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Policy Brief

Queering Aging

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Corinne Reczak, Ph.D., is an Associate Professor for the Department of Sociology and Department of Women's, Gender, and Sexuality Studies at The Ohio State University. Professor Reczek's research is situated in the fields of family, gender, and health. Her research focuses on articulating how gender, sexuality, and aging processes in family ties promote or deter health. A first strand of research explores how union status matters for health and health behavior for men and women in same-sex and different-sex unions. A second strand of research examines the parent-child tie, with a focus on the consequences of parent-child relantionships for the well-being of both generations across the life course. A third strand of research explores how same-sex family structures shape child well-being. Professor Reczak uses qualitative in-depth interview methods to ascertain processes, mechanisms, and meaning-making, and survey methods to ascertain large-scale population trends.

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Introduction

In this brief, I outline a "queer" theoretical approach to aging research and present qualitative empirical data to exemplify this approach. My aim is to encourage scholars to blend the bourgeoning work of sexuality studies with the long-standing innovation and rigor of aging studies. Below, I make the explicit case for the "queering" of aging research by way of bringing in gender and sexual minorities (e.g., lesbian, gay, bisexual transgender, queer, or LGBTQ, individuals) into conversations regarding aging and the life course. I use the term "queering" here to show how aging studies can be turned on its head by including LGBTQ populations and perspectives, as doing so provides new vantage points towards understanding the way in which we age across the life course. I note that while an equally important task of merging these two fields would be to draw on the aging literature to inform sexuality research, the focus of the current project is to demonstrate how sexuality studies informs aging in order to bring in an influx of new frameworks for thinking about aging and the life course.

My main starting place for "queering" aging studies is calling attention to the fact that most aging research is heteronormative: the supposition that everyone is or should be heterosexual or straight. As pointed out by Brown (2009) in her review piece on sexuality and aging, this assumption is made frequently—often inadvertently—when scholars use national survey data, experiments, or qualitative data that do not parse individuals by sexual identity. In doing so, scholars assume that everyone in our sample is heterosexual-identified or only has sex with people of the opposite sex.

Moreover, scholars also make assumptions about people in our samples being cisgender-normative: the assumption that an individual has the same gender identity as the sex they were assigned at birth. This assumption makes transgender individuals, or those who have a different gender identity than the sex that they were assigned at birth, invisible (Westbrook & Saperstein, 2015). Why are heteronormativity and cis-normativity

a problem in aging and the life course research? Why should someone who studies aging care about this problem? By not accounting for gender and sexual minorities, we miss important attributes, conditions, and contexts that strongly influence experiences and outcomes related to aging processes (Brown, 2009).Moreover, people in these non-normative categories might age differently than cisgender, heterosexual individuals due to cultural, social, and institutional factors. Thus, if we ignore LGBTQ populations and the perspectives that emerge from their experiences, we might obscure not only people's everyday lives, but also theoretical insights into the ways in which aging works more broadly.

A simple analogy is the studying aging only from the perspective of one racial category, for example, assuming that everyone had the same experiences of white Americans. Of course, this approach is ridiculous — we know that people of color have alternative aging processes based on their life experiences, likely influenced by social stress and discrimination. These different aging experiences by race have ultimately have changed our assumptions about aging, advancing the field insignificant ways. I am making this same argument the missing "queer", or LGBTQ perspective.

How is Aging Different for Gender and Sexual Minorities?

The argument I have suggested here is that gender and sexual minorities may have alternative aging due to queer culture and queer life experiences. But, what does "queering aging" look like? Below I present just a few examples of how we can start to think about aging from a queer perspective.

First, we recognize that aging processes are understood in social context with others — often others of a similar age. Yet, there is a greater age heterogeneity within romantic partnerships friendship groups in the LGBTQ community compared to the heterosexual and cis-gender community (Verbakel & Kalmin, 2014). Greater age heterogeneity in social networks may in turn shape the way gender and sexual minorities understand their own aging processes. For example, having consistent social engagement with individuals who are both ten years older and ten years younger, which is more common in the LGBTQ community, may shape the way you see one's own relative age and aging processes in comparison to someone who primarily is engaging with people of their own age. This may be reflective in how one understands their own

referential aging, which in turn might shape their health behaviors, financial decisions, other life choices, and sense of identity.

Second, we know that being a parent is a central aging context—as children facilitate and provide parental care later in the life course. Yet, parenthood is a life event that is very different for gender and sexual minority people, as LGBTQ individuals are significantly less likely to have children than heterosexual individuals (Black et al., 2000; Lofquist, 2011). Because parenthood is seen as one of the most life-changing events one can go through, with implications for later life, high proportions of childless LGBTQ individuals may have drastic implications for later life experiences. For example, if gender and sexual minority people are less likely to have children, they might have different cultures of generativity in their broader community, with increased efforts to impact the next generation in the form of mentorship of youth. Research in the heterosexual population indeed shows that even those who are childless still strongly value generativity in the community at large (Rothrauff & Cooney, 2008). This may create a different social cohesion among this group of individuals as they age over time. And of course, there's obvious implications for later-life gender and sexual minority people who might need caregiving in later life. Childless gender and sexual minority folk therefore raises questions about who will be caring for these older populations of adults. Given the growing childless population in the US more broadly (Rowland, 2007), these childless adults may provide early clues to how the structures of society support, or fail to support, childless adults into old age.

Third, social stigma across the life course can impact how we age in later life, and research shows that LGBTQ people tend to experience greater social stigma than heterosexual populations, including greater homophobia and social stress (Meyer & Frost, 2013). Stress and stigma are associated with accelerated aging, and therefore are in-depth processes through which discrimination shapes aging in this community. Also, the specific coping mechanisms enacted by gender and sexual minorities provide alternative approaches to coping that might be effective in dealing with aging-related changes. Relatedly, there are significantly higher rates of substance use among certain parts of the gender and sexual minority population, alongside higher rates of homelessness, and higher rates of mental health issues (Cochron et al., 2002; Hughes & Eliason, 2002). Again, all issues

that we need to care about across the life course that might shape aging processes that the current literature does not address.

Finally, we also see cultural differences in masculinity and femininity in the gender and sexual minority population. This relates to notions of agender or gender atypical people who do not ascribe to normative notions of what being a man is or being a woman is. And again, this context likely going to shape the way aging is approached. In cisgender culture, we see greater emphasis placed on women avoiding aging processes, with entire industries dedicated to preventing aging among women in particular (Berkowitz, 2017). Research suggests that aging may be very different among lesbian or queer women, who reject heteronormative notions of ageless beauty (Hammidi & Kaiser, 1999). What lessons might we learn about aging when looking at this population?

These are just some beginning ideas for how we might think differently about aging based on a queer perspective. For the rest of this paper, I want to talk about three additional and central ways in which gender and sexual minority aging experiences differ from those not in this community using empirical data: 1) family of origin relationships, 2) marriage norms, and 3) end of life planning. In the following I will map with empirical data how including gay and lesbian respondents in to our studies provides new insight into aging processes. I first provide a few brief overview of the methods of the study.

Methods

Data presented in the remainder of this brief come from 90 in-depth interviews with mid-life individuals in 15 gay marriages, 15 lesbian marriages and 15 heterosexual marriages. The men and women in this sample were aged between 40 and 70 in order to focus on mid-life couples, and were preimarily non-Hispanic white and highly educated. This data were collected in Boston, Massachusetts between 2014 and 2015. Note that federal marriage equality happened in 2016, so this data was collected after Massachusetts legalized same-sex marriage in 2004, but prior to marriage being legal on the federal level. In this data, we interviewed both spouses in order to obtain both perspectives of what was going on from each spouse. For more detail on the study methods, please see Reczek and Umberson (2016).

Queering family of origin

In this section, I provide an empirical example of what we gain when we approach questions of aging and family of origin relationships inclusive of gay and lesbian adults. First, we know that queer people tend to have less contact with their aging parents and their family of origin. This is in part because many gays and lesbians are rejected by their families of origin, sometimes violently, sometimes symbolically, sometimes financially, sometimes all three of those things. Gay and lesbian adults tend to live further away from their families of origin (Reczek, 2016), and report greater conflict and less support with aging parents. Overall, we know that gays and lesbians have worse relationships with their families of origin. This led me to ask the empirical question, how do these very different family of origin processes shape caregiving processes across these family types?

What I find is that in heterosexual couples, women were the primary caregiver for a parent who needed help. This is not surprising given existing research. However, what I found for gays and lesbians was surprising. Going in to this analysis, I had the expectation that gay and lesbian couples would not be caring for their parents, in part because given their histories of being rejected by their parents, and had not talked to them for years, but many of the gay and lesbian adult children actually did care work significantly for their aging parents when they needed it. Miranda, who is married to Bill, exemplifies the heterosexual couples in this sample:

> My father was ill with Stage IV prostate cancer. I was calling his doctors, I went to all of his oncology appointments with him, I helped them sign up for hospice," she was extremely intensively caring for him, "I was there a lot over the last couple of years, and I was there up until a couple of hours before he died when he was in hospice. My mother had health issues and I've been very involved with that too. That's sort of my job in the family. It was a source of stress because I was gone a lot." There were a couple of times where Bill, her husband, said, 'You know, you're gone a lot. Are you sure you need to be doing all this?' And so we had a little bit of conflict about that. I think sometimes it can make us grumpy, maybe argue a little bit more."

Miranda is demonstrating not only does she do the care work for her sick parents, but her husband Bill is not supportive of the fact that she's doing this care work and almost challenges her on the work that she's doing. Which was extremely consistent across the heterosexual sample.

In the gay and lesbian sample, we see that gay men and lesbian women were doing significant amounts of care for their parents, Craig who says, "My parents are adult children, definitely. Their roles reversed with them." In another example of caregiving in a lesbian couple, Judith says:

> When my mom was dying, Gloria was always with me, and even if I didn't ask her to come, she just expected that she would come. And I would have to tell her, 'you don't have to come if you don't want to on any particular day.' So she's like, 'I'm going to expect to go unless you tell me not to go. And, does your dad need anything?' Because my dad's still alive even after Mom passed, and I was sort of worried about the fact that now he's alone. And she was like, 'Well, I'm home. I can bring him meals, or do whatever.' And she was ready to jump right in. I think that's our mentality. We're there for each other, we're there for our families.

Thus, we have a very different response to parent's caregiving needs, wherein gay and lesbian spouses mutually care for that parent themselves, and support a spouse who's doing that primary caregiving. In another example Heidi, who is married to Sally, says:

> There was a week in July where we were supposed to go on vacation, and became aware that we shouldn't both be on a boat and unreachable by phone because of issues with Sally's mom. Sally just continued to work and I took the week off and I went and visited a bunch of assisted living places to see what places existed, what they were like, and what might be a good fit for their needs.

This suggests gay and lesbian spouses may be more involved in caregiving work for in-laws than heterosexual spouses, although this finding may be an artifact of the small qualitative sample and should be replicated with nationally representative data. I suggest that if we did not have the gay and lesbian data on this topic— if we didn't have the perspective outside of a heteronormative perspective of one man and one woman—we would miss critical data on the dynamics between gay and lesbian couples and not

fully understand the range of experiences on parental caregiving (for more information and analysis, see Reczek & Umberson, 2016). Moreover, our ability to explore parental caregiving within gay and lesbian couples provides an alternative model of caregiving that could potentially reduce caregiver burden.

Queering Marriage

A similar "queering" approach can be taken when looking at marriage, and below, I provide examples of why marriage is another informative site to look at the processes of aging across these different social groups. Typically, when looking at marriage and health, we focus on the gold standard — married heterosexual couples. Yet, as I've already discussed, this approach presumes heterosexuality and cisgender relationships, obscuring other formations of family that might be different from heterosexual cisgender couples. Gender and sexual minority married relationships may look very different than their heterosexual cisgender counterparts. For example, we have entire cohorts that are excluded from marriage, and we know that only half of gender and sexual minority older adults who are currently in a relationship are married (Goldsen et al., 2017).

So, how do marital dynamics look different across gay, lesbian, and heterosexual groups and how might this matter for aging? Let me provide an example. Couples in relationships negotiate and support one another's health and health behavior via what I call health work (Reczek & Umberson, 2012). For example, spouses pressure one another to go to the doctor when sick. We have assumptions about heterosexual couples that men need to be pressured into going to the doctor. But what is happening in gay and lesbian couples? Not surprisingly, given all the cultural tropes and everything we know about this, that in heterosexual couples pushing someone to get something checked out, is primarily done by heterosexual women. When healthcare work is performed by heterosexual women, it's done very coercively: making an appointment for somebody, forcing their husbands to go, asking them consistently over time to make an appointment. This is Curtis, and he recounts a conversation he had with Annette about going to the doctor, which demonstrates that he finds this type of pressure from his wife coercive:

> Oh yeah, my wife is the list-maker and she'll say, "It's time for this, it's time for this, I saw Doctor X and have you had your appointment?" I say "Nope!" She says, "Go, I signed you up." I say, "Good for you." And she says, "It's totally illegal but I don't care. I signed you up and you got an appointment."

Similarly, in draw on cultural tropes of manhood to explain her husband's lack of initiative in scheduling medical care, Diane says:

> I'm just more of a worry-wart. Gary didn't really grow up in a place where he was constantly kept after. I want him to know that I'm watching out. "Hey, it's a year, you should go get your blood work done." Or, "it's fall, I know sometimes you get bronchial stuff, you should go to the doctor." He's a man, and that goes along with just being a man anyway. I have to keep an eye on him. He may not admit it, but I think he appreciates that someone is looking out for him.

This work to get one another to the doctor was one-directional, done by women onto men. And, yet, similar things appeared when we look at the gay and lesbian sample for both men and women. Colleen was really aware of Maureen's risk for breast cancer because her mom had breast cancer at a very early age, and Colleen was into figuring out when she should get screenings. She says:

> She knew she should do it. She was aware that she was supposed to go to the doctor but it was hard for her. She had to go for her baseline mammogram because her mother had breast cancer, and different doctors started having different opinions about when a baseline mammogram should be, and I had to be like, 'I really want you to go. I know there's no consensus on what's the right age, but now at this point I want you to go and you have to go do this,' and she did.

In another example, Roger who is married to Patrick, also uses coercive health care to make appointments for his partner. He says:

> This is the place where being the same gender really worked to our advantage. While I would watch the phone and someone would say "calling for Patrick," and I could see that it was a health care provider, and I would say, "Yes," and they would go, "Can you verify your social?' And I would verify the last four digits of his social, and they

> would say, "okay, do you know that blah blah blah?" And I would say,"Yes," or they would say, "we're trying schedule an appointment and it's not working out."

In this case, the medical office is allowing a partner to make the appointments because they presumed the person they are speaking to is the patient and the partner does not correct that mistake.

The other scene that really came through in this particular part of the project was mutual health care work. And often because gays and lesbians had the same doctor, they would actually just make appointments together. Often this was for screenings like mammograms or colonoscopies. For example, Carlos, says:

> My doctor is his doctor. We have had an appointment with the primary care physician the same day. I went to my appointment and they told me he had an appointment on his birthday. So we go one after each other.

This couple is highly involved in each other's health care regimes. Tammy illustrates something similarly for mammograms, saying, "Yeah, she makes the mammogram appointments, I make the regular doctor appointments." In both examples, each spouse have the same doctors, and rely on each other to do that mutually.

As shown here, gay, lesbian, and straight couples have different ways of approaching getting one another to go to the doctor relative to heterosexual men and women, providing new theoretical and empirical insights that would be absent if not for the inclusion of this non-heterosexual population in this study.

End of Life Planning

The final illustration of why a "queering" aging approach is a critical intervention to aging research is the example of end-of-life planning. I've already mentioned that gays and lesbians have more strained family ties, fewer children, and historically restricted access to the legal protections of marriage. Because of these factors, one would suspect that end-of-life planning might look quite different in gay and lesbian couples. We investigated this question with the same 90 mid-life gay, lesbian, and

heterosexual individuals described above and found that gay and lesbian mid-life couples discuss end-of-life planning in detail. These couples know exactly what's going on in their end-of-life planning and talk about it extensively. In contrast, heterosexual mid-life married couples were much less prepared in terms of their end-of-life planning approaches. This is in part because heterosexual couples assume that they can rely on family, whereas gay and lesbian couples anticipate family conflict including family interference and legal discrimination if they have an issue with end-of-life planning (see Thomeer, Donnelly, Reczek, & Umberson, 2016 for greater details).

Let me give you a few examples of this dynamic in heterosexual couples. When asked about end of life planning in her interview, Sherry, a heterosexual women, says:

> I guess it's just one of those things that I don't want to think about, and he hasn't either. So we haven't talked about it. As far as going into a nursing home or something like that, I haven't thought about it.

Similarly, Dean, a heterosexual spouse, says:

> I haven't been faced with it, so I just assume what I would do. I mean, I have children and we still have mothers available to us.

What these quotes highlight is the notion that heterosexual spouses would just basically rely on their children or other families in this case to take care of them if they had issues at the end-of-life. Notably, most of these midlife adults never actually had conversations with their children or other family members about their end of life care. It was just assumed they would be there for them. In a final example, Cliff a heterosexual man who is married to Christie, and he says, "It's just one of those things that never really came up. We never really sat down and thought about it."

In contrast, in the gay and lesbian sample, there were tremendous thought and effort in their end-of-life planning. Remember, the data for this project was collected between 2014 and 2015 right before federal marriage equality; there were legal marital protections in Massachusetts where these interviews took place, but these couples knew they were not federally

protected and were afraid their state rights would be overturned. As an example, Debbie says:

> Because our families are not supportive, we were worried if something happened to one of us that our families would take over, and it would be bad. Our marriage doesn't mean much outside of Massachusetts. I mean, it's a social signifier, but legally it means virtually nothing at the federal level.

Debby and her partner were really drawing on this notion of their legal rights, and why they needed to think a lot about end-of-life planning and have the necessary documents to protect them. Similarly, Patrick says:

> The health care proxy stuff is really what started in the direction of making our relationship somehow legally connected because I very much worried that not being able to visit in the hospital, not being able to make emergency decisions, that sort of thing." Again, Patrick is calling on the notion of vulnerability and lack of access led gay and lesbian couples to needing this sort of work.

These empirical findings suggest that there is a clear difference in the approach towards end of life planning for gay, lesbian, and heterosexual couples. Without including the sexual minority population in our study, we may assume all midlife adults approach end of life planning in a similar way, but instead our gay and lesbian couples provide us new ideas for decision making around end of life planning processes. As same-sex marriage became legalized federally in 2016, these negotiations will likely change as more legal protections are provided to same-sex married couples, and future research should explore this with new studies.

Conclusion

I hope I have convinced you that queering aging is a useful if not imperative perspective to include in aging research; the turning of how we view aging processes on its head to see something unique and different in the LGBTQ community. I note that queering aging can provide insights both into the disadvantages of a non-heterosexual non-cis gender population, but also adaptive approaches to aging, wherein some aspects of aging while being gay and lesbian—as well as bisexual, transgender, and queer—might be seen as actually more ideal, such as increased partner caregiving support or more proactive end of life planning. To this end, I call for us to think through how sexuality matters for aging can make all of our work better, and I would add thinking through how aging matters for sexuality can really help make all our work better across these two disciplines.

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