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Perceptions towards lesbian, gay and bisexual people in residential care facilities: a qualitative study

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Abstract:

Background. Internationally, increases in the numbers of older people will be reflected in larger numbers of more socioculturally diverse groups of older people requiring care provided by residential care facilities. Covert and overt instances of homophobia are evident within residential care services provided to older lesbian, gay and bisexual people.

Aims. To explore the perceptions of care staff working in residential care homes towards older lesbian, gay and bisexual people.

Design. Critical gerontology formed the methodological foundations for focus group discussions with care staff from seven residential care facilities. Hypothetical vignettes were used to stimulate discussion amongst participants.

Results. Thematic analysis of the seven focus group interviews illuminated three themes: 'Knowing me knowing you', 'Out of sight out of mind' and 'It's a generational thing'. Subtle as well as not so subtle forms of homophobia were evident in each of the themes. Care staff felt they were largely unprepared to provide care to older lesbian, gay and bisexual people.

Conclusion. This small-scale New Zealand study identifies that the residential care sector is not always supportive, or prepared, to provide a care service to those people identifying as lesbian, gay and bisexual.

Implications for practice. Findings from this study recommend the implementation of principle-based guidelines, opportunities to participate in ongoing education and partnering with non-heterosexual community organisations in order to provide culturally appropriate care to older lesbian, gay and bisexual people.

Introduction

Significant social shifts occurred in the latter part of the 20th century, emphasising the previously unrecognised human rights of women, minority ethnic groups as well as lesbian, gay, bisexual and transgendered people (LGBT). Since the early 1970s, LGBT people and their relationships have become more visible and accepted within society. However, there continues to be issues with homophobia and discrimination, which can affect the care provided to this group of this research paper.

In line with other developed countries, the number of New Zealanders aged 65 years and over continues to grow. For example, between June 1999 and 2009, numbers increased by 104 700 (23.4%), from 447 900 to 552 600 with the largest recorded growth evident in those aged 90 years and over (Statistics New Zealand, 2010). Inherent within the ageing phenomena will be an increasing number of culturally diverse groups aged 65 and over. Increases in the over 65 age group equates to an increase in the number of older lesbian, gay and bisexual (LGB) people (Neville & Henrickson, 2010).

This research paper reports the findings from a qualitative study that investigated the perceptions of care staff towards LGB people in residential care homes utilising a critical gerontological approach. The key outcome of the study was to promote greater LGBT-inclusive services including the production of a set of practice guidelines appropriate to the New Zealand setting.

Literature was accessed via the following databases: Academic OneFile, Academic Search Premier, CINAHL, Psychology and Behavioral Sciences Collection, EBSCO, Health Source Nursing/Academic Edition, MEDLINE, Scopus, Social Science Citation Index and Web of Science. Keywords used in the search included as follows: gay, homosexual, bisexual, lesbian, transgender, same-sex, elderly, older adult, older person, old age, retirement, retirement intentions, long-term care, residential care, care provision, discrimination, ageism and heterosexism. Truncation and wildcard symbols were used to retrieve all variants and/or variants of spellings of a word stem to locate peer-reviewed research, published texts, best practice guidelines and commissioned reports. Inclusion criteria were that articles were published in English and were related to sexuality, LGB people and healthcare environments published from 2006 onwards. Articles published in the popular media and conference abstracts were excluded.

In the residential care sector, Registered Nurses oversee the work of care workers. Although care workers are the group who provide the majority of care to older

people, Registered Nurses have the ultimate responsibility to ensure appropriate care is provided. In New Zealand, Registered Nurses work within prescribed codes of practice and have legal, ethical and professional responsibilities, while care workers, who form 53% of the workforce in aged care facilities, are 'unregulated' and are not covered by legislation (New Zealand Nurse Organisation, 2009). Care workers are also not required to undergo any formal training and are often given training 'on the job' (New Zealand Aged Care Association, 2010). Consequently, this may have implications for the delivery of care that is culturally appropriate, particularly if care workers are not exposed to these issues during the course of any training they may have attended (Hinchliff et al., 2004). In New Zealand, cultural safety is a regulated competency within the Registered Nurse scope of practice that insists nurses' practice according to the patient's and/or family's cultural norms and beliefs. Cultural safety extends beyond ethnicity and includes other factors such as disability, age, gender, occupation, socio-economic status, religion and sexual orientation (Nursing Council of New Zealand, 2011). It is the Registered Nurse's responsibility to ensure that those to whom nursing care tasks are delegated to must also provide care that is culturally safe.

Living in a culturally safe environment is the right of any person living in a residential care facility; however, research has shown that for LGB people, this has not been a reality. For example, Neville and Henrickson (2010), in a sample of 2269 LGB people, found that within residential care facilities, workers often display heteronormative and heterosexist attitudes and as such do not provide care that is culturally appropriate to a non-heterosexual lifestyle. This is further supported by Knochel et al. (2011) who found that some providers of aged care services demonstrated strong homophobic attitudes including avoiding dealing with issues of sexual identity for fear of upsetting private financial donors. In addition, registered nurses and other care staff do not always feel comfortable with discussing issues related to sexual behaviour or sexual identity with anyone, let alone someone identifying as LGB. Consequently, LGB people are frequently invisible and remain so.

LGB older people who are now reaching old age are from a generation who have lived through times when same-sex attraction and activities were pathologised and criminalised resulting in enforced conversion therapies, loss of family, friends and employment and even imprisonment (Dickinson et al., 2012). As a result, some may still be less open about their sexuality than younger generations resulting in self-enforced invisibility within the residential care environment. This makes it difficult for care providers to be responsive and provide services to this group. The invisibility of older LGB people is further compounded by widely held stereo-typical ageist views that older people are asexual (Dixon, 2012). All of these views result in a complex

corollary of circumstances that negatively impact on the health, well-being and care provided to this group. This is supported by Johnson et al. (2012) who claim that ignorance, societal stigma and discrimination associated with leading a non-heterosexual lifestyle have infiltrated nursing practice and as such negatively impact on the care provided to this group of people.

Recent research has begun to focus on the services provided by residential care facilities to non-heterosexual people. For example, GRAI and Curtin Health Innovation Research Institute (2010) identified a lack of awareness about the needs of non-heterosexual people with care providers frequently identifying that they treat everyone 'the same'. This only reinforces a one size fits all approach to providing care, which is contrary to the ethos of patient-centred care that underpins all nursing practice activities (Bellamy & Gott, 2013). Doing so negatively impacts on the health and well-being of non-heterosexual groups, leading to the potentiality for social isolation (Heaphy, 2009), loneliness (Hughes, 2009), as well as mental and physical health issues (Johnson et al., 2012).

Findings from GRAI and Curtin Health Innovation Research Institute (2010) research clearly identified that Australian workers within residential care facilities are often unaware of the presence of older LGB people in their care and were not interested in people's sexuality. There was typically a lack of policies and guidelines specific to this group, and an overall absence of an environment that was inclusive of these people. Ironically, the research also found that a significant number of organisational charter documents claimed that '... residents' beliefs and personal diversity were promoted within their facility's policies and procedures' (GRAI and Curtin Health Innovation Research Institute (2010), p. 4). These findings suggest that residential care facilities are not culturally safe environments for LGB people. Further inter-national work is needed especially in countries where legislation exists making it illegal to discriminate on the grounds of sexual identity.

The literature presented so far has painted a somewhat grim and sobering picture of the care provided to older LGB people. Although research has begun in this area, it remains in its infancy and more is needed to ensure the healthcare needs of this group are met in a culturally safe and appropriate manner. All older people regardless of their sexual identity experience negative age-related societal attitudes. However, non-heterosexual older people experience discrimination on dual fronts; they are marginalised due to age and sexual identity (Clarke et al., 2010).

Consequently, this study contributes to an understanding of the views of those people who provided direct care to older people living in residential care homes. Doing so will identify opportunities to develop future practice-based initiatives

aimed at challenging existing views about working with older LGB people.

Methods

Aim

This study explored the perceptions of care staff working in residential care homes towards older LGB people.

Methodology

A critical gerontological framework formed the methodological foundations for this study. Critical gerontology is not a single distinct theory but is an amalgamation of multiple theoretical perspectives including the critical, feminist and sociological (Neville, 2006, 2008). Holstein and Minkler (2007) assert that critical gerontology can be utilised to challenge and change attitudes towards groups of older people. The critical gerontological principles of illuminating insensitivity and indifference (Calasanti & Slevin, 2001; Cruikshank, 2003) towards groups of older people underpinned the methods for interrogating the data relating to older LGB people. Consequently, this study sought to expose for critique homophobic and heterosexist views and beliefs that care staff in residential care facilities had towards older LGB people.

Design

A purposive sampling technique was utilised to identify potential participants to approach for the study. Polit and Beck (2012) identify purposive sampling as approaching people who are representative of the population being studied. Consequently, care workers who worked in residential care facilities were identified as being the group to be interviewed. People were excluded from participating in the study if they did not speak English or were not employed to provide direct care to older people. To maximise diversity, research participants were recruited from various geographical locations in a large metropolitan city in New Zealand. A letter of invitation to participate in the project was sent to managers of residential care facilities. Those facilities interested in participating in the study made contact with a designated member of the research team who visited each of the seven participating residential care facilities to deliver written participant information sheets. Data were collected via a focus group in each of the seven facilities. A consent form was signed before the commencement of the interviews, which were held in residential care homes where participants worked. In addition, participants

were reminded of the confidential nature of focus group discussions, and this was reinforced on the consent form. All interviews were digitally recorded. Focus groups were used as they are a useful data collection tool for gathering sensitive information or for understanding people's beliefs and attitudes through an interactive process (Wilkinson, 2011).

Rather than using a semi-structured interview process to collect data, two vignettes were developed by members of the research team. The use of vignettes in focus groups is supported by Brondani et al. (2008) particularly when the topic is sensitive as is the case in the present research. In addition, focus group vignettes expose other participants to contrary views and can be a catalyst for change. Two hypothetical vignettes were developed and 'tested' for their credibility and appropriateness by older LGB people living in the community who formed part of an advisory group. The vignettes were deployed throughout each focus group to generate discussion amongst participants related to working with older people who do not identify as heterosexual. One vignette highlighted the story of an older gay man; the other focused on the story of an older lesbian.

Ethical approval was obtained from the relevant university ethics committee. Confidentiality of all participants was assured through the allocation of code letters, for example 'HC' to each focus group member. All data were scrutinised for any references that had the potential to identify people, places or institutions. Any identifying features were removed. The focus group data set was transcribed and checked for accuracy. The data analysis software package NVivo was utilised to manage the coding of the data. Following this process, Braun and Clarke's (2006) six-step data analytic technique for analysing qualitative data was employed. This involved repeated reading of the transcripts to determine recurring themes. A series of main themes and associated subthemes of the data were constructed that captured the main dimensions of the areas discussed in the focus groups. The research team at a dedicated workshop subsequently verified these.

Participants

A total of 47 care workers from seven residential care facilities participated in the focus groups. Participants ranged in age from 19 to 69 years with three-quarters being aged 40 years and over, and all but two were female. A diverse range of ethnicities were represented with just over one-third identifying as New Zealand European, one-quarter Maori, one-quarter Indian and the rest comprised of Pacific Island and Asian. The ethnicities reported are neither reflective of the population of New Zealand nor the nursing workforce (Nursing Council of New Zealand, 2010).

Two-thirds of

participants were employed full-time. Just over half of the care workers held a qualification relevant to the residential care sector.

Results

Thematic analysis of the focus group interviews identified three themes, which have been labelled 'Knowing me knowing you', 'Out of sight out of mind' and 'It's a generational thing'. In addition, contradictory views will be presented as a means to show the complexity associated with providing care to older LGB people.

Knowing me knowing you

Many participants in the study who have a family member, friends and/or colleagues who are non-heterosexual were more accepting of either the idea or reality of providing care to older LGB residents as evidenced in the following two excerpts. Firstly, C's younger sister identifies as lesbian:

She was a school girl when they started [having a relationship]. Initially it was hard for me and my mother.... my brother kept saying it's not your life, it's her life, and she has to deal with it. You just have to be there to support them, it's alright now (C).

Similarly, B recounts a story related to a friend of the family who was gay:

... [T]he first gay person was my sister's best friend and her husband always picked on him and was mean, it was sad and it touched my heart. They were just around the corner and we still meet up ... you just accept it [meaning their sexuality]. At the end of the day they are your friends and they are your families (B).

However, being accepting of a persons' non-heterosexuality was not the case for everybody. Even though M knew and appeared to be accepting of others who were gay or lesbian, when asked further, she admitted that if her son or daughter was gay or lesbian she would not tolerate it:

Where I'm from... mostly people wouldn't accept it. Even me if my son was gay or my daughter was lesbian I won't accept it. I'm telling you the truth. I won't accept it. Are you talking about here [meaning her workplace], it's alright here... But not my own people especially in my own family I won't accept it (M).

Another participant openly admits to not being accepting by stating:

I mean probably if I was honest if any of my kids came to me and said that they were gay or lesbian I would be horrified. Not horrified but well I don't know but I would find it

very difficult to accept because of my upbringing and my religious beliefs and so forth (HS).

While both of the above participants were adamant their own personal beliefs about homosexuality would not negatively impact on the quality of care they would provide to LGB people in the residential care environment; comments like these are homophobic. The holding of such views whether expressed or not can directly affect older LGB. While research has pointed out gay men desire above all else competent care from healthcare providers (Adams et al., 2008), other research has described how LGB people are very sensitive to picking up on homophobic attitudes from health professionals and will only respond to the extent that they feel their responses will be heard and respected (Neville & Henrickson, 2006). This could mean that older gay men and lesbians are at risk of not receiving the care they require if they consider carers hold negative attitudes even if they perceive them to be competent in other ways.

Out of sight, out of mind

Residential care settings usually prefer to avoid rather than accept and address issues related to sexual behaviour in older people (Gilmer et al., 2010). Avoidance regarding sexual identity is a form of ageism and usually begins on admission, for example:

We've got a question on sexuality on our admission forms, and they've never been completed because not discussed is usually the sort of format that people went for (Me).

The main way to integrate non-heterosexual people into the residential care environment was for workers to ensure it was hidden. Any form of same-sex expressions of affection were typically kept firmly behind closed doors, in other words 'out of sight, out of mind'. The following excerpt illustrates how an older persons' sexual identity is never considered or thought about and by keeping the door shut matters of a 'sexual nature' remain invisible and therefore do not challenge attitudes of other care staff or residents:

No because we don't actually have that situation with... well here. . or anywhere that I've worked because they're both elderly... they just go into their room and shut doors so it's no different [to anyone else] is it? They should have time together, they're a couple (A).

However, several participants felt comfortable with same-sex expressions of affection as long as they could be construed as platonic:

... [I]t is quite usual to see two women giving each other a hug and a kiss but it would more than raise a few eyebrows in an elderly situation if two men did the same thing (HS).

I think two women wouldn't even be conspicuous really. I can think of quite a few people who have friends come to visit, close friends, women friends, and they might sit with their arm around each other. They might give each other a hug and a kiss (M).

Avoiding issues related to sexual identity and sexual behaviour reinforces a heteronormative and ageist view of the world. This avoidance only seeks to reinforce the validity of heterosexuality as the only valid sexual identity.

It's a generational thing

When asked about why older people identifying as gay or lesbian were invisible within care environments, as well as why this group are further marginalised by other residents, a clear response was 'it's a generational thing'. The current older generation grew up in a time when homosexuality was not only illegal but also classified as a mental illness. In addition, a level of conservatism and as a result homophobia is evident in this group. Homophobia can manifest as in the following account:

Well when this gentleman first came in, somehow one resident got to know that he had a partner and he was homosexual. He was overheard telling another resident that 'we have got a poofter over there'. He said this in a loud voice and pointed him out . . . he tried to kind of make a big thing of it, and turned people against this man for his sexual orientation (B).

A need to be accepted, especially when having to live in close proximity to others and when reliant on others to provide care may force some to not disclose their sexual identity for fear of reprisal. This is supported by Barrett (2008) who identifies that older non-heterosexual adults may hide their sexual identity as they are fearful of being discriminated against:

The man who lived here was, he came here for palliative care, his partner of thirty years who was married in a heterosexual relation- ship, but they had been partners sexually for thirty years. When he was dying he asked me one day would I take him out to do a message and that was to go and visit the grave of his partner, and it was sad really. Yeah and I went with him and he talked about how the partner and he had decided that because of their generation they could never tell. So his partner lived in that marriage and they never ever told anyone (S).

However, contradictory accounts are evident in these data. For example, even though instances of homophobia are clearly present towards older people, there are also situations where openly gay care staff and board members are accepted by older people. For example, the following two excerpts identify how residents living in care homes accept some LGB people:

Maybe it's the fact that we've also got a board member who's homosexual. The residents see him as just a normal ordinary guy, you know? He comes in with his partner and nobody thinks anything (K).

We have had a gay nurse and they [the residents] loved him (M).

A possible explanation to the above contradictory comments could be that all older people living in residential care are vulnerable and discriminated against based on age (Petersen & Warburton, 2012). This might mean that some older people may feel obligated to appear accepting of all staff no matter what other views of them they may have, as not doing so could be perceived as negatively impacting on their future care and treatment.

Explanations by care staff as to why residents in care were homophobic towards those who were non-heterosexual were offered, for example:

... they're less enlightened, and older people might not sometimes ... they're stuck in their ways ... The older generation are definitely quite biased on not only about sexuality but about all sorts of things. It's a generational thing, you know (A).

Well a lot of them haven't been brought up [being exposed to gay people], I mean a lot of these residents haven't had a lot to do with gay, bisexual, lesbian couples. They've got that sort of attitude, they're not going to change their minds at that age anyway (C).

An initial read of the excerpts above could be interpreted as merely explaining reasons for homophobic behaviour. By interrogating the texts further, an alternative reading of the excerpts could suggest that care staff are excusing older residents' attitudes towards those who are non-heterosexual, and as such are supporting the continuation of a care environment that is both homophobic and heteronormative. In addition, to suggest these as valid reasons and excuses is also patronising and suggest the existence of an ageist environment where the perceptions of care staff about older people are that they are biased and 'stuck in their ways'.

Finally, clearly evident within these data and the resulting themes were statements from care staff identifying a lack of knowledge in relation to working with people

who do not identify as heterosexual as evidenced in the following excerpt:

See that's something we should have a bit more education on 'cos we perhaps aren't aware of those inside cultures. I mean we're aware of a lot of different cultural things but when it comes to homosexuality as a different culture, I'd be floundering with that one (B).

Discussion

This study sought to explore the perceptions of care staff working in residential care homes towards LGB people. The findings from this research suggest that providing culturally appropriate care to older LGB people is complex. The utilisation of a critical gerontological approach has made visible some of these complexities, as well as providing a lens to challenge the attitudes of care staff towards LGB people. The findings clearly identify that older non-heterosexual people are a heterogeneous group who are vulnerable to being discriminated against by both care staff and other residents alike.

The transition from adult to older adult is frequently associated with being subjected to ageist societal attitudes and actions (Lyons et al., 2012). Ageist environments are where older people are discriminated against based on age. For example, 'On the one hand older persons are perceived as asexual; on the other hand, older gay men are perceived as sexual perverts and predators' (Ramello, 2013, p. 121). Discrimination can take the guise of many forms, including overt, subtle, intentional or unintentional discrimination. Such discrimination can exist regardless of organisational charters stating otherwise and results in feelings of isolation, invisibility and a desire to conceal their sexual identity (Jewell et al., 2011).

Findings from this study identify that questions related to a person's sexuality do exist on current assessment forms and should be asked by residential care staff as part of the assessment process. However, these sections typically remain uncompleted and don't include specific questions that allow an older adult to talk about all aspects of their sexuality, including how they would like to be identified as well as providing information about their sexual behaviours. In addition, care staff report they do not have enough knowledge about non-heterosexual lifestyles. These findings may explain why the sector struggles with issues related to sexuality in general, but more specifically with older LGB people even though organisational charters promise an environment that will meet the needs of all older people. The reasons health professionals avoid addressing issues related to sexuality in older people are often directly related to their own levels of comfort and attitudes towards the topic (Bauer et al., 2007). Consequently, care staff's unease with non-heterosexual groups promulgates and supports both overt and covert homophobic practices, as well as a care environment that is not deemed culturally appropriate or safe.

The sociocultural diversity of both care staff and LGB consumers of residential care services highlighted in this research means it is difficult to develop a comprehensive all encompassing set of guidelines to assist the residential care sector in providing culturally appropriate care to the range of older non-heterosexual groups.

Internationally, guidelines are beginning to be developed, for example in Australia, the publication of best practice guidelines for accommodating older gay, lesbian, bisexual, transgender and intersex people aimed at providers of retirement and residential aged care services (GRAI and Curtin Health Innovation Research Institute, 2010). However, no such resources are available that are specific to the New Zealand sociocultural context. Consequently, the availability of, and access, to targeted staff development relating to providing a care service to older non- heterosexual groups remains limited in New Zealand.

As a result of this study, a set of principle-based practice guidelines ('Caring for Lesbian, Gay and Bisexual (LGB) Residents in Aged Residential Care: Guidelines for staff') have been developed based on the findings of this study. A community advisory group comprised of representatives from key non-heterosexual community organisations have assessed the content, design and potential usability of these guidelines. Following this process, the guidelines were then reviewed and approved by the facilities that took part in the study. The guidelines are available to all health professionals and healthcare providers, including residential care facilities as an A4-sized brochure allowing for the contents to be easily accessed. In addition, we ensured the language utilised in the guideline was accessible to all care staff from Registered Nurses through to untrained caregivers, many of whom English is a second language. Nursing education and health- care organisations should also use the guidelines produced from this research as a foundation for staff/student and practice development opportunities to ensure health professionals have the knowledge to provide care that is culturally safe. However, the integration of theory into practice is paramount and health professionals '... should have to demonstrate they understand LGB specific issues, when, for example undertaking assessments ...' (Neville & Henrickson, 2010, p. 592).

As with any research project, there are always limitations and this study is no exception. Firstly, the focus of the vignettes related to older people identifying as either gay or lesbian and as such did not necessarily allow for participants to discuss and explore issues related to bisexual, transgender and intersex people. This is certainly not only a limitation of the present study, but should be central to the focus of future research. However, this study was the first of its kind in New Zealand to explore the views of care workers.

Another limitation is that the views of older LGB people were not sought, and again this should be the focus of future research particularly to see whether the implementation of the practice guidelines have positively impacted on the provision of care. The challenge in seeking this groups views in future research is in ensuring the various subgroups are appropriately represented. Neville and Henrickson (2009,

2010) identify there is a tendency for researchers to use convenience, viral and snowball sampling strategies as recruitment methods, resulting in participants who are well connected within non-heterosexual communities, and who are more likely to have fully integrated their sexual identities into their lives. Consequently, the views of those people who are not comfortable with their sexual identity and 'remain in the closet' are not represented.

As identified above, the limitations provide a platform for future research. Firstly, further research is needed that is inclusive of all sexual and gender minority groups. In addition, the guidelines developed and distributed are a positive outcome of this study and also serve as the foundation for future research projects. In addition, a further study is underway that involves utilising action research and evaluation methodologies to work with interested aged care facilities to further refine and to ensure the principles inherent in the best practice guidelines continue to be appropriate but most importantly ensure those LGB people are provided with a healthcare service that is culturally safe.

Conclusion

The predicted increase in older people entering residential care homes will also mean more LGB people will be seeking supported living arrangements. This study clearly identifies that the residential care sector requires further preparatory work if they are serious about meeting legal and ethical obligations of providing a service that is culturally safe and appropriate for non-heterosexual groups. The adoption, utilisation and implementation of principle-based guidelines need to occur, accompanied by staff education and partnering with non-heterosexual community organisations. Nursing influences care provision in residential care homes, and as such should be instrumental in ensuring care facilities are places where older LGB people can feel comfortable living in.

Implications for practice

- Residential care homes need to ensure their organisational charters are reflective of the care services offered to non-heterosexual people.
- The adoption and implementation of principle-based guidelines.
- The commitment to providing staff and other residents with educational opportunities to address homophobia and the discrimination of older people.
- Overtly display contact details of non-heterosexual organisations within the residential care home and develop partnerships with those organisations.

Contributions

Study design: SN, JA, GB, MB, NG; data collection and analysis: SN, JA, GB, MB, NG and manuscript preparation: SN, JA, GB, MB, NG.

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