Lesbians as family elder carers

Orla Parslow-Breen

Thesis submitted for the degree of Doctor of Philosophy

School of Psychology
Faculty of Health and Medical Sciences
University of Surrey
2016

Supervisor: Professor Peter Hegarty

© Orla Parslow-Breen 2016
Declaration of Originality

This thesis and the work to which it refers are the results of my own efforts. Any ideas, data, images or text resulting from the work of others (whether published or unpublished) are fully identified as such within the work and attributed to their originator in the text, bibliography or in footnotes. This thesis has not been submitted in whole or in part for any other academic degree or professional qualification. I agree that the University has the right to submit my work to the plagiarism detection service TurnitinUK for originality checks. Whether or not drafts have been so-assessed, the University reserves the right to require an electronic version of the final document (as submitted) for assessment as above.

Signed:

Date: 2nd August 2016
Abstract

Extant caregiving research indicates family caring as being a female gendered task and the family caregiver as a related, heterosexual, female. On the other hand, research examining caregiving by the LGBT population is focused on partner caregiving or parenting. Taken together, the experiences of lesbian family caregivers remain unexamined by both caregiving research and LGBT psychological research. To redress this omission four empirical studies were undertaken.

Study One was a Foucauldian genealogy, which aimed to establish how the current construction of the informal carer concept came into being. The analysis highlighted how the current carer concept influences research leading to some carers being considered more valid than others. Study Two examined the elder caregiving experiences of lesbian women (n = 10) using grounded theory methodology. Issues pertaining to lesbian identity, privacy and living as an “out” lesbian were raised. Study Three explored the anticipated future caregiving involvement with aging families of young lesbian women (n = 20) using thematic analysis. The young women anticipated future, unproblematic, connectedness with their families, as well as future lesbian created families of their own. Study Four examined how a general population (n = 324) perceived lesbian family caregiving using a vignette questionnaire with 8 conditions. Overall an effect of modern homonegativity was found.

In sum, the lesbian caregiver experience is elided due to the dominant heteronormative family discourse that dictates the focus of caregiver research. Examining the lesbian caregiver experience indicates unique issues for lesbian carers around the loss of lesbian identity, loss of lesbian social networks, and difficulties in lesbian identity performance within the home. Younger women anticipated providing family elder care, but did not envisage sexual orientation related problems. While general perceptions of lesbian caregiving are mediated by modern homonegativity that work to deny the lesbian carer agency.
Acknowledgements

My first thanks must go to my supervisor, Professor Peter Hegarty, who helped me understand that the personal is political, taught me the importance of feminism, and changed my world view forever by introducing me to Foucault. I am forever indebted to you for all the advice, support, insight, encouragement, and crisis management you have provided along this journey. I cannot thank you enough for your patience to see me through until the end of what has been a long road! You have been, and remain, an exemplary mentor and role model. I have learned far more than I ever expected I would from this journey all thanks to you. If I can hope to be half the social psychologist you are I know I will be doing ok! Go raibh maith agat, Mo chara.

I also have to thank everyone at the School of Psychology, University of Surrey past and present, who have helped me along this PhD journey. From the early days, big thanks must go to my very first office mates, Dr Corrine Huntington and Dr Mazlina Muhammed, both of whom welcomed me into the PhD community and were invaluable sources of knowledge and advice for a rookie post-grad. Thanks also have to go to staff who have moved on to pastures new, namely Prof Adrian Coyle and Prof Martin Milton, whose support whilst a Masters student and subsequently on this PhD have been motivational. I also have to thank my current office mate, Dr Cristina Ruscitto, for the laughter, chat, advice and moans we have shared over the years. Our era is coming to an end and our office will have two new roomies next year! Thanks also to all Peter Hegarty’s PhD students, past and present: Dr Dan Shepperd, Dr Gavi Ansara, Dr Freyja Quick, Dr Katherine Hubbard, Dr Sebi Bartos, Rai Thorne, Mona Al-Sheddi, Tove Lundberg, and Marta Prandelli. Not forgetting Peter’s honorary student, Tasha Bharj. You have all made this PhD journey a doable one, and the various incarnations of Peter’s lab group/reading group over the years a fun and lively place of learning, whether in the “boss’s” office or in the pub.

A special mention in “despatches” has to go to Dr David Frost, who came on board in the last few months. Your understanding and liking of my work, the friendly support, and your fresh pair of eyes on the project have been a great help, thank you. I also want to thank Nigel Woodger, Andrew Barnes and Mark Cole. You have all been a fount of endless knowledge, help and support through out my PhD, which has been invaluable. Thanks also to Julia King and Renata Richardson for their back-room administrative advice and support over the years, without which no-one would ever get though!
Special thanks have to go to Dan Shepperd, Katherine Hubbard, Sebi Bartos, Dr Bridget Jones and Alice Herron. Each of you at different times along the way, have supported me with coffee, tea, lunch, dinner, encouragement and chat throughout the ups and downs of this journey. Whether you knew or not, your support over the years has powered me through to the end. I owe you all dinner big time.

The final thanks must go to my nearest and dearest. My Dad, despite not really understanding what exactly I am doing at University still, your love and support has been appreciated, especially your concern about me having enough money. Even if I didn’t, I wouldn’t tell! And my wife, Marian Parslow-Breen, whose unwavering belief in me “back in the day” set me on this path. Your support, patience and faith in me over the years have been astounding. I am so very lucky to have you in my life. I hope now to be able to give to you as much as you have given me.
List of Acronyms

ADL Activities of daily living
APA American Psychological Association
CIT Caregiver identity theory
DHSS Department of Health and Social Security
GHS General Household Survey
IADL Instrumental activities of daily living
ICA Invalid Care Allowance
IPT Identity process theory
LAT Living apart together
LGBT Lesbian, Gay, Bisexual, Trans
NCSWD National Council for Single Women and her Dependents
NHS National Health Service
NSPA National Spinsters’ Pension Association
SCT Self categorisation theory
SIT Social identity theory
SSD Social Security Directive
UK United Kingdom
US United States
Publications arising from this Thesis

**Peer Reviewed Journal Articles:**


**Conference Presentations:**

Parslow-Breen, O. (2016, February). From homosexual subject to queer participant: The changing position of the LGBT person in psychology. Presented at LGBT History Festival Conference – how to do LGBT History: Approaches, Methods and Subjects Conference 2016, Manchester Metropolitan University, 27th-28th February

Parslow-Breen, O. & Hegarty, P. (2015, July). Family carer or lesbian – do I have to choose? Paper presented at BPS Psychology of Women Section Annual Conference, Cumberland Lodge, Windsor, 8th – 10th July

Parslow-Breen, O. & Hegarty, P. (2015, July). Family carer of lesbian – is it a choice or can I be both? Paper presented at Intersections of Aging, Gender and Sexuality Conference, University of Surrey, Guildford, 6th – 7th July


¹ This paper is derived from the qualitative analysis presented in Chapter 4.
heterosexual world” Paper presented at BPS Social Psychology Annual Conference, Winchester University, 7th-8th September

# Table of Contents

Declaration of Originality .............................................................................................. ii  
Abstract .............................................................................................................................. iii  
Acknowledgements .............................................................................................................. iv  
List of Acronyms ................................................................................................................. vi  
Publications arising from this Thesis ................................................................................. vii  

Chapter 1: Introduction ..................................................................................................... 1
  1.1 Background and aims to the Thesis ............................................................................. 1  
  1.2 The LGBT alphabet soup, the “homo” prefix, and the use of language ..................... 2  
  1.3 Methodological approach and epistemology ............................................................... 4  
  1.4 Overview of the Thesis ............................................................................................... 7  

Chapter 2: Literature Review ............................................................................................. 11
  2.1 Introduction .................................................................................................................. 11  
  2.2 Contemporary relevance: Why is caregiving important? .......................................... 11  
    2.2.1 Models of elder care in the UK and Europe ......................................................... 13  
  2.3 The concept of care ...................................................................................................... 16  
    2.3.1 The Meaning of Care ........................................................................................... 16  
    2.3.2 Types of caregiving .............................................................................................. 18  
    2.3.3 Practical care research .......................................................................................... 19  
    2.3.4 Definitions of caring ............................................................................................. 21  
    2.3.5 Who is cared for by whom? .................................................................................. 22  
    2.3.6 Thesis focus ........................................................................................................... 23  
  2.4 Who in the family is the elder caregiver? .................................................................... 24  
    2.4.1 Various carers but mainly daughters .................................................................... 25  
    2.4.2 The model carer .................................................................................................... 25  
    2.4.3 Assumptions around the women who care ........................................................... 26  
  2.5 Caring and lifespan development .............................................................................. 27  
    2.5.1 Traditional Stage Theories ................................................................................... 27  
    2.5.2 Social Clocks and the Life Course ...................................................................... 29  
    2.5.3 The non-normative life course .............................................................................. 30  
  2.6 Why is caring gendered? ............................................................................................ 31  
    2.6.1 Why do women care? .......................................................................................... 31
2.6.2 A gendered division of tasks ................................................................. 33

2.7 The effects of caregiving ........................................................................ 33
  2.7.1 Caregiver burden, stress and strain .................................................. 33
  2.7.2 Physical ............................................................................................... 35
  2.7.3 Psychological ...................................................................................... 36
  2.7.4 Social .................................................................................................. 36
  2.7.5 Economic ............................................................................................ 37
  2.7.6 Positive aspects .................................................................................. 38
  2.7.7 Conclusion .......................................................................................... 38

2.8 Why is it different for LGBT people? .................................................... 39
  2.8.1 Lesbian relationship status ............................................................... 39
  2.8.2 Lesbian economics .......................................................................... 39
  2.8.3 Conclusion .......................................................................................... 40

2.9 Overview of LGBT research corpus ....................................................... 40

2.10 LGBT Person as research object .......................................................... 41
  2.10.1 Historical position .......................................................................... 41
  2.10.2 Pathologising & Curing ................................................................. 42
  2.10.3 Paradigm Shift ................................................................................. 44
  2.10.4 Development of homosexual identity ............................................. 45
  2.10.5 Coming-out ...................................................................................... 46
  2.10.6 Minority Stress ............................................................................... 48
  2.10.7 Same-sex relationships ................................................................. 50
  2.10.8 Consequences of this research position ......................................... 51

2.11 Heterosexual perceptions ...................................................................... 51
  2.11.1 Stereotypes ...................................................................................... 52
  2.11.2 Attitudes & Prejudice ...................................................................... 53

2.12 LGBT involvement with family of origin ............................................. 58
  2.13.2 What do we know about family of origin involvement? .................. 59

2.13 Lesbian and gay caregiving ................................................................. 59
  2.13.1 Parental ............................................................................................ 60
  2.13.2 Partner ............................................................................................. 61
  2.13.3 HIV/AIDS caregiving ..................................................................... 62
  2.13.4 Family of origin .............................................................................. 64
2.14 Mind the gap – what are the issues? ........................................................................ 66

Chapter 3: A genealogy of the informal elder carer concept: Who is the carer and why aren’t they queer? ................................................................................................. 68

3.1 Introduction .................................................................................................................. 68
  3.1.1 Women and their caring ...................................................................................... 68
  3.1.2 The present study .............................................................................................. 74

3.2 Method ......................................................................................................................... 76

3.3 Analysis ......................................................................................................................... 78
  3.3.1 Political and social change ................................................................................ 78
  3.3.2 The Move to “community care” ....................................................................... 86
  3.3.3 Family care provision and the Carers Movement ......................................... 91
  3.3.4 The Feminist Critique ....................................................................................... 98

3.4 Discussion .................................................................................................................... 102
  3.4.1 Findings ........................................................................................................... 103
  3.4.2 Conclusion ....................................................................................................... 104

Chapter 4: Who Cares? UK Lesbian caregivers in a heterosexual world .......... 107

4.1 Outline of study presentation ..................................................................................... 107

4.2 Introduction .................................................................................................................. 107
  4.2.1 Duty and obligation ......................................................................................... 108
  4.2.2 Caring and boundaries ................................................................................... 111
  4.2.4 Lesbian community links ............................................................................... 122
  4.2.5 The present study ........................................................................................... 124

4.3 Method ........................................................................................................................ 124
  Table 4.1: Participant Relationship and Caregiving Status ..................................... 126

4.4 Analysis ........................................................................................................................ 128
  4.4.1 Duty and Obligation ....................................................................................... 128
  4.4.2 Boundary Setting ........................................................................................... 130
  4.4.3 Loss of Lesbian Identity ................................................................................. 131
  4.4.4 Connections with lesbian communities ....................................................... 133

4.5 Discussion: Part 1 ....................................................................................................... 135

Chapter 5: Behind closed doors: Relationships, outness, and privacy of UK lesbian caregivers ......................................................................................................................... 137

5.1 Outline of Chapter ....................................................................................................... 137

5.2 Introduction .................................................................................................................. 137
Chapter 1: Introduction

1.1 Background and aims to the Thesis

This PhD thesis was conceived of against a backdrop of psychological research in which the experience of lesbians was at best under represented and at worst left unexamined. When examining the limited LGBT psychology research base, where the lesbian experience should be documented, consistent with mainstream psychological research (Hegarty, Parslow, Ansara & Quick, 2013), a mainly androcentric focus was to be found (Kitzinger, 1987; Lee & Crawford, 2007; 2012). This androcentric bias suggests that gay men are the category norm for homosexual people (Hegarty & Pratto, 2004). The LGBT psychology examined, focused mainly on issues such as coming out (Savin-Williams, 1998; 2005), LGBT identity development (Cass, 1979) and parenting (Patterson, 2006); concerns mainly (although not entirely) of younger rather than middle-aged adults. Further, when the family lives of lesbians and gay men had been documented the focus was purely upon lesbian and gay people as couples and parents (Patterson, 2000; Peplau & Beals, 2004). When their family of origin was discussed this was always in relation to coming out. The overall effect of this position is that it situates the lesbian or gay individual as being beyond the normative family with L/G families seen as unique and separate. And, when looking at mainstream lifespan development work, this work was not only heteronormative, as Barker (2007) identified in relation to bisexuality, but also ageist and biologist in relation to women (Gergen, 1990); these positions separate the sexual minority person from their family of origin. Taken all together these positions elide the family of origin experiences and interactions that many sexual minority people engage in. In sum, issues pertaining to out mid-life lesbians was conspicuous by absence, as a result this thesis focuses on issues that can face middle-aged lesbians and their families of origin.

Given APA recognition of the need to redress the heterosexist bias in psychological research (Herek, Kimmel, Amaro & Melton, 1991), the aim of this thesis was to add to the growing LGBT affirmative research base and help work towards redressing the balance. A further aim was to address the lack of psychological knowledge in respect of lesbians over thirty five. As much of the extant LGBT research positions the LGBT subject as being an individual rather than part of a family, whilst family oriented research focuses almost exclusively on the heterosexual family, the experiences of lesbian family of origin interactions post coming out was quickly identified as being where there was a lack of
knowledge. However, given the lack of research in the area one thesis cannot hope to address all issues, therefore the thesis focus is on how normative constructions of the family and gender roles impact lesbian women’s relationships with their families of origin, and how lesbian women negotiate their family of origin relationships and responsibilities with a specific focus around the issue of caregiving.

The focus on family of origin care in the lives of lesbian women is particularly salient in light of recent legislation within the United Kingdom (UK) in respect of family formation over the last twelve years. First, the Civil Partnership Act (2004) allowed same-sex couples to have their relationships legally recognised in the form of Civil Partnerships with effect from December 2005. Less than 10 years later, marriage rights were also extended to same-sex couples within England and Wales when the Marriage (Same Sex Couples) Act 2013 received Royal Assent, with the first marriages taking place in March of 2014; and for Scotland in December 2014 as a result of the Marriage and Civil Partnership (Scotland) Act 2014. Given the expectations about women being assumed to be the natural family caregiver, along with the changing social construction of what constitutes a family (heralded by UK government legislation), research that examines family of origin relationship expectations and experiences of both older and younger lesbians is timely.

The balance of this chapter will outline how I use LGBT-related terms within the thesis, address the methodological approach taken, and finally offer an outline of the thesis shape.

1.2 The LGBT alphabet soup, the “homo” prefix, and the use of language

The initials LGBT are in common parlance both within and without the academy as shorthand to refer generally to lesbian, gay, bisexual, and transgender people as a group. At times other letters get added to the mix. For example, less common but occasionally added is Q, at times taken to mean either Queer or Questioning, rarer to be found is I for intersex, and A for either Asexual or Ally. The most common variant found is the more familiar LGBT often used in the media. Indeed, use as both a label and an organizing umbrella can first be found in the early 1970s. However, the use of LGBT creates a surface sense of community that belies the diversity that lies within, particularly so when used uncritically.

---

2 As UK laws involving marriage are devolved, legislation in respect of same-sex marriage for Scotland and Northern Ireland is the responsibility of devolved governments. At the present time there have been no legislative changes in respect of same-sex marriage in Northern Ireland. As a result Norther Ireland is currently the only country within the United Kingdom to not allow same-sex partners to marry.
Within the academy LGBT, or shorter variations (e.g. L/G or LGB), have often been used as a catchall “initialism” within research papers when there is a need to refer to non-heterosexual people generally. For example, Meyer (2003) examined minority stress issues for lesbians, gay men and bisexual individuals and used the term LGB; whilst Holland, Matthews, and Schott (2013) examined college student’s attitudes towards LGBT people generally, using attitude questionnaires in relation to lesbian, gay, bisexual and transgender individuals. However, at times the uncritical use of the LGBT initials can lead to confusion. For example, work by Almeida, Johnson, Corliss, Molnar and Azrael (2009) examining psychological distress in LGBT youth, do use LGBT youth as their sample; however, the breakdown of the sample is not given. Without knowing how many of the participants were lesbian, gay or bisexual, or whether any were transgender it is difficult to understand how their findings relate to the various groups of people under the LGBT umbrella. This position was similarly found with research on smoking within the LGBT community (Sivadon, Matthews & David, 2014). Is smoking generally an issue for all those represented under the LGBT umbrella, or is it more an issue for one or other sub-group within the overarching LGBT group? This position is not made clear within the paper. Whilst not to decry the value and contribution made here, offering a more detailed account of their population sample would add depth, richness, and greater understanding to their findings.

By invoking the LGBT “initialism” research may subsequently be generalized to populations to which it does not apply, a byproduct of this is the unwitting rendering invisible the experiences of those caught up within the initials whose experiences do not match the majority within the minority. As Eisner (2013) notes in relation to bisexuality, the LGBT movement is primarily concerned with gay issues. Further, the concept invoked by the use of the initials LGBT is that of homogeneity; by this I mean that a false impression of homogeneity is created which brings with it the assumption that all those represented under the umbrella of the LGBT initials are an homogenous group of equal experience. The inherent assumptions caught up here are similar to the issues created when the discursive construction of the category of woman is considered (Mohanty, 1984) in that the life experiences of power, powerlessness, oppression (both as oppressor and oppressed), homophobia and homonegativity are experienced equally by all those purported to be represented by the LGBT initialism rather than being experienced differentially and relationally.
The experiences of lesbians, gay men, bisexual women and men, and transgender people can and does vary considerably, not least due to the differing gender socialization experienced by women and men. To avoid conflation and elision of experience in this thesis the use of the letters LGBT will be used in accordance with research population target and focus appropriately. In short, I will use lesbians or gay men when referring to either the lesbian or gay male populations on their own, and when referring to both groups: lesbians and gay men or L/G. When discussing research that includes bisexual and transgender populations I will use LGB or LGBT as appropriate. And, in the interests of avoiding erasure, I will endeavour to highlight the relevant research population, for example bisexual women, or trans women where this proves possible. However, the focus of this thesis is lesbian women, and so the focus of research discussed will be, wherever possible, lesbians with the exclusion of other groups.

Equally, the term homosexual and the related terms homosexuality and homophobia are often taken to mean, and refer, only to men. This androcentric bias can be found in the in psychological research base, most notably in the research corpus on heterosexual attitudes towards gay men (Herek, 2004). Similarly, the term gay can refer to both men and women however, as with homosexual, homosexuality and homophobia, gay is often taken to mean and refer primarily to men. Notwithstanding this, many homosexual women prefer to use the term gay to refer to themselves and eschew the term lesbian. Despite the position of some women, in the interests of critical transparency and clarity I adopt the following terminology: lesbian when referring to homosexual women, gay men when referring to homosexual men, and lesbians and gay men when referring to both homosexual women and men. At times, however, the use of the terms homosexual, homosexuality and homophobia is unavoidable if there is no indication as to which group is being referred to within the evidence being examined. This is particularly the case when examining the archive. Given this position the terms homosexual, homosexuality and homophobia are used within the thesis but are restricted to when more accurate terminology cannot be used; this is generally when discussing historical and conceptual positioning only.

1.3 Methodological approach and epistemology

Contrary to the more usual approaches within psychology, the research presented in the empirical chapters of this thesis engages with a mixed method approach. Three of the four studies undertaken have used qualitative methods, whilst the final study has been
quantitative in nature. There is no single definition for the mixed methods approach, however the overall consensus is that the research design employed should allow for a better understanding of the concepts being examined (Johnson, Onwuegbuzie & Turner, 2007). It is this understanding that guided the design decisions made here and led to a pragmatic approach being taken in order to utilize the most appropriate method for the questions being examined.

The more usual approaches within social psychology fall within either the experimental or the critical approaches. Experimental social psychology is based upon the epistemology of positivism. Positivism holds to the notion that there is a clear and straightforward relationship between the world and people’s understanding of it. Further, this epistemological position holds to an ontological assumption that there is a social world that exists beyond human involvement, made up of observable and measureable social phenomena (Stainton-Rogers, 2003). Central to this paradigm is the concept of objectivity. Research undertaken from within this paradigm aims to discover objective neutral facts about this social world and does so by designing research that utilizes the scientific method. This recourse to neutrality and objectivity would suggest that experimental social psychology generates pure, distilled, universal knowledge that is positioned beyond ideology. However, the scientific method is but one approach to knowledge creation. Critical social psychology, on the other hand, is predicated on an ontology that asserts that there is no social world that exists separately from human involvement; rather that the social world is a human construction, and one which is constructed intersubjectively between people (Stainton-Rogers, 2003). More simply this position is known as social constructionism. Central to the social constructionist paradigm is subjectivity and meaning making. The constructionist position does not make claims to universality. Research undertaken from a social constructionist standpoint aims to offer insights into social events and phenomena that are socially situated and generally does so via qualitative enquiry.

The social constructionist position posits that all knowledge is constructed socially between people; a position that is often considered to be sociological. A more psychological position is that of social constructivism where knowledge is constructed by people individually. Social constructivism is predicated on the cognitive constructivism of Vygotsky (1978). From this perspective cognitive functioning is situated in, and is a product of, social interaction. Vygotsky argued that language and culture are the framework by which people experience and understand reality, as a result human cognitive structure and cognition are
socially constructed and knowledge is co-constructed via a collaborative process of response to, and interpretation of, external stimuli. Both social constructionism and constructivism are theories of knowledge that focus on the social context and posit that reality and knowledge are constructed intersubjectively. Indeed, it is in the interactivity between people that what can be considered as reality and knowledge are constructed (Burr, 2003). However, the difference lies with the locus of construction. From a constructivist standpoint people construct knowledge as they interact in their environment. The constructivist epistemology is more concerned with an individual’s meaning making within their social context (Vygotsky, 1978); whilst social constructionism is more concerned with the development of constructs relative to social context; that is the construction of social knowledge (Burr, 2003). In sum, from a constructivist standpoint the individual within their social context is the constructor of knowledge which leads to unique and personal knowledge creation; whilst from a social constructionist position the social context is where knowledge is created and so is a collective account that provides shared understandings about the world. As the research questions examined within this body of work are more concerned with shared understandings rather than personal knowledge, a social constructionist standpoint has been taken.

The mixed method approach has sometimes been considered as a third, pragmatic, paradigm that sits alongside the positivist paradigm most associated with the quantitative approach and the constructionist paradigm linked with many qualitative methods. Often the positivist and constructionist paradigms are considered as being dichotomous; however some theorists argue against this suggesting that they sit at either end of a continuum and that the mixed methods approach sits between the two (Cresswell, 2014). The exact position of any particular mixed methods body of work depends upon the unique mix of qualitative and quantitative elements contained in the research design. The pragmatic worldview, or epistemology, posits that rather than focusing on method the focus should be on addressing the research question and utilizing the most appropriate method in order to answer the question at hand and so engage in a pluralistic approach (Cresswell, 2014). Despite this pragmatic argument the mixed method research undertaken here has been from a social constructionist position; Stainton-Rogers’ (2003) argument that experimental and critical approaches are incompatible notwithstanding. Pragmatism has been offered as a potential philosophical framework for mixed methods research because all research, whether positivist or constructionist, requires the subjective engagement of the researcher’s imagination in respect of interpretation, intentions, and values (Yardley & Bishop, 2008). This position
chimes with Pratto’s (2002) argument, that the methods of science had to be invented and are therefore socially constructed. Further, the pragmatic approach concurs with Gergen (1973) in suggesting that research occurs in social, historical, political, and cultural context (Creswell, 2014). Given these assumptions I would argue that it is precisely this subjectivity, inventiveness, and contextuality that allows for a social constructionist standpoint to be taken.

Within psychology the epistemological positioning of much research often goes unstated (Cresswell, 2014). This is particularly the case when the research is undertaken from a positivist position. However, the philosophy that underpins the research influences how the research is conducted and so needs to be made explicit, particularly with respect to the qualitative methods of grounded theory (Charmaz, 2006; Glaser & Strauss, 1967/2006) and thematic analysis (Braun & Clarke, 2006), as both these methods can be undertaken from differing epistemological positions. Further, positivist research involves subjective engagement in the operationalizing of variables and the development of hypotheses, as well as in the personal and political interests that drive them; indeed drives all research (I. Parker, 1994). It follows, therefore, that research methods previously considered the preserve of positivist experimental psychology can fall under the umbrella of a critical social psychological position. It is from this social constructionist standpoint that my mixed methods research thesis has been undertaken.

In a more lighthearted account, I would argue that my approach is analogous to Barker and Langridge’s (2010) advice in respect of polyamory research. My epistemological orientation is from a critical social psychological position which allows me to have a primary relationship with social constructionism, a secondary relationship with feminism, a mutually engaging encounter with positivism (rationalized via the rules and boundaries set within the primary relationship viz: all knowledge is socially constructed\(^3\)), as well as frequent but turbulent, love/hate, encounters with queer theory.

### 1.4 Overview of the Thesis

The thesis consists of a total of eight chapters, the first being this Introduction. The next chapter is dedicated to a review of the literature (Chapter 2). This is followed by five chapters dedicated to the four empirical studies conducted (Chapters 3 to 7). The final concluding chapter provides an overall discussion of the thesis findings (Chapter 8).

---

\(^3\) Even the objective empirical decisions made within a positivist experiment.
The literature review in Chapter 2 offers an overview to the extant literature. As this thesis brings together a number of areas of research the literature review, by necessity, is wide ranging. Theory and research has been examined from gerontology, developmental psychology, LGBT psychology, social psychology, and LGBT social work. The constraints of space and breadth of topics covered only allow for a review that highlights why there is a knowledge gap. Each subsequent empirical chapter offers a more focused and detailed engagement with the literature pertinent to the area of study therein.

The first empirical study is presented in Chapter 3 where the construct of the gendered informal caregiver is examined by way of Foucauldian genealogical analysis of the archive. Genealogy examines the conditions that lead to the emergence of discourses and associated social practices. Genealogy, as a method, has been utilised by critical researchers within the health and welfare field to examine operations of power and governmentality, in particular their effects in the social welfare arena. Genealogy aims to explore the historical development of the present state of affairs by way of examining the interaction and influence of developing social processes and procedures on social practices (Fraser, 1989). Working from within a Foucauldian framework, this chapter offers a genealogical account to the construction of the informal carer and how this construction has informed psychological enquiry. An analysis of the emergence of the concept of informal carer is offered, grounded in a UK setting, which looks at when the concept first emerged, how it has been shaped, and what currently constitutes the construct. The analysis also illuminates how the current conceptualisation of the informal carer interacts with the psychosocial identity of carer such that some types of carer are sanctioned whilst others are not, a position that empowers some whilst silencing others.

The second study is presented over two Chapters, 4 and 5. Research on informal elder care has shown that family elder caring is a female gendered task; whilst normative assumptions surrounding models of family caregiving further position women carers as heterosexual. However, psychological research asserts that disclosing a lesbian sexual orientation is related to greater levels of self-esteem and is central to lesbian identity formation. Given the limited research into lesbian family of origin caregiving the aim of this study was to gain a grounded understanding of the experiences of lesbians who have elder care responsibilities; to discover how elder caring impacts lesbian lives in relation to issues of outness, in particular how outness is lived out differently in differing contexts such as in the home environment; to discover how elder caring impacts upon socialisation within the lesbian
community; and to gain an understanding of how elder caring impacts upon the personal relationships of both single and coupled lesbians. Utilising a grounded theory approach, the concerns and experiences of 10 lesbian carers (aged 48-62) who either have had, or currently have, familial elder care responsibilities were explored.

The women were interviewed and the resulting interview transcripts analysed using the method of constant comparative analysis. The analysis identified six themes; four of which are presented in Chapter 4, whilst the final two are presented in Chapter 5. The themes presented in Chapter 4 examine issues that can be thought of as being relevant to all family caregivers although they may impact upon lesbian caregivers differently; whilst those presented in Chapter 5 can be thought of as more lesbian oriented. Presented in Chapter 4 are the themes “Duty and Obligation”, “Boundary Setting”, “Loss of Lesbian Identity” and “Connections with the Lesbian Community”; whilst the themes “Different Models of Relationship” and “Outness in the Homespace” are explored in Chapter 5. All themes, taken as a whole, highlight the issues that elder caregiving brings and illuminates the ways in which family of origin elder caring is incorporated within the framework of lesbian lives despite its impact on lesbian identity, social support, engagement in non-normative relationships, and lived outness. Overall this study offers insight and new understandings of what being a family carer can be, despite the hegemonic heteronormative family discourse.

The limited lifespan psychology focus with respect to lesbian interaction with their families of origin over time is a theme that runs through-out the thesis. One aspect of the lifespan focus is the lack of understanding of what young lesbians anticipate for their future possible “out” selves. Many of the common cultural representations available to young lesbians present an out lesbian lifestyle as one lived away from their families of origin. These representations are often situated against the backdrop of an anonymous city landscape or “gay village”. Other cultural stereotypes position older lesbians as being lonely and isolated. Meanwhile psychological research focuses on coming out, lesbian parenting, prejudice, and homophobic attitudes. There is limited research examining lesbian relationships with their families of origin post coming out. Particular issues not addressed are the expectations of what young lesbians hold for their future in light of the representations available to them.

Accordingly, Chapter 6 explores how young lesbian women imagine that their future selves will relate to their families of origin. The study presented here utilizes thematic analysis on data generated via focus group sessions that discussed future lived outness and family of origin relationships with 20 lesbian identified women (aged 22-30). The analysis
identified three core themes: “Out and Proud”, “Family Support”, and “Lesbian Family Futures”. Within each theme are a number of sub-themes. The first theme, “Out and Proud”, is made up of sub-themes “Authenticity”, “Don’t be a Dyke”, and “Misidentification”. The theme “Family Support” contains two sub-themes: “Relationship Support” and “Disaster Support”. Whilst the final theme, “Lesbian Family Futures” is also formed of two sub-themes: “Marriage and Motherhood” and “Family of Origin Connectedness”. Considered as a whole, the themes provide insight into the early post-coming out years of contemporary young lesbians, make clear the issues that are of central concern to this group of women, and highlights the women’s future relationship and family expectations. Areas of common concerns with respect to identity, and difference with respect to family of origin engagement, are apparent between the older women of study two and the younger women of study three.

Given the general propensity towards constructing stereotypes of lesbians as being more similar to heterosexual men, along with the constructions of caring and the caregiver as being a female gendered and tasked; Chapter 7 examines whether these stereotypes impact on how elder care tasks might be allocated between lesbian and heterosexual siblings of the same gender. Additionally, given Kimmel’s (1992) suggestion that lesbians and gay men might be considered more able to take on caregiving due to their being unmarried and so having less personal responsibility and in light of the changes in relation to the legal status of same-sex relationships with the introduction of Civil Partnerships in 2005 and more recently same-sex marriage in 2014; this study also examines the allocation of elder care tasks to women on the basis of sexual identity and relationship status.

Finally Chapter 8 offers an overall discussion and conclusion to the thesis. The overall findings are summarized and then discussed and interpreted in light of the extant literature and original research questions. The contribution to knowledge is considered as well as the implications of the findings. The chapter ends with a discussion of the research limitations as well as a consideration of the direction for future research.
Chapter 2: Literature Review

2.1 Introduction

As outlined in Chapter 1, this thesis is situated at the intersection of familial caregiving and lesbian sexuality. Because of this positioning it is necessary to examine the literature pertinent to both core thesis areas. This chapter therefore, provides a broad overview of the extant literature in respect of both familial caregiving and Lesbian and Gay psychology.

Starting in the arena of caregiving, the state of the United Kingdom (UK) in respect of population demographics pertinent to care need and caregiving provision are examined in Section 2.2, before moving on to an examination of the concept of care from various angles in Section 2.3. Section 2.4 looks at who within the family is the caregiver, while Section 2.5 reflects upon elder care and the lifespan. The gendered nature of caregiving is examined in Section 2.6, followed by an exposition of the effects of caregiving in Section 2.7. The scrutiny of the caregiving research is concluded in Section 2.8 which highlights the unexamined position of lesbian familial caregivers.

The second part of the chapter examines the field of Lesbian and Gay psychological research, with a particular focus on lesbian oriented research where possible. Starting with an overview of the research corpus in Section 2.9, I move on to focus on two strands of LG psychology research. The first strand examined in Section 2.10 takes an historical perspective looking at research where the lesbian or gay individual is the object of study, both pre- and post- removal of homosexuality from the DSM. The second strand of research is the focus of Section 2.11, where heterosexual perceptions of lesbian and gay people are the focus in an examination of lesbian and gay stereotypes, attitudes and prejudice. Section 2.12 highlights the familial connectedness of sexual minority people, and Section 2.13 looks at caregiving by lesbian and gay people. The Chapter culminates in Section 2.14. Here I highlight the issues that have been neglected by the extant research in both fields and give focus to the issues that the empirical chapters of this thesis address.

2.2 Contemporary relevance: Why is caregiving important?

The age demographic in industrialised nations, including the UK, is an aging one. The population age of Europeans currently positions Europe as the oldest continent, and the
population continues to age (United Nations, 2009). The population percentage of Europeans over 65 in 2008 was 17%, and this figure is predicted to rise to around 30% of the population by 2060 (Eurostat, 2010). The proportion of individuals aged 80 and over is predicted to almost triple from 4% in 2004 to 11% by 2050 (Eurostat, 2005). The UK is no exception to the aging trend. On the whole the very elderly (or “oldest old”), that is those aged 85 years and above, is the fastest growing age group in the UK (Pickard, 2008; 2015; Pickard, Wittenberg, Comas-Herrera, King & Walley, 2012). Many of the oldest old continue to live at home rather than in care homes or nursing homes. The 2011 Census found that in England and Wales 91% of men and 88% of women aged 85 or over were living in one of three scenarios: alone, with a partner, or as part of an extended family with their adult children (ONSa, 2013).

This growing section of the population, which is a result of decreases in mortality and fertility rates, brings with it an increase in demand for help and support, more commonly known as care. In the UK there are around 6.3 million people providing informal care. This figure breaks down to 5.8 million (10% of the population) in England and Wales, and 0.5 million (9% of the population) in Scotland (NRS, 2013; ONSb, 2013). In England and Wales, the number of unpaid carers rose by 0.6 million between 2001 and 2011, demonstrating a faster growth in the number of carers than actual population growth within the same time frame (ONSb, 2013). In 2007 there were 1.4 million older people (that is those aged 65 and over) with disabilities who were in receipt of informal care in the UK (Pickard et al., 2012).

The discrepancy between the number of people giving care (6.3 million) and the number of older people receiving care (1.4 million) can be attributed to a number of reasons. Firstly, the 2011 figure is based on self-report questions contained in national census questionnaires that asked individuals whether they provided any unpaid care to another person as a result of their physical or mental ill-health, disability, or old age. There were no differentiating questions therefore the total number of care providers includes all those involved in care provision. Second, there are no corresponding questions that asked whether an individual was in receipt of unpaid care in the census. Therefore, accurate numbers of those in receipt of unpaid care have to be gathered via other means. The 2007 figure of 1.4 million offered by Pickard et al., (2012) is based on 2006 ONS estimates of numbers of elderly (those aged 65 and over) in receipt of any informal care, as such the exact figure for 2006/07 will be different. Given the overall trend of decreased mortality, the corresponding number of elderly people in receipt of informal care for 2011, or indeed the present day, will
be higher than 1.4 million. Finally, perceptions of what counts as care can and does differ both between caregivers and care receivers; perceptions being moderated by gender, relationship and personal experience. For example an adult child performing household cleaning tasks for an elderly parent unable to complete the tasks themselves may well consider the cleaning activities as caregiving; however the elderly parent may not consider the child’s undertaking of cleaning as caregiving, rather they may well view the completion of housework tasks as part of normal family exchange and interaction despite being unable to undertake the tasks themselves (Walker, Pratt, & Eddy, 1995). Taking these factors into consideration it is safe to assume that the actual numbers of people actively engaged in parental elder caregiving falls between the two parameters: 1.4 and 6.3 million. Based on NHS survey data, Carers UK (2012) suggest that around 40% of carers are providing informal care to either their parents or parents-in-law. Using the 40% figure as a guide would suggest that around 2.5 million people are involved in providing some form of informal elder care.

The increasing older population is of concern to the Government as greater numbers of the oldest old are more likely to be in need of some form of care provision, whether formal or informal. Of particular concern however, with the increase in demand for care, is the cost implication of formal, or professional, care. This concern has been evident in government action and political debate over recent years.

2.2.1 Models of elder care in the UK and Europe

Towards the end of the 2007-2010 Labour Government the Personal Care at Home Act (2010) was passed. The purpose of this Act was to ensure independent living for the frail elderly in their own homes for as long as possible by extending the provision of free personal care to those in greatest need. The passing of this Act, opposed by opposition Conservative and Liberal Democrat Members of Parliament, so close to the general election ensured that caring in all its guises was a “hot topic” during the run up to the 2010 general election. Electioneering claims by the then leader of the Conservative Party and subsequent Prime Minister, David Cameron, suggested that if all informal carers ceased to provide care, the cost to the country would be in the region of £50 billion. This was a conservative estimate when compared to estimates by Carers UK and the University of Leeds whose research suggests that unpaid care provision is worth around £87 billion per annum (Buckner & Yeandle, 2007). Notwithstanding the importance placed on care needs, since the coalition government (2010-2015) and the subsequent Conservative government (2015-to date) has come to power, the Personal Care at Home Act (2010), despite being on the statute book, has not been
implemented. Instead, based on the premise that existing care funding and provision was not fit for purpose, the new government established an independent commission, the *Commission on Funding for Care and Support* (more commonly known as the Dilnot Commission) to review the existing funding system of care and support in England. The Commission’s key terms of reference were to provide recommendations in respect of meeting the costs of care, envisioned as a partnership between the individual in need of care and the state, how individuals could protect themselves against the costs of care, and how public funding could be put to best use going forward. The commission was not given carte blanche, as any recommendations were required to be affordable and sustainable and consistent with planned budget deficit reductions outlined in the June 2010 Budget (Dilnot, 2011). In sum, the Commission’s remit was to report on how to achieve affordable and sustainable care funding for the future.

The Dilnot Commission delivered their report in July 2011, the findings of which have gone to inform the Care Act (2014). A recommendation of the Commission was in respect of personal liability to care costs, with an individual’s lifetime contribution cap recommended as £35,000. The principle of this contribution cap is to limit the amount an individual has to pay towards the cost of any formally provided care received either in their own home or in a care home. However, within the Care Act (2014) the contribution cap for individual care cost liability has been set at £72,000, more than double the Commission’s recommendation\(^4\).

What is clear here is that the Government’s foremost concern is in respect of the financial implications that the provision of care has to the State.

In line with concerns about cost to the state, and despite the increase in potential care needs, the actual amount of government spending on care is reducing. The reduction in government funding of care services means that available services are focused on smaller numbers of people, namely those with greatest need and least resources. The numbers of older people in England (aged 65 and over) in receipt of any form of state funded care, whether in a care home or in their own home, has reduced by 20% in the 6 year period 2006-2012, with 991,000 care service users in 2012 compared with 1.23 million in 2006 (Health and Social Care Information Centre, 2013). This reduction is even greater in relation to older people receiving community-based services, such as carer visits to people in their own homes, which has reduced by 22% (Humphries, 2013). This means that there is a gap between the amount of care that the state provides and the amount of care that is required, or than has

\(^4\) The implementation of contribution cap outlined in the Care Act (2014) has been postponed until 2020 (Carers UK, 2015)
traditionally been considered necessary. This “care gap” is filled, on the one hand, by the private sector in the form of privately paid for formal care, and on the other by unpaid-for informal, community based, care from family and friends (Lyon & Glucksmann, 2008). The numbers of the oldest old (85+) living in private households rose by 31% between 2001 and 2011, whilst the numbers of those aged 85 and over living in communal homes fell by 3.5% in the same timeframe (ONSa, 2013). These figures suggest that the care gap has been filled by informal carers to a greater extent in recent years.

Notwithstanding recent reductions in funding levels and plans to change the way care provision is funded, the UK relies substantially on the informal care of the elderly. Historically, care provision was provided within the family, and it is only with the advent of the post-war social reforms that brought about the Welfare State in the late 1940s that the state became involved in care provision or management to any degree. After the establishment of the Welfare State, some areas of care came under the auspices of the public sector (Lyon & Glucksmann, 2008). Currently, in the UK elderly people have a right to be assessed for their care needs by their local authority. “Care” that is assessed as necessary can include moving to live in a care home or the provision of support in the elderly person’s own home. Whether these care needs are offered free of charge is means test dependent, with only those whose combined income and assets are extremely limited receiving free care and assistance. Those who do not qualify for state funded care have to meet the costs themselves, go without if they are able, or enlist care from within the community: from family, friends and free (or subsidised) voluntary services. Care arising from health needs is entirely free. The result is a hybrid model whereby medical related care is free whilst social care (that is non-medical care needs arising out of general frailty) is means tested (Rubery, 2010). Care needs that are not met via the state or from voluntary services (that is services provided by charities such as Age UK or other voluntary organisation), when they are met, are generally filled by family and are therefore defined as informal care within current policy.

Across European nations, there is variation in the balance of state and voluntary sector funding and provision (Comas-Herrera et al., 2006), but there is generally a lean toward informal care. For example, elderly Italians rely on informal, unpaid, family, provided care with around 83% of long-term care being met by family, friends and neighbours (Bettio, Simonazzi, & Villa, 2006). Most elderly people live at home (either alone or with their relatives) rather than in residential care homes. Very often the primary caregivers are women within the elderly person’s family, with estimates of around 11% of women in the over 50
population providing care. Of this carer population in their fifties 80% are women (Lyon & Glucksmann, 2008). Similar figures can be found in respect of the Netherlands. Here again, there is a significant reliance on informal care, known as Mantelzorg, for the elderly with around 80% of care being provided by the family. The provision of family care is the responsibility of around 12% of the population, and again the majority of these informal caregivers are women who are related to their care recipient being either partners or daughters (Glucksmann & Lyon, 2006). There are similar patterns to be found in Spain, Greece, Austria and Germany. Exceptions can be found, for example in the Scandinavian countries where informal care takes a back seat to the state (Bettio & Plantenga, 2004). Here around a third of the elderly are in receipt of care available on a universal basis and funded via taxation (Daly & Lewis, 2000). Beyond the Scandinavian exceptions, overall the European trend is for informal care to be the norm rather than the exception.

Given that the UK, and indeed much of Europe, is reliant on models of informal care it is necessary to understand what care is. The concept of care is the focus of section 2.3. Here I develop an understanding of what care is via an examination of what can be understood by the meaning of care, the development of caregiving terms, an examination of what is considered as formal and informal caregiving, an exploration of the typical types of caregiving, and look at who are the givers and receivers of care, in particular informal care.

2.3 The concept of care

2.3.1 The Meaning of Care

Care can mean different things depending on context. At a macro level care can be about having general concerns about particular issues; examples here can be concern about global warming or climate change, or being generally concerned about how the elderly in general are cared for. At a more micro level care is focused on objects of significance such as friends and family (Fisher & Tronto, 1990). In terms of meaning, on the one hand care can mean to provide for, or look after, someone or something; whilst it can also refer to psychological dimensions of concern and affection. This psychological dimension can be further split into having feelings of concern about someone or something, or having feelings towards someone in an engagement of meeting emotional need (Thomas, 1993). Of particular import to the business of caregiving are two particular definitions, both of which are interrelated and go on to inform the concept of care in relation to caregiving, again ensuring
that this concept has duality. Firstly, we can care about someone; that is the engagement in the business of meeting the emotional needs of a person; secondly, we can care for someone; that is engaging in the business of care work (Thomas, 1993).

The dual aspect of care, that is caring for and caring about, has led to different concepts of care being posited within the academy that have differing boundaries, that of either private or public. Care activities engaged in by family, or kin, undertaken within the home, encompassing both the emotional and task based aspects, fall within the private sphere. Graham (1983) refers to this construction of care as home-based kin care, which is bound up in the caring for/caring about duality. Graham’s concept of kin care is further bound up with notions of normative family construction, clearly identifying “the caring relationships women enter into – with husbands, children, parents” (1983, p16). Constructed this way, the family is a heteronormative construct and family members are heterosexual. Further, this construction of care places other forms of caregiving beyond the remit of what can be considered care within the for/about dimension. Care provided by non-heterosexual family members, or formal care provided within the home via external agencies, cannot be considered genuine care. Seen via the lens of Graham’s “kin care” the only genuine form of care is in the engagement of both emotion and activity caring by heterosexual family members.

Graham’s concept of care has been criticised by Ungerson (1987) who argues that the fusion of caring for and caring about has brought about a false dichotomy. Ungerson argues that these ideas are not necessarily linked in that people can care for others without actually caring about them, and vice versa. In other words, we can be engaged in either emotional support or with task based care work without the need of being involved in both. However, despite Ungerson’s claim, the dual aspects of care are not mutually exclusive, many of those involved in the business of care work are also very firmly involved in caring about their care recipient. Care encompasses both the physical aspects of direct, labour intensive, care work such as meeting the needs of the care recipient, whether that involves being engaged in routine household tasks or delivering personal care needs of the care recipient, as well as psychological and emotional aspects involving love, affection, concern, and the giving of emotional support. For many familial carers, as Graham (1983) indicated, these two aspects of care are distinct but entwined; caring is both labour and love.

In sum, “care” is the provision of whatever is necessary for the health, welfare, maintenance, and protection of someone. Looked at from this standpoint, care is a descriptive concept that illuminates and quantifies the disparate activities of carework that people engage
with. Taken as such, care is therefore a practical category concerned with social action and interaction between people, the consequences and impact of which can be examined in varying ways from the practical to the psychological.

2.3.2 Types of caregiving

Care may be required at any stage in the life cycle depending upon need; as such, care is a fluid process that can ebb and flow depending upon circumstance (Phillips, 2007). As caregiving is linked to an individual’s specific care need, providing care is something that can occur at any time, or not at all. Caregiving is an activity that can be engaged in across the lifespan rather than being restricted to particular age periods (Phillips, 2007). As such, people can be involved in different caregiving scenarios at different times in their lives. For example people can be caring for their children as young adults in their 20s and 30s followed by caring for elderly relatives as middle aged adults in their 40s and 50s. Caregiving may also have to be given simultaneously to different recipients, such as having to provide both child care and elder care during the same period of life (Brody, 1981; 2004). Care may not only be provided to children and elderly parents, people may also be engaged in providing care to family members with disabilities and to those who have a serious, disabling or debilitating illnesses and may be considered to be an adult dependent. Finally for some, providing care may be an endeavour that is never engaged with because individual choice or personal circumstance may mean that caregiving is not an activity that is required. When caregiving is engaged with it may fall into one of three broad categories; child care, dependent adult care, or elder care.

The caregiving category division is also reflected in the caregiving literature where the research focuses, broadly speaking, on dependent adult care and elder care. The business of caring for children within the family is the domain of parenting. The term “child care” is generally not classified as caregiving in a family sense. Within the domain of non-familial child caregiving there is a distinction between “child care” and “childcare”. “Child care” refers to the public arena and the children who are cared for within the state care system; whilst “childcare” is usually taken to refer to formal day care provision that parents purchase. Caregiving as a term, when used in respect of children as recipients, generally refers to the caretaking done by family other than the child’s parent (Phillips, 2007).

Turning to dependent adult care, this arena covers a wide range of caregiving situations. For example, a caregiver can be providing care to a related adult who has care needs that arise from a debilitating physical illness, mental health issues, or some form of physical disability; or a combination of these causes. The adult care receiver’s needs may be
anywhere along a continuum of complexity as well as a continuum of labour demand connected to routine tasks; both of which move along a continuum from low to high levels of complexity or labour demand. Another dimension involved here is the time caregivers invest in caregiving duties. It must be noted, however, that complexity is not necessarily linked to labour demand; despite this it can be hypothesised that increases in either dimension will lead to an increase in time spent engaged in caregiving tasks. Generally, caregiving for dependent adults, be it complex or routine, labour intensive or relatively undemanding, is dependent upon the unique needs of the care recipient (Phillips, 2007).

The final key area is that of elder care, within this domain research is often focused on issues arising from providing care to people living with specific debilitating illnesses such as dementia (see as example Chappell & Reid, 2002; George & Gwyther, 1996; Skaff & Pearlin, 1992; Wright, Lund, Caserta & Pratt, 1991) or cancer (see as example Higginson & Gao, 2008; Ussher & Sandoval, 2008; Williams & Bakitas, 2012). The research into the effects of elder caring also identifies different categories of caregiver with studies that specifically examine the partner, or spousal, caregiving dyad (see as example Kiecolt-Glaser, Dura, Speicher, Trask & Glaser, 1991), and the adult child elder caregiving situation (see as example Brody, Hoffman, Kleban & Schoonover, 1989). Many studies, however, include all categories of caregiver together (see as example Cho, Zarit & Chiriboga, 2009). There are benefits to each of these approaches to research in that by examining the issues of all caregivers comparison can be made and general issues identified, whilst research more focused on a specific caregiver population can identify the unique issues that are faced by particular caregiver sub-groups.

Finally, elder caregiving is sometimes referred to as intergenerational caregiving. However, this term often conflates the caregiving of adult children to their elderly parents with the caregiving that young carers give to their parents. Whilst there may be some overlap here, these two distinct groups may face subtly different issues.

2.3.3 Practical care research

With respect to researching the activities of caregiving, only one facet of the dual notion of care has been under the research lens and that aspect is in relation to the business of caregiving activities. The emotional support that caregivers provide to and receive from their care recipient has gone unremarked, bound up as it is within the family support system. This research position can be understood quantitatively as the physical work of caregiving quantified into tasks such as assisting with mobility around the house, helping someone get
dressed, or bathing someone; any engagement with psychological support is not so tangible. Caregiving tasks are often quantified into “activities of daily living” (ADLs) and “instrumental activities of daily living” (IADLs) (Noelker & Browdie, 2013). ADL tasks include bathing, dressing, mobility around the house, toileting, continence control and feeding. These tasks were originally identified in the 1950s by Dr Sidney Katz and his team at the Benjamin Rose Hospital (Cleveland, OH) for use in assessing the physical function abilities of stroke and hip fracture patients’ during their recovery. These tasks were subsequently developed into a standardized measure of function scaled from dependence to independence (Katz, Downs, Cash & Grotz, 1970; cited in Noelker & Browdie, 2013).

The index of ADLs was developed further by Lawton and Brody (1969) who included IADLs in the task list. Lawton and Brody sought to develop a scale that measured independence with respect to activities that they considered to be critical to the independent living of elderly adults. Reflecting gender roles of the time, the developed scale measured eight activity domains for women: using the telephone, shopping, preparing food, housekeeping, doing laundry, using transportation, taking medications, and managing finances; and five domains for men who were excluded from the domains of housekeeping, doing the laundry, and food preparation. Men appear to have been excluded from these three dimensions because they are female gendered activities, thus suggesting that men’s ability to undertake these tasks did not need to be measured as they are not expected to have to engage with them as these tasks would be assumed by their female relatives. This position seems to suggest that men will be cared for by women, whilst women will care for themselves. Overall, IADLs are more complex than ADLs and include transportation, housework, grocery shopping, preparing meals, managing finances, administering and supervising medications, and arranging for and supervising paid services.

Initially developed for use in a clinical setting as a measure of patient recovery, the subsequent development of IADLs (Lawton & Brody, 1969), and continued research by Katz led to the recommendation that the index of ADLs be used as a tool to assess elderly clients care and nursing service needs (Katz, Ford, Downs, Adams & Rusby, 1972; cited in Noelker & Browdie, 2013); a recommendation that was embraced by the medical profession and social services alike. Taken together, the tasks identified by the ADL and IADL scales are now used extensively by care provision professionals to assess and measure potential caregiving need and by gerontological researchers to assess caregiver engagement with caregiving tasks.
2.3.4 Definitions of caring

As previously indicated, care provision can be either formal or informal. Any care, help, and support provided unpaid by non-professionals, generally family and possibly friends, is what is considered as informal caregiving. The provision of assistance, in other words care, by professional organisations such as Local Authority Social Services in the UK, private Care Service Providers, and other health and social welfare organisations is considered as formal caregiving. This type of caregiving is paid for, either by the care recipient (or their family) or by the public purse for those who qualify for financial assistance. Formal social caregiving is generally limited to identifiable tasks such as help with washing, dressing, toileting, and so on.

Looking more closely at informal caregiving, the term afforded the care, help and support that is provided, unpaid, by non-professionals – generally family, and possibly friends and neighbours, here the caregiving that families provide has a much wider remit than formal caring. Informal caregiving encompasses activities such as “just being” with the care recipient to the provision of emotional and psychological support, general household chores such as cooking, cleaning, clothes washing, small household maintenance tasks, gardening, helping out with the payment of bills and other financial management, organizing medical appointments, shopping, running errands and providing transport, as well as incorporating the types of task that formal caregivers generally provide (Chappell & Reid, 2002; Lee & Porteous, 2002). The amount and complexity of care any one caregiver provides will sit somewhere between the two positions outlined. Care and support is given with differing levels of commitment on behalf of the caregiver. Some caregivers live with the family member being cared for; whilst other carers visit on a regular basis undertaking a range of tasks whilst visiting. Still others provide their support at a distance, often telephoning regularly and generally arranging for the smooth running of the care recipient’s home and life via telephone and internet, often ordering shopping and arranging appointments. Further, depending on the complexity of need of the care recipient and the need and commitments of the caregiver there can be a blend of both formal and informal care provision. The present system of elder care provision in Europe, and again the UK is no exception, has a significant reliance upon this unpaid informal care provided by families (Kraus, Czyampionka, Riedel, Mot & Willeme, 2011).
2.3.5 Who is cared for by whom?

When informal care is provided, whether within the home environment or as a supplement to formal caregiving support, either at home or in assisted living facilities, it is usually the responsibility of one person (Baum & Page, 1991; Brody, 1985). A combination of factors including gender, marital status, existing responsibility level, and living arrangements, generally determine who within a family takes on caregiving responsibility. However, this role generally falls to a partner or adult child (Arber & Ginn, 1991; Bracke, Christiaens, Wauterickx, 2008; Pickard, 2008). Research indicates that in caregiving situations for older adults the primary caregiver is most often their spouse if the older adult is married or partnered. Where there is no spouse available to care, perhaps due to widowhood, prior divorce, or because the spouse is unable to provide care themselves, adult children step into the role (Cantor, 1983).

2.3.5.1 Partner, or spouse, caregiving

Many elderly people in need of carer support receive this from their spouse (Arber & Ginn, 1991). When spouses provide care they are often likely to be the primary caregiver and to become involved in intense levels of caregiving over protracted periods of time. Despite the demands of the task, spouse caregivers are, in general, older than other caregiver populations. Further, whilst caregiving in general is a female gendered role (Thomas, 1993), within the domain of partner caring, historically men over 65 are just as likely as women over 65 to become a carer for their spouse or partner. An examination of the General Household Survey (GHS) for 1985 indicated a level of gender equality in respect of spousal caregiving in the over 65s, with men accounting for 23% and women accounting for 24% of carers (Arber & Ginn, 1991). This gender equality in spouse caregiving was also reflected an analysis of the 1992 GHS where 13% of men over 65 and 14% of women over 65 were caregivers to their spouses (Orme, 2001; cited in Phillips, 2007). Whilst an analysis of the British Household Panel Survey for the period 1991-1998 indicated that more men than women have taken on the role of spouse caregiver leading to an equal ratio of men to women (1:1) being involved in spouse caregiving. However, looking at the overall caregiving picture, gender inequality in the numbers of men and women providing informal care still remained with women providing a greater amount of caregiving support than men (Hirst, 2001). It is only when a spouse is no longer able, or is not available, do adult children become involved in caregiving (Arber & Ginn, 1991; Aronson, 1992; Cantor, 1983). This hierarchy of caregiving within the family arises from the notion that the marital relationship brings with it an
expectation of duty and so is the locus of care. From this position spousal caregiving in advanced years is purely an extension of a mutual loving and supportive on-going relationship (Arber & Ginn, 1991; G. Parker, 1994; Phillips, 2007).

2.3.5.2 Familial, or Parental, elder caregiving

When caregiving is no longer available via the marital relationship, perhaps because the caregiving partner is no longer available or is unable to provide care, the role of primary caregiver will fall to an adult child if there are any children. When the primary caregiver is an adult child, often that child is a daughter (Arber & Ginn, 1995; Brody, Litvin, Albert & Hoffman, 1994; Qureshi & Walker, 1989). Caregiving stereotypes have suggested that the traditional familial elder caregiver is a middle aged unmarried daughter living with her parents (Parker, 1990), a position that was supported by Parker (1992) who found that the majority of carers for elderly parents were daughters aged between 45-65 years. However, the adult child who engages with the caregiver role is most often the child with the least amount of conflicting responsibility. Studies have indicated that when care is given to elderly parents within a family setting, if there is more than one adult child, the sibling perceived to have the least amount of personal responsibility is the family member most likely to be expected to take on elder care responsibility. Very often it is the child without children of their own, or who is not married, or perhaps not working who is the one most likely to take on the role of care provider (Brody, et al., 1994; Stoller, Forster & Duniho, 1992).

2.3.6 Thesis focus

However the concept of care is constructed, whether it embraces a universal account that encompasses the original narrow definition of home-based kin care (Graham, 1983) or a much wider concept of care work posited by Ungerson (1987), the informal caring for and caring about that LGBT individuals engage in within the informal arena fall beyond the currently constructed care boundaries and so go unnoticed and unremarked. This is in part due to inherent assumptions within the elder caregiving literature that assumes that the normative informal carer is heterosexual. These assumptions result in lesbian women who are engaged in elder care, and their experiences when engaged in that role, being rendered invisible. A key aim of this thesis is to explore this hitherto ignored life experience.
2.4 Who in the family is the elder caregiver?

Within Western nations O’Dell (2007) argues that there exist implicit assumptions and tacit family expectations that women will take on family caring duties. Public sector research indicates that two thirds of the caring that takes place in the family environment is undertaken by women and that single people (or those who are officially counted as single) are more likely to be involved in caregiving than those who are considered married (Pickard, 2008). The likelihood of a woman becoming involved in caring is quite high and this likelihood rises considerably as she gets older. Carers UK (2009) suggested that one in four women between the ages of 50-59 are, to some degree, involved in family care giving. And, when looking at adult caregiving across the lifespan, the Social Policy Research Unit (2001) found that two thirds of women are likely to have provided some form of informal family care by the time they reach 75 years. Overall, the picture painted by the public sector is that women account for the overwhelming majority of primary caregivers.

Survey research and social policy research from the public sector indicates that across the United States (US) and Western Europe caregiving to family members is predominately a female affair. Research from the academy is in accord with public sector findings. Survey research in the US has found that 72% of all informal carers were women (Stone, Cafferata & Sangl, 1987). Whilst a more recent US study has found that 77% of caregivers are women (Pope, Kolomer & Glass, 2012). Taken together, these findings indicate that over the years women have continued to provide a significant proportion of the help and support older family members receive as these studies indicate similar percentages of women in the carer role. Further, given the increases in population over the last 25 years the actual number of women involved in family caregiving has increased overall. Despite differing government approaches to the provision of care across Europe, figures from Europe indicate a similar trend towards female familial caregiving. European research has found family caregivers provide over 80% of all care support (Hoffman & Rodrigues, 2010) and that women provide the majority of family based care (Bracke et al., 2008), with around 59% of overall informal care provision being undertaken by women (Riedel & Kraus, 2011). The women who provide this care are daughters, daughters-in-law, wives and partners (Hoffman & Rodrigues, 2010). Looking at individual countries and eldercare, the main providers of informal care are women. Of the over 50s providing familial eldercare in Italy 80% are women (Lyon & Glucksman, 2008). Whilst in the Netherlands around 69% of informal elder carers are related women (Mot, Aouragh, de Groot & Mannerts, 2010). And, looking at the position closer to
home, the UK is no exception as research indicates that, similar to the Netherlands, two thirds of family based informal care and support is provided by women (Carers UK, 2009; Pickard, 2008; Social Policy Research Unit, 2001). Overall, therefore it is women who are most likely to be found in the role of caregiver to an ageing parent (Boyd & Bee, 2006; Stone et al., 1987); a position supported by Pickard (2008) who suggests that nearly twice as many women as men have some involvement in informal elder caring.

It is clear that provision of informal family care is predominantly a female endeavor, and acknowledged as such by government and social policy. In sum, the picture that emerges from both the academy and from public sector research is that the responsibility for providing informal family care falls disproportionately upon the shoulders of women.

2.4.1 Various carers but mainly daughters

With respect to elder care within the family, there is a hierarchy of carers in that if a spouse is available (and able) they will be the primary carer. When there is no spouse to take on caregiving duties, it is the sibling that has no children at home, is not married, or is not working who is most likely to be the one expected to take on elder care responsibility (Brody et al., 1994; Stoller et al., 1992). Whilst there are a number of variables that interact, such as the gender of the care receiver and the number and gender of adult children in the family, when elder caregiving is being provided by an adult child, that child is very often a daughter (Bracke et al., 2008; Brody et al., 1994). Overall adult daughters provide more assistance in general than adult sons, with twice as many daughters as sons engaged in caregiving tasks (LaBorde Witt, 1994). This situation has arisen due to gender role expectations and attitudes which position caregiving as part of the female gendered role (Gerstel & Gallagher, 2001); a position which in turn leads to adult sons not being expected to provide parental elder care (Campbell & Martin-Matthews, 2003).

2.4.2 The model carer

It is clear that caregiving within the family is a task taken on, in the main, by women. In keeping with the assertion that elder caregiving is taken on by the sibling deemed to have least responsibility, early models of family caregiving characterised the women who care within a “spinster model” in which caring is seen as the responsibility of the unmarried women in the family (Manthorpe, 2003). A position supported by Brody et al., (1994) who examined caregiving, marital status of the caregiver and caregiver burden and found that the
amount of care provided was mediated by the marital status of the caregiver such that single
caregivers provided more care than married caregivers.

Other models of elder care have also been utilised such as the “sandwich model”
(Brody, 1981; 2004). This model encompasses patterns of caring responsibility by a married
daughter who is “sandwiched” between multiple competing demands upon her time. In other
words, the adult daughter who provides elder care to either her own or her partner’s parents
also has to cope with other, non-eldercare demands on her time. Women coping with other
competing demands were termed “women in the middle”; they are in the middle by dint of
their being middle aged, the middle generation of a family between old and young, and they
are in the middle of competing demands; sandwiched between caregiving duties to both the
older and younger generations, taking on the caregiver role to elderly parents whilst also
being a parent to her own children. These “women in the middle” are also, more often than
not, in the middle of other competing demands on their time from both within and without the
home. For example, they may have partner relationship demands and workplace demands
(Brody, 1985; Stone et al., 1987).

2.4.3 Assumptions around the women who care

The dominant ideology of family-based support leads to most of the responsibility for
adult care to fall within the remit of home based care from related females (Aronson, 1998),
whether that female is a wife or a daughter. However, all models of caregiving hold inherent
heteronormative assumptions about the women who care. Brody et al., (1994) identified a
number of different kinds of “daughter” who are involved in caregiving: married, divorced,
widowed or never married. However, the inherent assumption is that whatever the category
of daughter, these women are heterosexual. Further, all the women who care, whether they
are wives or daughters, can be identified by their relationship, or lack of, to men. Lesbians,
however, are not positioned within the taxonomy of daughters that Brody identified. Indeed,
when identified by their sexuality, it may be that lesbians can be considered as outside the
defined boundaries of what it means to be a woman (Wittig, 1992). As such lesbians, whether
single or in relationships, are rendered invisible by heteronormative models of caregiving;
their sexual orientation is unquestioned and they are perceived as never married daughters or
divorcees (Manthorpe, 2003). Further, when positioned as lesbian, their engagement in
familial caregiving goes unnoticed and unremarked. It would appear therefore that these two
identities are mutually exclusive, a woman can be a lesbian or a familial caregiver but not
both.
2.5 Caring and lifespan development

Historically, research into familial caregiving has been an interdisciplinary affair that generally takes a bio-psycho-social position with research collaboration across the fields of gerontology, health care, psychology, social work and sociology. Early cross disciplinary research examining child and adult development, faced with changing population demographics, was expanded to examine wider lifespan issues such as familial elder caregiving (Roberto & Jarrott, 2008). An applied topic, caregiving research is generally situated within the fields of gerontology and social work as it seeks to address the issues brought about by the demands of the caregiving role. When it is considered from a purely psychological position it is often only discussed within a lifespan development framework; with any attention to non-parental caregiving to be found within the textbooks of developmental psychology, see Boyd and Bee (2006) as example.

Many psychological theories of lifespan development are situated within the Western perspective that encapsulates a lived life conceptualised in a linear format from birth through to old age; and one where the life course is often thought of in terms of stages (Greene, 2003). In this perspective the individual moves from birth through successive stages, often endeavouring to achieve a required goal, or resolving a specific crisis, which enables them to move on, with the required skills, to face the next goal or crisis that characterizes the next life stage (Boyd & Bee, 2006). There are a number of different lifespan development theories that adhere to this notion of stages throughout the life course, and that espouse the idea that individual development occurs in a fixed order or sequence (Erikson, 1959; Freud, 1905/1962; Levinson, 1978).

2.5.1 Traditional Stage Theories

Stage theories posit that individuals develop as they progress through a number of stages, with each resolved stage providing the stepping stone to the next stage. One such stage theory of lifespan development was put forward by Erikson (1959). In his theory of psychosocial development he proposed eight stages of life, starting with Infancy, which covers the period from birth to around 18 months, moving through seven further stages: Early Childhood (around age 2 to age 3), Preschool around age 3 to age 5), School Age (around age 6 to age 11), Adolescence (around age 12 to age 18), Young Adulthood (around age 19 to age 40), Middle Adulthood (around age 40 to age 65), ending in Maturity which starts around age 65 and culminates in death. During each stage a normative dilemma or crisis has to be resolved or, as Erikson posited, a psychosocial task had to be successfully negotiated in order
for the individual to become fully developed. The successful resolution of each dilemma equips the individual with the skills and knowledge to move onto the next stage and engage with the next dilemma. For example, the first psychosocial task, or dilemma, during infancy is “trust versus mistrust” where the infant needs to develop a basic sense of trust which is developed via interaction with primary caregivers. The second stage involves the toddler facing the dilemma of “autonomy versus doubt” where, using the sense of trust developed in the first stage, the child needs to establish a basic sense of autonomy by developing a sense of personal control over physical skills that leads to a sense of independence.

When elder caregiving is located within the wider lifespan, in particular when examined via the lens of Erikson’s psychosocial stage theory, two stages, six and seven are of particular interest. Looking at stage six, here the dilemma of “intimacy versus isolation” needs to be resolved during early adulthood, with the key task being the achievement of intimacy. If this stage is not resolved the individual will feel lonely and isolated from others whilst successful resolution brings the virtue of love, or an overall sense of caring for others. It is in this stage Erikson (1959) proposed that women develop their identities through relationships with others, suggesting that they might gain fidelity and love simultaneously. This notion finds support from Gilligan (1982) who posited that women determine who they are, how to be a woman, and what to believe in terms of relationships and care for others. Turning to stage seven, that of middle adulthood, here the key virtue is care and the task to be achieved is generativity, or “care and concern”. It is clear that the skills women are expected to achieve in stage six, that is an overall sense of caring for others linked to identity development and formation, could be considered as equipping them to take on the tasks of familial caregiving to both children and aging parents. When examining the profile of women caregivers, it is between the ages of 50 to 59 that many women are engaged in this task (Carers UK, 2009), an age range that fits neatly into Erikson’s seventh stage of middle adulthood. Given this position it may be argued that it is during Erikson’s seventh stage that engagement with elder caregiving is a normative task for women.

However, despite the apparent “neatness of fit” between elder caregiving and Erikson’s seventh stage of middle adulthood, criticism must be noted. Erikson (1964) suggested that women and men achieve their identities differently. Women’s identity formation, and ultimately their fulfilment, is based upon their biology; that is women’s biological ability to bear children and the subsequent fulfilment of that ability, interwoven with a biological, psychological and ethical commitment to care. Women are constructed as
being “bound” by their femininity, which is intrinsically linked to their biology. However, as Weisstein (1971) indicates, developmentally situated psychological accounts of women’s behaviour, such as those of Erikson, assumes that human behaviour is predicated on inner dispositions, often argued to be a result of biology, without regard to social situation and social expectation. In other words, behaviour is considered out of context and attributed to innate dispositions which are assumed to be a result of biology. Further, normative descriptions constructed within a developmental psychology framework often become naturalised prescriptions that dictate behaviour and maintain class and gender norms (Burman, 1994). How an individual behaves however, is predicated upon the social situation rather than from within the individual, being contingent upon the contextual situation in conjunction with the behavioural expectations that others within that situation hold. As Weisstein posits, women’s behaviour is predicated on their social conditions, and social conditions are predicated upon social expectations about women. Therefore, caregiving during middle adulthood, rather than being naturalised sex-role behaviour can be understood as being socially expected normative behaviour.

2.5.2 Social Clocks and the Life Course

However, the way the life course is divided up has varied across historical time periods. Take, for example, adolescence, the period between childhood and adulthood, is a late 19th century construction. Over the 20th century this particular period of life can be seen to have lengthened in line with the demand for a more educated workforce (Greene, 2003). What is clear from this is that societal demands can alter the temporal structure of the life course, in other words: the life course is socially constructed (Kohli & Meyer, 1986). The roles individuals have to engage with at each stage of their life course are defined by the circumstances of the society in which they live. Further, it can be argued that stage theories such as those posited by Erikson are describing an artefact of societal norms.

Society regulates social life in terms of the roles that are expected of an individual according to their age (Kohli, 1986). Within the Western standpoint there are societal expectations, or social norms, that set a social clock which dictates a timetable for when events, such as leaving the parental home, going to university, getting married, having children, and retiring from work should occur. The social clock is an internalisation of social norms, in respect of the timing of life events, linked to the broader norms and assumptions in respect or normative life stages (Neugarten, 1979). Events that occur during the time period in a person’s life that corresponds with society’s timetable can be considered as “on-time”. It
follows that events that occur outside the scheduled time dictated by society are “off-time”. For example, leaving school and going to university to study for a first degree between the ages of 18 to 25 is the norm and so is “on-time”, whereas first degree study at university at a very young age or in middle age is “off-time”. Helson, Mitchell and Moane (1984) examined the social clock in relation to women’s lives and found that women who were late in terms of expected schedule, or not following any recognisable social clock, were less well-adjusted in terms well-being and self-acceptance. It is clear that conforming to or deviating from the cultural social clock can bring psychological implications, life events that occur on time are arguably less stressful than those occurring at non-normative times due to their being better integrated into the wider social system (Helson et al., 1984; Neugarten, 1979); further being on time or off time can also impact upon self-esteem when comparisons against peers are made.

The culturally constructed social clock for women can be considered as differing to that of men, with women being expected to have a different relationship with the life course than men. The shape of the public life course is structured around employment (Kohli, 1986) which, hand in hand with the traditional discourse of home-making, affords men a public life in the world of work whilst women remain in the private sphere to raise children, keep house, and tend to kin. The cultural social clock for women indicates that the “on time” for elder caregiving is in middle age range of 50-59 (Carers UK, 2009).

2.5.3 The non-normative life course

The traditional discourses, whilst fully acknowledging the normative familial engagement expected of women, do not fit with all current life course patterns. Many women, both lesbian and heterosexual, are engaged within the public sphere in the world of work and in the private sphere of family life and the roles that she has to therein engage with (Greene, 2003). Further, when looking exclusively at lesbian women, these discourses do not acknowledge their non-normative life course and their need to be normatively creative; that is, being able to generate new rules and norms with which to guide different ways of being within the world when the dominant culture does not provide a road map (Brown, 1989). Taking these points together therefore suggests that lesbians who are involved in elder caregiving are going up against two discourses, or norms. Firstly there is the discourse of familial expectations and non-engagement within the work force; and secondly against the heteronormative expectation that women in caregiving roles are heterosexual.
2.6 Why is caring gendered?

The research thus far examined describes variously the need for caregiving, what caregiving is, the profile of the typical care giver: a related female, and the relationship between caregiving and the lifespan. Why women more generally undertake this role has not been directly examined.

2.6.1 Why do women care?

The family in pre-industrial society was often an extended family unit, wherein it can be surmised that any elder caregiving that was needed was one of many exchanged tasks undertaken by family members for other family members (Fulcher & Scott, 2003). With urbanization, industrialization and the emergence of the nuclear family, greater gender role differentiation between men and women occurred (Parsons & Bales, 1956). This gender role differentiation positioned men more concretely in the occupational role of provider for the family in the public sphere of work, whilst women were more focused upon the emotional, nurturing and caregiving work within the family, situated in the private sphere of the home (Walker, 1992). This division of labour along the axis of gender, such that women nurture within the home while men achieve out at work, serves to maintain the status quo of gender role attitudes and expectations (Eagly, 1987). That is, that people’s gender role beliefs are formed by their making observations of the type of activities that women and men in society are engaged in (Eagly & Wood, 1999). Therefore, as women are more often engaged in home-making activities, childcare, and elder caregiving than men in most Western societies women are believed to be more nurturing and caring than men. Conversely, because men are more likely than women to be engaged in the world of work and in working in higher status work roles men are believed to be more dominant and assertive. Further, by observing women and men in the activities that they are engaged in their roles become crystalized into normative expectations, and so gendered in nature. As a result gender role expectations go on to influence how people behave. In this context, gender role expectations naturalize care giving as part of the female gendered role and thus women are expected to care.

Researchers have sometimes considered “femininity” as something natural that explains why women are more caring and why caring is associated with the home and family, areas that are closely linked with women (Finch & Groves, 1983). Caregiving for women has been explained as being motivated by their attachment to the receivers of care (Chodorow, 1978) and as central to a woman’s identity (Graham, 1983). Baker Miller (1976) and Chodorow (1978) argue that caregiving is central to a woman’s identity as it is via the activity
of caring that women achieve their femininity. Whilst Gilligan (1982) suggested that women are more empathetic, compassionate, and more concerned about attending to the needs of others compared to men; in other words care and relatedness form part of the essence of femininity. Greeno and Maccoby (1986) indicate that women being the primary caregiver within a family has become universally accepted; a position that is given credibility by theories such as Gilligan’s that suggest that women’s caregiving stems from the essence of their femininity. Essentialist theories such as these posit that it is inherent sex differences which underlie actual observed differences between men and women. From this position, women engage in caregiving due to their very nature. However, as Greeno and Maccoby (1986) and Mednick (1989) point out, the sex differences that are posited by Gilligan as being essential are congruent with gender stereotypes. Although these psychological models prioritize the care that women give to children rather than to elder parents, they suggest that elder caregiving might be an extension of the heteronormative construction of caregiving naturalised within the female role.

In contrast to Gilligan’s essential notions of care and relatedness, from a sociocultural perspective, autonomy and relatedness may be considered as dependent upon a person’s social position rather than being intrinsic to their gender (Hare-Mustin & Maracek, 1988). This argument suggests that differing social positions afford differing levels of power and resources within society, such that people positioned lower along the social scale are less powerful and less able to access resources than those higher up. Individuals who have less power in society are more focused on issues of relatedness and compassion than those who are more powerful; further, the focus on relatedness and compassion subsequently impacts behaviour. Behaviour, therefore, is more a result of an individual’s position within the social structure rather than of their gender (Mednick, 1989). From a sociocultural position then, caregiving behaviours by women may be explained by their, generally, lower position within the social hierarchy and their assigned role therein (Eagly, 1987).

Irrespective of cause, whether a result of essentialist naturalisation or the sociocultural positioning of women, caregiving is both gendered and heterosexual. This gendered heterosexual positioning is supported by legislation and social policies that focus on the centrality of the family in caregiving with the family seen as natural carers (Phillips, 2007) and the preferred choice (Walker, 1992). For example, direct state involvement in care only occurs when there are no family members to provide care or the family is unable to assist (Phillips, 2007). As such, there is a dominant Western ideology of family-based support
which leads to most of the responsibility for adult care to fall within the remit of the home with care being provided by related women (Aronson, 1998). Finally, notwithstanding the naturalizing or sociocultural positioning of care as being considered as women’s work, the definitions of family and constructions of caregiving leave little room to theorize the experiences of lesbian women involved in a familial caring role outside of the heteronormative family with its constitutive division of labour as the “family” that is conceptualized within law and the social policy that surrounds caregiving is inherently heterosexual.

2.6.2 A gendered division of tasks

When men are the sole caregiver clearly a gendered division of tasks is not possible. However, when sons are involved in a family network of care provision there is often a gendered division of care tasks (Abel, 1990). Daughters help more with direct hands-on, intensive and instrumental tasks, and emotional support; whilst sons help more with financial management, advice, heavy chores and shopping (Campbell & Martin-Matthews, 2003). Women also tend to take responsibility for tasks that are continuous, repetitive and routine. To take on this additional work the women tend to reduce the amount of time they spend on personal tasks that benefit themselves. On the other hand, men tend to undertake tasks that are infrequent, irregular and non-routine, and they are less likely than women to allow family responsibilities to interfere with personal tasks (Blieszner & Hamon, 1992; Thompson & Walker, 1989).

2.7 The effects of caregiving

2.7.1 Caregiver burden, stress and strain

For those who engage in elder caregiving directly, research has examined the effect caring has in their lives. Being in the role of primary caregiver can bring with it burden and stress, also referred to as “caregiver stress”, “caregiver strain”, or “caregiver burden” within the literature. These three terms are often used interchangeably whilst their meanings and definitions can vary widely between disciplines (Cantor, 1983). The discrepancy of definition and meaning can impact upon how the caregiver role is understood and the impact the role has upon caregivers (Braithwaite, 1992; Kramer & Kipnis, 1995; Poulshock & Deimling, 1984; Vitaliano, Russo, Young, Becker, & Maiuro, 1991). Much of the research into burden, stress and strain has been with those caregiving for people with Alzheimer’s Disease or
another dementia (Kinney & Stephens, 1989). Other research has examined the situation for those who provide care to people with general physical impairments (Montgomery, Gonyea, and Hooyman, 1985; Brody, 1981; Brody 1985; Brody et al., 1989; Brody, 2004). Despite discrepancies, there are some agreed upon definitions as well as predictors of the negative impact of caring.

A common definition of “burden” is as a set of “physical, psychological or emotional, social and financial problems” (George & Gwyther, 1986, p.253). There is also differentiation between subjective and objective burdens (Kinney & Stephens, 1989; Montgomery et al., 1985; Poulshock & Deimling, 1984). “Objective burden” generally involves a change or disruption of roles, family life, or social activities (Kinney & Stephens, 1989; Montgomery et al., 1985); whilst “subjective burden” entails feelings, emotional responses, and perceptions. The feelings may include overload, entrapment and resentment (Montgomery et al., 1985; Poulshock & Deimling 1984; Zarit, Reever, & Bach-Petersen, 1980). In sum, objective burden is observable structural changes, whilst subjective burden is psychological responses. The predictors, or contributors, to caregiver burden include how impaired, and as a result demanding, the care-receiver is, the caregiver’s level of social support, decreased finances (as a result of caregiving), physical strain, isolation, sharing a home with the care-receiver, health problems of the caregiver (both underlying health issues and those that result from caregiving), and psychological distress (Kinney & Stephens, 1989; Kosberg, Cairl, & Kellor, 1990; Poulshock & Deimling, 1984; Zarit et al., 1980).

The term “caregiver stress” is not as common within the literature. Caregiver stress can be considered as a response to the issues that providing care brings and is conceptualised as the impact, usually negative, of the caregiver experience (Poulshock & Deimling, 1984; Robinson, 1983; Zarit, Todd, & Zarit, 1986). Stress involves caregiver characteristics, available support and the roles performed by the caregiver. Caregiver “strain,” is sometimes considered to be part of the stress process, or as being interchangeable with a stressor (Cantor, 1983; Robinson, 1983; Shultz, Visintainer, &Williamson, 1990). Strain is often linked to roles, involve personal relationships, and relationship sacrifices. Caregiver strain is often equated with “burden” (Cantor, 1983). Contributors to strain include care-receiver characteristics, subjective perceptions and emotional health of the caregiver, physical and financial stressors, disruptions to family life and impaired personal relationships (Cantor, 1983; Mui, 1992; Mui & Morrow-Howell, 1993; Robinson, 1983).
Caregiving can have positive as well as negative effects. However, the vast body of research examines issues of “caregiver stress” or “caregiver burden”. Both these terms are often used interchangeably in the literature; however caregiver burden is used more frequently. Caregiver burden, which is suffered as a consequence of caregiving, has been defined as being the experiential and measurable differences between carers and includes stress effects, consequence of care giving and the overall impact of care giving (Chappell & Reid, 2002). Other researchers have suggested that caregiver burden is the totality of physical, psychological, emotional, social, and financial problems experienced by someone in the family care giving role (George & Gwyther, 1986). Chappell and Reid found that caregiver burden and number of hours of care provided had negative associations with carer well-being in that greater burden and the higher level support a caregiver offered negatively impacted with carer well-being.

Research into the factors that go to make up caregiver burden have found that carers physical and mental health, social life, family life, and work life are significantly impacted by their involvement in caring (Jones & Peters, 1992; Lee & Porteous, 2002). These outcomes are consistent with the findings of Pinquart and Sörensen’s (2006) meta-analysis which revealed that overall higher levels of burden and depression are associated with lower levels of subjective well-being and physical health, with women carers being more likely to suffer these ill-effects than men who provide care. Pinquart and Sörensen suggest that this gender difference may be due to women experiencing more caregiving stressors in the form of multiple role expectations such that women may have to engage with elder caregiving, caring duties for other family members, and work related duties. Alongside these multiple roles may be reduced access to social and monetary resources. The issue of the multiple roles of women has been reviewed. Whilst potentially having multiple roles could increase the demands on women’s time, positive experiences in one role can offset the effects of negative experiences in another (Doress-Worters, 1994; Stephens & Franks, 1999).

2.7.2 Physical

Caregiving can affect a carer’s physical health by causing strain and exhaustion and by preventing the carer taking care of themselves (Roberto & Jarrott, 2008). Research has, therefore, looked at the detrimental effects that caregiving has on carers’ physical health (Shultz et al., 1990). For example, research by Kiecolt-Glaser, Glaser, Shuttleworth, Dyer, Ogrocki, and Sprecher (1987) found caregivers for Alzheimer’s patients had poorer immune functioning than non-caregiver peers; and further, that caregivers also reported more distress
which indicated stress-related immunologic changes resulting from the caregiving situation. Chenoweth and Spencer’s (1986) study found that carers self-reported poorer health as a reason for putting the person they cared for into formal caregiving institutions. The health conditions reported by participants were heart attacks, ulcers, nervous breakdowns, bone fractures, and exhaustion-related illnesses. Subjective perceptions were reported by Stone et al., (1987) whose participants indicated perceptions of being in poorer health than non-caregiver peers; whilst Haley, Levine, Brown, Berry and Hughes (1987) also found that caregivers reported poorer health as well as greater prescription drug use than their non-caregiver peers.

2.7.3 Psychological

The mental health of caregivers is another axis of enquiry. Psychological distress reported by caregivers is considered the outcome of the interaction between the predictors of caregiver stress or burden (Pearlin, Mullan, Semple & Skaff, 1990). Caregiver psychological distress is the result, therefore, of the interaction between level of impairment that the care-recipient has, the amount of care that the caregiver needs to provide, the amount of support for the caregiver (both physical and psychological), and the hardships of any reduced financial circumstances.

Psychological distress in the form of anger, anxiety and depression are often reported by familial elder caregivers (Pinquart & Sörensen, 2003; Roberto & Jarrott, 2008). Self-reported incidence of depression is higher in caregiver populations than non-caregivers. Research by Haley et al., (1987) examined the mental health of 44 caregivers to people with dementia. These participants reported higher levels of depression and lower levels of overall life satisfaction than their control group. Similarly, Kiecolt-Glaser et al., (1987) examined 34 caregivers, and found higher reported levels of depression and lower levels of life satisfaction than their control group of non-caregivers. More recently, longitudinal research by Rush Smith, Williamson, Miller and Schulz (2011) found relationships between caregiver stressors, caregiver depression and quality of care with increases in stressors such as caregiver health, restriction of caregiver activity and care recipient demands being related to increased caregiver depression.

2.7.4 Social

Some researchers have noted that the impact of care and its attendant negative effects may be mitigated by social support (Cantor, 1983; George & Gwyther, 1986; Montgomery et
al., 1985; Pearlin et al., 1990; Thompson, Futterman, Gallagher-Thompson, Rose, & Lovett, 1993; Zarit et al., 1980). Similar to the multiple definitions of caregiver burden, stress and strain, carer social support has been variously defined. Some studies define social support in terms of the number of people within the carer’s network that are available in times of need (Thompson et al., 1993); whilst others define social support in terms of emotional support, such as listening and advice, and instrumental support such as assistance with physical tasks (Pearlin et al., 1990). Social support that provides social interaction and enjoyable activities were considered as the most important in alleviating caregiver burden. When social opportunities were restricted greater burden was perceived (Thompson et al., 1993).

2.7.5 Economic

Caregiving, whether paid or unpaid within the home involves emotional involvement, or “emotional labour” (James, 1989), as well as physical effort, both of which ultimately have an economic cost. Caregiving, as an activity, positioned as love and commitment rather than being considered as work (Wuest, 2001) obscures the value of women’s effort and labour in the tasks of caregiving. Analysis of interview data by Rae (1998), drawing upon symbolic interactionism, found that caregivers are extensively engaged in emotion work as part of their caregiving and that not managing their emotions within the social norms that define what is appropriate to feel in given situation (Hochschild, 1979), in this case caregiving, has a negative effect on the caregiver’s sense of self; which is implicated in how caregiver burden and stress are perceived. However, given the common assumption that women are thought to be more emotional than men (Forssen, Carlstedt & Mortberg, 2005), the effort expended by women in respect of emotional involvement in their caregiving roles becomes elided.

The gendered pattern of caring means that caregiving responsibility also intersects with women’s participation in the economy. If a woman’s socioeconomic status will allow her to delegate responsibility she may buy in caring help to insulate her from direct caring duties, most often from women with lower socioeconomic status (Brewer, 2001; O’Dell, 2007). In general, caregiving responsibility has a detrimental effect on a woman’s socioeconomic status as she may have to reduce or give up employment. Daughters who care are more likely than caregiver sons to re-arrange their work schedule, reducing their hours of paid work or leaving paid employment in order to provide parental elder care (Arendell & Estes, 1994; Stone et al., 1987). Any reduction in, or cessation of, paid employment has both short and long-term economic consequences for caregivers. The short-term impact is loss of earnings and a lowering of socioeconomic status. However, lower earnings lead to lower
payments towards pension savings and/or social insurance tax (national insurance), which leads to the long term consequence of reduced economic circumstances with the receipt of a smaller pension in the caregiver’s old age.

2.7.6 Positive aspects

Despite the many negative effects of caregiving many people continue to be involved in caregiving for their loved ones and may value some of the positive aspects of the role. For example, some carers get satisfaction from knowing that the person they are caring for are being provided for in their preferred environment, the home. Motenko (1989) found that wives of dementia sufferers reported both positive and negative aspects of their caring role linked to meaning and appraisal of the caregiving provided rather than being linked to the amount of care given; key to satisfaction for the women here was perceived reason for giving care. Those who provided care purely out of duty were less positive than those who cared from a position of reciprocity and love. Whilst filial carers may gain satisfaction from giving something back to their loved one, that is to reciprocate the care given to them in childhood (Piercy, 1998), in being able to fulfil what may be perceived as a family obligation (Farran, Keane-Hagerty, Salloway, Kupferer, & Wilken, 1991), and in creating closer relationships between the caregiver and care receiver (Allen & Walker, 1992). The positive aspects of caregiving are, in the main, theorised as being fulfilling and meaningful for the caregiver because the act of caregiving is connected to the individual’s concern and affection for their loved ones (Walker, 1992); and focusing on the positive aspects of care has been considered as a coping strategy to ameliorate the negative aspects (Hudson, 2004). Despite this research, overwhelmingly the empirical caregiving research base examines the negative aspects of the caregiver role.

2.7.7 Conclusion

In summary, it is clear that whilst there are some positive aspects, caregiving often has a negative impact with carers reporting negative effects on their health, social life, family life and work life. It is clear that the majority of carers are women, and it would appear that the women who care are most likely to be the daughters who are perceived to have the lowest amount of pre-existing commitment. Further, most research, practice and political discourse serves to construct elder caring as a natural role for women; in essence therefore, a naturalizing ideology that appears to work to the disadvantage of women caregivers.
2.8 Why is it different for LGBT people?

Aside from any financial or psychological support that may be proffered, Kimmel (1992) hypothesized that lesbians and gay men may become carers for elderly relatives in their families of origin due to unique characteristics afforded by their sexuality. For example, recent UK and US same-sex marriage legislation aside, lesbians and gay men are considered as unmarried (whether in a long term relationship or not), may be geographically mobile, and possibly willing to move in with and care for an aging parent should this becomes necessary. These characteristics are consistent with the profile of the familial elder caregiver highlighted in Section 2.3.5.2, namely the familial caregiver is generally the adult child who is considered as having the least amount of personal responsibilities. However, there are some issues that can be considered as unique to the lesbian who cares.

2.8.1 Lesbian relationship status

Consistent with all women, whether lesbian or heterosexual, the social pressure to remain in contact with their families of origin and become carers for their elderly parents is greater for women than men (Etaugh, 1993; McGoldrick, 1999). A notion which finds some support from Laird (1998) whose research with 19 lesbians in the US suggests that most lesbians are not estranged from their families of origin, often choosing to maintain familial connections even over long distances. Laird (1998) suggests that, despite periods of alienation in some cases, many women undertake aspects of informal caring for parents when age and infirmity challenge a parent’s independence. Further, and consistent with the notion that homosexual people may be considered as being single despite their relationship status, Laird found that if a lesbian couple do not make consistent efforts to define “their coupleness” (p.214) to their families of origin then the family may make demands that impact upon their relationship as a couple. In other words, if the women are not acknowledged as a couple then the women are defined as single by their families of origin. Taken together these two issues have the potential to increase the pressure upon lesbian women to become involved in familial caregiving.

2.8.2 Lesbian economics

Again consistent with all women, caregiving has an economic impact on lived female lives. However, models of the economic impact of caregiving on women’s lives have failed to incorporate an analysis of sexuality; which may be particularly acute in the case of lesbians involved in caregiving. Caregiving heterosexual women in committed relationships may
experience support from their generally higher earning male partner. However, a lesbian in a committed relationship will be supported by a female partner, who is likely to earn less than a male partner, and be less likely to provide financial support for caregiving (Badgett, 1997). The intersection of caregiving and lower earnings has the potential to create particularly acute situations in lesbian relationships should both women be presented with familial caregiving demands.

2.8.3 Conclusion

The examination of the care literature has highlighted a number of issues that face the women who provide care. However, what has become clear is that heteronormative assumptions implicit in theory and research within the caregiving arena mean that any LGBT caregivers have been overlooked and their specific caregiving issues unacknowledged despite their potential position as primary familial caregivers. Similarly, from an early review of the family studies literature Allen and Demo (1995) concluded that research on lesbian and gay families has been very limited because of both a perceived difficulty of defining the families of lesbians and gay men, and heterosexist assumptions which lead to the invisibility of lesbians and gay men as a population because “lesbians and gay men are thought of as individuals, but not as family members” (p.112), as such within the arena of family studies sexuality is not considered as an axis of analysis. Given the invisibility of lesbians within the care giving research corpus a logical question is what is the position of lesbian caregiving in the LGBT research base?

2.9 Overview of LGBT research corpus

Turning to the LGBT research base, that is research with an LGBT focus, this falls into two distinct corpora. On the one hand there is a body of research that holds the LGB or T person as being the focus of research: that is as the object of study. The other avenue of research engages with heterosexual perceptions about LGB or T people. Looking first at research that has the sexual minority person as the object of study, again two distinct positions can be discerned: that of pathology and affirmation. First there is a body of work that seeks to establish the aetiology of homosexuality, with much of this early research pathologising the homosexual subject. More recently, however a more affirmative stance can be discerned with research being focused very much on the wellbeing of the homosexual individual, with studies examining issues such as coming out (Jordan & Deluty, 1998; Savin-Williams, 1998),
lesbian and gay parenting (Patterson, 2006), and same-sex relationships (Kurdek, 2003), as example. Aside from the family based research that overlooks the LGBT population, of which caregiving is an example, and the LGBT research that examines sexual minority people and their lives, the second main strand of research focuses on heterosexual people’s perceptions of lesbians and gay men. This research corpus has examined issues such as attitudes, prejudice, and stereotypes. Each of these two research corpora, that of heterosexual perception research and LGBT affirmative research, will be briefly examined in turn.

2.10 LGBT Person as research object

2.10.1 Historical position

Early research on the lesbian or gay person, or “homosexual”, developed from the classification of same-sex behaviours and case studies. Homosexuality as a term was coined in the second half of the 19th century as a medical category to classify same-sex sexual behaviour as opposed to opposite sexed male-female sexual behaviour. According to the sexologists of the day homosexuality was considered to be inborn, natural and congenital. Homosexuality was also considered to be a form of gender inversion or sexual inversion, that is a congenital inversion of the sex drive (Krafft-Ebing, 1886/1935). The sexological theory of a female homosexual therefore was an inverted woman displaying masculine traits. Sexual inversion was considered to be a reversal of gender traits; for example, female inverts were considered as being inclined towards male pursuits and to be of mannish appearance. The sexologist Krafft-Ebing, based on case studies, described female sexual inversion as “the masculine soul, heaving in the female bosom” (Krafft-Ebing, 1886/1935, p. 395). For the early sexologists sexual inversion was connected to androgyny, with Ellis (1927) arguing that in the homosexual individual development had not advanced in the normal way and that homosexual people were in an androgynous state. However, unlike Bem’s (1993) notion of androgyny, the androgyny of the sexologists’ female invert manifested purely in the expression of manly behaviours and traits. Ellis also suggested that this deviation of development led to both male and female inverts being unable to feel normal emotional desires towards the opposite sex. Despite this, however, Ellis popularised the notion of homosexuality being an inversion and an in-born non-pathological biological gender anomaly and therefore neither immoral or a disease. In sum, therefore, the early sexologists offered an essentialist theory of homosexuality based on case studies that posited that homosexuality was innate and natural.
Whilst Krafft-Ebing and Ellis held to essentialist theories of homosexuality, other scientists held differing opinions with respect to its aetiology, holding to the idea that homosexuality is not innate but acquired. Freud (1905/1962) viewed homosexuality as being the result of non-normative psychosexual development; as such it was socially and psychologically developed, a result of experience and interaction with parents and significant others. Normal development would lead to a heterosexual orientation; whilst non-normative development to a homosexual orientation. However, development towards either heterosexuality or homosexuality was from a bisexual standpoint in that Freud posited that people were innately bisexual with the potential to develop into either sexual orientation (Freud, 1920/1955). Freud (1905/1962) acknowledged a difference between perversion and inversion, categorising homosexuality as an inversion and so he did not view having a homosexual orientation as being pathological (Freud, 1905/1962). Freud’s 1905 work is where he set out his understanding of homosexuality and is focused on male homosexuality. In respect of female homosexuality, his main engagement in this regard is in *The Psychogenesis of a Case of Homosexuality in a Woman* (1920) where he develops and modifies his original theoretical account of homosexuality. Here, based on a single case study, Freud posits that the homosexual woman is neither ill nor suffering from any neuroticisms.

### 2.10.2 Pathologising & Curing

Whilst Freud did not believe that homosexuality was pathological this was not the position of other, later, psychoanalysts. In *Psychogenesis* Freud expresses scepticism in respect of whether there is a possibility of curing homosexuality however later analysts took much more pathologising and pejorative positions and sought to cure their patients. For example, neo-Freudians such as Melanie Klein (O’Connor & Ryan, 1993) refused to consider that same-sex sexual relationships (whether between men or women) could be happy and fulfilling, suggesting that the achievement of heterosexuality can be considered as the end goal of therapy, as at this stage the patient is cured of any pathology. Whilst Helene Deutsch, initially faithful to Freud’s ideas regarding the non-pathology of homosexuality, subsequently labelled female homosexuality as a “pathologic distortion” (O’Connor & Ryan, 1993, p.72). More recent, mid-20th century, psychoanalysts have also adhered to a pathologising stance. Masud Khan posited the view that female homosexuality was perverse and a result of unresolved pre-oedipal conflicts and a need to remain identified with the mother’s body; that is, female homosexuality is a defence against loss and abandonment of the mother figure.
Based on this notion, Khan argued that successful analysis would allow for normal development to resume and heterosexuality achieved; subsequently the female homosexual can be cured via therapy (O’Connor & Ryan, 1993).

Psychoanalysis, however, presents just one approach to pathology and cure. The historical position of psychology as a discipline is one in which homosexuality was considered as a mental illness. In the first edition of the *Diagnostic and Statistical Manual: Mental Disorders* (DSM – I) published in 1952 homosexuality was listed as a sociopathic personality disturbance, whilst in 1968 it was re-classified as a sexual deviancy rather than a personality disturbance in DSM – II. Being listed in the DSM positioned homosexuality as pathological. This positioning allowed for a medical model of homosexuality to be pursued such that homosexuality was a mental illness and the appropriate role of psychological and psychiatric research was to understand what caused it and potentially seek out ways that the illness could be cured. Between the 1950s and 1970s, therefore, psychological research positioned the subject, lesbians and gay men, as sick, abnormal, and deviant; whilst the object of the research was to seek out the reasons why. Morin (1977) noted that much of the research between 1967 and 1974 examined three questions: 1) Are homosexuals sick? 2) How can homosexuality be diagnosed? and 3) What causes homosexuality?

Despite Freud’s original position that homosexuality was not an illness, subsequent pathological positioning by the psy disciplines across the board led to many psy practitioners attempting treatment of LGB people in an endeavour to convert them to heterosexuality. These therapeutic attempts to change people’s sexual orientation were called reparative therapies which came to the fore in the 1950s and 60s. Reparative therapy was premised on the dual notion that homosexuality is both pathological and changeable; that is homosexuality is an illness that can be cured. Various different approaches to therapy were used from psychoanalysis, behaviourist based treatments such as aversion therapy utilising electric shocks along with homosexual stimuli, hormone based treatments, castration and clitoridectomy, and lobotomy (Clarke, Ellis, Peel & Riggs, 2010). Reparative therapies undertaken in the 1950s and 60s occurred at a time when homosexuality was considered a mental disorder, and for gay men a criminal activity, and so there is some merit in an argument that therapists who provided reparative treatments were endeavouring to assist their clients in becoming happy, healthy human beings. Further, for the lesbian or gay individual life in the mid-20th century would have been extremely difficult with no positive role models and derogatory representations in the media (Smith, Bartlett & King, 2004). Indeed, from an
historical perspective reparative therapy is appropriately named, in that the therapies on offer were seeking to repair an individual who was considered by society as being sick (Riggs, 2004a). However, despite changes to the pathological positioning of homosexuality reparative therapy, or more appropriately conversion therapy, still persist.

2.10.3 Paradigm Shift

In 1974 homosexuality was removed from DSM – III. This move was precipitated by both the changing social climate as well as by pioneering psychological research. First, Hooker (1958), using the same projective tests previously utilised to establish whether men were homosexual or not, found no differences in response between gay men and heterosexual men. Following Hooker, other psychologists established that lesbians and gay men had similar levels of psychological adjustment and self-esteem as heterosexual individuals (Thompson, McCandless & Strickland, 1971). Following DSM removal there was a paradigm shift in how homosexuality was positioned, moving away from being considered as an illness towards that of being considered as having to cope with a stigma. This change in position also brought with it changes in research focus with new questions being explored.

Looking at the number and type of paper published pre and post de-classification it is clear that prior to de-classification the main focus was on diagnosis of, cause of, and adjustment away from homosexuality. In other words: who has it, what caused it, and how can we cure it. Whilst, post de-classification rather than focus on finding a cure, research starts to explore more affirmative topics such as lesbian and gay parenting and the stigma of life as a homosexual in a heterosexual environment. Another area of research that expanded post de-classification was in looking at the causes of prejudice against lesbians and gay men (Morin, 1977; Watters, 1986). Watters (1986) reported that by the mid-1980s 75% of research became focused on either special topics unique to the lesbian or gay population (56%) or on attitudes towards homosexuality (19%). Lesbian, gay, bisexual and transgender affirmative research has continued to grow, however this research is still specialised rather than mainstream. Lee and Crawford (2007) examined published research between 1975 and 2001 and discovered that non-heterosexual people were included in only 1% of research. Whilst Allen and Demo (1995) looked specifically at family based research and found that less than 1% of published research included non-heterosexual people in their research sample. It is clear that the removal of homosexuality from the DSM has led to a change in the way lesbians and gay men are viewed by psychological research, with a shift in focus away from
psycho-pathologizing, and a move towards affirmation of the lesbian or gay individual. However, the literature reviews indicate that this arena of research is still a minority.

Looking specifically at women, it is worth noting that most of the published LGB research has focused on men rather than women, with lesbians and bisexual women being significantly less likely to be studied than gay or bisexual men (Lee & Crawford, 2007). This is a position which has not changed significantly; a more recent update by Lee and Crawford (2012) examined the period 1975 to 2009 and found that less than 2% of all publications engaged with a lesbian and/or gay population. In both studies an increase of publications were found that coincided with the HIV/AIDS crisis; however, Lee and Crawford (2012) noted that the rate of increase now appears to have stalled and in fact there would appear to be a decline in in publications since 2000. This latest study also confirms the disparity of treatment between lesbians and gay men previously found within the research base, such that gay men are still more likely to be the target of research than lesbians. This continued disparity of research focus lends support to the notion of men, *per se*, being the normative category, even when linked to sexuality research.

### 2.10.4 Development of homosexual identity

One area of research that developed immediately post de-classification from the DSM-III was an attempt to establish a theory of homosexual identity development. Early theories in this regard were stage theories, and similar to developmental stage theories, they posited a progression through a number of stages, such as the model posited by Cass (1979), arguing that homosexual identity development moves along a continuum. Generally starting with a state of identity confusion about sexuality the individual moves linearly toward the final stage of achieving an integrated identity. At the final stage, Identity Synthesis, the individual has a fully developed sense of their lesbian or gay identity, which is seen as important. However, rather than sexual identity being all important, the individual recognises their lesbian or gay identity as being just another part of the self along with other aspects and identities (Cass, 1979). In sum, the individual integrates their lesbian or gay identity into the multiplicity of identities to which they may subscribe. Overall, stage theories posit that an individual’s lesbian or gay identity develops along a linear trajectory.

The Cass Model has been examined in respect of lesbian identity development. Research by Jordan and Deluty (1998) utilised the Cass framework in their examination of the coming out process for lesbians in relation to anxiety, positive affect, self-esteem and social support. The study hypothesized that disclosure of sexual orientation would be positively
related to issues of self-esteem, positive affect, better social support and greater involvement with the lesbian community; whilst being negatively related to high levels of anxiety. The findings indicated support for the predictions in that the more widely a woman disclosed her sexual orientation the lower her self-report anxiety and the higher her levels of self-esteem and positive affect. Overall, Jordan and Deluty argue that the findings lend support to the Cass model.

However, general stage models of homosexual identity development have been criticised. Criticism has often been in respect of their male bias and the applicability to lesbians, the rigid linear nature of the stages and assumptions of fixedness of sexuality, and assumptions of essentialism. With the exception of Cass (1979), many stage models, Troiden (1979) for example, have been entirely male oriented but often assume that lesbian and gay identities follow an identical pattern, whilst having nothing to say with regard to bisexuality. When she tested her model, Cass (1984) acknowledged differences in female and male identity development, however due to low cell numbers she was unable to make statistical comparison and so conflated all data together and provided an overall account of general homosexual identity development. However, it can be argued that there will be differences in identity development for lesbians and gay men, not least due to the inequalities which exist between women and men in society (Markowe, 2002a). And second, the essentiality and fixedness of the linear stage model is not flexible enough to acknowledge the fluid nature of female sexuality (Kitzinger, 1987; Kitzinger & Wilkinson, 1995; Minton 1997; Rust, 1993).

2.10.5 Coming-out

A significant arena for LGB research is in respect of coming out and the associated family response to disclosure. “Coming out” is the process of acknowledging one’s non-heterosexual sexual orientation, firstly to oneself and then to others, has been identified by many researchers as key to becoming a balanced and well-adjusted individual (Jordan & Deluty, 1998; Markowe, 2002b). Hiding one’s homosexual sexual orientation can be a stressful experience and has been identified as a contributing variable of minority stress (Meyer, 2003). Focused research has reported that a positive lesbian or gay identity and greater self-disclosure are associated with better mental health. A positive lesbian or gay identity has been related to better psychological adjustment with those holding a positive identity having fewer neurotic anxiety symptoms. Further, homosexual individuals who have a positive identity, identify more frequently with a lesbian and gay label than those who hold a more negative identity (Miranda & Storms, 1989).
The coming out process itself can bring with it a degree of risk, particularly with respect to the individual’s family of origin. Disclosure of a lesbian or gay identity is risk laden as it may be the catalyst for family crisis. The extent of which can range from a minor family disturbance on the one hand, to a more extreme position of rejection by one’s family of origin on the other (Gramling, Carr & McCain, 2000). It is therefore not surprising that a parent is generally not the first person that an LGB youth discloses their sexuality to, generally confiding in a close friend initially, followed by a sibling, before disclosing to a parent. When parents are confided in there is generally more openness with mothers compared with fathers, with more mothers aware of their child’s homosexual sexuality than fathers. When disclosing sexuality, mothers are the parent most likely to be told first, usually directly, whilst fathers generally learned of their child’s sexuality via an indirect approach. This difference in coming out to mothers and fathers stems from a belief that mothers will be more supportive and understanding than fathers (Savin-Williams, 1998).

Given the potential for family crisis a significant amount of research focuses upon the impact of coming out to family as well as to parental reactions to a child coming out (Peplau & Beals, 2004). Parental reaction to their child coming out is often negative (Cohen & Savin-Williams, 1996), however this negativity often improves over time (Patterson, 2000). Greater negative reactions are more likely to be forthcoming from older parents, those who are less well educated, and those whose pre-disclosure parent-child relationships were troubled (Cohen & Savin-Williams, 1996). Given the significance of parent-child relationships parental acceptance has been found to be positively linked to a favourable self-image for young lesbians (Savin-Williams, 1998; 2005). When someone does come out Strommen (1998a; 1998b) suggests the family reaction to the news is suggestive of a two-stage process. Initially the family struggle to understand and assimilate the news. Once assimilated the family may either reject the gay family member, or reorganise itself to accommodate the new information, eventually re-including the gay person in family activities. Parents particularly may find this reorganisation process difficult and so this may be a lengthy process, if it is achieved at all. Integral to the parental reorganisation processes are worries and concerns for their children, rooted in the possibly limited knowledge available to them. Parental knowledge of homosexuality and lesbian and gay lifestyles may well be based around myths, stereotypes, and popular anecdotes that circulate within the culture rather than actual knowledge.
Despite the potential pitfalls of coming out to family, US research suggests that young people are more likely to come out as having an LGB identity (Savin-Williams, 2005), and to do so at a younger age (Maguen, Floyd, Bakeman & Armistead, 2002) than has previously been the norm. Clarke et al., (2010) suggest that this may be due to a more positive social climate for LGB people and a greater exposure to positive LGB sexualities. This youthful trend in coming out must be tempered by the point that much of the research that examines coming out issues does so with a young population sample. However “cohort effects”, that is the political and economic experiences that separate generations, have a considerable impact in this arena as people’s lives are shaped by the societal climate in which they are socialised. As a result, individuals who grew up prior to de-criminalisation when homosexuality was pathologised may have never come out to their families, instead choosing to live their lives in secrecy (Pugh, 2002). Indeed, a smaller corpus of research has previously found that older lesbians and gay men have not come out to parents or other members of their families (Brown, 1989). It is only with de-criminalisation, and the advent of the women’s movement and gay liberation movements in the 1960s that afforded a more open way of living (Heaphy & Yip, 2003).

Despite the positive aspects of coming out, it must be noted that coming out to family and friends is still not always possible or safe. For Muslim LBT women coming out may bring with it family rejection, pressure to get married and domestic violence. Further, for those who are financially dependent upon their families of origin coming out may bring with it problems with housing, education and employment (Clarke, et al. 2010). The issues here are particularly pertinent to the younger LGBT person. Not everyone can or does come out as a youth and those who come out when older may face different, less researched issues.

2.10.6 Minority Stress

As indicated above, where previously, under the disease model of homosexuality, LGB people’s mental distress had been accounted for due to their having a mental illness, that of homosexuality, which was considered to be the direct cause of a homosexual individual’s mental distress. Under the stigma model, any mental distress suffered is as a result of suffering from minority stress. As defined by Brooks (1981), minority stress is psychosocial stress that manifests as a result of an individual’s minority status. In other words, minority stress is the stress that members of stigmatised minority groups experience as a result of their minority group membership; and it stems from stigma, prejudice and discrimination; all of which combine to create a stressful social environment for a minority group member (Meyer,
The key component of minority stress is the “stressor” and the need to cope with it. Generally, stressors are considered to be events in an individual’s life that have to be coped with; however minority stress is social stress. Social stress is when aspects of the social environment, such as prejudice, act as a stressor. Minority stress, therefore, is a specific form of social stress that results from the dissonance between an individual’s minority sexual orientation and the prevailing values and norms of the sexual majority (Meyer, 2003).

The Minority Stress Model posits that stigma, prejudice and discrimination combine to create a hostile and stressful environment that causes mental distress to minority group members. The model is inferred from a number of sociological and social psychological theories, such as Durkheim’s (1897; reprinted in Shneidman, 2001) theory of anomie, Allport’s (1954/1992) writings on prejudice, Goffman’s (1963/1990) ideas about stigmatised identities, the symbolic interactionism of Cooley (1922; cited in Collier, Minton & Reynolds, 1991), Tajfel and Turner’s (1986/2004) Social Identity Theory (SIT), and Turner’s (1999) Self Categorization Theory (SCT). In sum, minority stress theory utilises symbolic interactionism and social comparison approaches which suggest that people derive meaning from their social environment and social interactions, a process that drives subsequent behaviour. Individuals learn about themselves through their interactions with their social and environment and other people, developing their sense of self as a result. For the minority individual this “looking glass self” process (Cooley, 1922; cited in Collier at al., 1991) also includes discovering and internalizing negative stereotypes and prejudice (Allport, 1954/1992) and so negative regard from others leads to negative regard for the self. Minority stress theory also posits that minority individuals are isolated from the dominant culture and any resources or social support situated therein which results in anomie, or normlessness, stemming from cultural isolation and alienation (Durkheim, 1897; reprinted in Shneidman, 2001). This position of anomie is exacerbated by the processes of SIT (Tajfel & Turner, 1986/2004) and SCT (Turner, 1999). These theories suggest that people generate their social identities from group membership, from which they receive support (SIT), however the processes of categorisation (SCT) leads to the intergroup processes of competition and discrimination, thus intensifying any pre-existing antagonism between the sexual minority individual and the sexual majority individual.

Meyer (2003) indicated three key assumptions that underpin minority stress; that it is unique, chronic, and socially based. It is unique in that because the effects are in addition to the general stressors experienced by everyone, stigmatised and non-stigmatised alike, the
minority individual needs to make additional effort compared with the non-stigmatised individual in order to cope with this extra stressor. It is chronic in that it is derived from long-term and stable underlying social and cultural structures such as the discourse of heterosexism. Finally, it is socially based, in that it originates from social processes, institutions and structures. Being social in origin it is created by both interaction with members of the majority, heterosexual, group and from interaction with external heteronormative institutions and social structures. As such, there is a potential to encounter minority stress from everyday living for the sexual minority individual.

In addition to the three core assumptions, Meyer (1995) indicated three processes to the minority stress model pertinent to LGB individuals; 1) external, objective stressful events and conditions, such as prejudice, discrimination and homophobic events appertaining to sexual minority status, 2) the expectation that these events are likely to happen and therefore the need to be vigilant against this expectation, and 3) the internalisation of negative societal attitudes towards lesbians and gay men, that is internalised homophobia. Added to these three stress processes is the further stress process of the need to conceal, or hide, a non-normative sexual orientation; a position that negates any ameliorating benefits that being open about one’s sexual orientation brings. Further, concealing one’s minority sexual orientation is, often at times, adopted as a coping strategy as a means to avoid the processes of one and two above (Meyer, 2003). Essentially, Meyer posits that the experience of prejudice, the expectation of rejection (due to having a minority stigmatised sexual orientation), the hiding and concealing of sexual orientation in order to avoid prejudice and rejection, the internalising of homophobia (that is the internalising of anti-gay attitudes which are then directed towards the self), and the loss of any ameliorating benefits that being out brings when sexual identity is concealed, all combine, in varying degrees, to create a hostile, stressful, environment that can cause mental distress.

2.10.7 Same-sex relationships

Also examined are perceptions of social support and same-sex relationship support. Doctoral research by Aura (1985; cited in Peplau, 1991) found that both lesbian and heterosexual women held similar values regarding social support, however the women received their support from different sources with lesbians relying less on family support compared with heterosexual women and more upon different support from partners and friends. The idea that lesbians and gay men are more reliant upon partners and friends than kin within their social network for support, compared to their heterosexual counterparts, has
been theorised by Boyd and Bee (2006) as being due to family of origin disapproval of their sexual orientation. However, lesbian and gay individuals, and same-sex couples, are rarely completely estranged from their families of origin; potentially difficult and stressful relationships with their families of origin notwithstanding (Laird, 1998; Weston, 1991). Laird and Green (1996; cited in Rostosky, Korfhage, Duhigg, Stern, Bennett & Riggle, 2004) suggest that same-sex relationships rarely receive unequivocal support from families of origin when initially disclosed, however family of origin disapproval of a homosexual orientation can change over time moving form disapproval to ambivalence and acceptance towards positions of support (LaSala, 2002).

2.10.8 Consequences of this research position

A common stereotype of lesbians and gay men is that they are not engaged in family life; instead their lives are thought to be lived outside of the family circle. These stereotypical ideas render the notion of lesbian and gay couples as family and the idea of lesbian and gay parenthood as nonsensical (Patterson, 1994). Further, this stereotypical positioning has often been mirrored in research when lesbians and gay men have been positioned as individuals first and foremost rather than as part of their families of origin. Affirmative research that examines same-sex couple relationships does go some way towards re-casting the same-sex relationship as an alternative relationship model, whilst lesbian and gay parenting research has provided clear and much needed support in terms of the law and legislation for lesbian and gay led families. Despite this affirmative research, the focus purely on the lesbian or gay individual and their partner or child continues to marginalise homosexual people who are still apart from their biological families. As Patterson (1994) has indicated any family with lesbian or gay family members can be considered a lesbian or gay family; however apart from the coming out research there is limited focus on lesbian or gay people’s interactions with their families of origin post coming out and how having a non-heterosexual sexual identity may affect family relationships (Allen & Demo, 1995).

2.11 Heterosexual perceptions

Research looking at heterosexual perceptions of LGBT people has engaged with the beliefs that heterosexual people hold about homosexual people. These perceptions include stereotypical beliefs about lesbians and gay men, as well as attitudes and prejudice towards lesbians and gay men. Taking stereotype research first, a considerable amount of research
has, in the main, focused on the stereotypes of gay men (see as example Fingerhut & Peplau, 2006). A much more limited body of work looks at stereotypes of lesbians (see as example Brambilla, Carnaghi & Ravenna, 2011), and male and female homosexual stereotypes together (Kite & Deaux, 1987); a pattern which, in the main, holds true for attitude and prejudice research (see as example Herek, 2000). Given the extant research position and the thesis focus, the work examined in this section focuses first on perceptions of homosexual people generally along with gay men, followed by work that bears specific relation to perceptions of lesbians.

2.11.1 Stereotypes

From a social cognition perspective stereotypes, along with other theoretical mental structures such as attitudes, are mental representations of social groups and their members (Fiske, 1998). Stereotypes, act as a form of schemata, to allow cognitive resources to be utilised to best effect in the processes of encoding and retrieving information from memory. In sum they are cognitive representations that allow heuristic thinking; that is they act as a template to guide thinking and so allow for quick social categorisation based on salient but generalised features of group members without having to assess people on an individual basis (Augoustinos & Walker, 1998). Stereotypes are formed via social interaction in that they are constructed intersubjectively and shared by society (Augoustinos, Walker & Donaghue, 2006). Stereotypes can also be defined as social representations, in that they are cognitive, affective, and symbolic representations of social groups that circulate within society (Moscovici, 1984; 1988). Whilst from a discursive position, the construct known as a stereotype is not so much a cognitive tool, but rather a situated discursive practice (Edwards, 1991) whereby social categories are actively constructed in the course of interaction (Wetherell & Potter, 1992).

2.11.1.1 General lesbian and gay stereotypes

Cultural representations, or social representations, of lesbians and gay men are readily available within society. Many of these representations paint pictures of lesbians as being butch and masculine, with gay men as being effeminate. Indeed, early stereotype research found support for these cultural representations, indicating that widely held beliefs about lesbians and gay men were that they present gender inappropriate characteristics (Levitt & Klassen, 1974; MacDonald & Games, 1974). In sum, stereotypes about lesbians and gay men
conform to a generalised gender belief system that maintains a masculine-feminine dichotomy, such that lesbians are considered to be more masculine than heterosexual women.

2.11.1.2 Lesbian stereotype research

Research purely on lesbian stereotypes is limited, however the research that has looked at lesbian stereotypes has generally subscribed to gender inversion theory (Kite & Deaux, 1987); such that lesbians are considered as not very feminine, lacking in maternal instincts and displaying typically male behaviours and habits. Further, lesbians as a general category are viewed as competent but not warm due to their being perceived as similar to heterosexual men (Fiske, Cuddy, Glick & Xu, 2002).

Stereotypes, being a representation or schema of a category of person, are implicated in an individual’s attitudes toward a group, with negative stereotypes having the potential to contribute toward prejudice toward a group. Early research by Laner and Laner (1980) into the likeableness of lesbians and non-lesbians based on descriptions that fell along a masculine-feminine continuum found that non-lesbians were liked better than lesbians, and that lesbians described as butch were more disliked than those described as feminine. Whilst research into the lesbian stereotypes held by female nursing students included lesbian seduction of heterosexual women, lesbian boasting or preaching about their lifestyles, as well as lesbians wishing to be men (Eliason, Donelan & Randall, 1992).

More recent research into lesbian stereotypes has revealed more diverse and complex lesbian stereotype representations, however a consistent finding in this recent work has been the category of masculine (or butch) lesbian (Brambilla et al., 2011; Geiger, Harwood & Hummert, 2006). The work of Brambilla et al., (2011) identified four categories of lesbian stereotype; however, similar to Fiske et al., (2002), three of these categories (butch lesbians included) were judged to be more competent than warm. Given the persistence of the gender inversion perception of lesbians, these gender based stereotypes may work towards positioning lesbians as less likely to be engaged in female gendered and tasked activities such as caregiving as they are perceived as being less competent in female gendered activities.

2.11.2 Attitudes & Prejudice

Stereotypes of lesbians and gay men are implicated in negative attitudes and in turn negative attitudes drive prejudice. Prejudice, or pre-judgement, are pre-conceived judgements, generally unfavourable, about someone grounded upon pejorative attitudes and beliefs that are grounded in stereotypes. In his canonical text, Allport (1954/1992) linked
prejudice to categorical, or heuristic, thinking suggesting that people are predisposed to being prejudiced as a result of the way they think, for example in the use of stereotypes as short cuts when thinking about people. Discrimination is prejudice in action as it is the treating of members of particular social groups in a prejudiced way based purely on their group membership. Examples of discrimination are against women, or sexism, discrimination on the grounds of ethnicity, or racism, and discrimination on the ground of sexuality, or sexual prejudice more commonly known as homophobia: all are forms of prejudice.

The term homophobia was initially coined by Smith (1971). Weinberg (1972; cited in Herek, 2004) quickly followed, defining homophobia from a heterosexual position as being a fear of homosexuals, whilst from a homosexual position it could be considered as self-loathing. Weinberg also indicated that homophobia was also a form of prejudice directed at homosexual individuals which he classified as the “phobia in operation” (Weinberg, 1972; cited in Herek, 2004, p.8). This conceptualisation of homophobia as prejudice against the homosexual individual situated the problem to be explained as being within the heterosexual individual. This positioning resulted in a research program that explored the aetiology of homophobic prejudice with a view to uncovering the correlates of homophobia, which in turn has led to the development of prejudice reducing interventions (Herek, 2004). This focus was diametrically opposite to the historical position, prior to homosexuality being removed from the DSM, where the object of research was the aetiology of homosexuality with a view to seeking a cure.

Early homophobia research subscribed to the attitude research framework with a number of scales being developed to measure anti-gay, or homophobic, attitudes. Examples of these scales are Smith (1971), Larson, Reed and Hoffman (1980) and Kite and Deaux (1986). A widely used scale being Herek’s (1984) Attitudes to Lesbians and Gay Men Scale, a landmark in homophobic attitude scales in that with the use of sub-scales for lesbians and gay men it allowed comparison of attitudes towards lesbians and gay men. Developing this avenue of research further, the predictors of homophobia have also been examined. A consistent finding in this body of research is that homophobia is more common in men, those with conservative religious or political views, and those who have not had (known) contact with lesbians or gay men (D’Augelli, 1989). By identifying the predictors of homophobia it is possible to identify those who are most likely to be homophobic and so develop targeted interventions (Harding & Peel, 2007; Peel, 2002).
Protection within the law helps to create an anti-discriminatory social climate where it is less acceptable for people to be overtly homophobic. Since 2000 there has been a considerable amount of legal changes that prohibit discrimination on the grounds of sexuality both in the UK and many other Western nations. For example the recent Equality Act (2010) in the UK affords protection against discrimination on the grounds of sexual orientation by businesses and public services. However, some LG (and BT) people can still find themselves excluded from social institutions. The UK has legislated in favour of same-sex marriage, however same-sex marriage cannot take place within the Church of England; and, due to an amendment of the Equality Act (2010), Ministers of other religions can refuse to perform same-sex marriages without fear of prosecution. In the USA access to same-sex marriage differs between States. Currently same-sex couples can marry in thirty-five out of the fifty States. Generally, however, within Western countries LGB and T people have some level of equality and protection within the law. Whilst the apparent reduction of overt homophobia is to be applauded this does not mean that homophobia has been eradicated. Ironically, anti-discriminatory changes in the social climate have led to research participants modifying their responses when discussing their attitudes in order to avoid being seen to make negative assertions (Maison, 1995). Given this type of behaviour change, driven by changing societal norms, studies on homophobia that utilise self-report are at risk of floor effects, evidencing little or no homophobia. To combat this position more subtle scales have been developed such as Morrison and Morrison’s (2002) Modern Homonegativity Scale. In this scale participants are asked whether lesbians and gay men have been given too many rights or whether they have sought too much equality rather than asking more direct questions in respect of participant attitudes towards lesbians and gay men.

The concept of homophobia has not been without criticism with a number of issues surrounding the term. First, Herek (2004) posits the term itself to be problematic. Of minor issue is the prefix homo, which can be defined as either “man” (from Latin) or “same” (from Greek). It is the suffix phobia however, with which there is more at issue in terms of mental distress and anxiety. This is because a phobia is an anxiety disorder where the sufferer has an intense fear of specific objects. And, whilst those who are homophobic may well possess such a fear the more usual negative emotions that are to be found are anger and disgust (Herek, 2004). Further, the term homophobia, and indeed homosexuality also, in its use is narrow, often being used to mean and refer to gay men only. Often, research that seeks to examine homophobic attitudes using the term “homosexual” can be interpreted as referring to
men only (Herek, 2004). This is a position which elides lesbians as well as other non-heterosexuals rendering them invisible. This androcentric usage is in fact reflective of Weinberg’s initial conceptualisation in which he indicates the consequences of homophobia in relation to male gender norms (Weinberg, 1971, cited in Herek, 2004). Finally, the focus on the psychological leaves little room to consider wider social and political issues. Lesbian feminist psychologists have criticised homophobia as being individualistic in that it reduces sexuality prejudice to the individual (Kitzinger, 1999). In other words, if the locus of homophobia is situated within the individual, in effect homophobic prejudice is a part of their personality. Situated on a personal level, institutional, or cultural, homophobia remains unacknowledged and unattended. In sum, whilst the individual approach does allow for attitude measurement and the development of targeted intervention, this personal positioning of prejudice does not acknowledge how homophobic attitudes can reflect homophobic prejudices that are woven into the fabric of society (Clarke et al., 2010).

Concurrent to the development of homophobia as a concept, the term heterosexism also began to circulate (Herek, 2004). A more inclusive term, heterosexism can be considered as an ideology that perpetuates the stigmatised position of sexual minority people (Herek, 1990; 2004; Herek & McLemore, 2013). Heterosexism is more encompassing than homophobia as it acknowledges prejudice as being directed against all non-heterosexuals and recognises the social marginalisation of LGBT people (Herek, 1990). Heterosexism manifests in two ways: cultural and psychological. Cultural heterosexism, or institutionalized homophobia, is inherent in social custom, social institutions, education, the legal system, the health system and so on. Heterosexism is a heterosexual bias in society that privileges heterosexual experience and heterosexuality over sexual minorities’ experience (Clarke et al., 2010; Herek, 1990). Psychological heterosexism is anti LGBT attitudes and behaviour that may be more commonly understood as homophobia (Clarke et al., 2010).

Heterosexism shares some of the same predictors as racism and sexism (Herek, 1984); however there are unique differences. Heterosexism is more complex in that there is no equivalent to homophobia, as defined by Weinberg (1971; cited in Herek, 2004) and being the fear of homosexuals based upon a fear of being gay or becoming gay, within racism or sexism (Young-Bruehl, 1996). Further, homosexuality carries courtesy stigma, that is the stigma that attaches to those who associate with homosexual people and which affects friends and families of lesbians and gay men (Goffman, 1963/1990), again without equivalence in racism or sexism (Herek & Capitanio, 1999). Finally, religious based heterosexism has no racial or
sexist counterpart, as race and gender are not categorised by religions as being immoral life choices whilst homosexuality is (Barton, 2012). Heterosexism can therefore be considered as categorically different from racism and sexism, as such the lived experiences of sexual minority people will also differ. Further, given these differences it can also be expected that there will be differences in experience at the various intersections of gender, race, and sexuality.

Closely related to heterosexism and grounded in the ideas of Rich (1980), Rubin (1984/1993) and Wittig (1992) is the concept of heteronormativity. In essence a form of heterosexual ideology (Warner, 1991) in that society itself is heterosexually oriented (Wittig, 1992), heteronormativity is the social production and reinforcement of beliefs about sexuality within social institutions, government policies, and social and cultural practices (Clarke et al., 2010). Heteronormative beliefs and presumptions hold to the notion that there are only two sexes; that normal, natural, sex is what takes place between a heterosexual couple; that marriage is for opposite sexed people; and subsequently that the family is the heterosexual couple and their children (Kitzinger, 2005). Heteronormativity is produced by institutionalised heterosexuality: that is culturally produced heterosexuality. In other words heteronormativity culturally situates heterosexuality as normative and natural; a position that simultaneously reinforces heterosexual male privilege and subordinates other forms of sexuality (Rich, 1980). In sum, heteronormativity privileges heterosexuality as normal, natural, taken for granted, and therefore unquestioned.

The privileging of heteronormative beliefs has a marginalising effect on all those who do not comply. Heteronormativity, therefore, is very much a social norm that can be evidenced in the way people behave and communicate with each other (Kitzinger, 2005). Heteronormativity is clearly evident in the assumptions surrounding who can be considered in family roles. For example, the roles of “husband” and “wife” are constructed by heteronormativity to be purely for men and women respectively; such that lesbian women stating themselves to be partnered are assumed to have husbands unless they explicitly state otherwise (Land & Kitzinger, 2005). The heteronormative assumptions that surround family roles are also extended to gendered expectations of behaviours in those roles, such that wives and daughters are considered as heterosexual and engage in the gendered behaviours expected of those roles, such as familial caregiving. Lesbian and other non-heterosexual women engaged in familial caregiving are doing so in a heteronormatively charged environment
which assumes their heterosexual compliance and commonality of heterosexual experience without question.

### 2.12 LGBT involvement with family of origin

From a research perspective, lesbians and gay men have been positioned as individuals first and foremost rather than as part of the family. When family of origin relationships are examined it is usually in the context of young people coming out (Savin-Williams, 2005). However, family of origin relationships are not just about the coming out process, more needs to be known about the everyday lives, kinship, and culture of lesbian and gay lives; and that includes lesbian and gay relationships with their families of origin beyond the coming out process (Laird, 1998). Looking at the family research perspective, an analysis of research published in high impact peer reviewed family and developmental oriented journals between 1980 and 1993 found only 1% of published papers mentioned lesbians and gay men (Allen & Demo, 1995).

Allen and Demo’s (1995) finding is consistent with the widely held, heteronormative, belief that lesbians and gay men, especially those who are older are isolated from their families of origin. Other commonly held beliefs about this group of people are that they are believed to be depressed (Friend, 1991) and, specifically in relation to lesbian women are unattractive, unemotional and lonely (Berger, 1982). In reality however, research indicates that older lesbians and gay men self-report as psychologically healthy and well adjusted (Deevey, 1990; Dorfman et al., 1995). Despite the positivity of lived reality it is the common cultural representations and inaccurate stereotypes that are available to young lesbian and gay people which present an out lesbian and gay lifestyle as one lived in isolation from their families of origin; further, lesbian and gay sexuality is often constructed as not being connected to family life (Allen & Demo, 1995; Herek, 2007).

The myths and stereotypes that abound often depict a hedonistic LGBT lifestyle that is focused around clubbing, partying and pride parades where those middle aged and beyond are not often found (Pugh, 2002). Moreover, these lifestyle images are often situated away from home in the urban anonymous landscape of cities, and centred around “gay villages”. Other stereotypes position older lesbians and gay men as being lonely, isolated, and miserable (Peplau, 1991; Clarke et al., 2010). If the lesbian and gay individual has had little contact with other lesbians or gay men they themselves may well hold some belief in these notions. It can be surmised, therefore, that it is from these myths and stereotypes that young lesbian and
gay people will articulate their expectations about their future out lifestyle, particularly so as there are no clear rules or norms that tell them how to live a lesbian or gay life.

2.13.2 What do we know about family of origin involvement?

Laird (1998) examined lesbian family of origin narratives interviewing 19 lesbians (aged 26-68) and found that despite the popular myth that paints a picture of a lack of connectedness to their families of origin the women interviewed were not in fact estranged from their families of origin. The women often chose to maintain familial contact even over long distances. Laird’s (1998) research indicates that despite periods of alienation in some cases, which resonates with the findings of Cohen and Savin-Williams (1996), many women retain complex ties and connections with their families of origin, a finding which has been supported by more recent research by Taylor (2007). Lived experience very often blurs clear cut boundaries and lesbians (and gay men) are involved with and remain part of their families of origin.

Despite the assertion that lesbians are not isolated from their families of origin there is a lack of research that examines the family of origin context of lesbian lives. Following coming out, family of origin relationships are often maintained over time (Laird, 1998) and research that examines same-sex couple relationships and family of origin support suggest that support from one’s family of origin is important in sustaining same-sex couple relationship satisfaction (Oswald, 2002; Solomon, Rothblum & Balsam, 2004; Rostosky et al., 2004). Raphael and Meyer (2000) theorise that over time, as the years pass by, the interaction between lesbian women and their families or origin appears to increase. Indeed, research by Deevey (1990) found evidence of joint living arrangements for older lesbians, their partners, and the elderly parents of one or both partners of the lesbian couple. The limited familial caregiving research aside there is sparse research that focuses on post-disclosure relationships with one’s family of origin over time (Patterson, 2000; Peplau & Beals, 2004; Valentine, Skelton & Butler, 2003).

2.13 Lesbian and gay caregiving

Despite Allan and Demo’s (1995) assertion, there has been some research with respect to caring responsibility and lesbians and gay men; however the main focus of this research has been in relation to childcare where the focus is upon lesbian parenting (Dunne, 2000; Patterson, 1998; Tasker & Golombok, 1998); and in caring for their partners or friends
One area of partner and family of choice caring which has been the focus of much research is in relation to caring for other adults with HIV/AIDS (Turner, Catania & Gagnon, 1994), and to a lesser extent same-sex partner caring (Hash, 2006). Again, this caregiving research base, focused on the individual within a sexual minority community, clearly positions lesbians and gay men as being set apart from their biological family. Conspicuous by absence in this arena is research into how the burden of caring for elderly relatives impacts upon the lives of lesbians and gay men. Taken as a whole, the family caregiving research approach creates a narrow discourse of family caring that elides lesbians and gay men whose sexuality does not fit the prescribed characteristics of a caregiver, whilst the individual approach of LGBT research appears to elide lesbians and gay men carers whose family connectedness does not fit with sexual minority norms.

One US survey examining caregiving by lesbians and gay men suggests that patterns of caring are gendered. Fredriksen (1999) found that more lesbians than gay men had childcare responsibilities and adult care responsibilities for the elderly aged over 65; whereas more gay men had adult care responsibilities for working-age adults, very often those with HIV/AIDS; a finding that may now be different. In this study, lesbian carers of adults were typically aged between 40-49 years, had little education, and were more likely to be partnered than gay male caregivers. There were also differences of caregiver experience between gay men and lesbians and that of heterosexual caregivers with homosexual caregivers providing more hours of care and higher levels of care than heterosexual caregivers. Lesbian and gay caregivers also reported higher levels of caregiver strain and were more likely to give up work due to caregiving responsibilities than their heterosexual peers. Fredriksen’s survey also found that 82% of lesbian and gay men carers reported experiencing harassment (mainly verbal) due to being homosexual.

2.13.1 Parental

The family focused LGB research to date focuses upon issues surrounding LGB caring, in particular the main area of research has been lesbian parenting (Clarke, 2002: 2008; Patterson, 1994; 1998; Ryan-Flood, 2009; Stacey & Biblarz, 2001: Tasker & Golombok, 1998). Such research was prompted by the assumption within the legal arena that lesbians are necessarily poor parents, an assumption that had widespread effects on child custody decisions, adoption decisions, and visitation rights (Patterson, 2006). Prior to the advent of child development research on children with lesbian parents many lesbian mothers lost custody of their children purely on the basis of their sexual orientation (Falk, 1989;
Golombok et al., 2003; Patterson, 1994). And when custody was lost, visiting arrangements were subsequently littered with conditions, particularly in respect of a lesbian mother’s female partner (Tasker, 2002). The initial research focused on children who had been born into heterosexual relationships finding that the children with lesbian parents did not show any greater prevalence for psychological disorder than children from heterosexual homes and there was no evidence of gender identity confusion (Golombok, Spencer & Rutter, 1983). More recent research has focused on children born into lesbian-led families, and again it has been found that these children, like the children born initially into heterosexual relationships, were no different than the children born and raised in heterosexual relationships (Golombok, Tasker, & Murray, 1997; Patterson, 2006). This research has had a significant impact upon legal decision making and has informed public policy with the research literature being cited in APA amicus briefs filed in the US (Patterson, 2006).

2.13.2 Partner

In light of the growing elderly population, a small body of research has examined lesbian and gay aging, including this aging population’s impending care needs. Some of this research does look at family of choice care giving, typically focusing on caring occurring within a same-sex partnership. For example, Hash’s (2006) study of the experiences of midlife and older lesbians and gay men caring for their same-sex partners, indicated unique aspects of the caregiving experience related to their interactions with formal and informal support people and services. These experiences included having to come out with respect to the nature of their same-sex relationship to facing unaccepting family members, friends and co-workers. Participants also reported that medical organisations and other health services did not recognize their same-sex partnerships, refusing to acknowledge their same-sex partners as “next of kin”. As Cohen and Murray (2007) suggest, in US jurisdictions where lesbian and gay partners are considered legal strangers, people who cared for their partner experienced stress related to issues of relationship recognition. Much more recently Valenti and Katz (2014) conducted survey research around same-sex partner caregiving and found similar results. Four key themes were of concern in the more recent research surrounding the need for health care workers to be supportive of LGBTQ issues, recognition of same-sex partners and rights to make decisions as primary caregivers, the need for sensitivity to LGBTQ patients and caregivers, and more open and accepting environments.
2.13.3. HIV/AIDS caregiving

The advent of HIV/AIDS brought with it an increased demand for informal caregivers and so a further strand of research on lesbian carers is in the context of caring for people with HIV/AIDS (Brotman et al., 2007; Fredriksen-Goldsen, 2007; Shippy, Brennan & Cantor, 2007; Turner et al., 1994; Turner & Catania, 1997); this research came to the fore in the late 1980s and early 1990s. For example, survey research by Turner et al., (1994) found that 54% of gay and bisexual men and 33% of lesbian and bisexual women had provided informal caregiving to a friend, partner, or family member with AIDS. Caregivers to people with AIDS are particularly vulnerable to higher rates of mental distress, and bereavement grief (Lennon, Martin & Dean, 1990), and can experience ‘courtesy stigma’ by virtue of their association with HIV/AIDS (Snyder, Omoto, & Crain, 1999). More recently, Wight and colleagues (2002; 2003) found that caregivers who were also HIV-positive suffered greater levels of stress overall. The effects of family support from the care-recipient’s family of origin did little to ameliorated the burden of care (Wight, Aneshensel & LeBlanc, 2003)

Similarly, assistance from families can have the potential to be harmful to gay men trying to cope with AIDS when previous family conflict over homosexuality has a negative impact on coping (Turner, Hays & Coates, 1993). In response to the potential lack of support and possible negativity from family of origin members care teams, buddy systems and community based care arrangements have emerged to offer support for those in need (Adam, 1992; Schneider, 1992). This body of research strongly suggests that the care giving the lesbians and gay men may provide may be undervalued, and even stigmatized because lesbians and gay men, and their relationships and family formations are stigmatized and dismissed.

There are many similarities between traditional caregiving and HIV/AIDS caregiving. Turner et al., (1994) found that HIV/AIDS caregivers had many of the same concerns that traditional caregivers had with respect to avoiding institutionalisation, increased financial problems, the need for social support, along with the negative impact on personal relationships for the caregiver. Turner and Catania (1997) found that, again, like traditional caregiving, the need for caregiving for people with HIV/AIDS is increasing due to the development of treatments for HIV/AIDS. Further, caregivers for people with HIV/AIDS, like traditional caregivers, note positive aspects to the caregiving experience in regard to emotional closeness, personal confidence and strength (Wardlaw, 1994).

However, from a traditional caregiver perspective, HIV/AIDS caregiving may be considered as a non-normative life experience (Hash, 2006, Turner et al., 1994). Normative
life experiences are those that are developmentally expected, that is they are expected to happen at a given age or time of life (Kohli, 1986), whilst non-normative life experiences are those that are not considered as developmentally expected being either out of time or gender role inappropriate (Helson et al., 1984). A key difference between traditional caregiving and HIV/AIDS caregiving is the caregiver/care-receiver dyad, with gay and bisexual men being most often in both the caregiver and care-receiver roles (Turner et al., 1994). Research by Folkman, Chesney and Christopher-Richards (1994) estimated that between 30-40% of men with HIV/AIDS are in committed relationships. Further, many of those providing HIV/AIDS caregiving are under 40 years of age (Turner et al., 1994), this contrasts with the profile of the traditional caregiver to adults and with the familial caregiver experience being considered as normative family stress (Brody, 1985). Turner et al., (1994) argue that caregiving within an HIV/AIDS context is a non-normative experience because of both the age of the caregiver and the caregiver/care-receiver dyad in conjunction with the caregiver engaging in non-traditional sex-role activities, that is personal caregiving tasks and household chores. Research has found that in traditional caregiving men generally provide more assistance with bill payment, transportation and appointment management, whilst women are more likely to provide personal care and undertake household chores (Miller & Cafasso, 1992, and others). Further sources of stress for HIV/AIDS caregivers in the Turner et al., (1994) study can be found in their own HIV status as many were HIV positive themselves and had had the experience of losing many friends to the illness. Finally, engaging in a non-normative lifespan activity can, of itself, be a stressful experience as normative, developmentally expected life experiences are less stressful than non-normative ones (Kohli, 1986).

There is limited research that examines the impact of caregiving on caregivers whose partners have HIV/AIDS, however the study by Folkman et al., (1994) examined the issues that gay men caring for their partners with HIV/AIDS. Folkman et al., (1994) found that 84% of their sample indicated that they helped with household chores, meal preparation and shopping; many also worked full-time. Also reported were issues of psychological distress related to their partner’s illness and the unpredictability of it, having increased responsibilities and greater need to make decisions, their own HIV status, and fears for their future and the future loss of their partner. Role conflict was also reported with regard to demands on their time from working outside the home as well as being their partner’s primary caregiver. Some participants reported financial burden due to reducing their work hours to provide care. Those participants who were HIV positive were also worried about their own future care
needs. With respect to family support, this was often unavailable with the family being either geographically distant or unaccepting of the relationship.

It can be argued that HIV/AIDS caregiving sits outside the traditional, normative, adult caregiving/care-receiving dyad and potential support network, where heterosexual husbands and wives along with adult children are often in the primary caregiver role with auxiliary support from extended family. Instead, within the HIV/AIDS caregiving/care-receiving dyad family of origin support can be limited and negligible (Folkman et al., 1994), however, support may be found from friends within the LGBT community as well as other people with HIV/AIDS (Delgado & Rose, 1994; Hays, Chauncey & Tobey, 1990; Turner & Catania, 1997). For those involved in the HIV/AIDS caregiving they may well be helping more than one person with HIV/AIDS; equally, those with HIV/AIDS may well receive help from more than one caregiving source (Delgado & Rose, 1994; Wardlaw, 1994). This system of caregiving is in contrast to the traditional notion of “primary caregiver” that is found in much traditional caregiver research, however the tasks involved for caregivers in these non-traditional caregiving networks are the same as for more traditional caregivers (Delgado & Rose, 1994; Wardlaw, 1994).

2.13.4 Family of origin

Given continued family of origin involvement it can be expected that LGBT individuals will be involved with familial caregiving. Kimmel (1992) argued that as lesbians and gay men get older they may become involved with familial caregiving due to characteristics that have been considered adpotive to their sexuality, such that they are unmarried (although this position is changing). This unmarried position may be considered as carrying less responsibility, greater potential mobility, and fewer demands on time. A position that might be seen by some to offer more free time and the potential ability to afford joint living arrangements should an elderly parent need this. Looking at the research in this area, survey research has identified that lesbians and gay men are involved with familial caring (Cantor, Brennan & Shippy, 2004; Friedriksen, 1999; Shippy, 2007). Whilst more recent empirical research has examined some of the unique issues that lesbians and gay men face when providing informal care to family members (Price, 2010). This LGBT familial caregiving research base remains limited however, leaving many questions to be answered; not least how caregiving responsibilities are negotiated between heterosexual and homosexual family members.
Much of the research into LGBT caring has been from the perspective of LGBT social work in the US. Survey research by Fredriksen (1999) questioned 1466 gay men and lesbians found that gay men and lesbians are involved with caring for children, friends, partners and parents. Around 33% of participants provided some form of care for an adult or child and 27% provided care for an adult. Focusing on those who cared for adults, 61% were providing care for friends and 13% for their same-sex partner. Many of those who provided care to adults indicated that they did receive support from their family of origin, with only 7% reporting no biological family support. Another survey by Tully (1989) questioned 73 midlife lesbians and found caregiving support was both given and received from family, friends and partners, with formal carer support being of limited personal use. Sixty percent of survey participants felt that professionals were not accepting of lesbian sexuality and did not understand their lesbian relationships and specific sexuality needs.

Focus group research in the US with older adults undertaken by the National Gay and Lesbian Task Force and Pride Senior Network in 2000 indicates that older gay men and lesbians have a potential dual caregiving burden. This potential dual burden is linked to assumptions by their heterosexual siblings of their being unmarried and not having children and so being the most likely and most appropriate candidate to take on parental caregiving should elderly parents be in need of care and support (Hash, 2006). Whilst a small body of research has considered familial caregiving by lesbians and suggests that as lesbian women get older they may find themselves providing informal care and support to their family of origin when elderly relatives become in need of care and support (Raphael & Meyer, 2000; Cayleff, 2008).

Kimmel’s (1992) argument that lesbians and gay men may be particularly likely to become involved in familial caregiving is also supported by the findings of survey research of Cantor, Brennan and Shippy (2004). These researchers found that many LGBT people with family of origin care giving responsibilities reported that their biological family members expected them to take on greater caring responsibilities because they were perceived as single and had fewer family responsibilities. In contrast to the context of HIV/AIDS, and consistent with the gendered pattern of elder care, Fredriksen’s (1999) survey of lesbian and gay carers in the US indicated that lesbians had more responsibility for child care and for elder care than gay men. Lesbian carers of older adults in Fredrickson’s (1999) survey were more likely to be in their forties, have less education, and were significantly more likely to be partnered than gay male caregivers. Similarly, Shippy (2007) found that lesbian and bisexual women were
twice as likely as gay men to be family of origin caregivers and that the relative most likely to be cared for by lesbians and bisexual women was an elderly parent. The women involved in family of origin care giving were also more likely than the men involved with family of origin caregiving to report higher levels of caregiver burden, consistent with the meta-analysis of Pinquart and Sörensen (2006). Consistent with minority stress (Meyer, 2003), the women were also more likely to take time off work to provide caregiving, conceal their sexual orientation when involved in caregiving duties, and report strained relationships with their partners as a result of caregiving. Shippy indicated that around one third of the family of origin caregivers also reported an expectation on behalf of other family members that they take on greater responsibility for caregiving due to their being perceived as not having the immediate family responsibilities of a spouse or children compared with heterosexual family members, often despite having a same-sex partner.

In summary, the current LGBT research on elder care issues is from a social work perspective and focuses mainly on same-sex family of choice and partner caring. Survey research has consistently highlighted involvement of lesbians and gay men in providing care for family of origin members (Cantor et al., 2004; Fredriksen, 1999; Shippy, 2007; Tully, 1989), and has demonstrated that the gendered pattern of parental elder caring seen within the wider literature is also apparent with the LGBT caregiving that has been documented to date (Cantor et al., 2004; Cayleff, 2008; Fredriksen, 1999). However, it must be noted that the vast majority of research that examines caregiver burden or stress resulting from caregiving to adults within LGBT populations focuses exclusively on caregiving in the context of HIV/AIDS.

2.14 Mind the gap – what are the issues?

The small body of research discussed above notwithstanding, there would appear to be no further research which has as a focus lesbians and gay men who have familial elder caring responsibilities. This is despite APA recognition of a need for lesbian and gay affirmative scientific research to re-dress the heterosexist bias that frames much psychological research (Herek et al., 1991). Also, it can be argued, that despite “caring as part of the lived experience of lesbians” (Manthorpe, 2003, p.755) and a recognition that caring in the family is mainly a female experience, the lesbian experience of caring is largely neglected in the research. Indeed, much of the research which is focused upon lesbian and gay issues, or has lesbian and/or gay participant population samples, examine topics such as prejudice,
homophobic attitudes, issues pertaining to coming out, and parenting. Whilst the caregiving research base holds to inherent assumptions that those involved with family caregiving are heterosexual women (Manthorpe, 2003), positing models of caregiving for women that juggle heteronormative family commitment with elder caring (Brody, 1981; 2004). This absence of lesbian research is consistent with the conclusions of Lee and Crawford (2007) whose content analysis of research indexing on PsychInfo over a 27 year period revealed that less than 1% of published psychological research featured lesbians and gay men; and further, that lesbians were less likely to be studied than gay men. This position continues to hold true (Lee & Crawford, 2012).

Whilst the LGBT issues examined are very worthy, conspicuous by absence is research into issues that arise from the burden of elder care responsibility in LGB lives. Particularly with the awareness that the social norms that act as a guide to family life stem from the dominant culture, as a result they are heteronormative in nature and so can be pathologising (D’Augelli, 1994; Herek, 2007). This heteronormative default position means that there is no LGB “road map” available for everyday life. Those who are normatively different need to create new rules to live by where the dominant ones are not particularly useful. As Brown (1989) indicates, being lesbian and gay in a straight world requires normative creativity; that is an ability to generate new rules and norms to guide different ways of being in the world when the norms of the dominant culture are not useful. Research which has lesbian and gay experiences as the central focus will allow for an understanding of how lesbians and gay men create new ways of being and coping. Middle aged and older lesbians have engaged in norm creation, however their narratives are not usually available to younger women. Given this communal lack of knowledge of the lifespan development of some lesbian women it is expected that younger lesbians will have limited notions of how their future out lives may develop, particularly in relation to their family of origin.

The research presented seeks to directly address Brown’s (1989) ideas of normative creativity by focusing upon the lesbian experience of caring. First with an examination of the current construct of the informal carer (Chapter 3) followed by an examination of the impact of elder care responsibility on lesbian lives which highlights how having elder care responsibility impacts upon issues of the self and identity for lesbians (Chapters 4 and 5). The future expectations of younger lesbians lived outness and family of origin involvement is then examined (Chapter 6). Finally general expectations of caregiving and the potential impact of lesbian stereotypes are examined (Chapter 7).
Chapter 3: A genealogy of the informal elder carer concept: Who is the carer and why aren’t they queer?

3.1 Introduction

As examined in detail in Chapter 2, informal care is the support and assistance given to those less able and independent, such as the elderly, by family or friends. Informal care is usually provided either alongside of, or instead of, any formal caregiving arrangements. Care is often provided by many people within the family; however there is usually just one person that takes on the role of primary caregiver. And, when considering familial caregiving to the elderly, the primary caregiver role is disproportionately undertaken by related women, either a wife, partner, daughter, or daughter-in-law. This gendered distribution into the carer role is reflected in the current findings of government censuses and surveys, in the extant social science research literature, and in popular models of informal family caregiving that are offered by theorists in social work, gerontology and sociology.

Whilst there is a considerable body of research examining models of familial caregiving and the issues that female caregivers face, much of which informs social policy, limited attention has been given to who takes on the caregiver role and why women are disproportionately situated therein. Genealogy aims to explore the history of the present state of affairs by way of examining the interaction and influence of social processes and procedures on social practices (Fraser, 1989). This chapter offers a genealogical account to the gendered construction of the informal carer as it has manifested in the UK and will discuss how this construction has informed psychological enquiry.

3.1.1 Women and their caring

Inherent within all the research highlighted in Chapter 2, whether social policy based or academy based, in models of elder caregiving, and in the differing systems of family caregiving employed, is the over-arching discourse of the heteronormative family. This position holds to the assumption that couples, families, and family members are heterosexual by default; and further, that the family carer is female by default. Within this position, two competing narratives can be evidenced within the corpus of caregiving policy and research. First, there is an essentialist narrative of the naturalness of female caregiving which is evidenced in early research; a position which renders invalid questions as to why women are more likely to be engaged in the caregiver role. Second, some of the more recent work holds more to a narrative of gender-role socialization. Whilst this latter position does have the
potential to explain questions about the greater number of women found in the caregiver role. This is not the question that has been addressed; rather, the theory has been used to explain the differential experiences of caregiver burden between men and women.

3.1.1.1 Social policy and social science

Social policy research, whether undertaken directly by public office, or commissioned by public office and subsequently undertaken within the academy, paints a clear picture that the lived experience of caregiving to family members in the United States and Western Europe is predominately a female affair. In the US Women have consistently made up around 75% of informal carers (Pope et al., 2012; Stone et al., 1987). A similar position can be found in European countries including the United Kingdom. Numbers vary across European states; however between 59% and 69% of European informal carers are women (Mot, Aouragh, de Groot & Mannaearts, 2010; Pickard, 2008; Riedel & Kraus, 2011). Social policy research in respect of caregiving is predominantly focused on the availability of informal familial caregivers (Pickard et al., 2012; Pickard, 2015). Given the financial implications of a completely formalized approach concern has been focused on the provision of support to the usual informal carers, such as the daughters, daughters-in-law, wives and partners (Hoffman & Rodrigues, 2010). In sum, social policy research has nothing to say in respect of the essentialist naturalness of women as the familial caregiver, or indeed why there are more women than men in the caregiver role, purely accepting the situation as is. However, social policy research is predicated on the discourse of the heteronormative family unit with subsequent policy being based upon existing norms.

The female gendered position highlighted by social policy based research is also reflected in the academy. Research that seeks to examine the impact that caregiving has on the lives of those who provide the care almost always have women, either exclusively or, as the overwhelming majority of their sample population. This female oriented position can be seen in both current and historical research. For example, early work examining the effect of caregiving on spouse carers examined the issues affecting caregiving wives rather than husbands (Goldletcher, Evans, Heinritz & Gibson, 1969; Fengler & Goodrich, 1979). More recent examples of research examining the impact of caregiving retains the female participant focus. In the study by Thompson, Futterman, Gallagher-Thompson, Rose and Lovett (1993) women made up 82% of their sample population (179 out of 217); for Gallicchio, Siddiqi, Langenberg and Baumgarten (2002) women made up 79% of their sample (259 out of 327); whilst 73% of Lai’s (2012) sample were female (248 out of 340).
Looking at the early research in more detail, in their study of the home care of the chronically ill and disabled Golodetz et al., (1969) unapologetically highlight their use of the female pronoun in acknowledgement that the caregiver, or “responsor” as they termed the role, is most often undertaken by women, clearly stating that the caregiver is “almost always a family member, generally a woman. Her involvement in the illness and its care is crucial. We will use the female pronoun in speaking of the role in the abstract” (p. 386). Indeed, consistent with their statement, and with government figures previously highlighted, of their 59 study participants, 83% were women. The position that Golodetz et al., take here with the use of the female pronoun is unusual for the time period when it was the norm to use the much more androcentric “he” in formal writing when referring to both men and women (Hegarty et al., 2013). Despite this non-androcentric approach to the use of pronouns the authors do not escape essentialism or the discourse of heteronormativity with their argument that the responsor role generally follows “natural” family caring relationships such as between wife and husband. This position assumes that caring is in the essence of a woman and therefore natural; whilst the family unit can only be conceptualized as such if it is heterosexual, thereby eliding and invalidating non-heterosexual family forms. Further, with the dual acknowledgement of women being the main carers and that the caring dyad follows essentialist heteronormative family caring relationships men are implicitly positioned as the care recipient.

A decade after Golodetz et al., (1969) purposefully used the female pronoun in acknowledgement of the greater incidence of women carers, Fengler and Goodrich (1979) argued that women tended to take on the caring role as their husbands were generally older than them. Fengler and Goodrich chose to focus their study on the impact that caring had on wife caregivers using a participant sample entirely made up of wives caring for husbands. This position led them to posit that elderly wives who engaged in spousal caregiving were potential “hidden patients” as their caring put them at risk of physical ill-health and psychological distress. Despite their entirely female sample Fengler and Goodrich did not essentialize the naturalness of female caring, noting that the directional “wife to husband” caregiver dyad is not the only one. They acknowledged that husbands care for wives and adult children provide care for their frail elderly parents; clearly positioning caregiving as a family affair. However, all the other caregiving relationships noted were constructed from within the frame of a heteronormative family discourse, where marriage is heterosexual, in tandem with the implicit unquestioning assumption of normative heterosexuality for all.
Interestingly, and in contrast to the earlier essentialist narrative, Grad de Alarcón, Sainsbury and Costain (1975) offered socialization as an explanation as to why men provide less care. In their study of mental illness referrals and the uptake of psychiatric services they argued that elderly women suffering from dementia were more likely to be referred for psychiatric treatment than elderly men. Grad et al., theorised that this was because elderly men were less able to care for their ill wives than elderly women were able to care for their ill husbands due to differences in gender socialization. Here, men were constructed as bereft of caregiving skills due to their socialization rather than any innate inability to provide care. Unchallenged however, is the essentialist position of the naturalness of women’s caregiving here. However, this socialization argument makes it apparent that caregiving ability is derived from nurture rather than nature. It therefore follows that women are not essentially better equipped to provide care, rather it is their socialization experiences that equip them with the life skills to engage in caregiving irrespective of any innate possession of caregiving skills. The argument here is that women and men are not innately pre-dispositioned to care, or to not care, depending upon assumed innate traits bound up with their biology, rather it is the social roles in which they find themselves that perpetuates the caregiving positions that they find themselves in (Eagly, 1987; Eagly & Steffen, 1984).

Examining more recent research, women still make up the greater proportion of participants in caregiving research; a pattern that is to be expected given the caregiver demographics found in government reports. This pattern can be most readily seen in the meta-analysis of Pinquart and Sörensen (2011). This study compared the experiences of differing categories of elder caregiver: that of spouses, adult children and adult children-in-law, across 168 studies. They found that women made up 69% of spousal caregivers, 77% of adult child caregivers, and 89% of adult child-in-law caregivers respectively in each of the three categories. An interesting turn in the more recent body of work is in the examination of gender differences in the caregiving experience. Three key findings in this regard are: first, that men and women tend to define caregiving differently with men including domestic tasks such as housework as caregiving, whilst women generally do not consider household chores as caregiving tasks (Allen, 1993; Thompson et al., 1993); second, women caregivers usually report higher levels of caregiver burden than men (Gallicchio et al., 2002; Lai, 2012); and finally, that women caregivers generally report greater levels of psychological distress and unmet need (Perz, Ussher, Butow & Wang, 2011; Ussher & Sandoval, 2008). Gender differences are also held accountable for the type of care provided and to differentials in
gendered access to social support (Pearlin, et al., 1990; Miller, 1990). Noticeable by absence in this recent body of work is less recourse to the essentialist narrative of women as natural carers, whilst more prominent is a move towards explanation of these three gender differences; particularly why women experience the caregiving role differently to men. Here explanations follow gender-role socialization theory in suggesting that women report higher levels of burden as a result of their being socialized to being sensitive to the needs other others (Miller & Cafasso, 1992). This move to a socialization-based explanation of why women experience more burden does not negate the earlier essentialist narrative of women being considered the natural caregiver. Rather, it purely explains why women perceive more burden when they care, a position that has the effect of reifying the unchallenged essentialist narrative. As such the heteronormative discourse of the family continues to position women in the carer role unchallenged.

3.1.1.2 Models and systems of family caregiving

The female gendered position of social policy and social science research is also reflected in the competing models espoused to explain caregiving, along with the systems of care identified within families. Here again the overarching discourse of the heteronormative family is ever present. For example, stereotypes of caregiving and the “spinster” model of caregiving suggest that the typical carer was a spinster, an unmarried daughter available to engage in the role of caregiver (Allen & Pickett, 1987; Parker, 1990). This model characterises the single woman engaged in caregiving as someone who by lack of any heterosexual familial responsibility, such as a husband and children to care for, was considered available to engage with familial caregiving duties (Manthorpe, 2003). This thesis has received empirical support in the past. Allen and Pickett (1987) found that the majority of unmarried women in their study engaged extensively in family caretaking duties to a range of family members including parents, aunts and uncles; whereas the married women’s caretaking activities were oriented towards husbands, children and grandchildren. Furthermore, Brody et al., (1994) found that single daughters, whether previously married or never married, were more likely to be living with elderly family members and that these single women caregivers provided more hours of care than their married women caregiver counterparts. Interestingly, the general impression that emerges in respect of the shape and direction of care for single women appears broad and oriented toward older generations, whilst the married women appear to be more narrowly focused on her legitimate spouse and younger generations. From this pattern the operation of heteronormativity can be discerned; single women fill the
caregiving gap left unattended by her heterosexually married sisters whose caregiving is targeted at her husband, children, and grandchildren.

Despite single women caregivers providing more hours of parental eldercare, the largest number of caregivers in the Brody et al., (1994) sample were married daughters rather than those considered as single, a position that reflects the competing “sandwich” model of family caregiving posited elsewhere by Brody (1981; 1985; 2004). In this model women are perceived to be sandwiched between the competing demands of parent care and childcare, her sexuality assumed and unquestionably heterosexual. The women identified by the “sandwich” model have been termed the “sandwich generation” and are often the unique focus of research due to their demanding position. Some key areas of examination are the tensions between the different caring demands (Grundy & Henretta, 2006), the impact of different caring demands and engagement in employment (Hammer & Neal, 2008), caregiver health (Schumacher, MacNeil, Mobily, Teague & Butcher, 2012), and of course psychological distress (Dautzenberg, Diederiks, Philipsen & Tan (1999). As with the “spinster” model, however, the “sandwich” caregiver is always a heterosexual female with heterosexually defined family demands.

A less well examined area, but no less gendered, are the differing systems of caregiving that families adopt. Research by Keith (1995) identified three systems of caregiving: the primary caregiver system, the partnership system, and the team system. In the primary caregiver model one person takes on the caregiving responsibility, whilst in the partnership model two family members take on the work equally between them. In the final model, the team system, many family members take on caregiving duties in a planned and delegated way. Keith argues that the most common of these systems is that of the primary caregiver, however which system is ultimately adopted by a particular family is dependent upon family size and gender composition. Partnership caring needs a minimum of two siblings of the same gender, whilst team caring requires a large base of siblings and a shared desire between them to work together to support both themselves and the care recipient. Interestingly the examples provided by Keith highlight a gender bias, as in the brother-sister dyads the primary caregiver model was adopted with the sister in the role of primary caregiver, rather than the partnership caregiver model. Further, when team caregiving was in operation male siblings undertook financial management and dispute arbitration between the other caregivers, who were usually female. Further empirical support for Keith’s systems of caregiving has been found by Piercy (1998), Dilworth-Anderson, Wallace Williams and
Cooper (1999) and Brewer (2002). Across all the systems however, the overwhelming position is for the women of the family, whether in a team, a partnership or as sole primary caregiver, to be the main providers of informal familial caregiving.

3.1.1.3 The heterosexual female caregiver

This brief examination of the caregiving literature has highlighted that women’s caregiving appears to be unquestioned and, due to the prevailing discourse of the heteronormative family, potentially unquestionable. This position is despite acknowledging that men can and do care, and is a result of women undertaking most of the familial caregiving engaged in. As a result, research is first and foremost focused on the female caregiver. Accepted at face value is the position that the family is heterosexual and women within the family will engage in caregiving whenever it is needed for whoever needs it. This position both heterosexualizes and feminizes caregiving; a position that elides any other caregiving performed by those who fall beyond the narrowly defined heterosexual feminine boundary such as that by lesbians or men. Indeed, if the care that non-normative carers engage in is acknowledged the caregivers themselves become feminized and heterosexualized (see Chapter 4).

3.1.2 The present study

As previously highlighted in Chapter 2, informal care provided unpaid by female family members covers a wide range of tasks and can be engaged with across a myriad of situations. Informal caring can encompass a range of activities from the emotional position of “just being” with the care recipient to the provision of emotional and psychological support, as well as incorporating assisted daily living type tasks more usually in the remit that formal caregivers generally provide. The informal care environment is also as varied as the type of care provided with some informal carers living with the family member being cared for (either in the caregivers home or the care receiver’s home), other informal carers may visit their care receiver on a regular basis undertaking a range of tasks whilst visiting. Whilst others provide support at a distance, telephoning regularly and generally arranging for the smooth running of the care recipient’s home and life via telephone and, in the digital age, via the internet (Lee & Porteous, 2002). Many of the tasks that informal carers often engage with are general household chores such as cooking, cleaning, clothes washing, small household maintenance tasks, gardening chores, helping out with the payments of bills and other
financial management, the organizing of medical appointments, shopping, running errands and providing transport; in sum the myriad of tasks that keep people’s lives running smoothly.

Given the type of tasks that informal carers often provide, many of those who provide support to relatives do not always perceive themselves as informal carers and would argue that what they are engaged in is not caregiving; rather, that they are going about the business of being a family. This non-caregiving viewpoint, that of family members undertaking household tasks, can often be the position taken by the elderly family member who benefits from the help and support of family members. Further, the care receiver’s viewpoint may also be biased by exactly who within the family is undertaking the support tasks, with men being more likely to be seen as providing these tasks under the umbrella of caregiving whilst women are just doing the housework; in essence caregiving is defined by gendered divisions of household labour (Walker, Pratt & Eddy, 1995).

This non-caregiving position sits well with the notion that being an informal carer to elderly relatives is a relatively recent phenomenon. Forty years ago both the term and the concept of “informal carer”, or carer as is more common, were unknown. In the Foucauldian sense we can argue that carers, the claiming of being a carer as a role, or as an identity, did not exist (Foucault, 1994). The tasks that are now constructed within the remit of the caregiver role were indeed engaged with, but no-one claimed that they were a “carer”. Caregiving was a range of tasks that people engaged with and did without title, rather than their being in a specific carer role. It is only in the 1970s that the concept of “the carer” emerged, with wider recognition being found in the 1980s and 1990s. The concept has essentially been defined via a developing discourse of informal care which was crystalised into United Kingdom law with the Carers (Recognition and Services) Act 1995.

The aim of this study is to examine the current construction of the informal carer in the UK and to ask what the conditions of possibility were that brought about the current construction of the concept; and further, to examine how the current conception of the informal carer intersects, and so informs, caregiving research. This will be discussed in relation to the non-normative category of the lesbian family caregiver. Therefore the analysis will examine changing social and political discourses in order to establish a genealogy of the concept “informal carer”.
3.2 Method

Genealogy, as developed by Foucault, has its roots in his archaeological method. Archaeology looks to explore the specific historical conditions under which statements combine to form and define distinct fields of knowledge by way of an examination of the archives of society such as parliamentary records, prison records, other such official records, grand theory, popular knowledge, subjugated knowledge and so on. In sum the archaeological method is the examination of the “archives of discourse” (Kendall & Wickham, 2003, p.23) as evidenced in early works by Foucault such as Madness and Civilisation (1961/1992) and The Birth of the Clinic (1963/2003). A key concern of archaeology is the history of social structures or conceptual frameworks; in other words systems of thought or knowledge which Foucault called epistemes (Danaher, Schirato & Webb, 2002). It is epistemes that define and shape the boundaries, or extent, of knowledge, ideas, and discursive formations in any given historical period (Danaher et al., 2002; Fraser, 1989). As espoused in The Archaeology of Knowledge (1972/2002) epistemes gain voice, or ‘speak themselves’, via the production of discursive formations, which can be thought of as the ordering principles of an episteme, that allow for the formation of ideas and produce objects of knowledge. The application of archaeology as a method allows for the constituent parts of accepted knowledge to be set apart and deconstructed. This deconstruction process brings into relief the notion that knowledge per se is not an essential truth, rather that knowledges are the products of specific epistemes. This is because the examination of the archive of society uncovers the processes by which discourses are made possible (Kendall & Wickham, 2003).

Influenced by Nietzsche’s conception of genealogy which examined historical origins of discourse that were considered as universal and enduring (such as Christianity), together with Nietzsche’s notion of history being grounded in irrationality and accident (Danaher et al., 2002), Foucault developed a genealogical approach to enquiry. And, whereas archaeology looks to examining systems of discourse and their development, genealogy focuses on the inter-relatedness between power, knowledge and the individual. The more developed genealogical approach is evidenced in Discipline and Punish (1977/1991) and The History of Sexuality (1978/1998). Working from the premise that history is not linear and progressive but rather the consequence of happenstance and accident, the objective of genealogy is to identify the happenstance, or accidents, that bring about the existence of a ‘thing’. And, as a result of this process, bring forth issues of power, because what things
exist, do so due to power. Further, genealogy endeavours to map out, or expose, the different discourses that combine to constitute a ‘thing’, or object and in in the process highlight the connections between discourses as well as illuminating socio-political agencies. Finally, genealogy disrupts the everyday and taken for granted by examining the objects, or concepts, that we perceive as being without history, such as sexuality (Foucault, 1994).

The approach is an investigative method that is simultaneously a process of critique and one of knowledge generation (Hook, 2005). Genealogical enquiry endeavours to uncover the relationships between knowledge, power and the individual in society by deconstructing conventional, taken for granted, objects of knowledge. In other words, this methodology allows us to problematize that which is considered natural within current social existence and view it in a new light. For Foucault knowledge, in the guise of rationalism, permits power; thus socially constructed scientific knowledge grants status and domination (Hook, 2005; Turner, 2000). A way to address and critique this is by way of genealogy which attempts to re-read and re-examine the antecedents of constructed categories. This can be more easily understood via a brief encounter with Foucault’s own work. For example, in The History of Sexuality (1978/1998) Foucault established the socially constructed nature of sexuality via the interplay of power, culture and society by way of an examination of the conditions of possibility that allowed sexuality to become established as an organizing and controlling discourse. Foucault does this by questioning the “repressive hypothesis”; that is, that sexuality was suppressed within Western culture up until the middle of the 20th Century. Foucault argues that, far from being repressed, sex was in fact at the centre of a number of discourses; that of religion, science and politics. His genealogical account highlights sex as being the focus of religious discourse via the confessional, the focus of scientific discourse via the medical gaze accounting for ‘deviant’ sex falling outside of the matrimonial bed, and the focus on political discourse in legislation concerned with immoral sexual matters; all of which combined to create sexual morality as a means of surveillance, regulation and control.

As demonstrated in The History of Sexuality (1978/1998), core to the genealogical approach is the assumption that current cultural practices are created historically and so are contingent upon other, prior, historically created contingent practices (Fraser, 1989). Based on this assumption, the methodological aim is to explore how the current position, or state of affairs, has been established; the aim of this chapter, therefore, is to explore how the concept of the informal carer, in particular within the UK, has become crystalized, and in the genealogical process make clear positions elided by taken for granted assumptions.
surrounding the concept. The genealogical method examines the conditions that lead to the emergence of discourses and associated social practices. The approach involves looking for what can be considered as the circumstances, or conditions of possibility, that are required for a concept to emerge, by way of examining the archive of social process and procedures (Fraser, 1989).

Given the inherent critical nature of genealogy, the genealogical approach allows for an examination of the operation of power and governmentality and their effects on the individual. It is therefore a useful approach to utilize in respect of the case of the “informal carer” where I seek to establish the conditions of possibility that led up to the emergence of the informal carer as the concept is understood in the UK today by examining public policy, legislation, and the influence of the carers movement.

3.3 Analysis

The emergence of the discourse of informal care and the concept of the informal carer can be related to four differing, but interrelated, changing social discourses: that of political and social change; the move to community care; family care provision and the caregiver movement; and the feminist critique of the role of women. Each of these social threads will now be examined in turn.

3.3.1 Political and social change

Up until the establishment of the Welfare State in 1948 provision for those unable to provide for themselves in England and Wales was to be found in a system of poor laws that developed out of medieval and Tudor laws. In the Middle Ages the poor and those in need of care looked to Christian religious institutions such as monasteries, almshouses, and hospitals for poor relief assistance. With the advent of the Reformation, between the years 1536 and 1541, monasteries, along with almshouses and hospitals, were dissolved (Spicker, 2014). Almshouses and hospitals were caught up within the Reformation as they were intricately bound up with the Church. Almshouses were very often aligned with religious orders and religious institutions, as too were hospitals which were often considered as just another form of religious institution. Up until the dissolution of the monasteries poor relief and care of the poor elderly and infirm was a charitable exercise. The dissolution of these religious institutions, and their affiliated charitable establishments, saw the provision of care disappear with the poor elderly and infirm being left without support (Rushton & Sigle-Rushton, 2001;
Slack, 1988; 1995). The absence of any Church mediated charity and support led to a raft of legislation in the Tudor era that developed into the Poor Laws targeted purely at the very destitute in society.

3.3.1.1 The Old Poor Law

_The Poor Relief Act 1601_, formally An Act for the Relief of the Poor of 1601 also known as the Elizabethan Poor Law or Old Poor Law, created a system of relief that was administered at parish level and paid for by the levy of a poor rate on local property owners. The Old Poor Law was in fact a collection of acts that were amended and developed over the Tudor era and subsequently codified into law in 1601. The 1601 Act consolidated earlier Tudor legislation and formed a “Poor Law” system in England and Wales, originally passed to deal with the problems created by the dissolution the monasteries (Slack, 1988; 1995). The Act provided relief for the poor and was, in essence, an ancient system of laws, the original primary aim of which was the mobilization of an agrarian workforce along with the management of vagrants and beggars rather than in the provision of care and support to the elderly.

The Act was aimed at providing assistance to the “deserving” poor who would be glad to benefit from the receipt of some form of assistance. Within this ancient relief system the poor were categorized into the _idle poor_, that is those who were able to work but would not; and the _deserving poor_. The deserving poor were further sub-divided into those who were able to work but could not due to lack of work and so would be considered as unemployed in the modern sense of the word, and the impotent poor; that is, those people who were unable to work in order to raise themselves up out of poverty. The impotent poor were considered as being the ill, the infirm, the elderly, and children who had no-one to support them such as orphans. Relief came in the form of either indoor or outdoor relief. Indoor relief was based in workhouses or almshouses, whilst outdoor relief was in the provision of money, clothing or food. The able-bodied deserving poor were given outdoor relief or set to working; whilst those considered impotent were often provided with money, food or clothing (Slack, 1995). A key point to note is that the 1601 Act expected families to look after themselves, young and old alike. When the impotent poor sought relief from the Parish the 1601 Act allowed Parish Overseers to seek recompense from other family members:

_“The father and grandfather, mother and grandmother, and children of every poor, old, blind, lame and impotent person, or other poor person not able to work, being of_
sufficient ability, shall at their own charges relieve and maintain every such poor person” (An Act for the Relief of the Poor of 1601)

As can be noted in the “liable relatives” clause above, the liability extended across three generations, should they be in a financial position to do so (Ottaway, 1998; Thane, 2000; Thomson, 1984). Despite the clear outline of filial responsibility within the 1601 Act, Thomson (1984) points out that evidence suggests that the “liable relatives” clause was seldom used and therefore argues that with the establishment of the Old Poor Law the community rather than the family were the main source of support for the elderly in need. Crawford and Walker (2009) argue that the origins of the present system of Local Authority involvement with social care in the UK can be found in the system of relief established by the Old Poor Law as this placed an obligation towards destitute parishioners onto the local community. However, these obligations were in the raising of money via local taxation in order to provide for the deserving poor of their communities. Care, akin to the formal elder care provision that Local Authorities currently provide, was never the intent of the Act; a position that is clear when considering the preferred form of support – outdoor relief, in the form of monetary payments. Indeed, outdoor relief in the form of money was the preferred form of support if those applying to the Parish were living in their own home (Slack, 1995). When the elderly made claim to the parish under the 1601 Act it was against a backdrop of having no family to help, or one where their families were unable to help them; being either destitute themselves and so also claiming parish support (Ottaway, 1998), or unavailable to provide support due to migration to work elsewhere in the country or in another part of the world (Smith, 1998). Finally, it should be noted that records only show those making claim to the parish. Many of the elderly, that is those over 60, supported themselves (Ottaway, 1998); these people, along with those who had help from their families are not accounted for in the limited Poor Relief Parish Records (Thane, 1996).

The poor relief system set up with the 1601 Act remained in place, with supplementary legislation, until 1834. Some of the intervening legislation was geographically specific, designed to address the welfare issues pertinent to specific areas. It was these “local acts” that brought the workhouse into being. Knatchbull’s Act, more formally known as An Act for amending the laws relating to the Settlement, Implyment, and Relief of the Poor 1722, extended the workhouse provisions nationally and allowed for the establishment of workhouses across England and Wales. Further, Knatchbull’s Act brought into being the “workhouse test” which required those who sought poor relief to enter the workhouse and be
put to work. Although practices varied between parishes, this amending legislation had the potential to bring the poor infirm elderly into the workhouse with the expectation that they work for their board since the majority of Almshouses, where the elderly and infirm had previously been accommodated, had been abolished during the Reformation. A key improvement to the workhouse situation came from the Gilbert Act, formally An Act for the better Relief and Employment of the Poor (b) 1782. The Gilbert Act allowed for groups of parishes to combine to share the cost of poor relief for the old, sick and infirm via a “poorhouse” rather than the workhouse. However, as the name suggests, Gilbert’s “poorhouse” was only for those who were entitled to parish relief; that is those without family support.

3.3.1.2 The New Poor Law

Eventually the rising cost of poor relief brought about a review of the 1601 poor relief system in the Royal Commission into the Operation of the Poor Laws of 1832. This report led to An Act for the Amendment and Better Administration of the Laws relating to the Poor in England and Wales 1834, often referred to as the Poor Law Amendment Act 1834, and generally known as the New Poor Law. The revised poor relief system that came into being with the advent of the 1834 Act was still in place for most of the first half of the 20th Century, although again was subject to review at the turn of the 20th century.

The Amendment Act of 1834 brought about administrative reform to the 1601 system of poor relief. Under the 1601 Act poor relief was administered at parish level by Parish Overseers. With the Advent of the New Poor Law parishes were organized into Poor Law Unions with an elected Board of Guardians, who replaced the Parish Overseers, to administer poor relief (Thomson, 1984). The core features of the original 1601 Act remained in place but with some significant changes. Key changes surrounded the withdrawal of relief to those deemed able to work, the provision of separate workhouses for the different classes of pauper, and the removal of outdoor relief (Thane, 2000). The move to eliminate outdoor relief had previously been attempted via the “workhouse test” of the Knatchbull Act, as too had the different types of parish accommodation for the different classes of pauper via Gilbert’s poorhouses for the destitute elderly. However, due to the voluntary nature of the earlier legislation the application of these earlier Acts varied between parishes and between areas of the country (Thane, 2000). Under the revised Amendment Act, those in dire need would have to enter the workhouse in order to receive relief (Thane, 2000). In theory the disabled and the elderly poor were to be accommodated in different, better appointed, poorhouses than those
considered as able bodied. In practice, however the impoverished disabled and elderly did not find themselves in any more comfortable accommodations than the able-bodied poor (Thane, 2000).

Extant research into the effects of the changes brought about by the Amendment Act offers divided opinions. Some suggest that the Act had little or no impact (Thomson, 1991), whilst others indicate severe changes (Snell, 1985). These polarized positions are a result, in part, from different scholars examining different Poor Law Union records. As with the Old Poor Law legislation, the application of the 1834 Act varied between Poor Law Unions, and this difference in application manifested in the Union records. Some Unions were more rigorous in interpreting and applying the law than others; and this difference in application led to the establishment of the Select Committee on the Poor Law Amendment Act of 1837-38. Despite the intent to eliminate outdoor relief a key question that the Select Committee considered was whether the weekly sums paid to aged paupers in outdoor relief were adequate, whilst another key issue was the defining of the lower age limit for elderly paupers. In answer to these questions, the Select Committee settled on a consensus of 60 years as the lower boundary for old age for the purposes of relief. In respect of weekly payments, no set amount was established but each Union was expected to consider applications individually and award relief as considered appropriate based on the proviso that poor relief be a residual safety-net. Poor Law Officials expected families to support their own and the availability of liable relatives usually determined whether relief was forthcoming, and if so in what form and how much (Thane, 2000); a position that continued throughout the 19th and early 20th century.

Despite the Select Committee’s apparent benign position toward aged paupers, following the 1834 Act there was a turn towards what in today’s parlance would be termed austerity. There were overall reductions in outdoor relief payments, the separation of married couples when living in Poor Law Union accommodation, and the pursuit under the law of family for financial support of their elderly relatives. Evidence can be found of reductions in outdoor payments when a relative was considered liable to provide support (Robin, 1984). If the aged pauper without family was unable to survive on the outdoor relief given the only alternative was to enter the workhouse; and, post 1834, married couples were often separated in these institutions (Thane, 2000). Although in the years following the 1834 Act elderly paupers living in the workhouse were an exception, partially due to the pursuit of family members under the still existing “liable relatives” clause. Indeed, under the 1834 Act the ability to pursue families for maintenance was strengthened as magistrates became members
of the Board of Guardians. Evidence from magistrates’ court records indicates that Poor Law Unions prosecuted sons in pursuit of maintenance for their elderly parents. One such early example is the prosecution of John King by the Ampthill Union who, in 1835, was ordered to pay 3s. per week to maintain his mother (Thomson, 1984).

Evidence suggests that the position of the aged pauper brought about by the Amendment Act 1834 continued throughout the 19th century, again with variability (Thane, 2000). However, by the late 19th century another Royal Commission was appointed, this time to examine the lot of the aged poor. The remit of the Royal Commission on the Aged Poor of 1893 was to establish if any alternative system of poor relief could be utilized to assist those in destitution as a result of age-related incapacity. The Commission’s 1895 report found that most destitute elderly received outdoor relief, but not at a level to sustain independent living. Shortfall of support was made up either by begging, family support (either voluntarily made or under order of the Union Boards), friends, or charity; or a combination thereof (Thane, 2000). The Commission re-affirmed the need to distinguish between the deserving and un-deserving aged destitute, however a key recommendation was to pursue the feasibility of old-age pensions for the deserving aged poor.

Swift social change in the latter half of the 19th century saw the advent of trade unions, friendly societies, and the establishment of local government. This social change also brought with it a change in gendered patterns of use of the workhouse. The former organisations provided their members in need with assistance, whilst the County and District Councils established in the 1880s and 1890s had responsibility for housing. These new organisations brought changes in the demands on the poor law system and so in 1905 Parliament set up The Royal Commission on the Poor Laws and Relief of Distress to investigate how the ancient Poor Law system should be changed. With respect to the elderly and their recourse to poor law relief, the commission found that more elderly men were to be found in the workhouses than women. Alderman McDougall of the Manchester board of Guardians offered the following explanation to the Commission:

“Families in poor circumstances find it less possible to provide food and shelter for an old man who is a relative than for an old woman. He expects more...a larger portion of the food...He is not so useful in domestic matters” (Moroney & Krysik, 1998, p 170)

The message here is that old women were considered as useful domestic workers within the extended family, being able to help out with the traditionally female gendered
domestic and caregiving tasks; whereas elderly men were just another mouth to feed. Indeed, evidence of intergenerational support in the 19th century, between co-residing older women and their working daughters in respect of childminding and household tasks, has been found in Preston (Anderson, 1971) and the Potteries (Dupree, 1995).

The notion of informal caregiving as we currently understand it did not form part of either the Old or the New Poor Law. Occasionally, under the Old Poor Law (less so the New), another pauper would be paid to care for a sick or infirm pauper irrespective of age (Johnson & Thane, 2003). Often when outdoor relief took this form the pauper paid to provide the support was generally a related female pauper. Williams (2011) highlights instances under the Old Poor Law of married daughters being engaged to care for their elderly, infirm mothers. In this way two paupers would be provided for, in many respects, for the price of one. However, this type of arrangement was the exception rather than the norm (Thane, 2000), and certainly a distance away from current understandings of formal Local Authority provided care in the community. If any comparison to current practice can be made, it is to the payment of the carers allowance to an informal carer rather than with any formal provision of care. These successive poor law relief systems were more oriented towards being a type of residual state assistance in the form of a pension rather than towards the provision of care. It is from this centuries old position of public financial assistance to the deserving poor that the Welfare State, as proposed by Beveridge, developed.

3.3.1.3 From the Cradle to The Grave

The 1601 Act was only repealed in 1948 when the Welfare State came into being, three years after the end of World War II. It was based on the 1942 Beveridge Report Social Insurance and Allied Services. The 1948 Welfare State had its antecedents in the system of poor relief consolidated in the 1601 Act. However, unlike the residual welfare system created by the 1601 Act, and subsequently amended by the Poor Law Amendment Act 1834, where relief given to the poor was provided as a safety net to prevent destitution (Spicker, 2014), the Welfare State of 1948 was an institutional welfare system established on Keynesian economic principles of public spending to achieve full employment and welfare support when needed (Spicker, 2014). Institutional systems of welfare\(^5\) are based on the principle of welfare being

---

\(^5\) The institutional welfare system is a model of welfare provision based on universality, in sum benefit as of right. An alternative system is the residual welfare system where welfare provision is provided selectively (Briggs, 1961; Spicker, 2014). The Welfare system of Poor Law England was a residual system, whilst Beveridge’s Welfare State was based on institutional welfare and has allowed for NHS services being free at point of contact as well as state education for all.
a citizen’s right to a minimum income and social protection at times of insecurity and available for all citizens (Briggs, 1961). The central feature of this new welfare state was the notion of social insurance. Workers would pay into the state run compulsory national insurance scheme when they were in work, this would then allow them to receive benefits when out of work, and eventually provide the worker with a pension to support their old age (Timmins, 1995).

Beveridge’s public policy was predicated upon an inherently heteronormative model of family life based around the assumption of the male breadwinner and female caregiver, a caregiving system that was similarly found in the US (Boris & Lewis, 2006) as well as being central to the New Poor Law (Thane, 1978). The central idea of Beveridge’s Welfare State was that of a safety net designed to support the worker, and indirectly the worker’s family, with state assistance in times of need (Beveridge, 1942; Timmins, 1995). Further, during WWII women had taken up the work roles left vacant by those men who were fighting in the armed services, however at the end of the war the returning men needed employment and the role of women reverted to the home place. Full employment in Beveridge terms was paid work for men, and home work for women:

“The great majority of married women must be regarded as occupied on work which is vital though unpaid, without which their husbands could not do their paid work and without which the nation could not continue” (Beveridge, 1942, para 107, p49)

For Beveridge the worker was the able-bodied working man, the worker’s family being his wife and dependent family members. Married men were to be paid more social security benefit or pension than the unmarried man, on the basis that the married man had family responsibility. The Beveridge citizen, therefore, was the male bread-winner who was expected to provide for his wife and family. The worker participated in the labour market with the support of his wife, who stayed at home to provide care and support for the children, to care for him in order to enable him to go out to work, and care for any other dependents of the worker such as incapacitated, elderly or infirm relatives, and finally care for him when he gets to old age. In sum, therefore, the worker would support his dependents at all times, either from his own resources when he was in work or with the support of the State if he was out of work.

With respect to women: single women, like single men, were expected to work and pay into the social insurance scheme. Once married however, the woman’s role would be expected to change to one more oriented towards domestic duties which including caregiving,
rather than paid work, effectively situating them as dependents of their husbands. This position was reflected in the reduced rate of national insurance contributions for married women, sometimes referred to as the Married Women’s Stamp, introduced as part of the 1948 social welfare changes. The object of this reduced stamp was to allow housewives an entitlement to a small pension (around 60% of the full state pension), based on their husband’s national insurance contributions. So, for Beveridge the citizen was male and in work, married women were dependents of men and were relied on to provide care (Beveridge, 1942; Timmins, 1995). This reduced stamp effectively reinforces the position that married women’s citizenship was achieved indirectly, via their husband’s economic position (Millar, 1989). The main social insurance provisions did not apply to men and women who did not fit the category of able-bodied male or unmarried female without dependents. There were no provisions for men who were not able-bodied, single women with children or in caring roles, and divorced and separated women. Those not able to pay into the social insurance system were expected to be supported by their able-bodied male spouse or relative in return for the care they provided. In sum, the Welfare State legislation reinforced the patriarchal heteronormative discourse in operation.

3.3.2 The Move to “community care”

Integral to Beveridge’s all-encompassing welfare vision was care, but care in the newly established Welfare State was conceptualised as being firmly within the remit of the family. If an individual was in need of more than family care and support, such as medical care, this was provided for by the National Health Service (NHS); a concept that Beveridge had recommended in his 1942 report. This conceptualization of care was also the position under the Poor Laws. Prior to the establishment of the NHS, the sick were cared for according to their means. Those who had the ability to pay engaged private medical assistance from doctors and if they needed hospital care would pay for it; whilst those unable to pay would have had to rely on charity, voluntary hospitals, and the parish Poor Law Hospitals and Infirmaries6. However, when the NHS came into being on 5th July 1948 it inherited a legacy of institutional care for the poor elderly within the workhouse and workhouse infirmary. Given the legacy of poor elderly care that the newly established NHS found itself with, it is necessary to go and look at the condition of possibilities that led to this position and so examine the rise of Poor Law medical care.

---

6 New Poor Law medical facilities were referred to variously as Poor Law Hospitals, Poor Law Infirmaries, Workhouse Hospitals and Workhouse Infirmaries. I have endeavoured to retain the same term as the source reference.
3.3.2.1 Poor Law medical care

Poor Law medical facilities mainly developed after the Amendment Act 1834. Of course, prior to the 1834 Act medical provision was a part of the poor relief system, however there is a lack of research into how medical care operated under the Old Poor Law. Record keeping under the Old Poor Law often did not make clear the purpose of relief; that is whether it was for health or welfare reasons. But the advent of ill-health was often a point of entry into the poor relief system; and the limited research does suggest that the sick were cared for, often in their allocated places within the workhouse (Fissell, 1991). The 1834 Act heralded not only changes to the administration of able-bodied poor relief, but also to changes in how the sick and infirm were to be provided with relief. Under the New Poor Law relief was to be primarily indoors, that is within the Union Workhouse. With the grouping together of parishes into Unions larger accommodations were demanded often providing separate rooms or wards for the sick and infirm, with very large workhouses having separate infirmaries (Crowther, 1999; Morrison, 1999)\(^7\).

The workhouse infirmaries were primarily intended for the inmates of the workhouse, that is, the destitute; those who were merely poor did not have access to them. The medical needs of the poor not classified as paupers were usually met by voluntary hospitals that were funded by charity. However, getting into a voluntary hospital was not easy. Often a person needed a letter of support from a member of the board of hospital governors or a subscribers ticket\(^8\) (Fissell, 1991). Further, they generally did not admit anyone with chronic illness or infectious disease (Powell, 1992). The chronic sick or infectious poor had to seek medical assistance from the Poor Law infirmary. Those poor, but not destitute, who sought medical assistance from the Poor Law infirmary had to submit to means testing and, if deemed affluent enough, contribute towards their treatment and care. Admission to a Poor Law infirmary brought about classification as a pauper because medical care received from the Poor Law infirmary was considered as poor relief. Classified as a pauper, because of the Poor Law infirmary care received, the patient lost their right to vote (Spicker, 2014)\(^9\). However the

\(^7\) Interestingly, new purpose built workhouse buildings were designed with surveillance in mind; the objective of the workhouse being that of deterrence. Often variations of the panopticon design was used in order to allow the workhouse master to oversee the inmates (Driver, 2004; Morrison, 1999); surveillance being key to any disciplinary system (Foucault, 1977/1991).

\(^8\) A subscriber, that is a private funder, of the voluntary hospital was entitled to nominate a number of in-patients and out-patients depending upon level of donation (Fissell, 1991).

\(^9\) Whilst there were few poor who did have the right to vote, the Great Reform Act 1832 and the second Reform Act 1867 together extended the franchise, linked to property, to include men who were small land owners, tenant farmers, and shopkeepers, as well as male urban householders and lodgers those whose rent amounted to £10 per annum (or more).
Medical Relief (Disqualification’s Removal) Act 1885 abolished the link between medical relief and poor relief (Crowther, 1981) and so access to the workhouse infirmary became extended. Without the stigma of pauperism and the associated loss of the vote more people turned to the Poor Law infirmaries for care.

The position of elderly inmates within a workhouse, whether in the hospital or the workhouse proper, is difficult to establish. Aged and infirm paupers first coalesced as a category as a result of the Amendment Act 1834. Formal classification of workhouse inmates over the age of seven into gendered groups was not a requirement of the Act, being a result of the 1832 Commission of Enquiry into the operation of the Poor Laws, nevertheless the Act separated workhouse inmates into seven groups of which aged and infirm men and aged and infirm women made up two groups\(^\text{10}\). Following the 1834 Act ‘the aged’ as a group made up a small percentage of the total workhouse population, ranging between 12.5% and 20% depending on location; children made up the largest group within the workhouses (Thomson, 1983)\(^\text{11}\). However, by the late 19\(^\text{th}\) Century the numbers of workhouse inmates aged 65 or over increased to between 33% (outside London) and 50% (within London) of the total workhouse population (Thomson, 1983). Exactly why these elderly inmates were in the workhouse is not clear as records do not indicate the reason, either medical or social, for their admission (Thane, 2000; Thomson, 1983), however the demographic changes seen in the workhouse population may well have been as a result of greater employment opportunities for the able-bodied (Rivett, 1998). To obfuscate matters, age-based statistics were not formally collected until 1913 (Crowther, 1978; Ritch, 2014). Despite the lack of formal statistical workhouse records, workhouse day counts suggest that those aged 65 or over were the largest single group within the workhouse system. However, as the care of sick inmates was decided at individual workhouse level disaggregating ‘the aged’ into those in need of social care, medical attention, or indeed neither is difficult. Further, there were differences in opinion as to how the sick elderly should be best accommodated within the system (Crowther, 1999; Ritch, 2014; Thomson, 1983). Overall, by 1891 6.6% of the 65-74 years age group and 12.7% of the 75 plus age group were accommodated in Poor Law institutions (Thomson, 1983).

These institutions of the New Poor Law, that is the Workhouse and Workhouse Infirmary, were administered by a succession of managing boards. First, instigated by the

\(^{10}\) The seven groups were: aged and infirm men, aged and infirm women, able-bodied males 13 and over, able-bodied females 13 and over, boys aged 7 to 13, girls aged 7 to 13, children under 7.

\(^{11}\) Thomson bases his estimates on national census figures from 1851 onwards.
1834 Act, was the Poor Law Commission. This was succeeded in 1847 by the Poor Law Board, and in 1871 by the Local Government Board (Slack, 1995). The final transference of Poor Law management came with the Local Government Act 1929. This legislation transferred Poor Law powers to local councils which resulted in workhouses and Poor Law Hospitals being integrated into the other local authority services. The Boards of Guardians were abolished and the workhouses officially became known as Public Assistance Institutions (Charlesworth, 2011). Despite the name changes and the transfer of powers, the principles of operation remained intact and the relief provided was done so under the legal authority of the 1601 Act which remained in place until abolished in 1948.

3.3.2.2 NHS and Local Authority care

Following World War II, the Welfare State came into effect in 1948 as a result of a raft of enabling legislation. The National Assistance Act 1948 abolished the 1601 Poor Law along with the workhouses and workhouse hospitals. The National Health Service Act 1946 (implemented 1948) brought the Poor Law Hospitals under the auspices of the NHS; whilst the workhouses themselves remained under the control of the local councils. The National Assistance Act also established the National Assistance Board (NAB) which empowered local councils to provide accommodation for the old and the disabled who were in need of care and so the Poor Law workhouses became the new residential homes of the local authority. From its inception, therefore, the Welfare State inherited an impoverished elderly population contained either within the former workhouse or the workhouse infirmary.

Despite the inherited elderly populations in the newly minted Welfare State institutions, the majority of old people were not accommodated in public facilities. Thane (2009) suggests that upon the establishment of the Welfare State around 132,000 old people were accommodated either in hospital (circa 90,000) or residential accommodation (circa 42,000). In 1948 the overall UK population stood at circa 48 million, whilst those aged 65 and over amounted to circa 6 million; based on these figures the greater proportion of the elderly remained in the community, and this was where government policy intended they should be. Explicit government policy from the 1950s onwards has been towards “community care” (Walker, 1983). Indeed Townsend (1962) quotes the 1958 Minister of Health with saying “the best place for old people is in their own homes, with help from the home services if need be” (p.196); a position born out when examining figures of residential

---

12 Figures extrapolated from Jeffries (2005) and Bozio, Crawford & Tetlow (2010)
homes and beds in Townsend’s seminal study of old people in institutions. Overall, Townsend found that there were a total of 3335 residential institutions (of which 1414 were local authority based) providing 110,767 beds. Of these institutions and beds, 309 institutions were former workhouses which provided 33% of the total beds (Townsend, 1962). The position is clear, in the years following the war the majority of the elderly remained within the community rather than living in local authority accommodation.

The policy of community living for the elderly rather than in local authority run residential care homes has continued over the years and is evident in the myriad of government white papers, green papers and subsequent legislation. Further, the policy position taken with the elderly can be seen in relation to other populations. In the early years following the establishment of the NHS the number of in-patients within mental hospitals rose, reaching a peak of 143,000 in 1954 (Richter, 1984; cited in Morgan, 1993) which reflected well over a third of the total NHS capacity (Rivett, 1998). This position was to change, however with the arrival of the Mental Health Act 1959. A key tenet of the Act was to allow, where possible, the mentally ill to live in the community rather than in government funded mental hospitals. In respect of the elderly, the National Assistance Act 1948 (Amendment) Act 1962 extended the powers of the local authority towards older people. This legislation required local authorities to provide meals and recreational facilities, essentially day care, to support the elderly in their community environment. Local authority powers were further extended with the Health Services and Public Health Act 1968 (implemented 1971). Predicated on a belief that community care was cheaper (Rivett, 1998) and that being cared for in the community reflected the wishes of the elderly themselves (Jones & Peters, 1992), the emphasis was upon people being supported to live locally rather than in hospitals and in residential care homes with support from services that focused on supporting people in their domestic environment.

By the end of the 1960s “care in the community” equated to community living supported by the state in the form of community nursing, home help and meals on wheels; essentially formal or, professional, community carers. However Heaton (1999) argues that over the course of the 1970s the meaning of community care changed from care in the community to care by the community. Rather than the elderly living in the community supported by the state as per the 1960s model of care in the community; the elderly should now live in the community supported primarily by the family, essentially care by the community. This subtle shift is reflected in the White Paper “Growing Older”:

90
“...the primary sources of support and care are informal and voluntary. These spring from the personal ties of kinship, friendship and neighbourhood. They are irreplaceable...Care in the community must increasingly mean care by the community.” (Department of Health and Social Security, 1981, p.3, para 1.9)

The Government position here is clear, the quote highlights the shift in emphasis towards the role of family members as sources of support and care and makes explicit that care in the community is by the community. During the 1960s and 1970s the term “community care” generally referred to the changing locus of care, from the inherited large scale Poor Law institutions of hospital and asylum to smaller, locally based residential units (Finch & Groves, 1980). However by late 1970s, early 1980s, community care no longer referred to formal care based in local community but care by community itself; that is informal care from family and if need be friends. This trend continued in Griffiths Report (1988), a Green Paper commissioned by the Thatcher Government. The Report took the role of family as the primary source of care as the starting point for its recommendations and went on to position the foremost role of publics services as being in support of the family as carer. The Griffiths Report was closely followed by the White Paper “Caring for People” (Department of Health, 1989), a key point of which was that local authorities should provide support for carers. Both these government papers fed into the National Health Service and Community Care Act 1990 (implemented 1993). The support for carers that this legislation heralded was in the form of the right of those in need of local authority services to be assessed for such services and in the process of assessing this need informal carers were taken account of. In sum, people in need of care should be supported to live in the community, and the primary means of support should be the family rather than living in the community supported by formal carers.

3.3.3 Family care provision and the Carers Movement

The Poor Law system of welfare with its “liable relatives” clause, and the conception of citizenship created by the subsequent Welfare State that followed, clearly positioned non-medical care, what we currently define as social care, firmly within the remit of the family. This historical position notwithstanding, the term “carer” was unheard of until the latter half of the 20th century; despite this, family support has long been instrumental for many elderly people in order for them to live without recourse to Poor Law (or Welfare State) support. Turning to this family support, that is the unpaid work that can be termed as familial elder
careing, with the changing political landscape in the twentieth century (see Section 3.3.1) political organisations emerged to pressure Parliament on behalf of women engaged in the caregiving role. These pressure groups were instigated by the very women who were engaged in providing caregiving support within their families with the aim to raise the awareness of Parliament to the hard work and hardship family caregiving entailed and to achieve some financial support for the impoverished caregiver.

3.3.3.1 Legacy of care

Overall, the numbers of elderly within the welfare system (whether Poor Law institution or Welfare State carehome) has consistently been a small percentage of the total elderly population. However, there was an acknowledged increase of older people within the workhouse system over the latter half of the 19th century. Based on census figures from 1851 around 3% of the 65 and over population of England and Wales were workhouse inmates, however by the end of the 19th century this figure had risen to 5% (Thane, 2000). The rise in older workhouse inmates can, in part, be attributed to changes to employment practices between 1850 and 1900. The continued spread of industrialisation at the time demanded an able-bodied workforce. Those deemed unfit for paid work due to infirmity or age-related frailty were not needed by employers. However, retirement as we currently know it did not exist and so those unable to work fell into poverty. If the infirm elderly did not have any family to support them then their only recourse to support was from the workhouse (Thane, 2000). Despite this rise in the elderly workhouse population the overwhelming majority of people aged 65 and over lived outside of state welfare provision. Therefore, contrary to the position of writers such as Thomson (1984) and Crawford and Walker (2009) who suggest that eldercare in the UK has long been a state responsibility, the elderly who were not paupers, and that is the greater majority, remained outside the remit of the Poor Law (or Welfare State) institutions and when in need looked to family for support (Thane, 2000).

The majority of over 65s remained outside of state institutions because of the family support they received, such as the undertaking of caregiving tasks by (mainly) female relatives in conjunction, at times, with joint living arrangements. In a longitudinal study examining census records of the parish of Colyton, South Devon, in the 19th century, Robin (1984) found that unmarried daughters had an important role to play in supporting the elderly of the parish. Robin’s research traced the living arrangements of a cohort of women and men aged 50-59 at the time of the 1851 census. By 1871, when the cohort was aged 70-79, 35% of the group had an unmarried daughter living with them, in some circumstances the daughter
returned to live with their elderly parents after a period away. A smaller percentage of the cohort lived with either ever-married daughters or sons, however there were more ever-married daughters to be found within this living arrangement than ever-married sons. Obviously census records do not document actual engagement in tasks, however it is clear from this historical evidence that it is the living arrangements and formally acknowledged relationship status of women that can make them available to take on the caregiving support role; something that they continue to do.

Intergenerational family living arrangements and familial support tasks, known today as caregiving, were often key to independence from the workhouse or carehome for elderly people, and continued to remain so in the early 20th century. This provision of family care and support, whether in the form of monetary support, shared living accommodation, or help with the everyday tasks of living, was most often provided by the women of the family. This was due, in part to the construction of the female role within society which was shaped by social and political forces along with culturally held notions that caring was the primary work of women (Lewis & Meredith, 1988) in conjunction with her “natural” role: that of wife to the “natural” male role of breadwinner (Holden, 2004; 2007). Married women were often expected to give up work to look after their husband and family. Those that remained within the world of work, along with unmarried women within the workforce, were paid less than men on the assumption that men had dependents to support (wives and family). Further, men were also eligible to claim higher levels of state benefits than unmarried women, whilst married women were often ineligible for any benefits. This inequitable position assumed that married women would be supported by a husband and that unmarried women had no dependents (Holden, 2004). In essence, therefore, at the turn of the 20th century marriage and family caring were the primary work activities of women, once a woman married paid work was considered a less important, secondary, activity. However, unmarried women were also subject to this expectation.

3.3.3.2 National Spinsters’ Pension Association

Despite the centrality of family caregiving to the constructed role of married women, not all caregiving was undertaken by wives, unmarried women also had a key caring role. Holden (2004) argues that in the first half of the 20th century the economic realities of life could mean that people without the resources of savings and/or family to provide care for them in their old age led some families to try and steer a younger daughter from marriage in order to provide for their care rather than their going into a Poor Law institution. Whilst
wives who were caregiving, considered as dependents, would be expected to be supported by their husbands, single women who were caregiving would have no financial support. Early activism on behalf of single women in need of financial help came from the National Spinsters’ Pension Association (NSPA) (Holden, 2004).

The NSPA was founded to represent mainly older, lower middle class, and working class unmarried women on the single issue cause: that of reducing the pension age of never married women to 55 rather than 65 for the contributory pension, or 70 for the non-contributory (public assistance) pension (Holden, 2004; 2007). The NSPA was the largest women’s movement of the time. Formed in Bradford in 1935 by Florence White, it had a majority membership base in the northern textile towns of England where the majority of its members were, or had been, textile workers. The NSPA’s argument for lowering the pensionable age for unmarried women was that many never married women did not retain their right to the contributory pension payable at 65 because they had incomplete insurance contributions; a result of a number of factors, one of which was having to leave work to look after elderly parents (Holden, 2004; 2007, Thane, 1990; 2000). Without a fully paid up insurance record these women were prevented from claiming a pension until they were 70. The NSPA campaigned on this issue via demonstration and petition, submitting a petition to Parliament in 1938 with close to a million signatures (Holden, 2004). Their campaign argument was based on claiming equality with other single women, such as war widows, who were able to receive a pension after the age of 55 based on their late husband’s national insurance contributions (Holden, 2007; Macnicol, 1988).

The single aim of the NSPA was in seeking earlier pension rights for single women whose national insurance records were incomplete, rather than in campaigning on behalf of all women, or indeed all female family caregivers. The 1938 petition did bring into political discussion the financial difficulties that many never married women faced and led to Parliament establishing the Le Quesne Committee to examine the financial argument put forward by the NSPA (Holden, 2007; Macnicol, 1988). Ultimately, the Le Quesne Report of 1939 rejected the Association’s case as it was based on the flawed logic that the incomplete insurance contribution made by unmarried women unfairly subsidised widows pensions; however the Report did acknowledge the issue of genuine hardship for women brought about by caring for elderly relatives (Le Quesne, 1939; Macnicol, 1988; Smith, 1995; Thane, 1990; 2000).

13 The greatest support for the NSPA was to be found in the Northern textile towns of Yorkshire and Lancashire. In this region there had been strong support for the war effort with large numbers of men volunteering for the “Pals” battalions resulting in a “lost” generation of men (Macnicol, 1988).
2000). Whilst unsuccessful in its 1938 aim, the lobbying of the Association brought women’s retirement age, generally, into political discussion and so they had some limited influence on the lowering of the retirement age for all insured women in 1940 from 65 to 60 as part of the Old Age and Widows’ Pension Act\textsuperscript{14}. Further, although the group’s campaign was not just for single women caregivers, the NSPA was the first political group that acknowledged the impact that caregiving had on the financial position of single women (Holden, 2004).

3.3.3.3 National Council for Single Women and her Dependents

Whilst the single woman caregiver was not the figure of central concern for the NSPA, her cause was directly taken up by the National Council for Single Women and her Dependents (NCSWD). The NCSWD was founded by the Reverend Mary Webster, a Congregational Minister who gave up work, aged 31, in 1954 to care for her elderly parents. By giving up her career to take on family caring Webster put herself into reduced financial circumstances, foregoing personal financial security in order to assist her parents. It was from this position Webster pursued a campaign to bring the issue of family caring to into the public consciousness. By 1963 she was a frequent writer to the press, constantly highlighting the position of single women “under house arrest” (Cook, 2007, p.9) providing care and support at home to family at the expense of their own financial security. Webster’s media campaign brought the position of single women carers to public attention and garnered the support of many women who were in a similar position. As a result of the overwhelming support she received, in 1965 Webster established the NCSWD (Cook, 2007).

The NCSWD highlighted the numbers involved, circa 310,000 single women caring at home. The organisation dedicated its time and resources to publicity, campaigning and lobbying the government. Webster gained the backing of some influential supporters. Two of the twelve founding members of the NCSWD were Sir Keith Joseph, Conservative MP, and Baroness Nancy Seear, Reader at LSE (later a Liberal peer). Joseph was instrumental in garnering Carnegie UK Trust funding for the Council during the Council’s infancy, whilst Seear was instrumental in having pre-Council meetings hosted at the House of Commons. Seear was closely involved with the organization, eventually becoming Patron of a later incarnation of the organization, the Carers National Association, in 1988 (Cook, 2007).

\textsuperscript{14} It would be disingenuous to attribute the 1940 pension changes that benefitted women entirely to the NSPA campaign or the Le Quesne Report as neither the Association or the Committee asked for or recommended them (Smith, 1995).
Webster died in 1969 without seeing any of the successes the Council achieved. However, the charity that she started was well established and by 1970 had its first paid director. As a professional lobbying organization with strong political allies on side the Council successfully gained tax concessions and pension credits for single women who were obliged to give up work to provide family care. The first achievement was the Dependent Relatives Tax Allowance in 1967 which provided a tax allowance for those caring for elderly or infirm relatives. This tax concession was eventually abolished in 1988, however the NCSWD went on to secure significant lasting legislative changes during the 1970s. 1971 saw the introduction of Attendance Allowance to assist those in need of constant care at home, 1976 saw the introduction of Invalid Care Allowance (ICA), the first benefit paid to carers, and 1978 saw the introduction of the Home Responsibilities Protection Act that provided protected basic state pension rights for carers (Cook, 2007).

3.3.3.4 The Association of Carers

The NCSWD did not remain the only pressure group in the field. In 1981 the Association of Carers was formed by Judith Oliver. Oliver, who cared for her disabled husband whilst also raising a young family, set up this second organization to support all carers with the remit to support anyone “leading a restricted life because of the necessity to care for a person” (Cook, 2007, p36). This second organization was initially refused charitable status owing to its focus on the carer, who the Charity Commission did not consider as a charitable case. Only in 1984 when the constitution of the Association made clear that their aim was to help relieve carers from poverty and sickness was charitable status granted. Being oriented towards the needs of all carers the organisation successfully campaigned for the Invalid Care Allowance to be extended to married women in 1986 (Cook, 2007). However, achieving parity of treatment for married women had to be pursued in the European Court of Justice.

The Social Security Directive (SSD) (Council Directive 79/7/EEC) of 19th December 1978) addressed the principle of equal treatment for women and men in respect of social security payments seeking parity of treatment across social security allowances. The principle behind the legislation was the elimination of discrimination on the grounds of sex (either directly or indirectly) in respect of benefit access. Member states were reluctant to implement this equalizing legislation due to the prevailing economic conditions of the time; namely increasing unemployment and the need to reduce public spending. The extension of social security benefits to women would bring about further government spending pressures
(van der Vleuten, 2007). This position was particularly difficult for economies based on the principle of husband as breadwinner with a dependent wife and family; that is the Beveridge model that underpinned the Welfare State in the UK. This difficulty was related to indirect discrimination because, despite women being able to apply for benefits the same as men, the criteria for entitlement were predicated on male working patterns: that is full-time uninterrupted employment. As such only women who worked full-time would qualify for benefit entitlement. Further, income support was based on family rather than individual income (van der Vleuten, 2007). The first case to challenge indirect discrimination was in respect of the Invalid Care Allowance. Jacqueline Drake gave up work to look after her disabled mother but was refused the ICA on the basis of being a married woman. The refusal being based on the principle that as she was married she was a dependent of her husband and therefore would be supported by her husband’s income (whether earned wages or social security benefit); a clear example of the Beveridge model of welfare in operation. However, the Association of Carers took Drake’s case to the European Court arguing that the decision was in breach of the SSD requiring equal treatment in social security access. On 24th June 1986 the Court found in favour of Drake but before the decision was formally announced the Thatcher Administration capitulated and agreed to extend the ICA to married women (Cook, 2007).

3.3.3.5 From Carers National Association to Carers UK

The NCSWD clearly campaigned on behalf of the single woman carer whilst the Association of Carers had a much broader base, as a result the Association had a larger membership and a broader reach. Subsequently the two groups merged to become the Carers National Association in 1988 and ultimately Carers UK in 2001. Mergers and name changes notwithstanding, the various incarnations of caregiver pressure groups have made more visible the issues that face the family caregiver. The groups have raised awareness of carers’ needs with successive governments leading to legislation that directly recognizes the informal family caregiver. Previous White Papers (DHSS, 1981) and legislation (Disabled Persons (Services, Consultation and Representation) Act 1986) discussed care in the community and alluded to the fact that people would be cared for within the community by another person. However, the first piece of UK legislation that acknowledged the role of family caregivers was the Carers (Recognition and Services) Act 1995. This piece of legislation was achieved with the lobbying of the Carers National Association and the support of Labour MP Malcolm
Wicks. The Act was the first official record of the term “carer” being used in any form within government documents in respect of the “other person” who would provide care. The legislation gave the carer the right to have their needs assessed by their local authority when the person they cared for was being assessed. Previous legislation had implicitly assumed caring would take place by someone within the family irrespective of the family’s ability and willingness to do so; however as a result of the 1995 Act, in principle local authorities needed to take account of the carer’s needs, that is their ability and willingness to provide care.

3.3.4 The Feminist Critique

The term “informal carer” first crystalised in the early 1970s. This occurred simultaneously with the significant legislative gains that were secured by the first pressure group that emerged in the 1960s. The term rapidly gained much wider recognition during the 1980s; and it is during this period that care itself and the role of women in caregiving became the focus of feminist discussion both within and without the academy.

3.3.4.1 Second wave feminism and caring research

Engagement with care and caregiving as a research topic for feminist researchers first materialized around the same time as the term informal carer solidified as a concept. The first feminist academic work in respect of women and care was distinctly European. Early work emerged from feminist sociologists in the UK (Finch & Groves, 1983; Graham, 1983; Ungerson, 1983) and Norway (Waerness, 1984). This work addressed the issue of caregiving; and in particular the social relations of care and gender. However, work on caregiving as well as the theory of care and caring subsequently appeared from a variety of other disciplines, including the multidisciplinary field of gerontology (Brody, 1981), nursing (Montgomery, Holley, Deichert & Kosloski, 2005), social policy (Arendell & Estes, 1994), philosophy (Noddings, 1984; Tronto, 1994) and psychology (Gilligan, 1982). Different disciplinary work addressed the issue of care from a different perspective, each discipline addressing different research questions and so bringing greater insight to caregiving and gender inequality overall. For example, work from a gerontological perspective has engaged with questions relating to informal care relations (Brody, 1981; 2004; Campbell & Martin-Matthews, 2003, Stone et al., 1987), whilst nursing research has mainly focused on the formal caregiving arrangement (Montgomery et al., 2005). However, much of this feminist academic

---

15 It was Wicks’ Private Members Bill that ultimately became the Carers (Recognition and Services) Act 1995.
work appears to accept the essentialness of female caregiving unchallenged, accepting the caring role of women as is.

3.3.4.2 Ethics of Care

From a philosophical and psychological perspective care research took on a more theoretical position. Ethics of Care have been the topic of psychological and philosophical debate since the early 1970s. The Ethics of Care is a normative moral theory that posits a moral significance to the social relations between people; put more simply, there are right and wrong ways in which to conduct relationships between people (Allmark, 1995). Ethics of Care, or “care ethics” has as its particular focus the nurturing relationship between people and the motivation behind it. Early work on care ethics can be found in the work by Mayeroff (1972) who argued that the essence of caring involves a deep regard for another individual. However, it is via the work of Gilligan (1982), Noddings (1984) and others (Held, 2006; Ruddick, 1989; Tronto, 1994; 2006) that ethics of care emerged as a distinct moral theory.

Gilligan’s (1982) theory of moral development posits that, on the whole, women and men differ in their views of morality with women holding to an ethic of care, whilst men to an ethic of justice. Gilligan’s theory stands in challenge to Kohlberg’s (1981; cited in Boyd & Bee, 2006) theory of the stages of moral development. Kohlberg argued for a developmental trajectory of morals that moved through the stages of pre-conventional, conventional and post-conventional morality, with each stage containing two sub-stages. In the pre-conventional stage moral decisions are based on the individual; that is how the outcome impacts on the decision maker in terms of 1) punishment and 2) reward. At the conventional stage decisions are made on the basis of others’ perspectives; that is how the outcome impacts the decision maker in terms of 3) gaining and avoiding others’ approval and disapproval and 4) obeying rules and avoiding guilt. In the final stage, post-conventional, decisions are made on the basis of 5) societally agreed right and 6) personal moral guidelines. Movement between the stages is contingent upon developing cognitive abilities. These three stages were developed from longitudinal research interviews with an entirely male sample of children and adults, when girls were included in later studies they scored lower than boys. A further source of male bias is in Kohlberg’s conception of morality as being deontological, that is focused on the rightness or wrongness of an action. Put simply, from a deontological perspective moral decisions are based on notions of rights and duties based on principles of justice; a position that favours traits considered as more masculine (Pettersen, 2008). It is this
androcentric bias that Gilligan argued made Kohlberg’s theory limiting in its applicability to women.

Gilligan’s (1982) counter thesis also offered a stage theory of development, this time with a focus on women. And, similar to Kohlberg, Gilligan held to the three stages of development: pre-conventional, conventional and post-conventional. At the pre-conventional stage the individual is focused upon themselves in order to survive, at the conventional stage the focus is directed towards responsibility to others, whilst at the post-conventional stage the individual comes to accept the principle of care for both themselves and others. However unlike Kohlberg, for Gilligan transition between the stages was linked to changes in the development of one’s sense of self rather than in developing cognitive abilities. According to Gilligan there are two distinct moral “voices”, that of the feminine and masculine. The “masculine voice” was as proposed by Kohlberg’s original theory of moral development. In this “voice” moral decisions are guided by notions of rights and justice. The “feminine voice” however, sees decisions being guided by the maintenance of interpersonal relationships and caring for other people. In sum, the focus of an ethical decision rests on the ethical “voice” position. From a “masculine”, or justice, perspective the rights of an individual are considered paramount, whilst from a “feminine”, or care, perspective the needs of an individual are more important. Gilligan argued that as Kohlberg’s theory espoused a masculine position it was not a suitable tool with which to assess the moral development of women.

There is a tension between essentialist, natural notions of care and caring behaviours as a result of socialization. Gilligan herself is unclear as to the origins of moral differences between the genders (1982). Despite this Weisstein (1993) intimated that Gilligan’s work is at worst essentialist and at best decontextualized. However, others have argued the case that her more recent work (Taylor, Gilligan & Sullivan, 1995) takes account of relations of power in in the construction of difference and that an essentialist reading of In a Different Voice may not be warranted (Heyes, 1997). Heyes’ argument is based on a failure to explore differences between people (Tronto, 1994). However, it can be argued that if her theories are decontextualized then there is no challenge to the dominant essentialist discourse. Further, based on the notion of relational power, if there is no challenge to the dominant discourse then there is silent acceptance.

Whilst Gilligan’s theory regarding an ethic of care originated in her psychological research Noddings work was firmly situated within the philosophy of education. Despite the
differing disciplines, like Gilligan, Noddings (1984) argued that traditional ideas on morality were androcentrically biased. Noddings (1984) theorized a feminine relational ethic of care which gave priority to the caring relationship. She argued that caring should be considered as being central to morality. Noddings’ theory draws on the maternal position of caring relations and so for her caring relationships consist of the “one-caring” (carer) and the “cared-for” (caree). In this theory caring is a natural “engrossment” of the carer for the caree, that is being engaged with the caree and concerned for their needs, as well as the displacement of selfish motives of the carer so that they act for the good of the caree. In return the caree must acknowledge the engaged caring of the carer. It needs to be noted here that Noddings’ position assumes all caring takes place in a dyadic one-to-one situation where caring is engaged in in a reciprocal relationship that satisfies these three positions. Caring that does not satisfy the three conditions is not, in Noddings opinion, caring. This position elides any caring that takes place outside of this reciprocal dyad. As such, caring that is not acknowledged by the caree, or caring that is undertaken by more than one person is not considered as genuine caring. Further, Noddings’ position suggests that any burden experienced as a result of caring are avoided provided the reciprocal relational aspect of care is in place; again this negates the lived experience of many caregivers and renders the burden experienced by caregivers in an unacknowledged caring relationship as something other than caregiver burden.

3.3.4.3 Caring and the feminine identity

Care research is either theory oriented or action oriented, therefore whilst not speaking directly about the hands on activities of caregiving Gilligan (1982) argued that the feminine personality defined itself in relation to and in connection with others which manifests as a concern for others, or an ethic of care. It is this ethic of care that drives women to the caring role. On the other hand, Graham (1983), basing her arguments on the psychoanalytic perspective, argued that it is the caring role that provides women with their feminine identity. Either way, however, this critique maintained the status quo by positioning women as the natural carers, which Finch and Groves (1983) argued put women in an unequal position with regard to taking on caregiving roles. They argued that family caring was in fact just a shorthand for women’s caring per se and that the move towards care in the community (Section 3.3.2), that is primarily provided by the family, imposed an unequal burden on women carers such that there was an expectation that they take up the additional caring role in respect of the elderly who need care. And, whilst Finch and Groves argument that women
take on an unequal caring burden rings true, and continues to do so today, this support for the essentialist argument of the naturalness of women’s caregiving has remained unchallenged, despite the social psychological argument in favour of gender socialization (Eagly 1987; Eagly & Steffen, 1984)

Much of the caregiving research is multidisciplinary. However irrespective of discipline, all of it is shaped by the nature of the caregiver construct in the shape of a heterosexual, related, female family member, such as a wife, daughter, or daughter-in-law. Gerontological research into care expanded following second wave feminism in the 1960s, however it has focused almost exclusively on the heterosexual female family caregiver as the literature examined above (Section 2.1) demonstrates. Further, the essentialist narrative of natural female care was not questioned. This research position elides the caring undertaken by those who do not fit the normative caregiver construct.

Focusing on the psychological research perspective, psychology generally and social psychology in particular, can offer insight and theorisation in respect of care. However, they are little used and when they are the position is no different with, the heterosexual female relative being the main focus. From a Foucauldian perspective psychology can be considered to be a disciplinary discourse, which is legitimated by a recourse to the scientific, which in turn imbues its research and findings with the power to regulate the behaviour of people via the defining of what is considered to be normal and acceptable. Moreover, the discipline also ensures that those who do not fit within those defined boundaries of normal are assisted to conform by way of intervention and treatment (Rose, 1989). When psychology focuses on caring the aim of much psychological research is to treat the psychological symptoms of caring, such as care giver stress and burden (Kiecolt-Glaser, Dura, Speicher, Trask & Glaser, 1991; Pearlin et al., 1990), or to ensure that positive aspects of caregiving are made more salient (Schulz & Sherwood, 2008), both of which may encourage women to engage more with their expected role, whilst remaining silent on the question of nature or nurture; a theme often central to any psychological enquiry. In sum, the political objective of both positions within psychological research is to ensure that those who are caring continue to engage with their prescribed roles within the discourse and continue to care irrespective of personal cost.

3.4 Discussion

The focus of interest for this study was how the current UK conception of the informal carer came into being. As with Foucault’s (1978/1998) approach to sexuality, the study took
an historical approach, adopting a genealogical method of enquiry. It is in the nature of an empirical PhD chapter, that of necessity limited justice can be given to any genealogical account; however this limited analysis can provide the following conclusions.

3.4.1 Findings

In respect of political and social change, the legacy of the social and political changes to social welfare deriving from the Old and New Poor Laws situated caregiving and support for relatives firmly in the arena of the family, a position that was reinforced by the Beveridge vision of welfare as of right. Irrespective of whether the welfare system was residual or institutional, all were predicated on a patriarchal and heteronormative discourse of family life. Further, with the advent of the social insurance arrangements proposed by Beveridge reinforcing the heteronormative discourse of women’s role within the home, the overriding organizing axis unquestioningly positioned women as caregiver within that homemaking role.

Meanwhile, the move to community care was a result of legislation that, conversely, brought larger numbers of people under the remit of Poor Law jurisdiction. The Amendment Act 1834 put in place administrative procedures that led to the reduction of outdoor relief along with the establishment of separate workhouse infirmaries. Subsequent legislation extended access to the workhouse infirmary to those who were not formally classified as a pauper. Together, this had the effect of bringing larger numbers of people into the institutions of the New Poor Law, whether pauper or not. Over the course of the 19th century the numbers of aged and infirm within the workhouse system increased and when the Poor Law Institutions transferred into NHS and Local Authority control in 1948 so too did the resident elderly population therein. From the inception of the Welfare State, however, successive governments have legislated to transfer care of this population back into the community and therefore back to the care of the family.

Historically only a small proportion of the elderly population fell under the remit of welfare state support. The majority of the elderly population lived independent of the state with varying levels of additional family support. The family support provided was most often provided by daughters, both married and unmarried. Women who gave up paid employment to provide family care often suffered financially, both at the time of caregiving and continuing into their own old age. Spinsters were at a particular disadvantage in respect of the old age pension, often losing their entitlement to the contributory state pension at 65 due to an interrupted contribution record. The inequality caused by these pension arrangements was campaigned against by the NSPA, but without success. And, whilst not the NSPA’s raison
d’être, it should be noted that the Association were the first political group to recognize the impact that caregiving had. However, the move to community care in the years following the establishment of the Welfare State provided the impetus for caregiving to become a direct political issue, becoming the core remit of the NCSWD. The NCSWD lobbied Parliament to successfully achieve welfare benefits for single women carers during the 1970s. Other organisations, such as the Association of Carers, joined the arena to work on behalf of all caregivers to achieve wider ranging benefits. These two pioneering organisations were set up and run by carers for carers to provide support and information to the carer as well as to work on behalf of the carer in securing positive legislation changes. The overlap of remit saw the merging of the two organisations and the establishment of what is known today as Carers UK, the largest voice for carers in the United Kingdom. The creating of an umbrella pressure group to work on behalf of all carers provided greater political weight and subsequently achieved the formal recognition of informal family carers in law.

The activism of the carers movement of the 1960s and 1970s occurred concurrently with second wave feminism which saw the emergence of feminist care work within the academy across multiple disciplines, but most notably in the fields of gerontology, philosophy, and to a lesser extent psychology. The gerontological work was often taxonomic and descriptive of the caregiving relationship and the effects of care, whilst work within the remit of philosophy focused on the theory of care. The psychological focus, however provided both enquiry into the theory and effect of care. All this research, however, did not challenge the essentialist positioning of women as the natural carer. Indeed, the caregiving research base, psychological or otherwise, generally failed to engage with the more structural, social psychological theories of gender socialization as explanation for women’s continued caregiving. Further the disciplinary nature of psychological science has engaged with research that ensures the continued engagement of caring by those who are most likely to suffer by doing so.

3.4.2 Conclusion

What becomes apparent from the examination of political changes and the activism of carers themselves, is the contentious relationship between women and the patriarchal social system. A welfare system predicated on the male breadwinner model leads to normative heterosexual relationships and adopted gender role norms clouding the issue of discrimination. Policies that on face value appear to offer fairness in an equitable manner in actuality perpetuate inequalities both socially and academically.
Much of the empirical psychological and gerontological research that is focused on the informal carer examines the many dimensions of the informal caregiving role; whilst much of the gerontological research is descriptive and taxonomic of caregiver type, and caregiving task. The limited psychologically focused enquiry into elder care and caregiving is narrowly focused on caregiver stress and burden, and how best to alleviate this in order to allow the caregiving dyad to continue. Whilst the aims of this research corpus are certainly worthy, what is clear is that the research has been shaped by the construct of the informal carer that is available. It is only when the concept has been named in the early 1970s do we find research beginning to emerge, with considerable growth in the field following the wider emergence of the informal carer concept in the late 1970s and early 1980s.

Types of care given and who provides the care has been extensively researched by Brody and colleagues in a number of studies in the 1980s (Brody, 2004). The experiences of carers have been explored by Lewis and Meredith (1988) who recruited their participants from the membership of the National Council for Carers and their Elderly Dependents. Issues such as caregiver burden, suffered as a consequence of providing care, and the psychological and social impact it has, has been explored by researchers such as George and Gwyther (1986), Chappell and Reid (2002), Jones and Peters (1992) and so on. However, this body of research does not question why the family provides care, or why the family member who is the carer is most often a related female. In the first instance the political discourse dictates that care is a family affair, whilst in the second the early feminist discussion naturalised the care giving role to the women of the family. As such those individuals who do not conform to these requirements, such as men or lesbians are not sanctioned as carers.

By conceptualizing caregiving into formal and informal arenas a professional/non-professional dichotomy is invoked; such that community care is seen as voluntary rather than statutory, informal and so less expert than formal and therefore expert, and unpaid rather than paid (Horden & Smith, 2013). Formal caregivers are conceptualized as professional and come in the guise of those employed by the state either directly or indirectly in the form of Social Services provided home help and frontline medical workers such as district nurses or disease specialist nurses such Parkinson’s Nurses in the UK. These formal caregivers are conceived of by UK legislation as being facilitators, or enablers, of a family-based home care network (Graham, 1991; Heaton, 1999). However, nursing practice itself can be thought of as part of the medical gaze (Foucault, 1963/2003; Fox, 1995) and therefore a tool of

---

16 An interim name adopted between the National Council for Single Women and her Dependents and the merged name of Carers National Association.
governmentality. In sum, formal care is a technology of power (Rose, 1999) as it aids the
control of society via the use of disciplinary power in that it guides and directs the behaviour
of both the informal caregiver and the cared for individual.

The Old Poor Law, despite counter claims in the academy (Slack, 1988; Thomson,
1984), situate responsibility for non-financial and non-medical support within the family. Put
simply, this is the type of caregiving that many families provide to their older relatives. The
system of care underpinned by the Old Poor Law paved the way for the future. The powers
created by the 1601 Act, to raise money from the parish through taxation, can be considered
more a proto local authority rating system than a proto care system; whilst the poor law
hospitals can be seen as the ghost of the NHS yet to come. The advent of the Welfare State in
1948 reinforced the heteronormative family and the gendered division of labour within it.
And, whilst inheriting a population of elderly within the Poor Law hospitals and infirmaries,
the NHS quickly sought to return them to their families where possible.

The gendered division of labour within the family maintains the status quo of
patriarchal heteronormative ideology, arguably reifying an essentialist male
breadwinner/female domestic labourer position (Burman, 2007). In turn, this position
privileges Western heteronormative models of caring where the task of caregiving is a
gendered one undertaken by those considered female and related. Burman argued this
position in relation to child care, however all care falls within the remit of the private sphere
and so can be extended to elder care. As previously noted, caregiving research is a
multidisciplinary affair. However, within this multidisciplinary approach, as a discipline
psychology is not often engaged with and when it is its role is very much disciplinary.
Despite this, the work of psychology, offers concepts and theory that can critically engage
with the prevailing discourse of heteronormative caring and illuminate previously elided
caregiving, as evidenced by the work of Burman (2007). Indeed, by doing so the
understanding of both the caregiver’s and care receiver’s experience of informal caring will
be enhanced.
Chapter 4: Who Cares? UK Lesbian caregivers in a heterosexual world

4.1 Outline of study presentation

This chapter along with Chapter 5 presents the analysis of data and findings from empirical study 2. Overall, the grounded theory methodological approach to the analysis identified six key themes with four themes being presented in this chapter and two in Chapter 5. The decision to present in this way is related to theme focus. The themes examined here mainly highlight issues that can be of relevance to all carers irrespective of sexuality, although how these issues are germane to a lesbian family caregiver are made more salient. Whilst those explored in Chapter 5 are more unique, although not entirely, to non-heterosexual carers.

Presenting the data across two chapters has allowed for a more focused examination of the extant literature as well as a more thorough discussion of the findings. The structure of this chapter follows a traditional qualitative approach incorporating a relevant Introduction, Method, Analysis, and Discussion. However, as this chapter presents part of the findings of one overarching study the Discussion (Part 1) presented here only summarizes the findings presented here. A more detailed General Discussion will conclude the study in Chapter 5. Finally, with respect to the review of the literature, one approach to grounded theory methodology is to engage in data collection and analysis first, before engaging with the extant literature in order to avoid imposing existing concepts and ideas on the data set (Charmaz, 2006; Glaser & Strauss, 1967/2006); a position that was adopted with this study. As a result the chapter Introduction Section presented here were completed post analysis and serve to introduce and reflect the themes presented.

4.2 Introduction

The genealogical study presented in Chapter 3 outlined how the current construction of the informal caregiver came to be, from a UK perspective. This examination indicated that the informal family caregiver role is both heteronormatively positioned and female gendered. The heteronormative family discourse that has helped shape the current construction of the informal carer has also been instrumental in shaping the research literature about carers and

17 A version of this chapter has been published as: Parslow, O. & Hegarty, P. (2013). Who cares? UK lesbian caregivers in a heterosexual world, Women’s Studies International Forum, 40, 78-86
caregiving, with the overwhelming focus of this body of research being the heterosexual female caregiver. This body of research indicates that caregiving has considerable negative effects on the health, social life, family life, and work life of carers. This research base, along with caring in practice and political discourse, serves to construct caring as appearing to be a natural role for women. This position is bolstered by the evidence which indicates that informal carers are mainly women, related either by blood or marriage, to the care recipient. The female family members most likely to be in the caregiving role are either a wife, and if there is no wife the daughter that is considered by others within the family to have the least amount of pre-existing commitment. The extant research examined in Chapter 2 is in many ways a reflection of many caregiving experiences.

However, the existing research positions the carer within a heteronormative discourse and assumes the heterosexuality of the caregiver, despite Kimmel’s (1992) argument that lesbians may be considered as a potential family carer due to being perceived as having fewer responsibilities than heterosexual family members. These heteronormative constructions of caring, and the norms that surround them, elide the caregiving that non-heterosexual caregivers, such as lesbians, engage in. These women, who by virtue of their sexuality are normatively different, and in being different have to create new rules to live by where the dominant heterosexual ones are not particularly useful (Brown, 1989). The small body of caregiving research from an LGBT framework (see Chapter 2), whilst recognizing that parental caring is taking place, is mainly focused upon same-sex partner caring and caring within a friendship context. Both of these positions situates the lesbian woman as being outside the normative family, whilst neither of these positions addresses the intersection that is the lived experience for lesbians who have become involved in family of origin caregiving. The overall aim of this study was to address the elided experience of lesbian family of origin caregivers. The specific aims of this chapter are to gain an understanding of the experiences of lesbian women with elder care responsibilities.

4.2.1 Duty and obligation

Much of the caregiving literature addresses the practical issues that hands-on caregiving entails, or the health and psychological effects that actual engagement in caregiving brings with it (see Chapter 2). A third area of caregiving research addresses the issue of the caregiver’s sense of duty and obligation toward the care recipient, often referred to in the literature as filial obligation, filial responsibility (Blieszner & Hamon, 1992), or filial piety (Funk, Chappell & Liu, 2013).
The filial sense of duty and obligation is grounded in societal assumptions that the parent-child relationship lasts a lifetime and involves responsibilities on both sides of the relationship (Stein et al., 1998). Conceptualised as a societal expectation, or social norm, filial responsibility suggests that elderly parents are entitled to be cared for, and that their children have a duty to provide that care (Stein et al., 1998). As a social norm, filial responsibility brings with it prescriptive expectations of behaviour in respect of adult children such as assistance with general household upkeep, shopping, emotional support, physical care and, potentially, in shared living accommodation should the need arise (Blieszner & Hamon, 1992). Research findings suggest a complexity of factors are involved in how people perceive and engage with filial responsibility including felt affection toward the parent, role conflict, gender role socialization, past parent-child relationship quality and legitimacy of care needs, and cultural values; all of which have influence on how caregiving is coped with by the carer.

Research into the development of adult child feelings of filial obligation has found predictors of felt obligation varied both by the gender of adult child caregiver and the parent in need of care. With respect to adult daughters and their parents there were differences in predictors between mothers and fathers as care recipients. Level of affection for the mother predicted the level of felt obligation, such that the greater the level of affection the greater the daughter’s sense of filial responsibility. This was not the case in respect of fathers. Here role conflict, that is competing demands, affected levels of felt obligation, such that the more the daughter found role responsibilities conflicted the less obligation she felt. Theoretically, a woman’s felt obligation to her father might be considered as more costly, in terms of her other competing demands, than those felt toward her mother (Finley, Roberts & Banahan, 1988). Lower felt filial obligation is likely to reduce an adult child’s engagement in parental care, however if a woman has no other caregiving options available to her other than to provide the care needed she may potentially experience more caregiver stress and burden when caring for fathers despite feeling less obligated, as a result of other competing demands.

The socialization process can be considered to influence gendered subjective experiences of filial obligation. Women’s socialization across the lifespan can lead to their developing a stronger sense of felt filial obligation towards physical engagement with caregiving than men. This is a result of caregiving being seen as a natural feminine trait which has been conceptualised as part of the female gendered role, whilst male roles are more oriented towards work role practices (Brewer, 2001). Gendered socialization leads to
different approaches to the filial caregiving situation. Women who internalize gender role norms engage more with caregiving to avoid being considered as morally deficient (Friedemann & Buckwalter, 2014). Men are more likely to engage in caregiving tasks considered male gendered whilst also feeling less obligated, and so more prepared to engage outside help where necessary (Calasanti & King, 2007). In sum, women may be more likely to take on the burden of caring directly, whilst men may be more likely to manage the caregiving activities of others; a position that may leave women open to experiencing greater levels of caregiver burden.

The past relationship between the caregiver and care-recipient has been found to influence the carer’s sense of obligation, as well as the perceived legitimacy of the care need. Research by Wuest (1998) examined health outcomes and the use of coping strategies of women caregivers. She found differences linked to the caregiver’s past relationship with the care receiver as well as the degree to which felt obligation contributed to their taking on the caregiving role. When past relationships had been strained and caregiving was driven purely by obligation poorer health outcomes and greater levels of perceived burden were found. This conception of obligation, however, is linked purely to notions of societal pressures and others’ expectations rather than any caregiver feeling of affection toward the care recipient. How obligated the caregiver felt was related to their sense of how legitimate they felt the claim for care was in terms of the care recipient’s perceived dependency and the expectations of others. This result has been supported. Lyonette and Yardley (2003) also found that caregiving brought about by external forces, that is the expectations of others or lack of alternatives, have been associated with greater levels of caregiver stress. More recent work by Wuest, Hodgins, Malcolm, Merritt-Gray and Seaman (2007) has indicated that the more strained the past relationship the greater the sense of obligation. Wuest et al., posit that increased obligation may be as a result of heightened awareness of expectations from professionals and other family members. It appears that felt obligation on its own without feelings of affection or accompanied with a difficult relationship history can lead to increased levels of caregiver burden and stress.

Finally, cultural expectations and felt obligation have also been found to influence the effects of caregiver burden. Research with non-Western cultures with high levels of filial responsibility consider elder caregiving as part of people’s life expectations whilst also reporting low levels of felt caregiver burden (Martin, 2000). Cross-cultural research by Funk et al., (2013) examined the impact of cultural differences in the relationship between filial
responsibility and caregiver well-being in three different cultural groups: Caucasian Canadians, Chinese Canadians and Hong Kong Canadians. Overall, the results were mixed, but a clear finding was that for the Caucasian Canadians greater filial responsibility was associated with lower health status, there were no significant findings for the other two groups. Funk et al., theorise that this outcome for the Caucasian group may be related to the individualistic nature of Western cultures where family involves personal choice and external pressures to take responsibility are considered as a negative influence. In sum, it appears that depending upon cultural context felt obligation may have a differing impact on whether caregiving is perceived as more or less burdensome. From a Western individualist position, social norms to engage with family caregiving lead to greater levels of felt burden.

4.2.2 Caring and boundaries

Engaging with filial elder caregiving brings with it a number of negative consequences in relation to both physical and mental health ranging from tiredness through to anxiety and depression (Schrag, Hovris, Morley, Quinn & Jahanshahi, 2006). Further, the task of providing care itself, irrespective of any other issues, has been found to be stressful in and of itself (Savla, Almeida, Davey & Zarit, 2008). As well as these health issues the impact of caregiving can also be felt in other arenas such as work life and social life. Working caregivers may find they need to reduce their hours of work or forego career advancement in order to provide care. Both situations bring with them financial implications for the caregivers’ current socio-economic position as well as their personal retirement resources (Wakabayashi & Donato, 2006). In respect of social engagement, many caregivers find that engagement in social life and social activities diminishes as caregiving demand increases (Pearlin, et al., 1990). In order to ameliorate these issues many caregivers engage in strategies to avoid or limit the impact caregiving can have. One such strategy is in the setting of boundaries, particularly where the caregiver has other competing demands.

Research by Aronson (1992) with 28 Canadian women who had cared, or were providing care, for their elderly mothers qualitatively explored how the women’s sense of responsibility in respect of caring for parents was shaped by social norms in respect of gender performance. A key finding here was that the women set limits to their caregiving in terms of space, finances, time, energy and commitments to others such as husbands and children. Here legitimate and unacceptable explanations for setting limits emerged, with the needs of other family members such as husbands and children being considered as more legitimate than

18 18 participants were engaged in caregiving, 10 had previously been caregiving.
personal reasons such as work or education. In particular, explanations that were self-focused were considered as selfish and unacceptable. Explanations deemed as legitimate adhered to the prevailing norms and expectations of the feminine and female gendered role norms; whilst reasons deemed unacceptable were centred on autonomous activities that were more aligned with male gendered role norms. Overall, there was a division in the participants with respect to legitimate and unacceptable setting of limits. Married women provided legitimate boundaries and unmarried women more generally the unacceptable ones. Having unacceptable reasons for limiting care led to feelings of guilt. In sum, it appears that to set a limit to caregiving is only acceptable if the time and energy released by the self-imposed limit is transferred to other acceptable heteronormatively defined female tasks such as caring for a husband or child.

Irrespective of the acceptability of women’s reasons for why they set their caregiving boundaries, it is clear that setting boundaries has been a technique used by women to allow them to manage competing demands. However the acceptability of the reasons for limiting care may have psychological consequences. Some of Aronson’s (1992) caregivers were setting their boundaries in relation to non-caregiving demand, therefore a more psychological perspective may well better explain the issues that are being faced by those whose boundaries are for self-focused reasons. For example, the self-discrepancy theory of Higgins (1987) may be a useful vehicle to explain the feelings of guilt experienced by the women giving “unacceptable” reasons for limiting their caregiving in Aronson’s (1992) study. Higgins’ theory posits that discrepancies between an individual’s self-state representations (that is the actual, ideal and ought selves) and the standpoint of either the individual (own) or that of a significant other will bring about differing emotional responses depending on where the discrepancy lies. A discrepancy between actual self from the individual’s own standpoint and ought self from the other standpoint predicts feelings of guilt due to having violated a personally accepted moral standard that others would expect them to uphold. Therefore, for the women in Aronson’s study the setting of parental caregiving limits for personal reasons rather than legitimate socially accepted gendered reasons such as care for other family members produces a self-discrepancy along the actual/own versus ought/other axis, and so leads to feelings of guilt.

However, setting boundaries to care has not always engendered guilt. Notably, research with the “baby boom” generation has not found guilt being an outcome of setting

---

19 Marriage at the time in Canada was only available to heterosexual couples.
caregiving boundaries. Rather, boundaries to caring were utilised as a strategy in order to maintain multiple social identities and roles. “Baby Boomers”, the first post-World War II generation\(^{20}\), have been characterised as being more individualistic and focused on self-realization than previous generations (Roof, 1993). Further, this generation grew up in a changing social environment, both in respect of women’s participation in the workforce as well as in respect of marriage in the form of increasing divorce rates (Brewster & Padavic, 2000; Easterlin, Schaeffer & Macunovich, 1993). As a result, the baby boomer generation are more likely to have work commitments as well as more social and cultural interests than previous generations of family caregivers, whilst being less likely to have family support to fall back on if there is a need to become involved with family caregiving. The qualitative study by Guberman, Lavoie, Blein and Olazabal (2012) with a cohort of 39 Canadian\(^{21}\) “baby boomer” caregivers supported this premise, finding that many of their cohort of baby boomer caregivers worked outside the home and were more involved with social and cultural activities. Further, the baby boomers made clear that their participation in caregiving came with limitations in order to prevent them engaging entirely with the caregiver identity and role at the expense of relinquishing other social identities and roles. Conditional engagement with caregiving was in a more managerial and organisational role rather than hands-on caregiving in order to allow continued engagement in social and work life. Overall, the participants were reluctant to reduce their autonomous public facing commitments and engaged in boundary setting in order to achieve this.

4.2.3 Caregiving and the salience of identity

Both a carer identity and a sexual identity can be pertinent to an individual’s understanding of themselves in terms of both self-concept and identity. The concepts of the self and identity are everyday ways in which people understand themselves and how they act within the world as well as being concepts that have been examined by psychology. From an individual perspective identity can be considered to be the subjective conception of the self that an individual has of themselves. From a psychological perspective the concepts of self and identity have been considered and examined from different epistemological positions. Empirical social psychology has posited the self-schema approach to the self, grounded in the

\(^{20}\) The baby boomer generation is considered as being those born between 1946 and 1964, approximately. Consensus on dates vary, and there may be an overlap between the generations, as the following generation, Generation X, has been hailed as including those born in the early 1960s (Roof, 1993).

\(^{21}\) 29 French-Canadian; 3 English-Canadian; 7 Italian descent.
ideas of social cognition, where the subjective self is considered to be a reified construct that can be examined to establish its function and structure, whilst identity is the way people understand who they are within the world (Augoustinos et al., 2006). Social psychological approaches to identity have been Identity Process Theory (IPT) (Breakwell, 1986; 1993; 2001) and Social Identity Theory (SIT) (Tajfel & Turner, 1979) (see Chapter 5). Other approaches to identity have been from a sociological and social interactionist position (Stryker, 1968; Stryker & Burke, 2000). On the other hand, from a social constructionist position, the subjective experience of self and identity are constructed intersubjectively (Burr, 2003). Irrespective of the epistemological position, conceptions of the self and identity hold to the importance of the social situation and of social interaction to an individual’s understandings of their self and identity.

4.2.3.1 The Self in Social Cognition

From a social cognition perspective the self is the sum total of knowledge a person holds about themselves. This combined knowledge forms the individual’s self-concept; that is representative knowledge stored in the memory which becomes activated by social encounters (Augoustinos, et al., 2006). In many respects this representative knowledge can be considered to be a set of interrelated self-schemas which are generalised self-knowledge based on past experience. The knowledge contained in these self-schemas guide the individual’s action within the present (Markus, 1977). In this way individuals can be seen to relate to the social world in a consistent manner. This body of self-schemas can be thought of as the *global self-concept*. However, the self is a work in progress and as experiences occur over time the *global self-concept*, although stable, will change to accommodate new information. Given the potential volume of self-knowledge an individual holds, not all self-concept information can be readily available. Only a sub-set of information is available to the individual at any one time, which is the *working self-concept* relevant to an individual’s current behaviour and experience (Markus & Kunda, 1986). Differing sub-sets of information are available in differing situations, as a result the *working self-concept* allows for a dynamic “self” that differs in relation to current situation.

The Self-Discrepancy Theory of Higgins (1987), discussed above, is firmly situated in the social cognitive perspective; as too is Markus and Nurius’ (1986) concept of *possible selves*. Possible selves can be considered as the individual’s personal representations of the self in the future. They can be considered to be all the individual’s possible futures, encompassing positive images of the self, and so a hoped for future self; or negative self-
images, and so a feared future self. These potential future selves are based on the current self-concept and act as the motivation to current behaviour, either to avoid the feared future self or to work toward the hoped for future self (Cross & Markus, 1991). Put simply, the current self-concept draws meaning from future projections of the self which then allow it to change as a result of future representations of what the self might be (Markus & Wurf, 1987). Whilst both self discrepancy theory (Higgins, 1987) and possible selves (Markus & Nurius, 1986) assume that potential aspects of the self (the ideal self of Higgins or the future self of Markus and Nurius) are axes of understanding the current self they differ in relation to how that explanation can be understood. For Markus and Nurius, future possible selves serve as motivation and direction to current behaviour; whilst for Higgins, discrepancies between the actual self and the ideal or aught self can provide explanation for negative affect.

4.2.3.2 Theories of identity

With respect to identity, Deaux (1993) points out that the concept of identity is one used by both people themselves, and psychology, as a way in which to define the individual and their behaviours. For the individual, they may actively claim an identity, and give a value to the meaning that the identity holds for them; whilst others may categorise the individual as belonging to an identity, irrespective of whether the individual claims the identity for themselves. Further, some identities are ascribed, that is the individual has none (or very little) control over category membership, such as gender, race and ethnicity; still others are acquired identities and are the ones that the individual has more control over, often choosing the identity themselves (Augoustinos et al., 2006). All these identities form the basis of individual self-definition (Deaux, 1993).

IPT (Breakwell, 1986; 1993; 2001) posits that identity is a social psychological process that manifests through action, thought and affect. People are “self-constructions” building, changing, and monitoring their identity through the two processes of assimilation-accommodation (this is how identity absorbs new information into its structure) and evaluation (this is the constant evaluation of identity). IPT is based on four motivational principles. First, is continuity, that is the sense that the self is the same over time, despite changes; second, that of self-esteem, that is the individuals’ feelings of self-worth; third, that of distinctiveness, that is a feeling of being unique, distinct and separate in relation to others; and fourth, that of self-efficacy, that is the individual’s sense of agency, control and competence. The salience of each of these principles may differ between people with some people more concerned with distinctiveness, others continuity. The focus of IPT is on threats
to identity and coping strategies. Threats to identity occur when the processes of assimilation-accommodation and evaluation are unable to satisfy the four principles. Threats can originate either internally, when an individual wishes to change their social position; or externally, from the individual’s social context. Once identity has been threatened, coping strategies are employed in order to restore the equilibrium in the four motivational principles. Coping strategies fall into three distinct areas: intrapsychic, interpersonal, and intergroup. Intrapsychic strategies involve deflection, acceptance and re-evaluation of current identity contents. Interpersonal strategies involve isolation, negativism, passing, and compliance. Intergroup strategies involve being a member of multiple groups, group-support (self-help), and group action (social movements).

Identity theory offers explanation for behaviour based in terms of the relationship between the self and society (Stryker, 1968). A more sociological approach than social cognition, the theory is grounded in the ideas of Meadian social interactionism whereby an individual’s social behaviour is predicated by the influence of society on the self. Based on the ideas of James (1890) in respect of a person having as many selves as they have interactions with others, Stryker’s theory posits that each self is an identity that brings with it a position and role, and in turn roles bring with them expectations of behaviour. A person’s identities are organised in accordance with a salience hierarchy (Stryker & Burke, 2000), with those that are more likely to be acted upon featuring higher up in the hierarchy (Hogg, Terry & White, 1995). Stryker defines identity salience as being the likelihood that a particular identity will be invoked, either across situations or in relation to a person or persons in any given situation (Hogg et al., 1995; Stryker & Burke, 2000). Drawing from the social cognitive approach to the self (Markus, 1977), identity theory argues that identities can be considered as schemas that act as a guide to interpret and define situations and as a guide to behaviour therein (Stryker & Burke, 2000). Further, the position in the hierarchy of a particular identity in relation to other identities will predict the likelihood of a particular identity being invoked and so the type of behaviour engaged in (Hogg et al., 1995).

Identity theory also argues that identity salience is linked to both affective outcome and level of commitment that an individual has to a particular identity role. Such that identities that have a more psychologically positive outcome in relation to the self will be more salient; whilst commitment to an identity role is greater where there are more social relationships connected with it (Hogg et al., 1995). The implication of losing an identity role that is invested in social relationships is the loss of a social network. Further, an identity
network linked to social relationships and a social network may well be linked to psychologically positive outcomes in relation to the self. Therefore ultimately, a socially invested identity role loss may have a negative impact on the self-concept.

The approaches to both the self and identity so far discussed hold to the notion of the self and identities as being situated within the person. On the other hand, from a social constructionist perspective the experience of self, that is subjectivity, and the understandings of identity that the self contains, are socially created and maintained via the multiple differing and competing discourses that are available to the individual within their culture (Burr, 2003; Parker, 1989). This position can be understood more easily by example. Individuals generally consider themselves in terms of a number of identities – gender, sexuality, as a daughter and so on. Each of these identities are constructed by the influence of the discourses present in society, that is the discourses of gender, sexuality, and family to use the given examples. So, traditional discourses of gender would provide two dichotomous gender identities that of male or female; whilst more recent discourses of sexuality provide a wider selection upon which to create identity including lesbian, gay, bisexual, pansexual as well as heterosexual. Prevailing discourses of the family provide identity roles that a person can claim such as being a wife, mother, daughter, and so on. It is via the mix of these differing discourses that identities are claimed or rejected and someone can identify as being female, lesbian and a daughter. However, not all discourses are compatible. Prevailing family discourses have, until recently, denied the possibility of being a lesbian and a wife. In sum, the subjective experience of the self is created intersubjectively as the product of the social environment, and so all identities can be thought of as being social. A social constructionist approach to identity is sensitive to the multiplicity of identities that go to make up the whole individual, and can encompass the identities of gender, ethnicity, sexuality, class, as well as other relevant identities that are salient to an individual.

In sum, all approaches to the self and identity examined here acknowledge the influence of the social environment on an individual’s perception of their self and their identities. Put simply, it is the influence of the social situation that creates a sense of the self that contains identities that are multiple and shifting. The difference between the approaches lies in their acknowledgement of where the concepts are formed and located: either within or without the individual. For social cognitive approaches, the self and identities are mental representations formed as a result of the self interacting with the social environment; whilst
from a social constructionist position the subjective experience of self and identities are constructed within the social interaction.

4.2.3.3 Caregiving and lesbian identity

Identity is salient to caregiving on two levels. First, caring has been considered to be an essential part of the feminine identity (Baker Miller, 1976; Chodorow, 1978), and second because the caregiver identity is something that has been both embraced and rejected by those who provide care. The family member who takes up the caregiving role, such as a spouse or daughter, may do so out of a degree of felt obligation or filial responsibility to take on the demands of care that stem from social norms and expectations, or out of a sense that caring and caregiving is in some way essential to their personal feminine identity (Graham; 1983). However, the amount of care and the degree to which any one caregiver engages with the carer role is governed by a number of variables, such as culture, personal circumstance, and family expectations (Montgomery & Kosloski, 2013). Personal circumstances are often the reason that caregivers engage in boundary setting. As a result there are differences between caregivers as to what they perceive as the level of care they are able to provide, what care they ought to provide, and whether they engage with the identity of caregiver.

Care itself is a changeable construct. Informal caregiving is very often a changing and fluid endeavour that is dependent on the care needs of the care recipient. Further, caring is a role that individual caregiver’s move in and out of across the lifespan in relation to the ebb and flow of the care needs of family. As a result the carer identity is one that becomes more or less salient at different times over the lifespan. With respect to familial elder caregiving, caregiver involvement usually follows a process of greater involvement over time, a process that brings a change to the relationship between care giver and receiver (Montgomery & Kosloski, 2013). Over time, with increased caregiving engagement the caregiver’s role identity changes in relation to the care recipient from one of daughter, or wife, to that of caregiver as the original adult child-parent relationship, or spousal relationship, is transformed into a caregiving one. Eventually, the caregiver’s behaviour toward the care recipient is no longer congruent with the caregiver’s identity as adult child or spouse. This Caregiver Identity Theory (CIT) approach (Montgomery & Kosloski, 2013) is very much grounded in the role identities posited by Stryker (1968). Caregiver identity theory is predicated, however on unproblematic acceptance of the caregiver identity and an individual’s other salient identities.
Homosexual identities, including lesbian identities, are usually seen as sexualised identities (Fullmer, Shenk & Eastland, 1999), a position that is evident in the various stage models of homosexual identity formation explored in Chapter 2 that focus on the individual’s coming to terms with their non-heterosexual identities (Cass, 1979; Troiden, 1979). Whilst the stage models previously examined attempt to provide an explanatory account of the developing lesbian or gay identity they do not offer insight into why a lesbian identity might be considered something of value to an individual, particularly given its potentially stigmatizing nature. The importance of having a positive lesbian or gay identity has been the focus of enquiry, the key finding being that a positive lesbian or gay identity and being out about that identity is related to better mental health.

Research has indicated that accepting one’s sexual orientation, having a positive lesbian or gay identity, and being out about that identity is related to better mental health as well as being conducive to good psychological adjustment. Miranda and Storms (1989) examined the relationship between lesbian and gay identity and psychological adjustment. The research found that participants who held a more positive lesbian or gay identity self-reported less symptoms of neurotic anxiety as measured by the Eysenck Personality Inventory, greater levels of ego strength (defined by Miranda and Storms as the ability to adapt to and derive satisfaction from the world), higher levels of self-disclosure (that is coming out about one’s sexuality), and self-labelled themselves as lesbian or gay more often. Self-labelling and self-disclosure of a lesbian or gay identity have been identified as coping strategies in the development of a positive lesbian or gay identity (Coleman, 1982; Sophie, 1986). Whilst having lower neurotic anxiety and higher levels of ego strength are supportive of a positive psychological adjustment. Overall, the results of the Miranda and Storms study support the positon that a positive lesbian or gay identity is associated with better psychological adjustment. These findings similarly been supported by other, more recent work (Fingerhut, Peplau & Gable, 2010; Kertzner, Meyer, Frost & Stirratt, 2009)

The research discussed here has focused on lesbian, gay and bisexual populations combined. However, as Markowe (2002a) indicates in relation to identity development, there are differences in development of sexuality between women and men, a result due to differences in socialization and the inequalities that exist between women and men within society. These differences will also hold true for other aspects beyond the development of sexual identity such as the lived experience of being a lesbian or gay male individual. However, research that examines the purely lesbian identity experience is limited, but not
entirely non-existent. Work by Fingerhut, Peplau and Ghavami (2005) examining lesbian women’s affiliations in both heterosexual and lesbian cultures found that the women who were more lesbian-identified, that is having a stronger sense of belonging to a lesbian community, evidenced greater levels of life satisfaction. Other research has examined issues of identity support and social support in relation to psychological well-being and depression in lesbian women.

Identity support, that is being valued and supported as a lesbian woman, has been identified as being linked to higher levels of psychological well-being and lower levels of depression in lesbians. Research by Wayment and Peplau (1995) examined the relationship between types of social support and well-being in 391 lesbian women and 273 heterosexual women. They found that the strongest correlate of well-being for the lesbian sample was “reassurance of worth”, defined as a feeling of being respected for who one really was, which Wayment and Peplau posit is identity support. For the heterosexual women, however, the most strongly correlated type of support was “guidance support”. Wayment and Peplau suggest that identity support for lesbians is significant as it chimes with the overall need for support to match an individual’s perceived needs, which for the lesbian women was to feel valued as a lesbian. Other, more recent identity support research by Beals and Peplau (2005) examined issues of self-esteem, life satisfaction and depression, that is psychological well-being, in lesbian women. Overall, the women who reported higher levels of identity support scored more highly on measures of psychological well-being compared to those reporting lower levels of identity support. In particular, the women reported higher levels of self-esteem, greater life satisfaction and lower levels of depression. Overall, therefore feeling accepted and supported as a sexual minority woman is suggestive of better psychological well-being and fewer depressive symptoms.

Social support per se has also been found to be associated with symptoms of depression in lesbians. Oetjen and Rothblum (2000) examined risk factors and depression among 167 lesbian women and found that perceived social support from friends, relationship status satisfaction, and perceived social support from family were significant predictors of depression. Similar to heterosexual women, a negative correlation was found between depression and being in a committed relationship; whilst perceived social support from both friends and family were also negatively correlated with depression, again a reflection of the experience of heterosexual women. However, the lesbian women in the study relied more on social support from friends than from family. Oetjen and Rothblum argue that this is a result
of the women being more likely to be out to their friends than their family. Overall, it would appear that whilst family support is important, the support that the lesbian women derived from their friends was considered more so. As the women in the study indicated that they were most out to other lesbian and gay people rather than family, support from friends was more likely to be from other lesbian or gay people.

More recent research by Fingerhut et al., (2010) has examined the issue of identity, minority stress and psychological well-being. Whilst this research does conflate the experiences of lesbians and gay men, the issue of minority stress is pertinent to both men and women within lesbian and gay communities. As indicated in Chapter 2, minority stress is the stress that an individual experiences as a result of their minority status that is a result of stigmatization and discrimination (Meyer, 1995; 2003). Fingerhut et al., (2010) tested the hypothesis that lesbians and gay men who are more “gay-identified”\textsuperscript{22} will hold to a stronger sense of the self which in turn will buffer the experience of minority stress. Further, they argued that sexual minority individuals who are more connected with the LGB community are more able to access community support when experiencing minority stress. The findings indicated that, as predicted, gay identity and a sense of belonging to an LGB community, did have a buffering effect against the negative effects of stress on psychological well-being.

The understanding of self and identity so far examined has been considered from within an experimental and positivist framework where the concept of identity is central to the understanding of the self. This position indicates that having a positive lesbian identity brings psychological benefits linked to engagement with a lesbian community. How this may be important has also been examined from a social constructionist perspective. Here, identities are relational concepts that develop intersubjectively, as such the lesbian identity is one that is developed via whatever the prevailing discourses within society indicate a lesbian can be. A social constructionist account of lesbian identity development by Kitzinger and Wilkinson (1995) examined the discursive production of lesbian identities. This research highlighted the fluid and continual nature of the women’s transitioning identities. Post identity transition, the continued elaboration of what it means to be a lesbian were central to the development and maintenance of lesbian identity. Put more simply, once a lesbian identity has developed in order for it to continue it is important for the women to maintain their lesbian identity. As a lesbian identity is achieved via the processes of social interaction, the women in the study achieved this by way of reinterpreting past experiences through a lesbian lens, and by the

\textsuperscript{22}Fingerhut, Peplau & Gable (2010) use the term “gay identity” to refer to the social identity of both lesbians and gay men, generically.
creation of a lesbian future via involvement in lesbian communities. In sum, their participants were continually constructing, and re-constructing, their lesbian identity by actively taking up lesbian subject positions within the discourses available to them (Davies & Harre, 1990). Overall, therefore it would appear that for women post-coming out there is a need to maintain their lesbian identity by way of involvement with lesbian subject positions.

4.2.4 Lesbian community links

Whatever epistemological position is taken it would appear that social interaction with similar others is important for sexual minority women. Indeed, engagement with LGB communities may be thought of as an important coping resource as this can provide a stigma free environment and greater positive support from similar others, both of which may ameliorate the effects of stigma (Crocker & Major, 1989; Meyer, 2003). Given this importance lesbian and gay engagement with, and connections to, LGB communities is a useful area to examine.

Over the years a number of studies have considered LGB community engagement and LGB friendship networks. Research by Quam and Whitford (1992) which examined the expectations of 80 lesbians (n = 39) and gay men (n = 41) over 50 found that 64% of their sample indicated having engaged in an LG social group. Breaking this figure down further, 77% of the lesbian participants indicated engagement in lesbian and gay social groups compared to 52% of gay men. In contrast only 9% of their participants indicated taking part in non LGB community activities. Use of scene space was also examined, where 35% of the total sample indicated going to a lesbian or gay bar. However, in this regard engagement was reversed between the lesbian and gay participants with 47.5% of gay men, compared with 23.1% of lesbians indicating attendance. Further, the make-up of friendship networks of the participants was examined with over half of the lesbian participants indicated that their closest friends were other lesbians23. The results found by Quam and Whitford (1992) have been supported elsewhere (Beeler, Rawls, Herdt & Cohler, 1999; Grossman, D’Augelli & Hershberger, 2000). Whilst research with a purely lesbian cohort aged 55 and over found that many of the women primarily associated with other lesbians, Examining a purely lesbian cohort aged 55 and over, Jones and Nystrom (2002) found that many of the women primarily associated with other lesbians, even to the exclusion of men irrespective of sexuality24.

23 Exact figures not reported by Quam & Whitford (1992)
24 Statistical breakdown not provided in this qualitative study.
Overall, therefore it is clear that for lesbians, engagement with, and connection to, other lesbians is considered important.

Engagement and use of LGB community activities as well as spaces traditionally considered as the gay scene, that is commercial clubs and bars, is one way of engagement with other lesbians\(^\text{25}\). The “scene” has often been considered as a site where young lesbians and gay men turn to as a means of finding support from similar others (Valentine & Skelton, 2003). However, the “scene” has been found to be less welcoming for some people.

Research by (Skeggs, 1999; 2001) on working class women’s experience of spatial entitlement in Manchester’s Gay Village found differences in women’s experiences of gay spaces dependent upon sexuality. Heterosexual women were welcomed within the gay space via friendship with gay men, and the use of which provided a sense of security. Whilst lesbians within that same space felt marginalised within the supposedly safe gay space, particularly from the demonstration of entitlement of the heterosexual women, creating a feeling of insecurity and displacement, a position supported elsewhere (Casey, 2004).

However, as Taylor (2008) points out, neither straight nor lesbian women have full entitlement to “gay” social space. Age too, has been identified as a barrier to engagement in gay social space. The lesbian participants in Taylor’s (2008) study indicated that the scene was a place for those who were “young and pretty” (p. 532); overall the women in Taylor’s study constructed the generic gay scene as being mainly young, white, able bodied and male.

In sum, lesbian women may be less likely to make use of gay social space due to feelings of exclusion related to age and, ironically, sexuality.

However, if connecting to other lesbians is important and scene space is not a welcoming space other arenas need to be invoked both physical and virtual. The lesbian home and the virtual space of the internet are both sites of lesbian connection to others. Whilst homes are clearly a private space, many older lesbians use the home as a socializing venue for lesbian social groups, social networks, leisure group activities and similar (Elwood, 2000; Valentine & Skelton, 2003). Another area where lesbians can maintain their connections to other sexual minority women is in the use of the internet. Research by Wincapaw (2000) examined the use of lesbian and bisexual women’s mailing lists surveying 100 subscribers. The study found that many of the subscribers joined the online group in order to connect with other lesbians and bisexual women, make friends with other lesbian and bisexual women, avoid men and heterosexuals, and engage in virtual socializing with

\(^{25}\) Indeed the use of urban space as a focal centre to gay identity and community has been traced as far back as the late nineteenth century (Valentine & Skelton, 2003)
likeminded others. Overall, the lesbian and bisexual women’s online mailing lists provided a means of keeping in contact with other sexual minority women in a safe environment away from homophobia, biphobia, and misogyny. In sum, both the home and the internet have become vital resources in lesbians maintaining connections with other lesbians.

4.2.5 The present study

Given the established heteronormative position, along with the issues raised here, caring might exacerbate minority stress (Meyer, 1995; 2003) by making the enactment of lesbian identity and engagement with lesbian communities harder to achieve. However, lesbians sometimes achieve ‘normative creativity’ (Brown, 1989) and create their own life norms when the dominant heteronormative norms are not useful. The aim of this study was to explore how family elder caring intersects with “out” lesbian lives among a small sample of lesbian identified women and explore the experiences of lesbian women with family elder care responsibilities.

4.3 Method

The analysis is based upon ten interviews with lesbians (aged between 48 and 62) who were currently providing, or had provided, care or support to an elderly parent or parents. Participants were recruited via advertisements and posters placed with formal and semi-formal UK based lesbian social networking groups, both internet and face-to-face based. I attended a number of the face to face networking groups over a period of three months in order to engage the women in dialogue about the proposed research and answer questions. Posters and leaflets were also left in shops and venues frequented by lesbian women in London. The groups, shops, venues, and internet sites included Gingerbeer, Kenric, the Older Lesbian Network (London), the Drill Hall Theatre and Arts Centre, First Out Café, and Gay’s The Word Bookshop. As a result of the recruitment process, ten women demonstrated interest in taking part.

The women’s individual relationships and caregiving experiences are shown in Table 4.1. At the time of the interview all the participants lived in London or the South East of England and identified as White. Six of the women identified as British, two as Irish, one as South African, and one German. All were living in the UK at the time of interview. All

---

26 The initial call for participants was made in 2009. Some of the venues have since closed or changed use. The Drill Hall Theatre became the RADA Studios in 2012, whilst First Out Café has closed down.
affirmed that they considered themselves as “out” lesbians in their home environment. The interviews were semi-structured and very much in the nature of a “guided conversation”, employing open-ended questions as well as more focused questions in order to develop rich description (Charmaz, 2006). The participants were asked a number of questions around the care and support that they were providing (or had provided) and how this may have impacted, or currently did impact their lives. A copy of the interview schedule can be seen in Appendix I. The interviews lasted between 50 minutes and 1 hour 45 minutes and all were fully transcribed using a simplified version of the transcript convention offered by Silverman (2000) which posits a more simplified transcript annotation than that utilized in Conversation Analysis, where much finer detail with respect to pausing, word emphasis and over-talking is required.
### Table 4.1: Participant Relationship and Caregiving Status

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Age</th>
<th>Current Relationship Status</th>
<th>Caregiving Status</th>
<th>Type of Care Given</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ann</td>
<td>49</td>
<td>Single</td>
<td>Daily visits to elderly parents living close by</td>
<td>Emotional support; help with domestic tasks and shopping.</td>
</tr>
<tr>
<td>Ellen</td>
<td>51</td>
<td>Living apart relationship</td>
<td>Elderly mother lives with Ellen</td>
<td>Emotional support; help with domestic tasks and shopping.</td>
</tr>
<tr>
<td>Gwen</td>
<td>54</td>
<td>Civil Partnership</td>
<td>Elderly father lives with Gwen and partner in their home</td>
<td>Emotional support; help with domestic tasks and shopping; medical case management.</td>
</tr>
<tr>
<td>Joanne</td>
<td>55</td>
<td>Single</td>
<td>Daily visits to elderly parents living close by</td>
<td>Emotional support; help with domestic tasks and shopping.</td>
</tr>
<tr>
<td>Julie</td>
<td>53</td>
<td>Single</td>
<td>Daily visits to elderly mother who lives close by</td>
<td>Emotional support; help with domestic tasks and shopping; hands on caregiving tasks such as bathing; medical case management.</td>
</tr>
<tr>
<td>Melanie</td>
<td>48</td>
<td>Single</td>
<td>Elderly father lives with Melanie in family home</td>
<td>Emotional support; help with domestic tasks and shopping; medical case management.</td>
</tr>
<tr>
<td>Mary</td>
<td>59</td>
<td>Single Identifies as polyamorous</td>
<td>Elderly mother used to live with Mary and previous partner</td>
<td>Emotional support; help with domestic tasks and shopping; medical case management.</td>
</tr>
<tr>
<td>Susan</td>
<td>50</td>
<td>Single</td>
<td>Daily visits to elderly mother, lives close by</td>
<td>Emotional support; help with domestic tasks</td>
</tr>
<tr>
<td>Vivien</td>
<td>62</td>
<td>Single Identifies as polyamorous</td>
<td>Daily telephone calls to elderly mother living a distance away. Overnight visits on regular basis. Has previously provided live in help when family in crisis.</td>
<td>Emotional support via telephone; help with management of household maintenance tasks as and when required; medical case management.</td>
</tr>
</tbody>
</table>
Grounded theory methodology is particularly useful for exploratory research with under-explored topics about which little is known, consequently research questions are often flexible and open ended (Creswell, 1998). Originally conceptualised in the 1960s as a method to develop explanatory theory for social processes, grounded theory (Glaser & Strauss, 1967/2006) has developed over time with several differently situated methods available depending upon the ontological and epistemological position taken by the researchers (Charmaz & Henwood, 2008). To understand these differently positioned methods it is useful to consider them as being situated along a continuum. At one end is the objectivist grounded theory of Glaser and Strauss, whilst at the other is the constructivist position of Charmaz (Hildenbrand, 2007). A constructivist approach to analysis is based upon the premise that both the data and the subsequent analysis are social constructions that reflect their production process; whilst objectivist grounded theory, which is firmly situated in the positivist tradition, sees the data as being real, as representing objective facts that can be analysed whilst ignoring the context from which the data was generated (Charmaz, 2006). The epistemological position taken in this analysis was a social constructionist one (Burr, 2003) that aimed to acknowledge the active role of the researchers’ decisions in shaping the research space from conceptualisation through to creating categories in the data analysis process and, therefore, the analysis that follows is but one possible interpretation of the interview data. Further, whilst grounded theory has generally been seen as a method to theorize about situated social processes, it can also be used to examine individual situated experience rather than to generate theory (Willig, 2008). It is within the latter framework that this study has adopted a grounded theory approach, to explore individual experience in an under-researched arena.

Whatever the epistemological foundation or aim of research, the core approach within any analysis that utilises grounded theory methodology is the method of constant comparative analysis. This is an iterative approach in which the data are read and re-read to identify categories and concepts, to describe how they may be interrelated, and to develop themes and interpretations (Pidgeon & Henwood, 1997). This study adopted the coding, constant comparison, and memo writing methods from the grounded theory approach particularly espoused by Charmaz (2006) and engaged in initial coding, focused coding, and selective coding. Initial coding involved comparing, conceptualising, describing and categorising the data with labels. This initial coding process was inductive with codes being created from what was present in the data. Once initial codes were identified focused coding was then
engaged with which involved discarding or combining significant initial codes to synthesise the data. Finally selective coding was engaged with which entailed identification and description of the key categories (Charmaz, 2006). Throughout the analytic process the method of constant comparison was engaged with to establish similarities and differences across the dataset. Memo-writing was also utilised through-out the various coding stages. Memo writing allowed the researcher to both record and develop the analysis as it helped to conceptualise ideas and allow for data interpretation. Memos were at the heart of the data analysis linking all stages of the analytic process from the initial coding process through to later analytic interpretations. Materials pertinent to the study can be found in Appendix I.

4.4 Analysis

Through the analysis six themes were conceptualised, four of which are presented here. In the interviews, the women indicated how and why they became involved in familial caregiving and their words became the focus of a theme about “Duty and Obligation.” The women also described the need to balance caring with personal space and relationships; these issues were examined in the theme: “Boundary Setting.” These first two themes address issues that are of relevance to all carers. The theme “Loss of Lesbian Identity” represented the analysis of the women’s talk about how their behaviour and others’ perceptions of them were at odds with their identity as lesbians. Whilst the women’s concerns surrounding communication and support are highlighted in the theme “Connections With Lesbian Communities.” The last two themes, whilst appearing to be more salient to the issues that lesbians who care may face also hold relevance to all carers as they address issues of identity and social support.

4.4.1 Duty and Obligation

Despite the heteronormative models of the family that stigmatize and erase lesbians, some women in the study experienced duty and obligation towards their families. A clear thread ran through the interviews, incorporating duty and felt obligation as reasons why the women became involved in caring for elderly parents. Ellen, who lives with her elderly mother, says:

“I can’t deny that living with Mum hasn’t caused problems with girlfriends. But, I dunno, if Mum wasn’t living with me she would be in a home and somehow I just couldn’t allow that to happen, it wouldn’t be right”
Whilst living with her mother had caused relationship problems with previous girlfriends, it would appear that, for Ellen, these problems are secondary to the feelings she has about providing a caring home environment for her mother. Ellen does not explicitly spell out what duty or obligation are, she just feels that providing care is the right thing to do, demonstrating a strong desire to do what she feels is right.

However, duty is not always embraced with enthusiasm. Melanie, one of three siblings, describes caregiving as a duty. As Melanie says:

“I see it as a duty. And I suppose, as I didn’t have a strong relationship with a girlfriend I was the one out of the three of us most able to take on the role. But I feel like I am marking time, I am fulfilling my obligation to my father by caring for him”

This negative construction of care is echoed throughout the course of Melanie’s interview, in which she clearly expresses her feeling that caregiving is a duty. And, Melanie makes very clear that her caring role is a result of other family members’ expectations of her given her personal circumstances. This position is in line with Kimmel’s (1992) argument that lesbians and gay men may be more likely to be expected to engage in family caregiving due to their perceived single status. Further, by talking about “marking time” it would appear that Melanie has a hoped for future self (Markus & Nurius, 1986) which will begin only when she no longer has to be a caregiver.

In other words, similarly to the experiences of assumed heterosexual women who provide familial elder care, these lesbians experience both sides of the duty and obligation coin. Both women appear to take on parental caring out of duty. Ellen finds caring to be something that she needs to do, despite the negative impact on her personal relationships. Whilst Melanie finds caring prevents her from leading her life as she wishes. For other women, however, becoming involved in parental support is neither described as “care” nor as a chore and help is provided because “that is what families do.” As Julie indicates at the very beginning of her interview:

“No, I don’t mean it to be chore, I mean it as just something that I do, but not something that is a chore”

Julie, who provides support to her mother, later pointed out that everything she does for her mother is an integral part of her day to day routine and emphasizes the point that “it’s not a chore to be managed it is just something that is part of my day”. The feelings expressed by all these women seem to provide support for Finley et al., (1988) who theorized that women experience obligations towards their mothers and fathers differentially; with women
potentially feeling more distress as a result of caring for a father than a mother. Finally, for Julie the care and support she provides is not constructed by her as caregiving; for some lesbians they clearly stand within the construction of “the family” as the natural and best source of elder care.

4.4.2 Boundary Setting

When caregiving is constructed as either a taken-for-granted duty, or burden, it often has to fit into a life along with other, competing, demands. In order to manage their competing demands some of the women in the study talked about needing to impose boundaries.

At the time of interview Melanie was living with her elderly father and providing him with quite high levels of practical care and support. However, she has very clear ideas about what level of practical help and support she feels able to offer her father and how she intends to manage his care as his dependency and needs increase over time.

“I took on a caring role very early on due to their being no one else to do it but I set out limits to what I will do as I get older I won’t hesitate to call in social services to sort my father out”

Melanie appeared to have a personal boundary to caregiving that she was not prepared to cross. Throughout her interview Melanie is very clear that when her father becomes too physically dependent upon her she will step aside as his primary carer. This straightforward approach to future care needs is very much in line with what Calasanti and King (2007) suggest is how men approach caregiving, and one that may limit the effects of caregiver burden.

However, setting boundaries extends beyond the physical tasks and competencies a person is willing to take on; boundary setting also occurs around personal and private space and personal relationships. Melanie has also defined this area very explicitly:

“For at least twenty years no friends of mine have stepped foot into the house I live in with my Father [...] My last relationship? We conducted that relationship in hotel rooms...I live my social life completely away from home”

So for Melanie the boundaries extend not just to what she will or will not do for her father but also what her friends and lovers can expect from her. Melanie is clear that she does not want her family of origin and her lesbian social and love life to mix and meet, despite her assurances that she is out to her family of origin. Melanie is aware that the way she chooses to conduct her social and intimate life differs to many of her friends and past lovers,
commenting in her interview that friends and partners perceive a “certain awkwardness” related to the limited access to her home. However she is very non-plussed and matter of fact about it, managing any judgement that the interviewer might bring to her account of herself. This refusal to mix her lesbian social life and home life is in contrast to the home being seen as a venue of lesbian socialization (Elwood, 2000), something that Melanie appears aware of. However this clear demarcation between family of origin involvement within the home and family of choice involvement outside the home is a clear boundary that Melanie acknowledges has been brought about by her living and caregiving arrangements. The boundaries being set by Melanie appear to be similar to those being employed by the participants of Guberman et al., (2012) whose boundary setting was engaged with in order to maintain their social identities. For Melanie, the setting of limits and boundaries to all aspects of her life, allow her to manage and maintain both family commitment and social and romantic engagements.

For most of the women who lived with their elderly parent, personal boundaries were maintained by managing space for their lesbian identity inside the home27. Within the routine of her life living with her mother and her then partner, Mary set boundaries regarding the involvement of that partner with her mother’s care saying “what I never wanted was: I’m doing everything for your mother”. Further, issues of privacy surrounding intimacy within the relationship did arise when all were living together as Mary indicates that the presence of her mother in the home led to Mary and her girlfriend going away from the home to “find space for ourselves”; a tactic more similar to Melanie’s and reported by other women too.

Generally, all the interviewees consistently valued clarity with respect to individual expectations regarding who does what and for whom, and their implicit definitions of successful negotiation of the caring role included such clarity. Many of the women indicated a need for “ground rules” of behaviour if sharing a home with an elderly parent. However, they were not successful in achieving a completely private arena for intimacy and sex within the home, resorting to romantic nights and weekends away to generate relationship space.

4.4.3 Loss of Lesbian Identity

Of course, constructions of care giving as taken-for-granted duty, or as a burden, and the setting of boundaries are not unique to lesbians. However, a particular issue for some women in the study appeared to be an incompatibility with their lesbian identity and their caregiving responsibilities.

27 Lesbian living and caregiving in the home is examined in more detail in Chapter 5
All of the women in the study had differing caregiving arrangements. Some of the women had their elderly relatives living with them, whilst others provided care and support via regular visits and telephone calls. Despite the differing caregiving arrangements, however, a particular issue for some of the women in the study was how their behaviour as caregivers, and others perceptions of them as carers were felt to be at odds with their marginalised sexual identity. Vivien, who provides support to her mother in the form of telephone calls and regular visits to her mother, says:

“I dread the idea that I might have to go live at my mum’s, even though I really love her, I think it would be incredibly difficult for me, I think that the village she lives in would squash my identity”

Here we see that Vivien fears that an increase in her mother’s care needs might require that she move in with her mother, something that she feels would have a negative impact upon her lesbian identity. These fears are very much an expression of a feared future self and may act as motivation for Vivien to work towards avoiding this situation (Cross & Markus, 1991; Markus & Nurius, 1986). The fears voiced here resemble the realities reported by the women who shared a home with their elderly relatives, and so Vivien’s fears may be well grounded. Mary, who lived with her elderly mother until just prior to interview, says:

“I suddenly, I didn’t feel heterosexual. But I felt more errm, I felt as though I was being publicly heterosexual (. ) yes, I felt that was how I was being read by others.”

Here Mary is discussing how she felt not long after having her mother come live with her. Later in the interview she goes on to say:

”I appeared to be heterosexual and I felt it took a part of my identity away and it was a weird feeling”

In both quotes Mary articulates her unease at appearing to be seen by other people as heterosexual when she and her mother lived together; she felt that she was being perceived by the public as an older heterosexual woman, an identity at odds with her lesbian sexuality. The caregiving that Mary engaged in positioned her to others as being heterosexual, a position that made her feel “weird” a result of the discrepancy between Mary’s actual sexuality and the sexuality that she believes the generalised other (Mead, 1934; cited in Collier et al., 1991) ascribes to her. For both Vivien and Mary moving in with elderly parents to provide care was associated with a perceived loss of lesbian identity and an assimilation into a heterosexual lifestyle, a loss with which neither woman was comfortable.
These concerns were also detected in the interview with Ann, whose sense of identity loss occurs in spite of maintaining a separate residence:

“I think I could be mistaken for any heterosexual woman my age; I’m divorced, I have a grown up child, a job, and elderly parents that I keep an eye on. All these things seem to mark me as heterosexual but that’s not the real me. […] A part of me does know that these things are part of what makes me who I am I just feel that they hide my sexual identity, I feel like I have gone back into the closet.”

For Ann, it would appear that the regular and unremarkable aspects of her life as a family carer position her as heterosexual. To all intents and purposes, having a lesbian identity and providing care were incompatible. This position is analogous of Gabb’s (2005) argument in relation to lesbian mothers, where the signifiers of lesbian identity are overlooked in the presence of heterosexual reproduction. In respect of Ann’s experience, it would seem that the heteronormative caring imperative expected of women generally, elided Ann’s lesbian identity.

Whilst for some women it is the moving in with a parent that brings about a loss of lesbian identity; for others it is the enactment of a caring role to children and parents that is sufficient to make a lesbian woman feel that she is re-entering the closet. However, what is clear is for these lesbian women with caring in their lives the heteronormative discourse of family caregiving threatens lesbian identity and positions the women as heterosexual-by-default. This positioning can potentially lead to identity loss and the social networks and relationships connected to that identity role (Hogg et al., 1995). How then do women find creative solutions to this problem?

4.4.4 Connections with lesbian communities

All of the women who were interviewed were concerned about maintaining existing friendships with other lesbian women and with being involved with local lesbian communities. Ann talks about her lesbian friends saying:

“I would say most of my socialising is with lesbian friends. Don’t take me wrong, I do have heterosexual friends, but when I look at who I go out with, where we go and what we do, I realise it is mainly with other lesbians. I think, actually, you know, if I were cut off from my lesbian friends and social life I would really feel isolated”

The emphasis that Ann places on being part of a network of lesbian friends is consistent with a large body of research showing the benefits of community in mitigating minority stress (Meyer, 2003). Ann places more importance on lesbian communities, with respect to
belonging, than she places on heterosexual friendships. Later in the same passage Ann suggests that her lesbian friends are important because her straight friends would not always be interested in, or understand her relationship problems. Ann placed importance on staying in contact with her lesbian friends and framed socialising with other lesbians as something that happened away from the home.

However, for other women socialising with other lesbians was not so easy, particularly within the home environment. Gwen, who lives with her civil partner and elderly father, indicates the difficulty she and her partner experience in socialising with other lesbians in the family home:

“I think myself and my partner are losing out by not inviting lesbian friends round because it is easier not to”

Here Gwen highlights the direct impact having her elderly father live with them has had. Further along in her interview Gwen expands upon her points indicating that she has to explain to her father who visitors to the house are and how she knows them: “like when you were a child at school and having to explain who you were hanging around with”. Gwen also indicated that her father appears to want to socialise with everyone who visits the house whether they have come to see him or not as he “sits and takes over the conversation”. The overall result of her father’s interest in Gwen and her partner’s friends has led to Gwen and her partner preferring not to entertain at home.

The effects having a parent share a home on socialising within lesbian communities was mentioned by other women also. Whilst not living with her mother, Vivien reported worries about what might happen if she needs to move in:

“That’s why I make all that fuss about the internet, because the internet would allow me to continue to have a sexual orientation. It’s the potential for me to feel not just that I was Mrs XXXXX’s daughter”

Here we can see Vivien creatively anticipating how moving in with her mother would lead to identity loss and looking to the internet for a creative solution to the problem she anticipates. This thinking is consistent with Wincapaw’s (2000) work on the use of the internet and online mailing lists as a means of community contact and support. Further, it would appear to be a clear coping mechanism to mitigate identity threat (Breakwell, 1986; 1993; 2001). Clearly, internet access would allow her to remain connected to other lesbians through lesbian message boards, chat rooms and internet forums that would allow her to maintain her lesbian identity (Kitzinger & Wilkinson, 1995).
In sum, these women attach importance to being connected to lesbian communities by whatever means available. Elwood (2000) has found that socialising within the home was an important social space for older lesbians. However as this traditional site of private identity has ceased to allow easy socialising with other lesbians, these women looked to other forms of privacy and community. Although such identity-based communication was not available when Brown (1989) described “normative creativity” interviews such as Ann’s and Vivien’s show lesbian carers taking pro-active steps to deal with familial living arrangements scripted to erase their identities. Both the internet and socialising at home with friends were important means of maintaining connections with other lesbians.

4.5 Discussion: Part 1

Taking the themes presented here as a whole, it would appear that for the lesbian women in the study, like anyone who takes on the caring role, some have found the demands and expectations of the caregiver role sit better with some than others, potentially as a result of felt filial obligations. Once engaged in caring, in order to manage the demands of the role, the women felt the need to engage in boundary setting. Whilst boundary setting is something that all caregivers may engage in, this appeared to be of particular importance in relation to maintaining a lesbian identity; as caring for some led to their lesbian identity coming under threat by their perceiving that they were positioned as heterosexual. In order to counter the identity threat the women felt challenged to maintain their links to lesbian communities in new and creative ways.

The findings here accord with the literature examined, some of the women engaged in caregiving as a result of felt obligation (Blieszner & Hamon, 1992). For women felt obligation to care has been found to vary depending on the gender of the parent (Finley et al., 1988), and evidence of this was found with this limited sample. However evidence of other aspects that affect levels of felt obligation, such as quality of past relationship, were not found (Wuest, 1998). In order to relieve, or deflect, potential burden and stress that might arise from caregiving the women considered and engaged in coping strategies such as boundary setting. However not all boundaries are socially sanctioned. Only those related to female gendered family roles, such as caring for others, are deemed acceptable reasons for limiting care to the elderly. Boundaries that are unacceptable may lead to feelings of guilt. However, unlike the women of Aronson’s (1992) study who expressed feelings of guilt in relation to personal boundary setting the women did not identify feelings of guilt, but allowed the
women the space to maintain important social identities and links. The women in the present study established boundaries in order to manage and maintain their personal and social lesbian identities and social networks.

The salience of identity, both as a caregiver and as a lesbian, may impact on how caring is experienced and it was clear that feared future selves (Markus & Nurius, 1986) were seen as a motivating factor (Cross & Markus, 1991) in order to avert lesbian identity loss. Both identities are socially constructed and closely tied to the individual’s relationships with others; a caregiving identity may originate from the changing relationship between family members, whilst a lesbian identity is constructed (and maintained) by way of interactions with similar others. A positive lesbian identity is beneficial with regard to better psychological adjustment, greater levels of life satisfaction, and lower levels of depression, as well as having a contributing effect in counteracting the effects of minority stress. However, key to maintaining a lesbian identity is in engagement with lesbian communities (Kitzinger & Wilkinson, 1995), something not all the women in the study were able to do. Engagement with lesbian communities often means connections within social networks that move in non-commercial scene environments, such as private homes and the internet.

To conclude part one, engagement with caregiving has challenged the women in this study to be normatively creative (Brown, 1989). They have had to forge ahead to create new norms for themselves; norms that allow them to engage in caregiving whilst also allowing them to retain their lesbian sexual identity. At times more successful in achieving these two goals than others, their creativity allows for new insight into what it means to be a family carer. This new insight is not just for lesbian women but all women who engage in caregiving as the themes presented here are representative of Sedgwick’s (1990/2008) universalizing gay discourse, being relevant to all. The themes presented in the next chapter, can be considered as representative of Sedgwick’s (1990/2008) minoritizing gay discourses, as they are much more distinctly queer and lesbian in tone.
Chapter 5: Behind closed doors: Relationships, outness, and privacy of UK lesbian caregivers

5.1 Outline of Chapter

As indicated previously, this chapter along with Chapter 4, presents the analysis of data and findings of Study 2. Four themes were presented in Chapter 4 that explored issues that are more pertinent to all caregivers, whether they identify as lesbian or not. The exposition of themes offered here, whilst they may hold some relevance to all caregivers, can be considered as being of more relevance to the lesbian caregiver.

As this chapter is the second part of one larger study the chapter structure differs slightly from a traditional qualitative paper. Here a relevant Introduction, Analysis, and Discussion are offered. Discussion (Part 2) will summarize the findings presented here. This will be followed by a General Discussion in respect of the overall study that concludes the study findings. A Method Section has not been included in this chapter, for details please refer to Chapter 4. Finally, as with Chapter 4, the analysis presented here utilized a grounded theory approach that engaged with analysis first rather than a literature review, therefore the following Introduction Section was completed post analysis.

5.2 Introduction

As indicated by Chapter 3 the construct of the informal carer has had influence on the research into the impact of caregiving on the carer such that most research examines heterosexual women caregivers. Given this position, the overall aim of this study was to look at the elided experience of lesbian family of origin elder caregivers and gain an understanding of their experiences. The analysis presented in Chapter 4 goes some way to addressing this aim. The analysis suggested that some key areas of concern for the lesbian women in this study centred around issues of filial duty, the need to set and maintain boundaries, that the caregiving role can lead to a loss of lesbian identity, and a need to maintain connections to the lesbian community. These issues are considered to be of a universal nature (Sedgwick, 1990/2008) as all caregivers will grapple with issues of filial duty, the setting of boundaries, the loss of identity, and the need to connect with others for social support. Germane for the lesbian women of this study was that their identity concerns were focused on their lesbian identity and in remaining in touch with the lesbian community.
As well as seeking an understanding of lesbian women’s experiences of elder caregiving, further study aims were to discover how elder caring impacts upon lesbian lives around the issues of outness, socialization and personal relationships, issues that can be considered as more minority in nature (Sedgwick, 1990/2008). The aims of this chapter are to examine these more specific aims.

5.2.1 Lesbian Relationships

Following the removal of homosexuality from the DSM the relationships of lesbians and gay men became a growing area of interest. In the move towards affirmative lesbian and gay research, work has thrown scientific light on the nature and diversity of sexual minority individuals that has expanded the existing knowledge base (Peplau, 1991). This position is of benefit on a number of counts. First, scientific research into non-heterosexual relationships can do much to replace any myths and stereotypes that circulate around non-normative relationships. Second, this research can provide scientific evidence in respect of sexual minority relationships in relation to legal and public policy issues and changes. Third, the research into lesbian and gay relationships has been used to establish the generalizability of relationship models based purely on heterosexual relationships. Finally, same-sex relationship research has offered new ways of examining gender within close relationships (Peplau, 1991; Peplau & Fingerhut, 2007).

5.2.1.1 Comparative cohabiting couple relationship research

Much of the research into lesbian and gay relationships has been in respect of couple relationships where a number of issues have been examined. Basic survey research conducted in the US about lesbians, gay men, and relationships, undertaken prior to recent legislation changes in favour of same-sex marriage, indicated that 74% of lesbians and gay men would marry if they legally could and that marriage was important (68%) (Peplau & Beals, 2004). Whilst online survey research undertaken with participants from 27 countries found that 94.5% believed that same-sex couples should be able to marry (Harding & Peel, 2006). This positive opinion has been reflected in recent legislative changes in many Western countries.

---

28 Professor Peplau was one of the key expert witnesses in the legal challenge to Proposition 8, an amendment to the California State constitution which barred same-sex marriages in the state. Her research based evidence indicated that individuals gain physical, psychological and social benefits from being married and that the quality and stability of same-sex relationships are similar to those of heterosexual relationships with no significant differences. Proposition 8 was overturned on 4th August 2010.

29 Same-sex marriage became legal across the USA in June 2015 following the ruling of the United States Supreme Court in the case Obergefell v. Hodges.
where legal recognition to same-sex relationships in the form of civil unions, civil partnerships, or marriage has occurred. Qualitative research has highlighted that legal recognition for partners within same-sex relationships is important in respect of financial rights, achieving relationship recognition from other family members, protecting non-birth mother’s rights within lesbian families, as well as being a public statement of love and commitment (Clarke, Burgoyne & Burns, 2007). Legal recognition of relationships aside, issues such as that of division of labour within the relationship, issues of power, love and commitment, relationship satisfaction and quality, and social support have all been topics of enquiry in respect of lesbian and gay couple relationships in comparison to heterosexual coupled relationships. Pertinent to the study however are the issues of love and commitment, relationship satisfaction and quality, and social support.

Past research has found that some heterosexuals have held stereotypical views about lesbian and gay relationships being inferior to heterosexual relationships; being unhappy, dysfunctional, and less satisfying (Crawford & Solliday, 1996; Testa, Kinder & Ironson, 1987). However, a clear finding has been that many lesbians and gay men want to have long term love relationships and, indeed, are in them. Survey data from 1990 indicated that around 60% of gay men and 80% of lesbians were in romantic relationships (Peplau & Cochran, 1990), and many same-sex relationships are long term with between 18-28% of gay male relationships and 8-21% of lesbian relationships lasting for more than 10 years (Kurdek, 2004). However, these figures need to be considered in conjunction with the fact that until same-sex relationships were afforded formal recognition there were fewer formal barriers to ending them, such as divorce. Similarly, little was known about longevity in same-sex relationships as previously there were no statistics that could be compared to heterosexual divorce rates (Peplau & Fingerhut, 2007). Given the changing legislative landscape since the turn of the century more recent academic enquiry may find changes here.

Research examining relationship satisfaction and relationship quality has found few differences between lesbian, gay and heterosexual couples. Blumstein and Schwartz (1983) seminal American Couples study found that for all couples, irrespective of sexuality, poor relationship quality was related to non-monogamy, not enough time spent together, disagreements about money, and a lack of work life balance. Indeed, research utilizing psychometric testing in respect of five areas considered as being implicated on relationship satisfaction, including psychological adjustment, personality traits, relationship style, conflict

---

30 This position is now changing in the UK as civil partnership dissolution and same-sex marriage divorce statistics are now being collected, along with heterosexual divorce rates, by the Office for National Statistics.
resolution and social support, found no differences between lesbian and gay couples and heterosexual couples with children on over half of the measures (Kurdek, 2004). Where differences were found, in relation to conflict resolution, lesbian and gay couples appeared to be functioning better than their heterosexual counterparts; however, in relation to social support the lesbian and gay couples fared less well than their heterosexual counterparts (Kurdek, 2004). Whilst Peplau and Fingerhut (2007) found that, similarly to heterosexual couples, there are relationship benefits when partners in lesbian and gay couples have similar backgrounds and hold similar attitudes and values. Overall, therefore it would seem that in many respects lesbian, gay and heterosexual couple relationships are similar.

However, Kurdek (2004) indicated that there are areas where there are differences between lesbian, gay and heterosexual couples. One such area of difference was in social support. Here research has found that, on the whole, lesbian and gay male couples derive most social support from their friends. Early research focusing only on lesbian and gay male couples identified that their social support was derived from friends, partners, family, and co-workers; with friends being the most frequently listed provider of support. Friends made up 43% of the total support network, whilst family members accounted for 13.5%. Overall, friends were considered as the primary support providers; a position that is in contrast to heterosexual couples (Kurdek, 1988). A further finding in this study was that social support from friends and partner was positively related to psychological adjustment (Kurdek, 1988). Similar findings were obtained with research that directly compared lesbian and gay couples with heterosexual couples. Kurdek (2004) compared lesbian and gay couples with heterosexual couples with children and found that compared with the heterosexual couples, both the lesbian and gay couples perceived less support from their families of origin than the heterosexual couples. The lesbian partners in this later study also indicated they received more support from their friends than the heterosexual participants did. Similar findings have been obtained in the UK. Heaphy, Yip and Thompson (2003) indicated that friends were the first call for emotional support (59%) compared to family of origin (9%). Overall, therefore it is clear that like single lesbians and gay men (Oetjen & Rothblum, 2000) friendship networks are the most important source of support for lesbian and gay couples.

Whilst this comparative research suggests there is little qualitative difference between same-sex and heterosexual coupled relationships (Kurdek, 2005), the generalization of models predicated on heterosexual couple relationships is not always helpful. This is particularly the case in the issue of fusion and power within lesbian relationships. Fusion can be thought of
as a blurring of boundaries between the lesbian couple, with partners becoming enmeshed and merged, potentially to the extent that one or both parties within the relationship may lose their sense of individuality (Krestan & Bepko, 1980). The concept of fusion has been posited as a problem as it has been thought to create dysfunctional co-dependent relationships in which neither partner is able to engage separately in activities (Elise, 1986). However, traditional ideas surrounding fusion were originally developed with regard to the norms of heterosexual relationships where separation between partners is considered usual, and that healthy relationships involve a balance between autonomy and intimacy (Ackbar & Senn, 2010). By measuring lesbian couple closeness against norms developed in relation to heterosexual couples fusion is thought to be abnormal and unhealthy, despite being viewed by many lesbian couples as being central to their happy relationship (Ackbar & Senn, 2010). Further, some psychologists have considered fusion as being a coping strategy of the couple in the face of stigma and rejection by a homophobic world (Kitzinger, 1996). In sum, the generalising of models predicated on normative heterosexual relationships is potentially harmful and pathologising to non-heterosexual relationships.

The comparative relationship research so far examined has been focused on the couple relationship. This research base, whether intended or not, assimilates lesbian and gay relationships within the dominant discourse of monogamous couple relationships. This discourse implies that the only appropriate and morally acceptable format for relationships is that of monogamous relationships between heterosexual couples (Rubin, 1984/1993). However, not all LGBT individuals embrace a monogamous relationship with one other person and so the relevance of heteronormative models of monogamy are of little use.

5.2.1.2 Looking beyond normative couple relationships

Monogamy is just one form of relationship. For some, remaining single is an active choice, as too is remaining celibate; further there are increasing numbers of people who identify as asexual. For those who embark upon relationships with others, beyond the normative couple relationship, some live independently from their partners rather than together, whilst others may identify as polyamorous and have more than one sexual relationship and/or partner.

---

31 Of course not all heterosexual individuals embrace monogamy either and the variety of relationships outlined in relation to LGBT individuals are also practiced by heterosexual individuals. However, given the space limitations of a thesis and the thesis focus, the research discussed focuses on the LGBT population.
Turning to the relationships of those who chose to live independently whilst in a relationship, these relationships have been described as “living apart together” (LAT) and are defined by intimate partners choosing not to cohabit. Recent UK research suggests that around 10% of adults who are in relationships do not live with their partner (Duncan, Carter, Phillips, Roseneil & Stoilova, 2013; Duncan, Phillips, Carter, Roseneil & Stoilova, 2014). Why people choose to live apart when in a relationship can be for a number of reasons. UK survey research has found that this form of relationship is adopted for reasons of personal choice and, as well as for some, a result of personal circumstances (Duncan et al., 2013; Duncan et al., 2014). Personal circumstances that might lead couples to live apart may be in relation to situational constraints32, financial constraints33, or other family responsibilities34. Personal preference may be in relation to a variety of reasons, such as neither partner wanting to live together, abiding by the wishes of only one partner who did not want to live together, waiting to get married or enter into a civil partnership before living together, or feeling that it was too early in the relationship to live together. The final reason was the most prevalent given for not living together (Duncan et al., 2013; Duncan et al., 2014), so for some people a LAT relationship is a transitional arrangement on the way to living together. Despite waiting to get married or enter into a civil partnership being given as a reason for not living together, marriage or civil partnership does not preclude couples from engaging in an LAT relationship. Duncan et al., (2013) nor Duncan et al., (2014) did not report any formalized relationship statistics; however, in a briefing paper based on the same data set Duncan, Phillips, Roseneil, Carter and Stoilova (2013) indicated that 3% of their sample were married, there was no mention of any of the participants being in a civil partnership35. Further, despite having non-heterosexual participants they neither provided descriptive statistics nor a breakdown of whether the participants were lesbian, gay or bisexual. However, again, the briefing paper indicated that 3% of the sample were reported as being in a same-sex relationship (Duncan, Phillips, Roseneil, Carter & Stoilova, 2013); and similarly, there was no indication as to whether these were male or female same-sex relationships.

However differences have been found between lesbians, gay men and heterosexual couples with respect to LAT relationships. US research has found that more gay men than heterosexual men were in LAT relationships, whilst higher (although not significantly so36)

---

32 Work, study, or prison (Duncan et al., 2013).
33 Cannot afford to live, or would lose benefits if living, together (Duncan et al., 2013).
34 Children from a previous relationship (Duncan et al., 2013).
35 At the time of the research marriage in the UK was restricted to heterosexual couples
36 No significant difference was found
numbers of lesbians compared to heterosexual women were in LAT relationships. Also, age mediated the likelihood of being in a LAT relationship for lesbians rather than gay men, with older lesbians more likely to cohabit than being in a LAT relationship (Strohm, Seltzer, Cochran & Mays, 2009). Notwithstanding the position that 3% of the overall UK sample amounts to 17 participants (Duncan et al., 2013), so potentially not offering any statistically significant findings37, an engagement with and the reporting of, the data from the L/G participants would have offered some measure of insight for the position in the UK.

Given that there were non-heterosexual participants in the UK data set it is surprising that issues and potential reasons as to why lesbians and gay men in relationships might choose to live separately were not addressed rather than assume similarity across the board. Others have theorised a number of reasons as to why lesbians and gay men may choose to not cohabit with an intimate partner. And, whilst many reasons may well be of a similar nature to heterosexual couples, such as wishing to remain independent (Duncan et al., 2013; Peplau & Cochran, 1990), some issues may be unique to same-sex couples, perhaps centred around the avoidance of stigma by way of maintaining separate homes (Peplau & Cochran, 1990). Others have argued that living together may not be as important for same-sex couples because childcare is not as common among same-sex couples (Black, Sanders & Taylor, 2007). A qualitative engagement with same sex couples within the more recent UK data might have supported these ideas, or offered alternative insights.

Recent qualitative research with a European38 cohort which included non-heterosexual participants has been undertaken. Stoilova, Roseneil, Crowhurst, Hellesund and Santos (2014) interviewed 21 participants, 8 of whom were in same-sex LAT relationships, all of whom were living in metropolitan areas. Stoilova et al., (2014) considered their data along an axis of how the LAT relationships were conceptualised in terms of togetherness and apartness experience39. Whilst their analysis did not focus specifically on the participants with same-sex partners, the issues they highlighted in respect of some of their non-heterosexual participants offered some points of interest. One gay male Bulgarian participant’s relationship was conceptualised as “unrecognizable”; not because this was a gay relationship, rather because it was positioned outside of normative and acceptable coupled relationships within his cultural context. As such the relationship was experienced as being a difficult intimacy that was hard to describe; his five year relationship had been kept secret due

---

37 Total sample was 572
38 Bulgaria, Norway, Portugal and the UK
39 The five axes were: chosen, temporary, transitional, undecided and unrecognizable (Stoilova et al., 2014)
to his partner not seeing himself as gay, coupled with a lack of acceptance on same-sex relationships within his and his partner’s families. This account of a same-sex LAT relationship provides support to the idea that same-sex couples may choose to live apart in order to avoid stigma (Peplau & Cochran, 1990). Similarly, a lesbian participant, whose LAT relationship was categorised as being “transitional” stated a preference for living together, however felt unable to do so as she struggled to make an open commitment to a person of the same sex. Finally, another gay male participant, whose LAT relationship was conceptualised as being “chosen”, was in a non-cohabiting relationship as well as having a live in partner. Stoilova et al., argued that this relationship challenged normative notions of togetherness as well as the normalisation of same-sex relationships, that is the heteronormative idea of monogamous coupled relationships. This final example of a LAT relationship may well have more in common with polyamorous relationships.

Polyamory is the term used to describe an approach to relationships which takes the position that it is both possible and acceptable to have multiple, concurrent, intimate, long term relationships with more than one partner (Barker, 2005). Often termed ‘poly’ for short, there are a variety of different polyamorous relationship arrangements, including people having one or two “primary” partners with other “secondary” ones, relationships between three people (triads), and relationships between two couples (quads). Some poly people live together in “tribes” which can be either “open” or sexually exclusive, known as “polyfidelity” (Barker, 2005). Polyamorous relationships stand in direct challenge to the dominant discourse of intimate monogamous couple relationships as they involve a direct and open refusal to engage with the social norms of monogamy and fidelity (Barker, 2005). This open challenge described by Barker (2005) to the normative couple discourse is the position of the gay male participant discussed above, whose LAT relationship was categorised as chosen. Whilst Stoilova et al., (2014) argued that their participant’s LAT relationship was a political statement his political standpoint can also be linked to his polyamorous relationship choices of having open and concurrent relationships with both a live in partner and LAT partner that challenged the normative monogamous couple. In sum, polyamory is the term for one form of non-monogamy that stands in challenge to the prevailing social norm of heterosexual coupledom40.

40 There are other forms of non-monogamy, such as swinging and open relationships (Barker & Langdrindle, 2010). However, the focus here is on polyamory, the form that some of the current study participants identified with.
Early work on lesbian non-monogamous relationships, based on both the doctoral research and clinical practice of Kassoff (1989), suggested that non-monogamy comprises differing styles. Kassoff categorized five styles: stable, transitional, self-oriented, couple oriented, and symbolic. Stable non-monogamy is classified as consciously planned and long-term with primary and secondary partners\(^{41}\). In this clinically oriented work Kassoff notes that lesbian non-monogamy was an issue often brought into both individual and couple therapy, commenting that the desire to engage in more than one concurrent relationship was often a conscious and political decision for many women; a position echoed by Barker (2005). Indeed, whilst Kassoff does not use the term polyamory, there are similarities to be seen in the descriptions offered by both Kassoff and Barker, particularly in relation to primary and secondary partners and in the political choices made by some. As well as being a political choice, Kassoff notes that non-monogamy was sometimes utilised variously by the women as a means of de-merging the fused lesbian couple, as a way to structure co-dependency within the couple relationship, to terminate or affirm a primary relationship, and to develop the self. Kassoff’s central message, however, is that many non-monogamous couples never enter therapy as they do not experience distress, that non-monogamy \textit{per se} is not a pathological condition, and was often chosen as a means to develop a consciously different approach to normative coupled relationships.

Despite Kassoff’s (1989) early work, research into non-monogamous relationships is a relatively recent phenomenon. More recently, Barker and Langdridge (2010) indicate that there has been an upsurge of interest in examining non-monogamous relationships. In their review of research and theory in the area they indicated that research generally focuses on only one category of non-monogamy (gay open relationships, swinging or polyamory) rather than include differing kinds within one study. Also noted was that in general much of the research up to that time had been with gay men; the reasoning for this was that non-monogamies had been more common in gay male rather than lesbian communities. Finally it was noted that most of the polyamorous people studied were bisexual (e.g Barker, 2005) and most swingers were mainly heterosexual. However, as the work of Kassoff and \textit{The Lesbian Polyamory Reader} (Munson & Stelboum, 1999) attest, these non-monogamous relationship models are not entirely absent within lesbian circles.

Barker and Langdridge (2010) found a number of themes in the extant research, indicating that research engaged with comparisons between consensual non-monogamy,\(^{41}\) Kassoff (1989) anecdotally acknowledged triadic relationships however there were no participants in triadic relationships in the study and so no discussion of them.
monogamy, and infidelity; the distancing of the different forms of non-monogamy; different non-monogamy arrangements; the rules and boundaries employed within poly relationships; work focused on couples and parenting in open relationships; and in the more recent development of intersectional research examining the meeting of non-monogamies and other identities and communities. “Comparison” themed research focused on positioning consensual non-monogamy in whatever form on the moral high ground compared with secretive infidelity in monogamous relationships; whilst “distancing” themed work positioned the greatest distance as being between swinging and polyamory which Barker and Langdridge note may be a result of these two forms being heterosexual options unlike gay non-monogamy. Work on the different non-monogamy arrangements explored the various differing models; whilst the focus on rules and boundaries examined what was needed in order to maintain and manage complex personal relationships, ensure relationship stability and security, as well as minimizing difficult emotions such as jealousy. The research examining couples and parenting has an historical development. Early work examined the couple, whilst more recent work examines issues of poly family parenting. The final intersectional theme has examined areas of identity and community cross-over in areas such as bisexuality, and kink/BDSM (Barker & Langdridge, 2010).

Interestingly, although this has not been an exhaustive examination, as with LGBT research, an area of absence here would appear to be at the intersection between polyamorous relationships, a poly identity, and family of origin interactions. The polyamory research base, similarly to the LGBT psychological research base, positions the poly individual as being separated from their family of origin whilst at the same time situating them within a poly family; whereas the family based research is centred upon issues of poly parenting rather than any engagement with families of origin.

5.2.1.3 Sexual citizenship and identity politics

Also discussed by Barker and Langdridge (2010) was the issue of sexual citizenship and identity politics. Sexual citizenship can be understood in different ways. Richardson (2015) indicates a number of areas of analysis that the term covers including work on the construction of sexual citizenship via capitalism, how rights are given or denied based on sexuality, and on sexual citizenship being defined in terms of heterosexual marriage. Citizenship confers the individual with legal rights, whilst identity confers the individual with social and cultural positioning (Plummer, 2003). Therefore, in terms of a lesbian or gay
identity and relationships and/or a poly identity and relationships, sexual citizenship is in relation to seeking rights based on sexual identity and relationship status.

Currently in the UK the only legally recognised relationships are between two people in the form of a marriage\textsuperscript{42} which affords both heterosexual and LGBT individuals a measure of sexual citizenship, provided they only wish to have their relationship to one person legally recognised. Heated political and social discussions ensued prior to legislative changes that heralded both civil partnerships (in the UK) and subsequently same-sex marriages in countries such as the UK, Ireland and the US, which were driven by ideals of what can be defined as a legitimate family. At the heart of these discussions was a challenge to what has been considered as being the ideal family: the Parsonian family (Parsons & Bales, 1956). This model takes the form of a heterosexual monogamous married couple; and is reflected in the heteronormative family discourse. The Parsonian family was predicated on a gendered division of labour within the family unit with men engaged in instrumental activities and decision making, whilst deferential women engaged in caretaking activities (Parsons & Bales, 1956). And, whilst this patriarchal arrangement has been extensively critiqued from a feminist standpoint (e.g. Chodorow, 1978; Hochschild & Machung, 2003), until the debates surrounding, first civil partnerships in the UK (Jowett & Peel, 2010), and then same-sex marriage, it appeared to stand unchallenged.

5.2.2 Identity, outness and the homespace

Regardless of relationship status, the issues of a place to live and whether or not to come out are key aspects related to the lesbian woman’s identity. The identities that people ascribe to themselves in respect of their sexuality can often be read in the fabric of their home, traditionally a space associated with the heterosexual family. Social geography research asserts that the home is a heterosexual space designed for the heterosexual nuclear family rather than extended families and relationships or non-heterosexual relationships (Johnston & Longhurst, 2010). However, lesbian geographic research suggests that the private sphere of the home can be a refuge from society (Johnston & Valentine, 1995; Valentine, 1993), a place where people can be open about their sexual identity (Elwood, 2000), and a space that can be shared with other lesbians (Gorman-Murray, 2006); a position that queers and troubles the hegemonic heterosexuality of the home. All these positions reflect that identity affords the individual a social position in life.

\textsuperscript{42} And civil partnerships which are available only to same-sex couples.
5.2.2.1 Identity

Chapter 4 considered the self and identity from a social cognition perspective, however the concepts of self and identity can also be understood in terms of personal and social identity. In this regard the lens of social identity theory (SIT) (Tajfel & Turner, 1979) can be of use here. Within SIT understanding of identity is in terms of personal and social identity. Personal identity is the part of the self-concept that originates from individual experience and personal relationships, whilst social identity stems from the individual’s memberships of social groups and the value that their group memberships offer. Put simply, social identities are derived from the descriptions of the self that an individual ascribes to themselves, based on the characteristics that define the social groups to which they belong. In this way social identity can be said to emerge by way of intergroup engagement. Sexual orientation can be considered as a personal identity, social identity or both. Homosexuality considered purely as a way behaving sexually situates sexuality as being a personal identity; that is an identity drawn solely from the experience of personal feelings and behaviour (Cox & Gallois, 1996). Of course identities that are personal can also be social, and so an individual may consider their lesbian or gay sexuality as being one of their social identities. That is, they may consider themselves as being a part of a group that defines themselves as being lesbian or gay, in sum categorizing themselves as lesbian or gay and identifying as such.

There are two key processes involved in SIT, that of self-categorisation and social comparison. First, social group membership is determined by way of self-categorisation, that is the defining of the self as being a member of a particular group or social category (the in-group), in opposition to the other social categories (out-groups). By way of self-categorization individuals develop their multiple social identities. When individuals self-categorize they acquire labels, behaviours and attitudes for themselves in respect of each of their identity labels. This position is based on the premise that the social groups and categories that people belong to are central to their sense of self and identity. An individual’s social group memberships form part of how they see themselves and how they feel about themselves. This is because of the values that are assigned to group membership and the emotional significance that the individual holds in respect of their group memberships (Augoustinos et al., 2006). SIT posits that individuals are motivated to think positively about themselves (Tajfel & Turner, 1986/2004). As an individual’s sense of self is bound up with their social identities the theory suggests that people look for positive distinction in respect of
their in-groups compared to out-groups; this is the second process of SIT, social comparison. It is via this social comparison process that self-esteem is derived. By making this in-group out-group distinction and engaging in social comparison the individual endeavours to make positive comparisons between their in-group(s) compared with the out-group(s) and so create a positive social identity and increased self-esteem (Augoustinos, et al., 2006). From an SIT perspective any characteristic can be the basis upon which a person self-categorises, which identities become important and so have influence on how an individual thinks about themselves is predicated on individual circumstance and in how the individual categorizes themselves. Research that examines the development of homosexual identity formation (e.g. Cass, 1979; Troiden, 1979) is concerned with the processes of self-categorization as a homosexual.

However categorizing the self as lesbian or gay is positioning the self as part of a stigmatized and negatively stereotyped group. Belonging to a negatively stereotyped group can threaten an individual’s self-esteem. Despite this, people derive value in their lesbian or gay social identity. This arises for a number of reasons. First, individuals can seek social change in order to achieve a higher status and more positive evaluations for their in-group. One way this can be achieved is by collective social action. Alternatively, positive evaluations can be made by changing the axis of evaluation, that is on which points comparisons are made, and by revaluating the original comparison dimension seeing attributes that out-groups members devalue as being of worth, for example lesbian women being out and proud about their sexuality. Second, this can be achieved with in-group comparison where an individual compares themselves with others within their group. As social comparison occurs both between and within groups, members of stigmatized groups can insulate themselves from a negative comparison by comparing themselves with similar others. Finally, negative comparisons can be attributed to out-group prejudice rather than in-group failings. Again, this position will protect personal self-esteem (Crocker & Major, 1989). Put simply, using these strategies, group membership of a stigmatized group can still afford the individual self-esteem benefits. Given this position, maintaining their social identities, in particular their lesbian social identity, may be important aspect that lesbian women may value in relation to self-esteem. And, as was identified in Chapter 4, engagement with lesbian communities is important in maintaining a lesbian identity.
5.2.2.2 Outness and the meaning of home

Despite the legal recognition of same-sex partnerships, most public space is heterosexualised. This position means that while a heterosexual couple can exchange public displays of affection freely and without thought this is not necessarily the case for lesbians and gay men. If a lesbian or gay male couple engage in public displays of affection they may find themselves the target of homophobic abuse. Indeed, as recently as 2014 incidents of homophobic abuse have been reported in the press for lesbian and gay couples kissing on buses and in supermarkets (Molloy, 2014); something that often goes unremarked should the couple be heterosexual. Therefore, given that public space is heterosexual space, often the only public place where lesbians and gay men will have their sexuality sanctioned is within the lesbian or gay space of the gay scene (Valentine, 1996). Put more simply, you can only demonstrate your lesbian or gayness in certain spaces without risk of sanction. However, as indicated in Chapter 4, the gay scene is not a space that everyone feels is a welcoming environment for reasons as diverse as class (Skeggs, 1999; 2001), age (Taylor, 2008), and even for being a lesbian (Casey, 2004). Being excluded from what many consider should be a safe environment means that for some lesbians and gay men the private space of their home is the only space in which they are fully able to be themselves and express their sexuality.

Early work by Cooper (1974/2014), using Jung’s theory of collective unconscious, theorised that the “home” can be seen as a symbol of the self. She argues that the physicality of the house, in that it both encloses and excludes space, acts as a symbol of the self. This is because the interior is a reflection of the intimate self only seen by the individual and whoever is invited inside, whilst the exterior (based on the Jungian notion of the persona) is the public self that the individual chooses to show others. Cooper argues that people project themselves onto their house in their choice of furniture, décor, items on display and so on. In this way the house becomes a home and “an avowal of self” (p. 169), in other words an objective symbol of the self in which the self is revealed. Further, Cooper suggests that the living room, as a “public” and social room, is where the individual expresses their social identity. Cooper’s argument was not tested empirically; however the meaning of home was explored in a study by Sixsmith (1986) who utilised both multidimensional scaling (MDS) and content analysis. The MDS analysis identified three experiential meanings of home: personal, social, and physical. By far the largest experiential aspect of the home was the “personal” aspect. Using content analysis, the personal domain of the home was found to be considered as an extension of the self and as a centre of meaning for an individual, as well as being a place of self-
expression whereby with the choice of decoration, furniture and so on reflect valued aspects of self-identity. This second finding offers some support for Cooper’s ideas. The second experiential aspect of the home was in the “social”. Here Sixsmith found that the home allowed for the development of personal relationships both with family, partners and friends; becoming a place that is shared as well as a site of both entertainment and enjoyment. Whilst not discussed by Sixsmith, it can be argued that this social role of the home can help maintain an individual’s social identity, which would support Cooper’s position.

However, the research into the meaning of home can be criticised. First, Moore (2000) argues that there is an assumption in this body of work that the meanings associated with the home are experienced equally by everyone. Added to this, it can further be argued that how individuals experience these meanings may be assumed to be unproblematic and that all experiences of home are positive. And, whilst privacy is an important “meaning” and experience of the home (Moore, 2000), as it allows people to get away from the gaze and surveillance of others, this is not always afforded within a family home. Here, family members can be subject to the gaze of other family members and so experience a loss of privacy within the home (Johnston & Valentine, 1995). The privacy afforded by a family home is one that allows family intimacy and togetherness, which may erase individual privacy. Further, the children within a family home are generally afforded less privacy by their parents (Hunt & Frankenberg, 1981; cited in Moore, 2000).

Further criticisms can be identified when considering the research from a non-heterosexual perspective. As the home is considered as being synonymous with the heterosexual family (Allan, 1989) and the site of heterosexual family life (Johnston & Valentine, 1995) it is often theorised and examined from a purely heterosexual perspective. However, not all homes are exclusively heterosexual. How the lesbian or gay man experiences their home may be different and dependent on their living arrangements, such as whether they live alone or with others, with an intimate partner, children, or with their families or origin. The lesbian or gay individual may find they encounter more difficulties if they are sharing a home with their family of origin than if they lived alone or with their partner. The issues of strained family relationships affecting the safe experience of home (Sixsmith, 1986) can be something that lesbian women may experience should their sexuality be problematic for other household members. Finally, whilst Hunt and Frankenberg (1981; cited in Moore, 2000) were considering young and adolescent children within the family
home, depending upon individual family relationships, power and privacy may be an issue for adult children living in the parental home.

The home experiences of lesbians and gay men living within the heterosexual family home has received some attention. Work in respect of young people coming out has found that actually coming out whilst living within the parental home was considered as a risk because of potential homophobic reactions, whilst those who chose not to come out when living in the family home experienced isolation. Indeed, in relation to homophobia some participants indicated that family members behave in homophobic ways and express homophobic views (Valentine, 1993; Valentine, Skelton & Butler, 2003). Work by Johnston and Valentine (1995) focusing exclusively on the experience of lesbian women living within the parental home has found that for those women who had not come out to their parents the lack of privacy impacted upon their ability to perform their lesbian identity within the home. Particular problems highlighted were in relation to inviting girlfriends home, and if a girlfriend was brought home in respect of sleeping arrangements with shared beds and bedrooms often being banned. However, the out lesbian women in the study also struggled with these issues too, for these women the issues also extended to expressions of affection such that behaviour was modified to the point that partner relationships appeared invisible within the parental home. It was not only in relation to demonstrations of affection that issues were to be found. The heterosexist, and at times homophobic, behaviour of other family members also impacted upon the women’s lesbian identities. Also, the women often refrained from expressing their sexuality in their surroundings, even in the supposedly private space of their bedrooms, by not displaying lesbian fiction or pictures of a lesbian nature. Further, the concern not to perform their lesbian identities was also reflected in their choice of clothes or in endeavouring to look “straight” for other family members’ guests. Johnston and Valentine concluded that for lesbians residing in the shared family home it can be a place where the performance of heterosexuality by other family restricts the women’s performance of lesbian identity leading to the women feeling out of place. Overall, it seems that for lesbian women living in the parental, or family, home their experiences are at best restrictive in expressing and performing a lesbian identity, and at worst oppressive and homophobic. Taken together it could be argued that there is heteronormative pressure to conform to heterosexuality or conceal a lesbian sexuality within the parental home. Indeed, research has found that out lesbian women who need to return to the family home may conceal a previously out lesbian sexuality (Elwood, 2000; Johnston & Valentine, 1995).
For those lesbians and gay men who live alone or with significant others research has found that for some the home may be one of the only places that they are able to express themselves fully. Some of the women in Elwood’s (2000) study indicated that it was only in their homes that they felt fully able to visibly assert their lesbian identity in what they chose to display such as lesbian books, posters and art, rainbow flags and so on. Despite this, the privacy of the home can be challenged, and the lesbian and gay home subjected to disciplinary surveillance, in the form of hostility from visitors to the home and harassment from members of the local community. Indeed, the removal of items that could identify the householders as lesbian to visitors to the home, such as trades people and others, has been reported in some studies and homophobic abuse and harassment experienced from neighbours (Johnston & Valentine, 1995; Valentine, 1993). Nevertheless, the lesbian or gay home is often central to socializing and the social networks of lesbians. Some of the older women in Elwood’s (2000) study indicated that as they no longer engaged in social activities that many younger women did, such as sports, and because lesbian bars were geared towards younger women, social gatherings in their homes were their primary means of connections to other lesbians. This finding was supported by Ellis (2007) where age appeared as a linking factor in accessing formal LGBT community resources. The women over 40 in her study indicated that they rarely accessed formal lesbian and gay community activities; preferring to rely on extensive social networks that meet in private homes rather than public spaces. Overall, it is clear that despite potential homophobia from without, the lesbian home is a site where a lesbian identity can be affirmed (and re-affirmed) by way of expressing this identity in the décor and choice of what is on display, as well as being a site for continual construction and maintenance of a lesbian identity via interaction with the lesbian community.

5.2.3 The present study

The broad literature base examined here suggests that lesbian women enjoy a variety of relationship forms that include coupled relationships, living apart relationships, as well as polyamorous relationships. And, irrespective of the type of relationship a lesbian prefers, she must consider the issues of whether to come out and where to live. Both of these issues are closely linked to identity, both personal and social. When lesbian women are living, whether out of choice or circumstance, with their families of origin it would appear that all forms of lesbian relationship become more difficult to engage in and maintain. These issues surrounding relationships, outness and the home are core issues germane to the second part of the study analysis.
The initial aims of this study in respect of lesbian women’s experiences of family elder caregiving have been examined in Chapter 4. Still mindful of minority stress (Meyer, 1995; 2003) in relation to identity expression and living arrangements, as well as being aware of ‘normative creativity’ (Brown, 1989), the further study aims were to discover how elder caring impacts upon lesbian lives around the issues of outness, socialization and personal relationships. These additional aims are examined in the analysis presented here.

5.3 Analysis

As indicated in Chapter 4, the study analysis conceptualised six themes. The four themes of “Duty and Obligation”, “Boundary Setting”, “Loss of Lesbian Identity” and “Connections with Lesbian Communities” were presented in Chapter 4. The first two themes presented in Chapter four were focused on issues pertinent to all carers. Whilst the second two themes were focused on issues that a brief examination would suggest are purely of relevance to lesbians, however the core issues being addressed here were identity and social support.

The final two themes of the analysis are presented here. Both these themes were closely related to the way the women lived their lives. The first theme “Different Models of Relationship” highlights the ways in which the women felt their significant relationships with other women were both similar to, and different from, more normative, dominant, monogamous heterosexual relationships. Whilst in the second theme, “Outness in the homespace” the women’s experiences of lived lesbian outness within the homespace is explored. These themes, whilst not entirely lesbian focused, are more pertinent to non-heterosexual carers than those presented previously.

5.3.1 Different Models of Relationship

Over the course of the interviews all of the women talked about their relationships with other women. In their talk the women used words such as independent, polyamorous, civil partnership and separated to describe past, present and potential significant relationships. Some of the women constructed personal relationships that differed in shape and form from the more dominant heteronormative relationship model of coupled men and women in monogamous relationships. The women demonstrated a “normative creativity” (Brown, 1989) in their construction of relationship models that included independence, monogamous
relationships which encompass both civil partnerships,\footnote{The data collection was conducted after civil partnerships became available but before the advent of same-sex marriage within the UK.} non-formalised coupled partnerships, living apart together relationships, and polyamorous relationships.

Relationships framed within an independent lifestyle are illustrated by Susan, who says:

“I don’t do others’ baggage and I won’t take on other people’s problems. I am very independent, I won’t move in with my mother despite the fact that I visit daily, so why would I want a live in partner?”

Here Susan clearly paints a picture of independence; she currently lives alone and does not wish to change this for either her mother or any lover. In this model relationships never become live in and each partner retains their own autonomy and independence. Susan’s desired relationship form appears to chime with the type of LAT relationship described by Stoilova et al., (2014) as “chosen”. Chosen LAT relationships are considered as being reflective of changing relationship norms. Previously the normative relationship was a monogamous heterosexual marriage, however increases in divorce, separation and cohabitation have brought about a greater diversity of accepted relationship formats (Levin, 2004; Roseneil, 2006, Stoilova et al., 2014). Further, chosen LAT relationships are considered by those who prefer them as being an alternative, non-conventional, format for intimate relationships (Stoilova et al., 2014).

A LAT relationship was also the preferred choice for Vivien whose position on relationships is made clear when she says “I don’t do live-in relationships very easily, we were together for ten years and didn’t live together”. Vivien goes on to describe how her LAT relationship and the care and support she was providing to her elderly parents were not in conflict:

“I don’t feel that my commitment to my Dad and Mum competed with the attention I could give to my relationship… I feel that because maybe the model we had of our relationship, in which we didn’t have the expectation that we would dedicate all our free time to each other, and we both felt, we both believed, that our relationship would be more healthy if we didn’t”

Interestingly, one reason why people might choose a living apart rather than a living together relationship has been in order to engage with caregiving for an elderly parent (Levin, 2004). Both Julie and Vivien were engaged in elder caregiving, however neither woman chose to live with their elderly parents. The relationship choices made by these women were not driven by
the need to care, rather they were driven by personal preference and a desire to remain independent, something that Roseneil (2006) terms as “gladly apart”. Nevertheless, despite eldercare not being the determinant of these women’s LAT relationship choices, for Vivien at least, this type of intimate relationship form appears to allow the individual greater freedom in respect of other family commitments.

Another relationship form alluded to by the women was that of a monogamous one. Whilst some of the women had been in previous living together relationships only two of the women were in a monogamous living together relationship at time of interview. These two women, Lyn and Gwen, were in a civil partnership with each other at the time of their separate interviews. Although neither woman used the term monogamous to describe their relationship, when Lyn was discussing going for weekends away to make relationship space she indicated her belief that the relationship was exclusive by saying: “I suppose it’s like having an affair on the side, going to a hotel to be together”.

That Lyn felt that the weekends away made space for their relationship and may have been her way of dealing with Gwen’s family’s view of their relationship. Here, her partner Gwen indicates how she feels her family of origin considers her and Lyn’s relationship:

“I get the impression that my family regard myself and my partner less of a married couple but just two girls who are mates living together. Two girlfriends in the platonic sense. It’s as if they, we are regarded as though we are in a platonic relationship as opposed to having a umm a, a romantic relationships, if that doesn’t sound old fashioned (.) or a sexual relationship even”

Here Gwen seems to feel that her family do not consider her relationship with her partner to be of the quality and standing that a heterosexual couple’s relationship might be accorded. This view is in keeping with the ideas posited by Kimmel (1992) who argued that lesbians and gay men may become involved with family of origin caregiving due to their relationships being considered as less committed than had they been heterosexually married. Indeed, from Gwen’s account it would appear that her family do not consider her relationship as being an intimate coupled relationship. The lack of relationship acknowledgment from Gwen’s family of origin may lead to them placing demands on her that impact her relationship with her partner. Research by Laird (1998) found that unless a lesbian couple make their relationship explicit to families of origin families may place demands on the women that impact their coupled relationships.
Despite the perceived ambivalence from her family Gwen has clear feelings about her civil partnership commitment to Lyn:

“...civil partners, viz wife and wife, we’re no different to a heterosexual couple, to my brother and his wife”.

Notwithstanding the different legal status of same-sex civil partnerships compared with marriage; from this quote it would appear that Gwen feels that her civil partnership is comparable to a traditional heterosexual marriage. This perspective on same-sex couple relationships as being comparable to heterosexual coupled relationships is in keeping with much of the comparative couple research. Despite the obvious difference between heterosexual and lesbian or gay couple constitution, lesbian and gay coupled relationships are comparable to heterosexual coupled relationships (Kurdek, 2004; 2005).

The comparable nature of same-sex and heterosexual coupled relationships is echoed by Vivien, who says:

“I do think civil partnerships have done quite a lot to make things nameable really, I think that’s what the change has been, to make people think that it’s a comparable commitment”

Here, however the comparableness is not in terms of relationship satisfaction and quality, but in terms of wider social acceptance, and constructs civil partnerships in terms of equality. However, despite the women’s opinions that civil partnerships are comparable to marriage it is clear that Gwen was aware that these views were not held by all as she goes on to say:

“...people don’t regard civil partnership in the same way that they do a heterosexual marriage I don’t think. I think people are still unaccepting...possibly down to the newness of it”

Gwen’s use of “people” here, consistent with her use of the term throughout her interview, is that of the generalised other. From this quote it would seems that Gwen recognises that despite her view that her civil partnership is of equal standing to that of a heterosexual marriage her view of equity is not shared by all. These differing views on how civil partnerships are considered by wider society cuts to the heart of the debates about sexual citizenship. On the one hand, others would argue that same-sex partnerships have the potential to challenge the Parsonian family unit, something that has become reified by heteronormative patriarchal family discourses (Coontz, 1992). Whilst on the other hand the assimilationist argument posits that the legal sanctioning of same-sex relationships, first in the form of civil partnerships and subsequently same-sex marriage by the dominant
heteronormative discourse normalizes same-sex couples and allows them to conform to mainstream heterosexual culture (Sheff, 2011). This liberal position situates the sexual minority individual as being the same as heterosexual people which in turn will lead to a reduction in social prejudice (Clarke, 2003).

Not all the women in the study identified as monogamous, two of the women identified as polyamorous. Indeed, despite Vivien’s previously voiced support for civil partnerships she went on to say that “civil partnerships are not the model for everyone”, a stance she based on her polyamorous identity. Vivien then went on to expand:

“..my queerness, that my, I don’t really like to say deviance but I’d rather be deviant than conventional if I had to be faced with the truth, and my marginality is being pushed into being a mainstream gay person and I’m not, I’m, I’m a queer in many ways, like the way I do my relationships, umm all kinds of things about me. I don’t want to situate myself as in a kind of; I’m just the same as heterosexuals”

The position that Vivien takes here is very much the position taken by queer theory and queer theorists; that is a resistance to the dominant discourses of hegemonic heterosexuality (Minton, 1997). Clearly Vivien very much values what she sees as marking her as being different to mainstream conventionalism. In particular she sees the way in which she conducts relationships (both LAT and polyamorous) as what marks her out as queer. Further, and in accord with some queer theorists (Warner, 1991) it appears that she considers that formal recognition of same-sex relationships operate to normalize and assimilate. In sum, it would appear that part of Vivien’s polyamory is a consciously chosen political challenge to the heteronormative social norms of monogamy and fidelity (Barker, 2005; Kassoff, 1989). However, Vivien’s positioning of both monogamy and civil partnership as normalizing technologies effectively de-queers those who choose these ways of performing their same-sex relationships. Ironically, this stance against same-sex relationship recognition (whether civil partnerships or marriage) situates queer in the same camp as the anti-LGBT campaigners but for differing reasons. As Sheff (2011) argued in relation to the US, the conservative position on same-sex marriage is that it is a threat to the heteronormative institution of marriage. However, this is precisely the position taken by some queer and feminist thinkers, which argues that same-sex relationship recognition has the power to challenge, and so queer the concept of marriage itself (Butler, 2004; Matsick & Conley, 2015).

However, political challenges to normative heterosexual monogamy aside, lived polyamory can have consequences as another participant, Mary, indicates;
“I tried to explain to my mother she is not a girlfriend, she is a lover; and she would ask well why is she not a girlfriend? And well I’m not mono and my Mum has known that but she would always say I was being unfaithful”

Mary, identified as polyamorous, and at the time she was caring for her mother had her mother and a live-in partner living at home with her, whilst she also had a concurrent living apart lover. As Mary makes clear, being poly is not the same thing as being unfaithful (Ritchie & Barker, 2006); however it appeared that she had difficulty in getting her mother to understand this. Despite Mary’s assertion that her mother understood she was poly, it seems her mother struggled to construct Mary’s relationship with her concurrent LAT partner as anything other than infidelity. Mary’s difficulties in getting her mother to understand the qualitative difference between monogamous infidelity and her concurrent polyamorous relationships clearly demonstrate that non-normative relationship models might lead to some women experiencing particular difficulties in justifying, whether to their own sense of duty, to the people they provide care for, or interested others, why their diverse relationships require time, space and privacy.

5.3.2 Outness in the homespace

Space, privacy and lived outness in the home are the issues explored in the final theme. However, depending on the women’s relationship status, living arrangements, and level of involvement with caring responsibilities, the performance of outness within the homespace varied. The issues of space and privacy were not issues for all the women in the study. Some of the women lived alone. For these women their homes were considered an important aspect of their social life as Ann indicates:

“I am part of a couple of lesbian social network groups and take part in a few organised events as well as less organised, personal events and social invites. I like to entertain at home, dinner parties and barbeques in the summer, and umm, you know, I would say most of my socialising is with lesbian friends.”

Ann, who describes her involvement with her elderly parents as one where she “looks in on” them, lives on her own. From what Ann says here, it is clear Ann uses her personal space of the home to socialise with lesbian friends, she further intimates that her lesbian social friendship networks are, to degree, organised around personal and social invitations. The idea that the home can serve as a focal point for lesbian socialisation is consistent with the findings of Johnston and Valentine (1995), Elwood (2000) and Ellis (2007) all of whom found that for many lesbians the home becomes a lesbian social venue and meeting space. Further, for those
who do not feel able to socialise in public gay scene spaces the home takes on an important role in the maintenance of social networks (Elwood, 2000). Whilst Ann did not give any indication of whether she socialised in gay scene space or whether she did not feel able to do so, socializing at home with other lesbian women has been found to be a preferred means of socializing and maintaining lesbian social networks for women over 40 (Ellis, 2007). Ann also makes it clear that her social life is mainly oriented towards other lesbians, a position not inconsistent with the research findings in relation to social support for both coupled and single lesbians and gay men (Kurdek, 1988; 2004; Oetjen & Rothblum, 2000). This research indicates that lesbian and gay couples and singles receive most of their social support from their friendship networks.

Based on Ann’s account of her social networks the performance of lesbian outness at home was unproblematic. However, this was not the position for all the women in the study. For Gwen and her partner Lyn, living with Gwen’s elderly father presented difficulties in respect of socialising with friends in their home. This is what Gwen had to say about entertaining at home:

“I think myself and my partner are losing out by not inviting lesbian friends round because it is easier not to. There’s an issue bringing lesbian friends home as Dad wants to sit and talk and be part of the conversation and join in so say you wanted to watch a lesbian type film, *Tipping the Velvet* type of thing, it’s just not possible. So it’s easier not to bother”

So for Gwen and her partner socialising with their lesbian friends is not something they feel able to do in their home, and by saying she is losing out it seems clear that she feels this in a negative way. This view was shared by her partner Lyn who said:

“Our lives pass us by; we cannot entertain friends so we have […] very few friends”

Clearly as a couple Gwen and Lyn appear to be struggling with maintaining their social lives within their homespace and both women are clear they feel they are losing out as a result. Gwen makes explicit that the loss is in relation to their lesbian friends and social networks. Lyn is not so specific about whom it is they cannot entertain, however she seems to feel that they have few friends as a result of not being able to use their home as a social venue. Lyn goes on to say “It seems we don’t do what other lesbian couples do”, so it may be that what she feels is missing here is social engagement with other lesbians in the home. Taking account that for older lesbian women the home is the primary place to build and maintain

---

44 TV adaption of the lesbian themed novel *Tipping the Velvet* by Sarah Waters
lesbian friendship networks and community links (Ellis, 2007; Elwood, 2000) Gwen and Lyn’s feelings about losing out may be warranted.

Further, although neither woman reported psychological distress, nor was it in any way measured within the study design, loss of lesbian networks and friends has the potential to put lesbian caregivers at psychological risk. Kurdek (1988) found that support from friends, the main source of social support for lesbians, was positively related to healthy psychological adjustment. Relatedly, social support has also been implicated in ameliorating the effects of minority stress (Meyer, 2003). Further, reduced social support is implicated as being a predictor of greater caregiver burden, along with sharing the home with the care receiver (Thompson et al., 1993; Zarit et al., 1980). Finally, being unable to maintain contact with lesbian networks and friends as a result of caregiving arrangements may well put lesbian caregivers at greater risk of losing their connections to the valued social groups that allow social comparison bolster self-esteem (Tajfel & Turner, 1979; Crocker & Major, 1989).

Taken together, for some lesbian caregivers the loss of social group membership and contact can potentially lead to an increased risk of lower self-esteem and greater psychological distress resulting from both minority stress and caregiver burden.

The issues pertaining to maintaining connections to lesbian social networks and friends was not an issue for Julie, who considers her separate living arrangements here:

“We do live separately, she doesn’t know what I do and maybe she doesn’t ever want to know, and if she lived with me maybe she might be confronted with something that she didn’t want to know”

Clearly Julie acknowledges that shared living arrangements with her mother had the potential to be problematic as her mother might not be comfortable with aspects of her daughter’s lesbian life if she were faced with them directly. A short while later in the interview when asked if she had any advice to give to potential lesbian caregivers she said:

“out of respect I wouldn’t bring anyone home if we were living together and expect to do the sort of things we would do if I was living on my own with somebody else. And so I would probably just say well if this was the choice that you make to live with your elderly parents or partner’s elderly parents then I think you just have to respect that there is an age difference and that you know, if you want to go and watch lesbian movies then go and do it in your bedroom. That would be my advice for a start and maybe think about things before you get into the situation if you want to carry on like that”
Here Julie is offering some fairly forthright advice, and it is clear that if she were to have shared living arrangements with her mother she believes she would behave differently. By using the words “the choice that you make” Julie constructs elder caregiving as being a choice and, in conjunction with her advice about watching lesbian movies in the privacy of a bedroom, one that she positions as not compatible with a lesbian performance of outness within the shared and more public areas of the home. Julie’s construction of this potentially incompatible intersect is in keeping with the lived experience offered by Gwen and Lyn. This incompatibility however, can lead to an inability to perform and maintain their lesbian identity at home via engagement with lesbian subject positions (Kitzinger & Wilkinson, 1995).

This inability to engage with lesbian subject positions in the homespace goes directly against one of the key roles a home fulfils. Allan and Crow (1989) posit that the home is a locus of identity being the site where identity is constructed and reconstructed. A key role for the home in identity construction is as a repository for the signifiers of the self and identity (Cooper, 1974/2014; Sixsmith, 1986). However, the ability to leave items on display is not something every woman in the study was able to do as Ellen indicates:

“Mum’s mobility means that she doesn’t come into my room at all so I do have privacy there. She sleeps downstairs as she can’t manage the stairs so I tend to keep my stuff upstairs. I wouldn’t leave something like Diva magazine45 or anything laying around downstairs”

Whilst Ellen, who lives with her elderly mother, does have some private space, she just feels she has to be careful about what she leaves where in shared household space. However, as Young (2005) argues a home is not purely a storage place for personal goods, it supports the display of who a person is, that is their personal identity. The inability to express a lesbian identity via the display of signifiers in the home suggests that an out lesbian identity is not compatible with living as part of an extended family in a shared family home something that holds implications for creating lesbian couple identity. Gorman-Murray (2006) found that for lesbian and gay couples a shared couple identity was created via the display of shared ornaments, photographs and object in shared domestic space. If lesbian signifiers are only to be displayed in a personal bedroom, as Julie suggests and Ellen attests, then the performance of an out lesbian couple identity at home appears severely restricted.

45 Lesbian lifestyle magazine
The ability, or lack of, to express a lesbian identity within the home is closely linked to issues of privacy and safety. The home is often conceived of as a private place of safety, something Young (2005) in her feminist critique of the value of home suggests is a right that everyone should enjoy. However this construction is not afforded to everyone as Gwen indicates:

“He tends to invite the next door neighbour in who we have a feeling may be homophobic, erm but he’s my Dad’s, he’s coming in at the invitation of my Dad, who also lives in the house, so we’ve got no choice but to let him in. But [...] we believe he might be homophobic so we definitely don’t show any outward affection, err, when he’s around, when he comes into the house, to the point where we almost avoid him ‘cos we feel he might be, judging by things he’s said in the past, he might be homophobic”

Gwen and her partner’s experience is not in accord with Young’s position, that the home is usually the one place where a person has most control over who is allowed to enter and spend time there; something that is key to the home being a safe space. This aspect of control allows it to be a place where the lesbian or gay individual can escape from potential issues of homophobia into their personal space (Gorman-Murray, 2006). Further, Gorman-Murray argues that the lesbian or gay home may be the only place where a same-sex couple can feel safe to engage in displays of affection such as holding hands.

Gwen and her partner’s experience of lack of privacy in the home was something experienced by others in the study. But whilst Gwen and Lyn did not indicate that the private space of their bedroom was invaded for Mary this was not the case:

“I just didn’t like the idea also of her looking in my drawers in my bedroom I just sometimes had the feeling really that she did. I did offer to buy her a dildo and she said “oh no I know what they look like now and I don’t think I could, I can’t hold them” that sort of thing. So it wasn’t the fact umm “oh gosh she’s seen it”; it was just that it was my intimate life and it had been invaded”

Mary’s account of her mother’s disregard to the private space of her and her partner’s bedroom suggests that their privacy as intimate adult partners appears to have disappeared entirely. The position that Mary finds herself here is similar to the position of young and adolescent children living at home with their parents whose privacy levels are dictated by their parents (Hunt & Frankenberg, 1981, cited in Moore, 2000). This lack of privacy
suggests that when a home is neither exclusively “homo” or “hetero” –sexual, then the dominant normative sexuality takes over and the home becomes a heteronormative home.

A heterosexual home that does not accede any space for a lesbian private life can lead to lesbian living in the family home as not being a viable option. This was the position for Melanie:

“Well really, sort of within relationships, certainly over the last 10 to 20 years, its been based on alternative settings as opposed to my home […] I am able to book hotel rooms for special weekends or an overnight stay. My last relationship was conducted in hotel rooms”

So for Melanie, lived lesbian outness has been entirely removed from the home space and situated within the public arena of a hotel; ironically, a space that Valentine (1993) suggests is an extreme heterosexual environment with its connections with heterosexual courtship rituals and it use as a vacation alternative to home for heterosexual family units.

### 5.4 Discussion: Part 2

Taking these final two themes together as a whole, it would appear that for the lesbian women in this study family elder caregiving held the potential of presenting them with particular issues uniquely connected to their lesbian identity. First, whilst the forms of relationship described by the women of the study and elder caregiving are not unique to lesbian women, how these differing relationships and caregiving responsibilities intersect with the women’s lesbian sexuality leads to different outcomes for these lesbian women compared to heterosexual women caregivers. For some of the women in the study both monogamous and polyamorous lesbian relationships were not considered as being as valid, of the same commitment level, and of the same standing by their families of origin compared with formalized and committed heterosexual relationships receive. With respect to living at home as an out lesbian, the women who lived alone were able to use their home as a venue to socialise and maintain their lesbian social networks and friendships. However, the women who shared their homespace with the elderly relative that they cared for struggled to maintain these networks. Further some of these women found that the privacy and safety that they hoped their home would provide was no longer there.

When considering these findings with the extant research base there are mixed results. Consistent with the extant literature, the women of this study were no different to other women and described a variety of different relationship forms. Despite the limited sample
evidence of monogamous relationships of a comparable nature to heterosexual relationships were found (Kurdek, 2005), as were LAT relationships (Stoilova et al., 2014) and polyamorous relationships (Barker, 2005). When considering the comparability of monogamous same-sex and heterosexual relationships, the women were in accord with the extant literature that suggests these relationships are of a comparable nature (Kurdek, 1988; 2004; 2005), however it appeared that the women’s families of origin were not of the same opinion. With respect to LAT relationships, Strohm et al., (2009) argued that older lesbians were less likely to be in LAT relationships, however evidence for this was not found with this, albeit, small sample as five out of the ten women indicated a preference for some form of LAT relationship. LAT relationships have been seen as a solution to managing eldercare responsibilities (Levin, 2004), however this was not why the women in this study preferred them. Consistent with Roseneil (2006) LAT relationships were chosen in relation to a desire to remain independent; whilst polyamorous relationship choices were considered as being a challenge to the normative monogamous coupled relationship (Barker, 2005).

Looking at the role of home and the performance of lesbian identity in the home, again there are mixed findings. The women who lived independently of their elderly parents used their homes as a social venue for meeting with other lesbian women, whilst the women who lived with their elderly parents reported being unable to do so. This social use of the home is consistent with the findings of Johnston and Valentine (1995), Elwood (2000) and Ellis (2007). Of course using the home as a social venue is something that all women, irrespective of sexuality may wish to do. However, for lesbian women using the home socially with other lesbian women has been found to play an important part in the maintenance of social and support networks, particularly for lesbian women over forty (Ellis, 2007; Elwood, 2000). These lesbian social and support networks are important in maintaining self-esteem (Crocker & Major, 1989) and in ameliorating the effects of minority stress (Meyer, 2003). The home as a social space is not the only benefit for lesbians, the home has also been considered as a place where an individual can express themselves (Cooper, 1974/2014), to get out of the public gaze and achieve privacy (Moore, 2000; Young, 2005), and be safe (Gorman-Murray, 2006; Young 2005). However, for some of the women who shared their homes with their elderly family members these core aspects of home were missing. The home, when shared with heterosexual family members, becomes subject to the more dominant heterosexual norms and so shared space within the family home can become heterosexual space. The public/private distinction, on a micro level, can mean privacy is restricted to certain rooms,
such as the women’s bedroom. And some women found that this level of privacy disappeared. The lack of privacy that some of the women experienced is analogous to Hunt and Frankenberg’s (1981, cited in Moore, 2000) argument in relation to young children being afforded less privacy in the family home.

### 5.5 General Discussion

Overall it must be noted that, despite the small sample, the issues touched upon were wide ranging and as a result the literature examined in Chapter 4 as well as in this chapter has been a broad spectrum, and by necessity due to space constraints, not as exhaustive as it might otherwise be. Notwithstanding the broad sweep of the literature, the issues the lesbian women of the study discussed concur with the caregiver research undertaken with heterosexual women. Many caregiving issues are universal in nature, such as the experience of felt filial obligation and the need to create boundaries to manage the demands of caregiving. Issues in relation to identity loss and in maintaining social support networks are also universal.

However, this exploratory study with lesbian women who become involved in family elder caregiving has indicated that there are issues that are unique to the lesbian family caregiver. Identity loss may be in relation to the loss of a lesbian identity, and the need to maintain support networks related to being connected to lesbian networks and communities. Intimate relationships also appeared to be more problematic with lesbian relationships, for this small sample at least, being considered as less valid in terms of commitment than heterosexual relationships. This finding, however, must be considered in historic context, given that legally sanctioned same-sex partnerships were a recent development for the middle aged women of the study and their families of origin. The women in this study may never have expected to be able to formalise any relationship. And whilst the women consider their intimate relationships as being comparable to heterosexual marriages, their families of origin may not be of the same opinion. Shared living arrangements also proved problematic for the lesbian women of this study connected to expressing a lesbian identity within the home. The women interviewed, despite affirming their out status with their families of origin, needed to live their outness within the home space in very different, context dependent ways, depending upon their living arrangements and caregiving responsibilities they had.

Despite the findings there were limitations to this study in respect of the sample. The small sample size and its relative homogeneity are reflective of the difficulties in locating and recruiting participants in what is a traditionally hard to reach population (Price, 2010). The
recruitment process engaged with lesbian social networking groups that are aimed at the target age of family elder caregivers. However, as has been noted in the caregiving research, maintaining social support links for carers can be problematic. And, as the present research has found, maintaining links to lesbian communities and social networks can become problematic when involved in caregiving. Given this potential to lose social networks it is not surprising that participant numbers were limited. Whilst there was some utility in seeking participants from the lesbian networks that were approached, future LGBT carer research would benefit from seeking to recruit participants from carer support organisations and groups as well as LGBT networks and groups.

Despite the limiting sample, it would appear that the heteronormative family discourse that shapes the literature about carers and caregiving does not square with the experiences that the lesbian women in this study reported. And, by that same token, the positioning of lesbians as being bereft of contact with their families of origin, as the extant literature examined in Chapter 2 suggests, is also not entirely reflective of these women’s experiences. Whilst the greater level of responsibility and involvement that familial caregiving brings has implications for all those who provide care, irrespective of sexuality, family elder caring for lesbians can interject into a once independent life narrative and lead to a much closer involvement with family members that bring changes in the way an individual expresses their lesbian identity in space, particularly space that is perceived and positioned as heterosexual family space. This can lead to the need to live outness differently than one has previously been inclined to do.

As has been noted in earlier chapters, heterosexual women are considered as the traditional providers of care, however as the women in Study 2 have demonstrated, when lesbians become involved in caregiving they disrupt and challenge normative heterosexual expectations by their very engagement in traditional heterosexual roles. The idea that lesbians may become more involved with their family of origin over time is at odds with the stereotypical notions of lives lived independently and in isolation from one’s family of origin. Despite normative stereotypes, the women of Study 2 were involved with their families of origin. The next chapter will focus on how younger women imagine their family of origin involvement and out lesbian lives will play out for them in later life.
Chapter 6: Lesbian family futures: And every one lived happily ever after

6.1 Introduction

The study themes presented in Chapter 5 indicated that the middle aged lesbian women faced issues with respect to their relationship choices and how they lived out lesbian lives as a result of their family of origin caregiving. Negotiating these issues successfully, if they managed to at all, required the women to engage in creating new ways of living and therefore create new norms (Brown, 1989). However, despite the norm creation of middle aged and older lesbians, these narratives are not usually available to younger lesbian women, as a result of age stratification.

The norms, or rules, that are available stem from the dominant culture and so are heteronormative in nature (D’Augelli, 1994; Herek, 2007). The heteronormative default position means that there is no L/G “road map” available for everyday life so those, who by virtue of their sexuality are normatively different, have to create new rules to live by where the dominant heterosexual ones are not particularly useful (Brown, 1989). Taking account of the communal lack of lifespan knowledge it is expected that younger lesbians will have limited notions of how their future out lives will develop, particularly in relation to their family of origin. This study aims to explore the hopes and fears that young lesbian women hold with respect to their future lived outness and family of origin relationships.

6.1.1 Cultural Representations of lesbians and the “LGBT” Lifestyle

Common cultural representations of lesbian and gay people present a youth oriented lesbian or gay lifestyle where families of origin are absent (Pugh, 2002). This position also holds true for entertainment media representations of lesbians (Diamond, 2005). Lesbian and gay sexuality is constructed as not being a part of family life, which is oriented towards the heteronormative family form (Allen & Demo, 1995; Herek 2007). The alternative to the heteronormative family is the “LGBT” lifestyle which is often depicted as being oriented around a commercial gay scene that is consumption based, youth oriented, and androcentric (Pugh, 2002; Wahler & Gabbay, 1997). Further, the location of the “scene”, the backdrop of the LGBT lifestyle, is based in urban locations often termed “gay villages” rather than in more mainstream locations. Finally, the gay scene is primarily a gay male space in which women are less likely to be found (Pugh, 2002). The orientation within the scene towards young gay men leads to social stratification whereby older lesbians are less likely to make use
of scene space (Elwood, 2000). Therefore, if young lesbian women make use of the gay scene they are less likely to have contact with older lesbians.

Consistent with the lesbian stereotype research discussed in Chapter 2 (Section 2.11.1.2) research has found that lesbians are stereotyped as masculine, abnormal, aggressive and unattractive, with a negative attitude towards men (Markowe, 1996). These culturally held representations persist (Brambilla, et al., 2011), and are similar to the pejorative stereotypes of older lesbians as being unattractive and unemotional (Berger, 1982). Pejorative stereotypes of older lesbians have also been portrayed in mainstream entertainment media, for example the character Barbara Covett in the film Notes on a Scandal (Robson & Sumara, 2015). Further, there are also stereotypes, circulating both within and without the gay scene, that position older lesbians as being lonely, isolated, and miserable (Peplau, 1991; Clarke et al., 2010). Given that lived experience does not always equate with stereotype content, unless young lesbian women have contact with older lesbians their expectations in respect of living an out lesbian life as they grow up and grow old may be limited to the stereotypes, myths and media representations available to them, irrespective of accuracy. Further, their own acceptance of their developing sexuality and how they wish it to be perceived will be influenced by the social representations that they have access to.

6.1.2 Coming out

As has been examined in more detail in Chapter 2 (Section 2.10.5) a significant area of LGB research examines coming out, the process of acknowledging sexual orientation, and family of origin response to any disclosure. There are many benefits to being out. It has been linked to good psychological well-being and adjustment (Clausell & Roisman, 2009; Jordan & Deluty, 1998; Markowe, 2002b; Miranda & Storms, 1989) and better romantic relationships (Knoble & Linville, 2012; LaSala, 2000). Relationships satisfaction is not limited to romantic relationships, as openness about sexuality has been linked to relationships satisfaction irrespective of relationship type (Potocznia, Aldea & DeBlare, 2007); whilst other research has also found that being out leads to an increased sense of cohesion and integrity (Knoble & Linville, 2012). The message here is clear, overall it is better to be open and out about sexuality than closeted. The flipside of this is that hiding one’s non-heterosexual sexuality can be a stressful experience.

Not disclosing one’s sexual orientation, at times used as a coping strategy, comes with costs. Concealing a lesbian or gay sexual orientation can be used to avoid stigma, however used consistently over time can lead to high levels of stress (Miller & Major, 2000); indeed,
concealment has been identified as one to the contributors to minority stress (Meyer, 1995; 2003) (For more detail on minority stress see Chapter 2, Section 2.10.6). Looking at lesbian oriented research, work by both Jordan and Deluty (1998) and Markowe (2002b) looked at themes that underlie coming out as a lesbian and found that despite the risks in coming out to others, overall the women felt there were very real benefits in disclosing their sexuality to others. These benefits took the form of strengthened personal relationships and an affirmation of their lesbian identity, along with a sense of being true to the self. The benefits highlighted by Markowe are those identified by Meyer (2003) as the ameliorating factors identified in the minority stress model. In essence then, coming out affords the women a sense of their being an authentic and whole person. It can be seen that remaining in the closet can bring with it a significant amount of anxiety and stress, while the benefits of coming out for the individual are in the form of better mental health outcomes and a sense of personal authenticity.

For young people coming out to family is not without risk as parents sometimes react negatively (Cohen & Savin-Williams, 1996). However affirmative support from family is particularly important for young LGB youths and adults, having been associated with lower depression and suicide risk (Ryan, Huebner, Diaz & Sanchez, 2009) as well as being linked to self-acceptance (Shilo & Savaya, 2011) and better self-image for young lesbians (Savin-Williams, 1996). Negative reaction can lead to homelessness, suicide risk and drug abuse (D’Augelli, Hershberger & Pilkington, 2001; Savin-Williams, 2005). Research has found that any initial family negativity may improve with time (Patterson, 2000). Initial family of origin reaction goes through a two stage process; first the family may struggle to understand and assimilate the knowledge. Then once assimilated they may either reject or re-organise accommodate the LGB family member. The accommodation process may take some time, if it occurs (Strommen, 1998a; 1998b). Integral to the reorganisation processes are worries about what the future holds for the LGB child which may be exacerbated by a lack of knowledge about how LGB people live their lives and driven by stereotypes.

6.1.3 Lesbian parented families

One common stereotype that has been subscribed to until recently was that lesbians (and gay men) do not have children. However, whilst many lesbians and gay men no not have children there have always been lesbian mothers and gay fathers. Clarke et al., (2010) suggest that around a third of lesbians and between 10% and 20% of gay men are parents. A significant body of research has explored lesbian and gay familial caregiving in the context of child caring. Here the overwhelming focus has been upon lesbian parenting (Clarke, 2002;
Early research was focused on countering legal assumptions regarding the lesbian mother’s ability to parent in the face of child custody issues, adoption and visitation rights (Patterson, 2006). Similarly to couple research, a considerable amount of this research has been comparative in nature with the aim to dispel negative assumptions about lesbian and gay parents. For example, Golombok et al., (1983) compared 37 children in lesbian parented families with 38 children with heterosexual mothers and found no significant differences between the two groups of children.

The lesbian parented children studied by Golombok et al., (1983) were originally born into heterosexual relationships. However having children whilst in a heterosexual relationship is not the only way in which lesbians or gay men become parents. Planned lesbian or gay families are also common and generally consist of a birth parent and a co-parent, or social parent (Clarke et al., 2010). Achieving planned lesbian or gay parenthood does not happen by accident. Many lesbians, whether coupled or single, choose to become pregnant via donor insemination whilst gay men may choose to become parents via surrogacy arrangements (Clarke et al., 2010). Alternatively couples may choose to adopt or foster (Riggs, 2004b).

More recent research has reflected these new formations of lesbian family. Still from a position of comparison, research has been undertaken with lesbian and heterosexual families where children have been conceived via donor insemination. The findings of these studies concurs with the earlier research: children in lesbian families do not differ in terms of psychological well-being or gender development than their peers raised in heterosexual families (Chan, Brooks, Raboy & Patterson, 1998; Golombok et al., 1997).

6.1.4 Lesbian families of origin

Families are not just about children they also involve families of origin beyond the coming out process. However as Laird (1998) indicates there is limited research in this area and more needs to be known about the everyday lives, kinship, and culture of lesbian and gay lives; and that includes lesbian and gay relationships with their families of origin, beyond the coming out process. Research has indicated that lesbians and gay men, both as individuals and in couples, receive more support from friendship networks and partners rather than their families of origin (Ellis, 2007; Elwood, 2000; Heaphy, Yip & Thompson, 2003; Kurdek, 2004). However, lesbian and gay individuals and couples are rarely entirely disengaged from their families of origin (Laird, 1998; Weston, 1991). Whilst same-sex relationships are not usually offered unconditional support in the initial stages (Laird &Green, 1996; cited in
Rostosky, et al., 2004) research indicates that families can move towards acceptance and support (LaSala, 2002). Further, research has found that despite periods of alienation in some cases, which resonates with the findings of Cohen and Savin-Williams (1996), many women retain complex ties and connections with their families of origin. Laird (1998) examined lesbian family of origin narratives interviewing 19 lesbians (aged 26 to 68) and found that despite the popular myth that paints a picture of a lack of connectedness to their family of origin the women interviewed were not in fact estranged from their families of origin. The women often chose to maintain familial contact even over long distances. These findings have been supported elsewhere (Taylor, 2007; Study 2 – Chapters 4 and 5).

The family focused L/G research to date has mainly focused on lesbian parenting (see Chapter 2, Section 2.13.1: Clarke, 2002; 2008; Patterson, 1998; Ryan-Flood, 2009; Tasker & Golombok, 1998). A smaller body of work has theorised familial caregiving by lesbians suggesting that as lesbian women get older they may find themselves providing informal care and support for their family of origin when elderly relatives become in need of care and support (Raphael & Meyer, 2000; Cayleff, 2008). The empirical work in Study 2 (Chapters 4 and 5) has supported this position with the finding that these greater levels of responsibility and involvement can interject into a once independent life narrative and lead to a much closer involvement with family members that bring changes in the way an individual expresses their lesbian identity in space, particularly space that is perceived and positioned as heterosexual family space, which can lead to the need to live outness differently than one has previously been inclined to do. The idea that lesbians may become more involved with their families of origin over time is at odds with the stereotypical notions of lives lived independently and in isolation from one’s family of origin.

6.1.5 The present study

The evidence in Study 2 notwithstanding, there is a lack of research that examines the family of origin context of lesbian lives. The limited research indicates that following coming out family of origin relationships are maintained over time and distance (Laird, 1998; Laird & Green, 1996; cited in Rostosky et al., 2005). Indeed, support from one’s family of origin has been found to be important in maintaining same-sex couple relationship satisfaction (Oswald, 2002; Solomon et al., 2004; Rostosky et al. 2004). Given the potential for the developing involvement that lesbian women may have with their families of origin with respect to caregiving (Raphael & Mayer, 2000; Study 2 – Chapters 4 and 5) it can be argued that as both lesbian women and their families of origin age the women’s interaction with their families
appears to increase over time. However, there is limited research that focuses on lesbian post-disclosure relationships with their families of origin over time (Patterson, 2000; Peplau & Beals, 2004; Valentine, Skelton & Butler, 2003). Particularly, there is a lack of understanding of what young lesbians anticipate for their future possible “out” selves in relation to their families of origin.

The present study aimed to gain an understanding of young lesbians’ future expectations of lived outness and family of origin relationships. In particular how a lived out lesbian life and family of origin involvement may intersect and interact over time. In sum, the aim of this study was to explore the hopes that young lesbians hold about their future lives in relation to lived outness and a performance of a lesbian identity as they mature, involvement with members of their family of origin, and how lived lesbian outness and family of origin involvement may intersect and interact over time.

6.2 Method

The analysis is based on four focus groups with twenty lesbians aged between 22 and 30 years of age. The study aimed to explore the future expectations that young lesbian women hold about their future lives in relation to living as out lesbians, as well as their expected involvement with their families of origin. Based on these aims the only criteria to taking part in the study was of identifying as lesbian, considering themselves as being out, and being aged between 18 and 30 years old. The participants were recruited via posters placed around campus, a short presentation of research to the University of Surrey LGBT+ Society, and via a snowball recruitment method with early focus group participants passing on the study details to other lesbians who satisfied the study criteria. Other groups were contacted, namely Outcrowd (run by Surrey Outline), Crocus 18-30, and Shout LGBT (a South West London youth support group). The organisers of these youth groups were contacted by email to discuss the study and the potential recruitment of participants from the group via leaflet or poster. All three group organisers agreed to email the study poster and details to their mailing lists. As a result of the recruitment process twenty women demonstrated an interest in taking part.

At the time of focus group participation all the women who took part in the study were living in and around the Guildford area, none of the women were living with their families of origin, and all the women identified as lesbian. Eighteen of the women identified as British, one as Swedish and one as Norwegian. All the women affirmed that they considered
themselves as being out, however two of the women indicated that they were not explicitly out to their families of origin. As with Study 2 (Chapters 4 and 5) the small sample size and relative homogeneity of the participants reflects this difficult to recruit population (Price, 2010). The four focus group sessions lasted between 1 hour and 10 minutes and 1 hour and 45 minutes and took the form of a moderated conversation. The sessions were recorded and the resulting data recordings transcribed. The resulting transcripts were analysed using a thematic analysis approach informed by Braun and Clarke (2006).

The focus group approach to data collection involves convening a group of ‘relevant’ people and engaging them in discussion on a specific topic. The benefits of this approach to data collection are that they allow for participant interaction that generates the meaning making that is found in everyday conversation (Merryweather, 2010). Focus group discussion is primarily based around the group participants’ conversational interaction upon the topic at hand with less consideration for a pre-defined list of questions to be asked by the researcher (Barbour, 2007). Advantages to this method of data collection is that a greater amount of data can be gathered in a relatively short period of time compared with the interview method; further, the focus group setting is less artificial than the one to one interview and so provides for a higher level of ecological validity (Willig, 2008). There are disadvantages however, as it can prove difficult to encourage all the participants to voice their opinions as well as in keeping the focus group on topic (Millward, 2006). In order to ensure each session remained focused on the research topic a focus group schedule was created for use in the sessions, a copy of which is available in Appendix II. The questions were oriented towards exploring the women’s involvement with their families of origin, their support networks, and how they envisaged their future out lives would develop.

There is no preferred approach to analysing focus group data (Wilkinson, 2003). Given that the future expectations of young lesbians have had little research attention, thematic analysis was deemed an appropriate method as it is a flexible method that can be applied to many types of data and allows the researcher to identity, analyse and report themes that are found within the data set (Braun & Clarke, 2006). Thematic analysis can be either inductive or theoretical. With an inductive approach to analysis the themes constructed are closely linked to the data set and do not fit with any pre-defined coding frame, this approach is similar to the grounded theory methodological approach. Whilst with a theoretical approach the themes constructed are driven by extant theory and the researcher’s analytic interest, this approach provides a less rich description of the data set (Braun & Clarke, 2006).
Further, constructed themes can be based on either the *semantic* (explicit) or *latent* (interpretive) content of the data. In a semantic approach to analysis themes are identified within the surface meaning of the data without concern for meaning beyond what has been said. However a latent approach to analysis endeavours to go beyond the surface meaning to identify and examine underlying assumptions, ideologies and so on that may be considered as shaping the meaning of the data. In this way an interpretive analysis will engage in both description and theorization of the data (Braun & Clarke, 2006). Analysis undertaken from an interpretive approach that is focused on latent themes is generally conducted from a social constructionist epistemology as it will be focused not in individual psychologies but on sociocultural contexts and conditions that allow for the accounts to be made (Braun & Clarke, 2006).

The thematic analysis presented was an inductive, latent analysis, conducted within a social constructionist epistemology (Braun & Clarke, 2006; Burr, 2003). Explicit in this position is that themes do not emerge from the data set as they do not have any existence within the data, but are constructed during the interpretive analysis. The analysis followed the six phases identified by Braun and Clarke (2006) which included; familiarization with the data set, the generation of initial codes, searching for themes, reviewing themes, defining and naming themes, and finally the writing of the analysis. Specifically, each transcript was repeatedly read in order to glean meaning and to note patterns in the data. The data set was then categorised into initial codes, here interesting sections of data were coded. Once all the data were coded a list of codes was produced which was then sorted into potential themes and sub-themes. Once potential themes and sub-themes had been established they were reviewed and refined. At this stage of the analysis the original coded data set was re-visited and re-read in relation to each theme to assess whether they appeared to form a coherent pattern. Once satisfied the themes were defined and named and the analysis written. Similarly to a grounded theory approach, the analysis was iterative and recursive rather than linear as it involved the moving back and forth between the data set and the constructed themes. Materials pertinent to the study can be found in Appendix II.

**6.3 Analysis and discussion**

Overall, three main themes were constructed from the data set as follows, “Out and proud”; “Support Networks” and “Lesbian family futures”. Each theme had a number of sub-themes. The first theme “Out and Proud” incorporated the sub-themes of “Authenticity vs
Mis-identification”, and “Don’t be a dyke”. Here the women discussed the issues surrounding the disclosure of their sexuality. The two sub-themes highlight core issues bound up with coming out such as feeling the need to be true to themselves. The sub-themes of “Disaster support” and “Relationship and emotional support” formed the second theme “Support Networks”. This overarching theme was entirely support focused. Whilst the first two themes were firmly grounded in the present or very recent past for the women, the final theme, “Lesbian family futures” was very much concerned with future hopes and expectations. This theme contained the sub-themes “Marriage and motherhood” and “Family of origin connectedness”. Both these themes were concerned with family; first the families the women wished to create for themselves, and second their continued future engagement in their extended families of origin. A brief exposition of all three overarching themes is presented below.

6.3.1 Out and Proud

The first theme was concerned with why the women felt the need to come out and how disclosing a lesbian sexuality, or not, positioned the women and made them feel. Both positions, disclosure and non-disclosure, brought issues and concerns. The former position brought concerns of being seen as heterosexual, whilst the latter held concerns for the women in respect of being seen as stereotypically lesbian. The women talked about how not disclosing their sexuality at times led to them feeling that they were automatically positioned by others as being heterosexual, something that led to a feeling that they were in some way incomplete or inauthentic. The feelings of inauthenticity that the women discussed were something that prompted some of the participants to actually come out. However, what was clear from the majority of participants was that whilst they wanted to come out, in order to feel more complete and authentic, some of the younger participants expressed a fear of actually being seen and considered by others as what they called a stereotypical dyke. All these concerns are the explored in the two sub-themes, Authenticity vs Mis-identification, and Don’t be a dyke.

6.3.1.1 Authenticity vs Misidentification

For all of the women in the study their sexuality was felt to be an important part of themselves. Despite this acknowledgement, the women stressed that their lesbian sexuality was not the most defining aspect of themselves, in keeping with many stage models of identity development (Cass, 1979; Troiden, 1979 as example). Notwithstanding the
acknowledgement that sexuality was just a part of what goes to make up their selves and identities, at times in situations where the women’s sexuality was not known by others the women felt as if an important part of them was missing. This is evident in what Tara says here:

“Strangely, it’s not everything but then like when I meet someone new or I’m around someone and there’s no need at all for them to know my sexuality so obviously it doesn’t come up, I feel like a little, like quite a big, bit of me is missing. Like, here’s a stupid example but my driving instructor, he doesn’t know I’m gay, but because he doesn’t know I’m, like, I do feel like there’s a bit of me missing, I don’t know, in the conversation. It’s like he talks a load of crap about me and a presumed boyfriend”

This extract highlights the dilemma nicely. Engaging in a run of the mill activity like having driving lessons, should have no bearing on sexuality, however the overriding heteronormative discourse leads to assumptions of heterosexuality for all and so Tara’s driving instructor makes heteronormatively driven assumptions that Tara has a boyfriend. In turn these assumptions lead Tara to feel that her sexuality has been elided; which she has expressed as “like quite a big bit of me is missing”. This sense of something being missing because her sexuality is unknown chimes with the findings of Knoble and Linville (2012) who found that being out leads to an increased sense of cohesion and integrity. Whilst a driving lesson is not the most important place to share one’s sexuality, continued concealment of sexuality over time and across situations can contribute to minority stress (Meyer, 1995; 2003).

Now despite feeling that their sexuality was not all consuming, linked to the idea that part of the self was missing and so inauthentic, was the idea of “mis-identification” highlighted here by what Fran says:

“Umm, but there’s always the worry that in like passing, like saying partner or whatever that you don’t get mis-identified. So, like there’s that kind of balance isn’t there, trying to keep it as a non-issue but also not get mis-identified in doing so”

Here we see Fran acknowledging that although she doesn’t want to bring sexuality into everything by using the non-gendered term partner, by using the word partner rather than girlfriend can bring about the mis-identification she is seeking to avoid. Worthy of note, however is the choice of word, that is “partner” rather than “girlfriend”. It could be argued that when Fran says “partner” she is using “covering” as an identity concealment strategy in which she is censoring herself in order to avoid being explicitly out (Meyer, 2003). If there are subsequent heteronormative assumptions as a result of using the term partner that Fran
does not go on to correct, her speech act is complicit with the heterosexual norm (Land & Kitzinger, 2005). Looked at from this position, Fran’s being mis-identified is the desired outcome. Despite the ambiguity of Fran’s use of the term partner, the feeling of not wanting to be considered by others as heterosexual was found across the focus groups and is made clear by Casey:

“It's always, like, there is the need to disclose it in some way, so that people don’t get you wrong ... you just have to announce it at some point to tell people otherwise”

From what Casey says, the need not to be mistaken as heterosexual in certain circumstances is important. Looked at as a whole, these quotes also make clear that coming out is not a one-time only event, rather coming out as lesbian is an on-going phenomenon; and further, whether one comes out or not is a decision that is taken, often on a situation by situation basis.

Taken together, it would appear that the women are acknowledging a dilemma in that they do not want their sexuality at the forefront all the time, as being out was not always relevant to every situation, often using strategies in managing other’s knowledge of their sexual identity. However, the women’s non-heterosexual identity was important to them and there were times when it was clear from the discussions that the women did not want others to assume that they were heterosexual.

6.3.1.2 Don’t be a dyke

Whilst the women were happy for their sexuality to be known in the circumstances they dictated, being thought of as butch was not desired. Put simply, being thought of as gay was acceptable; being labelled as a butch lesbian was not. On the whole, mainstream lesbian stereotypes are negative in nature and the women, whilst wanting their identities to be recognised did not want to be stereotyped. The women considered the butch lesbian as being the stereotypical lesbian, a position is made clear in the following exchange:

Fran:  I wasn’t exposed to stereotypes until I came out to the scene and then it appeared that everyone was like the typical stereotypical lesbian, draggy and masculine

Casey: But don’t you think that portrayals of lesbians are much better now though? I’m just thinking Lip Service and the L word

May: yeah, images are more positive, of lesbian bars and the scene

Fran: there is loads of variety, but there is only one stereotype

Karen: But there’s always one who is really draggy and masculine, one in particular who could be the stereotype
In this exchange, the women are clear that they see the lesbian stereotype as being masculine, both Fran and Karen clearly verbalise this. Further, that this stereotype is a negative one, as alluded to by Casey, who positions the stereotype as negative by indicating that media portrayals are better, and by May who clearly indicates a turn to positivity. The discussion here suggests that the women are aware of the common cultural negative representations of lesbians which continues to conform to gender inversion beliefs (Markowe, 1996; Brambilla et al., 2011); and rather than resisting these heteronormative constructions accept and assimilate them into their way of viewing the world.

Many of the young women in the study preferred to label their sexuality with the words gay or queer, arguably gender neutral words, despite often being culturally associated with men rather than women. This preference for gender neutral sexuality labels may well be a result of the term lesbian being associated with the butch lesbian stereotype and culturally positioned in a negative light. This “othered” negativity of the butch stereotype was something that the women did not want to have associated with themselves. Made clear here in this quote from May:

“The one’s I know are like giant stereotypes. Well in my mind giant stereotypes that I have avoided my whole life to be. Which is why probably at home, it took ‘til I was 20 to become comfortable with myself, because of coming from a football background, all the girls that I knew that played football they were all, they were all extremely gay and so it was like, don’t be a dyke, don’t be a dyke”

Here May is clear that she does not want to be categorised as the lesbian stereotype, and with her use of the words “extremely gay” something she considers will stand out from the heterosexual norm. Further, saying “don’t be a dyke” suggests that she equates the term dyke as being descriptive of the obviously lesbian stereotype: that is the butch lesbian. Whilst the word “dyke” is now considered to be a reclaimed term, and could be used as such by May given her sexuality, she is using this more pejoratively as a descriptor for the stereotype she wishes to avoid (Speer & Potter, 2000).

Overall, it would appear that these young women have been influenced by heteronormative notions of lesbian acceptability, in that they want to position themselves, or be seen as inhabiting the heteronormatively feminine lesbian image, rather than be associated or be seen to be the pejoratively positioned butch stereotype.
6.3.2 Support Networks

The next theme focused on the women’s support networks. There were two distinct areas that women identified in their talk in relation to needing support from others. The first area where they felt they looked for support was in respect of disaster support. The women who identified this as an area where they turned to others for help most often identified family and parents as their main support resource. The second area where they felt they needed support from time to time was in connection with emotional issues and relationships. All the women indicated that at times they turned to others for support, however not all women looked to the same sources for support here.

6.3.2.1 Disaster support

The first strand of this theme focused around who the women contacted if major problems arose. The problems that were discussed were practical and structural in nature and focused on issues such as housing and landlord issues, financial problems, and computer problems. This quote from Casey provides a flavour of this sub-theme:

“Family are always there in the background for you, to soothe and support, and like if I had any sort of major problem then it’s straight back home. Dad is really supportive and practical with money and organisational stuff, things like that”

Not all the women in the study raised these as issues with which they needed support; however those that felt they needed support with these issues were the younger women in the study. The women at the younger end of the age range were either in their last year of undergraduate degree program or had recently graduated within the previous 12 to 24 months. Most of these women were still finding their feet with respect to establishing the next steps in relation to their education and careers.

6.3.2.1 Relationship and emotional support

Turning to the area of relationship and emotional support, here again the participant age profile indicated differences. Reflective of the position of the younger women in the study who had not long been independent adults in the world indicated that when relationships were in difficulties or broke down they turned to their families for support. This is despite the fact that the women are endeavouring to make lives for themselves away from their families of origin. Here Tara is clear that she values the support she receives from her Mum:
“I do feel like I am building my own life away from my family which is more detached, but like mum and I talk every two or three days and it’s always about relationship stuff”

Although it’s not all about Mums, the women indicated they turned to their closest parent for support. In May’s case she had a very close relationship with her father visiting him often, something she missed when he lived abroad. This valuing of relationship support from their families of origin is very much in accord with the research findings of Oetjen and Rothblum (2009) who found that family support was important for single lesbian women. However, their research also indicated that support from friends was considered as being more important, something that Tegan indicated:

“I would say like emotionally things ... that kind of has been related to my being queer ... I have talked to my queer friends about that because I get the feeling that they might understand”

Tegan was the oldest participant in the study and her position with respect to seeking support differed to the younger women and is more consistent with the extant research findings. Wayment and Peplau (1995), Beals and Peplau (2005) and Oetjen and Rothblum (2009) all indicate that lesbian women are more likely to value support that offers them identity support, something that is more likely to be found from their friendship networks who may well be LGBTQI themselves.

6.3.3 Lesbian family futures

The final theme was very much about what hopes the women had for their futures. Again, two issues were a feature of the women’s talk here. First were hopes surrounding marriage and motherhood, with all the women expressing desires and wishes to create their own lesbian led families, within a committed partnership with another woman. At the same time as developing their own lesbian led families the women also expressed expectations about remaining involved with their families of origin over their lifespan.

6.3.3.1 Marriage and motherhood

Across all the focus group sessions the women were very much children of their time. All the women talked about civil partnerships and same-sex marriage, although there were differing opinions and positions taken up by the women in respect of formalized same-sex
relationships. Some of the women in the study were married\textsuperscript{46}, or in committed relationships with firm plans to get married, whilst some discussed hoping to get married in the future, either to their current or a potential female partner. A common view in respect of civil partnerships was of achieving more equal rights. This view was expressed by Sophie, who says this in relation to civil partnerships:

“I was happy it finally happened. It does kind of feel, like when I first heard about it, that I was suddenly slightly more accepted. Err, it did feel like a very positive thing and maybe the playing field is starting to level a little bit. It’s sort of less like a second class citizen in a way. I suppose that comes from me feeling how come we don’t have the same rights as they do, we’re no different”

Here Sophie is clear that she feels that civil partnerships are a positive move towards equality, a position that many of the women echoed. By suggesting that she felt “slightly more accepted” and that “we’re no different” Sophie constructs equality and acceptance in terms of sexual citizenship (described in Chapter 5: Plummer, 2003; Richardson, 2015). Whilst for many, civil partnerships were considered as a move in the right direction, some of the women also held hopes of getting married at some future date. This position was reflective of the political debate at the time focused on same-sex marriage, and so marriage was a “hot” topic for the women\textsuperscript{47}. These desires to get married are made clear by May’s comment: “I just hope and expect to find the right woman and that we will get married and be partners for life”. May’s hopes about finding the right woman, getting married and being together for life very much echo the dominant heteronormative relationship position (Rubin 1984/1993).

So it seems that most of the women are both aware of, and readily accepting of, state approved forms of lesbian relationships that are very much in the image of the families they grew up in. However not everyone happily accepted civil partnerships and same-sex marriage predicated on heteronormative models of the family. Similarly to the women in Study 2, not all the women in Study 3 were so keen to engage in what they viewed as an assimilationist position. Here Tegan expresses her views on the topic:

“So now you can be institutionalised and forced to marry. Because that’s what happened, like me and Alex actually got married because we had to if we’re having

\textsuperscript{46} The two participants were from Norway and Sweden respectively and had been married (to each other) in Sweden where same-sex marriage had already been legalised at the time of data collection.

\textsuperscript{47} The study data was collected at a time of changing legislation within the UK in respect of same-sex marriage. At the time of the first focus group only civil partnerships were available, although same-sex marriage was a topic of political debate. By the time of the last focus group legislation had been enacted to allow the first same-sex marriages to take place in March 2014.
children, and if the other partner want to adopt you have to be married, so...which I think is just bullshit to be honest”

Here Tegan appears to take a Queer position with respect to same-sex marriage. Despite having married her partner Alex, she feels that she has been forced, or assimilated, into a relationship that has been shaped and formed by the dominant heterosexual norm of coupled relationships, purely to ensure the non-birth mother has formal rights in respect of any child she and her partner may have (Clarke et al., 2007). From a queer perspective, the debates surrounding sexual citizenship and same-sex marriage are in relation to the possibilities of assimilation of LGBT individuals into the dominant heteronormative discourses. This argument posits that the sanctioning of same-sex marriage by the dominant heteronormative discourse is in some way a politics of assimilation, whereby same-sex marriage allows same-sex couples to conform to mainstream heterosexual culture (Warner, 1991).

At the time of the study none of the women were mothers and most hoped children would have a place in their futures. All but one of the women expressed a desire to have children in future female partnerships, whether they or their partner carried the baby. Tegan and her partner Alex, were the only participants actively engaged in lesbian baby making. Here Tegan stresses how important having children and starting a family is for her:

“Something that is very important for me is that I actually would like to have children. I’m very focused on getting some cells...hopefully within five years we will have started a family”

Despite Tegan’s strong views about being forced into what she considers as a heteronormative form of relationship, she is doing so in order to create her and Alex’s lesbian led family. The creation of a lesbian family within a state recognised partnership would appear to comply with all the norms of the heteronormative family discourse. However, as Barrett and McIntosh (1991) point out, IVF has been perceived as being an attack on the hegemonic status quo of the heterosexual family unit. A delegate to the Council of Europe in 1981 suggested that artificial insemination was part of a world campaign to undermine the fundamental unit of society, namely marriage and the family. The debate and furore that artificial insemination and the development of IVF technology engendered brought into relief the precarious recourse to naturalness of the conservative argument in respect of the traditional family unit (Barrett & McIntosh, 1991). Conceptions via IVF, irrespective of

---

48 Sperm cells via donor IVF clinic
whether the mother is heterosexual or lesbian, serve to trouble the ‘naturalness’ of the heterosexual family unit.

Despite the strong desires of the women to form their own lesbian-led families many of the women were aware that the lesbian model of motherhood may not necessarily be plain sailing. One issue that troubled the women was in respect of parental roles, as Liz indicates:

“you don’t get to be the only mummy and, you know, you have to share that sort of mummy role. You know, I think definitely, in a straight relationship, you kind of automatically have your role as the mum or the dad”

Concern over parental roles would suggest that breaking free of the heteronormative model of the family is very difficult, even for women who had been presented with more positive role models in the media in this regard. This difficulty in conceptualising a form of childcare that moves away from the dominant heteronormative model would appear to be consistent with some of the findings of Gabb (2004) who reported that some of the lesbian mothers in her research have replicated the traditional female/male family model. However, it may be that the women of the present study who struggled with this issue might have done so purely because they have not yet had to think about childcare; indeed Fran did not see future parental roles as being a problem as she was sure “that roles will develop”. This latter position may be more in keeping with the more usual finding that childcare for lesbian parents is a more equitable endeavour (Patterson et al., 2004).

6.3.3.2 Family of Origin Connectedness

The last strand of this theme was related to the hopes that the women had about remaining in contact with their families of origin. Despite the differences in who the women turned to for support, all the women in the study felt they were close to their families of origin and wished to continue the closeness that they all currently experienced with their families of origin. This position was made clear by May, who says:

“I can’t imagine not having them in my life. Especially my Dad, I would never move far away. He lived in Spain for a year and I was miserable”

May, who was from a large family and close to her father was very family oriented and did not envisage a life without her family of origin playing a big role. May’s hoped for future connectedness with her family of origin can be thought of as a hoped for future self (Markus & Nurius, 1986), particularly as it has the potential to act as a guide to behaviour seen here in the comment “I would never move far away”. However other women, despite wanting to
maintain the current closeness they were enjoying, knew that in forging their own careers and lives they might well be some distance away from their parents, as Tara notes:

“I expect my career will take me away from this area and so I know I won’t see my Mum as often but I don’t think we will ever stop talking”

Both women’s hopes for future family of origin involvement positions are consistent with the findings of both Laird and Green (1996; cited in Rostosky et al., 2004) and Laird (1998) which found that lesbian women were never entirely without family of origin contact. Indeed, early work by Kennedy and Davis (1993; cited in Laird, 1998) found that women maintained contact with their families of origin, even where family relationships had initially become estranged and difficult upon disclosure of a lesbian sexual orientation. Whilst Laird (1998) found that some of the women in her research maintain parental contact over long distances, a position that Tara feels she will be in.

As well as hoping to maintain contact and involvement with their families of origin in the future many of the women also talked about their parents as they aged, indicating feelings of responsibility for their parents in their future years when health problems may arise. Prompted by the example set by her own mother, Casey says:

“So I feel like I don’t want her living away from me as we’d have to commute or travel long distances in order to make sure she’s ok, I’m gonna want her close by”

Casey’s grandmother suffered from memory and other health problems which has prompted her mother and her aunts to take on a caring role, something that Casey feels she would do if her mother needed her support as she also says: “I’m very aware that I want to look after her”. However not all the women in this study were so accepting of the potential need for their involvement in future parent elder caring. Some of the women were conscious that they may be the one in the family who might be seen as the one to take on elder caregiving despite not wanting the role, as Sarah indicates:

“I’ve got two siblings, so I’m hoping that one of them would, like, would want to take them in or something, but if they didn’t, because I’m the only girl in the family, I suppose I would, if they needed care, I just don’t know if I would be...good enough...kind of”

It is clear that for Sarah she does not want to be the sibling who takes on the responsibility of providing care for her parents. However despite not wishing to take on the caring role feels that as she is the girl of the family then the task is likely to fall to her. Here Sarah seems to be voicing a felt imperative, arising from the dominant heteronormative discourses of family and
caregiving that construct the informal caregiver as being female family members, made explicit in Study 1 (Chapter 3), that as a woman Sarah will be the sibling expected to take on the caring role. Further, and consistent with the positions of the older lesbians engaged in caregiving in Study 2, the women in the present study are seen to express differing levels of felt filial responsibility around potential future caregiving.

Whilst for most of the women in the present study future parental elder caring was something very much in the abstract, some of the women had already felt they had begun to engage with taking on more of a support role as Lou indicates:

“I'm already dealing with stuff because they are getting older and it's kind of just like happening. So in terms of like now they are older there is definitely a shift in terms of me helping them. Things have changed a bit”

Lou indicated that her parents were older than those of many of her peers and, as a result of medical issues with both parents, she was already engaging in a support role. However, it would appear that by saying “it's kind of just like happening” she has not consciously made a decision to engage with providing support, rather it is something that has gradually developed. This position is consistent with Julie, the participant in Study 2, who indicates that she considers that care is not seen as something engaged with consciously, but just part of what family members do for each other.

Related to the discussions of providing support for their parents, if and when they eventually needed it, some of the women in the study went on to discuss potential future extended family living arrangements. Most felt that if the need arose they would feel able to entertain joint living arrangements; May indicated that she would be happy to have her Dad live with her, whilst Casey said she would share her living space with her Mum. However, not all the women felt having older parents living with them was ideal, as Liz indicates: “It's very idealistic, because it would mean that you had to give up so much of your life”. It would seem that Liz is aware that returning to a shared living arrangement with parents as a mature adult may have some impact on how she might live her life. However, Liz’ views were in the minority. Most of the young women in the present study held expectations that if their parents were to move in with them at a future date it would be un-problematic and, moreover, their parents would need to fit in with them, as May suggests:

“You can’t stop living your life just because you have got an older person living with you and they have to be appreciative of the fact that as your parent they shouldn’t want to hold you back from living your life just because they are with you”
May’s sentiment was one that was shared by other women in the study. Indeed, the views of the younger women appear to be counter to the lived experiences of the women in Study 2 who had an elderly parent live with them. The older women found the joint living arrangements held implications for the way they socialised, lived as out lesbians, and with their partners. Whilst none of the younger women felt that their outness and sexuality would be in any way impeded. The views of the younger women may be linked to the finding that young adults tend to feel a stronger sense of felt obligation compared with middle-aged adults which is linked to the relative likelihood of needing to provide actual care. For young adults providing care and support is a theoretical future possibility which might not occur, whereas the middle-aged face the very real possibility of having to provide assistance (Stein, Wemmerus, Ward, Gaines, Freeberg & Jewell, 1998).

6.4 Conclusion

Taking all three themes as a whole, it would appear that the young women of this study felt that their lesbian sexuality was important to them, but was just one part of them and not their most defining feature. Despite this the women were concerned about others assuming them to be heterosexual which at times made them feel inauthentic, something that may lead them to disclosing their sexuality. However, disclosing their sexuality brought concerns about not being categorised as the stereotypical butch lesbian, which many of the women perceived as being a negative outcome. Consistent with the women being young adults many of the women still looked to their parents for practical issues and many of the women looked to their closest parent for emotional support as well. However, the older women in the study were more likely to look to their queer, lesbian and gay friends rather than parents for emotional support. Finally, looking to the future all the women held hopes of creating their own lesbian families with a partner. Most of the women hoped to get married, whilst one of the participants was already married. Whilst most of the women were living away from their home towns, they all were in contact with their families of origin on a regular basis and overall the women reported happy, close, and supportive relationships with parents and siblings. When considering relationships with their families over time all the women hoped that the current happy relationships would continue, but were mindful that career developments might mean that their relationships became more long distance than they currently were. Finally, the women were also mindful that as their parents aged they might be
required, as women, to take on a more supportive role toward their parents which, from the vantage point of youth appeared uncomplicated.

Whilst this study engaged in an inductive analysis that was not driven by extant theory, it is possible to theorize these findings in relation to possible selves (Markus & Nurius, 1986). These possible selves can be thought of as an individual’s representations of potential selves in the future which can be either feared or hoped for (Markus & Nurius, 1986). Considered as a motivational psychological construct (Cross & Markus, 1991), differing possible selves can be the motivating factors that help guide behaviour. The hoped for selves can be the motivation to engage with changes in lifestyle and behaviour to achieve the desired outcome. In contrast, the feared self will motivate the individual to avoid behaviour that will move them closer to the undesired possible self. Possible selves take shape and form from the individual’s socialisation, past experience and current knowledge. As possible selves are derived from the environment they can be influenced by others, particularly significant others such as friends and family (Curry, Trew, Turner & Hunter, 1994). Future feared “possible selves” were verbalised by participants here in the form of wishing to avoid being the stereotypical butch lesbian in the theme “Out and Proud”; whilst hoped for “possible selves” can be seen in relation to the creation of future lesbian families in the theme “Lesbian family futures”.

In the main the findings of this study appear consistent with the extant research. The concerns the women of this study had about their sexuality and how they were perceived and stereotyped by others is consistent with the extant literature. Similarly to the older women in Study 2 the younger women of this study indicated that their being assumed to be heterosexual caused them some concerns. Whilst the younger women in this study did not go so far as to indicate a loss of identity, they did voice an uneasiness about being mis-identified that could be considered being inauthentic and lacking cohesion (Jordan & Deluty, 1998; Knoble & Linville, 2012). Although being out was important for these women, being labelled as the butch lesbian was to be avoided; a position that would suggest that the women were concerned about being associated with the still widely held pejorative stereotype (Brambilla et al., 2011). Consistent with the extant literature the women enjoyed family support and peer support (Oetjen & Rothblum, 2009), something they hoped would continue throughout their lives. Looking to the future families played an important role both as potential parents themselves and as remaining a part of their families of origin (Laird, 1998).
There are limitations to the study, however, in the form of this small, homogenous sample. This particular sample was made up of a majority White, lesbian identified women. All the women were well educated having completed A’level education, thirteen held a first degree, and three were educated to masters level. Had the recruitment process been more successful in attracting participants from beyond a university town the conceptualised themes may well have been different. Indeed, two of the participants from different focus group sessions separately remarked that their perceptions may be coloured by the fact that they lived in a prosperous university town where they faced little or no prejudice and that they were aware that theirs was a more protected existence than others faced (c.f. Taylor, 2007).

Despite the limitations of the sample with regard to education, it would appear that the women have been influenced by dominant heteronormative perceptions and discourses. In respect of their future expectations, the women generally held desires to marry and create families of their own families; a position, which could be considered as being influenced by the dominant heteronormative discourse of coupled relationships. The women were also influenced by heteronormatively driven pejorative stereotypes in respect of lesbians evident in the concerns the women had about not being seen to conform to the butch lesbian stereotype. Given the heteronormative influences on these women it is unremarkable that they expect to be engaging in other traditional aspects of the female role such as family caring later in their lives. However, bearing in mind that normative caregiving expectations construct the caregiver as heterosexual and that pejorative lesbian stereotypes that conform to notions of gender inversion theory still persist, the next chapter will focus on whether sexuality influences the allocation of caregiving tasks.
Chapter 7: Hierarchies of caregiving: the intersect of caregiver sexuality and eldercare

7.1 Introduction

The studies presented in the thesis so far have indicated a number of findings in relation to family elder caregiving and lesbian lives. First, that informal elder caregiving is constructed as a female gendered task that is usually undertaken by related middle-aged women (Study 1, Chapter 3). Second, that middle-aged lesbian women who take on the role of parental elder caregiving face unique challenges in relation to how their caregiving and their identities as lesbians interact with respect to issues of maintaining a lesbian identity, remaining in contact with lesbian communities, outness, and privacy (Study 2, Chapters 4 and 5). Finally, that younger lesbian women envisage their future out lesbian lives will be uncomplicated with regard to living as out lesbians, in creating a family of their own, in being involved with their families of origin, and in providing caregiving and support if needed (Study 3, Chapter 6). Indeed, the younger women constructed a future of family of origin involvement free from the challenges that the women in Study 2 faced, which may be a reflection of the changing social and political landscape.

Being mindful that the changing social landscape with respect to same-sex relationships may have influence on how same-sex relationships are perceived; taking the thesis findings together, as well as taking account of current stereotypes that construct lesbian women as being more similar to heterosexual men than heterosexual women, this study aimed to examine how familial eldercare tasks might be allocated to women on the basis of sexuality and relationship status. This chapter expands the scope of the thesis to consider not only how lesbian caring is experienced and anticipated, but also how it is perceived by people who are unlikely to have this lived experience.

7.1.1 The importance of informal caregiving

As has been examined in more detail in Chapter 2 (Section 2.2) the age demographic in Western nations is aging, this is particularly the case in relation to Europe (United Nations, 2009). The UK does not buck this aging profile with the population of over 80 year olds expected to triple by 2050 (Pickard, 2008; 2015; Pickard, et al., 2012). This growing section of the population brings with it an increase in demand for help and support, put simply care. Care can be either formal or informal. Formal caregiving is the provision of assistance by professional organisations and comes at a price, paid for by the care recipient (or their
family), or by the state depending on means. Informal caregiving is the care, help and support that is provided by family. Formal caregiving is generally limited to identifiable tasks such as help with washing, dressing, toileting, and so on; whilst informal caregiving has a much wider remit. Informal care often begins with “just being” with the care recipient and the provision of emotional and psychological support, something very much a part of what family members usually do for each other. It can then move on to incorporate general household chores including cooking, cleaning, clothes washing, small household maintenance tasks, gardening, helping out with the payments of bills and other financial management, organizing medical appointments, shopping, running errands and providing transport. Finally informal care can also move on to the tasks that formal carers provide (Chappell & Reid, 2002; Lee & Porteous, 2002).

Despite commonly held perceptions that the elderly are entirely cared for by the state, the majority of older people are not to be found in care homes or nursing homes, rather they can be found in their own home or living as part of an extended family (ONSa, 2013). Given the living arrangements of the majority of the elderly population, if care is needed it is more likely to be provided by their families. Put in formal, government terms: informal care.

Indeed, the present system of elder care provision in the UK relies significantly on the unpaid informal care provided by families (Kraus et al., 2011).

7.1.2 Who cares, and what do they do?

Within families, the caregiver is generally a partner or adult child (Arber & Ginn, 1991; Bracke et al., 2008; Pickard, 2008). When the caregiver is an adult child, they are very often a daughter (Bracke et al., 2008; Brody et al., 1994; Brody, 2004). As detailed in Chapter 2 (Section 2.4), survey research indicates that over 70% of all informal caregivers in the US are women (Pope et al., 2012; Stone, et al., 1987); whilst similar figures can be found in respect of the UK with approximately 66% of informal care being provided by women (Carers UK, 2009; Social Policy Research Unit, 2001). Indeed, adult daughters provide twice as much assistance overall than adult sons (Bracke et al., 2008; LaBorde Witt, 1994). Why this is the case can explained in terms of gender role expectations and attitudes which position caregiving as part of the female gendered role (Gerstel & Gallagher, 2001); a position which is consistent with the current construct of the informal caregiver (Study 1, Chapter 3).

When men are involved in family care provision for an elderly parent this is most often as part of a network of care (Keith, 1995) and leads to a gendered division of caregiving
tasks (Abel, 1990; Keith, 1995). Daughters are usually to be found involved with the tasks that have traditionally been considered as women’s work within the home, such as cooking and cleaning that fall into the IADL task category, as well as the hands-on ADL tasks (bathing, dressing, toileting) (Campbell & Martin-Matthews, 2003; Noelker & Browdie, 2013). Correspondingly, sons are more usually engaged in tasks that have been traditionally considered as male oriented such as home maintenance and gardening (Campbell & Martin-Matthews, 2013). Overall, women undertake more continuous and on-going tasks, whilst men take on less regular tasks. The nature of this gendered split of tasks leads to women’s caregiving to intrude more into their lives and impacting upon their other commitments (Blieszner & Hamon, 1992; Thompson & Walker, 1989).

7.1.3 Lesbians, families and caregiving

From a research perspective lesbians have been positioned as individuals first and foremost rather than as family members. An early examination of the family based research (1980-1993) found lesbians and gay men received scant attention (Allen & Demo, 1995). The position in respect of the literature on informal family caregiving does not differ; lesbians and gay men are not to be found in this body of work. This position with regard to the family research literature may be as a result of the family being constructed as heteronormative in nature. The informal caregiving research base holds inherent assumptions that those involved with family caregiving are heterosexual women, positing models of caregiving for women that juggle heteronormative family commitment with elder caring (Manthorpe, 2003). Turning to the LGBT research base, specifically research that has sexual minority people as the object of study; this research is focused very much on the individual, with studies examining issues such as coming out (Jordan & Deluty, 1998; Savin-Williams, 1998), lesbian and gay parenting (Patterson, 2006), and same-sex relationships (Kurdek, 2003), as example (See Chapters 2, 4, 5 and 6 for detail). The limited research that does examine LGBT caring has been focused on caring for people with HIV/AIDS (Turner et al., 1994) and same-sex partner caring (Hash, 2006) (see Chapter 2 for detail)49. This research base clearly positions lesbians and gay men as being set apart from their families of origin and situates them as being either individuals situated within a sexual minority community, or as part of lesbian or gay created families.

49 It should be noted that cohort effects may be in evidence with this body of work, particularly in relation to care and HIV/AIDS
Taken as a whole, the family caregiving research approach creates a narrow discourse of family caring that elides lesbians and gay men whose sexuality does not fit the prescribed characteristics of a caregiver, whilst the individual approach of LGBT research appears to elide lesbians and gay men carers whose family connectedness does not fit with sexual minority norms. Despite these positions, lived experience very often blurs clear cut boundaries: lesbians are involved with, and remain part of, their families of origin. The research looking at on-going relationships with family of origin is extremely limited but there is evidence that lesbians and gay men are rarely completely estranged from their families of origin (Laird, 1998; Weston, 1991; Studies 2 and 3, Chapters 4, 5 and 6). Early research by Laird (1998) indicates that family of origin relationships are often maintained over time, finding that many women retained complex ties and connections with their biological families, in some cases over long distances, despite periods of alienation following coming out; a finding that has been supported elsewhere (Taylor, 2007).

Given continued family of origin involvement it can be expected that LGBT individuals will be involved with familial caregiving. Kimmel (1992) argued that as lesbians and gay men get older they may become involved with familial caregiving due to characteristics that have been considered apposite to their sexuality, such that they are unmarried (although this position is changing). This unmarried position may be considered as carrying less responsibility, greater potential mobility, and fewer demands on time. Looking at the research in this area, survey research has identified that lesbians and gay men are involved with familial caring (Cantor, Brennan & Shippy, 2004; Friedriksen, 1999; Shippy, 2007). Whilst more recent empirical research has examined some of the unique issues that lesbians and gay men face when providing informal care to family members (Price, 2010; Study 2, Chapters 4 and 5). This LGBT familial caregiving research base remains limited however, leaving many questions to be answered; not least how caregiving responsibilities are negotiated between heterosexual and homosexual family members.

7.1.4 Lesbian stereotypes

Aside from the family caring research that overlooks the LGBT population and the LGBT research that examines sexual minority lives independent of their families or origin, there is another strand of research which focuses on people’s perceptions of lesbians and gay men. Here the research has engaged with attitudes and prejudice towards lesbians and gay men (Herek, 2000) as well as with homosexual stereotypes. A significant amount of this stereotype research has been on stereotypes of gay men (e.g. Fingerhut & Peplau, 2006).
whilst research on lesbian stereotypes is more limited. However, the research that has looked at lesbian stereotypes has generally subscribed to gender inversion theory (Kite & Deaux, 1987). A feature of lesbian stereotypes is the transgression of gender roles (Kite & Whitley, 1996), such that lesbians are considered as not very feminine, lacking in maternal instincts and displaying typically male behaviours and habits. Further, lesbians as a general category are viewed as competent but not warm due to their being perceived as similar to heterosexual men (Fiske, et al., 2002).

More recent research into lesbian stereotypes has revealed more diverse and complex stereotypes of lesbians, including subtypes such as feminine lesbians, feminist lesbians, and sexually confused lesbians, as well as butch lesbians (Geiger, Harwood & Hummert, 2006). However, a consistent finding in this recent work has been the centrality of masculine (or butch) lesbians (Brambilla et al., 2011; Geiger et al., 2006), consistent with the gender inversion theory (Kite & Deaux, 1987). The work of Brambilla et al., (2011) identified four categories of lesbian stereotype. However, similar to Fiske et al., (2002), three of these categories (butch lesbians included) were judged to be more competent than warm. Overall, the central message of the lesbian stereotype is that lesbians are more masculine than heterosexual women (Fiske, et al., 2002), a position supported elsewhere (Blashill & Powlishta, 2009). The butch lesbian has also been stereotyped as physically unattractive (Geiger et al., 2006). Given the persistence of the gender inversion perception of lesbians, these gender based stereotypes may work towards positioning lesbians as less likely to be engaged in female gendered and tasked activities such as caregiving as they are perceived as being less competent in female gendered activities.

7.1.5 The Current Study

The current study has been designed to test several predictions about the allocation of familial elder care tasks to women on the basis of their sexual identity and relationship status. First, that lesbians might be assumed to be less competent kinds of carers than their heterosexual counterparts because of stereotypes linking femininity and care. Such a hypothesis would be confirmed if participants shifted the work of care away from the lesbian woman and toward the heterosexual woman in the vignette. Second, that lesbian women might be gender stereotyped and be assumed to be more suited to male gendered caregiving tasks because of stereotypes of lesbians linked to masculinity. This hypothesis would be confirmed if participants allocated female gendered care tasks to the heterosexual woman and male gendered tasks to the lesbian woman. The allocation of caregiving tasks may well be
moderated by relationship and family responsibility, therefore the third hypothesis, is that lesbian relationships may be taken less seriously than heterosexual relationships and so lesbian women may be considered to have less committed relationships and more available time for caring duties. If this hypothesis is supported, then coupled lesbians should be given more care duties than coupled heterosexual women.

In addition to examining experimental effects, I also examined if responses to the vignette were moderated by modern prejudice. In contrast to old-fashioned measures of heterosexism, which are based on negative beliefs about lesbians and gay men (Herek, 1984), modern homonegativity takes the form of denying lesbians and gay men their requests for equality in modern societies (Morrison & Morrison, 2002). In regard to caring, this denial could take the form either of allocating unwanted tasks to lesbian carers or denying lesbian carers their desired levels of care. Correlations between modern homonegativity and responses to the vignette were explored.

7.2 Method

7.2.1 Design & Participants

The study was a vignette questionnaire of which there were eight conditions, making up a 2x2x2 design. There were four independent variables and seven dependent variables, a summary is provided in Table 7.1 below. Overall three hundred and fifty participants took part. All participants were living in the US and indicated their ethnicity, the participants were not asked their nationality. The ethnicity of the initial 350 participants was: 245 White, 28 Mixed Ethnicity, 21 Asian, 20 African American, 14 did not indicate their ethnicity. Of these 350, twenty six were excluded from the analysis as they failed to pass the manipulation checks (see Results below) in respect understanding the vignette. Of the remaining 324 participants 145 were female, 177 were males and 1 did not identify their gender. M age = 34.28, age range 19-75 years.
Table 7.1 Independent and dependent variables

<table>
<thead>
<tr>
<th>Independent Variables</th>
<th>Dependent Variables</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target’s sexuality (lesbian/heterosexual)</td>
<td>Understanding of vignette</td>
</tr>
<tr>
<td>Target’s relationship status (long/short term)</td>
<td>Gender stereotyping of the sisters</td>
</tr>
<tr>
<td>Target’s family status (children/no children)</td>
<td>Judgements of the sisters relationships</td>
</tr>
<tr>
<td>Level of care (more/less caregiving)</td>
<td>Allocation of caring tasks pre request</td>
</tr>
<tr>
<td></td>
<td>Judgement of the fairness of request to change caring</td>
</tr>
<tr>
<td></td>
<td>Allocation of caring tasks post request</td>
</tr>
<tr>
<td></td>
<td>Allocation of personal care tasks</td>
</tr>
</tbody>
</table>

7.2.3 Materials

There were eight versions of the vignette which made up a 2x2x2 design. All vignettes began with a paragraph describing an elderly woman:

Margaret is 81 and has lived alone since the death of her husband six years ago. In the intervening six years Margaret’s health and mobility have been in slow decline. Margaret struggles to do the housework; she is falling behind on gardening and household maintenance chores. Since becoming deaf Margaret also finds paying bills and organising her medical appointments hard as she finds talking on the telephone difficult. Also, she is not computer literate. Despite her declining abilities, Margaret wants to remain living at home and live as independently as possible.

The next paragraph introduced Margaret’s daughters, Carol and Ann. Ann had a long-standing relationship and Carole had a new relationship. One of the daughters had a male partner and one had a female partner. This paragraph manipulated two independent variables; whether the lesbian or the straight woman had the longer-standing relationship, and whether the woman with the new relationship was always described as not having children. In sum, this paragraph manipulated which daughter was heterosexual or lesbian, and whether the woman with the long-standing partner had children or had no children:

Margaret has two grown up daughters, Carol and Ann. Carol is 47 and has been single for most of her adult life. She met [Emma/John] two years ago, and they have recently moved in together. Ann is 49 and lives with her [husband/partner], [Ian/Jane], who she has been with for 20 years. [Ann and Ian do not have children/Ann and Ian have two teenaged children aged 17 and 15/ Ann and Jane do not have children/ Ann and Jane have two teenaged children aged 17 and 15]. Both
Carol and Ann are in full-time employment, and both live and work a ten minute drive from where their mother lives.

Following this paragraph, the participants completed five items which checked their understanding of the vignette so far:

- What is the name of Carol’s partner?
- What is the name of Ann’s partner?
- What is Carol’s sexuality?
- What is Ann’s sexuality?
- Does either daughter have any children? If so please give details below.

Next, participants rated both Carol and Ann each on four items that measured agency and communion to assess whether the lesbian daughter was stereotyped as having ‘inverted’ personality traits (Kite & Deaux, 1987). The four items were helpful, self-reliant, understanding, and assertive. These items were all presented as 6-point scales ranging from 1 “very” to 6 “not very.” Participants always answered these questions about Carol first and Ann second.

The next six items asked participants to report their beliefs about the women’s romantic relationships. Three items asked about Carol’s relationship and three about Ann’s relationship. All were presented as 6-point items, and scale end-points and shown below in square brackets after each item. Participants always answered questions about Carol’s relationship first:

- How happy do you think [Carol/Ann] will be with her partner? [Very happy, Not happy]
- How committed do you think [Carol’s/Ann’s] relationship is currently? [Committed, Not Committed].
- How likely is it that [Carol’s/Ann’s] relationship will last forever? [Likely, Not Likely]

Next, a further paragraph of the vignette was presented that described the division of caring responsibilities. This paragraph was the same in all conditions.

- In order to assist Margaret in her wish to live independently in her own home Carol and Ann feel they should provide some help with washing Margaret’s clothes, cooking her meals, cleaning her house, gardening, household maintenance, paying her bills, and organising her medical appointments.
Participants were then presented with seven tasks and asked to allocate them between the daughters on a 6-point scale where “1” indicated that Carol was to take sole responsibility for the task and “6” indicated that Ann was to take sole responsibility for the task. The seven tasks were those listed in the paragraph above. These tasks were selected on the basis of their seeming ‘gendered’ as feminine tasks (washing clothes, cooking, cleaning the house), masculine tasks (gardening, household maintenance, paying bills), and one task which was neither clearly masculine nor feminine (organising medical appointments).

The third independent variable was introduced in the next paragraph. This paragraph described Carol as making a request to do either more or less caring for Margaret.

It is now a year since the initial allocation of tasks between Carol and Ann. In the past year Carol and [Emma/John] have moved in and gotten married. [Since the wedding Carol has found having a partner around, she is better able to cope with the demands of caregiving and feels able to increase the amount of help and support that she is currently able to give./ Since the wedding Carol has found it difficult to manage the current caregiving tasks that she was asked to do and feels that she needs to reduce the amount of help and support that she is currently able to give.]

Carol asks Ann if they could re-negotiate the allocation of caregiving tasks.

Participants completed a single 6-point item assessing Carol’s request:

Do you think Carol’s request is fair and reasonable [Fair, Not Fair]

Next participants were instructed to re-allocate the seven tasks described above using 6-point scales to indicate the level of responsibility Carol should take (where “1” meant not doing the task and 6 meant taking sole responsibility for the task).

The final paragraph described a further change, prompted by Margaret’s changing needs. This final paragraph was the same in all conditions of the experiment:

A few years have passed and, as her health is deteriorating, Margaret’s care needs have increased. Carol and Ann have continued to provide the help and support that they previously agreed to do over the last few years, but Margaret now needs help with personal care; this means that she needs assistance with bathing, toileting, and dressing herself. They now need to allocate the additional tasks with which Margaret needs help with.

Participants were asked to advise Carol and Ann on how to divide up personal care tasks between them using 6-point scales where “1” meant that Carol took sole responsibility for the
task and “6” meant that Ann took sole responsibility. The personal care tasks were bathing, toileting, and dressing.

Finally, participants were presented with an open-ended item in which they could explain their advice:

_In the space below please explain why you allocated the tasks to Carol and Ann in the way that you did._

Participants completed several attitudinal variables; a measure of modern homonegativity specific to lesbians (12-item MHS-L: Morrison and Morrison, 2002); the 22-item ambivalent sexism inventory (Glick & Fiske, 1996); and the 10-item revised gender role belief scale (Brown & Gladstone, 2012).

Finally, participants reported their gender, sexuality, age, ethnic origins, highest educational qualification, current occupation, marital status, and number of children.

### 7.2.4 Procedure

The questionnaire was designed to be an online survey with participants being sourced from the Amazon Mechanical Turk participant pool. The questionnaire was uploaded into Qualtrics and hosted on the university website. The study was advertised to Mechanical Turk participant pool members with a secure link to the university server which allowed participant access to the questionnaire. The study was open to anyone over the age of 18. Participant pool members who chose to take part clicked the link and were taken to a study information page which informed them of the nature of the study and asked them to confirm they wished to take part. If they answered in the affirmative they were then randomly allocated by the online system to one of 8 conditions. Once the survey was completed the participants were paid $1 for completing the questionnaire via Amazon Mechanical Turk.

### 7.3 Results

There were seven kinds of dependent variables in this study; (1) understanding of the vignette, (2) gender stereotyping of Ann and Carol, (3) judgments’ of Ann and Carol’s relationships, (4) allocation of caring tasks to Ann and Carol, prior to Carol’s request, (5) judgment of Carol’s request to change this allocation for fairness, (6) allocation of caring tasks to Ann and Carol, following Carol’s request, and (7) allocation of personal care tasks. Each of these is discussed separately below followed by tables summarising the key means and standard deviations by variable (Table 7.2) and key inferential statistical results by
Understanding of the Vignette: Five items checked whether participants correctly remembered Carol and Ann’s names and inferred their sexualities as intended form the vignette’s first paragraph, and remembered whether or not Ann had children. Participants were deemed to pass the sexuality manipulation check if they inferred the women’s sexualities as intended, and the children manipulation check if they correctly noted whether or not Ann had children. Nineteen participants failed the sexuality manipulation check and seven failed the children manipulation check. These 26 participants were excluded from the analysis below. The analysis reported on the remaining 324 participants.

Gender Stereotyping of Targets: The data was examined to check if participants gender stereotyped the target daughters. Attribution of all four traits to each of the two targets were significantly positively correlated with each other. Accordingly I calculated a measure of masculinity and femininity for each woman rather than a single measure of masculinity-femininity. These measures were then used to conduct a 2x2x2x2 ANOVA with two between subjects variables and two within subjects variables. The two between-subjects variables were Carol and Ann’s sexualities and the presence or absence of children in Ann’s family. The two within-subjects variables were the gender attribute rated (masculinity vs femininity) and the target rated (Carol vs Ann). This analysis revealed no significant main effects, all \( F < 2 \), and only one significant higher order interaction between gender attribute and target, \( F (1, 320) = 3.92, p = .05, \eta_p^2 = .01 \). Irrespective of condition, participants rated Carol as somewhat higher on the masculine traits than the feminine traits (\( Ms = 4.14, 4.01 \) respectively), but rated Ann similarly on masculine and feminine traits (\( Ms = 4.06, 4.05 \)). As this interaction was independent of experimental condition, these measures indicated that the lesbian targets were not stereotyped according to an implicit inversion stereotype (c.f. Kite & Deaux, 1987).

Relationship Quality: Next the data was examined to see if participants perceived the women’s relationships differently by relationship length and the women’s sexualities. Each of the three-items assessing the quality of Carol’s and Ann’s relationships formed internally reliable scales (Cronbach’s \( \alpha = .79, .88 \) respectively). These measures were then used to conduct a 2x2x2 ANOVA with two between subjects variables as before, and ratings of Carol and Ann’s relationship as the within-subjects factor. I observed only one main effect of the within subjects variable, \( F (1, 320) = 87.25, p <.001, \eta_p^2 = .21 \). Participants described the daughter in the short-term relationship as having lower relationship quality than the daughter.
in the long-term relationship ($M_s = 2.76, 2.17$ respectively). This main effect was moderated by only one significant interaction involving the independent variable describing Ann’s family as including children or not. Ann’s relationship was described as being of higher quality if she had children than if she did not ($M_s = 2.02, 2.31$ respectively). Ratings of Carol’s relationship did not differ according to whether Ann was described as having children or not ($M_s = 2.75, 2.76$ respectively). Again, as none of these variables interacted significantly with target sexuality, this analysis demonstrates that targets were not viewed as having lower quality relationships if they were lesbian rather than heterosexual.

**Allocation of Tasks Prior to Carol’s Request:** I next examined the allocation of tasks prior to Carol’s request to see if sexuality impacted this allocation. The correlations between the tasks did not justify the splitting of the tasks into masculine and feminine tasks. Accordingly, I constructed a measure by averaging the allocation of all tasks between the two daughters that ranged from 1 (all to Carol) to 6 (all to Ann). Scores on this variable were close to, but significantly below 3.5, the mid-point of the scale ($M = 3.44$), one-tailed $t (323) = -2.76, p = .006$. A 2x2 ANOVA using the two independent variables showed neither main effects nor an interaction, all $F < 2.5$, all $p > .1$. Target sexuality had no impact on the allocation of these care tasks.

**Fairness of Carol’s Request:** I next examined the perceived fairness of Carol’s request using a 2x2x2 ANOVA using Carol’s sexuality (lesbian vs heterosexual), Ann’s family (with vs without children) and Carol’s request (to do more vs to do less) as independent variables. I observed only a main effect of the nature of Carol’s request, which was perceived as more fair when she requested doing more rather than doing less ($M_s = 2.09, 3.95$) $F (1, 324) = 172.38, p < .001, \eta^2_p = .35$. No other main effects or interactions were significant, all $F < 3.7$, all $p > .05$. As above, target sexuality had no impact on the perceived fairness of this request.

**Allocation of Tasks After Carol’s Request:** Participants were asked to adjust the allocation of tasks following Carol’s request. As above, an aggregate measure was calculated by averaging the amount of each of the 7 tasks that were reallocated to Carol from 1 (none) to 6 (all). I observed only a main effect of Carol’s request. Participants re-allocated more of the tasks when Carol requested to do more than to do less ($M_s = 3.78, 3.22$ respectively), $F (1, 324) = 62.83, p < .001, \eta^2_p = .17$. No other main effects of interactions were significant, all $F < 3$, all $p > .08$. Carol’s sexuality did not significant impact participants’ responses to her request.
Allocation of Personal Care Tasks: Finally, I examined the allocation of personal care tasks to Carol and Ann at the end of the story. I constructed an aggregate measure of the allocation of the three tasks ranging from exclusive allocation to Carol (1) or to Ann (6); and again conducted 2x2x2 ANOVA using all three experimentally manipulated variables.

Consistent with the nature of Carol’s request, participants allocated more intimate care tasks to Ann if Carol had earlier asked to do less rather than more care (Ms = 3.54 vs 3.34), $F (1, 316) = 7.14, p = .008, \eta^2 = .02$. This effect was modified by a significant 2-way interaction involving Ann’s parental status, $F (1, 316) = 5.73, p = .02, \eta^2 = .02$. When Ann had children, participants allocated the personal care tasks similarly, irrespective of whether Carol had earlier requested to do less or more care (Ms = 3.39, 3.37 respectively). However, when Ann had no children, participants allocated more personal care to Ann when Carol had earlier asked to less than to do more (Ms = 3.31, 3.71 respectively). In other words, participants re-allocated tasks in accord with Carol’s request only when Ann had no children. Again, these effects were not moderated by the target’s sexualities.

Table 7.2 Means and Standard Deviations

<table>
<thead>
<tr>
<th>Dependent Variable</th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender stereotyping of targets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Masculine</td>
<td>4.14</td>
<td>1.12</td>
</tr>
<tr>
<td>Feminine</td>
<td>4.01</td>
<td>1.11</td>
</tr>
<tr>
<td>Relationship quality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Short term</td>
<td>2.76</td>
<td>1.05</td>
</tr>
<tr>
<td>Long term</td>
<td>2.17</td>
<td>1.14</td>
</tr>
<tr>
<td>Allocation of Tasks pre request</td>
<td>3.44</td>
<td>0.37</td>
</tr>
<tr>
<td>Fairness of Request</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less tasks</td>
<td>3.95</td>
<td>1.37</td>
</tr>
<tr>
<td>More Tasks</td>
<td>2.09</td>
<td>1.15</td>
</tr>
<tr>
<td>Allocation of tasks post request</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less tasks</td>
<td>3.22</td>
<td>.53</td>
</tr>
<tr>
<td>More tasks</td>
<td>3.78</td>
<td>.73</td>
</tr>
<tr>
<td>Allocation of personal care tasks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less tasks</td>
<td>3.54</td>
<td>.76</td>
</tr>
<tr>
<td>More tasks</td>
<td>3.22</td>
<td>.53</td>
</tr>
</tbody>
</table>
Table 7.3 Summary of results: F, T & p values

<table>
<thead>
<tr>
<th>Dependent Variable</th>
<th>F value</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender stereotyping of targets</td>
<td>3.92</td>
<td>.05</td>
</tr>
<tr>
<td>Relationship quality</td>
<td>87.25</td>
<td>.00</td>
</tr>
<tr>
<td>Allocation of tasks pre request</td>
<td>All F &lt; 2.5</td>
<td>All p &gt; .1</td>
</tr>
<tr>
<td>Fairness of request</td>
<td>172.38</td>
<td>.00</td>
</tr>
<tr>
<td>Allocation of tasks post request</td>
<td>62.83</td>
<td>.00</td>
</tr>
<tr>
<td>Allocation of personal care tasks</td>
<td>7.14</td>
<td>.008</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>T value</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Allocation of tasks pre request</td>
<td>2.76</td>
</tr>
</tbody>
</table>

Modern homonegativity: Finally, I examined if these responses were moderated by participants’ modern homonegativity. To conduct the first set of analyses, I separated out the participants by target sexuality (that is, the conditions in which Ann was lesbian and Carol straight, and the condition where Ann was straight and Carol a lesbian). I calculated correlations between modern homophobia and each of the dependent variables. The allocation of masculine and feminine traits to Carol and Ann was not significantly correlated with modern homonegativity in either set of conditions with one exception. Where Ann was described as a lesbian, participants who scored higher on modern homonegativity rated her as less feminine, $r (155) = -.19, p = .02$. No other correlations between modern homonegativity and gender stereotyping were observed, all $|r| < .15$, all $p > .05$.

I also observed correlations between homonegativity and ratings of the targets’ relationships, but these were only consistently significant when the target was lesbian. Where Carol was lesbian and Ann straight, modern homonegativity more strongly predicted evaluation of Carol’s relationship than Ann’s $r (168) = .36, .18$ respectively, $p < .001, p = .02$ respectively. However, in the conditions where Ann was lesbian and Carol was straight, modern homonegativity more strongly predicted evaluation of Ann’s relationship than Carol’s $r (168) = .32, .16$ respectively, $p < .001, p = .06$ respectively.

Modern homonegativity and predicted the initial allocation of tasks, but, only in the condition where Carol was lesbian. In these conditions, higher homonegativity significantly predicted the allocation of more of the tasks to Carol, $r (167) = -.17, p = .03$. Where Carol was straight and Ann lesbian, homonegativity predicted more task allocation to Carol, but the relationship was not significant , $r (155) = .11, p = .19$. These correlations suggest that modern homophobia is related to the belief that caring can be readily done by single lesbian daughters.
For the final three measures, I split the participants according to the daughters’ sexualities and according to whether Carol requested to do more or less care. Homonegativity predicted responses on the single item response to Carol’s request to change the allocation of tasks when she was a lesbian who requested to do less, $r (88) = .19$, $p = .07$, or to do more, $r (79) = .30$, $p < .007$, but not when Carol was a straight woman who requested to do less, $r (76) = -.03$, $p = .78$, or to do more, $r (78) = -.08$, $p = .49$. Modern homonegativity was not correlated with the allocation of tasks irrespective of the targets’ sexualities or the nature of Carol’s request in any of the conditions, all $|r| < .08$, all $p > .48$. Nor was homonegativity correlated with the allocation of intimate care tasks in any of the conditions, all $|r| < .22$, all $p > .05$.

In sum, individual differences in homonegativity were somewhat predictive of responses to the vignette. More prejudiced participants stereotyped the lesbian target as less communal, consistently rated lesbian targets’ romantic relationships as being of lower quality, allocated more caregiving tasks to the lesbian daughter, and considered her request to reallocate the tasks as less legitimate.

7.4 Discussion

Overall the findings in respect of the six study variables suggest little stereotyping of the targets by sexuality, but an effect of modern homonegativity on reactions to the vignette. In terms of ratings of the targets’ gendered attributes and relationship quality, their relationship status affected responses whilst their sexualities did not. The initial allocation of caregiving tasks was allocated evenly between the siblings also. When Carol requested to change her level of caring responsibility this request was seen to be fair if she asked for an increase, and on re-allocation of the tasks if Carol asked to take on more she was given more. When the caregiving demands increased to include intimate personal tasks, these were allocated evenly between sisters with the exception of when Carol’s earlier request was to do less caregiving. In this case her request appears to have been borne in mind and more intimate tasks were allocated to Ann. However, if Ann had children the tasks were then equally divided irrespective of Carol’s previous request to do less caring. In all cases these findings were not affected by target sexuality.

However, given that pejorative stereotyping of lesbians still persists the impact of modern homonegativity (Morrison & Morrison, 2002) was examined. Subtle effects of homonegativity were evident here. Participants who scored higher on the prejudice measure
considered the lesbian, but not the straight woman, in the long-term relationship less ‘communal’. Homonegative participants consistently considered lesbians’ relationships to be of lower quality. They allocated more tasks to the lesbian daughter when she had not been in a long-term relationship, but judged her more harshly when her lesbian relationship developed and she requested taking on more caring responsibilities for her mother. In all, these findings accord with modern homoneagativity theory and its hypothesis that modern prejudice takes the form of denying agency to lesbians and gay men to enact decisions about their lives that matter. In the case of lesbian carers, this denial of agency can take the form of denying lesbians the communal traits thought necessary for care consistent with the female gender role, allocation of more care tasks, and denial of a lesbian’s agency in re-negotiating tasks with her siblings. Modern homonegativity does not simply predict that the beliefs that lesbian carers should do more or do less, but the belief that lesbians engaged in care dilemmas will be thwarted in their efforts.

When examining the results in conjunction with the extant literature a number of points are of interest. Turning first to the stereotyping of the sisters and the extant literature; the research on lesbian stereotypes has found that representations of lesbians hold to gender inversion theory (Kite & Deaux, 1987) along with a transgression of gender roles (Kite & Whitley, 1996). Based on these findings, it would have been expected that the lesbian sibling in the vignette study would have been gender stereotyped as being masculine, however this was not found. Moving on to the allocation of caregiving tasks, research has found that when both men and women are involved in caregiving a gendered division of tasks occurs with women usually undertaking the traditional female oriented tasks and men the traditional male oriented tasks (Campbell & Martin-Mathews, 2003; Keith, 1995). Taking this finding in conjunction with the masculine oriented stereotype content in respect of lesbians it was surmised that the masculine gendered caregiving tasks would be allocated to the lesbian sibling in each vignette condition. However the results of this study suggest that, despite the continued existence of these stereotypes, they have not influenced the allocation of caregiving tasks to the lesbian sibling with both sisters being allocated male and female gendered tasks equally irrespective of their sexuality. Finally, historically lesbians and gay men, irrespective of relationship status, have been perceived as having less responsibility and commitments than their heterosexual peers (in part due to not being able to form formally committed relationships) which would allow them more time to become involved in caregiving (Kimmel, 1992). If these assumptions surrounding lesbian relationships still exist it would have been
expected that the lesbian sibling would be allocated more caregiving tasks than her heterosexual sister however this was not the case. Overall, it would appear that the extant research findings were not borne out in this particularly study. However support was found for modern homonegativity (Morrison & Morrison, 2002) with the lesbian sibling being sanctioned with more caregiving when in a short term relationship and her wishes not being acceded to when her short term relationship developed and she wanted to take on more caregiving.

With respect to study limitations, there are two obvious limitations. First in relation to study design and the erasure of bisexuality in the manipulation check. The participants were asked to indicate the sexuality of the two sisters in the vignette study based on their understanding of the sister’s partner having either a female or male name. Participants were required to type in their response. The majority of participants (307) indicated that the sister with the female named partner was either lesbian, homosexual or gay, whilst 17 attributed potential bisexuality to the sister with a female partner indicating that this sister was either lesbian or bisexual. No participant indicated bisexuality only for the sister with the female partner. In analysing the data, the data from the 17 participants who indicated potential bisexuality were conflated with the participants who only indicated a lesbian sexuality. The decision to do this was based on a heterosexual/non-heterosexual dichotomy as no participant indicated bisexuality only, rather it was always given as a potential non-heterosexual sexuality along with lesbian. Second is in the US based sample. As the sample was not from the UK the impact of the changing legal standing that same-sex relationships in the UK could not be examined. Further, given that the data was collected before June 2015 when Supreme Court ruling in Obergefell v Hodges made same-sex marriage legal across the US, the status of same-sex relationships were not equitable across the board. Given that the participants were not asked to indicate their State of residence it is not possible to see whether the differing legal position with regard to same-sex relationships in the US at the time of data collection had any impact on the results. A further limitation was in the options available to allocate tasks. Driven by the necessity of creating a manageable study it was not possible to reproduce the myriad caregiving scenarios and options that might be available to families when caregiving is being considered. One option in particular, which may have had impact on how care tasks were allocated would have been to consider how a male sibling would have been allocated tasks.
Finally, the overall lack of findings in respect of sexuality and caregiving (with the exception of the detected modern homonegativity) is noteworthy in itself. The allocation of the caregiving tasks to both siblings, irrespective of their sexuality, would suggest that what is of concern is here is that caregiving takes place and that tasks are undertaken, regardless of who does them.
Chapter 8: Discussion - Troubling Normativities

8.1 Overview & research aims

This specific aims of this thesis were to examine and theorize the neglected experiences of middle-aged lesbians involved with familial eldercare caregiving. These aims sprang from the absence of research that addressed lifespan issues of mid-life lesbians. Lifespan development and family-oriented research has focused almost exclusively on the heterosexual participant. As a result, the issues and concerns of this particular group of women were conspicuous by their absence from mainstream psychological caregiving research. On the other hand, the more specialized LGBT psychological research base had not addressed the issues of this particular group either, focusing instead on young adults rather than mid-life adults. This lack of research knowledge about mid-life lesbians that existed at the start of this project in 2008 was in spite of the need for affirmative LGBT having been on the APA agenda since 1991.

At the outset of this project no research had been identified that examined familial elder caring by lesbian women. As the research focus fell at the intersection of both familial caregiving and sexuality research, a background research and literature review addressed these two core areas. First, the pertinence of familial caregiving was examined, next an examination of care and caregiving research, followed by an examination of the lesbian and gay psychological research. The literature review established that familial elder caregiving was generally undertaken by related women who were assumed to be heterosexual. This position elided any family caregiving undertaken by others. The picture painted by the LGBT literature base was that when lesbians were involved with caregiving it was in a parenting role or for a partner. Whilst there may be similarities between these lesbians and those who cared for elders in their families, any issues unique to familial eldercaring would be overlooked. To address the gap in the knowledge four studies were undertaken. The findings of each study will be summarized.

8.1.1 Study 1: A genealogy of the informal carer concept – the constructed carer

Based on the extant research it was clear that caregiving had been conceived of as being a heterosexual endeavour, and one that was engaged in mainly by related women. By extension, informal carers were also considered to be heterosexual women. But I was interested to know how this position came about? How did we come to understand the current conception of the informal carer in its present form?
In order to answer this question I took an historical approach, utilising a genealogical method of enquiry. Foucauldian genealogy aims to explore how the current position or state of affairs has emerged. That is, a genealogist aims to look for the circumstances, or conditions of possibility, that are required for a concept to emerge, by way of examining the archive of social process and procedures. In the case of the informal carer I sought to establish what led up to the emergence of the informal carer as a role within the UK by examining public policy, legislation, and the influence of the carers movement. In the mid-20th century the concept of “informal carer” or carer as is more common, was unknown. That is not to say that caring did not take place, but that “carers” did not exist, at least in the Foucauldian sense. It was only in the 1970s that the concept of carer emerged, with wider carers achieving wider recognition in the 1980s and 1990s. In order to establish how the current construction of the informal carer concept came about social and political discourses were examined to establish the genealogy of the informal carer. In particular four interrelated social discourses were the focus of attention. Namely, political and social change; the move to community care, family care provision and the carers movement; and the feminist critique of the role women.

8.1.2 Study 2: Who cares – Lesbian family of origin carers

The genealogy identified that the informal family caregiver role is both heteronormatively positioned and female gendered. The genealogy gave a detailed historical explanation and critique of why the overwhelming focus of caregiving research is on heterosexual female caregivers. Accordingly, any caring by lesbians becomes elided. In order to address this elision I interviewed 10 mid-life lesbian women who were, or had been, involved in providing care and support to older family members to explore what issues family of origin caring might create for lesbian women.

A number of themes were conceptualised in the study analysis including: Duty and Obligation; Boundary Setting: Loss of Lesbian Identity; Connectedness with Lesbian Communities; Different Models of Relationship; and Outness in the Homespace. The first four themes were presented together in Chapter 4 as they were considered as discussing themes relevant to all caregivers, despite the lesbian themed titles, as the issues surrounding identity loss and engagement in support communities are relevant to all caregivers. For the lesbians in this study it was their lesbian identity and connections with other lesbians that were of most concern. The final two themes were focused on topics of more distinct salience to lesbian carers, (although I acknowledge that heterosexual and bisexual women may have relationship concerns and forms that are not sanctioned by the overriding discourse of
monogamous coupled relationships). However, the final theme, surrounding living as an out lesbian within the home is most distinctly lesbian in nature, as the issues of disclosing one’s sexual orientation and living as an out lesbian is not an experience that heterosexual women have, nor is there anything a heterosexual woman can compare it with. These more lesbian oriented themes were presented in Chapter 5.

Taking the themes presented in in Chapter 4 as a whole, caregiving for lesbian women raises some of the same issues that face heterosexual women caregivers, indeed anyone who provides care. Some of the women felt caring was a duty and a chore and created burden, whilst others did not. All the women endeavoured to engage in boundary setting or felt it was something they should do in order to allow space for other aspects and identities. For the women of this study they were concerned with maintain their lesbian identity, which was felt to be important as some of the women felt that as carers they were positioned by others as being heterosexual. To counter this threat to their identity they endeavoured to maintain links to their lesbian networks and communities.

Turning to Chapter 5, the themes presented here had the potential to create issues more unique to a lesbian identity. The various different relationships described by the women, whilst not the preserve of lesbians, presented them with issues that arose as a direct result of their sexuality; for example, for the women of this study, both monogamous and polyamorous relationships were not considered as being comparable to formalised heterosexual relationships by their families of origin. Whilst heterosexual women in polyamorous relationships may also face challenges, a monogamous heterosexually married woman is unlikely to have her relationship form deemed less worthy. Whilst research has found that the lesbian home plays a key in the maintenance of lesbian identity and connections with lesbian communities. It is also conceived of as a place of safety. However this construction was not afforded to all everyone. Study participants who shared homes with their elderly family members and found themselves at times sharing their home space with friends of their parents who were homophobic. The fact that an elderly parent has moved in with an adult child may be as a result of their not being able to live independently, perhaps they are unable to cope with housework, bill payment and cooking; all of which can be considered as part of the caregiving role. Whilst the exact definition of caregiving can be debated, the very fact that an adult child has their parent living with them can be a source of stress surrounding issues of power dynamics and privacy in the home. The home environment is expected to be a place where an individual can be themselves without
interference, somewhere to relax, and enjoy the company of friends and lovers. However the home is synonymous with heterosexual family life. The privacy of the family home is a heteronormative privacy when it is shared with heterosexual family members as this positions the home as a heterosexual space where heterosexual norms are demanded.

Taken as a whole, this exploration of the issues that face mid-life lesbian family caregivers has found for this sample at least, that many issues that heterosexual women face are also faced by the lesbian women, something that might be expected. However lesbian caregivers face issues that are unique to the lesbian family caregiver centred around the maintenance of a lesbian identity, the ability to maintain links to lesbian networks and community, the non-acceptance of lesbian relationships as being of equivalence to heterosexual ones, and that shared living arrangements can impact the performance of a lesbian identity within the homespaces. To overcome these issues the women needed to be normatively creative (Brown, 1989) in how they lived their lives an endeavour to maintain their lesbian identities and relationships.

8.1.3 Study 3: Lesbian Futures

Despite the normative creativity of the older women interviewed, dominant cultural norms are heteronormative in nature. Moreover, age stratification of lesbian community networks often means that younger lesbians do not have access to the life narratives of older women. Study 3 aimed to explore the ideas young lesbians might hold about how their future lives will develop in relation to their living as out lesbians and being involved with their family of origin. The key areas of interest were their lived outness as these women mature; involvement with members of their family of origin; and how lived lesbian outness and family of origin involvement may intersect and interact over time. To explore these issues focus groups with twenty lesbian identified women aged up to 30 were conducted and three themes were conceptualised from the data: Out and Proud; Support Networks; and Lesbian Family Futures.

To summarise the findings of this study, the first theme highlighted how the women felt their lesbian sexuality to be important to them and that being mis-identified as heterosexual led to feelings of inauthenticity and prompted them to come out. Whilst the women wished to be perceived as lesbian, they did not want to be categorised as the stereotypical butch lesbian. This heteronormatively driven stereotype was perceived by the women as negative. The next theme explored support networks where many of the younger women still looked toward family as their support safety net. The final theme was entirely
future oriented and highlighted most of the women’s desires to create their own lesbian families within a same-sex marriage. The women also considered their relationships with their parents and were mindful that as women they might find that the direction of support might be reversed as their parents became older. However interestingly, and going counter to the lived reality of the mid-life lesbian carers of Study 2, these young women had expectations that their parents would fit into and around their lives and the way that they lived in an uncomplicated way.

8.1.4 Study 4: Hierarchies of care (or lack thereof)

The findings so far have found that family elder caring is constructed as a heterosexual female task, but despite this mid-life lesbian women find themselves in the caregiving role. However when they become involved, they can find they become re-closeted by the act of engaging with a task that has been constructed as a natural role for heterosexual women. As a result lesbians who engage in caregiving risk losing their lesbian identity, particularly so for those who share their homespace with their elderly relatives. These women find they also risk losing their privacy and personal space in which to conduct personal and social relationships. Meanwhile younger lesbians, from the distant position of youth, did not envisage the potential pitfalls that caregiving might bring, hoping to maintain family of origin connectedness and engage with caregiving but on their terms.

Considering all these findings, along with the position that family caregivers are heterosexual women, that lesbians are positioned as individuals first and foremost rather than being part their family of origin, and that lesbian stereotypes still conform to gender inversion theory (Kite & Deaux, 1987) working to construct lesbians as being more similar to heterosexual men and as more masculine and butch compared to heterosexual women, the final study looked to explore decisions around family elder caregiving. Study 4 used a vignette questionnaire to look at how caregiving tasks might be allocated between two female sisters across a number of conditions where the two women’s sexuality, length of relationship, and the presence of children were manipulated, along with a request by one of the sisters to change caregiving responsibilities.

Overall six variables were examined as follows: the gender stereotyping of the two sisters; judgments’ of the sister’s relationships; the allocation of caring tasks to the sisters prior to the request to change the level of caregiving; the judgment of the request to change the caregiving allocation for fairness; the allocation of caring tasks post request; and the allocation of personal care tasks. Across all the variable scenarios, the siblings’ sexuality had
no impact in the way caregiving was allocated between the sisters. Short term relationships were considered to be of a lower quality than long term ones and the presence of children was considered to add value to the relationship. The presence of children was also considered when the more burdensome intimate caregiving tasks needed to be allocated. Also examined was the impact of modern homonegativity (Morrison & Morrison, 2002), where a subtle effect was in evidence in respect of allocating more tasks to the lesbian sister in the short term relationship and then denying her request to take on more tasks when her relationship developed. These findings jointly seemed to deny the lesbian sister agency.

8.2 Methodological Implications

There are limitations to be found in all research, and the studies undertaken in this thesis are no exception. In respect of Study 1, the genealogical study, limitations in respect of participant sampling, generalizability and response rates do not apply given that it is an historical analysis. However the key issue of note for this study is in respect of secondary sources which may bring in a degree of bias. However, given the critical standpoint position of genealogical enquiry and its aim of accounting for the ‘history of the present’, it is appropriate to engage with all archival documents that go to make up the prevailing discourses. Secondary sources, such as the research of others do not stand in isolation but engage with, and change, the discourse.

Looking at the methodological limitations of Study 2, the original purpose of grounded theory was to allow theory to ‘emerge’ (Glaser & Straus, 1967/2006) by way of induction, via a process of researcher observation of the data set leading to new ideas. This positivist approach gives the impression that the data speaks for itself (Willig, 2008) without assistance from the researcher. However, from a social constructionist perspective this cannot be the case, all research is influenced by the researcher’s standpoint. This criticism was addressed in Study 2 by adopting the social constructionist approach to grounded theory espoused by Charmaz (2006) which acknowledges the role of the researcher within the analytic process, for example in the construction of categories and codes.

The limitations of the study were not confined to the method itself, Study 2 was also limited in terms of participant sampling. For example, only ten women were interviewed. This limited sample was due to a number of issues combining. First, as has been previously documented, lesbian women are a difficult population to access (Price, 2010). Second, the women were recruited from LGBT community sources, however given that one of the issues
that lesbian women who care face is a potential loss of their lesbian social networks seeking participants in this way may have meant that the target population would not be reached. The alternative approach to recruiting caregivers would be through doctor’s practices and local authority social services, however this would necessitate the need to obtain NHS ethical approval, something that would have protracted the research process. Finally, had the intent of this thesis been to generate full grand theory in relation to lesbian women who provide care for their families of origin a further limitation would have been that the process of theoretical sampling to include negative cases which would challenge the codes, categories, and themes that were constructed was not engaged with (Payne, 2007). However, given that the intent of this study was exploratory in nature, examining a topic where relatively little was known, engaging in negative case sampling was deemed inappropriate.

Originally a sociological method, the approach gained popularity in psychological research in the 1990s. However as Willig (2008) argues, the use of the method in psychological research, that is in examining experience rather than the sociological focus on social processes, leads to the method being used as a means of categorisation rather than in general theory. It is in this approach that the method was used in Study 2. Grounded theory methods provided a useful framework in which to engage with the data and provided a systematic way in which to code and categorise the data. However, given that I sought to explore the women’s experiences rather than generate grand theory, a more experiential approach such as Interpretative Phenomenological Analysis may have been more useful vehicle given that IPA and grounded theory share much common ground in terms of their systematic approach to data analysis (Smith, 1999). Or, alternatively Thematic Analysis, another method that offers a similar structured approach to data analysis (Braun & Clarke, 2006).

Indeed, Thematic Analysis was the method chosen for the analysis conducted in Study 3. A criticism of thematic analysis has been that there has been a lack of researcher guidelines for this method (Boyatzis, 1998), however this issue has been addressed by Braun and Clarke (2006) who offer a clearly defined approach to undertaking thematic analysis. The main methodological issue that arose with Study 3 surrounded using focus groups as a means of data collection. First, in some focus group sessions participants were more vocal within the session than others, despite encouragement. A group discussion session may not be the most ideal environment for free expression for some people, particularly if their views differ to those already expressed by other participants in the group. Further, whilst the
encouragement of group discussion is welcomed, there were times when all participants were talking all at once which proved difficult to subsequently transcribe accurately. Inability to transcribe some instances of discussion may have meant that interesting points were omitted from the analysis.

Finally, an issue that some may suggest is a limitation of the qualitative research undertaken here is the aspect of generalizability. However, generalizability is not the aim of qualitative research; particularly when the aim is not to establish any form of universal or grand theory and when the research is being undertaken from a social constructionist positon (Mayring, 2007). The results of the qualitative studies presented in this thesis should be considered within the context they were conducted and the findings may not apply to all. For example the lesbian family carers in Study 2 were city dwellers, their issues may be different from lesbian family carers living more rurally; whilst the women in Study 3 were living in an affluent university town, had women from a less advantaged area in terms of both educational and economical opportunities the issues raised may have been different. However the concept of theoretical generalization (Fine, 2006) can be considered appropriate here. That is, the extent to which theoretical notions identified in one context can be applied to another. I would argue that there is theoretical generalisation in the qualitative studies within this thesis. For example, the themes identified in Study 2, such as “Duty and Obligation” and “Boundary Setting” are focused on issues that are relevant to non-lesbian family carers. Similarly, the sub-themes identified in Study 3, such as “Relationship and Emotional Support” and “Disaster Support” engage with issues that are relevant to all young women living away from home.

Turning to the final, quantitative study, a potential limitation to note here is in the use of Amazon’s Mechanical Turk (MTurk) to recruit the study sample. MTurk is a relatively new website owned and run by Amazon as an “online marketplace” (Buhrmester, Kwang & Gosling, 2011, p.3) that allows researchers (requesters) to post surveys or other computer based tasks (tasks) and participants (workers) to complete tasks for nominal payment. Key questions about the use of MTurk for psychological research are the representativeness of samples sourced via this system and the quality of the data obtained. Research has found that MTurk participants are significantly more demographically diverse than the standard American college sample and that the data obtained is at least as reliable as data obtained by more traditional methods (Buhrmester et al., 2011). Given these findings and the objective of
Study 4 in reaching to reach a more diverse sample than university students, the use of MTurk has proved useful in achieving these aims.

8.3 Reflexivity

Reflexivity is a key feature of qualitative research, and was engaged with throughout the research process. In this section I will describe what reflexivity is and how I engaged with it, reiterate why it was important to engage with this research, how the research developed, and what my position was in relation to the research process. Further, I will also discuss how my position may have had influence in the research process with relation to participant involvement and how this may have influenced the analysis and conclusions.

Reflexivity can be considered as a way of making clear the central position of the researcher within the research and analysis process and in the construction of knowledge (Tindall, 1994). In respect of feminist psychological research, one definition of reflexivity suggests that it is the process of the researcher engaging with their personal experience of the research process (Wilkinson, 1988); put simply, that is the position of one’s self within one’s own research. The main reflexive strategy I employed in the research process was in the keeping of a research journal. In this journal I routinely noted my reflections surrounding my relationship with the research topic and the research process. I also re-visited my journal throughout the analytic process in an attempt to clarify my interpretation of the data.

Overall my interest in this research topic stemmed from my personal position. As a mature lesbian woman returning to higher education I was struck by three biases in psychological research; that of androcentrism, heteronormativity, and ageism. All three positions worked to lead to the majority of psychological research focusing on the interests of young, heterosexual men; a position that did not speak to me and my personal experiences. In sum, there was scant research that spoke directly to my experiences; a position that I sought to rectify with the research undertaken in this thesis. To address the research gap I undertook four studies, two of which were qualitative studies that engaged directly with participants.

Study 2 was the first study in which I engaged with participants. Here the study was exploratory in nature with the aim to gain an initial understanding of the issues that face lesbian women who are involved in family elder caregiving; a position that I had found myself in. The analytic method chosen for this study was grounded theory methodology, where a school of thought is to engage with data collection and analysis prior to conducting the literature review in order to avoid bringing pre-conceived notions to the data and to ensure
that the analysis produced is grounded in the data rather than in the existing literature (Charmaz, 2006). However, as Charmaz (2014) later indicates, the researcher cannot be removed from the research process. The resulting analysis is the product of the research process in its entirety; that is the engagement of the researcher and the participants in data collection and the engagement of the researcher with the data in the analytic process. Given this position my experience as a lesbian family elder carer will have had impact on both the experiences I sought to explore in the interviews and in my engagement with the participants in the interviews. For example, at the start of data collection interviews I discussed my research and why I was interested in the issues that lesbian family elder carers faced. Whilst opening the interviews in this way may made clear to my participants where I was situated in relation to my research, it may have had an adverse effect on what participants shared in the following interview. For example, the participants may have endeavoured to answer my questions in a way they felt appropriate to their understanding of my personal construction of lesbian family elder caregiving. The consequence of this position is that any potential contrasting views may not have been aired within the interview process and so be absent from the subsequent analysis.

The second qualitative study that engaged with participants was Study 3. Here the study focus was on the future expectations of younger lesbian women in terms of future lived outness and involvement with their families of origin. This subsequent study was conceived of as a result of reflecting on my personal position as well as on my interactions with the women in Study 2, and the findings of this piece of research. From a personal perspective, family elder caring had not been something I had previously reflected on as a young woman, nor had I considered it as a task that might have any significant impact on my later life. It appeared that family elder caring had crept up on me. It was a task that I found myself engaging with more and more over time without much thought, until it became more central in my life. This slow engagement with more and more caregiving was also the position for some of the women engaged with in Study 2. Furthermore, in talking to the women who took part in Study 2 (before, during, and after), I was struck by the general consensus that providing care and support for their elderly parents had never been something the women thought they would be involved with, either because they had moved away from home for education, work and/or to ‘come out’, or because they felt that others within their immediate family would be more suited to the carer role or would be the ones to take on this role for their elderly parents. Given the general lack of prior caregiving expectation of the current
mid-life lesbian family caregivers I was interested to know the expectations of younger
lesbians. Therefore my personal reflections and experiences, along with my reflections on
participant interaction in Study 2 certainly influenced the focus and design of Study 3 as it
gave direction and intent to the overall aims of the study.

In considering the research process in Study 3, on face value my personal position
would not appear to have any direct influence on participant involvement within the research
process, however this may not have been the case. For example, the younger women were
recruited via the university and surrounding locale via posters seeking lesbian women to
discuss future lived outness expectations. As all of the women were either connected with, or
had been connected with the university many of the participants may well have been familiar
with my earlier published paper (Parslow & Hegarty, 2013) in which I discuss lesbian elder
caregiving. Particularly so as my research and my research interests are made clear on my
university web page. As a result a general knowledge of my previous research study may
well have influenced the direction of discussion as involvement in elder caregiving did feature
in some of the discussions.

8.4 Implications for Theory

Considering all the findings together it is clear that despite social psychological theory
that would suggest otherwise (Eagly, 1987; Eagly & Steffen, 1984), elder caregiving, like
child caring (Burman, 1994; 2007) is considered as a natural task for women. This is driven
by the gendered division of labour within the family that stems from the patriarchal discourse
of the heteronormative family. This discourse holds to the assumption that couples, families
and family members are heterosexual by default. Taking these two positions together the
family elder carer should be a heterosexual female relative.

This heteronormative construction of the carer has implications for lesbian women
who are involved in family caregiving as issues and experiences that are unique to their
lesbian identity status are rendered invisible and remain unexamined as they are not of
concern to the normative family caregiver. The direct exploration of the lesbian experience of
family caring in Study 2 found that issues surrounding the loss of lesbian identity, the need to
maintain links to lesbian social networks, and the space and privacy perform a lesbian identity
within the home were found to be of most concern for lesbians family caregivers.

Identities form the basis of self-definition (Deaux, 1993) however the women’s
caregiving involvement brought about a threat to their lesbian identities. From the
perspective of Identity Process Theory (IPT) (Breakwell, 1986; 1993; 2001) caregiving involvement can be perceived as an identity threat. When one’s identity is threatened IPT posits that coping strategies are employed, such as intergroup strategies involving group membership. As the women were concerned to find ways to maintain links to their lesbian social networks, they could be considered as engaging in intergroup coping strategies, in accord with IPT.

Loss of lesbian identity and the importance of connections with the lesbian community can also be considered from the perspective of identity theory (Stryker, 1968) where identity salience is linked to affective outcome and commitment to particular identity roles. From this perspective, commitment to an identity is greater when it is invested in social relationships. The loss of an identity that has many social relationships associated with it brings with it the loss of that particular social network. From the perspective of the lesbian carers, the loss of their lesbian identity implies the loss of their lesbian social networks, which in turn may lead to a negative impact on their self-concept.

The engagement with lesbian social support networks was found to be important. For the women in Study 2 maintaining connections with their lesbian social networks was linked to being able to socialize within the home, something that at times was difficult to achieve. However, the importance of being able to use their home to maintain their social connections has implications for coping with the effects of minority stress (Meyer, 2003). Minority stress is a particular form of social stress that occurs as a result of the incongruity between an individual’s minority sexual orientation and the values and norms of the majority. A part of the minority stress process, along with prejudice, the expectation of rejection, and internalized homophobia is the concealment of minority sexual orientation (Meyer, 2003). The inability to perform their lesbian identities within their homes for some of the women in Study 2 meant that for some they were concealing their sexual orientation and for others they were experiencing prejudice; both positions have implications for exacerbating minority stress. Further, as these positions limited the women’s ability to maintain their social support networks, the ameliorating effects of social support in relation to minority stress was lost (Meyer, 2003).

Being open about one’s minority sexual orientation is not only important in terms of ameliorating minority stress but also in terms of strengthened personal relationships and a sense of authenticity and wholeness (Markowe, 2002b). In sum, concealment can bring about anxiety and stress, whilst being out can ameliorate stress and provide a sense of personal
authenticity. And, whilst the women in Study 3 did not express concerns around minority stress, they did indicate concerns about being inauthentic as well as a lack of cohesion when they perceived themselves as being mis-identified by others who assumed they were heterosexual. Despite their concerns about being thought heterosexual, the younger women were not comfortable with being perceived as the butch lesbian; a stereotype that was normatively considered pejorative (Brambilla et al., 2011).

A consistent finding across research studies is the persistence of the butch lesbian stereotype. Overall, lesbian stereotype research generally subscribes to gender inversion theory (Kite & Deaux, 1987), in that lesbians are generally considered as not very feminine and viewed, similarly to heterosexual men, as being competent (Fiske et al., 2002). Consistent with this body of research Study 4 found the lesbian target was stereotyped as less feminine than the heterosexual target.

8.5 Overall Conclusions

Cohort effects need to be considered as playing a role in the emergence of the carer identity, the differences between the experiences reported by the women of Study 2 the hoped for futures that the women of Study 3 expressed, and the lack of stereotyping and effects of modern prejudice captured in the experiment. Cohort effects are a result of the social and political experiences that separate generations and can be reflected in academic enquiry. An example of this is in relation to the HIV/AIDS crises. The observed increase in LGBT research publications, between 1975-2009, was found to coincide with the HIV/AIDS crisis (Lee & Crawford, 2007; 2012). Figures post 2000 have begun to indicate a decline (Lee & Crawford, 2012). This pattern may suggest that the very real crisis caused by HIV/AIDS has had an impact on research focus. In considering this body of work, the qualitative work presented in this thesis was conducted at a time when the social and political landscape with respect to same sex relationships was changing. Therefore, the difference between the experiences of the women in Study 2 and the uncomplicated future expectations of the women in Study 3 may be as a result of cohort effects in relation to both relationship and family formation on behalf of the two groups of women and their respective families of origin.

In respect of relationships, the women of Study 2 developed their sexual identities and came out at a time when same-sex relationships were not legally sanctioned, whilst the women of Study 3 have grown up, developed their sexual identities during this current period of rapid social change regarding same-sex relationships. Indeed, some of the youngest
women in Study 3 would have been in their mid-teen years when Civil Partnership legislation was enacted and the first civil partnerships occurred (2005-2006). Whilst the eldest participant in Study 1 was born just after the end of World War II, at time when for men homosexual behaviour was a criminal offence and attitudes towards lesbians and gay men were more pejorative than the climate in which the young women of Study 2 were born into. Although lesbian sexual behaviour has never been a criminal offence, lesbian women have had to face similar social sanctions and restrictions in their behaviours. These social sanctions will have influenced the older women’s behaviours and expectations and may well have influenced their views on different relationship formations. Given the unavailability of socially approved coupled relationships the older women may well have forged their own norms (Brown 1989) and created their own relationship formations.

Following on from relationships, family formation expectations will also be different. Again, these two different generations of women will have been socialized differently in this regard and they would have had differing expectations. In neither study were the women asked about children, either whether they had them or whether they wanted them. The women of Study 2 were not asked directly whether they had children of their own but they were asked about their involvement with their families of origin in respect of care and support; whilst the women of Study 3 were asked about their future expectations in relation to their involvement with their families of origin. All of the women in Study 2 described their family formations across the course of their respective interviews with some of the women discussing adult or teenaged children who were born into previous heterosexual relationships. However, the majority of the women in Study 3 indicated that children would be a part of their future lesbian coupled relationships, whether they were the birth- or non-birth mother. In sum, the younger women are expecting a lesbian created family; an expectation the older women would not have had at their age. Given the rapid social change with respect to same-sex relationships and taking the results of study expectations between the generations of women, the uncomplicated expectations of engaging family of origin caring in there later lives may well come to fruition.

Considering all the findings together it is clear that elder caregiving, like child caring (Burman, 1994; 2007), is on the one hand very much affected by historical change and on the other consistently considered as a natural task for women. Social psychological theory (Eagly, 1987; Eagly & Steffen, 1984) suggests that these stereotypes which appeal to ‘women’s nature’ are driven by the gendered division of labour within the family and the
patriarchal discourse of the heteronormative family. This discourse holds to the assumption that couples, families and family members are heterosexual by default. Taking these two positions together the family eldercarer should be a heterosexual female relative.

This heteronormative construction of the carer has clear implications for lesbian women who are involved in family caregiving, and experiences that are uniquely inflected by their lesbian identities and relationships are rendered invisible as they are not of concern to the normative family caregiver. In particular issues surrounding the status of lesbian relationships and the space and privacy perform a lesbian identity within the home were found to be of most concern for lesbians family caregivers. However as the more specialized LGBT body of research situates the LGBT individual either as part of a sexual community or as part of an LGBT created family rather than as part of their families of origin, knowledge about family of origin engagement post coming out is lacking.

This lack of knowledge has implications for younger women as age stratification leads to a communal lack of lifespan knowledge with regard to how their lives might pan out. Further the dominant norms that impacted the lives of the women in Study 2 may hold implications for the women of study 3 over time as the dominant norms, in respect of the family and intimate relationships, that is the discourse of the heteronormative family unit and the discourse of intimate monogamous heterosexual coupled relationships, dictate how their relationships may or may not be sanctioned and how they may find themselves engaged in family responsibilities that challenge their lesbian sexuality and assimilate them back into heterosexuality. Indeed it can be argued that the influence of these discourses is evident in the future focus of the women in Study 3 was toward creating lesbian led families that queer theorists would argue are in the image of the heterosexual norm (Warner, 1991).

Troubling the discursive normativities, be they about sexuality or relationship constructions, is the business of queer theory. Queer theory and queerness, developed in the early 1990s, stands in challenge to hegemonic heterosexuality (Minton, 1997; Warner, 1991). At the heart of queer theory is the Foucauldian notion of relational power. In Foucault’s concept of power, power is not exerted from above; rather, power is all pervasive, constantly produced between people and institutions, comes from everywhere, and is inescapable (Foucault, 1978). It is in the interplay of power between people that the relational aspect of power becomes apparent, and resistance to the dominant discourses is achieved. Accordingly it is best to see lesbian carers – and lesbians who might care in the future – as struggling to enact power in a situation where they have been made responsible for the care of others but
are caught in competing discourses about relationship family, gender, sexuality, home, privacy and the future. From a queer perspective the debates surrounding sexual citizenship and same-sex marriage are in relation to the possibilities of assimilation of LGBT individuals into the dominant heteronormative discourses.

The issues that surround the debate about assimilation and normalization in respect of same-sex marriage are in many ways similar to the debate about family that faced the feminists of the 1980s in relation to the position of women within the world of work and the family (Barrett & McIntosh, 1991). The social construction of femininity impacted significantly on the structural engagement of women and men in society such that women and men tend to occupy differently, the spheres of public and private, and in many ways continues to do so. Should the feminist position have been to accept this structural separation and seek for “women’s work” to be suitably acknowledged, or to fight against this socially constructed position? The queer project seeks to celebrate difference and avoid normalization and so some argue against same-sex marriage rights seeing them as being a normalizing technology. However, as Butler (2004) suggests, the very act of those considered subversive engaging in acts that what would be heteronormative trouble the hegemonic discourses and queer the waters. Often overlooked, the private struggles of lesbians who care ought to be theorized as part of this framework.
References


Barker, M. (2005). This is my partner, and this is my … partner’s partner: Constructing a polyamorous identity in a monogamous world, *Journal of Constructivist Psychology, 18*, 75-88

Barker, M. (2007). Heteronormativity and the exclusion of bisexuality in psychology. In V. Clarke, & E. Peel, (Eds.). *Out in psychology: Lesbian, gay, bisexual, trans and queer perspectives* (pp.95-117). Chichester: John Wiley & Sons Ltd


Bracke, P., Christiaens, W., & Wauterickx, N. (2008). The pivotal role of women in informal...
Burman, E. (2007). Knowing silences or the Epistemology of the Closet? Commentary on
Article by Martin Weegman, ‘Group analysis and homosexuality: Indifference or hostility?’ *Group Analysis, 40*, 77-82
Carers UK (2015). *Policy Briefing August 2015: Delayed implementation of Care Act phase two*, London: Carers UK
Psychology, 13, 519-529
Clarke, V. (2008). From outsiders to motherhood to reinventing the family: Constructions of lesbian parenting in the psychological literature – 1886-2006, Women’s Studies International Forum, 31, 118-128
Coontz, S. (1992). The way we never were: American families and the nostalgia trap, New York: Basic Books


233


well-being in lesbians, gay men, and bisexuals: The effects of race, gender, age, and sexual identity, *American Journal of Orthopsychiatry*, 79, 500-510


LaSala, M. C. (2002). Walls and bridges: How coupled gay men and lesbians manage their intergenerational relationships, *Journal of Marital and Family Therapy, 28*, 327-339


for older people and the relationship with the care recipient, *Aging & Society*, 23, 487-506


238


NRS (2013) 2011 Census: Key results on population, ethnicity, identity, language, religion, health, housing and accommodation in Scotland – Release 2A.

ONSa (2013) What does the 2011 census tell us about the “oldest old” living in England and Wales.


Patterson, C. J. (2000). Family relationships of lesbians and gay men. *Journal of Marriage...


Ritchie, A. & Barker, M. (2006). ‘There aren’t words for what we do or how we feel so we have to make them up’: Constructing polyamorous languages in a culture of compulsory monogamy, *Sexualities, 9*, 584-601.


Ryan, C., Huebner, D., Diaz, R., & Sanchez, J. (2009). Family rejection as a predictor of negative health outcomes in white and Latino lesbian, gay, and bisexual young adults, *Pediatrics, 123*, 2460352


Savin-Williams, R. C. (1998). The disclosure to families of same-sex attractions by lesbian, gay, and bisexual youths, *Journal of Research on Adolescence, 8*, 49-68


effects of caregiving, *Journal of Gerontology, 45*, 181-191
Sophie, J. (1986). A critical examination of stage theories of lesbian identity development,


persons with AIDS in the United States: Caregiver characteristics and their implications, Social Science and Medicine, 38, 1543-1552


Valentine, G., Skelton, T., & Butler, R. (2003). Coming out and outcomes: Negotiating lesbian and gay identities with, and in, the family, Environment and Planning D: Society and Space, 21, 479-499


Waerness, K. (1984). The rationality of caring, Economic and Industrial Democracy, 5, 185-211


Watters, A. T. (1986). Heterosexual bias in psychological research on lesbianism and male
homosexuality (1979-1983), utilising the bibliographic and taxonomic system of Morin (1977), *Journal of Homosexuality, 13*, 35-56
Zarit, S. H., Reever, K. E., & Bach-Peterson, J. (1980). Relatives of the impaired elderly:
Correlates of feelings of burden, *The Gerontologist, 20*, 649-655
Appendix I

Materials pertinent to Study 2

a. Study 2 Interview Schedule

1. Can you tell me a little about yourself and who you provide support for?

2. And can you tell me how you become involved with these responsibilities?

3. Tell me a little about what you do on behalf of the person you support?
   Prompt: How did you find yourself getting involved in these tasks?

4. Could you tell me about what a normal week for you is like?
   a. And what about a typical day?
      Probe for different times of day/different times of week/year

5. Can you tell me about any other people involved in providing support to ______
   Prompts: For instance from family, partner, friends, social services

6. Tell me about any support that you personally receive
   Prompts: Family, partner, friends, social services

7. Have you or the person you support received help or support from any outside organisations?
   a. How did they help you?
   b. How did you learn about them?

8. Could you tell me about how out you are in the various areas of your life
   Prompts: Home/family/parent/caring role/work/socially

9. Can you tell me how you manage to balance caring with the other aspects of your life?

10. How has being involved with caring for your parent affected your personal relationships?
    Prompts: Partner/Socializing

    How, can you tell me more?

11. Have you developed any coping strategies to create space for your personal relationships?
    a. Can you tell me more about these

12. Has there been any physical changes in the way you live your life since you became involved caring
    a. Could you tell me more about this

13. Can you tell me what negative changes have occurred since you have become involved in caring

14. And what about positive changes?
15. Can you tell me what you have found to be most useful to you since you have been involved in caring?
   Prompts: Other people/Personal skills/Sense of humour?

16. Based on your experience, do you have any advice to give to someone who finds themselves in a similar position to you?

17. Is there anything that you might not have thought about before that has occurred to you during this interview?

18. Is there anything else you think I should know to help me better understand how caring affects your life?

19. Is there anything you would like to ask me?

20. And finally, what did you think I would ask?
b. Example Interview Transcript

1. O: Right, so a little bit of background in that I look after my Dad, from a distance, as he lives in Buckinghamshire. And I live with my partner and her father so we have a, we say its care but its really support in that we are providing him with support whenever necessary. Umm, since you said you find care is a word that means chore to you.

2. J: No, I don't mean it to be a chore, I mean it as just something that I do but not something that is a chore, yes?

3. O: Yes, right () so that's why I came into this research and why I think it's important that we get to know people's stories and how caring affects their lives; but in particularly not straight lives because that has been recorded time and time again, how caring impacts upon people and it might impact differently for a lesbian population. So, first of all I would like if you can tell me a little bit about yourself and who you provide support for.

4. J: Ok so you said a little bit about myself? Such as?

5. O: Yeah, if you tell me about yourself. As much or as little as you want, but situate yourself and what you do.

6. J: Ok, umm (.) well I'm originally from XXXXX and my parents umm separated when I was quite young. Then my mother re-married, but my stepfather was killed in a car accident in France in 1992. Umm, my mother has had, historically, quite bad health, she only has one lung and umm, so she's had bronchiectasis for all of my life I've known her. And umm since being about seventy she's had osteoarthritis as well and currently she's just been, thank God, just been looked into at hospital to have umm, you know where the do keyhole surgery on your knee and take out the bits and bobs. So that's has been her problem more than the bronchiectasis has been as her mobility has been affected. She lives on the same estate as I do () and umm, so she's on the first floor and she has to climb up quite a number of stairs. So () she's been back there since, she's been back, living on the estate since 1996 I think it is () yes () umm

7. O: And that's where?

8. J: Here, just up the road. Yes, in Fulham. Umm, I'm unemployed at the moment unfortunately. I had to leave my biggest job, I was a gardener, and umm, that's it really.

9. O: Yes, umm, and how did you () does your mother live with you?

10. J: No, but we live on the same estate.

11. O: Right ok

12. J: So its not difficult for me as she is close at hand.

13. O: Umm, so how did you become involved in providing support for your Mum?

14. J: Well because my brother lives in Cape Town and I'm the only close family she's got in London you know. And I, and I, of course I wanted to you know. Umm, and I, and the support I provide for her is company for her, someone for her to rely on, and moral support, and help with shopping and caring and housework, and you walking her about, ferrying her about, that sort of thing.

15. O: Do you drive?


17. O: And, umm can you tell me about the story of how you, did you both end up in the UK at the same time or did you both come over separately?

18. J: No, I moved over here, although my parents were both originally from England and they went separately to live in XXX My Dad, my Dad was a, was in the Police Force, joined the police force in XXX and my Mum went over to teach. And then we left and came back to England but my parents couldn't settle. They couldn't get back into the English way of life so we went and lived in XXXXX. I left there at nineteen and have been living in London ever since. My Mum then left my father and well, over I suppose several years, separated and divorced and
then remarried and lived in Spain for a little while. Then her and her new
husband came over to England and did jobs, err caring jobs as it happens,
caring for wealthy people in their homes so that they didn’t have to go into
care. And as I said my stepfather was killed in a car accident in 1992, my
Mum at that stage had got a Peabody Estate housing association flat. And
um, I then was staying, living with her after John, my stepfather got
killed then I applied for one myself and fortunately got one so I live in the
block opposite to her, so essentially we’ve been living in close proximity
to one another since 1996.

O: But you arrived in the UK [in
J: 1977, yes a long time before, and I’ve been
here ever since.
O: Umm, so you didn’t both come over here together then?
J: No, no
O: Erm () the next thing that I’m interested in is what you do for your
mother, could you expand upon the things that you do for her?
J: Well, umm () such as?
O: Can you tell me what you do for your mother, perhaps describe what it is
you actually do?
J: Ok () well she has a bath once a week, umm she showers the rest of the
time but I have to, I have to lift her when she tries to get out of the bath
because of her knee. When her knee’s really bad I have to help her with
her medication () umm, obviously I do, I do her shopping with her all of
the time and I also obviously carry it up the stairs to her flat for her. I ferry
her to and fro from places that she needs to go like to her doctor and to
hospital appointments when I have to pay the damn congestion charge, she
goes to Chelsea and Westminster which is a hundred yards inside the
congestion charge zone which I think is outrageous, you know there
should be some consideration for the patients. Erm, and yes, basically I
don’t see her an awful lot but I give her moral support and I take her
where she needs to go because basically she can’t get around on her own.
Now if you met her she’s very charming and she doesn’t look as if she is
disabled but she also comes from a background where you don’t say or
talk about your, your pain and stuff. She doesn’t moan and groan so you
know, so people don’t necessarily know she is disabled because she
doesn’t really talk about it to non-family members.

O: Yes
J: Now sometimes that’s good and sometimes it’s bad and I think I
understand why she does it but if you are looking for some moral support
for yourself it can be difficult, you are sort of in a situation where my
parent doesn’t look ill or sick and if you talk to a third person about it then
you are somehow breaking a part of their trust with you, so in some
respects you can’t say anything that you are in a bind somehow.
O: Yes, yes
J: And well it’s a big thing for her, a big issue that she presents a good self
image. I suppose it’s her confidence really, and her self respect, her
confidence and you know her independence, all of that is at stake, all of it.
So then well you have to put yourself a step back from it because it’s not
yours to share, so at times it can be difficult.
O: Erm, obviously you do a lot of supporting, is there anyone else who
provides support at all?
J: Erm, no not really, umm you know obviously she gets help from the
doctors, and help with medication, and thank God we live in Fulham
where we’re getting good health care from Chelsea and Westminster
Hospital. You know please God we are in area for Chelsea and
Westminster () well it’s had its ups and downs hasn’t it? But you know
but when you think of other hospitals and you hear of people being left in
corridors on trolleys and the like, you know it sounds terrible.
O: Yes I think your local hospital has a pretty good reputation. I suppose all
hospitals have their ups and downs [but
J: art hospital isn’t it?
O: I haven’t actually been in there myself
J: It’s like an art gallery with all modern art, ha, ha
O: No, I haven’t actually been there myself but I do know that it is supposed to have a good reputation. So then there is doctor’s support for your mother?
J: Well they are very sympathetic I have to say, the doctors surgery is very sympathetic and umm since she, since the correct diagnosis for her knee has been given, because in the beginning they said that it was arthritis, and then because of the osteoarthritis they were thinking, well now, now they are talking about a chipped bone, so when they go in and do the key hole surgery they are going to go in and take the bits and bobs out. This erm (.) now if they do then hopefully this will sort it out, but before they did want to do a knee, a complete knee, knee change or whatever they call it, a knee replacement, but I was anxious about that as was she because it seemed just such radical surgery, if they could just go in and do this type of thing to begin with.
O: Yes, umm a knee replacement it is fairly radical surgery, but it depends upon what is wrong with your knee and how it impacts upon you as to what you need to have done.
J: Yes, yes, it seems to me that what they are now proposing is the best option as I think you need to explore all, less intrusive, options first. Because when, I think, when you get to a certain age they seem to tell you what you want doing, ’cos I tend to say what I want whereas with my Mum I’ve found that though she’s quite a strong person, well a very strong personality, when it comes to doctors she seems to just say yes and I think no, it’s your body, your life, don’t just have this done; explore the options you know. And she went back to them and said I don’t want the knee change or a new knee, I want you to do this, because obviously with only having one lung any form of anesthetic is dangerous to her. Now apparently they could umm (.) now what is it that you have, oh and epidural in her spine so it’s like your not having a general anesthetic and so it’s much less dangerous for her.
O: Yes
J: And I even said to her that I’d seen something on television where you could actually keep awake because why not, when you have a baby your awake? So why couldn’t they do something like that for her, you know where she’s not asleep and I think if she’s conscious and that, if she’s conscious in the operation and in control, in control of her breathing I think that will go a long way to help her.
O: Yes, that’s a very good point umm. Now, do you think, and this is conjecture really, and it’s a question that has come up in an interview with another woman who was incidentally also providing care for her mother. Umm she mentioned a similar sort of thing with regard to her mother and doctors in that her mother also seemed to go along with what the doctors suggested. Do you have any ideas why that might be?
J: Umm, I don’t know really. I think it might have to do with the way the older generation has been brought up. I think we as younger women, we are more inclined to say “do you think that is the best option” and be a little more questioning whereas I think the older generation of women have been brought up to accept the authority of the doctor and what he says. They have been conditioned to think that what the doctor says as always being right when I don’t think that they always are. And I also think that you, that there are more options and although, you know having been brought up in a country where there wasn’t a welfare state and I can’t sing the praises of this country high enough, you know, in terms of the welfare state and NHS it’s been fantastic. I still think, umm, you know they’re very erm, financially conscious now and you know and I, rather than just take the cheap option, you should be given the option, and that's
my feeling you know. That's, you know, sort of, for example when the
knee was diagnosed as, as arthritis I think she should of said at that point
“how do you know? You can't look at my knee and tell me I've got
arthritis” which is what I would have done. And if they'd have given, if
they had X-rayed the knee then they would have found out that it was a
chipped piece of bone rather than arthritis and her walking on it, as she has
done, for fourteen months (.) so you know, I, I wish she had been stronger
but you know I can't take away all her independence from her.

O: Totally, totally
J: You know it was a tough call but you know I think there is something
different between how I would have approached this and how my mother
has done. I would have asked the doctors whether they were sure about the
diagnosis but my mother was just prepared to accept what the doctor told
her.

O: umm yes
J: And also I think because of umm things that happened umm to her in her
past where she just accepted. And I have since read that there were options
you know available and that has made me more aware of the options that I
may take you know if god forbid anything should happen to me. I won't
just say ok fine go ahead, I would want to be sure of options.

O: So umm, apart from family and friends, most family are still in South
Africa?

J: Well umm, she's got a few freinds, well no, her family are in the North.
She's from the UK originally so she has a few family members up in the
north of England somewhere, we don't see much of them. Umm, and then
there is family in London on my, from my father's side umm, but basically
it's me you know.

O: You mentioned a brother, or someone?
J: In Cape Town, yes where we lived.
O: Ok, umm, does your mother get, obviously gets support from the doctors
surgery, but does she get any help from social services or anything like
that?

J: Umm (.)
O: What I'm getting at here is there any external help or, or support from help
groups or organisations other than you.
J: Well she goes to old age groups, like the 50 plus groups, in Kensington
which seem to provide better opportunities than Fulham and
Hammersmith and fortunately she can go to them as they are a wealthy
borough so (.) umm, as far as she's required to leave Peabody and go to a
sheltered housing thingy but it's quite a nice one it's not you know crabby
it's more sort of well better than most. It's up in Earls Court and it's only
for the disabled. You see social services did come in and re-arrange the
bathroom, but again you see the whole pride thing having some disabled
bathroom didn't appeal she'd rather have me lifting her out of the bath.
Which I understand, you know you have all these hoists and pulleys and
god knows what else and she didn't want that you know, she didn't want
her home to look like an older person's home.

O: So that's the support that your mother has been offered. Do you find that
you spend much time with your mother?
J: Well I see her everyday, umm and umm I suppose as I am unemployed
obviously I have more time. Umm, again it's a tough call because I feel
sometimes that she deliberately pushes me away and that it's the whole
independence thing you know. That, umm, I can't quite work it out and I
don't know whether she's saying “I need some space because I need to
believe in myself” or “I wish you would go and do stuff for your self” and
when frankly I enjoy her company and umm, I, I, I'm not you know, I'm
not that fussed about running around and going out to pubs and clubs and
all that stuff, I mean I've been there and done it (.) umm you know I'm
quite happy to sit there and watch telly with her you know but if she
doesn't want that then I have to also understand that maybe she needs her
space, but yes I see her everyday.

O: And would that be any particular time?

J: Well if she needs something, shopping done then she'll call me but otherwise I'll just pop in during the day and say hi and have a cup of tea.

Or if she needs something, she'll say to me "Look you know will you help me with my middle, or I can't walk or lift this or come and help me get that down" or you know, that sort of thing. I know she appreciates me but I know what it is, that it (.) she is fiercely independent umm, she err even, I think she was probably difficult to be married to because she is very headstrong. I do understand that and I know she appreciates everything that I do unquestionably but her way of, of you know, maintaining herself and her independence sometimes can get her a bit cross and defensive but I do know what is going on in her head and I know she appreciates what I do for her, although she doesn't always say she does.

O: Umm, the next area I'm interested in here is more to do with how out you are both at home and socially.

J: Well I brought it up to all my family (.) and I have been out from when I decided to come out in 1977. Umm, I don't, well unless it's perfectly obvious to other people I don't, I don't feel a great need to walk around with something written on my forehead, you know. Not like XXX at XXX, you know to me and I am sure to everybody else she's making it blatantly obvious about her sexuality. Now I don't make an effort to do that, but you know all my family and friends all know, my mother, have all known since day one and we've never had an issue, I am quite sure she would prefer, prefer me to be married and so to have had children but she has only ever been supportive and understanding and umm funny about it you know. She has never ever been angry, disappointed maybe, but anger and disappointment are two different things.

O: Quite, yes

J: You can accept disappointment but anger is more difficult. I mean there may be an element of blame, you know because of the hectic, the hectic time when she left my dad you know, but that's ridiculous. But then parents tend to blame themselves but it has nothing to do with her you know. I think that parents automatically think that if there's something not quite right with their child it must be something that they said or did and of course that isn't necessarily the case.

O: Absolutely

J: Yes, absolutely not.

O: You don't live with your mother, have you ever thought about the two of you living together?

J: Yes, I suggested it once but she went against the idea. Erm (.1) I think its more to do with, absolutely more to do with her own independence. I think that she would feel that she erm was beholden to me, and erm, that I may, may become, you know, resentful about it in some way, in some years down the line. Who knows maybe she, she would be, maybe she would be right, you know, maybe I would suddenly start thinking "cripes this is not what I expected it to be" and its a twenty four hours a day job, so you know maybe she's being really kind. Right now I really wouldn't want us to be living together.

O: Uhhm (.2). Why do you suppose that your mother has chosen to live this way?

J: I genuinely think that, erm. Yes, I genuinely think that she would rather keep her independence, I think that's what it is. I think she, well I think I think (. that she would also hate to be at a point where she was beholden to me, you know. That's you know, well it is six of one and half a dozen of the other you know, where she got to the point where maybe she had become infirm and umm you know, or, or had lost the use of her legs or something or, and that, and maybe because she did caring herself that she understand about it. You know these were wealthy, often wealthy people
and their children were often, were sometimes I think were either cheating
the system, or quite nasty and didn't want to get involved in caring and
well paid for outside care. The wealthy seem to do that, you know.
O:
Your mother seems to have seen a different aspect to care, providing care
for a family who have a different lifestyle and are able to buy in care.
J:
You see I don't understand that, you know I can't understand why people
do that and its a peculiar thing to England as well because when my Mum
lived in Spain what I liked was the fact that all the family were included, if
you had a party it wasn't just for young kids and the parents bugger off and
the grandparents aren't even thought of, everyone is thought of and, and
treated the same, and with the same amount of respect. So when Mum
says to me things like “well, you know I don't expect it” I don't understand
the thought process, so maybe because I'm single and don't have children
or other responsibilities but it never occurred to me that when she got old
that I would just discard her and I don't understand how anybody could do
that, how anybody could put some hire worker in a care home as a temp.
O: Umm, about fifteen years ago a local care home was closed down
ostensibly to be re-done, and it was foreclosed, it was sold. And what I
couldn't understand was the kids that could put their family into a place
like that, it was dreary and cold and you know the care was, was erm
simple and, and, and not really erm, I mean for example the thing that
used to really make me angry was that a lot of the old girls were
incontinent and they used to get these temporary care workers in and I was
horrified to find some of them were young men that were changing them
and you know it made me feel (.1) ill with anger that they were subjecting
them to, and if I thought that my mother was being subjected to something
like that I tell you fireworks would have gone up.
O: Yes
J:
You know I do seem to wonder that these people put their parents in there
and then buggered off that they were doing their best for them but they
weren't, they just couldn't give a damn. So maybe that was also a learning
curve for me as well.
O:
Do you think that this is a cultural thing, as you were brought up in a
different culture than the UK?
J:
No I don't think so, I think that possibly XXXXX, you know I mean
I'm, the, the environment I lived in in XXXXX was basically with
other English people as well you know we gravitated to and had more in
common with others, or at least first generation XXXXX people you
know and they're very much the same. I think, I think I have learnt the
way I am through observation and leaning and, and umm, you know what
I see happening in this country you know.
O:
You think, but, what you're describing here with regards to the old people
being put in care homes, you think that is a distinctly English thing?
J:
Well it is my only other experience, because in Spain you see they don't
do that, there they care for people at home. Well because of Catholicism I
think they are much more caring and also they have a cohesive family
environment that doesn't isolate. You know it seems to me that in this
country that (. ) well there is not so much about family is there, the
government don't seem to do anything for family and you get a pittyful
pension, you know which is all part of it.
O: Umm, obviously you are quite involved with your mother in that you see
her everyday and you don't currently have any work, so your time is very
much your own.
J:
Well I do voluntary work, I do work for Fulham Bouquet, but I do
gardening for them in the summer and winter we do decorating in peoples
homes, and I have a few little jobs on the cards, but it's all voluntary work
you know.
O: What I was going to ask there though is how do you manage things like
popping round to see your Mum while doing all the other things in your
life?
Interesting question, I usually just pop round to have a cup of tea with her. I pop round in the morning if I am on the way somewhere to make sure she's all right, when I come home in the evenings I'll pop in you know. Or, as I say she'll call, if she has something specific she wants she phones me. It's not a chore that has to be managed it is just something that just is part of my day.

So to you it is not a chore in any sense?

Oh no

Umm, yes I got that impression from you before we meet and when we spoke before the interview.

Yes, no. You know I dread the day, God forbid, when something happens, I know it will but it is something that worries me a lot, you know, how I will deal with the loss of her 'cos I like her and I like seeing her and you know she is a sweetheart and its mutual that's the thing.

I don't know umm, if you are in a relationship at all?

So to you it is not a chore in any sense?

Oh no

Umm, yes I got that impression from you before we meet and when we spoke before the interview.

Yes, yes. You know I dread the day, God forbid, when something happens, I know it will but it is something that worries me a lot, you know, how I will deal with the loss of her 'cos I like her and I like seeing her and you know she is a sweetheart and its mutual that's the thing.

I don't know umm, if you are in a relationship at all?

No, sadly, no.

Well funny enough, the last relationship I was in, umm and it is going back a while, which I am sad to say, but one of the things I learned then, was that my then partner was very jealous of the relationship with my Mum. She, in fact, because, it was primarily that which broke us up because she had a daughter who was thirty going on thirteen who she expected me to tolerate but she had absolutely no levels of tolerance for my Mum and she actually made my life a bit of a misery over it you know. So I would be very umm, you know I would quote “love me love my Mum” you know, and if you don't well bugger off you know.

So it is now a case of this is my family and if you accept it fine?

Oh yes.

Mmmm, yes I can see how you want people to accept your situation, Err, did you live with your partner at all?

No, umm, no, well mostly because I have err a Housing Association flat which I wouldn't give up for anybody you know. But also you know as much as you want them to, I'm cynical enough and old enough to know that with relationships as much as you want them to work they don't always work out. You know, I think possibly now I would be looking for companionship rather than anything else, you know 'cos then there's less trouble. But you know, she wanted me to live with her and thank God I didn't because it didn't, you knows things didn't pan out, and then I would have lost my flat and you know I just can't do that. But on the other side when I think about it I probably wouldn't want to have a relationship with someone who has kids. I was thinking about that the other day 'cos you know they impact so much on your life and I think I've got to the stage that I just don't do others' baggage and I won't take on other people's problems. I am very independent, I won't move in with my mother despite the fact that I visit daily, so why would I want a live in partner?

Umm, yes they can impact upon your life but wouldn't that depend on how old they were?

Well take XXX for example, she has got two boys of twenty eight and they drive her up the wall. She's got nothing to talk about other than them, you know I'm very fond of XXX but thats all she talks about. And I realised, you know, that as a friend it began to wear me down and made me think about how much I must talk about my Mum and my responsibilities, you know, because it can be dreary and wearing on other people.

Umm, I think I understand what your saying, yes; you feel you need to be aware that they only topic of conversation you have is about your mother?

Yes, it made me aware, and this is no reflection on XXX in any way whatsoever you know, she's a sweetheart and I really like her; or on her boys, they are both very nice people you know, but I felt that there were days when I thought I can't, I've heard it all before, and I haven't got
anything else to say, and I can't give you any more support because I don't have a similar experience and I just thought well I, I just must not do that. You know I remember thinking to myself you know you can't weigh your problems on other people you know constantly.

O: That's, that's interesting. You've given XXX as an example in that she's talking about her family, and you know possibly, although not necessarily asking for support, but she's sharing perhaps what ever problems she has and your conscious that you don't want to do that

J: It's not that I don't want to do that, I think it can become a habit; that's what you do when you see your friends is that you off load onto them and I don't think that that's what necessarily you should do all the time you know. Just because your friends will listen to what your, to to your issues doesn't mean you should use them all the time. You know when all said and done its your choice you know whether you off load or not.

O: So where would you feel that you do have a listening ear so to speak if not your friends?

J: Well if I had a partner it would be with her. Fortunately I've got a very close relationship with my cousin in Earls Court. She knows my Mum, umm you know she knows the history obviously. I can talk to her any time I like. And you know, when push comes to shove, although he's not always helpful I can phone and talk to XXX in XXXXXXX, but that's the last resort because its so far away and also so expensive to phone although you can get these phone cards now that make it a little bit more affordable.

O: So umm, what I was interested in here was whether your involvement with helping your mother impacted on your relationships in any way

J: It did but it had nothing to do with her, it had to do with the other person. I think now, I'm older and wiser and I would, I would umm I would be much more strict about, with my level of accepting their criticisms. I would say at the outset that this is how it is, and if you can't cope then we will just have to be friends 'cos this is how it is. Whereas I tried to appease all the time and and and you know find ways of not making it a problem and I think I, you know you are just false to yourself.

O: What do you think that the issue was with your former partner?

J: I just think she was bloody stupid actually. To be honest with you she had a chip on her shoulder umm, and umm, because she had such a strange relationship with her daughter, because she was divorced and she wanted to, I mean I already said this girl was thirty going on thirteen and it just drove me crazy. When I think about it I was far too lenient, you know, erm I think that she was envious of my Mum and I, my relationship with my Mum being so straightforward you whereas hers, her relationship with her daughter was so complex and peculiar. She was possibly looking at the relationship I have with my mother and comparing it with the relationship she has with her daughter and being jealous about us you know. She was so critical of my mother about being herself and then I eventually worked it out that it was in fact you know about her. I mean there's no one more critical about my Mum than herself you know.

O: When you went round to support your mother at her flat did she come at all?

J: Oh reluctantly, reluctantly. And I think about the times my Mum would cook, you know my Mum is a fantastic cook, and she would be deliberately late. So very rude you know, and yet she, she had these pretensions of being middle class and everything you know. I used to think "oh your so well bred, behave as though you're well bred". You know you're not, you're behaving in a really, really pathetic and bad way you know.

O: Yes, yes (.1) So there was some interaction between her and your mother?

J: Reluctantly, you know, reluctantly, but she expected me to interact with her retched daughter. And I say retched because she's a spoilt minx, you know but that was seen by her as different.

O: Umm (.1) Now, whilst you have been supporting your mother is there any
useful skill that you've developed or contact that you have found useful or
helpful to you.
481. J: Not really, no.
482. O: I think what I'm trying to ask here is have you developed a way of dealing
with things( .1) perhaps coping with the daily stresses?
483. J: Umm, well I suppose I'm fairly emotional you know erm I, I don't have
any problem with telling her things, maybe I tell her too much in fact. I
don't know, maybe I should be more careful in what I do tell her, but umm
484. I'm menopausal and I cry at the drop of a hat and I've always been a bit
wear my heart on my shoulder, or my sleeve, or whatever the word is, type
of thing. Umm, and so you know if I'm feeling stressed about anything I
mean I either cry or shout you know, and she's likely to cry or shout with
me. Or tell me to leave! Ha ha. The latter's what she's more likely to do.
485. But seriously in some respects this gets things out in the open as there is
nothing worse than things being bottled up, you know. But she, herself,
tends to bottle things up more. But I think that's a generational thing, and
also its her means of control, I think, funnily enough.
486. O: Oh really?
487. J: Well, yes you know, because if she's really cross with me sometimes what
she'll do is just remove herself. She won't discuss it, she'll just remover
herself and be quiet so you just can't talk about the issue. I put it down to
control anyway. Now sometimes she is in the wrong you see and it's her
way of protecting herself because if she has to talk about it then
sometimes she might just have to say she was wrong you know.
488. O: I hadn't thought about it like that when people don't talk about things,
umm.
489. J: You see if you talk about things then you might have to admit that you are
wrong, as we all are from time to time. To me it's don't let the sun go
down on an argument, that's my philosophy you see. Now, whereas with
my Mum, she's been absolutely silent for two or three weeks you know,
and it's like just silence, and she was just totally, totally in the wrong.
490. There was no way anybody or she could persuade herself otherwise, then
in the end it was almost although I was in the wrong, as by that time I'm
just so worn down about it all you know and I sort of give in.
491. O: Now if you were to meet someone who's mother had similar ailments and
was in a similar position to you, or one of your lesbian friends found
themselves in the position of needing to provide parental care, would you
have any advice to give them?
492. J: Umm, I don't know how being a lesbian would affect the advice that I
would give ( .1) everyone's circumstances are different and, umm. You
know, caring for my mother is something I do without question but I don't
know how it might be different for lesbians compared with straight people.
493. Though I do think living on my own, I don't necessarily know the issues
that others may have, I am sure it would be different if you lived with your
parent, or if your parent was much more dependent than my mother is
currently. Umm, (.1) you know if someone said to me I'm thinking of
moving in with my mother, or my father or whatever, you know I might
say you need to think about this, negotiate ground rules of a sort for the
relationship, particularly if you haven't lived with them for a while, or if
you, or if there are unresolved issues. I suppose sharing living space
together could be difficult if you are in a relationship with someone,
particularly if they don't understand, or perhaps don't want to think about,
the sexual nature of the relationship with your girlfriend.
494. O: Umm, yes
495. J: Now my mother, as much as she's never been anti or hostile or anything
she has for all my relationships, and there's not been that many I hasten to
add, refuses point blank to call them anything else other than my friend.
496. She refuses to call them my girlfriend and I just ignore that unless I am
particularly angry and then I might use it as a weapon you know.
497. O: Why do you think she does that?
J: I think that she ultimately doesn't want to go there in her mind and think about it. She is quite happy to accept that I might be in a relationship with another woman as a surface thing but she just doesn't want to think about anything else, the implications of any sexual relationship. I think she has always thought that we were just girl friends rather than partners in a relationship. But of course this is not an area we have deep conversations about.

O: Umm, yes, so given how you think your Mum thinks about any girlfriend you might have, if you had to give advice to someone who was considering getting much more involved in parental care would there be anything you would want to say to them?

J: Ahh, let me think, umm (.5) Well I doubt it because I think that in my mind this is my choice to live the way that I do. And umm, err I don't really think that I expect her to understand it and I don't really care if she does or she doesn't you know. But by the same token out of respect I wouldn't bring anyone home if we were living together and expect to do the sort of things we would do if I was living on my own with somebody else. And so I would probably just say well if this was the choice that you make to live with your elderly parents or partners elderly parents then then I think you just have to respect that there is an age difference and that you know, if you want to go and watch lesbian movies then go and do it in your bedroom. That would be my advice for a start and maybe think about things before you get into the situation if you want to carry on like that.

O: Umm, ok

J: You see maybe this is the sort of thing my Mum foresaw you see which I didn't. When she was put in that position maybe she didn't want to have to live with me and potentially somebody else, you know, having had the experience of caring for somebody else as service jobs are seen and not heard and get to see a lot more than their employers think they do. And of course also because we do live separately she doesn't know what I do and maybe she doesn't ever want to know, and if she lived with my maybe she may be confronted with something that she didn't know. She's wrong, I don't have any peculiar sexual habits, but I suppose when you think about it as far as she's concerned I do.

O: Precisely, yes, umm

J: We might well have done each other a big favour, we don't know really, by living apart.

O: Umm, now your previous partner had an adult daughter and you mentioned that you wouldn't want to get involved with someone who had children, but would consider getting involved with someone who had similar responsibilities to your self or even greater responsibilities?

J: I wouldn't think twice about getting involved with somebody who was looking after their parents but I would think twice about somebody who had children, because by definition that generally means they would have grandchildren or they are going to have grandchildren and it just means that then I think you start to take on a secondary role because suddenly they can get called on for grandparenting duties or they become one of these grandparents who become doting about their grandchildren and that would drive me nuts you see. I couldn't cope with that, I couldn't cope because I don't have children myself and I wouldn't want children and I've never regretted it, well maybe for a fraction of a second every other year I may think about it but that's it you know. And so I really wouldn't take on that sort of responsibility, that kind role as it were you know. I really wouldn't want to be doting and going on about the children and all that kind of nonsense. But I wouldn't hesitate in having a relationship with someone who was looking after their parents.

O: Umm, that's interesting, so umm, now we're coming towards the end. So, as we've been talking has there been anything that's come to mind that you thought that you ought to say.

J: I can't think of anything right now but the thing with me is that I will
probably go home and ponder about what you've said and if there is anything that I want to add I will send you an email. Because often it doesn't come to mind immediately. I definitely will think about what we've talked about and if I think of anything else I'll email you.

O: Umm, is there anything you think you should tell me, whether it's about your mother or about you that would help me understand your story really regarding your mother and yourself?

J: Well the only thing that occurs to me and umm (.1) I don't know whether I'm peculiar in that I think that I recognised that when I was very young that my mother had umm a difficult relationship with my father and I think that I became a parent when I was very young if that makes any sense. Or at least that I took on a role, a caring role, when I was I mean really young. And then I, towards, I rebelled heavily in my later teens and early twenties and this is why I came to England 'cos basically I was an absolute bitch, and you know my mother paid for me to come and live here. It was like she couldn't get me away far enough. I think it was because, you know basically I had worried so much about her and Daddy and her in particular and it was a way of getting rid of it. But it was only really after my stepfather died that I realised how vulnerable she was you know. Umm, so (.1) I think you know maybe I'm not normal in that respect you know.

O: Umm, yes but do you think you are measuring that against what others say normality is, and we are all different.

J: Yes, oh I know, but I say that specifically because you know when you grow up in a family where you have had both your parents there and umm you haven't you know my life has been different. It has been quite different, I mean I've not been subjected to anything horrible but it has been different and so, and my Mum, and the only other thing I think I suppose is that I think my Mum's way of getting attention when she was little was possibly surrounding her health.

O: Ok

J: Sometimes, I do recognise that I am being manipulated by her.

O: Umm, right (.1) So, if you could just remind me, it's just you and your brother.

J: Yes, and my brother is still in XXXXX. Yes. There is distant family, but in London my mother has no immediate family, but the rest of them are my father's family here in London or in England. Erm, and XXX my brother has been married twice, he is on his second marriage and he has two smaller children about 10 or 12 or something but I don't take an active interest in them frankly. Umm, yes so.

O: Does he come over at all?

J: Oh God no. He nearly died when he was a little boy and I think that my Mum has never forgotten that you know. And also I might be very wrong you know but I think that women never get over giving birth to little boys, ha ha, you know when they arrive they "that wasn't supposed to happen" ha ha ha. But seriously he was slightly more spoilt than me but I think that was because he nearly died you know, so I understand. But he's never really had any responsibility when it came to Mum you know, and she's very grateful when he's nice to her, he's a bit naughty in that respect you know.

O: Umm, now he's in XXXXX so he can't really be hands on help but if he lived in the country do you think he would be any more involved?

J: Nah, not really although Mum would be really happy if he took a more active role, if he phoned more often or bothered to write or did anything she would thrilled. But he's just, he, well I say it's not intentionally, its just a bit of a, well he was spoilt when he was a little boy and now I just. Well she goes over to XXXX every year to see him, sometimes for a month sometimes for longer. Now I don't know what sort of role she plays out there. XXX doesn't really say, and then I'm not there so I don't know but XXX would paint a very different picture to me I think, well I'm not sure that I would trust what he says necessarily because I think he, his.
well you know there's this whole daughter in law thing and I think
daughters in law can be very naughty too you know. And I think my sister
in law sometimes is a bit naughty when it comes to my Mum you know,
there's a bit of something there I think . Well there's often bad feeling isn't
there between mothers and daughters in law, you know.

O: Umm, yes
J: You know it astounds me how testy they can be to their mothers in law,
you know.
O: Umm, right. Now, what I have been asking people is there anything that
you would like to ask me?
J: Umm, well now, how do you find it? I mean having an elderly father in
law living with you? Honestly
O: Honestly? Well sometimes it can be frustrating, I think you just adapt the
way you are living to suit how it is for you and it is only when you come
to reflect on it you then think hang on other people don't live like this. For
instance I do really think that he thinks that he is the responsible adult in
charge of two wayward daughters as he will ask where are you going, how
long will you be. And of course there are times when those questions are
impossible to answer if you are going out with others. It feels like he's
checking up on us and it feels like he's in parent mode to adults and
sometimes you bristle against that particularly being a parent myself as I
don't think I behave in the same way to my son. I know that if I asked the
same questions of my son he would think I had gone a little soft in the
head. But most times you just have to let things go over your head because
if you didn't it would drive you mad.

J: Do you think that your sexuality has anything to do with it?
O: The general little irritations that happen, probably not it would most likely
be the same for everyone. But I do think some things are different, like not
being able to leave say Diva magazine out for example; or having to be
careful of who you might invite round you know, particularly if they are a
bit you know loud and raucus.

J: But the reason why I asked you about sexuality specifically is that I'm sure
that my Mum expects more of me because I don't have a family. I don't
think its got anything to do with my sexuality it is because I am single. I
think if I had kids and a husband, which is her definition of a family, you
know I would either be doing a part time job or I would be in a career or I
would be looking after children. She wouldn't expect the same amount of
time of me, if she expected any amount of time from me at all. But its got
nothing to do with, that has nothing to do with sexuality, its got to do with
me being a woman and in particular me being a single woman.

O: Umm, that's interesting, but by dint of your being lesbian you are by your
mother's definition single though.

J: Umm, yes I am.
O: Umm, do think that any expectation of caring as a single woman might
change now that there are civil partnerships, do you think that counts as an
equal form of family and so change this point of view?
J: This may do in a generation or so ahead for others but not now, and not in
my situation 'cos I don't think my mother would think of them as on equal
terms. To her she would still think of me as single. But I do think that in
twenty years time or so especially when those civil partnerships include
children and then you become more of a nuclear family you know, 2.2
kids and so on, the Mum the dad and 2.2 kids type thing, ha ha.

O: Ok, so now the very last question I have is what did you think I was going
to ask you?

J: Perhaps just what you did I suppose, yes, if I thought about it at all. But
you know I wasn't sure about it all really, but when you did ask it becomes
readily to mind.

O: Umm, so if there is anything you want to add or you suddenly think well I
should have said that or I thought you would have asked about that, or I
really wanted to tell you this, please do let me know by email.
J: Oh yes, I will think on about what we've talked about and if there is anything I want to add I will be sure to email you. Most probably I will think about it tonight as I'm a bit of an insomniac and so I do do a lot of late night thinking. On second thoughts, maybe I should try to avoid the late night thinking and I would get a bit of sleep, ha ha.

O: Ha, ha, yes, that's very true. I find that if I have been doing anything remotely taxing for an hour before I go to bed then I can forget about sleeping.

J: The only way I can resolve this type of thing is to listen to the radio, but then it's become a drug the radio. I can't sleep without the radio now. Well also I live on a flight path so that is subconsciously in my head and I just thing about the planes, but I grew up by the sea so I'm used to noise but the planes are loud so I think I just need to block them out, but now I can't I just have to have the radio on. So if I was in a relationship I would be a nightmare, ha ha.

O: I don't know, it may be just something that you need to block the planes, if you lived elsewhere you might not need the radio on. OK, so I think we've about covered everything now. If you do have anything you want to add please do let me know. Thanks very much for taking part.
c. Study 2 Ethics

On behalf of the Ethics Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the submitted protocol and supporting documentation.

Date of confirmation of ethical opinion: 19 May 2009.

The final list of documents reviewed by the Committee is as follows:

<table>
<thead>
<tr>
<th>Document</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summary of the project</td>
<td>15 May 09</td>
</tr>
<tr>
<td>Detailed protocol</td>
<td>15 May 09</td>
</tr>
<tr>
<td>Information sheet for participants</td>
<td>15 May 09</td>
</tr>
<tr>
<td>Consent form</td>
<td>15 May 09</td>
</tr>
<tr>
<td>Questionnaire/Interview Schedule</td>
<td>15 May 09</td>
</tr>
<tr>
<td>Standard letter</td>
<td>15 May 09</td>
</tr>
<tr>
<td>Risk assessment</td>
<td>15 May 09</td>
</tr>
<tr>
<td>Advert</td>
<td>15 May 08</td>
</tr>
</tbody>
</table>

This opinion is given on the understanding that you will comply with the University’s Ethical Guidelines for Teaching and Research. If the project includes distribution of a survey or questionnaire to members of the University community, researchers are asked to include a statement advising that the project has been reviewed by the University’s Ethics Committee.

The Committee should be notified of any amendments to the protocol, any adverse reactions suffered by research participants, and if the study is terminated earlier than expected with reasons. Please be advised that the Ethics Committee is able to audit research to ensure that researchers are abiding by the University requirements and guidelines.

You are asked to note that a further submission to the Ethics Committee will be required in the event that the study is not completed within five years of the above date.

Please inform me when the research has been completed.

Yours sincerely,

[Signature]

Arna Cox (Miss)
Secretary, University Ethics Committee
Registry

cc: Professor T Gesombr, Chairman, Ethics Committee
Dr Peter Hegarty, Psychology
Appendix II

Materials Pertinent to Study 3

a. Study 3 Focus Group Schedule

1. Describe what you think an out lesbian lifestyle is like
   - In an ideal world how what would being out be like
   - What would you stereotypically say an out lesbian life be like

2. How do you think your current lifestyle is similar to the:
   - Ideal out lifestyle
   - The stereotypical lifestyle

3. Who do you turn to when you are in need of support?
   - Friends, family?
   - What form does that support take?

4. Currently, how involved are you with your family (of origin)?
   - Are you out to your family?
   - How often do you see your parents and other family members
   - Are you out to all of your family?

5. Looking towards the future, how do you think your life will develop as an out lesbian over time?
   - Can you describe what you think being out will be like when you are older

6. How do you think your relationships with your immediate family will develop over time?
   - Do you think you will see them more or less?
   - How involved do you think you will be as your parents age?

7. What do you hope your out lesbian life will be like in twenty years time?

8. What do hope your out lesbian life will not be like in twenty years time?

9. Is there anything else you would like to add to this discussion?
b. Example Focus Group Transcript

I: As a tantalising sort of carrot, I think did XXX mention that you get paid?

G: No. [Laughter]

I: Basically, it says on the form, on that information sheet, you get a £15 gift card

G: Great. Thank you.

I: So, you’ve read the information sheet, yeah, erm, and you’ve all signed the consent forms, I see. Is everybody happy to be recorded? I’m putting that on the recording.

G: Yeah, Yes.

I: Essentially, my research is basically, well it’s about lesbian women, and it’s about, well it cuts across the lifespan. So, my first study actually was with older women, erm, what their life is like at the moment. – when I say “older”, I’m talking about women that were, well I think the youngest was 46 and the oldest was about 70, so it was quite a wide span, and they were women who, who. They were different women who had perhaps come out at different times, but they had, similar, funnily enough, they all had similar issues with regard to their sexuality and being out as someone who is non-straight. Erm, and now, this study is now looking at younger women, essentially, so that’s where you guys come in. The main thing, the main area of research this particular research, this piece of research is looking at is about outness, about being out as a young person now, erm, because, well, for example, I mean, I’ve been…I identify as lesbian and I’ve been out for…pushing well over 20 years, and it may be (.) to me, you know, this is just part of who I am and what have you. It may be that it might be different for people coming out or being queer in 2013 than it was for me when I came out, so I don’t know what you guys are actually facing and what the issues are and what issues you might have to bring to it. So, that’s basically where I want to start, what it’s like being out now and how that, you know, how you live your daily lives, how it’s impacted with various different things. The other area of my research is how involved people are with their families of origin. Do you…do you all understand – have you all heard that term?

G: Do you mean like our biological parents?

I: Yes. Basically, family of origin is your biological family. So people do have different expectations about family involvement. So it’s how involved you are with your family of origin and how you expect to be involved and how you think your life might pan out. So what I’m looking at is what you think will happen in the future as well, how you think – I know we can’t predict the future, but what you hope your life will be like and what you hope your life won’t be like. Okay? So, basically, for my benefit, when I come to transcribe this, could I ask you all, first of all, to introduce yourself to the recording so that I can recognise your voice, because like, when I’m typing it up, I’m going to think “Who is that? Who is that?” and at least, at the beginning, if I have a little snippet of someone saying who they are, I will be able to recognise their voice later in the thing. So…

E: I’m Emily.

S: Hi, I’m Sarah.

A: Hi, I’m Angie.

L: And I’m Liz

I: Okay. Thanks for that. It will help me. I mean, at one time, I recorded an interview with a few people and didn’t actually recognise my own voice, so I won’t bother saying – so the one that’s yakking now is me! Right, to start off the focus group, what I’d like to ask you, I mean, yeah, I’ve got a list of questions. This looks really scary, but I’m basically going to put a question out and essentially just give us your ideas, try and, you know, discuss points back and forth or whatever it might be. Umm, I may not ask every one of these questions.
These are aide-memoires to me so that if you haven’t sort of like broached the topic or come round to the topic, I will throw that in. So, to kick it off, I would basically like for you to describe what you think an out lesbian life – I mean, I know some women use the term “gay”, it’s not a word I use, but what basically you think a queer life is like, an out life is like for a young person now.

A: Well, I’m gay lesbian. I really have no issues with it at all. I suppose, eh... you know, I came out very early. I was always gay. I never thought I was straight. So, I fancied a woman and I was like, yeah, I fancy her, and it was fine, and perhaps because of that, I’ve sort of had quite an easy life of it really, and being out now is just, like saying, you know, that if I’m working somewhere new, I’ll say, yeah, my girlfriend this, my girlfriend that, and I feel I have no issues, but maybe... maybe there are, in the world, but, for me, I don’t think there is.

I: Is that, I mean... is that because of where... do you think that’s where you live or how you live or...?

A: I think it’s just how I project myself. If I think – the way I feel is, if I think that it’s okay, then everyone else will think it’s okay. Em... but if I go round being all pussyfoot about it, then I think that’s when people are like “Well, what’s your problem?” I don’t know...

S: I think it definitely depends on what kind of circles that you choose to be in as well, because like at university I was really comfortable coming out, and it’s only recently that I got like a job in London, em, with like a lot of straight girls, and I can tell that they’re all really uncomfortable about it, and it’s like I can’t just chat like I normally would. So I think, I think you can choose to sort of like surround yourself with accepting people. Like the bookshop is amazing, like the bookshop is like 50% gay...

G: [Laughter]

S: Yeah. So, I just...I didn’t really know that people are still a bit uncomfortable with the whole queer thing

E: Em, I would probably say that I don’t think I wouldn’t bring it up in a work environment. It’s...it’s our business, it’s not theirs, it’s... If you happen to go out socially and it crops up, I’ll mention it, but I don’t really see that it’s...it should be connected to your work. It’s...it has no relevance to how well you can do your job or whatever.

I: That’s interesting....

L: Yeah, no, I’m the same as Angie, I think as long as you’re okay with it and you don’t make it into a big deal, I think people are very open about it. I think, when I first started coming out, it was much harder to talk about because I was a lot less...a lot more insecure about it, so my friends didn’t feel like they could talk to me about it, whereas, when I went to uni and I met new friends, then immediately I came out to them and they never knew me any different. I think it’s never a touchy subject or a weird thing to talk about, or like, you know, I talk about my girlfriend the way they talk about their boyfriends, so, it’s just no issue. Especially at university, I think, it’s been really easy. I think Surrey is a great environment. My housemates in first-year, they...you know, I was a bit worried about coming out to them at first, but once I did, I was, you know, it was a topic every night before we went out. It was always about me, you know, love life and everything. So, yeah, I think definitely at university it’s been a really positive experience.

A: I think, like from what you’re saying about straight girls, because I’m a nurse, and that is like the straightest environment, very maternal, very, very moral women that do this job, and it’s very strange to have a lesbian.

S: My other job is in fashion so it’s like really not a problem

A: Oh right, yeah! So, I can understand what you’re saying. I don’t know whether, you know, some people have a problem with me, but I think that there’s a bit of, em, like hidden homophobia, but it’s just...it’s not to my face, therefore I’m like, well....

S: Yeah.

A: But I totally understand where you’re coming from.
S: It’s never been really obvious. It’s just sort of like everyone is gossiping and I’ll say something and then there’ll be like a bit of a silence or like one of the girls will be like “So, your boyfriend…” blah, blah, blah, when I’ve been saying “partner” like the whole time I’ve been working there and so I don’t know. But I think university maybe it feels a bit like a bubble, like everyone’s super like nice and…when you get in like the real world, it’s a lot different.

L: The real world is scary

G: laughter, Yeah.

L: I’m not out in the real world yet

S: Yeah, but like if your part of a creative group, then its not going to be a problem

L: But then I suppose you’re part of a creative group… it’s what you’re saying because if you look at fashion and nursing – I work in….well, “work in”, I study Theatre Studies, and it’s all, you know, I’ll probably work, I’ll work in a theatre you know and half of the people there are gay, maybe not so much – well, actually, quite a few techies are…queer anyway, em, so yeah, it’s kind of… I think there’s more, you know, lesbian women there than there’s actually straight, so yeah, it’s different environments.

E: I think you do kind of take it for granted when you’re with a group that doesn’t think of it.

G: Yeah.

I: So, in an ideal world, what would it feel like to be out?

S: Just the same, just everyone being the same and it not being an issue, not being like a special thing that separates you from other people.

E Like, just like, everyone being equal.

A: I wouldn’t, like for me, it’s not like a massive issue, but I think when… when my colleagues talk about “Oh yeah, yeah, he’s really hot, he’s really hot” and if I said “Oh, she’s really hot”, they’d be like “We don’t want to hear it, Angie.” So it would be nice if actually you could say that and everyone would be like yeah, yeah…

[Inaudible over talking]

I: The other thing is would you say that there’s stereotypical sort of like LGBTQ type lifestyle. Would you say that there is one or would you say that, em, you know…? You know, from someone who’s from a totally straight perspective, they’ve got a particular viewpoint of what being non-straight is like, so how would you… would you say that that exists or not?

L: I think there is a certain lifestyle. I think it definitely exists, erm… I think there is definitely…mainly maybe, women who are single, I don’t know. There’s definitely that sort of easy – it’s an easy way to make friends, to go to an LGBTQ society or to go to a, you know, an LGBTQ badminton club or something. There’s definitely that sort of, erm, you know… It’s nice to stick with that community, but then again, I think it’s nice to just be normal as well and not have to (. ) go there all the time. It’s kind of what you choose as, as being out and stuff. I think there are people that do have that sort of, straight people think, you know, partying all the time and sleeping around and I don’t know. I think there are people that live like that but, I don’t know, from inside, I don’t know. I’m not like that [laughing] but…

I: Do you know women who are like that?

G: Yeah. Yeah [laughing].

E: I don’t know.

S: I wouldn’t say they’re different to any other student.
L: Yeah. That’s what I mean. Straight girls are like that. They would probably sleep around and…

E: Yeah.

S: I don’t know, but there is something different about like the lesbian world.

A: I think it’s because it’s such a small community. So it’s like you when you are with your friend’s friend and like in the straight world that would like take forever so, if ever

G: laughing

L: It’s more of a community I think, in that sense.

A: I mean, yeah, like, yeah, I don’t know… You know, I would see it as a community but I’m not really like involved in it, but when I have been involved with it, it’s become, it’s become a lifestyle. It’s become like quite, you know, there is just so much drama and, you know

S: I would say there’s different sort of rites of passage for a queer person that maybe heterosexual people don’t have to go through. Like, ecause everyone has this thing in common of like coming out and, but I don’t know if I’d call that like a lifestyle

I: Maybe I’ve picked the wrong word but do you want to expand a bit more…?

S: I don’t know. I just think… I just think that you could sort of say that gay people have this, this and this in common, but I don’t know if that makes them the same or if it just means that they… I don’t know…

G: [Laughter]

I: I think that what we’re trying to grasp at here is something that’s like what I would call, umm, you know, errm perhaps for some of the women that you know they may live what we would call perhaps this more typical or stereotypical lifestyle, can you describe that sort of life, what their life is like?

[Laughter]

L: Yeah, I suppose there are some who are like looking for gay bars to go out to. They’ll always be – I think a lesbian thing is, well, is they always hang in like groups of friends and, em, they’ll go out to gay bars or they’ll go to Pride, like they go to all the different Prides in the country and they’ll… Some of them will go to an LGBT events or something. I think that’s the kind of… If you want to put it in a box, that might be the kind of lifestyle they lead.

A: Yeah, like that, when I think of like hard-core lesbians [laughing], I’m thinking like a bit promiscuous, em, out and about to get whatever they can – this is awful, eh, yeah erm stereotypical hate men

E: That’s the kind of stereotypical, yeah seem to hate men.

G: Yeah.

A And they are living in this bubble of just, it’s just lesbians, it’s just LGBT.

S: Yeah, they don’t like hanging out with straight girls or anything

I: Do you actually know any women that are like that?

G: Yeah, yeah, like, yeah, I do.

I: I’m not asking you to name names
G: [laughing]!

A: No. Yeah, I know a few, em, but I think, generally, when I do go out to gay bars, I do find that that’s quite… I mean, less so in people my age. I’ve found, but like people that are like late-twenties a bit older than me, I’ve noticed that like they seem to be a bit like that… Or if they’ve just come out and they’re trying to sort of like find this identity and they’ve, you know, become the identity of like their peers and…

S: That’s what I mean when I said like, rites of passage and that.

A: Yeah, that…and it may be, yeah…

E: It’s usually just a phase

G: laughing

S: I think that there’s a stereotype for older women as well, that they do the complete opposite, where they don’t go out at all. They stay in with their girlfriends and they like watch TV with the cat and whatever, em, but I think there might be a little bit of truth to that

G laughing

S I don’t know, I can just… I can feel it now that I’ve got a bit older, that that sounds really like nice, not having to go out all the time, staying in with a partner and the cat. And you go out to the gay bars and you’re like “Where are all the girls?” like, they must be somewhere, where do they go, and it’s… I don’t know… they’re all at home with a partner.

A: Yeah, exactly.

L: It’s this thing of, you know, where you see everyone one the gay scene going out is always single and going to LGBT and then when you get into a relationship, people seem to disappear off the scene as soon as they get into a relationship, and I, I think, used to think why, you know, keep going out with your friends, but it seems to be kind of difficult to mingle with other lesbians once you’re in a relationship because, I don’t know, it’s just that sort of single culture I think [laughing], that sort of going out to pull and not just to have fun with your friends. But then I don’t know… that’s obviously because that’s from what I know from the LGBT side. I don’t know if that’s the same for like straight people. Once you’re in a relationship, you might not, you know… I don’t necessarily think it’s a… queer thing.

I: I think that’s something that possibly us in this little room might not actually know the answer to.

G: No! [Laughter]

I: I think that’s something that possibly us in this little room might not actually know the answer to.

G: [Laughing]
S: So yeah, I think there was a bit of like drinking and stuff, in the early days, but I think I just thought it was expected of me maybe, I don’t know.

L: I think it might be something to…getting accustomed to a new identity…

S: Yeah, it could be that, and it’s easier to meet people when you’re drinking as well.

E: I suppose when you’re younger and first out, it’s sort of finding out where your preferences are and everything

G: hmm.

A: What was the question?

I: Yeah. I mean, I’m definitely not like on the scene, but it’s really nice having gay friends. Especially coming from nursing, the straight-straight world it’s nice to go and chat about women and…and things…

G: Laughter

A: …which is quite a silly thing to do, isn’t it? But em, yeah, no, it’s nice to have gay friends, but it’s not nice for me to be part of all the drama and things because, you know, I’ve no…I’ve no need for that in my life. But em, yeah, that would be it for in terms of like how much I get into the scene and stuff.

L: I think the scene is nice to sort of be on the sideline of a little bit. I used to go out quite a lot but I don’t feel like I ever really got involved because I didn’t, didn’t really (.) when I first came to uni and I was proper out, it was just really nice to find gay friends go to bars and LGBT stuff, and just to be like, oh, you have the same sort of experience as me and you also fancied the Spice Girls, like how weird [laughing], like, you know, like which one? Oh… But then I don’t think I was ever… I liked going out, but more like watching – that sounds really wrong [laughing], but I don’t like get involved. I like to think I don’t, but then lots of people say they don’t get involved and they do. But I…no, I like the gay scene, but I like to be able to step away from it and then find it when I need it, when you need some comfort or when you just need a night out with gay people because you’ve been around straight people [laughing], yeah.

I: I’d like to expand on the comment that both you two made. You talked about joining in, sort of going out on the scene, em, because you want gay company. Is that an important…would you say that’s an important aspect?

S: I would say, yes, that is important. There’s points now where I go out to a straight bar and I get weirded out because I haven’t been into one for so long. You know, it just feels very strange to see like straight couples. So you sort of submerge yourself and you forget that they exist [laughing], but yeah, I think it’s nice to go out with gay people.

I: Why do you think…?

S: I just think they’re less like… I don’t know what… They’re not as like macho, I don’t know, they’re not as like…stupid [laughing]. They just…I know…like I don’t really know how to explain it. They just seem like, em, more educated about things.

E: Possibly partly because most of, like quite a lot of the gay people you know would be at university.

S: Yeah, but even…even my gay friends that haven’t gone to university, they don’t…I don’t know, they don’t say anything offensive, and I don’t have to spend the night like kind of like skirting around certain conversations.

A: Mm. I know what you mean. I don’t know whether it’s about “the interesting bit”

G: laughing
S: Yeah, that as a bad choice of word.

A: I think it just depends on like which…which crowd you mixing with. I know what you mean, like in general, I suppose, people who do go out are like young and… But, em, yeah, for me, like, em, I think the straight world is very, em, materialistic and things, and, you know, and when you go into a gay club, you can just go in wearing trainers, there’s no issues… Typically, everyone is pretty nice to each other, you know. You can talk about things that you have in common [laughing], like you can talk about women, which, yeah, you can’t really talk about with like straight girls.

S: That’s what I was trying to say [laughing].

L: It’s one of those things where, when you’re in straight company, they’ll…they’ll talk about it, but it will be like a fascinating thing for them, like they’ll want to know everything about it, you know, and you’re like… And with lesbians, you’re just…sharing it. Like everyone’s got their own experiences and you’re just sort of exchanging experiences, whereas when you’re with straight people, it’s usually they’re exchanging their experiences and then they “So how is that for you?” and you’ll be the centre of sort of questions and…

E: You’ll be like the mysterious creature, mm.

L: It sounds really awful. It’s not always like that but [laughing]…

I: Do you feel – this is going to be… I’m asking these questions because – to you, it might sound really, really obvious, and to me, you know, it is, but obviously, for empirical research, for the outside observer, it may not be obvious. You all seem to want to use the queer community resources, the scene, as a…you know, correct me if I’m wrong, as perhaps a release or an escape from perhaps from the heteronormative world

S: It sort of feels less alienating. Like there’s times that you can be around straight people and just sort of feel like you don’t quite belong in this group because you don’t have the same…background maybe. That’s what is my experience is.

L: Yeah, I think it depends on what kind of straight people you’re talking, because I…I don’t really have friends that go, you know, talk about boys a lot or, you know, stuff like that, so I don’t really feel any different why around my friends, em, so yeah, it sort of depends I think about what kind of… Like you say, nursing or fashion, difficult industries [to work in]…

A: I think that is a good way of putting it, that you are kind of escaping into your own world, that you understand, that you know other people are…have the same mind-set as you. I never really thought about it like that. You know, we’re just living in this world and I’m gay in it and that’s fine and…yeah, but going there probably is a bit of an escape from…normal life [laughing].

I: Straight – I wouldn’t use…I hesitate to use the word “normal” because we’re normal…

G: Yeah, yeah, I know, yeah.

I: But like I tend to use it as a straight or heteronormative lifestyle as opposed to the queer lifestyle. Okay. On the same vein, when – I mean, most people turn to their friends for support and things like that. Who would you – if you were looking, who would you guys turn to for support? Friends, family, partners…?

L: Em…family…

I: And by family, you mean your biological family?

L: Yes, my Mum and my Grandma [laughing]. My family is really supportive. I don’t know necessarily about gay issues, but I think, now that I’ve been out for a while, I would, mm.

I: And what sort of – if you were to go to your family for support, what sort of, you know, what support would you expect and how would that…what form would it take?

L: It depends on…what the problem is…[laughing]. I think definitely now that I’ve been in a relationship for a while and they’re used to it more, I could definitely turn to them if anything was, you know,
relationship [laughing] stuff, but that would just be because…because, you know, they also advise me on [uni stuff] because they know me best. So, if Angie was telling me something, like “Oh, you’re doing this wrong” or “You’re doing this”, then I could go to them and they could tell me what…what is wrong because they would probably have the same issues with me or, you know, something… And they would just treat it as any relationship – if that was my boyfriend or my girlfriend, it wouldn’t make any difference. So that sort of support I think I could definitely get.

I: Mm. Anyone else?

S: I’d probably go to my partner because she knows me best, sort of like the same sentiment that… It’s not that I’m not close to my family because I see them like all the time. We just don’t really talk about…the important stuff.

I: Are you all out to your families?

G: Yeah. Yeah.

E: No

I: That’s ok, it’s not something everyone has to do

E: I don’t really consider it their business so I haven’t. My brother has sort of paved the way with this, he’s gay. He’s been living with his partner for like 12, 5 years, and he’s never formally come out. It’s just (.) it just is, like a tacit understanding. You know, yeah, so when I am in a relationship with a woman, I sort of expected the same sort of thing to happen, because we don’t really do conversations in my family about important things.

S: I never came out. I never came out formally.

L: Yeah, I never did either.

A: I just sort of said.

S: I was just sort of like it’s just a thing that’s accepted, that they just know, and like they forward me like emails of gay stuff and it’s really cool [laughing].

A: My family don’t do that.

G: Laughter

I: Do you think it’s easier then to…? I mean, you two seem to have… Your family don’t talk about it, but there is a precedent set, so if you were to bring a female partner home one day, you’d expect that to be fine. But you two sort of said something like “We don’t talk about it”…

S: Well, it’s not that we don’t talk about it. But it’s that, like they know so…

L: They just, yeah, I think like my (.) I don’t know, I think it’s just easier to just, for them to accept things without really talking about it

A: They’re completely accepting. It’s not that we don’t talk about it, you know, like it’s absolutely completely normal. It’s just like, you know, Liz could be my boyfriend, you know, if we were living in that society. It’s just there’s just no questions and no, there was never any worries. I just came out, you know I didn’t really come out, you know. Like I was saying, I just, I just had a girlfriend, and I just said I’ve got a girlfriend, and they were like, yeah, fine. I think like, later on, they said, well, you know, we knew you were gay anyway. So it’s not really been an issue. So, I’m very, very close to my family. You know, I’ll talk to them about anything, talk to them anything about Liz or (.) yeah. That’s’, that’s the kind of way with me. Is that the same with you? Like is spoken, it’s not spoken (.) it’s spoken about, but not like “You’re gay”. Maybe in a bit of a jokey way but, but
S: We don’t really talk about it in person. It’s more online. Erm, like I’ll write like a blog or an article about being queer and then my Mum will like share it to all her friends and like it’s quite, quite sweet, in a way, but we’ve never really had like a conversation about it. But when I was growing up, they’d always be like “You can be gay, you can be straight, you can be whatever you want”.

A: So they probably sort of felt that you weren’t perhaps straight…

S: Yeah, they probably thought that but this was when I was quite young, so I don’t know if it was that obvious, but yeah, so I never really had to come out, to them at least. I have to do it to other people.

I: But you are, in a sense, out because they know

S: Yeah. They know, definitely. Like I’ve had girls sleeping over with it before and they’ve been fine with it. It’s just never been like sit down, like, Mum and Dad, I’m gay.

A: Coming out sometimes isn’t like that. No, I think everyone thinks that.

S: It’s just like in all the movies though, isn’t it?

A: Sit down – I’ve got something to tell you.

G: Yeah. Laughter

L: It doesn’t necessarily always (.) Its like Thanksgiving dinner or something, not that we have that, no, but yeah, some big event thing, yeah…

E: I don’t know, with representations of LGBT people its about people’s coming out stories, it’s all them sitting down with their parents or one of their parents and going, “Yes, I’m gay. What now? But yeah, that didn’t, that didn’t really ring true to me. That’s not my experience.

L: No. I, I, I kind of came out twice because I was 17 and I had a girlfriend and I was really (.) upset about it, and then I never spoke, and then we broke up and I never spoke about it again, so I kind of felt like they didn’t know. So then I, I just had dinner with my Mum and I said, “Oh yeah, I’ve there’s been this girl.” So, it wasn’t really “I’m gay” but like, oh yeah. And Mum was like “Has anything happened at uni”, and I was like well there’s been this girl, you know, more like that. Aand I think she was still not really expecting it, even though I did have a girlfriend already, but they still didn’t really know. But it wasn’t like a big conversation. After that, it was just fine. So yeah…

I: No big comings-out then

S: I sort of, what I did for a while was out my friends to my parents, just to see how they’d react, because like my friends were all gay anyway, so I just wanted to see what they’d do, and they were fine [with that]. I never felt like I couldn’t be out, yeah.

I: Because I think that, I think that. I’m just observing here now. From my perspective, it was a big thing. I sort of like…I really wanted to tell my parents but I didn’t. I just sort of like moved away from home.

A: Yeah, I did the same thing.

L: I sort of, moved countries.

G: laughing

A: That’s one way of doing it

I: But it’s…and it’s only when I was a little older and perhaps more settled in my sexuality, if that makes sense, that it was like, well, if you don’t like it, we’ll just have a big argument about it and you’ll get over it [laughing] – I’m not reliant on living here so…

G: Yeah.
A: It really upsets me actually when I have friends who are like “I’m not telling them, going to move away”. That really upsets me because I…the relationship I have with my parents is so nice and like, you know, I think, well, people’s parents, well, the way I see it, people’s parents, they love you and, you know, and they’re not going to be upset with you,– like how can they be upset with something that you can’t help? But like…so I…I get really annoyed with like my friends that aren’t out [laughing].

L: But I think it’s what you say, like it was… Right now, talking about it, it doesn’t seem like a big thing because it was so easily gotten over, but that sort of leading up to “I have to tell them at some point – I’m going to have to tell them” was at least two years, I think, that period, so when you think about it, it is actually quite…it is big. But then, once it’s all over, you kind of…almost forget about it because it’s so easy now, and you think why…? But it is, yeah, definitely, the leading up to it, I’d say, was a big thing.

I: Why do you think that leading up to that is a big thing?

G: Laughter

E: Probably something to do with it might change the way your parents view you, errm, but it seems to be that, well, for a lot of people, that change just doesn’t happen but that’s why it looks like a…an anti-climax, from that perspective.

L: I think, for me, it wasn’t necessarily that I was worried about if they would accept it or not because I knew that they would. I think it’s just, em, first of all, coming to terms with it a bit yourself because I think the biggest critic of it was me myself, like I had to be comfortable with it. I’m glad, in a way, that I waited a few years because then I could sort of take on anything really because I was so comfortable and I was sure and I, you know… So, I definitely wouldn’t say like “Oh, come out straightaway”, but I think you get annoyed if people don’t do it straightaway. I’d say there’s nothing wrong with [me] having that sort of lead-up to it, but then sometimes it becomes such a big thing that…

A: Yeah, I think that’s where it gets to – it gets to this massive thing of [“What are] my parents going to say?” blah, blah, blah.

G: Yeah.

A: Quite a lot of people think that [way]. I think, in this day and age… Like maybe 20 years ago, and the older generation like [?] [laughing]. I think, you know, I can sort of see the issues there, but people, you know, our parents’ age, I don’t think… But, em, I think, for me, like I said, I’ve not really had any issues, but like I did sometimes think, you know, maybe I’ve let them down, I’ve let my family down – it’s not really what they want. But I know they don’t think that, but I think that’s something…

I: You’re nodding (S) do you think that?

S: Kind of. Like I was…I have always been worried that my Mum was going to be like “Well, you’re not going to give me any grandchildren now.” That’s why I haven’t told like my grandparents or anything because I just…I don’t think that they would be as accepting as maybe my parents would because I think they want like, you know, you’re going to get married, you’re going to have kids, and that might not be the case, and maybe they really want that for me…

I: That’s interesting. [It’s a later] question but we might as well [do it now], about, em, queer women and children, and families, their own families, like creating their own families and children. Do you all want children?

G: Yeah

S: I don’t think I do. But that – yeah, there are straight women who don’t want children. But, you know, a few years’ back, it was…I mean, gay people, male and female, have always had children, but to a lesser extent than other people, but it’s… Like you said about your grandparents may think that they’re not going to have grandchildren or whatever…

Yeah.
But do you think that you’ll have children? How do you think that will fit into your life?

S: I feel like I’ve got time to decide whether I want to or not. Right now, I don’t feel like I do, but I know that down the line I could always…have children if I wanted to. I suppose that people haven’t always had that choice.

I: I know it’s…I’m not starting a family planning clinic [in here]… But I mean, had you even thought about that part of the future or…?

S: Em…yeah, I mean, like, eventually, I do want kids, but not for a long period because, you know, I want my own life and… I think that’s normal. I think that’s how straight women think now as well, that, you know, I want to have my own life before I have kids, but yeah, I do want kids. How I have kids is a slightly more complex thing and…

A: It does need planning, you know, to an extent, because it’s a few year process…but em…it’s too much to think about.

E: How do you think your families would expect it if you were to create a family [?] with say a female partner?

L: I think my family would be so excited, like my parents would be so excited.

S: I don’t know how my grandparents or my aunts and things like that…just because they haven’t…they don’t know me that well. But yeah, my parents would be thrilled [laughing].

L: Yeah, I think, in general, my parents would just love to have grandchildren, no matter now [laughing]! Even if I was a single mum, they’d probably still want me to just have kids. Em…I don’t know about my extended family, to be honest, because I’m not very close to them. They all know I’m gay and I’m assuming [they’re fine]. They’re not close enough to me to actually give their opinion in my face I think, you know what I mean, like they…so…em, I don’t really… [This sounds really terrible], but I don’t really care what they think about it – it’s my family and it will be my…my children and the way I raise them and… Obviously, I care about…I want them to approve, but I don’t think they would disapprove.

A: I think like…my Mum is always like “You need to have your own kid” – she doesn’t say it, but like I know she’s thinking it. I don’t really want to have my own kid. I’d rather it be like you or…I’d rather adopt because I just don’t want to have childbirth so [laughing]…

S: Yeah, that’s the one thing, that’s the [only thing] that puts me off.

A: Yeah. I do want kids but I just can’t, yeah, don’t want [to myself]. But that…I think my Mum would only be like “Oh…” She would still love the child [laughing], regardless of whether it was adopted or whether it was from my partner or whoever, but, I don’t know, I think she’d [want a baby of her own blood].

S: Yeah. I just don’t want to be pregnant, I don’t think.

L: I think, in a lesbian relationship, what I would worry about would be if…you don’t get to be the only mummy and, you know, you have to share that sort of mummy role. You know, I think definitely, in a straight relationship, you kind of automatically have your role as the mum or the dad, whereas I think in a lesbian relationship, you would have to…I’d be worried – I know it will work, probably. I mean, I’ve seen lesbian mums and they’re great, so, em, I think it just…it might be hard to find that sort of…divide. Or if one of you is the biological mum and one is not, I think it would be quite a challenge in a way.

A: I’m really looking forward to like, in a decade or so, seeing some sort of research because it’s so new to have…you know, like…

S: I think there is research on it

A: Is there lots of research?
I don’t know.

Be nice to see like how children would turn out

There is research on it and the kids, they’re great. It’s back to the “normal” word – they’re more normal than normal.

Laughter

Not that I like to use the “normal” word but…

It’s [hard] though, you do think about it, you do think like is it… I know lots of lesbians would get really angry with me and be like “No, it’s just as good”, but sometimes I do think… is it genuinely better for a child to have a mum and a dad or does it genuinely not matter?

I think it genuinely doesn’t matter.

Gay parents might even over-compensate and be like way better parents because they’re worried that everyone is going to criticise them.

There’s no likelihood of a child being, em, LGBTQ from gay parents, whether they’re two men or two women, than heterosexual parents, and they’re just as…the children are as well-balanced and happy and everything. There’s a body of research, done in America, psychological research by Charlotte Patterson, you can Google her. She was at, em, University of… I think it was Virginia, and she’s done loads of stuff and it… as has a few people in this country. I can’t think of the names off the top of my head, but I’ve just read a lot of Charlotte Patterson’s work. So, yeah, no, it’s… we bring up children who are happy, sociable, well-balanced, erm, and do well. So, yeah, if you’re planning to have kids with a female partner, you will be fine. So, yeah, that’s interesting because it’s a question I’ve got further down about, em, do you envisage a future like with your own children, em, but…

I definitely expect to get married, you know, but I don’t think I expect to have children. I just expect I’m going to find that one person that I’m going to be with forever and then maybe we decide to have kids, I don’t know.

So, you, generally, don’t…you’ve all got…you guys are out and you do tend to talk…to turn to your family for support then, and you turn to friends?

I’d turn to my family for financial support [laughing] and to my partner for everything else.

So, (to L) you said you’d moved to a different continent?

Oh, no, my family moved with me, em, when I finished high school.

Oh sorry, sorry, I was under the impression that your family were…

No, they came over with me. I wanted to study here. But my parents live like a block away from me, so literally just down the road, so I see them like a few times a week, go over to like walk the dog and stuff.

Yeah, I’m also quite, you know, with my parents and they’ve recently like moved to Dorset, but when we move to Manchester, I don’t feel like we’re going to be apart, you know.

My family live in Holland, so I moved over when I was 18 [on my own]. I’m still as close to them and very involved, yeah. I mean, I definitely speak to them a lot on Skype or Facebook and they would never not be a part of my life and they wouldn’t want to be. They would…be devastated if they couldn’t be a part of my life [laughing], so they definitely want to know about Angie and how things are going and…

But just generally, even if it’s not about Angie?
L: Yeah, no, generally, yeah, no, definitely very important, my family, yeah.

I: Okay. You said you didn’t talk about important things, but you actually talk about the inconsequential?

E: Yeah, yeah,

S: Yeah, like I see my family all the time. My Mum came into the bookshop and brought me lunch today. She works on campus. My Dad always forwards me emails – he doesn’t talk a lot, but we do stay in touch and I go over sometimes and see them all.

I: So you’re all quite involved, even though you, on some, you know, not necessarily on everything, but you’re all fairly well involved, and even though you’re moving, moving up to Manchester is [?].

A: It’s not going to change anything. It’s just a couple of hours’ drive or something, you know, [in comparison] to Holland [laughing].

L: [It’s only an hour flight and there is] an airport in Manchester, so [it will probably] take about as long to visit my parents.

I: Yeah, the flight is probably not that much longer.

I: And how do you communicate across distances then? You’ve mentioned Skype…?

A: Skype, yeah, Skype and Facebook.

L: Yeah, Facetime, phoning, seeing them, you know…

I: Do your folks live locally or…?

E: No, Northamptonshire and Leicestershire.

I: So it’s…you’re the only one with family…

S: Yeah, but if I go like a couple of weeks without seeing them, I still like text and email. My parents are like really into computers so they are always on Facebook and stuff. Like, yeah, if I ever need my Mum, she’s always on Facebook chat.

I: Now, we’ve sort of like looked at what’s happening in sort of like being…being an out queer person now. What about how you think – this is moving on to sort of like looking to the future a little bit. How do you think your life is going to develop as…if you, you know, as a queer person? Do you think you’re going to be…? What do you think your life will be like when you’re older? I’m not putting a fixed amount on it – you can think five years older, 10, you know. Think about your lives in the future – what do you think you’ll be doing?

S: Hopefully have a job.

I: Jobs aside! I’d like one of them as well!

L: I think, as a queer person, it’s not going to be much different. I think, em, I don’t know, in terms of relationships or growing up or settling more [in my] sexuality. I think I’m pretty… Obviously, I said this like two years ago and I’ve changed since then, [broadly], but I think…yeah…

I: One of the things that I’d say is, in the light of say like recent legislation… In my lifetime, when I was your age, there was no such thing as civil partnerships, and I didn’t ever think that I would ever be able to form a legal commitment with another woman, which I did in 2006. Now, we’re talking about…they’re talking about gay marriage. So, you know, times have changed quite significantly in my lifetime and in my out lifetime, so…and I know that we can’t predict the future, but if you think about the fact that there is legislation, and I think it’s fairly confident that, within the next few years, there will be such a thing as gay marriage.

L: Like in Holland
I: And that’s something that you – I don’t know how long [have they had it in Holland]?

L: So long. I can’t believe they’re still discussing it here [laughing]. I mean, it’s amazing!

A: It’s true. I think it’s very much something that our generation isn’t as aware of older generations and I think it’s important to be aware of, to make sure it doesn’t reverse back to that, I think. I think that’s what I always think is… it’s gone really fast, like it’s changed really quickly, but as you see in America, you know, it’s been reversed before, hasn’t it, where it’s been legalised and then not, so I think it’s definitely still that sort of, em, yeah, just always been around, I don’t know.

E: Interesting, is there much difference between the UK and Holland in perspectives of acceptance of things like gay marriage?

L: Em…yeah, I think it’s… When I was watching the debate in…about gay marriage in the House of something – I can’t remember the English Government, parliament (.) in the Government Em, I think there was things said where I just can’t imagine anyone saying that in Holland, like just…just the way they think about marriage and…and…and gay people, just still such…so stigmas and stereotypes, even in the Government, but then again, I’ve never seen a debate like that in the Dutch Government so that’s just me thinking it, but… And I haven’t…really, haven’t really lived my life as an out gay person in Holland. I’ve mainly lived…been out since I’ve moved to England really, em, and I do think that it’s a…you know… That’s why I said like why are we still…we are you still discussing it here because it’s just normal in Holland, I think, but then I’m sure there are always the exceptions. There are always people that aren’t going to accept it, depending on where you are in the country as well I think. Like Amsterdam, obviously, no one’s going to give a [laughing]…

S: But it’s like in Amsterdam and they just like held hands in [?] and no one batted an eyelid, but in Woking, like people turn their heads, like…it’s ridiculous.

L: So I do think, yeah, parts of Holland…is…with time, it’s become more…normal, so I think once it gets legalised here, hopefully…

S: I think it’s a really slow process but it’s definitely going in the right direction. It’s just…like two steps forward, one step back.

A: Yeah. That’s why I think we need to…our generation needs to be aware that it is still possible that there’s steps back might happen, whereas I think a lot of us are just like, yeah, it’s normal, like it’s, you know, it’s happened, but there’s still people that are trying to stop it, and you need to, I think, you know, [always still be kind of aware of it] and grateful. Well, “grateful”, not grateful necessarily, but to the people that have made it possible I think, that do care and…

I: So can you all see marriage of some form ahead of you?

G: Yeah.

A: To be honest, I know when…when civil partnership was legalised, you know, I was like, great, I can get married [laughing] because, you know, I thought, you know, that’s like…that’s massive, you know, civil partnership is an essential the same thing for marriage, but…so, em…

[Talking at once]

S: Mm, oh, I really want to. I’d love to get married. My partner and I have already decided that we will. It’s just she’s in a like kind of difficult situation because she’s transitioning so it’s going to be another few years before that’s like okay, but yeah, I think we just…as soon as we started dating it was like, we just knew that that was going to happen eventually.

L: So you really want to get married and not have a civil partnership?

S: Yeah, I want to have a proper like wedding, proper signing the marriage licence…
L: But don’t think that, a civil partnership, you can still have pretty much everything that you can with a marriage?

S: I just think it’s such a bullshit term though. I don’t mean to offend you [laughing].

I: No, I’m not offended. We did civil partnership because that’s what was available.

S: Yeah. I think that…that…it shouldn’t be one thing for some people and another thing for other people. Like true equality would mean that everyone was…everyone was the same. Everyone could have a civil partnership and everyone had…yeah…

A: It depends, doesn’t it? Like maybe you want a civil partnership [and] a handfasting, you know, and…But yeah, I definitely see marriage as my…as part of my life thing.

L: I think even if I did get a civil partnership, I’d probably just still say I’m married. I don’t…I don’t really see the need to get stuck on terms and that realllt

G: Yeah.

I: I do use the term “wife” for my partner. So, you all imagine some form of commitment..

G: Mm. yeah.

I: Okay. So, we’ve thought about…so you think you’ll be in – I mean, I know that it’s a long way away and there’s a lot of water that’s going to go under people’s bridges between now and then and it’s hard to work out what is going to happen, but how do you think that your relationships with your family of origin will develop over time? Do you think you’ll be more or less involved with them?

[Pause]

L: I think, personally, I think I’ll be more involved with them as I’m growing up more. I think I’ve definitely grown closer to them since I’ve been away from them, if that makes sense, em, and I think… I don’t know how…what that’s got to do with me being queer…I don’t know…

I: No, I’m not necessarily thinking it is going to be in the sense of you being queer, but do you think that that will have any impact on the way you live your life? Do you think it will have any impact at all? Because I don’t know what your family circumstances are, obviously.

A: I hope not, and I think like, in my job and things, you see like family issues quite a lot. Maybe someone’s died and they all come back and, you know, you think, God, you wasted 20 years of your life and now, you know, your mother or someone is dying, and that’s actually terrible. So I think, for me, it’s more, well, why would you want to waste time? It’s not because, yeah, of any other factors, like who I am or what I do in my life, it’s just they’re my family and they’re my core and they’ve brought me up and that’s, you know… I hope that, forever, until they die or until I die, that we are close, as we are now.

S: Yeah, I just think the same thing. Like I probably won’t see my family as often if I move to a city or something, but I don’t think we’ll ever stop talking.

I: You two are probably…and you, did you say your folks had moved away or something?

A: Yeah, moved to Dorset.

I: Not that far away.

A: No!

I: You still see…expect to be involved with them over time… So, let’s talk about perhaps when your parents get really old, what do you think will happen then? How involved do you think you will be then?

S: I honestly can’t picture that far away [laughing].
A: No, [I don’t particularly want to though].

I: I know it’s hard to…

L: I think… I know I’m far away from them, but I think I would really struggle if any of them, even my Grandma – I’m really, really close to my Grandma, and she’s quite… she’s in her seventies and she’s still going strong, like she doesn’t need any care, but I definitely want to be there if something… Even if it’s – I wouldn’t necessarily move back to Holland, but I would definitely, definitely hope that I would have more money so that I could go and visit them more often and definitely phone them more often and make sure that they’re well looked after. I’d definitely feel that responsibility, as… towards them for what they’ve given me in my life. I’d never just… put them in a home if it wasn’t necessary or…

A: I think it’s a difficult debate though because, you know, I work in environments where families, they want to shove their parents in, because they are hard work, and I understand that like it can be hard, especially if they’ve got dementia or they’re very frail and very ill and, you know… I can understand completely all the issues that… but, you know, but I think our culture as well, like Westernised culture, is put them in a home, whereas like Africans, Indians, they all like look after their families and…

S: They never sort of move out, do they?

A: Whilst we’re way more independent… But then, you know, you’re putting a strain on the National Health Service and like everything and…

S: I’ve got two siblings, so I’m hoping that one of them would [laughing]… like would want to take them in or something, but if they didn’t, because I’m the only like girl in the family, I suppose I would, if they needed care. I just don’t know if I would be… good enough… kind of…

I: Well, nobody knows that question until they actually…

S: I’d like to think that I would be able to support them.

L: It’s a very idealistic [?] because it would mean that you had to give up so much of your life, I think. I think, once it gets to that, it’s… going to be a whole different question, I think, because I don’t think anyone would put their parents in a home because they necessarily want to, but I think sometimes it’s just, you know, you have no choice.

S: It depends like how ill they are, doesn’t it?

A: If someone’s got something that needs a lot of hands-on care, [?] that’s fine.

L: Mm. But I definitely want to be close, like involved, even if they were in a home, I’d want to go and visit them.

I: And you can…

G: Yeah.

I: I mean, one of the – this is the second focus group that I’ve held. In the first focus group, somebody actually said “Oh, I’d have my parents move in with me.” How would you think that… if you were to have someone say move in with you, how would you manage an out lifestyle with an elderly parent?

S: I think I’d be settled by then and it wouldn’t matter because they would have spent however many years getting to know my partner and I don’t think it would be an issue. It might be an issue for my partner, but I don’t know [laughing].

I: Yeah. Because that’s something you would have to take on-board too.

S: Yeah.
I: You don’t think it would be an issue for…?

S: No, I don’t think so, I mean, because I’ve been with my partner for three years already and…yeah… If I’m still with her in the future, then…they don’t have a problem with her so I’d like to think it was okay. Yeah, I don’t know. I like to think I’ve got [?] in people [laughing].

I: You don’t think…would it be…?

A: I think it…well, I mean, the whole thing would put a strain on your relationship, on your life.

I: Yeah, that would happen to a heterosexual person as well, but do you think there’d be anything different about being out? That’s interesting.

S: I don’t really see there would be any problems

G: What did the first group say [laughing]?!

I: Em, they didn’t actually see it as a problem, but knowing, having interviewed women who are in that situation, it actually does present problems with being out, em, presents problems particularly if their relationships break down and they want to start new relationships with someone else and things like that. So, that’s…it’s just…you know, that’s why I’m sort of like asking those questions really. Moving on to the future, still focusing on the future, and I know that this is possibly the hardest part that we’re doing, is that…what hopes have you got for yourself in the future as…? And I’m…I mean, I’m not saying, yeah, I want a job and I want this and I want that. I’m focusing on…as being a queer woman, what hopes do you have? What do you hope your future self will look like and feel like and be doing?

L: I hope I’ll be as confident in my sexuality as I am now. I hope I’ll never feel like I have to step it down or…or…feel like I’m not normal. So I hope I’ll just be able to have a family and feel like a normal family and not feel like I’m any different from anyone else, and I hope that I’ll be able to, you know… I hope that I won’t ever have to deal with…when…I do have children, that my children will be accepted and I will be in an accepting environment and no one would even consider not accepting, you know, my children. Yeah…

[Pause]

I: Do you all agree or…?

E: I do, yeah.

S: Em, I think it’s hard to…I think I maybe just focus, when I think about my future, my hopes and stuff, like being successful in a career, but, em, I really hope that I can find somewhere or some kind of place that’s as accepting and makes me feel as comfortable as the bookshop, like, because the…what I’ve…like all the places that I’ve been, where I feel at home, are places like [G3 and Diva], which are full of gay people, and I don’t want to always have to be in a queer space to feel like, that’s where I belong. So, yeah, I just hope that either I can like make a space of my own like and feel like that are cool and have a good career.

A: Well, I don’t know really. All I want in life, yeah, you know, success, to an extent, where I’m having a good life, you know, that I can, you know, pay for my family, you know, to have things, things like that, but em…yeah, successful, just a nice, peaceful, loving life, you know, nice environment to live in. And yeah, and obviously, a nice environment is to have nice people around you that aren’t going to judge you for who you are, em, but I think that, naturally, I wouldn’t choose to have someone like that wasn’t, that was going to judge me, I wouldn’t have them in my life, you know, wouldn’t let anyone that was negative like that in my life [laughing].

E: Em…I just want to be happy, yeah, I’m easily pleased

I: Do you all think – and I know that we all have different points of view – but do you think it’s important, em, and I suppose it will depend who you’re having a relationship with, but do you think it’s important to be out?

S: Em, I think it depends where you are. There have been times where it was definitely easier not to be out, like everyday situations, and like even being like harassed in the street the other day. I had some guy asking
if I had a boyfriend, and I just said yes so he would leave me alone. You know, if I’d have said like, you know, my partner is [like this or that] or “No, I’m single,” he would have just followed me and… So, I don’t think you have to…I don’t think you have a duty to be out all the time.

E: I mean, you won’t get into your personal life with some bloke on the street so…I think that’s sort of fair enough.

L: Yeah. I think it is, yeah, to that…that example, definitely, I would just not even get into it, but in a way, I think it’s definitely important to be out, em, because of… You know, there’s people in Africa that face the death penalty and they’re out, and like why wouldn’t we be out in a country like this? I think it’s very important to prevent that, you know, where you say two steps forward, one step back, to prevent it from going back again because I think it’s important for people to know queer/out people in-person so that they know that we’re not weird and like I personally think I’m quite normal, like people don’t necessarily know I’m a lesbian, and I don’t mind them knowing. as long as I know them - like it doesn’t have to be strangers in the street. I’m not going to go and shout it to people, but when I have a conversation with people, I think it’s important that they realise that I’m just normal and then we can talk about it normally and… I think definitely…because we can, we kind of do have a duty to be out. I know that’s hard because, you know, I’m not going to say you have to be out otherwise I’ll judge you, because I’m not judging people because I know that, in individual situations, it might be harder, but I just, yeah, well, I just think about, yeah, countries where lesbians are facing a death penalty and I think we…we have a duty to them to use our rights that we have and…but yeah…but that’s just me being…idealistic [laughing].

S: I feel like, in general, that’s a good principle to have, but I’ve definitely like had colleagues that, well, I didn’t want to be out to because they’re a bit homophobic.

A: Yeah, I’d never tell patients [laughing].

L: You’ve got to, yeah, there’s…yeah…

I: I mean within reason…

S: Yeah, within reason. You don’t have to go shouting it in people’s faces.

A: Well, there is nurse that wears like a gay badge, like she’s really gay, you know, like quite dyke-y and…that’s fine, but, you know, I think she is getting judged by like patients and things.

L: I think, in a way, that sometimes has the opposite effect as well, if you’re too in-your-face gay, then people…

A: Well, then I wonder if you’ve got…like if you’re, you know, trying to be some…be part of the pack and not your own individual self…

I: That’s a bit, like the importance of being out in things like public life, what about in private life? Do you think it’s important to be able to be yourself in your own private space?

G: Yes, definitely.

I: So how would you express your outness in your own private space?

L: Definitely to close friends and family, and just being able to talk about anything and not have to hide things… Yeah, professionally, I think it’s a different story because I don’t think straight people need to go around talking about their relationships or their love life all the time, so I think that’s definitely…there’s definitely a…a balance that you can find in that, but I think, definitely, if you want to be yourself, definitely, just…surround yourself with people who are accepting, as much as you can [laughing].

A: I think it’s important, yeah, to be open in, you know, your relationship or something, you know, like to be who you are and express that and…but then, you know, we are women [laughing] and, you know, we want to talk about everything and, you know, when I talk to my straight friends, they’re like, “Oh no, my boyfriend and I don’t talk about that kind of thing” and I’m like, “Oh no, like that’s really important to me to be open about everything,” but that’s me [laughing]!
S: That’s sort of relationship that I have, I like…I don’t sort of like shut up

G: laughing. Yeah. Laughter – talking at once

I: So, you know, it’s…but it’s…it’s interesting to know how people feel about in their own personal, private environment at home, that, you know, some people, if they share that environment with others, are not necessarily out at home. So, I don’t know what living arrangements that you guys are all. Do you live…?

S: I live with my partner and a friend, and obviously I’m out to my partner and my friend as well. I went to uni with her. But we talk about gender and sexuality every day, and when we watch TV, we criticise everything. It’s just a really comfortable environment.

I: Could you envisage having a different housemate that…?

S: Em, there’s like no way that me and my partner could not be visible, em, so I think that whoever we would be living with would have to be okay with it or we wouldn’t live with them.

A: Yeah, I lived with a girl, em, about a year ago, who was gay, but she’s not like me – like I’m, you know, massively open, like we’ll sit and watch TV and be like, yeah, and she’s not…she was never like that, and, do you know what, it was really, really difficult. I had to like, you know, calm myself down a bit and not even talk about it because she was so like “Yes, I’m gay, but [I don’t want to talk about it].” But now, I’m living with two, with a couple who are gay, and, em, yeah, it’s great. We’re all really open and…yeah…

L: I think I was a bit, em…. I got two new housemates this year. One of them, I knew was also gay – she has a girlfriend, and then I live with another two housemates who have known me since first year of uni, so they’ve never known me any different. And then there was one girl who we didn’t know that well, em, but I think that’s one that…it comes in again, your own attitude towards it. I just never really gave her the opportunity not to accept it, it’s just like that’s just the way it is [laughing]! And I think if you don’t really…go into discussion with someone, or go, “Oh, what do you think about [me]?” like if you’re just like, “Oh yeah, this is my girlfriend,” then there’s not really any space for people to… I mean, it sucks if they don’t agree, but then they probably will keep their mouths shut [laughing] because you don’t really give them that opportunity to say.

S: I’m in a situation now where I’m moving to London at the end of next month and we’re purposefully going on Facebook groups like Homes for Queers and things like that, just looking for somewhere that would definitely be a nice environment. So, yeah, we wouldn’t go on like Gumtree or something and look for somewhere random. So I think that’s quite important to us.

I: Are you and your partner moving?

S: Yeah.

I: And you think it’s going to be important to be out then when you’re…when you’re as old as me?

G: Yeah.

I: I’m old enough to be all your mums!

[Laughter]

S: I think [?] and just…I don’t know if that is ever going to be in our lifetime that it’s not an issue, but I would love to…for it not to matter what your sexual orientation was. I don’t think that’s going to happen in the next like fifty years but it would be nice.

I: How do you think – when you get old yourselves, like really old, and when you need to be, you know, social care and things, how do you think that’s going to pan out?

S: Em, hopefully they would have fixed the economy and…
L:  Hopefully they’ll have queer care homes – I think that would be awesome!

A:  How cool would that be?! Just a home for really old lesbians [laughing]!

L:  I reckon it…yeah, it will be our generation that’s old by then, so hopefully…

I:  Do you know, I won’t have to worry about this – I’ll be dead.

[Laughter]

L:  Because, right now, when you think about that, you’re thinking about really old people now who would probably have maybe issues with it, but by that time, hopefully, if you go into a care home, half of the care home will be gay or…will be living there with their partner, so…hopefully it won’t be an issue.

A:  I find now, as well, it’s not spoken about, like sexual things, with older people. I don’t know [if they don’t] speak about it. Well, like old men do, but I don’t know, like… Because I…I met a lesbian, em, you know, dementia patient, and I was so intrigued, and that’s probably a bit judgemental of me because I’ve never met someone older that was gay, like old-old, and I was just like absolutely intrigued by it, and she was like talking about how she found [?] and I was like…just so interesting because I’m not used to actually anyone talking about it, never mind an older woman talking about it, you know.

I:  Actually, that sort of reinforces the point that my PhD supervisor and I talk about is that there seems to be, in the LGBTQ community, there isn’t very much a crossover of ages and generations, and it’s really important that perhaps there should be because you said you found it fascinating to talk to an older lesbian who just had different experiences and different…

A:  Because times have changed…

L:  I think that [?], my Mum came out, last year, after me, and I think [laughing], in that sense, you think…generation – like I’ve had a completely different experience of being gay than she had, [probably because] she was straight for 25 years [laughing], but I think, in that sense, yeah, different generations can definitely learn from each other, and I think, definitely, the younger generation, there’s definitely people that take it for granted that we can be the way we are and I think it’s important…like…but that’s the same with feminism [laughing]. You know, girls take it for granted that they can do what they can do, and it’s been years of fighting and then, finally, now, we’re pretty much at the stage where it’s, you know, not even thought about, that women have the same rights as men, but I think that is the same, or it’s hopefully the same, with LGBT and it will be…but then we still shouldn’t forget about other people’s experience.

I:  Okay, that’s pretty much all the questions. First of all, there’s two questions that I always ask at the end of any interview or focus group. The first question is: what did you think I was going to ask? Because you then sometimes come up with, “Oh, I thought you were going to ask that” and then we can have a whole discussion about whatever particularly interesting aspect you want to discuss

[Pause]

A:  To be honest, I hadn’t really thought about it because Kat was just like “Oh, can you just go and do this?” and I was like, “Yeah, yeah, that’s fine.” So I didn’t really…I didn’t really know what I was expecting. I knew it was some LGBT stuff

I:  I haven’t brought the T in because I don’t want trans-experiences. I think someone-

S:  [Trans] people aren’t all gay anyway.

I:  Exactly, and I think that someone who’s trans has a totally different experience to someone who is not trans, and that…and I think that that isn’t – withstanding the fact that somebody can come out and do some bloody good research with trans people and their experiences and this would work for trans people, I think that their experience is so totally different to-
S: I think it’s very difficult on how it gets put in the same box. …which is a shame, in a way, but that’s something, you know…

I: Because, ideally, we would have had an extra participant if I had included trans people, wouldn’t we?

S: Yeah, well, yeah, my partner [?]. That’s fine. I didn’t even tell her I was coming really so…

I: I haven’t excluded her for any other reason that I think that her experience in life would be totally different.

S: No, it’s true though, it is very different, very different.

I: And that’s the bit that I’ve…you know, [because people have said, “I know someone who is trans” and [?] actually – I really feel bad about excluding them, but it’s because their experiences are so totally different that, em, you know, it’s worthy for own research in its own right really.

G: Mm, definitely.

I: The other thing is, the last question I always ask is if there are any questions you want to ask me?

[Pause]

S: Has there been anything that you haven’t expected to come out of your research in these responses?

I: Em, in my first… I call it my first study, it was my first empirical study, I did with older women, and the interesting experiences that came out of that, the thing that I didn’t know – I didn’t know what was going to come out of it, it was just exploratory research because, essentially, I think that the, the premise of my research is that lesbian women’s lifespan development is different to a straight woman, and that you can’t just put like developmental – the developmental psychology side of things is this like, you know, it assumes that everybody is straight, and I think that our experiences may be different. They may be different. So it’s exploratory research to see whether or not things are different, and I think that the biggest thing that came out of the first study was the…issues of…of outness actually and the importance of being…not being mis-identified. That’s a point. Do you have any issues about being mis-identified?

S: Em, I like [?] my hair because [?] people assume that I [?]. I don’t know… It’s…like I don’t really care but… It’s more I’m in queer circles that I don’t like being thought of as like [the straight friend].

L: Yeah, I always get [it] [laughing], like I always-with a gay guy or something, I always get seen as, you know, because gay guys always hang out with straight girls, so I get seen as the straight friend, but then that doesn’t really bother me that much, as long as I know what I’m happy [laughing] and…yeah…

I: Because that was the big thing that, em, the older women had, was being mis-identified really, that people would automatically assume they were straight and, the women did have a big issue about being mis-identified and about being able to have a space that was their space, whether it was home or perhaps community scenes, social, [although most of them] didn’t [?] because as they’d got much older, it was less and less of [?]. It became…the community became much more…social networking, online thing. So that was the – and then, when I had spoken to my other focus group, which I’m still in the process of transcribing and working on, em, issues there were, again, I think it was important… It was the importance of…being out was an important bit, and they thought that life would be much better in the future, a little bit like you sort of said, that it’s…you hope for a life that is…is going to be…

S: I [don’t think] that it’s going to get worse for queer people. I just assume that everything is slowly going to get improved. I don’t know if that’s just wishful thinking. That’s just how I see things panning out.

G: Yeah.

L: It’s just a question of whether it will happen by itself or whether [we all need to]…
S: I don’t think it will happen by itself.

L: No, that’s what I mean we need to keep aware of it, yeah.

S: I’ll never ever stop, it’s exhausting really [laughing]!

I: Ok, so if no other questions, that is all. Thanks for taking part.
c. Study 3 Ethics

Orla Parslow
Psychology
18 July 2011.

Dear Orla,

Young lesbians’ future selves in relation to lived outness and family of origin involvement EC/2011/78/FA1135

On behalf of the Ethics Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the submitted protocol and supporting documentation.

Date of confirmation of ethical opinion: 18 July 2011

The list of documents reviewed and approved by the Committee is as follows:

<table>
<thead>
<tr>
<th>Document</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summary of the project</td>
</tr>
<tr>
<td>Detailed protocol</td>
</tr>
<tr>
<td>Information Sheet</td>
</tr>
<tr>
<td>Consent Form</td>
</tr>
<tr>
<td>Questionnaire/Interview schedule</td>
</tr>
<tr>
<td>Standard letters / recruitment information</td>
</tr>
<tr>
<td>Risk assessment</td>
</tr>
</tbody>
</table>

This opinion is given on the understanding that you will comply with the University’s Ethical Guidelines for Teaching and Research, and with the conditions set out as follows:

- The list of potential benefits seems to end rather abruptly, please ensure that it is complete if not so already.
- Include the possibility to withdraw at any time (including a statement of whether this affects receipt of compensation/voucher) as part of the section on how risks are addressed.
- The Cover Sheet states that the research is not funded but then states that the vouchers will be “funded by the researcher”. Please clarify.
- The Cover Sheet states that all information will be destroyed “after the study is completed”. Please note that all data must be retained for 10 years in line with University data retention policies. This should be stated on the Participant Information Sheet.

This is an interesting and important study. However the Committee was a little surprised about what seems to be a limited age sample given the importance of the life course to the study.

I would be grateful if you would confirm, in writing, your acceptance of the conditions above.

If the project includes distribution of a survey or questionnaire to members of the University community, researchers are asked to include a statement advising that the project has been reviewed by the University’s Ethics Committee.
The Committee should be notified of any amendments to the protocol, any adverse reactions suffered by research participants, and if the study is terminated earlier than expected, with reasons. Please be advised that the Ethics Committee is able to audit research to ensure that researchers are abiding by the University requirements and guidelines.

You are asked to note that a further submission to the Ethics Committee will be required in the event that the study is not completed within five years of the above date.

Please inform me when the research has been completed.

Yours sincerely

Glenn Moulton
Secretary, University Ethics Committee
Registry

cc: Professor S Williamson, Chairman, Ethics Committee
Appendix III

Materials pertinent to Study 4

a. Study 4 Ethics

Ms Crida Paskow
Psychology
FAHS

30 June 2014

Dear Ms Paskow

Hierarchies of caregiving: the interface of caregiver sexuality and eldercare
EC/2014/38/FAHS

On behalf of the Ethics Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the submitted protocol and supporting documentation.

Date of confirmation of ethical opinion: 30 June 2014.

The final list of documents reviewed by the Committee is as follows:

<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Letter from researcher in response to queries from Committee, sent 19 May 14.</td>
<td></td>
<td>4 June 14</td>
</tr>
<tr>
<td>Email from researcher in response to clarification of statement request from Committee Protocol/ Cover Sheet</td>
<td></td>
<td>9 June 14</td>
</tr>
<tr>
<td>Risk Assessment</td>
<td>Sub.</td>
<td>6 June 14</td>
</tr>
<tr>
<td>Consent Form</td>
<td>Sub.</td>
<td>6 June 14</td>
</tr>
<tr>
<td>Project Summary</td>
<td>Sub.</td>
<td>6 June 14</td>
</tr>
<tr>
<td>Detailed Protocol</td>
<td>Sub.</td>
<td>5 Apr 14</td>
</tr>
<tr>
<td>Participant Information Sheet</td>
<td>Sub.</td>
<td>5 Apr 14</td>
</tr>
<tr>
<td>Caregiving Vignette</td>
<td>Sub.</td>
<td>5 Apr 14</td>
</tr>
<tr>
<td>Questionnaire related to Caregiving Vignette</td>
<td>Sub.</td>
<td>5 Apr 14</td>
</tr>
<tr>
<td>Questionnaire related to Information on participant</td>
<td>Sub.</td>
<td>5 Apr 14</td>
</tr>
<tr>
<td>Participant Debriefing Sheet</td>
<td>Sub.</td>
<td>5 Apr 14</td>
</tr>
<tr>
<td>Public Liability Insurance Certificate</td>
<td>Sub.</td>
<td>15 July 13</td>
</tr>
<tr>
<td>Research Insurance Preforma</td>
<td>Sub.</td>
<td>15 May 14</td>
</tr>
</tbody>
</table>
This opinion is given on the understanding that you will comply with the University's Ethical Principles & Procedures for Teaching and Research.

If the project includes distribution of a survey or questionnaire to members of the University community, researchers are asked to include a statement advising that the project has been reviewed by the University's Ethics Committee.

If you wish to make any amendments to your protocol please address your request to the Secretary of the Ethics Committee and attach any revised documentation.

The Committee will need to be notified of adverse reactions suffered by research participants, and if the study is terminated earlier than expected with reasons. Please be advised that the Ethics Committee is able to audit research to ensure that researchers are abiding by the University requirements and guidelines.

You are asked to note that a further submission to the Ethics Committee will be required in the event that the study is not completed within five years of the above date.

Please inform me when the research has been completed.

Yours sincerely

[Signature]

Mrs Gill Fairbairn
Interim Research Liaison Manager, Research & Enterprise Support