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Gay-friendly elderly care: creating space for sexual diversity in residential care by challenging the hetero norm

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ABSTRACT

Studies on older lesbian, gay, bisexual and transgender (LGBT) adults in residential care point to their discrimination, invisibility and the taboo on LGBT lifestyles, and call for development of 'gay-friendly' care. Yet, the literature is short on how to create inclusive residential care for older LGBT people. We aim to acquire in-depth understanding of experiences and needs of LGBT older people concerning their inclusion and participation in care settings to contribute to development of inclusive and responsive care that structurally enhances visibility, 'voice' and wellbeing of LGBT residents. Responsive, multi-stakeholder research using interviews, participant observations and focus groups was conducted within three elderly care homes in the Netherlands. Thematic, interpretative analysis was performed. LGBT respondents reported social exclusion and the need to feel safe and at home and be yourself. Exclusive activities for LGBT people foster personal and relational empowerment. However, heterogenous activities seem crucial in dealing with stereotypical imaging, heteronormativity and an equality-as-sameness discourse that influenced culture and daily practice in the homes and negatively affected the position of LGBT older adults. For development of gay-friendly elderly care exclusionary social norms need to be addressed. Dialogical sharing of narratives can help to empower LGBT older adults and stimulate understanding and shared responsibility between LGBT and heterosexual older people, as well as professionals.

KEY WORDS – LGBT, care homes for older people, exclusion, heteronormativity, dialogue, narratives.

Introduction

Worldwide, being homosexual was long considered a religious sin and a psychological and medical abnormality, as well as illegal (Bitterman and Hess

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2016; Keuzenkamp 2011). From around the turn of the 21st century onwards, it seems that at least in Europe and North America lesbian, gay, bisexual and transgender (LGBT)[1] people are gaining entrance to mainstream society and social acceptance is increasing (Bitterman and Hess 2016). In a care context, as more and more people attain old age and an increasing number of LGBT people are open about their sexual identity a 'new' population demographic of older LGBT people is established (Bitterman and Hess 2016). Addis *et al.* (2009) report, however, that the understanding of older LGBT people's needs with regard to their health, social care and housing is low and that research on this is scarce. Although the World Health Organization removed the status of homosexuality as a mental disorder in 1990, until the end of the 1990s many care professionals still regarded it as a mental illness (Liddle 1999).

Within the Netherlands, homosexuality became legal in 1971 and equal rights were formally established in 2001 when same-sex marriage was introduced (Hekma and Duyvendak 2011). Internationally, the Netherlands attains a repuation of a place of sexual freedom and emancipation (Hekma and Duyvendak 2011). In practice though, equality and equity of people according to sexual orientation appears ambiguous as discrimination of LGBT people in Dutch society is reported to increase (Keuzenkamp 2011; Keuzenkamp, Kooiman and Van Lisdonk 2012; Kuyper 2015). In relation to health care, studies show that older LGBT people in the Netherlands postpone entering residential care as long as possible for fear of stigmatisation and marginalisation (Keuzenkamp 2011; Schuyf 1996, 2006, 2011).

In Dutch health-care debates, as in the rest of Europe and North America, diversity overall is accepted as important on the premise that present society, as well as patient and client population, are highly plural (*e.g.* Holvino and Kamp 2009). Estimates are that around 10 per cent of the residents of elderly care homes in the Netherlands are LGBT (Factsheet Movisie 2007). However, when asked about LGBT residents, management and care professionals of care homes stated not to 'have' them or not to have 'any problems with homosexuality', and increasing discrimination and exclusion turned out to be an unknown subject to them which they had not thought of before. This might fit the popular belief in Dutch society that tolerance for sexual diversity is widely spread, as well as a general public and political idea that equality of all Dutch people is reality and renders specific attention and sensitivity towards minority groups in society unnecessary (Essed and Hoving 2014; Hekma 1998; Hekma and Duyvendak 2011).

From an environmental gerontology perspective, social interaction, participation and empowerment of older people in the local context of the

care home is of central importance to their wellbeing and quality of life (Wahl and Weisman 2003). Studies following this perspective stress the need for elderly care homes to stimulate the development and enhancement of social living conditions of older people (Abbott, Fisk and Forward 2000; Barnes 2005; Baur, Abma and Widdershoven 2010; Simpson *et al.* 2015). The social and family network of older LGBT people is generally smaller than that of older heterosexual people and they often do not have children and grandchildren (Dorfman *et al.* 1995; Grossman, D'Augelli and Hershberger 2000; McFarland and Sanders 2003). As social support and network size are identified as protective factors for people's mental and physical health, aspects of social support and participation in the care homes should be taken into account when studying the wellbeing of older LGBT people in care (Fredriksen-Goldsen *et al.* 2013).

Internationally, studies report on the social invisibility of older LGBT people that negatively affects their wellbeing and makes increase of awareness and social acceptance, inclusion and participation in care homes necessary (Brotman, Ryan and Cormier 2003; McFarland and Sanders 2003; Shankle *et al.* 2003; Stein, Beckerman and Sherman 2010). LGBT people are at high risk of being discriminated against in residential care homes as they lack 'voice' due to heteronormativity and the social taboo on sexual diversity (Cornelison and Doll 2013; Deacon, Minichiello and Plummer 1995; Jackson 2006; Simpson *et al.* 2015; Walker and Ephross 1999; Walker *et al.* 1998). As they experience and fear to be rejected by health-care providers, care professionals and other residents, LGBT people can feel forced to go 'back into the closet' (Stein, Beckerman and Sherman 2010). Next to homophobia, ageist tendencies in Western societies could add to the 'invisibility' of LGBT older people (Simpson *et al.* 2015).

To enhance the position of older LGBT people, some studies emphasise the urgent need for specific, tailored interventions and attention for older LGBT people in health care as different from their heterosexual peers (Bitterman and Hess 2016; Fredriksen-Goldsen *et al.* 2013). Other scholars, however, as well as policy makers, care professionals and LGBT people themselves, think it is important to work towards overall 'gay-friendly' living arrangements and care facilities, and particularly *residential* care practices, as awareness and theoretical insight on LGBT people in retirement and long-term care is lacking (Johnson *et al.* 2005; Kochman 1997; Low *et al.* 2005; McDougall 1994; Stein, Beckerman and Sherman 2010; Walker 2005). In line with this, several studies make a plea for empirical research involving elderly care organisations and the residents, care staff and management to seek ways to address and deal with sexual diversity *in daily practice* and study how to increase participation, integration and acceptance

of older LGBT people in these contexts (Brotman, Ryan and Cormier 2003; Johnson *et al.* 2005; Simpson *et al.* 2015).

In view of the continuing 'invisibility' of older LGBT people, this paper focuses on gaining insight in experiences and needs of older LGBT people in the Netherlands with regard to their social inclusion, participation and wellbeing in residential care homes that claim to work on a gay-friendly climate. In order to be able to work towards actual development of inclusive practices and structures for older LGBT people in the care homes, heterosexual older people, care professionals and managament are also included in the study. Our long-term objective is to enhance the wellbeing, social visibility and voice of older LGBT people – and LGBT people in general – in care contexts in the Netherlands and beyond. We will explore these issues from a responsive research approach and discuss our findings from a critical-empirical perspective, closely integrating data with theory (Hankivsky 2005; Jackson and Mazzei 2013; Zanoni *et al.* 2010).

Design and methods

Research settings and research design

The study was conducted in 2012–2013 within three residential elderly care homes in two major cities in the Netherlands. All care homes work on creating a gay-friendly climate in the home via, for example, the training of professionals and activities focused on raising awareness and positive attention on LGBT older people of professionals and residents. All three homes have been awarded with the Pink Passkey Award for gay-friendly care.[2] One was the first to receive this award in 2008 and, together with one of the other two homes, is seen as a good example of sexual diversity management by national advocates. The third home has only recently (2015) acquired the award. These settings have been selected according to critical case sampling (Onwuegbuzie and Leech 2007), as we aimed to select cases of care homes that would produce critical information on sexual diversity policies and practices. Since the research settings are metropolitan and relatively open towards LGBT lifestyles, findings are context dependent. However, as this in-depth or instrinsic case study research makes use of 'thick descriptions' of the research settings and presents respondents' narratives, the findings stimulate the 'vicarious experience' of readers, enabling 'naturalistic generalisation' from the studied to other contexts and the transferability of knowledge (Abma and Stake 2001, 2014).

The applied responsive research design differs from regular qualitative research as it pays special attention to the involvement of multiple stakeholders in the research process (Abma 2006; Abma and Widdershoven

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2005; Greene 2001). It has an inclusive agenda and aims to facilitate a mutual understanding on care practices from the perspectives of different stakeholder groups, particularly involving those who are structurally less heard and have less 'voice' than those in more acknowledged power positions in the research setting (Abma 2006; Baur, Abma and Widdershoven 2010). Through valuing of and reporting on lived experiences of stakeholders, responsive research tries to enable multiple stakeholders' active contribution to practice development. In this study, preliminary insights were shared with stakeholders in order for them to immediately translate findings into practice. Also, responsive research is characterised by a cyclical process of data collection and analysis in which findings of earlier phases are input and guidance for subsequent phases (Denzin and Lincoln 2005).

Research team and advisory group

The study was conducted by a team of three professional researchers and a research partner who is an experiential expert in the field of LGBT, *i.e.* is involved in advocacy groups and education activities on LGBT rights and gay–straight alliances, and who identifies as LGBT. The professional researchers carried out the data collection and analysis and wrote the final report (Leyerzapf *et al.* 2013). The research partner critically followed these research steps and provided feedback on analysis and reports and joined all the meetings of the research team. The value of involving research partners in scientific research has been increasingly acknowledged (Abma, Nierse and Widdershoven 2009; Schipper 2012; Schipper *et al.* 2010). Experiential knowledge complements the scientific perspective of academic researchers and contributes to the quality of research in various ways (Abma and Broerse 2010; Caron-Flinterman, Broerse and Bunders 2005). It helps to assure that research is grounded in relevant needs and targeted to relevant outcomes, can enhance study design and practicability, improves data interpretation and strengthens dissemination (Abma, Nierse and Widdershoven 2009). An advisory group consisting of 11 representatives of organisations for older people in residential care, and LGBT older adults in particular, monitored the study and was asked for input and feedback throughout the study. The members were selected for their position in the field of LGBT elderly care. The advisory group contributed to the quality of the study and the development of recommendations for practice.

Selection of respondents

The objective was to include older LGBT people and older heterosexual people, as well as both LGBT and heterosexual care professionals,

management and members of the client council of the care homes. Recruitment of respondents took place mainly during participant observation but also according to the snowball method, which entails asking respondents for other possible participants, via contact people in the care homes and the newsletters of the homes. Criteria for selection of older respondents were: LGBT or heterosexual orientation; age 55 or more; and being a resident or regular visitor of the home (*see* Table 1 for an overview of the respondents and their characteristics).

Data collection

Data collection consisted of 16 semi-structured interviews, non-structured informal participant observations of diverse activities within the care homes and five focus groups (*see* Table 2 for an overview of interviews and focus groups). In two interviews two respondents were interviewed together, leading to a total of 18 interview respondents. All interviews were performed by the conducting researcher (first author), lasted between one and two hours, and took place in the homes of the respondents or a public area within the care home. An exploratory literature review and the expertise of the research team were input for a topic list for data collection and an item list for analysis. The following themes were included in the topic and item lists:

- personal background;
- experiences with and needs for daily life and participation in the care home;
- social norms in the care home;
- contact with residents and professionals;
- preferences concerning social activities;
- preferences for inclusion in decision-making processes;
- views on sexual diversity;
- personal values;
- perceived identity.

For professionals of the care homes, questions on their work values and experiences were included.

The participant observations (aproximately 100 hours), performed by the conducting researcher, focused on gaining insight into the content and form of activities for older LGBT as well as heterosexual people, the atmosphere, styles of communication and social interactions. Examples of activities visited in the three research settings were:

- chat groups and discussion groups;
- afternoons with music and sing-a-long;

TABLE 1. *Overview of respondents*

	LGBT		Heterosexual		
	Male	Female	Male	Female	Total
Older adults (55+)	10	4	6	10	30
Care professionals and management	4	2	2	13	21
Client council members	1	1	6	5	13
Total	15	7	14	28	
Overall total	22		42		64

Note: LGBT: lesbian, gay, bisexual and transgender.

TABLE 2. *Overview of interviews and focus groups per care home*

Data collection	Care home A	Care home B	Care home C	Total
(Group) interviews	6	4	6	16 (18)
Focus groups	2 (23)	2 (15)	1 (8)	5 (46)

Note. The number of participants is given in parentheses.

- movie nights;
- reminiscence groups;
- educational theatre.

Due to the 'invisibility' of older LGBT adults and the sensitivity of the research subject, participant observations proved an important and effective form of data collection as it enabled informal conversations with the target groups, establishing trust and getting a sense of social norms enacted. During the research process, the conducting researcher, and sometimes other members of the research team, frequented the three care homes (approximately once a month per home, for 12 months).

Focus groups (46 participants across five groups) were organised to validate and deepen findings. The groups lasted between one and two hours, were held in the care homes and were chaired by a member of the research team or a professional of the care home in the presence of one of the researchers. Some focus groups included only older LGBT respondents, others, called dialogue groups (Abma 2001, 2003), included in some cases LGBT and heterosexual respondents and in other cases both heterosexual and LGBT residents and professionals (Krueger and Casey 2000). These dialogue groups were relevant for reflecting on gathered insights from a multi-stakeholder perspective and developing mutual understanding (Berg and Lune 2004; Bernard 2011). The focus groups were organised according to a protocol designed by the research team on the basis of the

topic list used in the interviews and on insight gained from interviews and observations. Thematic outcomes of the interviews and observations were introduced to open the discussion.

Data analysis

On-site field notes were taken during all data collection. These were crafted into preliminary interpretative and reflective reports and in the case of participant observations into extensive reports as these were not audio recorded, directly after data collection by a member of the research team. All interviews and focus groups were digitally recorded after obtaining verbal consent and transcribed *ad verbatim*. Transcripts or short reports were returned to the respondents for validation as member check. Data collection continued until, considering available time and resources, the research team established saturation of themes in the respondents' accounts and participant observations. In qualitative research, the exact sample size of participants is dependent upon whether saturation has been reached, which is influenced by the scope and homogeneity of the population. Data analysis was performed parallel to data collection to enable the researchers to profit from emergent insights and adapt research tools such as the topic and item list accordingly.

Analysis was carried out by a thematic analysis, constituting a systematic, inductive analysis of themes and sub-themes, *i.e.* the topics and items, in relation to context (Braun and Clarke 2006; Moretti *et al.* 2011). The conducting researcher analysed all data and discussed the analysis with a senior researcher. Recurrently, the conducting researcher met with the research partner to reflect on codings and interpretations. Every few months the research team critically discussed all findings and continuation of the research process (Braun and Clarke 2006; Denzin and Lincoln 2005). All insights from collected data were critically related to theoretical insights.

Quality criteria and research ethics

Credibility of data collection and analysis was supported with joint reflection with respondents. Besides triangulation via diverse methods of data collection and analysis, critical discussion of findings within the research team and advisory committee decreased the risk of bias. Parallel analysis by members of the research team also enhanced reflexivity and credibility of the research. To minimise bias further, the conducting researcher kept a diary for critical reflection (Blaxter 1996; Mays and Pope 1996, 2000; Miles and Huberman 1994). The input of a research partner with experiential knowledge enhanced credibility and resonance of the research (Abma,

Nierse and Widdershoven 2009). The transferability of findings was fostered via thick descriptions and vicarious experiences (Abma and Stake 2001, 2014).

Other quality criteria and ethical principles were confidentiality of reported data, privacy of respondents, and transparency in handling and transport of collected data (Blaxter 1996; Mays and Pope 2000). The study was reviewed by the internal board of the conducting department. The followed procedures were in accordance with the ethical standards of the Medical Ethics Committee of the conducting organisation. All participants voluntarily took part and gave informed consent. Confidentiality was maintained using restricted, secure access to the data, destruction of audio tapes following transcription and anonymising the transcripts. Considering the sensitivity of the research topics, the researchers tried to create a safe atmosphere during data collection by stressing these principles and taking time to establish trust before addressing research themes.

Findings

The four themes of the research findings are:

1. organisation of gay-friendly care;
2. social exclusion, (in)visibility and difference;
3. safety, feeling at home and being yourself;
4. corresponding experiences between older LGBT and heterosexual people.

Theme 1: Organisation of gay-friendly care

Many heterosexual respondents, as well as some LGBT professionals, were unfamiliar with the isolated and marginalised position of LGBT older people in care. Some referred to the dominant public image in the Netherlands of being tolerant and progressive on individual freedom and sexual diversity, as appeared from the following quote from a manager:

> It shocked me actually. I didn't know about it … that [LGBT] elderly in care homes were in such a bad situation. I thought this couldn't happen in the Netherlands…[3]

Additionally, an LGBT staff member said:

> People believe we don't need it, [they say]: 'we're done' – because we have gay marriage and the Gay Pride!

A heterosexual staff member stressed the unfamiliarity of heterosexual people with and the 'otherness' of LGBT older people and sexual diversity

in general: "For many, LGBT are men and women from Mars!" This invisibility and lack of awareness was also addressed by an LGBT advocate in one of the researched care homes:

> If a care home doesn't know of LGBT elderly or says they don't have them, then that's a signal too.

Older LGBT respondents, some resident and some not, and some of the care professionals said that awareness-raising on the position of LGBT older people should be first priority in care homes. With this objective in mind, two of the care homes established specific training for care professionals, and all three homes organised activities for heterosexual and LGBT residents, visitors and care professionals to bring the topic to the attention of all. The professionals advocating sexual diversity stressed the necessity of structural integration of sexual diversity in the care homes, meaning to include it as a structural focus in organisation vision and policy and to install central contact people.

Theme 2: Social exclusion, (in)visibility and difference

LGBT respondents reported feeling forced to keep their sexual orientation a secret out of fear of social exclusion and stigmatisation by heterosexual residents or professionals of the care home. They based this on their recurrent personal and peers' experiences. An older LGBT male recounted:

> For example, they [other residents] wouldn't sit next to me at dinner or coffee in the care home.

An LGBT female resident reported that she was often met with name-calling by older people in her care home: "They call me a dyke." An older LGBT female told of her time in a revalidation clinic:

> I felt I was constantly being hasseled and that the care professionals 'forgot' about me on purpose … You know of course only women visited me … Other patients watched me … No man, no children … that, I feel, makes you really strange … People notice things and think 'what's that?!' … These things stand out!

Other LGBT respondents told of stereotypical humour stigmatising homosexual people as a group. They told, for example, of older heterosexual people or professionals telling jokes in which they equate homosexuality with promiscuous behaviour and an overly sexually explicit appearance such as LGBT men dressed in tight black leather pants or wearing a '*tanga*' (thong) at the Gay Canal Pride.

Most of the LGBT respondents recounted they have learned to hide their sexual orientation on the work floor or even from their families and social circle in the course of their life. Some try to 'mold' their sexuality in such a

way that it becomes acceptable within the range of normal, *i.e. heterosexual* lifestyles and identities. Many have been married and some have children. Some stayed only shortly married and had to conclude that marriage could not 'free them' of their homosexuality. Others remained married for their surroundings but in secret had same-sex affairs, sometimes with the knowledge of their spouse. These respondents made clear that these experiences earlier in life influenced their coping as a resident in the care home or expect it to influence this when they become dependent on care.

Some LGBT respondents, however, said they deliberately choose to be open about their sexual orientation because they refuse to obscure their true identity. An older man said that he always introduces himself as homosexual in order to make clear 'this is me, you can take it or leave it', avoid misunderstandings and 'tell where the other stands'. LGBT respondents and professionals in the homes advocating sexual diversity indicated that age differences can account for the different strategies in coming out or not. They see 'older elderly' as more likely to adopt a strategy of silence. Indeed, some LGBT respondents argued their sexual orientation is a private matter. Different from this, some 'younger elderly' referred to the 1960s, in which they struggled hard for equal rights and sexual liberation, as their motivation for being explicit on their sexual orientation.

According to LGBT and heterosexual respondents, older LGBT people stand out as different on the basis of personal features, appearance and social behaviour that is recognised as 'homosexual'. This can be the fact of not getting visits from or not having children, grandchildren or a life partner of the opposite sex. LGBT and heterosexual respondents also described that having a 'feminine' walk, dressing 'queer or effeminate' and having 'affected and poofy manners and poses' are visible markers of homosexuality and thus difference. A heterosexual male respondent from the client council also referred to the topic of visibility and its relation to acceptance and tolerance:

> People never talked about it [homosexuality] … in my community. I only first came in contact with it when I was married … A [relative] came to my wife and said that he wanted to tell her something really bad: 'My son is homosexual!' … My wife replied: 'Is that bad?' She knew it already. And I knew it too. And now he has become a very famous person, but you know … He never represented himself as a homosexual … He doesn't stand out.

Theme 3: Safety, feeling at home and being yourself

All LGBT respondents expressed the need to feel safe, accepted and at home in their care home. Furthermore, they recurrently reported the

wish to be able to 'be themselves'. They explained that by this they meant being able to do and choose what they consider valuable, as well as being socially acknowledged and respected in this. Many of them made clear that they feel this is not or is hardly possible while having to stay secretive about their LGBT identity. Therefore, these respondents declared that the LGBT activities really make a difference as they provide a safe space to meet like-minded people and share and exchange personal experiences and emotions. An older LGBT woman expressed her wish to participate in activities but related:

> I would only visit activities in the communal area if they are also for homosexual elderly, because with like-minded people you can be yourself. I don't dare to go to the current activities; I am scared that they will start asking questions or make comments about me.

Professionals at the care homes involved in LGBT activities said that some of the participants speak in these activities about being homosexual, their life story and painful memories of exclusion literally *for the first time in their life*. The LGBT respondents spoke of a sense of individual and collective strength they feel when sharing their personal experiences with others who have similar life stories, and also described collective belonging and feeling at home. Some called the social contacts they made at these meetings their extended family. An older LGBT man who frequently visited LGBT activities stated:

> Here I really learned to express myself. Before, I didn't dare to but here I can just be open and tell about the things I have been through. I couldn't do that anywhere else.

Another older LGBT man who is a regular visitor to the Pink Salon, a weekly gathering in one of the care homes, explained:

> In the last few years since I visit the Salon, I really have become more outspoken. I have become the person I really am now … that opens his mouth. This is connected with the way people communicate there; everything is said out in the open. It was a sort of coming home as well. I can … be myself there. Well that has made me more assertive and also gave me peace of mind; … This makes me feel strong.

The LGBT respondents, as well as the care professionals involved, stated that for the LGBT activities a respectful and inclusive atmosphere and manner of communication and interaction are essential in order for them to develop feelings of safety, home-like being and mutual trust. Besides this, practical and material aspects are crucial, such as the coaching and facilitation of the activities by a trained and trusted professional. In one care home, confidentiality was impeded as other residents and professionals could see who visited the LGBT activities, *i.e.* who identifies as such. Thereupon the space where the activities were held was changed from a

room adjoining the central plaza of the care home to a backroom that can be reached almost unseen by other residents or staff. In the other two homes, privacy of visitors of the LGBT activities was also an issue. Staff members trying to set up LGBT activities reported that respondents were reluctant to join them as they feared negative reactions from other residents and subsequent consequences for their social integration in the care home.

LGBT activities in two of the care homes included older heterosexual people on the condition that they were respectful towards the LGBT participants. Some LGBT respondents stated that they believe that safety can more easily and structurally be acquired in an exclusive LGBT setting. Several LGBT older adults, as well as LGBT care professionals, however, said they feel more comfortable in a mixed setting and prefer activities for LGBT and heterosexual people alike. They saw this as 'only natural' considering daily reality throughout life. These LGBT respondents described experiencing exclusive activities for LGBT as limiting because their sexual orientation is only one aspect of their sense of self and social identity. In line with this, they stressed wanting to feel at home within the care home in general and connected with fellow older people and care professionals *independent* of sexual orientation. Advocating LGBT staff members stressed that they felt that to ensure acceptance, integration and participation of LGBT older people in the care homes *for the long run*, actions and policy need to go beyond exclusive and categorical activities and somehow address the structural organisation and culture of the care home.

Some care professionals in the homes were open about their homosexual identity and this was felt to be a valuable acknowledgement by the older LGBT respondents. An older LGBT man made clear he feels welcome, supported and safe in his care home because of the visible support for LGBT people:

> The flag is hoisted. The rainbow flag is hoisted every week when we're here! Our board wanted that.

In one of the care homes, the staff member advocating sexual diversity succeeded in organising, together with the management of the home, a festive afternoon for all residents, visitors and employees of the care home to raise positive awareness of LGBT issues. All kinds of information material on sexual diversity was handed out to participants, as well as pink buttons and boas to show their commitment.

At the same time, LGBT respondents, and LGBT and heterosexual advocating staff, stated that homosexuality should not be made *too explicit*, as they feel this would contribute to the visibility of the difference and 'deviance' of older LGBT people instead of adding to it being normal. This might be reflected in the fact that only one openly LGBT resident attended the

activity described above. According to the organising LGBT staff member, several LGBT residents and visitors who are in the closet did not want to come as they did not feel comfortable with the overly explicit and collective display of 'the LGBT issue'. Linking up with this, all LGBT respondents repeatedly and urgently expressed that they are '*foremost* humans' and 'we are *people* as well'.

Theme 4: Corresponding experiences between older LGBT and heterosexual people

Older *heterosexual* respondents also reported that feeling safe and at home is essential in their daily life in the care home. To acquire this, both LGBT and heterosexual residents pointed out the importance of good interaction with and personal attention from the care professionals. A heterosexual resident said the following:

> The nurses are fairly capable here … [But] If they would just take some time to sit with me for a while … They are always so quick to go!

Both LGBT and heterosexual residents reported that it is often difficult to establish contact with fellow residents. Also, all respondents made clear that social bonding and feeling connected with fellow residents is important for feeling safe and at home in the care home. A heterosexual female resident related:

> I would like to exchange thoughts with other people very much. There are lots of activities but often I can't participate [because of my physical condition] and things like bingo [traditional Dutch game] don't interest me that much.

An older LGBT man said:

> I participate in all activities but making contact … that just won't happen!

Care professionals and older heterosexual respondents reported social segregation in the care homes, some of the latter experiencing hassling and name-calling independent from sexual identity. A heterosexual staff member stated:

> The social contact within the care home is pretty difficult for everyone … also for heterosexual elderly. Some residents form tight groups that exclude others.

Respondents also indicated aspects that influence lives of both older LGBT and heterosexual people, such as the process of ageing itself, possible loss of physical, social or cognitive qualities and abilities, losing your partner, a decreasing social network, and changes in lifestyles and gender norms in society. In all the care homes reminiscence activities were held, focusing on the exchange of life stories evolving around themes like the experience

of the Second World War and childhood in the age before the internet and social media. In some of these, heterosexual as well as LGBT residents participated.

Both LGBT and heterosexual respondents experienced a taboo on intimacy and sexuality among older people, especially within the context of care, and thus reality being ignored. An older heterosexual respondent not understanding said that 'they all' – meaning care professionals and care organisations in general – 'believe love and intimacy among older people do not exist!' Nevertheless, some heterosexual respondents did seem to support this view when it came to LGBT older people in the care home, clearly expressing limits to visible expressions of love and intimacy other than 'normal'. A heterosexual resident said:

> You don't shout it out loud, do you? Heterosexuals shouldn't do that as well. They [LGBT] should act normal towards their fellow society members. It's not interesting at all if someone is homosexual, you don't talk about such things … that's private … I don't understand why [LGBT] people don't participate in activities, it's not as if you carry a mark on your forehead is it?! You act normal don't you? You're not going to fuss with your girlfriend in public or anything.

Notwithstanding parallels between experiences and needs of LGBT and heterosexual older people, professionals advocating LGBT acceptance in the care homes worried about structural and long-term support for sexual diversity. Only in one of the care homes was the professional assigned to advocate sexual diversity an official sexual diversity manager – the first and only one in the Netherlands. In the other homes two care professionals performed their work on an informal basis, *i.e.* acknowledged by the management but *next* to their primary activities. Like other respondents, they worried about the continuance of the attention for sexual diversity within the care home in case they should leave. Their worry seemed implicitly confirmed during a focus group with heterosexual care professionals in which the topic of shared responsibility for sexual diversity was discussed. One participant related:

> In general [homosexuality] is viewed quite positively … But then of course [name of LGBT staff member advocating sexual diversity] is a terrific ambassador … Yes, he truly is an advocate and motivator in this … And that is why, frankly, with homosexual diversity we personally don't do so much … [We do not have to] because he is into that!

Discussion

This study shows that LGBT older people in a care context experience being categorised as 'different' and are socially invisible or *hyper*visible. In residential care homes they often seem to stay secretive about their LGBT identity,

partner status and try to pass as 'normal' heterosexual people – even though these homes are striving for a gay-friendly climate. When LGBT older people are, however, open about their sexual orientation, they experience the risk of being met with everyday discrimination (Essed 1991) and social exclusion. These findings correspond with Hekma and Duyvendak (2011) signalling the social resistance to the visibility of sexual diversity in the Netherlands as two men kissing in the street, men behaving in an 'unmasculine' manner or lesbian couples being too sexually explicit. Heteronormativity and homophobia cause older people who are open about their LGBT identification and/or seemingly display non-heterosexual social conduct to easily become highly and *negatively* visible (Hekma and Duyvendak 2011). From our respondents' accounts it further became clear that being stereotyped as an LGBT older person and stigmatised as a group on a structural, macro level, they are also being denied their humanity in the sense that they feel they are not seen as a *person* any more with concrete, lived experiences and personal needs.

The social invisibility and hypervisibility of LGBT people are two sides of the same coin; they spring from a dominant social heteronormativity, meaning that the accepted norm is being heterosexual and behaving as such, *i.e.* according to social imaging on how a 'normal heterosexual' acts and *is*. As long as these social norms on sexual orientation and identity are dominant, LGBT people cannot be 'normal' people but constitute 'the Other'. 'Othering practices' are processes of selective exclusion and inclusion based on a social hierarchy of assumed cultural or other forms of difference (Johnson *et al.* 2004). In this case, LGBT older people are not only seen as different but are also less valued than those representing the norm, namely heterosexual older people. This corroborates with a study by Willis *et al.* (2014) on inclusive care for LGBT adults in residential and nursing environments in Wales, UK. They conclude that

> the institutionalised assumption of heterosexuality as a normative social marker, can have a twin-fold effect in reinforcing the silence surrounding sexual diversity and increasing the invisibility of non-heterosexual residents. (Willis *et al.* 2014: 285)

Respondents from the study similarly reported fear of social exclusion since they cannot meet heterosexual milestones such as marriage and having (grand)children, as well as having to go back in the closet and the need to feel safe and valued (Willis *et al.* 2014).

LGBT activities in care homes focusing on the sharing of experiences of exclusion seem to meet older LGBT people's needs to be with like-minded people and for safe, home-like spaces. This form of enclave deliberation (Karpowitz, Raphael and Hammond 2009) appears from participants' accounts on development of personal and relational empowerment

(Rowlands 1998) and clearly supports the wellbeing and developing voice of LGBT respondents in this study. However, respondents also stated that they want to feel included in the care home as a complete person and be able to connect with heterosexual residents and professionals as well. Bearing in mind the described processes of normalisation of heterosexuality and the social and emotional 'Othering' of everyone considered non-heterosexual, a crucial question is whether a categorical approach to sexual diversity in residential care could ever support structural and long-term empowerment and inclusion of LGBT people in this context.

In the Netherlands, equal rights for LGBT people are ensured and thus collective discrimination is rare, therefore 'Othering' of Dutch LGBT older people typically occurs through more implicit and invisible, everyday discrimination. The (c)overt discriminations of LGBT respondents, like name-calling and exclusionary humour, can be interpreted as micro-aggressions, a concept coined in the context of cultural or ethnic diversity (Sue 2010). Micro-aggressions are difficult to pinpoint because majority members are largely unaware of the possible deep and painful effect on minorities since they are rooted in and normalised by a dominant tradition of heteronormativity in society (Jackson 2006; Sue 2010). Due to the institutionalised and everyday normalisation of heterosexuality (Jackson 2006), micro-aggressions against LGBT older people are difficult to resist and can be easily set aside as 'just a joke' and the person that objects to the incident as unsporting or a nag (Essed 1991; Sue 2010). The heteronormativity works both ways as older people who identify with a LGBT identity and lifestyle are perceived as different not just by others but – to a certain extent – also by themselves (Hekma and Duyvendak 2011; Jackson 2006).

Willis *et al.*, addressing heterosexuality as a privileged social status, also point to the social power dynamics at play and describe care homes as

> spaces in which heterosexual relationships, norms and milestones are routinely privileged over other sexual identities and desires. (2014: 2)

As the process of privileging occurs through normative discourses and social imaging, characterised by stereotyped, static and categorical views on LGBT people, sexual diversity and sexuality generally, Willis *et al.* (2014) are reluctant to emphasise the specific needs of LGBT as a separate category for fear of sustaining these social divisions. These insights thus suggest that for structural development of space for sexual diversity within care homes and to stimulate collective foms of empowerment of older LGBT people, heteronormativity as well as the underlying categorical thinking and oppositional gender and social norms need to be *integrally* addressed by *all* stakeholders, *i.e.* not only in homogeneous activities and policy.

These findings are further supported by a literary study by Simpson *et al.* (2015) on older care home residents and sexual/intimate citizenship. They conclude that older LGBT people face a double invisibility and – potential – exclusion due to the existence of ageist attitudes about sexuality and intimacy, combined with homophobia and heteronormativity (Simpson *et al.* 2015). They call for holistic attention to the multi-dimensionality of sexuality and intimacy and its intersections with factors such as gender ideology, assumptions on (biological) sex and generational aspects, and a collective, systemic and organisational approach instead of leaving this to individual responsibility (Simpson *et al.* 2015). They also point towards valuing differences for practice improvement, something we believe is of extra relevance in the context of the Netherlands.

With moral and legal equality and consumer-hospitality in mind, Dutch residential care organisations claim to be 'open to everyone' and consider it inappropriate to name acceptance and participation of older LGBT as a focus in their policy. The belief that everybody is equal, *i.e.* should have the same legal rights, is very strong in the Netherlands. However, in managing diversity in organisations this 'equality as sameness' discourse can hinder recognition of those perceived as different (Ghorashi 2010; Ghorashi and Sabelis 2013). Strikingly, the mentioned study by Willis *et al.* (2014) also reports that care professionals and management often equate equality with sameness and thus equal care. Johnson *et al.* (2004), discussing 'Othering practices' in Canadian health care, describe how values of equality and respect for diversity are idealised and obscure the barriers and disadvantages that exist. We agree with these authors that structural inclusion of diversity requires differences to be made visible and discussed in a positive and respectful way, without ignoring tensions and emotions that unavoidably are present as well. When *personal* differences, instead of categorical-essentialist differences, are acknowledged, equity can develop. For this, awareness of the social hierarchy and power imbalances between heterosexual and LGBT older people as well as the dominant, exclusionary norm of sameness is essential. It has to be recognised that existing practices in care homes are not neutral but reflect these dominant social norms and hierarchies. Critical discussion of the – hetero – norms and what and who is considered normal for whom, enables challenging these processes of normalisation, power relationships and social hierarchies, and ensures refraining from tunnel vision and placing all responsibility for practice development with older LGBT themselves (Ghorashi and Sabelis 2013; Johnson *et al.* 2004; Willis *et al.* 2014).

From this study, we learn that mutual exchange of personal narratives in homogeneous and heterogeneous activities are essential for creating space for sexual diversity in residential care. In order to be able to fit respondents'

needs for safety, respect, and personal and social recognition, the characteristics of a good dialogue are helpful. Abma *et al.* (2001) and Ghorashi and Sabelis (2013), from an ethical and diversity management perspective, respectively, describe how dialogue is a joint learning process that requires transposition into the perspective of the Other. Dialogue and narratives are valuable when the aim is to embrace differences (Abma 2001, 2003; Ghorashi and Sabelis 2013). 'Storytelling workshops might serve as an organizational learning intervention' (Abma 2003: 223) particularly in a setting of 'unequal power constellations' as dialogue via narratives works towards divergence instead of consensus. This helps to identify canonised stories and *counter* stories, *i.e.* the voices that are often not heard (Abma 2003).

A 'good' dialogue that supports joint learning requires listening and being open and emphatic from all participants, and a subsequent development of mutuality and engagement, *i.e.* a sense of shared responsibility (Abma 2003; Ghorashi and Sabelis 2013). Besides dialogue between LGBT older people themselves (homogeneous), dialogue between LGBT older people and professionals and between LGBT and heterosexual older people and residents (heterogeneous) could stimulate gay-friendly care practices. In dialogue between LGBT people and professionals, stories of LGBT older people could be presented to care professionals and management of care homes. Quotations from the stories could be used to invoke reflections and develop new ideas about practice improvement. When confronted with LGBT stories expressing concrete experiences, professionals might become more aware of the nature and impact of their own actions, and they may learn to see residents' perspectives. Furthermore, they might reach better self-understanding and motivation to improve working practices in the care home. Dialogical sharing of narratives in a safe climate between LGBT and heterosexual residents could help to explore and experience common ground, like shared memories and experiences of loneliness.

Dialogical exchange of personal narratives simultaneously gives room to reflect on and discuss possible tensions and contentious feelings between LGBT and heterosexual people. It can ensure that differences among LGBT older adults, and older people in general, are recognised (Willis *et al.* 2014) instead of essentialising them as one homogeneous, static group. Such a biographical approach should also include and make room for narratives on intimacy and sexuality of older people, so that the double invisibility of LGBT older people can be countered (Simpson *et al.* 2015). These narrative encounters are especially relevant when taking into account that all respondents, LGBT and heterosexual, want to be able to be themselves and (re)claim their humanity. Feelings of agency

and autonomy are closely interconnected with feelings of authenticity and thus biographical approaches can play a key role in empowerment and change (Cornelison and Doll 2013; Willis *et al.* 2014).

To move beyond essentialist arguments and categorical care in dealing with sexual diversity in residential care, we propose a focus on heterogeneous activities in care homes that make use of dialogue and the sharing of narratives to include alternative, marginalised voices of older LGBT and enhance the space to be different. However, ensuring mutual trust and safety, foremost for minority groups as LGBT residents, is a prerequisite for this. Hence, specific LGBT activities cannot be passed over. These specific LGBT activities will be especially important in contexts different from the ones studied here, where societal acceptance of LGBT identities is even less and where specific organisation policy on LGBT intergation is lacking. In care contexts in general it can be believed that a biographical approach supports a responsive and inclusive climate for residents and professionals, as well as ensuring that attention for diversity does not become a form of window dressing, management fashion or rhetorical device (Knoppers, Claringbould and Dortants 2015). Such a bottom-up, critical and integral approach of diversity is essential in working towards more gay-friendly organisations internationally (Hankivsky 2005; Zanoni *et al.* 2010).

Limitations and suggestions for future research

As it proved difficult to include LGBT respondents because of their 'invisibility', the respondents included in this research are mainly open about their sexual orientation. We side with other studies (*e.g.* Addis *et al.* 2009) in that it is important for future research to study older LGBT people who lead a 'hidden life' and the different identifications within the extensive sexual diversity spectrum (LGBT(Q)), particularly bisexual and transgender people as these are even more invisible, in order to gain better insight of the relation between social (in)visibility, identifications, social position and status. As a biographical approach seems to support improvement of the social position and wellbeing of LGBT older people in care homes that actively strive for gay-friendly care (Willis *et al.* 2014), future studies should also focus on care contexts where sexual diversity is *not* part of formal policy and study ways in which practice change can be stimulated in these settings. As the studied care homes lie within big cities in the Netherlands, one of them known as the Gay capital of Europe, it would be relevant to study the wellbeing of LGBT older people in smaller cities and non-urban areas. Further research should follow up on differences between experiences and needs of younger elderly and older elderly

against the backdrop of the period of sexual liberation in the 1960s and 1970s in Western Europe and North America and in relation to living in the closet or being 'out and proud' (Bitterman and Hess 2016). Also, it may be interesting to focus on gender differences intersecting with sexual orientation, as social imaging on and social acceptance of sexual diversity according to gender seem to differ (Hekma 1998; Herek 1988; Simpson *et al.* 2015). As research in care contexts in the United Kingdom suggests that the idea of equality as sameness plays a role in management of and space for sexual diversity outside the Netherlands as well, it could be valuable to study this topic in a comparative manner (Willis *et al.* 2014). Lastly, it could be valuable to compare the experiences of LGBT respondents and how sexual diversity issues are dealt with in care organisations with experiences of cultural/ethnic minorities and cultural diversity issues, as current public and professional debates on equality, integration, participation and 'difference' in organisations and care contexts seem to affect both.

Conclusion

Heteronormativity, categorical thinking and an equality-as-sameness discourse are key in the experience of older LGBT people in Dutch care homes of being marginalised and classified as 'different'. LGBT activities stimulating development of personal and relational empowerment and safe spaces for older LGBT people in care homes are indispensable. However, separate activities for older heterosexual people and LGBT leave exclusionary practices and dominant heteronormativity largely uncontested, may support social segregation and easily place responsibility for inclusion of older LGBT people in care settings in the hands of LGBT people alone. Therefore, activities for LGBT *and* heterosexual people, making use of narratives, are crucial for engaging all stakeholders in dialogue on exclusionary practices, critically addressing what is considered different and what 'normal', and reflecting on shared norms and values. This way, older people together with professionals can work towards more inclusive and responsive structures for LGBT older people in residential care. In the long run, this can support increased space for sexual diversity in care settings generally.

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NOTES

1 In international literature the terms 'gay', 'LGB', 'LGB(T)Q' and 'homosexual' are all used to designate older people who identify with a non-heterosexual lifestyle and identity. Within the Netherlands, the terms 'homosexuality' and 'being homosexual' are most commonly used to address these identifications. In this paper, for practicality, we use the term LGBT to signify all these possible identities, however, in the findings section and in quotations of respondents the terms homosexual and homosexuality are mostly left unchanged.

2 Parallel to the international development of gay-friendly care, in the Netherlands attention started to go out to 'pink elderly care' (Hekma and Duyvendak 2011; Keuzenkamp 2011; Kuyper, Iedema and Keuzenkamp 2013). In 2008, an initiative was started by the nation-wide advocacy network for LGBT older people to create awareness in care homes and to stimulate action, which is then positively certified by an award. The so-called Pink Passkey Award (*Roze Loper*) can be acquired by care homes when they are gay-friendly in several areas, including activities for LGBT older adults, training for professionals, and focus on sexual diversity within policy and human resource management. The colour pink now positively signifies homosexuality in the Netherlands and is an identifying marker of many advocacy groups, however, it links back to LGBT adults being forced to wear a pink triangle during their collective persecution in the Second World War.

3 Displayed respondent quotations and sentences between double quotation marks are verbatim quotations translated from Dutch by the first author. The words and sentences between single quotation marks are paraphrased parts from respondents' accounts. Overall, as much as possible words and expressions from respondents were used to describe the findings.

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