuality was not decriminalised until 1967

and then only for adults over the age of 21. Within this hostile climate it was expedient for lesbian and gay men to adopt lifelong survival strategies such as secrecy and 'passing' (in their dealings with officialdom including health and social care services). Despite a liberalisation of laws and changing cultural attitudes towards homosexuality research suggests (Langley, 2001; Rosenfeld, 2002) that it is likely this group of 'old-old' LGB adults will continue to be secretive about their sexuality in later life. Langley's (2001) study of older LGB adults accessing social care demonstrates the active strategies adopted by this group of adults who have an understandable reluctance to 'come out to service providers'. Yet the ability to 'come out' in a supportive and accepting environment would affect the quality of care received. As a result Langley urges social workers in the first instance to become more adept at picking up clues in order to provide an appropriate level of service to this group, while Lee (2007) has highlighted the importance of service providers signalling their recognition of sexual diversity by creating 'gay-friendly' care settings. For many this will mean moving beyond the liberal humanitarian approach of many social workers which often results in 'sexuality blindness', i.e. treating all people the same and not recognising the very real differences that come from being an older LGB adult. In a more radical stance Harrison (2006) states that institutional heteronormativity present in the care services actively contribute to the invisibility of older LGB adults. Thus it may not simply be a case of old LGB adults continuing with outdated and by implication unnecessary strategies of secrecy and passing; older adults may have a genuine fear that 'coming out' will have a detrimental effect on both the quality of care they receive and their ability to continue to engage in long term relationships and friendships.

In contrast, Rosenfeld's second 'identity cohort' consists primarily of the 'young-old': women and men who embraced a lesbian or gay identity and lifestyle either during the GLM or in the period directly following it. This group had access to a self-affirmative and celebratory discourse, thus affecting personal conceptualisations of their sexual identity. This group is more likely to be visible, belong to social networks and communities and lobby for services. Despite the usefulness of Rosenfeld's identity cohorts, they do not address the experiences of women and men who have adopted a non-heterosexual identity and/or lifestyle later in life (Cronin, 2004) and hence may form a third identity cohort, which may cut across age boundaries. Just from this brief discussion it is clear that membership of 'identity cohorts' may affect the experience of care giving and receiving in later life.

Whilst not minimising the damaging impact that traditional cultural views and beliefs may have on individuals other research (e.g. Dorfman, et al. 1995; Fullmer, et al. 1999; Rosenfeld 2002) has helped to dispel the myth of the sad lonely old homosexual man or lesbian women, who has been rejected by both family and society.. For example, research suggests that compared to their heterosexual counterparts, older LGB adults may have both greater psychological strength to face the difficulties of ageing (Berger and Kelly 1986; Friend 1991; Kimmel 1978; Quam and Whitford 1992) and secondly, higher rates of participation in non-familial social networks (Cronin, 2004; Dorfman et al., 1995). Dorfman et al (1995) show that while older lesbian and gay adults, unlike older heterosexual adults, are less likely to receive support from family members, they do receive high levels of social support from friends, leading to the term 'friendship families'. Friend (1991) argues that the achievement of an 'affirmative' lesbian or gay identity encourages the development of

psychological strength which can be drawn upon in later life. Kimmel (1978) asserts that successful negotiation of the 'coming out' process and subsequently, learning to manage the challenges posed by living in a homophobic society leaves an individual with increased 'ego strength'.

However, as Fredriksen-Goldsen and Muraco (2010) note in their extensive review of the (largely American) literature on older LGB ageing, there are significant differences in experience related to gender, ethnicity, social class, geographical location and (dis)ability status. Hence, while some older lesbian, gay and/or bisexual adults may lead happy, socially integrated lives, others are likely to be socially isolated with significant effects on their physical and mental well-being (Grossman 2006; Sandfort, et al. 2006). Furthermore, Cronin (2004) suggests that older women who did not adopt a lesbian lifestyle until later in life, often following marriage and children may find it difficult to access and participate in lesbian networks and communities. The major barrier to participation for these women was the lack of a locally based lesbian network and an inability to move to one due to either a lack of financial resources or existing family ties. This situation was particularly acute for women with children still living at home and/or who were not in paid employment. These women found it extremely difficult, if not impossible to either initiate an intimate relationship or become involved in lesbian and gay networks and thus use of the Internet was considered an important access point to lesbian networks. Such findings both point to the diversity of experience and casts further doubt over the validity of assuming that sexual identity is fixed and unchanging. It is highly likely that this issue will also affect older gay men and as such needs to be taken into consideration in practice. These factors alongside other aspects of identity, including

gender, ethnicity and physical ability must be considered when assessing the care needs of older LGB adults thus avoiding imposing a false homogeneity on this cohort of older adults. This point is paramount when it comes to a consideration of the specific issue of care giving and receiving amongst older LGB adults.

Queering Care

We have already noted the absence of an understanding of the relationship between sexuality and ageing in institutional care settings, therefore in this section we focus on the informal care practices of older LGB adults. However before doing so it is useful to define what we mean by the concept of care. As others have noted (Fine 2005; James 1992; Thomas 1993), care covers a broad spectrum of tasks, relationships, contexts and identities; it is a complex set of emotional and embodied phenomena that are subject to change over time. Drawing on this understanding of care, we note that although practices of care are mentioned within studies of older LGB adults, they have not been a key theme of UK research, an omission that has been acknowledged (Communities Scotland 2005; Hudspith 1999; Milne, et al. 2001; Roulstone, et al. 2006). For example, research examining the housing, health and social care provision alongside the general experience of ageing (Heaphy and Yip 2006; Hubbard and Rossington 1995; Stonewall Cymru and Triangle Wales 2006) has indicated that the health care needs of older LGB adults are framed in accordance with stereotypical representations and understandings of their sexuality (Hunt and Minsky 2005; Robinson 1998), yet do not go on to further explore actual care practices.

However, where research has been conducted, care giving and receiving amongst the older LGB population differs from the general population in relation to both gender

and care practices (Kurdek 2005; MetLife 2006). For example, the MetLife study, which surveyed 1000 LGB adults aged between 40 and 61 years of age, indicates higher proportions of gay men providing care to elderly parents than their heterosexual peers, while they were less likely than older lesbians to be caring for adult children. In part, this reflects the heteronormative framework within which care giving and receiving have been theorised and explored in mainstream gerontological research models, which we have suggested then go on to influence policy and practice (see Cronin, 2004 for a discussion on this issue). Nevertheless, it does indicate how care practices reflect social divisions. Studies of LGB adults caring also highlights the importance of non-familial relationships - 'families of choice' - and the suggestion that roles of care givers and care receivers may be fluid, interchangeable and context-dependent (Manthorpe and Price 2005; Northmore, et al. 2005). Therefore, simply assuming that age and sexuality are preeminent identities affecting someone's experiences of care may be problematic, warranting a different approach to research, policy and the provision of care and support.

While recognising the importance of the aforementioned studies, we are arguing for an approach to care that focuses more on nuance and complexity; on what people do and how they narrate what they do, than with trying to 'fit' them into pre-existing identity categories or roles. To do this, we draw upon several approaches from the social sciences that in one way or another recognise that people's lives are too complex to categorise simplistically. Whilst practitioners may be well aware of this to an extent, the models and theories that inform policy, service provision and practice do not always reflect this complexity. To give an example, instead of suggesting that because someone is gay, lesbian or bisexual they are excluded, or marginalised, in

care settings, we are more interested in how a person who identifies themselves as such narrates exclusion and marginalisation, if at all, and how they construct their sense of who they are, their identity, in relation to these experiences. At the same time, we want to consider how the identities that they use affect their understandings of care.

The approaches that we have drawn upon to shed light on these issues include: queer theory; theories of intersectionality; ethnomethodology and conversation analysis; and narrative analysis. We do not have the space to outline each of these approaches in detail here (for more detailed discussions of our use of these see Cronin and King 2010; Earthy and Cronin 2008; King and Cronin 2010). Nevertheless, it is important for the reader to recognise what these approaches mean for the task at hand. Overall, these approaches emphasise that who people are, their identities, and what people do, their practices, are discursively and socially constructed; that is, social forces, relationships and ideas shape the meanings given to these things and it through the language and representations that this is given form. We noted earlier that in our society people construct their sexuality in relation to heteronormativity. All of the approaches that we are using recognise the significance of this and how it shapes the social contexts in which people live their lives.

Our perspective, therefore, explores the practices that people employ in different settings, the identity work that they undertake in those settings and what these practices can tell us about sexuality and care in later life. By adopting this perspective, we will demonstrate the complex dynamics between care, intimacy and sexuality in later life. We show how sexual identities and caring are liable to transform over time,

at both an individual and social level. We can see how these identities and practices are constructed in a wider biographical and social perspective. To outline this in more detail, we will sketch out the lives of two older gay men, Alec and Peter.

Alec is sixty-eight years old, has had diabetes for most of his adult life and more recently developed a lung condition. Peter is a fifty-nine year old former nurse and carer and has also experienced health problems. Alec and Peter have been friends for over twenty-five years, have previously lived together, although both now have partners with whom they live. Such relationships between Alec and Peter and their partners could be viewed as an example of a 'family of choice' noted earlier, although when examining their narratives the issue of choice and agency appears more complex. Indeed, although they are not a couple in the traditional dyadic sense, their lives are very much intertwined.

When Alec and Peter first met, Alec's diabetes had become erratic and he was ill on a regular basis. Peter had a well-paid job in marketing at the time and as their friendship developed he supported Alec physically, emotionally and financially. For instance, he took control, making Alec visit various private doctors and specialists, obtaining him better care, until his condition was stabilised; he nursed him when he was particularly ill; he helped him cope with the psychological stress of his chronic illness; and when Alec had to retire early on health grounds, Peter continued to support him financially. It could be assumed, therefore, that Peter has for many years taken the role and identity of being Alec's carer. This might be especially so since by this point Peter had retrained as a nurse and so care had become part of his professional identity. However, when examining their stories in more detail, about changes in their lives

and their current situation, a different, more complex representation is revealed. A representation that locates the care practices noted above within their understandings and feelings about their sexuality, about ageing and about the heteronormative society in which they have lived.

When they first met, in the late 1970s, Peter was struggling to come to terms with his sexuality. Although most of their adults lives have been lived after the 1967 Act, when the age of consent for male homosexuals was set at 21 years of age, both men had grown up and been socialised in a more homophobic climate. Peter felt that his family, and in particular his father did not understand his sexuality and would not accept it. This caused him considerable psychological distress, to the extent that he was advised by his GP to seek psychiatric help. It was also at this point in his life that he met Alec at a local lesbian and gay support network. Alec helped Peter to accept his sexuality and viewed through this lens, he can be seen as caring for Peter psychologically, whilst Peter tried to support Alec with his chronic illness.

In recent years, their lives have changed considerably. Alec has suffered from further ill health and Peter, although continuing to work, has also suffered periods of illness. Again, we can see a complex set of practices relating to support, care and interdependence. Peter is learning to cope with Alec's increasing infirmity, whilst Alec faces coping with Peter's growing depressions and frustrations.

Additionally, in the past few years both men have formed new partnerships with younger men and this has caused tensions and anxieties for them both. Alec fears Peter will no longer want to take a lead role in caring for him and is uncertain whether

his new partner, Joe, is able to do so. Peter explains that he is concerned he will not be able to cope, both physically and psychologically, with Alec as he ages; in effect, he needs care himself and is not sure if Alec can provide it. He is also distrustful of Alec's new partner, unsure if he has the ability to look after him. Moreover, Peter feels that his younger partner, Euan, does not always understand his relationship with Alec. Euan has had mental health problems himself and has an ambiguous relationship with Alec. Peter has found himself balancing the need to support Euan, whilst continuing caring for Alec and negotiating this with Joe.

What can this story tell us about the relationship between intimacy, care, sexuality and later life? Firstly, Peter and Alec do not simply perform pre-existing roles. At various points in time, both are carer and both are cared for by themselves and significant others. Thus, care giving and receiving are not fixed or determined roles, they are a mixture of practices both men undertake at different points, in different contexts and to an extent with different people. Any policy models or forms of service provision that identify care giving and care receiving as identity roles are thus problematic. Certainly, Alec and Peter do not fit this type of model and service providers would need to view these men according to what they are doing not according to pre-specified expectations.

Secondly, Alec and Peter's care practices are embedded in their identities as gay men; they care for each other partly because their sexuality brought them together and because of the lives that they have carved for themselves. This is in accordance with research we noted earlier, concerning the importance of social networks and the importance of 'families of choice' to counteract heteronormativity (Dorfman, et al.

1995; Weeks, et al. 2001). However, because they identify themselves as gay men and because they are not in a sexual relationship, their care practices transgress domestic and emotional norms related to gender and care, which, as we noted earlier, are largely heteronormative and often taken-for-granted. Neither man is the other's partner; both are involved in caring for each other in different ways and have other sexual and intimate partnerships. There are no legal or conjugal obligations to care. Their experiences transgress simplistic, dyadic and dualistic notions of care and intimacy, illustrating the need to 'take friendship seriously' (Roseneil 2004: 415). Indeed, for both policy makers and service providers, Alec and Peter's story demonstrates the complexity of negotiating care relationships and the understandings that we bring to them, while for sociologists of sexuality their story acts as a reminder not to prioritise dyadic relationships over other, more networked forms.

Thirdly, it may appear that Alec and Peter have chosen to care for each other. However, we must consider to what extent this so-called choice is actually a choice at all. Alec and Peter's choices have been and continue to be shaped by the heteronormative society in which they have grown up and grown old. Their personal experience of society and of homophobia has shaped what they do and how they do it. They may well have certain psychological strengths (Friend 1991; Kimmel 1978), although their narratives suggest choices and decisions made in an *ad hoc* manner, often in the face of discrimination and adversity; a local 'fix' to a social problem. Again, this raises issues about how policy makers and service providers can best serve those who may be highly self-sufficient because of their experiences. In addition, it is important to remember that Peter, in particular, continues to have considerable economic resources and indeed both men are culturally middle-class. As we have

noted, along with others, social class forms an important intersection in lesbian, gay and/or bisexual identities (Cronin and King 2010; Heaphy 2009; Taylor 2009).

Practices of possibility

In view of the points we have made in relation to the story of Alec and Peter, policy makers, service providers and practitioners in health and social care may wish to consider several points. Firstly, taking seriously the narratives of LGB adults means reconsidering (indeed reconfiguring) the purpose of fixed identity categories, both in academic and practitioner oriented texts and in everyday life. We cannot just assume that older LGB adults will identify themselves as such in care settings or when undertaking care.

Similarly, we should not assume that their reasons for not identifying themselves as LGB are marginalisation or exclusion. As we have demonstrated, older LGB adults, to use the category for explanatory purposes, are diverse, the practices of caring that they employ are similarly diverse and contextualised. Therefore, we would suggest that we need approaches that can examine this complexity, rather than viewing older LGB adults as an additional group to be added into existing models and debates about intimacy, care, sexuality and later life. In other words, to look at the care experiences of older LGB adults not as somehow distinct, but think about what they can imply for all older adults, whatever their sexual orientation. Coping with inequalities of power, of access to healthcare, of stigma, and developing mechanisms to become empowered are issues that affect all.

Whilst we are arguing for a more thorough analysis of the lives of older LGB adults, we do not wish to marginalise or categorise this broad group further. As we stated at the beginning of this chapter, recognising the categories that people themselves hold to be significant and useful in their everyday lives is essential. This places scholars, policy makers and service providers in something of a dilemma. As we call for the 'queering' or troubling of these categories, this does not mean that we should deny them or try to gather all people who do not identify themselves as heterosexual under the umbrella of queer. Instead, we hope to have demonstrated that focusing on how people's own practices trouble taken for granted understandings is significant.

Given the above, it is important to consider the significance of the points we have made for debates about intimacy. Whilst we think that there is significance in the work of those who argue that the intimate relationships of sexual minorities point to important social shifts (Beck and Beck-Gernsheim 1995; Beck and Beck-Gernsheim 2002; Giddens 1992), we would concur with others who argue for a more nuanced and complex view (Roseneil and Budgeon 2004; Weeks, et al. 2001). We are particularly concerned that the caring experiences of older LGB adults are not valorised in such a way that infers either a hetero/homo distinction or reinforces the dyadic model of intimate relationships. We agree with others, notably Roseneil (2004) and Rumens (2011), who point to the significance of exploring the significance of friendship networks as a way of moving beyond heteronorms.

Finally, there must also be a willingness to challenge heteronormative assumptions about sexuality and especially sexuality in later life in practical contexts. Thus, there must be a cultural shift, a new willingness on the part of policy makers and service providers who work with older people, to address these issues. Appropriate services for older LGB adults need to be developed, this might be within mainstream provision, or it might include the setting up of an older LGB group. Some organisations have already achieved this, but again we would caution against viewing these as examples of ‘doing enough’ or claiming to recognise diversity. As we have suggested, older LGB adults may not wish to be identified in certain care settings or other health and social care contexts.

Conclusion

In this chapter, we hope to have argued for a more complex understanding of the care practices of older LGB adults. We began by noting that the lives of these adults have often been ignored within academic research, policy initiatives and models of care. However, we have also noted that when older LGB adults’ lives have been studied they indicate that there are similarities and differences to their heterosexual peers. We have explained that this is due, in part, to the heteronormative framework that underlies our society and shapes how older LGB adults’ identities are viewed by themselves and others, together with the care practices that they employ. Recounting the story of Alec and Peter, we have illustrated the complexity, diversity and contextual nature of sexuality and care. No two LGB adults will experience their sexuality in the same way; likewise, how this shapes how they care and whom they care for will be similarly diverse. We recognise that this places scholars and practitioners in something of a dilemma. However, we believe that recognising

diversity as something that is lived, as experienced in daily life, not just as a policy agenda or initiative, means accepting and engaging with people as complex, contradictory social beings not simply identity categories who fulfil specific roles. Furthermore, it means questioning these at all levels, in all situations.

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