



# **Specific Considerations for LBGT Eldercare**

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<p>Abstract:</p> <p>The LGBT community has changed considerably in numbers, awareness, and acceptance in the past few decades. Due to the growing number of LGBT elderly, special considerations must be taken into account in planning their care.</p> <p>This study aimed at showcasing considerations that should be taken into account when planning elderly care and future elderly living arrangements. The research questions used were (a) are there special considerations for LGBT seniors? and (b), if so, what are the considerations. These were found to be community building and providing nursing staff with culturally competent training.</p> <p>A literature review was performed in order to gain information and formulate suggestions. The nursing theory of the Neuman Systems Model was used for comparison, with the idea of stressors being a main factor to the mental and emotional health of LGBT seniors and nursing intervention to be important. An inductive content analysis found two common categories.</p> <p>This study concluded that the members of the LGBT elderly community face higher levels of depression, substance abuse, anxiety, suicidal ideation, and feelings of invisibility than their heterosexual counterparts, but draw strong positive benefits and senses of satisfaction from “manufactured families” and LGBT-tailored programs. The need for culturally competent care was also found to be important, as it is currently lacking in eldercare facilities. In Finland alone, SETA offers information specific to LGBT elders, so the information is not out of reach.</p> <p>Ultimately, further research is needed.</p>	
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## **1. FOREWORD**

After being born in 1985 near the San Francisco Bay area – arguably the gay capital of the world – and growing up with many LBGT influences, I had never realized that Lesbian, Gay, Bisexual, and Transgender (abbreviated LGBT) issues were political until the Proposition 22 election of November 2000. It was during that time that it became apparent that “near” San Francisco wasn’t close enough. I later learned that I was living in one of the most moderately conservative counties in the state of California. While the ballot was eventually struck down, I was shocked to see the fervor with which family and friends eagerly tried to deny rights to gay couples. Signs were placed proudly in yards, television commercials ran continuously, and politicians weighed in.

Four years later and a passionate supporter of LGBT rights, I went to work in a long-term care facility in Oakhurst, California, and I witnessed first-hand how difficult life could be for LBGT couples. An elderly woman who had lived with her long-term partner for over 40 years was denied the right to see her after her children (who paid for her medical treatment) asked the staff to deny their mother’s partner’s entry. The patient frequently expressed sadness and frustration to the staff, but didn’t feel that she could complain to her children as they handled her medical bills. Because of the lack of LGBT support at the facility, no one ever raised this issue with the patient’s children. No one encouraged them to see the other side or to see how this was affecting their mother. She was emotionally drained, wept frequently, and often refused to take her medication or to eat. Our social services counselor who was called to help admitted to being ill-equipped to dealing with LGBT-specific issues. Even I with my passion was at a loss as to how to

help her. Internet searches at the time shed no light on how to help this woman with the loneliness and despair she felt. The patient died only two months after reaching our facility (after being admitted for a non-life threatening illness) without seeing her spouse a single time. Her partner was not permitted at her funeral at the directive of her children.

Since that time I have nearly completed a Bachelor's degree in Nursing. However, not a single time was the LGBT community mentioned, and my own research has shown scant results. I have completed this work in hopes of providing information to those looking for similar research, be it an institution for implementation or an individual simply seeking clarification. I hope it is informative and useful and broadens understanding and awareness of this "minority within a minority".

I wish to thank in no uncertain terms Pamela Gray, without whom this work would have been literally impossible. For your time, your effort, your enthusiasm, your lunch breaks... Thank you.

Ashley Claassen

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## 2. INTRODUCTION

“Two friends of mine, Vera and Zayda, had been together for 58 years. When Vera’s Alzheimer’s became too much, Zayda moved her to an assisted living facility. Zayda could barely trust family or neighbors with the truth, let alone strangers, so she and Vera became “sisters.” Much later, after Vera’s death, Zayda needed to move into an assisted living facility herself. She had many, many photos of the love of her life, but dared not display them in her new home. The other residents would talk about husbands, children and grandchildren, but she felt too vulnerable to tell the truth. Zayda was in hiding and terribly isolated.”

—Nina L., Carlsbad, CA (“Improving the Lives...” 2010)

According to the American Psychological Association, 1.5 million of the 39 million people in the United States aged 65 or older identify as LGBT. By 2030, the number of the minority population alone (which includes LGBT seniors) will increase by 217% (Administration on Aging, n.d.). While this number is large, only small amounts of information are known about gays and lesbians, and even less about bisexual and transgendered peoples. Due to the growing number of LGBT elderly combined with the unclear factors about their care, changes must be made in order to accommodate the LGBT elderly.

In the United States alone, seniors 65 to 69 years old expanded by 30.4% and increased from 9.5 to 12.4 million (“The Next Four...” 2010). This figure represents lower age limits of the “baby boom” (namely, persons born after the end of World War II) generation. The Finnish baby boom was larger in size comparatively, making the problem of

the incoming baby boom even more pressing (Karisto, 2007). According to Statistics Finland, one in every five people is now aged 65 or older. A 2007 Finnish study estimates somewhere between 5-15% of the population to be LGBT, but with no available statistics about the elderly population in particular (Lehtonen, 2007).

This study was commissioned by the city of Loviisa, Finland. It aims to explore the nuances in care for Lesbian, Gay, Bisexual, and Transgender (LGBT) elderly persons. This work serves to showcase some common themes raised by the LGBT community itself in regards to their health care, and focuses on the aspect of eldercare.

### **3. BACKGROUND**

#### **3.1 HUMAN SEXUALITY**

Human sexuality is an intensely complicated and controversial topic. Due to the lack of empirical evidence, human sexual behaviors before recent centuries are largely a mystery. However, it is a widely researched and talked about topic (Kelly, p.198). When using the US National Library of Medicine/National Institute of Health search engine, the term “human sexuality” produced 36,922 hits. Searching for orientation-specific articles is difficult, however, due to the fact that “heterosexual” is implied, not stated. Any article searching for human sexuality will include statistics implicitly stating figures for heterosexuals unless otherwise specified.

Western culture, to this point, tends to focus on the “heterosexual standard” – namely, that people are attracted to the opposite sex, and the ultimate expression of this is peno-vaginal sexual intercourse (the “coital standard”). Even the language we use to refer to other orientations and have used reflects a negative connotation towards different sexual orientations, namely homosexuality. (Kelly, p. 203). Because of heterosexuality’s dominance as a preference of sexual partner, it is typically seen as “normal” in myriad ways: statistical normalcy, normalcy by expert opinion, moral normalcy (usually implied by religious institutions), and the continuum of normalcy (Kelly, p.206).

The term “LGBT” is a blanket term coined in order to broadly refer to the lesbian (female homosexual), gay (male homosexual), bisexual (sexually responsive to both sexes) and transgender (non-association with one’s gender) (Dictionary.com, 2014). However, these terms are fluid and the initialism is sometimes lengthened to accommodate all orientations. For instance, LGBT may be expanded to ‘LGBTQ’, with ‘Q’ meaning ‘queer’ or ‘questioning’ (Petrow, 2014). However, due to the large number of variance and the limited availability of pre-existing studies, the term LGBT will be used.

### **3.2 Lesbian, Gay, Bisexual, Transgender (LGBT)**

The LGBT community in any form has had an uphill climb in terms of equality under the law and acceptance. While the term “homosexual” can stretch beyond simple sexual behavior and practice, it tends to be thought of with disapproval, fear, and even loathing (Kelly, p.207). Because of the numerous assumptions about its population (the effeminate



gay man, the masculine lesbian) the thought of the LGBT community is laden with stereotypes and ambiguities, which are not applied to heterosexuals. Because of this, a minority status is reached, and with it, possible feelings of persecution and isolation (Kelly, p.208).

The homosexual identity formation is a complex and sometimes lifelong process. Due to the lack of empirical knowledge, LGBT persons in the past have not had a solid positive influence other than “myths and stereotypes” (Kelly, p.401). Despite the fact that heterosexuals need not worry that their sexual orientation defines them, in the homosexual community, this is an unfortunate reality. While at times the self-labeling of LGBT can be helpful in forming an identity and community, it can also not be (Kelly, p. 402).

Due to societal stigmas concerning homosexuality, especially those overt during the lifetime of elderly LGBT people, coming out may be delayed for several years or possibly even a near lifetime. One subject of a 2013 study done by Sullivan quoted a 72-year old transgendered female, who only came out after she moved into an LGBT specific residence (Sullivan, 2013). It is also possible that subjects were previously in heterosexual relationships and are now in an eldercare home due to the loss of the spouse.

In 1989, Vivienne Cass developed the Cass Identity Model to describe the process of coming to terms with homosexual identity formation. While Kaufman and Johnson in 2004 have pointed out some deficiencies due to the model’s age, it is still considered a useful tool (Kaufman, Johnson, 2004).

- I. *Identity Confusion.* The subject begins to question their sexual orientation. They may purposefully avoid homosexual thoughts or images.
- II. *Identity Comparison.* The subject considers the broader implications of admitting their sexual orientation. They may feel pleased at their individuality, or grief at the loss of their “normalcy”. At this point, they may or may not continue to keep up a heterosexual façade. They may try to convince themselves that this is a phase, and may internalize homophobia towards themselves or others.
- III. *Identity Tolerance.* The subject commits to or begins to tolerate their sexual identity. They may seek out the LGBT to combat feelings of isolation and to search for role models. It is important to note that if at this stage, the responses are largely negative, the subject may never progress forward.
- IV. *Identity Acceptance.* The subject accepts their sexual orientation. They may take up in LGBT activism, and a healthy attitude may be adopted. This is the most common stage for “coming out”. The subject may feel intense loss again at the thought of losing their heterosexual life plan and disappointing any close friends or relatives.
- V. *Identity Pride.* Subjects at this stage no longer require heterosexuality as a standard. They may have pride in the LGBT community, and activism (passive or otherwise) is common. Anger towards the heterosexual community is

sometimes noted, and an “Us/Them” mentality can arise. A lack of support by family members (real or fictive) may halt progress.

- VI. *Identity Synthesis*. Subjects at this stage have lost the “Us/Them” mentality, and anger abates. (Kelly, p.401-404).

The Cass model, while not the framework for this study, still provides helpful insight for nurses. Knowledge of the Cass model can help better understand the “coming out” process and can ease the transition for seniors who may be struggling with expressing their sexuality to others, or even coming to terms with it themselves.

### **3.3 LGBT Elderly**

While younger LGBT youth have seen a much different reaction to their sexual identities, the LGBT elderly have quite a different story. Forty-five years ago, the violent Stonewall Riots took place in New York, making even LGBT elderly on the edge of the age scale aware of the socio-historical context of being a homosexual in the late 1960’s. Heterosexism – prejudice towards homosexuals by heterosexuals – was largely unchallenged and explicit (Hunter, p.13-16). Homosexuals alive at that time were forced to lead “secret lives” and only were to be shared in extremely private settings, as not only the culture of the time was not permissive, but also that the American Psychiatric Association classified homosexuality as a mental illness until 1973. Despite the fact that the perception and reception of the LGBT community is rapidly evolving, those who have lived the majority of their lives in hiding, fear, and shame cannot so easily let go. While elderly

LGBT adults do report being more content with themselves, they still on a large scale fear discrimination, particularly in a long-term care setting (Jackson, Johnson, Roberts, 2008).

### **3.4 Previous Studies about LGBT Aging**

“While most Americans face challenges as they age, LGBT elders have the added burden of a lifetime of stigma; familial relationships that lack recognition under (US) law; and unequal treatment under (US) laws, programs and services designed to support and protect older Americans. Further, the lack of financial security, good health and health care, and social and community support is a fearful reality for a disproportionate number of LGBT older adults.” (“Understanding the Needs...” 2010).

Lesbian, gay, bisexual, transgender and non-gender specific (LGBT) ageism is a widely understudied topic due to ignorance, heterosexism, and purposeful marginalization (Berger 1982, Cruikshank 1991, Orel 2004). As recently as 2006, the National Health Social Life, Health and Aging Project conducted a nation-wide study in the United States but did not address LGBT adults (Brennan-Ing, et al, 2011). While minority groups are frequently misrepresented in statistical studies, the LGBT community is even more so misunderstood for the fact that even interviewing them can be a challenge due to fear of social stigma and discrimination (Orel, 2004).

While the scientific community is trying to catch up, the standard of silence is quickly changing as LGBT social issues are becoming more prevalent and the LGBT elderly want their voices to be heard. For instance, during a poll concerning LGBT grandparents, the

survey response rate was more than 50%, compared to the national average of 30-40% (“Survey Response Rates” 2010). Subjects offered to come and speak “face to face” in order to deepen understanding of their experiences rather than mail in an anonymous survey (Orel, 2014).

The topic of the aging LGBT population is vastly under-researched and not well understood. For a time, it was assumed that the elderly LGBT community faced roughly the same age-related difficulties as their heterosexual counterparts (Kelly, p.194). This assumption is now widely controversial, as the LGBT community in particular has much higher rates of disabilities ranging from substance abuse to mental illness (McCann, et al, 2013).

While the exploratory studies of LGBT seniors are now in their infancy, elderly care facilities are not prepared to deal with the growing LGBT population soon to come through their doors. While the figures vary, the United States Health and Human Services (HHS) estimates that as of 2010, there were anywhere from 1.75-4 million LGBT seniors over the age of 60 living in the United States alone. In 2010 the HHS, in conjunction with Services and Advocacy for Gay, Lesbian, Bisexual and Transgender Elders commissioned a work to more intensively study factors specific to the LGBT elderly community. While this is promising, a study completed the same year by Bell, et al was troubling: while the polled elderly care facilities were mostly open to receiving new training on how to care specifically for LGBT elders, only 24% of the directors of said facilities had gotten one hour or more of homophobia-specific training within the last 5 years (Bell, et al, 2010). This figure only applies to the directors of these facilities, who are typically not

involved in direct patient care. This is pertinent, as a major cause for LGBT persons delaying health care treatment was due to fear of homophobic reaction from the provider and in particular, elderly care facilities (Sullivan, 2013). One subject in a 1989 study stated she would rather commit suicide than be placed in an institution where she may face discrimination or homophobia (Tully, 1989).

### **3.5 Aims and Research Questions**

The aim of this study is to, through literature review, provide information regarding important considerations concerning elderly lesbian, gay, bisexual and transgender clients when developing an elderly care facility.

In order to gain that information the following questions were formulated:

1. Are there special considerations in regards to elderly LGBT clients?
2. What specific aspects concerning LGBT elderly should be considered?

## **4. THEORETICAL FRAMEWORK**

“To a large extent, nursing faculty and nursing curricula lack adequate knowledge of LGBT health. Teaching, practice, and research on LGBT health are deficient, too.”

Nursing literature is lacking in content addressing LGBT health (Lim, Bernstein, 2012). In order to make this work more understandable and relatable to nursing, several theories were considered. After careful deliberation, the Neuman Systems model was chosen due to its near perfect application to the idea of nurses (nurses representing the eldercare home in Loviisa) implementing preventative measures as primary interveners in order to stave off depression, isolation, and other stressors. The Neuman Model was chosen not only for its compatibility with this particular study, but also to make a relatable model for nurses to further understand two things:

- How to care in a culturally competent way for LGBT elders
- How to identify and prevent illness in LGBT elders

#### **4.1 Neuman Systems Model**

The Neuman Systems Model describes an individual entity as a “system” which is affected by internal and external stressors. In order to properly evaluate a system, we must consider the system to be holistic and our focus to be how the parts of the system interact. The classic representation of a Neuman Systems Model is that of a circle surrounded by other circles (Appendix 1). The center represents the core things that are essential to the survival of the system, and may change depending on what the system is. Only by viewing the person in this way can we properly evaluate how each part affects others, and the subject as a whole (Reed, p.4). Appendix 1 shows a Neuman Systems Model.

The system is surrounded by several lines of defense. The outermost is the flexible line of defense, and defends the person's normal wellbeing against stressors. The strength of the stressor is inversely related to the strength of the flexible line of defense (Reed, p.9). For example, a verbal insult may wear down a system's flexible line of defense. A single insult directed at the system may not break through. However, repeated insults may break through to affect the wellness of the system (in this case, a person's mind). The insult would take the form of an external stressor. An example of an internal stressor would be low self-esteem – it originates from inside the system. (Reed, p10).

The aforementioned “wellbeing” is, in this model, the normal line of defense. This is the patient's baseline, or “normal” functioning. If the patient receives one insult a day (an external stressor) from the same person at the same time each day, they may be able to adapt and ignore it and continue to function normally. This may be their normal line of defense. However, if the insults are frequent and variable, the baseline may be affected, and the patient will begin to show signs of stress.

The last lines of defense are the lines of resistance. They maintain the system's integrity (Reed, p.10). If they are able to maintain the defense, the subject may not be seriously affected and may return to baseline quickly. However, there may be serious implications if the basic structure is affected.

#### **4.1.1 Assumptions of a Neuman System**



Some assumptions must also be drawn, thereby creating the “bottom line”, or baseline for the system’s health:

1. Each system is unique.
2. Each system is a whole.
3. Each client evolves to the point of having a normal line of defense with at least some internal and external stressors.
4. Each patient has a set of resistance factors. Their resilience varies.
5. Many named, unnamed, and general stressors exist within the system. Each has the potential to disrupt the lines of defense.
6. In the event that any of these variables interact in a way that disturbs the system, it affects the way the “flexible line” of defense affects the system. In this work, we will focus mainly on the psychosocial and sociocultural aspects of LGBT systems.
7. The aforementioned stressors are open to interpretation and depend upon the individual system for identification. (However, there were many consistencies in the literature about the LGBT community’s common stressors.)
8. The client is a mixture of variables (see section 4.1.2, “Client Variables” or the Neuman Systems Model in the appendix).
9. Primary prevention is general knowledge which carers are tasked with applying to and implementing in patient care.
10. Secondary prevention deals with treating whatever symptoms the client shows as a reaction to a stressor.
11. Tertiary prevention focuses on bringing the patient back to a primary prevention-baseline.

12. The client is constantly interacting with, affecting, and being affected by the environment (Reed, p.7).

#### **4.1.2 Client Variables**

There are 5 named variables, and each is capable of disturbing the stability of the system:

- a. Physiological, which is the system's physiological response;
- b. Psychosocial, describing the mental process and emotions of the system;
- c. Sociocultural, referring to the system's relationships and the expectations of said relationships, in addition to social and cultural activities relevant to the system;
- d. Spiritual, attributing to the spiritual beliefs of the system, and finally;
- e. Developmental, which is an accumulation of developments of the aforementioned variables that the system has cultivated over the span of their lifetime.

While the above describes the variables pertinent to each individual system (and each system is quite different and need to be defined by the individual), there are common themes. The term "stressors" applies to any intra-, inter-, or extra personal stressor which may affect the health or wellbeing of the system. These stressors can come from internal, external, and created environments.

#### **4.1.3 Nursing Preventions to Illness**

Preventions, in this context, refer specifically to nursing interventions to thwart illness (entropy) and drive the patient back into wellness (negentropy).

- a. Primary Preventions: The nurses attempt to shield the client's first line of defense by bolstering the flexible line of the defense and decreasing risk factors.
- b. Secondary Preventions: When the patient becomes symptomatic due to a normal line breach, nursing interventions include bolstering the lines of resistance to defend the basic structure.
- c. Tertiary Preventions: Helping the patient return to a state of wellness AFTER a breach (Reed, p.15).

In this study, the discovered stressors are mainly emotional, as the importance of "acceptance" occurred as a main theme in the breadth of this research. The coordinator's attention to detail serves as a "primary prevention modality", or a factor which can prevent any of the aforementioned variables from affecting the health of the system. This expresses that by creating an open environment and promoting a strong sense of community, the carers at Loviisa identify the risk of a stressor and pre-emptively remove it. This prevents breaches of the patient's normal line of defense and maintains their health, or wellbeing. This contributes to "system wholeness", or stability.

## **5. METHODOLOGY**

This study utilized a literature review, fitting Machi's definition: A written document presenting a logically argued case founded on a comprehensive understanding of the current state of knowledge about a topic of study (Machi, McEvoy, p.4). With an objective already formulated, a search presented the already available literature. Because we know there are LGBT seniors and we simply want to know more about them in this case a review of the existing literature for this purpose is relevant.

### **5.1 Ethical Considerations**

Ethics, defined by Resnik, are "norms for conduct that distinguish between acceptable and unacceptable behavior" In researching a scientific topic, adherence to ethical codes are of utmost importance, as it is usually the result of a collaboration of resources. In other words, "trust, accountability, mutual respect, and fairness" are critical elements (2011). An ethically non-compliant work provide information which cannot be relied upon ("Hyvää tietollinen..." 2014).

An ethical research code of conduct was followed arduously as laid out by the Arcada Good Scientific Practice guidelines. All works used for the completion of this study are cited in the "References" section. No copyrighted or intellectual material was used or duplicated in any malicious manner. All articles were accessed legally and were not disseminated ("Good Scientific Practice..." [n.d.]).

Plagiarism, using the work of others without attributing proper credit, can be tricky to distinguish as it can be done either intentionally or unintentionally (Kumar, et al,

2008). Quotations, ideas, and tables were given accurate references, and careful consideration for unintentional plagiarism found no such improprieties.

The writer's personal opinions and biases are limited to the "Introduction" section of this work (Resnik, 2011).

## **5.2 Data Collection**

The Arcada Nelli Portal was used, and a comprehensive Meta search was attempted using a Boolean query (Machi, McEvoy 2009). Searching "LGBT AND elderly", "lesbian AND gay AND transgender AND bisexual AND elderly" produced no hits. The categories "LGBT" "lesbian gay bisexual transgender" with subcategory "elderly" and "all fields" filter produced zero hits.

The Arcada library was helpful for seeking physical copies of books, but unfortunately the searches for "LGBT eldercare" were not successful. Any academic articles found were located through PubMed, using a simple toolbar search. Older printed information was also sought through Google Books. Many topic specific articles were inaccessible with the Arcada login information, but an article was found by a colleague with an academic access pass. All other articles were accessed via the University of Helsinki access domain, which provided unlimited access to all articles. When accessing the material at home or at Arcada, reliance on "View Free Article" was tantamount. This also limited the number of articles found.

Searches through PubMed.com were done using keywords, “LGBT” “elderly” “older” “lesbian gay bisexual transgender” “seniors”. Because the hits are narrow to begin with, an exclusionary search was not necessary. More unrelated topics were found with distant hits to search synonyms were found than on-point articles.

Articles must have been peer-reviewed and published. Due to the extremely small amount of articles available, the year of the study was not excluded unless specifically otherwise mentioned as obsolete in a more recent study. Due to the limited availability of University of Helsinki access, articles which otherwise restricted access were printed and kept on person. There was no distinction between qualitative or quantitative studies, as both provide perfectly reliable information concerning the research questions.

The original purpose of this work was to investigate the special considerations for LGBT elderly housing, but this search proved to be too narrow, with only a few articles specifically addressing this issue. The wider and more useful topic, “Are there special considerations for LGBT eldercare?” was considered for each article’s use, and the writer’s personal belief that this query is more helpful to health care workers in effectively caring for their patients under the Neuman Systems Model.

In this study seven relevant, peer reviewed articles were reviewed. They were numbered 1 through 7 for ease of reference and organized by the order in which they were reviewed. The articles are hereafter referred to by number. The year of publication, article title, author, methodology, and results were then shortly summarized. Common relevant themes to the aim of the study – What special considerations are there when caring for

elderly LGBT people? – are later identified and reviewed in accordance with the theoretical framework corresponding to the Neuman Systems Model.

Articles were selected based on title relevancy and the abstract summary. The articles were then scanned for relevant information, meticulously noted, and keywords and concepts highlighted. Applicable data was then stored for possible future use. The article and its notes were then skimmed and a more specific keywords were logged, and the information was then included or excluded through exclusionary questioning (Machi, McEvoy, p.46). The information gathered was then summarized.

### **5.3 Articles**

**The following articles were chosen for the study.**

1. “Acceptance in the Domestic Environment: The Experience of Senior Housing for LGBT Seniors”, Kathleen Sullivan, 2013, *Journal of Gereontological Social Work*.

Aim: To explore the reasons why elderly LGBT clients chose to live in LGBT-specific senior housing.

Findings: Presence of communal support was the driving factor. LGBT seniors fear discrimination, stigma, heterosexism, isolation, marginalization, rejection, and a ‘closed’ living space. The importance of “fictive kin”, which refers to created family members. Enhanced social network led directly to successful behaviors. Those who use social coping strategies (fictive kin, community based social support) tended to be more well-adjusted.

Design: Qualitative and quantitative data analysis method, with information collection provided through interviews of 7 focus groups living in 3 separate LGBT-specific elder homes over 3 months.

Themes Generated from Analysis: Acceptance; importance of social network/community support; fear of discrimination; lack of existing research; staff training needed, further research needed.

2. “Investigating the Needs and Concerns of Lesbian, Gay, Bisexual, and Transgender Older Adults: The Use of Qualitative and Quantitative Methodology”, Nancy Orel, 2014, *Journal of Homosexuality*.

Aim: To research the specific concerns and needs of elderly LGBT people.

Findings: A specific generational problem of elderly LGBT: They lived through a time when heterosexism was explicit in social/cultural institutions and forced closeted LGBT lifestyle. Experiences of discrimination within the healthcare setting. LGBT less likely to have these conditions evaluated by a medical professional due to fear of discrimination, stigma, and assumptions of heterosexuality. The subjects of this group felt they were at a double disadvantage due to not only their sexual orientation, but also their age. Both factors eliminated certain housing options and made it difficult to find emotional and/or spiritual support. Many had previous activity in the LGBT community, and that it comprised most of their social networks. Revealed fear of living in a “traditional” home, where discrimination, stigma, and homophobia is potentially existing.



Design: Surveys and interviews of three focus groups comprising of 7 to 10 LGB seniors. The transgender population remains unstudied in this case despite “rigorous” recruitment efforts. The average age was 72.3 years. Orel then used content analysis to examine the results.

Themes Generated from Analysis: Lack of existing research; invisibility/double invisibility; needs should be addressed across multiple domains; fear of discrimination, homophobia, and heterosexism; avoidance of health care; invisibility; importance of community; acknowledgement of sexism in aging providers; need for further research.

3. “LGBT older people in Ireland: Mental Health Issues”, McCann, Sharek, Higgins, Sheerin, and Glacken, 2013, *Aging and Mental Health*.

Aims: Investigate experiences/needs LGBT elderly.

Findings: Lingering fear of discrimination/exclusion in seeking somatic/mental health/social services, especially transgendered. The LGBT community support importance was also noticed. Researchers also noted the presumed heterosexuality by health care professionals as a barrier to health care access.

Design: 144 surveys and 36 interviews. A mixed qualitative and quantitative approach was used for data analysis.

Themes: Lack of existing research, invisibility/double invisibility/isolation: hesitation to seek/greater need for mental/overall health care: fear of discrimination; depression, suicide, self-harm, substance misuse, violence; need for equality; training of health care workers, importance of community: social exclusion: societal oppression, stigma: need for further research.

4. “Results from Community-Based Smoking Cessation Treatment Program for LGBT Smokers”, Matthews, Li, Kuhns, Tasker, and Cesario, 2013, *Journal of Environmental and Public Health*.

Aims: Investigates if culturally-specific health care programs are effective in the LGBT community.

Findings: Tailored an existing community outreach group participation stop-smoking program for LGBT groups. Participants in the study showed a “stronger preference” for stop-smoking programs tailored for them. This finding is new, but should not be surprising; the same is applicable for racial minority groups. The researchers focused on increasing the trust and overall acceptability of the group. They held the meetings at LGBT locations, employed LGBT staff, and “branding equipment and program materials with LGBT specific images.” The study’s main accomplishment was to describe the success of enrolling LGBT subjects is in itself a success.

Design: 198 participants, three separate groups under different names were held. Quantitative value measurements were recorded and plotted.

Themes Generated from Analysis: Lack of existing research, “Strong preference” for LGBT-focused health care groups; importance of community; prevalence of smoking, further research needed.

5. “‘I’m still raring to go’: Successful Aging among Lesbian, Gay, Bisexual, and Transgender Older Adults”, Van Wagenen, Driskell, Bradford, 2014, *Journal of Aging Studies*.

Aims: To describe experiences of “successful aging” by subject’s own definition, using physical health, mental health, emotional state and social engagement as guidelines.

Findings: LGBT face unique challenges in aging. Older have seen the emergence of the “modern homosexual”, concomitant social exclusion and medicalization of homosexuality as a mental disorder, the rise of the gay liberation and lesbian feminist movements, the emergence and devastating impact of HIV/AIDS, the proliferation of sexual and gender minority identities (including bisexual, transgender, and queer), the ‘normalization’ of the movement and shift towards a politics of civil rights, and the increasing visibility and incorporation of LGBT issues into mainstream social and political discourse.” Distinct experience of aging stemming from shared experiences in relation to LGBT community, the lifelong process of coming out, the experience of sexual and gender minority stress, marginalization inside and outside LGBT community. Distinctiveness within the LGBT community when it comes to aging. This LGBT group defined gradients of successful aging based on individual interviews, meaning definitions may be different for different groups of people.

Design: 22 LGBT subjects in a community-based interviews and an inductive type analysis.

Themes Generated from Analysis: Lack of existing research; hesitation to seek medical services for fear of discrimination; importance of community engagement, successful aging, success characterized by coping with health problems, noted elevated levels of depression, isolation, anxiety, may be adapted for use in practice to assess and intervene to improve health with LGBT elders; professionals need more training; mental health due to fear; need for further research.

6. “Training, geography, and provision of aging services to lesbian, gay, bisexual, and transgender older adults.” Knochel, Croghan, Moone, Quam, 2010, *Journal of Gerontological Social Work*.

Aims: To understand the preparation and attitude towards caring for LGBT seniors.

Findings: A minority of eldercare facilities were prepared for an LGBT client; only 24% of directors had at least 1 hour of training within the last 5 years. Majority of LGBT patients fear discrimination of going into institutionalized care. 80% facilities said they would be willing to give training on LGB patients only. 12% said they didn't think LGBT patients would be welcomed by local providers. A majority of facilities said they'd never served an LGBT patient. One fifth of facilities polled was unwilling to provide or fund staff training. Rural based carers were less likely to provide services than urban. “

Design: Mixed method online survey and interview comprising of 320 subjects.

Themes Generated from Analysis: Fear of discrimination in seeking healthcare, facilities not prepared to handle LGBT patients, need acknowledged; facilities desire training; further research indicated.

7. “Social Care Networks and Older LGBT Adults: Challenges for the future”, Brennan-Ing, Seidel, Larson, Karpiak, 2014, *Journal of Homosexuality*.

Aims: Discusses the state of social care networks for LGBT elderly.

Findings: Social care networks to be “vital”. Religious congregations may be used. LGBT fear bad care and judgment and assumption of heterosexuality. Professionals in general need more training to be “culturally competent”. Senior centers were frequented, as well as community based services. Those of the LGBT community who have such friends have lower instances of mental health issues. A majority wanted more socialization opportunities. Unmet needs for educational, cultural, spiritual and religious and recreational programs. Patients often live alone, so there is no informal caregiver. They will most likely end up in nursing care.

Design: 230 subject survey disseminated at LGBT social events and places. Mixed method data analysis used.

Themes Generated from Analysis: Lack of existing research, frequency of depression; hesitance to seek health care; importance of community/emotional/social support; high need for and use of services; prevalence of mental health issues; fear of discrimination; families of choice; lack of social support leads to “rope fraying” and hopelessness. Carers must better address LGBT social care needs; further research indicated.

#### **5.4. Data Analysis**

The data was then analyzed using qualitative content analysis, as the text called for the subjective interpretation of the content of written information (Hsieh, Shannon, 2005) in that codes, themes, and patterns were observed and categorized systematically (Evidence-Based Nursing, 2008). In the particular case of the abovementioned articles, the large amount of data was distilled into simpler, easier to streamline and categorize keywords. After keywords were identified, they were counted for frequency. The new information is condensed, yet broad (Elo, Kyngäs 2008).

For each article, the research questions were asked: Are there special considerations in regards to elderly LGBT clients? Which of these aspects should be considered in regards to their care? In drawing a conclusion from an existing body of work, this is a directed content analysis, in that this work attempts to validate or extend theoretically a hypothetical framework or theory (Hsieh, Shannon, 2005).

This methodology was inductive in nature. After carefully reading the information available, an open coding process began, in which generalized notes were taken and common codes were accumulated. They were then plotted onto coding sheets, and then grouped together. The codes were then systematically categorized. It was at this point that the abstraction became clear (Elo, Kyngäs, 2008).

Because of the vast amount of themes generated from analysis, a selective method had to be employed. Using an inductive method drawing from the themes, two categories

were found to occur the most frequently: The importance of community support, and the need for culturally competent care.

## **6. FINDINGS**

Based on a review of the available literature, a wide range of findings were reported, with several common categories. Two themes did appear with remarkable consistency.

### **6.1 Importance of Community/Social Support**

A frequently mentioned theme among the LGBT population is the importance of community (1, 2, 3, 4, 5, and 7). As many are unmarried, a large amount of LGBT (71% of men and 39% of women) live alone, contributing to feelings of isolation and depression (Brennen-Ing 2014). Reports of the importance of a strong sense of community were consistent, and had numerous benefits. Patients with a strong social network had fewer incidences of mental illness (7). Successful behaviors, such as making new friends and engaging outwardly were noted (1). The support makes coping with difficult situations less stressful (3). Above all, 83% of seniors from these studies wanted more social opportunities.

By design of the Neuman Systems Model, the nurse, in this case acting as a primary intervention force, can encourage the patient to engage in community activity targeted at/friendly to LGBT seniors. The isolation is an interpersonal stressor, as it originates inside the system (Neuman, p. 14). If the goal is to maintain the sense of community the LGBT seniors need and thrive on, the facility can also act preventatively by having

social events scheduled regularly which encourage a sense of communal togetherness. This maintains and even buffers the flexible line of defense, possibly making the subject less susceptible to illness.

It is clear from the literature review that the LGBT community does indeed have a special need for social and community support due to a multitude of factors – namely, that they tend not to have children and for the most part live single and alone. In planning policy for such patients, an emphasis on community involvement may prevent feelings of isolation, invisibility, and depression. Subjects in more than one study mentioned cultural and spiritual gatherings in an open and accepting setting. Social engagements are not limited to any one type – the focus is on the openness and acceptance of the group in a social setting.

## **6.2 Necessity for Lesbian, Gay, Bisexual, and Transgender Culturally Competent training**

Another oft-mentioned finding (1, 2, 3, 5, 6, and 7) was the need for culturally competent training for health care staff. As displayed above, LGBT seniors often avoid or put off seeing a doctor or health care professional due to the fear of discrimination, the disapproval of their sexuality, and the assumption of heterosexuality. During a study of elder care homes, it was revealed that only 24% of the directors of these facilities received at least one hour of training in the last 5 years in LGBT elder specific care. The majority of LGBT patients do not want to go into institutionalized care, fearing discrimination – a sharp contrast from the Sullivan 2011 study, which stated that LGBT elders would move into a care facility early if it were LGBT-specific. While most facilities (more than 79%) are open to providing training, this training is not being done.



In relating this example to the Neuman model, we come across a particular conundrum. If the patient is once again the system, and the nurse is the primary intervener, what is the nurse intervening between? In this unique perspective, the nurse is guarding the patient against herself and the rest of the care staff. While this may seem contradictory, it is perfectly applicable. The nurse with culturally incompetent care techniques has the power to change the patient's external and created environments. The nurse, in acting as an intrapersonal (interacting with the client) and extrapersonal (creating a hostile environment) stressor. This can lead to disruptions of the patient's baseline, and eventual symptomatology. However, the nurse has it within their power to change their role by behaving in a culturally competent way. The responsibility is not solely on the shoulders of one nurse. But she can start a reactionary process by simply asking for training and following the chain of command.

The need of more culturally competent training is a clear answer to the question, "Are there special considerations in caring for the elderly LGBT?" Unanimously, yes. Specialized care is needed. To answer the following question, "What are the considerations?" simply following the data from the literature review is enough: health care providers need more training in order to care properly for LGBT elders.

## **7. DISCUSSION**

The elderly LGBT community is a specialized minority which is rapidly growing in numbers, and will soon be a major health care concern. Due to the explicit nature of society's previous anti-gay policies and attitudes, deep-rooted feelings of fear, shame, and stigmatization still run deep, including when seeking health care. Contributing to these feelings is the provider's assumption of heterosexuality and lack of

culturally competent capabilities, through which more specialized care can be given. Because the LGBT community is at higher risk for a multitude of health problems, health care avenues should be as open as possible. Nursing care facilities are at least mostly agreeable to training their staff.

In the studies where the patients are content in their eldercare facility, LGBT-specificity, openness, and acceptance were of utmost importance. The LGBT community thrives on communal and social support, and may participate when available to and tailored to them. Because isolation and loneliness are common, most LGBT seniors crave more social interaction, especially in their home environment. However, a multitude of programs are welcome, including spiritual, cultural, and educational.

Finally, the need for further research is critical at this point, as the population is growing rapidly and facilities are not at this time culturally equipped to care for such specialized patients.

### **7.1 Need for Further Research**

A unanimous concession from the reviewed articles (1, 2, 3, 4, 5, 6, and 7) is that further research into LGBT matters is needed. Studies since 1991 have been pleading for more research, but it unfortunately has only begun. In the beginning purposeful marginalization was partially to blame, and also the reluctance of the LGBT community to come forward. However, attitudes have changed on the side of the LGBT community, who are now more accepted in modern society and want their voices to be heard and counted.

However, the deficiencies cannot be ignored for much longer. Academic research must flesh out the bare bones information we have now in order to broaden understanding.

Placing the entire LGBT elderly community in the model of the Neuman System tests its boundaries. However, since a system can technically be anything, we can say that the LGBT community as a whole is one system. Although the population diverse, we can use the generalizations found in the research to make educated assumptions. If the external environment applies to the world – mainly, the people in it – nurses have a tougher role making a direct impact on the system’s overall performance. However, if the system is not only a moment, or a day, but maybe a decade? Or a lifetime? It is possible that nurses, through research, could make some of the best preventative interventions possible. Through research, due to our unique perspective and close interaction, nurses can provide information absolutely instrumental to changing how we view culturally competent care, or caring for a transgendered patient, or a patient whose children will not let her mother’s partner into the room to see her.

To ask if the LGBT community needs special considerations, the answer is yes. Their unique status needs to be better explored and understood. At this time, only a few suggestions exist, but in regards to their health care, simply asking what health and successful aging means to them may very well suffice.

## **7.2 Strengths**

A major strength of this research is the consistency in which facts are available. For example, in 7 articles talking about roughly the same subject, three clear similarities were presented almost unilaterally. The articles sought are peer-reviewed, and the sources (with a university access code) are easily followed to the original work. Some of the researchers (such as Orel) have done multiple branches of research along the same vein, so specific deficiencies are noted and improved upon.

## **7.3 Limitations**

The main critique of this work is that the research limits any potential findings to a quite narrow group of conclusions. Through this study, I had hoped to shed more light on a problem that it lacking awareness and understanding, but unfortunately the work was fenced in by its own smallness. Many of the articles, while seeming to have new information, references the same decade-old studies other articles also cited.

Due in part to the number of articles available and the limited amount of study done on this topic, it still focuses more on gays and lesbians, while the world, mental health, and preferences of the bisexual and transgender community are still largely unknown. Because SOME information was acquired, the LGBT abbreviation is used, but in reality this work applies mostly to gays and lesbians.

This study also contains a very broad picture of the needs of LGBT elderly because each person who filled out a questionnaire is an individual, each with their own wants

and needs. What one elderly member of the LGBT community wants could be different or even with contradictory to another's wants.

Another critique of the work is that some of the recommendations presented in the literature are simply not feasible. For example, making elderly housing only for LGBT seniors (as suggested by the Sullivan study of 2011) is not at all a possibility for a country with universal health care. Because such a facility must be built and designed in order to serve the community, it is not possible to build one facility that would only provide services to a small minority. The other side to consider is that if such a facility were created, how could it only be available to LGBT seniors? Does that not discriminate against and exclude heterosexuals in the same way that has offended the LGBT community in the past? While the main difference is the lack of malfeasance, specific exclusionary policies cannot be recommended.

## **8. RECOMMENDATIONS**

After carefully reviewing the literature, mental health and counseling services specially tailored or especially friendly towards the LGBT community should be at least available. Sullivan recommends creating a "safe space" for LGBT clients. This is also echoed by the American Psychiatric Association:

"Psychological service providers and care givers for older adults need to be sensitive to the histories and concerns of LGBT people and to be open-minded, affirming and sup-

portive towards LGBT older adults to ensure accessible, competent, quality care. Caregivers for LGBT people may themselves face unique challenges including accessing information and isolation.” (“Lesbian, Gay...” 2014)

In the case that patients delay seeking medical treatment due to fear of discrimination during a health-care visit, there can be no other conclusion. Perceived or not, the LGBT community’s fear of discrimination or homophobia is a clear roadblock on their path to health. Asking the patient about their own particular needs and wants also seems to be beneficial. Sullivan (2013) recommends asking on the patient intake form about sexual orientation and gender identity. Van Wagenen (2013) also recommends, in the context of successfully aging, asking the patient directly what successful aging means to them.

Aging professionals should evaluate their own cultural competence, knowledge base, and comfort level when caring for LGBT patients (Sullivan, 2011). SETA (Sek-suaalinen Tasavertaisuus Ry, “Sexual Equality Group”), a Finnish LGBT equal rights group, offers an informative website in multiple languages, materials, videos, and presentations for professionals. They also specialize in elder LGBT issues and awareness.

Staff at elderly care facilities should also undergo training – just as they do for hygiene, patient privacy, and continuing education for job-related tasks – to identify, prevent, and discuss homophobia and its harms to patients. Open access to training was mentioned often (1, 3, 4, 5, 6, 7, In a study done by Cahill and South as recently as 2002, the “vast majority” of health care workers have heard disparaging comments about LGBT patients, and more than half know of “substandard care given to LGBT

seniors” (Cahill & South, 2002). Open dialogue with a specialist training in LGBT issues should be offered, and staff should ask questions freely to clear up any misconceptions or share any feelings about working with LGBT seniors. Knotchel, et al suggested providing incentives for exemplary behavior in caring for LGBT patients. While this may not fit in all cultures, positive reinforcement can facilitate the issue. The same study suggested “openness” posters, promoting a discrimination-free workplace. Also, marking LGBT important dates on a community calendar (Sullivan uses the example of Pride month) and reflecting the LGBT community in published materials.

Finally, the most ardent recommendation by the author of this study (and every source cited) is that further research must be done. While there is a limited amount of information, larger and more comprehensive studies must be done in order to flesh out the existing information into a depth of knowledge which can further lend a helping hand to the LGBT community. As stated above, the bisexual and transgender community is still largely understudied and there are many question marks about their preferences, mental health, and emotional wellbeing. Studies specifically targeted at these groups is imperative.

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# APPENDICES

Appendix 1. The Neuman Systems Model, ©1970, Betty Neuman.

