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Commentary

# Older LGBTQ People and Religious Abuse: Implications for the UK Regulation of Care Provision in Later Life

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**Abstract**

Research suggests health, social care, and social work professionals who are highly religious, and adhere closely to traditional doctrine, are more likely to take a negative view of LGBTQ people. This includes those who provide services to older people. Negative attitudes towards lesbian, gay, bisexual, trans and/or queer (LGBTQ) people can translate into poor care and even abuse. This commentary discusses recent literature on older LGBTQ people's experiences of religious abuse. It highlights the concerns among many older LGBTQ people about care from religious based providers where religion becomes a factor leading to abuse, associated with microaggressions, psychological abuse, harassment, discriminatory abuse, neglect, and poor care. Even though only a minority of religious care providers may hold negative attitudes towards LGBTQ people, and even fewer may allow this to inform poor/abusive practice, this is nonetheless an area of concern and merits further investigation. All care providers, including those with strongly held religious beliefs, should

deliver equally good, affirmative, non-abusive care to older LGBTQ people, and to LGBTQ people of all ages.

**Key words**
LGBTQ; religious care providers; abuse; adult protection; equality and human rights; law

## 1. Introduction

This commentary discusses tensions relating to the provision of affirmative care to older lesbian, gay, bisexual, trans and/or queer (LGBTQ) people in cases where religious providers disapprove of them on religious grounds. LGBTQ people face wide-ranging health and social care inequalities [1-4]. They are at increased risk of mental and physical health concerns, primarily attributable to minority stress, i.e., the effects of social exclusion and marginalisation across the life course [5]. Older LGBTQ people are particularly affected because they have experienced its cumulative effects over extended periods of time.

Current cohorts of older LGBTQ people living in more liberal contexts where they enjoy greater legal rights and protections nevertheless have histories involving structural and systemic legal, social, and religious censure [6-9]. Some of that is religious censure which remains to this day. This may be contextual to both liberal countries, among the more conservative/traditional arms of the major religions, and in those countries where they continue to play a dominant role in informing law, culture, politics, and everyday life [10]. Further, LGBTQ people of all ages continue to experience religious persecution and resistance to LGBTQ rights, some of which amounts to abuse, in both liberal and illiberal countries [11-16]. As Super & Jacobson observe,

> …religious abuse may occur when a religious group or leader, whether intentionally or unintentionally, uses coercion, threats, rejection, condemnation, or manipulation to force the individual into submission of the religious views about sexuality [17].

The same definition would apply in relation to gender identity, i.e., when religious 'coercion, threats, rejection, condemnation, or manipulation' are used to force an individual into submission to religious views about gender identity.

LGBTQ people have complex relationships with religious beliefs and religious organisations [18-27]. Some LGBTQ people, including older people, hold religious beliefs and some of these are affiliated with organised religion [18, 27-30]. Some are not. Many older LGBTQ people have reported historical experiences of abuse perpetrated on the grounds of religious beliefs [30]. Westwood [30] has described both historical experiences of religious abuse among older lesbian, gay and bisexual individuals, based on her empirical research. For example, one of her research participants described her religious mother's hostility towards her "homosexuality": 'I had the wrath of god put on me' (Cat, age 63). Rene, a 63-year-old lesbian, described her highly religious mother saying to her as a young woman, when she found out Rene was in a relationship with another woman, '"You're worse than a death in the family."' Several of her participants described trying to conceal their sexualities from their families: 'I mean, they were terminally Catholic and I would have been shoved out of the door' (Frank, a gay man, age 70). Another of Westwood's

participants, Ian, a gay man, described being forced to undergo religious 'cleansing' when he came out to his wife many years previously,

> …oh blimey, I had hands laid on me and all sorts [by Methodist minister], once I'd come out to [my wife] … to get rid of the devil and all that. Telling me, because we'd got kids by then, telling me, if you take a child to something, it's better if you have a rope hung round your neck, or drowned in the river or something. They quoted the bible and all that (Ian, age 69).

Although the majority of Westwood's participants were from Christian backgrounds, a lesbian of dual heritage, described religious rejection from the Sikh community,

> I had to seek out an Asian culture and try and get my head around it. So I sought out the Sikh community… But I wasn't accepted… We [me and a gay Sikh friend] were shunned. It was very hurtful (Alice, age 60).

Another older lesbian described cross-faith religious opposition to LGBT [sic] rights during the times of Section 28. This was a piece of legislation created by the Conservative Thatcherite government which prohibited discussion about same-sex relationships and rights (the "promotion of homosexuality") in schools and public services from 1988 to 2000 in Scotland and from 1988 to 2003 in England and Wales. The woman said,

> We'd a big campaign here around Section 28. And I lived in an area that was ethnically quite mixed. But the posters in the shop windows, in the Asian shop windows, [said] "Keep Section 28," "Don't let your children learn about homosexuality in school," "Don't let them be indoctrinated. It will turn them all into homosexuals." Usual kind of nonsense. And that was the kind of thing, posters, coming from the imams in the mosques, or the community leaders. That was most obvious. But I am sure the Catholic Church, the ultra-fundamental Christian sects, you know ... these people were usually opposed to each other but they were united in hatred (Claire, age 65).

These historical experiences can inform older LGBTQ people's fears and concerns about religious-based care in later life. Older LGBTQ people face wide-ranging structural inequalities in the provision of home care, day care and residential/nursing home care in long-term care facilities [31-41]. These inequalities are associated with heteronormativity, cisnormativity, homophobia and transphobia. Many care providers take a 'we treat them all the same' approach which fails to consider the lives, needs and diverse identities of older LGBTQ people [42]. Older LGBTQ people have expressed fear that healthcare, social care and social work providers will hold negative attitudes towards them and that this may impact the quality of the services delivered to them [43-49]. Some of these concerns relate to certain types of religious-based care, i.e., care provided by religious organisations and/or by healthcare, social care and social work professionals whose care practices are informed by religious beliefs. Religious beliefs can enhance care practices, e.g., promoting compassion, kindness and non-judgmentalism. However, some conservative, traditionalist, religious beliefs can involve disapproval of LGBTQ individuals, their lives and relationships, negatively impacting care providers' attitudes and, potentially, their practice [50]. Recent research suggests that those professionals who are strict adherents of conservative religious orthodoxy are more likely to hold such negative attitudes, and also be less comfortable/willing to deliver care to LGBTQ people, based on their beliefs [50, 51]. This has been documented among, although not necessarily being inclusive of, migrant religious care workers

from countries where LGBTQ people have few or no legal protections and are persecuted on religious grounds [50].

This commentary draws upon recent authorship to consider older LGBTQ people's experiences of abuse in general, religious abuse, and their associated concerns about religious-based care, specifically potential discrimination, religious conversion attempts, inferior care, and overt abuse. While overt incidents of religious abuse are clearly unacceptable and warrant formal intervention, there are many more subtle forms of religious microaggressions which also amount to abuse, but which may be harder to identify. Those religious health, social care and social work professionals who hold negative attitudes towards LGBTQ people may be in the minority of all religious professionals, but it is a minority whose actions need to be addressed to ensure equitable care for all LGBTQ people. This project was granted ethical approval by the University of York's Economics, Law, Management, Politics and Sociology Ethics Committee (ELMPS).

We first look at what we mean by abuse in later life. We then consider the research on abuse experienced by LGBTQ people in later life including the scarcity of research, the silences in the literature on abuse and its cumulative effects. Lastly, we discuss the specific issue of religion and abuse and the impact on the LGBTQ older population.

## 2. Abuse and Older LGBTQ People

The English Care Act 2014 is the primary legislation relating to social care and support for adults, including older people. It prohibits the abuse of adults (including older adults) and provides for a range of measures to protect adults from abuse and neglect ("Safeguarding"). Its Statutory Guidance categorises and defines abuse and neglect (see Table 1) as: physical abuse; sexual abuse; psychological abuse; financial or material abuse; discriminatory abuse; organisational abuse; domestic violence; modern slavery; neglect; and acts of omission.

**Table 1** Classification and definitions of abuse and neglect (Dept of Health and Social Care, Care and support statutory guidance, 2023, 14.17). [52]

| | |
|---|---|
| **Physical abuse** including:<br>assault<br>hitting<br>slapping<br>pushing<br>misuse of medication<br>restraint<br>inappropriate physical sanctions | **Domestic violence** including:<br>psychological<br>physical<br>sexual<br>financial<br>emotional abuse<br>so called 'honour' based violence |
| **Sexual abuse** including:<br>rape<br>indecent exposure<br>sexual harassment<br>inappropriate looking or touching<br>sexual teasing or innuendo<br>sexual photography<br>subjection to pornography or witnessing sexual acts<br>indecent exposure<br>sexual assault<br>sexual acts to which the adult has not consented or was pressured into consenting | **Psychological abuse** including:<br>emotional abuse<br>threats of harm or abandonment<br>deprivation of contact<br>humiliation<br>blaming<br>controlling<br>intimidation<br>coercion<br>harassment<br>verbal abuse<br>cyber bullying<br>isolation<br>unreasonable and unjustified withdrawal of services or supportive networks |
| **Financial or material abuse** including:<br>theft<br>fraud<br>internet scamming<br>coercion in relation to an adult's financial affairs or arrangements, including in connection with wills, property, inheritance or financial transactions<br>the misuse or misappropriation of property, possessions, or benefits | **Discriminatory abuse** including forms of:<br>harassment<br>slurs or similar treatment because of<br>race<br>gender and gender identity<br>age<br>disability<br>sexual orientation<br>religion |
| **Organisational abuse** including:<br>neglect and poor care practice within an institution, e.g., a hospital or care home or care provided in one's own home.<br>may range from one off incidents to on-going ill-treatment.<br>can be through neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation. | **Modern slavery** encompasses:<br>slavery<br>human trafficking<br>forced labour and domestic servitude.<br>traffickers and slave masters using whatever means they have at their disposal to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment. |
| **Neglect and acts of omission** including:<br>ignoring medical, emotional or physical care needs<br>failure to provide access to appropriate health, care and support or educational services<br>the withholding of the necessities of life, such as medication, adequate nutrition and heating | |

"Elder abuse" is, quite simply, the abuse of older persons, although attempts to produce more nuanced definitions have proved complex and lack consensus [53-60]. Growing numbers of authors are uncomfortable with the term "elder" because of the risk of stereotyping older people [60]. This article will generally refer to "the abuse of older people" unless engaging with authorship which specifically uses the term "elder abuse." The World Health Organization (WHO) offers the following definition: 'The abuse of older people, also known as elder abuse, is an intentional act, or failure to act, by a caregiver or another person in a relationship involving an expectation of trust that causes harm to an adult 60 years and older.' [61].

The abuse of older people may or may not be age-related in terms of the causal factors which are involved. In other words, it may not simply be because they are older. Some older people experiencing intimate partner violence (IPV), for example, may have been experiencing that same violence in earlier adulthood [62-64]. However, the abuse of older people *is* age-related in that older people - especially those in very old age, with heightened frailties and care needs – may be more exposed to the risk of abuse, less able to defend themselves when it occurs, and less able to advocate for themselves/make their voices heard when they are being/have been abused [65]. The abuse of older people is 'a human rights violation resulting in suffering, decreased quality of life and even in some situations hastening mortality' [66]. It involves an imbalance of power, with those older individuals in lesser positions of power being vulnerable to abuse by those (often younger) people in greater positions of power in relation to them [67].

The abuse of older people is generally under-researched [67] especially in relation to those from minority groups [68]. There is very little research in relation to older LGBTQ people and abuse [69-74]. Although there is a growing body of research on LGBTQ intimate partner violence [62, 63, 75-78] this primarily focuses on younger people, with, little research involving older LGBTQ people. Most recent reviews of the literature on "elder abuse" [53, 54, 56-59, 64, 79-83] fail to mention sexual orientation or gender identity at all. As Hannah Bows has observed, in her review of the literature on the sexual abuse of older people, 'little is known about the impacts of sexual violence' on older LGBTQ people [83]. The intersection of LGBTQ "elder abuse" in relation to other key social locations, e.g., race and ethnicity, is even less well-understood [84, 85].

This scarcity of research obscures the significance of abuse in the lives of older LGBTQ people. Focus groups conducted by Bloeman et al [74] identified that LGBTQ people consider LGBTQ "elder abuse" to have added dimensions to it. In addition to 'typical definitions of elder abuse,' participants also emphasised 'ostracism due to LGBT status' and issues in relation to service provision (poor/prejudicial responses, biased providers, under-resourced long-term care). Older LGBTQ people are at increased risk of abuse due to heightened marginalisation associated with both ageing [57, 86-88] *and* sexual orientation and/or gender identity [66, 70, 74].

Many older LGBTQ people have experienced abuse earlier in their lives, in the form of emotional, physical and/or sexual abuse as children, bullying and harassment in schools, family rejections, being ejected from the armed forces if 'outed', enforced psychiatric "cures" and "aversion therapy" and religious "conversions" [89-94]. In the UK, older gay and bisexual men lived in fear of criminalisation, many being targeted by undercover police and/or subjected to blackmail [95]. Some are now ageing with criminal records simply because of their sexualities. Gay and bisexual men ageing with HIV often experienced associated stigmatised rejection both in earlier adulthood and in later life [96]. LGBTQ people have also experienced abuse later in their

lives in the workplace, in social and familial contexts, in intimate relationships and in religious contexts [62, 63, 66, 70, 74].

## 3. Religious Abuse

Tensions between religious freedoms and LGBTQ rights remain an enduring dilemma [10]. The major world religions are closely implicated in prejudice towards LGBTQ people [97, 98] and in LGBTQ oppression worldwide [99]. In the UK, with increased legal protections for LGBTQ people, there are 'juridically competing equality claims' [100]. Many religious individuals feel that they are now the oppressed minority [101]. Christianity is divided on the issue. Christian fundamentalist dogma holds 'that homosexuals are bad, diseased, perverse, sinful, other, and inferior' [102]. The Christian Institute, a leading UK Christian campaign organisation, describes same-sex marriage as 'not real marriage', 'blasphemous' and 'sinful' [103] while claiming 'A transsexual is living in defiance of their Creator and "sex change" surgery desecrates a God-given body' [104]. When religious beliefs which disapprove of and/or condemn LGBTQ people are imposed on them, this amounts to "religious abuse."

In addition to historical experiences of religious abuse, described earlier, some older LGBTQ people have experienced religious-based rejection in later life. Westwood [30] has described the experience of Marcia, when she informed her religious choir that she was about to enter into a civil partnership with a woman,

> There was this silence for a while. And then some people clapped. Some people didn't. And as I went back to my seat, I could see and hear people ... saying "I didn't know she was like that! Did you know she was like that? We've known her for 10 years. I never knew she was like that." There was quite a stir ... After choir some people came up to me and shook my hand and other people didn't speak to me at all, people who would always speak to me, people in the row in front of me, turned their backs on me, did not speak to me. That was where I had my biggest rejection, in the choir (Marcia, age 66) [30].

Another woman spoke of her Catholic priest welcoming her when she left her abusive husband: "He said 'you come to the sacraments, you come to Mass…we don't need saints here'" (Ellen, age 64) [30]. However, the same priest rejected her when she formed a relationship with a woman: "'Well, it's quite obvious, I'm not welcome and I shouldn't receive the sacraments… So, soul in limbo, if you like. An outcast ... it's been torture" (Ellen, age 64)' [30]. Westwood also described how Arthur and Ian, a gay couple, were regular churchgoers for many years but have now left their church after the recent appointment of a senior figure who expressed public opposition to "homosexuality."

> We've recently stopped going to church. We've been going to an inclusive church in [town], very accepting, but we've recently withdrawn, because we don't think the hierarchy are as accepting … I do miss it (Arthur, age 60) [30].

> Now, for me, after my divorce, I went to another Methodist church, and that was fine. And then when I got together with Alan, we decided to go to the Anglican church round the corner, didn't we? Where we've been going since 1990 … We've always had great vicars [they've both had a number of key roles in church, on committees, volunteering, etc.] … We got very involved, didn't we? … But I've just lost it with them. I think the people are fine, but

> the clergy ... [details about specific new member of the clergy and public statements he has made against homosexuality]. Quite honestly, I'd sooner be down the allotment, and that's where we go (Ian, age 69) [30].

## 4. Religious Microaggressions and Abuse

Microaggressions are 'brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative slights and insults toward members of oppressed groups' [105]. LGBTQ microaggressions can be expressed in discomfort, unease and/or disapproval when in the company of LGBTQ people; assuming their deviance/pathology/sinfulness; discounting/denying anti-LGBTQ prejudice and oppression; language/assumptions which devalue LGBTQ relationships; and misgendering trans people, including not using their correct pronouns. Microaggressions can be amplified when they are grounded in religious beliefs, especially if there is an implied moral/spiritual authority associated with them [106-108]. This can be further complicated by other intersections, for example for LGBTQ people of colour, for whom there are additional racial and cultural implications [109, 110]; for LGBTQ people with disabilities, for whom there are intersecting ableist implications [111, 112]; and, for older LGBTQ people who face the added complications of ageist microaggressions [113, 114].

Microaggressions can be extremely harmful, having a profound impact on LGBTQ individuals' health and wellbeing, causing depression, low self-esteem, and trauma-related symptoms, including post-traumatic stress (PTSD) [115-117]. Their impact can be worsened when the source of microaggressions is from an intimate, important or significant relationship [118-120] including one involving a care provider such as a counsellor, therapist, healthcare or social worker [121, 122]. This is compounded when such microaggressions are perpetrated by care-based spiritual leaders, such as hospital chaplains [123], and/or when they are supported by organisational systems which directly or indirectly reinforce systematic bias [105, 124].

Westwood, James and Hafford-Letchfield have recently highlighted how a toxic ward culture can create fertile ground for homophobic and transphobic attitudes towards older LGBTQ people to go unchallenged [51]. Decker et al. [125] have identified the following LGBTQ microaggressions in healthcare settings:

- 'Using biased language in which LGBTQ+ identities are implied as unnatural or abnormal'.
- 'Communicating a lack of knowledge about LGBTQ+ identities and/or related healthcare needs, often requiring education from the patient'.
- 'Displaying discomfort such as tense body language, difficulty speaking, or avoiding eye contact'.
- 'Referring LGBTQ+ patients for care that could otherwise be completed by the provider'.
- 'Applying a generalized conception of LGBTQ+ identities while talking with the patient or making decisions about health services or needs'.
- 'Misgendering, misnaming, or addressing a patient with incorrect honorifics verbally or within health records'.
- 'Overattributing health concerns to or spending a disproportionate amount of time discussing a patient's identity'.
- 'Implying or stating that LGBTQ+ identity is invalid or shameful'.

Many of these microaggressions stray into the realms of abuse. According to the English Care Act's definitions of abuse, behaviour that involves emotional abuse, humiliation, blaming, intimidation, harassment, or verbal abuse amounts to psychological abuse [52]. Behaviour which involves harassment, 'slurs or similar treatment' because of gender and gender identity and/or sexual orientation, constitutes discriminatory abuse [126]. Neglect and poor care practice in a hospital, care home (aka 'long-term care facility') or domiciliary care is organisational abuse.

Microaggressions can impede care delivery. Trusty et al recently reported that religious microaggressions (minimization or avoidance of religious issues) were 'negatively associated with the working alliance and outcomes' in psychotherapy [127]. Microaggressions in care contexts may have a detrimental impact on an LGBTQ person's sense of psychological safety and willingness to disclose, and may result in 'feelings of shame, isolation, and humiliation' [125]. This can lead to LGBTQ people avoiding, resisting and/or disengaging from care and support, even when much-needed [35, 41, 128-132]. The UK Equality and Human Rights Commission's review of home care for older people [133] described the following:

> An older gay man with dementia decided to stop receiving services because of the homophobic reaction of care staff. This had led to him having to move into residential care earlier than necessary as his elderly partner had struggled to cope alone with caring responsibilities.

Those older LGBTQ people in positions of care dependency, i.e., in long-term care facilities which they cannot leave and where they are reliant on carers to meet their everyday living needs, have no exit strategies from exposure to microaggressions. This is something many older LGBTQ people fear deeply when anticipating future care needs [43, 44, 46-49, 92]. As Knauer [92] explains, 'they are afraid that as they age, they will lose the ability to retreat to the relative safety of their homes because they will be forced to live in a place that is both unwelcoming and dangerous.' As Webb and Elphick also observe, 'for many older LGBTI+ people there is a real concern that times may not have changed enough and that, as they age and are likely to navigate the health and aged care systems, experiences of […] discrimination may recur' [134].

## 5. Older LGBTQ People, Care, and Religion

There is a growing body of literature which now suggests that care services for older people lack awareness, understanding, sensitivity and expertise in relation to LGBTQ people [32, 33, 39] [135-137]. This can be compounded by providers' religious attitudes and beliefs. Many religious organisations and practitioners take an inclusive and affirmative approach to LGBTQ individuals, and indeed many practitioners identify as L/G/B/T/Q themselves. However, some religious practitioners have negative perspectives. In a recent scoping review of 70 selected studies from 25 different countries, Westwood [138], in a review of the literature, found a close connection between religious affiliation and negative attitudes towards LGBTQ people, heightened by elevated religiosity, particularly among Christian and Muslim, healthcare, social care and social work practitioners and students.

In many parts of the world religious organisations provide care to older people, and many health care, social care and social work professionals are affiliated with a religion [138, 139]. In the US, seven out of ten adults in the US are religiously affiliated [140] with many care and social work professionals motivated by religious beliefs [141]. In the UK's National Health Service (NHS),

despite the decline in religious affiliation in the UK to less than 50% of the population [142], over 70% of the NHS workforce identify with a religion [143]. Many reportedly experience conflict between their religious beliefs and their professional values [144].

Religious organisations play a key role in the UK voluntary sector [145]. Over 2,000 UK residential care and nursing homes are run by religious organisations [146], as well as day care centres and community support services. The leading providers include Methodist Homes Association (MHA), the Catholic Orders of St John Care Trust (OSJCT), the Salvation Army, and Jewish Care. 42% of social workers in England also identify as Christian [147].

Little is known so far about how negative religious attitudes inform the provision of healthcare, social care, and social work [138]. Westwood [148] has identified disagreement between UK social work practitioners in terms of whether religious disapproval impacts practice with LGBTQ service users. Some practitioners believe it is possible to separate off personal views, including those based on religious beliefs, while others believe it is not possible and that, indeed, religious disapproval of LGBTQ people and their lives are contrary to social work values [149]. These findings echo previous research on social work training from the US, where similar divided views prevail [150-155].

In terms of the minimal evidence available on problematic religious-based practice in UK care contexts, Knocker [163] has previously quoted an older disabled lesbian who was told that it was not too late for her to be 'saved' which Knocker reported 'has made her feel unsafe and alienated in her own home.' Guasp [128] has identified anxieties about religious-based care among older lesbian, gay and bisexual people, quoting the following research participant:

> There is a severe lack of understanding about the particular needs of older lesbian and gay people, especially from some faith-based organisations that provide care services. (John, 57, London)

Westwood has also described the experiences of some trainers delivering LGBTQ training to health and social care providers, including those working with older people,

> One woman said that if her daughter was lesbian she'd have to "exorcize the demon out of her" and another man just starting from the point of "where does this perversion come from?" on the training and then wanting to go into the whole spiel about how the male and female anatomy are meant for each other. (Joy, UK Activist) [30]

A UK action research project delivering training to care home staff working with older people also reported, "One staff member declared ... that they 'knew how to deal with that disease' and 'One woman [care staff member] stated she would ban her son from the house if he came out as gay.'" [32]. The researchers commented that,

> This observation suggests, despite emphasis on person-centred care, persistence of ingrained homophobia and partial tolerance of LGBT individuals in a setting where care is provided for vulnerable, older individuals. Such anxieties were animated by tensions between religious beliefs and sexuality.

Westwood, James and Hafford-Letchfield [51] reported on a recent case study in which a newly qualified nurse described a toxic work culture on an NHS hospital ward for older people, where she witnessed some religious nurses holding negative attitudes towards older LGBTQ people, which also impacted their care. The nurse, Claire (a pseudonym), described 'casual homophobia'

among some nurses, e.g., assuming someone is too old to be gay. She also described some religious nurses saying they disagreed with people being gay because 'it goes against my beliefs' and that some nurses expressed dislike of delivering care to an older LGBTQ person because '"I don't like being around them."' One religious nurse reportedly said she would pray for an older gay man who was a patient on the ward because he was '"going to go to Hell."' Another reportedly said she didn't want to let the gay man's husband visit '"because it's just encouraging their lifestyle."'

## 6. Older LGBTQ People's Fears about Religious-Informed Care

The provision of care is often reliant on a mixed economy within which providers from religious-based organisations are included. While people of faith employ strategies of empathy, compassion and care to accommodate minoritized people, Westwood has highlighted how many older LGB/LGBT individuals are fearful about religious-based care [50]. These relate to potential discrimination, religious conversion attempts, inferior care, and overt abuse which they may have already experienced or have been highlighted by others. These fears include concerns about the attitudes of care staff on whom they are forced to depend:

> Some religions are very hostile towards homosexuality and gender fluidity, and care workers who are members of those religions may carry that hostility into their work (SPL062) [50].

Older LGBTQ people are also fearful that they will receive inferior care from religious care staff:

> People sometimes use their religious beliefs as a reason for not wanting to provide care to an individual and/or providing poor care and/or being abusive as they believe for example, that their sexual orientation is wrong or a sin (SPL066) [50].

This potential for strained relationships, tense interactions and lack of recognition of gender and/or sexual diversity is complex and intersecting and can culminate in poor care and overt abuse if not recognised and challenged within care settings.

## 7. Regulatory Implications

Regulation provides a key role in care services in relation to addressing abuse of older people. This includes rules prohibiting such abuse, and systems for recognising, identifying and naming discrimination via the inspection of care services. and providing structures for abuse to be reported and responded to at both an interpersonal and structural level. However, it is rarely reported in practice [156]. 'Discriminatory abuse' is a category of abuse that frames the ways that prejudice can motivate abuse and impact adults with care and support needs. It is defined in the Care and Support Statutory Guidance [157] as: 'forms of harassment, slurs or similar treatment because of race, gender and gender identity, age, disability, sexual orientation, religion' (section 14.17). A review of existing research on discriminatory abuse [126] found definitional obscurity, differing interpretations and the hidden or stigmatised nature of discriminatory abuse which are likely to hamper reporting. The authors concluded that subtle micro-aggressions are often normalised and difficult to label as abuse and the link with protected characteristics may add layers of stigma, shame and embarrassment and give the example of labelling abuse associated with homophobia as physical abuse.

As highlighted in this article, LGBTQ people can be at risk of abuse across their lives. However, in older age, especially very old age when they are likely to have heightened care needs, LGBTQ people can be especially vulnerable to abuse and neglect; particularly discriminatory abuse and other types of abuse which might be underpinned by it. Some aspects of psychological abuse, also identified in the Care Act 2014, are particularly relevant, namely emotional abuse, deprivation of contact, humiliation, blaming, intimidation, harassment, verbal abuse, and unreasonable and unjustified withdrawal of services or supportive networks. Organisational abuse (a further form of abuse categorised in the Act) can also be relevant, where long-term care facilities systemically fail to meet the individual needs of older LGBTQ people. As recent research has highlighted, older LGBTQ people are very fearful of such abuse and neglect.

A review of published English Safeguarding Adult Reviews [126] identified four reviews in which there was limited analysis concerning any interaction between sexual identity, disability, contextual factors and experiences of abuse. Applying the lens of epistemic injustice, Mason highlighted themes of practitioner and institutional bias, inattention to social identities and the importance of context and place offer a more realistic reflection of the ways in which discriminatory abuse plays out.

Overt forms of religious abuse are likely to result in sanctions. For example, David Mackereth, a UK hospital doctor, was recently dismissed from his job for refusing to use the correct pronouns for transgender patients on religious grounds. His subsequent claim for unfair dismissal on the grounds of conscientious objection failed [158]. However, it is the more subtle interpersonal religious microaggressions in care contexts which pose particular challenges and can slip between regulatory frameworks. Moreover, religious care professionals are also entitled to assert their own rights to religious freedoms in expressing their views. As the recent "gay cake" cases in the UK and US have highlighted, organisations/individuals are within their rights to refuse to create products with messages which are contrary to their religious beliefs [159]. Similarly, while health and social care workers cannot refuse to deliver services to LGBTQ people under the Equality Act 2010, they are not required to enjoy doing so, and they cannot realistically be expected to authentically deliver affirmative messages to LGBTQ people if those messages are contrary to their religious beliefs.

This is where microaggressions/subtle forms of abuse can slip through the regulatory nets. The microaggression of discomfort in engaging with LGBTQ people can be demonstrated by some religious individuals who strongly disapprove of them, as highlighted by Westwood, James, and Hafford-Letchfield's case study [51]. That case study also highlighted how religious disapproval can prevent support for same-sex relationships and/or gender reassignment and fail to provide LGBTQ-affirmative caring relationships. Services will still be provided, thereby complying with the Equality Act 2010. However, the *quality* of those services come into question, which the Act is not sufficiently fine-tuned to address.

Discrimination law is primarily interested in whether a thing is done, rather than how well it is done: 'As long as you meet the legal standard … the law will not intervene: it has little interest in whether you just scrape into legality or whether you are with the angels, flying far higher than the legal minimum' [160]. This may miss the subtleties of relational services such as counselling, psychotherapy, healthcare, social care, and social work [161], which involve the intentional 'use of self' [162]. In such services, the quality of the professional interpersonal relationship will

determine whether the service is delivered *equally well* to all. Despite this being an equality issue, the Equality Act is not currently calibrated for this level of subtlety.

A lack of support for same-sex relationships (e.g., by not 'encouraging' partners to visit, due to religious approval) may be in breach of the European Convention on Human Rights (ECHR) Article 8 (right to respect privacy and family life). However, if it does not amount to actively preventing someone's partner from visiting, but "only" involves a lack of enthusiasm in doing so, this again may be too subtle to pick up on in relation to formal rights. Moreover, at the same time, religious care staff's rights under ECHR Article 9 (freedom of thought, conscience and religion) may be engaged, resulting in competing rights claims.

According to the Care Act 2014, discriminatory abuse includes harassment and slurs or similar treatment because of gender identity and sexual orientation. However, while overt conversion attempts by care providers would be considered unacceptable, offers to pray for someone might not. Yet, as the recent case study [51] showed, such offers may not be supportive and may actually be homophobic and/or transphobic microaggressions. Supervisors may find it difficult to challenge such behaviours, being wary of being accused of impinging upon a member of staff's religious freedoms. Similarly, while religious disapproval may leak into care delivery in ways which may leave a care-recipient feeling emotionally abused, blamed or humiliated, it may be difficult to identify how this is taking place, and, again, may be difficult to challenge via interpersonal and/or supervisory processes.

Moreover, also according to the Care Act 2014, neglect includes ignoring emotional care and support needs. Older LGBTQ people need affirmative services, which celebrate, validate, and approve of their lives, histories, and relationships. This is supported by the UN Principles for Older Persons [163] which state that a) older persons should be able to live in environments that are safe and adaptable to their personal preferences, and b) that they should be able to receive full respect for their dignity, beliefs and needs and privacy and for the right to make decisions about their care and the quality of their lives. As the case study described earlier highlights, some staff have attitudes which preclude doing so. Unless a care environment is explicitly LGBTQ-inclusive, then this may go unnoticed, especially in environments which take a "we treat them all the same" approach [42]. Such a systemic failure to address the needs of older LGBTQ people can amount to organisational abuse, under the Care Act 2014.

## 8. Conclusion

This article has highlighted the significance of religious abuse in the lives of some older LGBTQ people, and their associated fears and concerns about possible religious abuse in older age care contexts. It has also raised concerns about actual/potential incidents of problematic religious-based delivery of care to older LGBTQ people. Policies which explicitly support affirmative care for older LGBTQ people and which mandate LGBTQ-inclusive care practices can encourage care cultures which promote LGBTQ-equitable care. However, such policies and care standards are only effective if they are fully implemented. They cannot in and of themselves create LGBTQ-affirmative care environments.

Many authors suggest that training is the way forward, helping to raise staff awareness and encouraging self-reflective practice among practitioners, including religious practitioners [39, 164-170]. However, training is not enough [129, 171]. Research has suggested that deeply conservative

religious practitioners may avoid and/or resist engaging in training when it conflicts with their religious values and beliefs, and that indeed this can create tensions for them in their practice [136, 152, 172]. Training cannot undo those religious beliefs which underpin religious microaggressions and abuse towards LGBTQ care recipients. Indeed, many religious staff who feel their religious beliefs are being persecuted by compulsory LGBTQ-inclusivity will feel it is their duty to defend those beliefs if they feel they are being attacked [148].

The elephant in the room is what to do when those religious care providers who disapprove of LGBTQ people, their lives and relationships are required as part of their organisational/professional roles to affirm and celebrate them despite that disapproval. Common sense suggests that it is not possible to do so, given it would require them to authentically display values and beliefs which they do not hold. Similarly, employment screening for negative attitudes towards LGBTQ people could itself be perceived as discriminating against religious beliefs legitimately held by some employees/employers. There are no easy answers here. Nevertheless, the dilemma remains: how can the right to hold one's religious beliefs, including those which disapprove of LGBTQ people, be balanced against the rights of LGBTQ+ people to receive affirmative care? LGBTQ people are entitled to the delivery of equitable care provision, including from all religious care providers. The question is how this can be achieved. More research and greater dialogue is needed to continue to explore this challenging issue.

## Author Contributions

Dr Westwood wrote the preliminary and final drafts of the article. Professor Hafford-Letchfield made revisions. Ms James offered critical comments.

## Competing Interests

The authors have declared that no competing interest exist.

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