

Invisibility, Outness, and Aging Service Use Among Sexual and Gender Minority Older Adults

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BOSTON COLLEGE
School of Social Work

INVISIBILITY, OUTNESS, AND AGING SERVICE USE AMONG
SEXUAL AND GENDER MINORITY OLDER ADULTS

A dissertation

by

SARA KEARY

Submitted in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy

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SARA KEARY

Dissertation Chair: Kevin Mahoney, PhD

Abstract

Lesbian, gay, bisexual, and/or transgender (LGBT) older adults in the U.S. face disproportionate risk for increased health and mental health problems as compared to their non-LGBT counterparts. Experiences of harassment, discrimination, and violence due to sexual orientation and gender identity (SOGI) contribute to the chronic stresses associated with a sexual and/or gender minority. Due to fear of inadequate treatment because of SOGI, LGBT older adults may avoid or delay needed care or services in later life, rendering them invisible to health care providers (HCPs) if they do not disclose SOGI and if providers do not ask. This three-paper dissertation explored LGBT older adults' invisibility and outness in aging services. Paper 1 investigated gerontological social workers' biopsychosocial assessment practices to understand how they became aware of clients' SOGI; assessment forms were analyzed and qualitative interviews with social workers were conducted, showing that social workers did not have a systematic way of learning about clients' SOGI. Paper 2 was a quantitative analysis of survey data from 129 LGBT older adults that showed an association between experiences of SOGI-based discrimination/violence after age 50 and not disclosing SOGI to HCPs and having avoided using aging services for fear of coming or being out. Paper 3 was a qualitative

analysis of interviews with 22 LGBT older adults that sought to understand how they disclosed SOGI to their HCPs and found that clients disclosed willingly, sought out an LGBT or LGBT-friendly provider, or shared SOGI information with their HCP after being asked about their sex and/or love lives. This dissertation offers suggestions for social work policy, practice, and research aimed at supporting gerontological social workers and other aging service providers in learning about their clients' SOGI in an effort to address health disparities among LGBT older adults.

Keywords: LGBT older adults, gerontological social workers, outness, invisibility

DEDICATION

To the two most influential social workers in my life: my mom, Barbara Miller and my step-dad, Timothy Whelan. Mom, for a long time, it was just the two of us. Sometimes that could be one too many people and other times just enough. Nothing could have prepared me for how abundant our lives were to become when you and Tim got married. Tim, I have to constantly remind myself that I'm not dreaming and that I really do get to have you as my step-dad.

In a commencement speech he gave to Temple University MSW graduates in 2013, Tim said, "I love being a social worker because it has given me a lifelong purpose of working with and advocating for the powerless in our communities and empowering the people we serve; building on their strengths is the hallmark of our profession. I love being a social worker because I know my work makes a difference. I love being a social worker because I believe change is possible. I love being a social worker because I love being frustrated. We all know that relapse is part of recovery and that change comes oh, so slowly in lots of little fits and starts. Our work is often tedious, unappreciated, and just downright hard. You have not chosen an easy profession, so you might as well love it."

My mom's two catch phrases, "trust the process" and "everyone has a story" help me be a better social worker and a better person. Mom and Tim, the two of you have taught me how to love this profession, to trust the process, and to always remember that everyone has a story. Thank you for being the fiercest examples of how to treat others with respect and dignity, both in the field and at home.

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LIST OF ABBREVIATIONS

APA	American Psychological Association
D/V	Sexual orientation and gender identity-based discrimination and violence
HCP	Health care provider
LGBT	Lesbian, Gay, Bisexual, and Transgender
MAP	Movement Advancement Project
SAGE	Services & Advocacy for Gay, Lesbian, Bisexual, and Transgender Elders
SGM	Sexual and gender minority
SOGI	Sexual orientation and gender identity

CHAPTER I: DISSERTATION INTRODUCTION

Purpose and Specific Aims

Current estimates of lesbian, gay, bisexual and transgender (LGBT) Americans aged 65 and older range from 1.5 to 7 million people (Fitzgerald, 2013) and by 2030, this population is expected to double (Fredriksen-Goldsen et al., 2011). Based on this data, the United States could experience an increase of LGBT older adults from as little as 3 million people to as many as 14 million people in the next 15 years. Although research on LGBT older adults in the United States has recently been advancing, these estimates have remained erratic. One explanation for these variations in population estimates is that sexual orientation and gender identity (SOGI) data collection among nationally representative samples of all ages is rare and procedures are inconsistent¹ (Institute of Medicine, 2011; Cahill & Makadon, 2013). Most studies that do address the needs of sexual and gender minority (SGM) individuals focus on between those the ages of 18 and 65 (Conron, Mimiaga & Landers, 2010; Dilley, Simmons, Boysun, Pizacani & Stark, 2010). A second reason is that LGBT older adults may be reluctant to disclose their SOGI for fear of harassment and discrimination (Fitzgerald, 2013). A third possibility is that health, mental health, and aging services providers have yet to make a regular practice of asking their clients appropriate and sensitive questions in order to collect SOGI information (Cahill & Makadon, 2013).

¹ The National Health Interview Survey (NHIS) is one of the country's leading sources of population health data that has been tracking household health status and access to health care for over 50 years (Centers for Disease Control [CDC], 2013). It was not until 2013 that the NHIS inquired about respondents' sexual orientation; a date has not yet been set when specific questions about gender identity will be added (CDC, 2013).

While national surveys and population studies have been slow to change data collection procedures, direct practice aging service providers are at the forefront of collecting SOGI information from their older adult clients. By asking clients about their SOGI, aging service providers could take steps toward person-centered care and away from the silencing of SGM older adults. Healthy People 2020 suggests that health care providers (HCPs) should be “appropriately inquiring about and being supportive of a patient’s sexual orientation to enhance the patient-provider interaction and regular use of care” (U.S. Department of Health and Human Services, n.d.). As Cahill and Makadon (2013) note, health disparities between LGBT and non-LGBT individuals could be reduced “if providers both understood and discussed issues of SOGI with their patients and addressed health conditions disproportionately affecting LGBT people” (p.35).

People working directly with LGBT older adults are in a unique position to begin learning more about this population, not only for the sake of the current cohort of LGBT older adults, but also for cohorts to come. Cahill and Makadon (2013) use the example of progress with regard to smoking cessation once physicians started to make a regular practice of inquiring about their patients’ use of tobacco. In the same vein, they suggest that “primary care providers should consider what it means to LGBT patients to be greeted by silence on the part of their health care providers, both with respect to important aspects of their identity, as well as risks they might avoid and health screenings they might receive if counseled appropriately” (p. 35).

Definitions Relevant to Each of the Three Papers

Sexual orientation. The American Psychological Association (APA) (2013) defines sexual orientation as an “enduring pattern of emotional, romantic and/or sexual

attractions to men, women or both sexes” (2013). Although research has shown that sexual orientation tends to range along a continuum, from being exclusively attracted to the opposite sex to being exclusively attracted to the same sex, it usually tends to be categorized into the three following groups: heterosexual, gay/lesbian and bisexual (LGB) (APA, 2013). Heterosexual people (also referred to as “straight”) have attractions to people of the opposite sex, gay/lesbian people have attractions to people of the same sex and bisexual people have attractions to people of the same and opposite sex (APA, 2013). Until 1973, the psychiatric profession diagnosed people who experienced same-sex attraction, behavior or identity as homosexual (Bradford, Cahill, Grasso & Makadon, 2012). Due to the clinical and outdated nature of this term, it will only be used when discussing the historical context of sexual orientation in the 20th century.

Part of what can complicate the measurement of sexual orientation is that it is a concept with three distinct components, which may or may not be congruent with one another. These include sexual attraction/arousal, sexual behavior and sexual identity (Savin-Williams, 2006). For example, someone may have same-sex attraction, yet neither engage in same-sex behavior nor identify as gay, lesbian or bisexual, and instead identify as heterosexual. Similarly, one may engage in same-sex behavior, but not identify as gay or lesbian; or someone could engage in sexual behavior with both the opposite and the same sex, and identify as heterosexual, gay or lesbian, and not as bisexual. Alternatively, someone could experience same-sex attraction, engage in same-sex behavior *and* identify as gay, lesbian or bisexual.

The multifaceted nature of sexual orientation makes collecting data on this aspect of identity more complicated than simply asking people to answer a question such as “Do

you consider yourself to be heterosexual or straight, gay or lesbian, or bisexual?” “Do you consider yourself” tends to target only the *identity* component of sexual orientation and neglects to further inquire as to whether people have experienced attraction or have engaged in sexual behavior with persons of the same sex. For Paper 1, all three aspects of sexual orientation were considered. For Paper 2, analyses included the *identity* component of sexual orientation, as it was limited to only those who identified as LGBT. Paper 3 included participants who identified as LGB and/or transgender (T) or had a same-sex sexual relationship in their lifetime.

Gender identity. Different from sexual orientation, gender identity refers to “a person’s innate, deeply felt psychological identification as male or female,² which may or may not correspond to the person’s body or designated sex at birth” (Human Rights Campaign [HRC], 2013) and is specific to one’s internal sense of gender (APA, 2013).

Gender expression, on the other hand, includes

all of the external characteristics and behaviors that are socially defined as either masculine or feminine, such as dress, grooming, mannerisms, speech patterns and social interactions. Social or cultural norms can vary widely and some characteristics that may be accepted as masculine, feminine or neutral in one culture may not be assessed similarly in another. (HRC, 2013)

²The terms *male* and *female* are technically sex categories, referring to “the biological and physiological characteristics that define men and women” (World Health Organization [WHO], 2013) while the terms *masculine* and *feminine* (including *man* and *woman*) are gender categories, referring to “the socially constructed roles, behaviors, activities and attributes that a given society considers appropriate for men and women” (WHO, 2013). *Male* and *female* are often used when referring to *gender*, when they really are representations of *sex*, as noted above in the APA’s definition of *gender identity*.

Gender identity and gender expression are distinct from one another; a person who was born female may take on more masculine gender expression, yet not identify as a man. When individuals' *gender identity* and birth sex are incongruent, they may identify as *transgender*, which means that their "gender identity, gender expression or behavior does not conform to that typically associated with the sex to which they were assigned at birth" (APA, 2013). Some, but not all, people who consider themselves to be transgender will experience gender transition in their lifetime (HRC, 2013) and will identify as male or female, not as transgender. Also, it should be noted that people who consider themselves to be transgender do not necessarily identify as lesbian, gay or bisexual; in fact, many people who are transgender identify their sexual orientation as heterosexual (Bradford et al., 2012).

For Paper 1, gender identity was considered in the content analysis of psychosocial assessment tools and gerontological social workers' interview practices. Papers 2 and 3 also focused on participants' gender identity and included transgender-identified participants.

Sexual and gender minority (SGM). The term "sexual and gender minority" and its abbreviation "SGM" will frequently be used interchangeably with LGBT throughout each of the three papers to denote individuals who identify as lesbian, gay, bisexual and/or transgender (LGBT³). The reason for using *sexual and gender minority (SGM)* is

³ The omission of the frequently used "Q" in LGBT in the three papers is intentional. While the "Q" often stands for *questioning* of one's sexual orientation, it has also been used to mean *queer*. While younger generations of sexual minority individuals may claim the word *queer* and use it as a term of empowerment, LGBT older adults tend to reject this label as degrading and offensive since heterosexuals have used this term to identify sexual minority individuals as deviant, strange, and abnormal (Brown, 2009). As noted by Brown (2009), "Queer has not always been a positive point of identity for people in

to capture the complexity of SOGI. As noted above, regardless of how transgender individuals identify their sexual orientation, they will be considered in these papers as SGMs since their gender identities are incongruent, whereas most male persons identify as men and most female persons identify as women.

Background

Disparities Between SGM and Non-SGM Older Adults

Illness, dependency, and financial insecurity are some of the aging-related stressors that concern most older adults as they age. Fears about disability, worries about reduced income, and for some, anxiety with regard to possible abuse or neglect, are examples of how the aging process involves more than just biological and physical changes (Witten & Eyler, 2012). The Services for Advocacy for Gay, Lesbian, Bisexual, and Transgender Elders (SAGE) network (2012) has noted that SGM older adults face disproportionate risk for loneliness and social isolation compared to non-SGM older adults, especially with regard to living situations. Family members, such as spouses, children, and grandchildren usually comprise most of the social supports for older adults in the United States. But for SGM older adults, biological and legal family members may be limited. SGM older adults are more likely to live alone, to be single, to be estranged from their biological families less, and less likely to have children, than their non-SGM counterparts (SAGE, 2012).

Living with a spouse can have physical and psychological benefits by improving life satisfaction, happiness, and overall well-being (Lyyra & Heikkinen, 2006). Similarly,

the LGBT community; for older individuals, *queer* may have been used to humiliate and shame them; the violence behind *queer* may have made it impossible for them to be open about their sexual orientation (p. 65-66).

LGBT older adults who live with a partner have reported less loneliness and better mental and physical health than those living alone (Grossman, D'Augelli & Hershberger, 2000; Grossman, D'Augelli & O'Connell, 2001). While women are more likely to live alone in the general population, gay and bisexual older men are at greater risk for living alone as compared to heterosexual older adults (Fredriksen-Goldsen et al., 2011).

Although LGBT older adults tend to have fewer biological family members who make up their social supports, they are more inclined to have “chosen families” (as compared to non-LGBT older adults) that consist of a group of people, mainly friends, to whom gay and lesbian older adults feel emotionally close and consider to be their family, even though they are neither biologically nor legally related (de Vries & Herdt, 2012). Since SGM older adults are three to four times less likely to have children and grandchildren than their non-SGM counterparts and their partnerships are less likely to be legally recognized, they are more likely to have friends their own age who provide assistance (Fredriksen-Goldsen et al., 2011). This means that informal caregiving for SGM older adults is often provided by peers who may also be experiencing their own age-related limitations and stresses. Though this is also true for many non-LGBT caregivers, it is of particular concern for LGBT caregivers who may have limited familial supports of their own. Because of this, SGM older adults may need to access formal aging-services earlier than non-SGM older adults of the same age (Fredriksen-Goldsen et al., 2011). This is one of the main reasons why it is extremely important that aging service providers be sensitive to the composition of SGM older adults' social networks and caregiving supports.

Health disparities between LGBT and non-LGBT older adults are not simply byproducts of the differences in their social network composition; limited access to health care and negative experiences with the health care system have also contributed to disparities (U.S. Department of Health & Human Services, n.d.). “Legal discrimination in access to health insurance, employment, housing, marriage, adoption, and retirement benefits” are some of the social determinants of health experienced by SGM individuals that produce health disparities between them and non-SGM individuals (U.S. Department of Health & Human Services, n.d.). In addition, negative interactions with medical professionals can deter SGM individuals from seeking needed care (SAGE, 2010).

Living for years without medical care, either because it is unaffordable, inaccessible, or due to fear of stigma and discrimination puts SGM people at higher risk for negative health consequences, especially if they forego needed preventive and screening services. Further, many SGM older adults have had experiences of both perceived and actual violence over the course of their lives (Witten & Eyler, 2012) which, combined with restricted access to health care and limited biological family supports, puts them at greater risk for increased health disparities in older adulthood.

Theory

Life Course Perspective

A study of SGM older adults must take into account the influence that historical context has had on this population’s experiences. The life course perspective emphasizes the importance of key historical events and how they have shaped people’s experiences (Elder, 1998; Cohler & Hostetler, 2007). Since the 1950s, people who experienced same-sex attraction or engaged in same-sex behavior were considered to be either criminals

and/or mentally ill (IOM, 2011). Sigmund Freud is often cited for defining what was to come to be known as sexual orientation and divided people into two groups, “heterosexual” meaning sexual attraction to the opposite sex and “homosexual,” meaning sexual attraction to one’s same sex (IOM, 2011, p. 34).

Although Freud himself did not necessarily consider homosexuality to be an illness, American psychiatrists and psychologists did. In 1952, when the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) was developed, homosexuality was classified as a “sociopathic personality disturbance” and categorized under the same diagnoses as drug and alcohol abuse and sexual dysfunctions (IOM, 2011). Mental health professionals used various approaches to treat or attempt to “cure” their LGBT patients, some of which ranged from psychotherapy to invasive treatments such as electroconvulsive therapy, lobotomy, and castration (IOM, 2011, p. 36). In addition, because they were seen as mentally ill or immoral, gay men and lesbian women were often discriminated against; they were ineligible to receive the same employment and housing rights that heterosexual people were afforded and often lost their jobs due to their sexual orientation (IOM, 2011, p. 36).

In the context of the life course perspective, a cohort is considered to be a “group of persons who were born at the same historical time and who experience particular social changes within a given culture in the same sequence and at the same age” (Hutchinson, 2011, p. 12). The current cohorts of SGM older adults (those age 60 and older) were in their twenties or thirties during the time of the gay rights revolution of the 1970s. If they identified as LGBT at the time, they often did so secretively by “passing” as non-LGBT in their professional lives while spending their personal lives with other

hidden and stigmatized SGM adults (Cohler & Hostetler, 2007). Although the American Psychiatric Association removed homosexuality from the DSM in 1973 (APA, 2012) SGM individuals were not readily accepted into society and freed from discrimination and prejudice.

There are currently three main cohorts of LGBT older adults (those age 50 years old and older) in the United States; the Baby Boom Generation includes those who were born between 1946-1964, the Silent Generation includes those who were born between 1925-1945, and the Greatest Generation includes those born between 1901-1924 (Fredriksen-Goldsen, Kim, Barkan, Muraco & Hoy-Ellis, 2014). Members of these cohorts grew up in times of distinct periods of homophobia and heterosexism in the United States. For example, those born before 1946 (the Silent Generation) “came of age during the McCarthy Era, a time when same-sex behavior and identities were severely pathologized and criminalized” (Fredriksen-Goldsen et al., 2014, p. 85).

Coming of age during a time when same-sex attraction or gender variance carried the complex stigma of being illegal, a mental illness, and a moral and religious failing forced many LGBT older adults to be vigilant about protecting themselves by concealing their SOGI. Rodríguez Rust (2012) notes that “the historical time period in which an individual came out, and the age at which she or he did so, are factors that have profound and lasting effects on that person’s needs and experiences” (p. 163). SGM older adults who became aware of their SOGI and/or came out between the 1920s and 1960s in the United States have reported feeling isolated and alone during this time in their lives (Berger, 1984; Friend, 1987). These feelings of loneliness and isolation might be carried over from the hidden or secretive lives SGM older adults were forced to live in order to

avoid discrimination and harassment. As will be discussed in subsequent sections, Wight, LeBlanc, de Vries and Detels (2012) have noted the unique challenges faced by LGBT individuals due to the combination of common aging-related stressors and those associated with their SGM status. These challenges include:

stigma, discrimination, prejudice, internalized homophobia, and concealment...exclusion from legal marriage, limited legal rights for same-sex partners, lack of access to informal care within traditional family networks, insensitivity to sexual minority health issues among care providers, and ostracization in health care and long-term care settings. (Wight et al., p. 503)

In addition to the stigma associated with an SGM identity, HIV/AIDS has had an impact on the LGBT community's struggles and resiliencies. LGBT older adults age 50 years old and older who lived through the AIDS epidemic of the early 1980s have experienced a disruption in a "normal, multigenerational, and long-term perspective" (Witten, 2012, p. 4), affecting their aging-related experiences, such as access to health care and caregiving. LGBT individuals met the challenges faced by HIV/AIDS and provided "families of choice" support systems when neither biological nor formal caregiving options were available due to HIV/AIDS-related stigma. Over time, the cumulative negative effects of managing stigmatizing identities over one's life course have been shown to have detrimental health and mental health outcomes, as will be discussed in the following sections (Ragins, Singh & Cornwell, 2007).

SOGI Disclosure, Outness, and Stigma

SOGI Disclosure. Disclosure and concealment are ways in which LGBT individuals manage the sharing of information about SOGI identities when faced with

cultural and organizational heterosexism (Oswald, 2002; Moradi, 2009). Oswald (2002) notes that viewing disclosure and concealment as strategies suggests that revealing one's sexual orientation is a process, rather than a one-time event. Among a sample of sexual minority youth, D'Augelli, Hershberger and Pickington (1998) found that when they did not feel afraid of physical, financial or emotional harm, they were more likely to disclose their sexual orientation identity. Similarly, LGBT older adults who do not know how others will react upon learning about their SOGI may be reluctant to share this aspect of themselves if they fear rejection or anticipate discrimination, especially if they have not been out long about these identities (Fredriksen-Goldsen et al., 2014; Morrow, 2001).

Outness. Outness refers to individuals' self-reports of which people in their lives know (and to what extent) that they identify as LGB (Mohr & Fassinger, 2000). Level of outness and continued SOGI disclosure may vary based on individuals' experiences with first coming out. For example, Morris, Waldo, and Rothblum (2001) found that among lesbian women, the more years of self-identification as lesbian, the more out they were. Based on coming out experiences, LGBT individuals' level of outness may vary across situations, with different people, and may affect individuals in a variety of ways.

Although concealing their sexual orientation can help LGB individuals avoid stigmatization and discrimination, it can also have harmful effects over time, such as higher rates of stress and suicidality (Miller & Major, 2000; Morris et al., 2001). There is evidence that continually having to manage a stigmatized identity such as SOGI can have negative consequences. Ragins (2004) found being out in the workplace is an important part of individual development and is associated with mental health benefits. However, since LGBT older adults do not know how others will react upon learning about their

SOGI, they may be more likely to conceal this aspect of themselves if they fear rejection or anticipate discrimination.

Appleby and Anastas (1998) noted that sexual minority youth and adults must assess for themselves when they feel it is safe to disclose their sexual orientation and if it is safe, how much to disclose. LGBT older adults may also be hesitant to disclose their SOGI to others for a number of reasons, including perpetuated stigma of SGM identity, internalized guilt and/or shame, or fear of discrimination due to heterosexism. However, even though disclosure of one's sexual orientation may serve as a protective factor, greater concealment may be harmful for gay and lesbian people because it could increase social isolation and stress (Moradi, 2009). In employment settings, LGBT adults indicated that disclosure of their sexual orientation was related to positive workplace outcomes, such as "job satisfaction, organizational commitment, peer relationship support and satisfaction, and cooperative group process" (Moradi, 2009, p. 526).

With regard to timing of disclosure, although Rawls (2004) found that while coming out later in life did not greatly affect overall depression scores in a sample of older gay men, coming out earlier may influence level of outness in older adulthood, such that those who come out earlier in life may be more out and therefore more able to face aging-related stresses such as loneliness or age-related stigma since they experienced negative effects of heterosexism and have coped with challenges throughout life.

It should be noted that the conceptualization of degree of outness is different from what is commonly known as initial "coming out." In this dissertation, initial "coming out" refers specifically to the process that LGBT individuals experience when they first acknowledge to themselves, and perhaps then to others, their self-identification

as LGBT (Johnston & Jenkins, 2004). Similarly, Radnosky and Borders (1995) defined coming out as a “process of self-awareness and self-labeling in relation to one’s own sexuality” (p. 19), and generally involves one’s integration of a sexual minority identity within a larger context and is considered to be a one-time developmental event (Cass, 1979), rather than the strategic method of discerning when it is safe for SGMs to disclose their SOGI. On the other hand, outness refers to individuals’ self-reports of which people in their lives know (and to what extent) that they identify as LGBT.

Stigma. As defined by Herek (1996), stigma refers to “a pattern of serious social prejudice, discounting, discrediting, and discrimination that an individual experiences as a result of others’ judgments about her or his personal characteristics or group membership” (p. 198). As such, stigmas can be either visible or invisible. For example, people with noticeable physical disabilities would be unable to conceal their disabilities and others may make assumptions about them based on their appearance and/or limitations. An invisible stigma, such as religious affiliation, political belief, mental health diagnosis, or learning disability, on the other hand, means that some self-disclosures can place people at higher risk for negative judgment from others not in the stigmatized group (Herek, 1996). As such, SOGI are considered here to be invisible stigmas. For example, if someone disclosed the fact that she was taking an over-the-counter medication for a cold, she would be less likely to be judged or have assumptions made about her personality or character than if she disclosed she was taking an antipsychotic medication prescribed by a psychiatrist for the treatment of a mental illness.

People with an invisible stigma may utilize a number of “passing” strategies in order to manage who knows about what aspects of their stigmatized identity. These

include discretion (carefully avoiding sharing personal information that would reveal their identity), concealment (actively preventing people from learning about their identity), and fabrication (intentionally providing false information about themselves so that others would not find out about their identity) (Herek, 1996). For SGM individuals, living a double-life can create stressful situations for them as they attempt to manage parts of their identity. Pennebaker, Hughes & O’Heeron (1987) have found that intentionally restricting behaviors, thoughts or emotions can require a great deal of physiological effort, which, if consistently done over time, could lead to increased distress and negative health outcomes (Pérez-Benítez, O’Brien, Carel, Gordon & Chiro, 2007).

Minority Stress Theory

Though Minority Stress Theory applies to all minorities, within the context of SOGI, it posits that those who identify as LGBT may be more or less “out” depending on their anticipation of future hostility and judgment (Meyer, 2003). The fear of expected negative events has caused many SGM people to conceal their SOGI in order to avoid such harmful consequences (Meyer, 2003). Members of minority groups experience higher levels of stress than non-minorities due to stigma and discrimination related to their minority status, which can lead to increased health disparities (Meyer, 2003). Over time, distal stressors (outside of the individual) which include experiences of discrimination, prejudice, and rejection and proximal stressors (within the individual) such as minority identity concealment or anxiety/fear about anticipated rejection, prejudice, or discrimination, as well as internalized heterosexism, can contribute to higher

levels of poor health and mental health outcomes in minority groups as compared to non-minority groups (Meyer, 2003).

For LGBT individuals, personal experiences with discrimination and prejudice (distal stressors) can lead to fear of future rejection or discrimination (proximal stressors), which in turn may increase their concealment of personal information, such as their SOGI. Herek and Garnets (2007) reviewed a number of empirical studies on sexual minority individuals and found that both distal and proximal stressors were related to poor mental health outcomes in this group. Minority Stress Theory was used in this dissertation to provide insight into how SGM older adults might manage distal and proximal stressors when using aging services and what factors help facilitate or deter SGM older adults from sharing their SOGI with primary HCPs.

For LGBT individuals, the issue of negotiating SOGI disclosure/concealment is one of the ways in which minority stressors factor into older adults' general concerns about being unable to care for themselves, their dependence on others, becoming sick, disabled or cognitively impaired, and outliving their incomes as they age (MetLife, 2010). Evidence has suggested that early and repeated experiences of stigma and discrimination can have a cumulative and harmful effect on sexual minority older adults' well-being (Meyer, 1995; Grossman et al., 2001).

Fears and experiences of discrimination and stigma, a history of exclusion from legal protection (such as marriage), and limited access to informal and familial caregiving are a few of the challenges that SGM older adults face in addition to general aging-related stressors (Wight et al., 2012). Just as non-LGBT older adults anticipate problems associated with aging, SGM older adults do as well, but with added minority stress

regarding concerns about their SOGI (Meyer, 2003). General aging stressors, combined with minority stresses, could possibly put LGBT older adults at risk for greater levels of stress and poorer mental health outcomes than non-LGBT older adults. This is one of the main reasons why it is crucial for aging service providers to initiate the discussion of SOGI so that their clients do not have to take on the burden of worrying about this additional concern.

The Silencing and Invisibility of Sexual Minority Older Adults

Another main theme connecting each of the three papers in this dissertation is the idea that SGM older adults have been ignored in gerontology studies and related fields of aging (Brown, 2009). These fields of study and practice have been affected by traditional heteronormative influences and have ascribed such influences to aging, “leaving no room” for non-LGBT life course trajectories. Similarly, older adults have generally been absent in queer studies. As noted by Brown (2009) “the exclusion of LGBT elders from queer theory and gerontological theory has resulted in the silencing of LGBT older adults and their lived experiences” (p.66). Brown (2009) does not suggest that queer and gerontological theorists intentionally exclude SGM older adults. Instead, she argues that, “this silencing is an extension of homophobia and heterosexism in gerontology and ageism in queer theory” (Brown, 2009, p. 66), leaving SGM older adults without social or financial supports. This silencing has isolated SGM older adults from both older-adult and LGBT communities, as well as the human service agencies serving those communities (Brown, 2009).

The culture of heterosexism in the United States has also contributed to an assumption of heterosexuality, therefore equating “normal” sexuality with heterosexual

identity (Herek, 1996) and in this sense, people are considered to be heterosexual until proven otherwise. The notion that people are heterosexual, especially among older adults, is seen in the normalizing of the terms spouse or widow. But as Herek (1996) notes, these social roles, such as husband, wife, father, and mother are seen mainly as “indicators of social duties and behaviors; they are not perceived to be associated primarily or exclusively with sexual behaviors, even though they recognize private sexual conduct” (p. 200). Because heterosexuality is considered the “norm,” if an older lesbian woman referred to her wife, others might consider this an inappropriate disclosure of information about her private sexual behavior, rather than thinking of this as commonplace, uncomplicated, and desexualized (Herek, 1996).

In order to avoid placing themselves at risk to be stigmatized, judged or discriminated against, SGM older adults may engage in passing behavior as mentioned earlier, which perpetuates their invisibility. They may either omit this information in interactions with health and aging service providers if they are not asked, or they may lie about or hide their SOGI if they do not feel supported or validated by the professional seeking this information (Ragins et al., 2007).

Overview of the Three Papers

Paper #1: The Invisibility of Sexual and Gender Minority Older Adults in Gerontological Social Work Assessment

Paper 1 aimed to learn about how Boston-area gerontological social workers assessed for new clients’ SOGI upon admission to a program or enrollment in a service. Intake assessments and/or social work biopsychosocial evaluations are one of the primary ways in which service providers learn about the social aspects of clients’ lives. If SOGI

questions are asked of older adults at the start of services, providers may be alerted to potential sources of support, as well as possible needs, risks, or hardships for SGM clients. By including specific wording about SOGI in intake assessments, social workers take on the responsibility of asking clients directly about their SGM status. Regardless of whether or not clients are forthcoming about this information, the responsibility would lie with the clinician to initiate the question.

There were two stages to Paper 1: Stage 1 involved a content analysis of 32 intake assessments/social work psychosocial evaluations used by different gerontological social workers in the Boston-area. Social workers who provided assessments worked in a variety of settings, including nursing homes, adult day programs, assisted living facilities and personal care homes, hospice programs, and inpatient hospital services. Stage 2 involved a qualitative analysis of semi-structured interviews with 10 randomly selected social workers who provided their agency's biopsychosocial assessment tools. Constant comparative analysis was used to identify whether and how gerontological social workers asked their clients about SOGI if this information was not asked directly on assessment documents.

The goal of Paper 1 was to explore how aging services assessment practices understand the needs and strengths of the older adults they serve. Learning whether or not SOGI are part of the intake process is important in determining how much these practices may be influenced by heteronormativity, which may deter LGBT older adults from offering information about their SGM identity. This study sought to understand whether there is a need to change how gerontological social workers address these issues at the

point of contact with new clients, or if structured assessments were already considering these aspects of individuals' identities.

Paper #2: The Effects of Cumulative and Age-Specific Experiences of Sexual Orientation and Gender Identity-Based Discrimination and Violence on LGBT Older Adults' Attitudes and Behaviors Regarding Aging Service Use

Paper 2 used secondary survey data from the Care and Service Needs of Older Adults at Congregate Meal Sites Study (MEALSITE Study), which was conducted by the Fenway Institute and the Massachusetts LGBT Aging Needs Assessment coalition (M'LANA). This quantitative analysis considered the relationships between cumulative and age-specific experiences of SOGI-based discrimination and violence (D/V) and LGBT older adults' attitudes and behaviors regarding aging service use. Attitudes included concern about sexual orientation discrimination and using aging services and concern about coming or being out and accessing aging services. Behaviors included being out to all HCPs, having chosen an aging service provider because they were LGBT-friendly, and having decided against asking for help from a place that provides services for older adults due to concerns about coming or being out. Bivariate statistics and appropriate regression analyses were conducted to determine whether cumulative and/or age-specific D/V experiences were associated with LGBT older adults' attitudes and behaviors regarding aging service use.

Paper 2 offered important insights into what might influence LGBT older adults' concern when accessing mainstream aging services which are not specifically LGBT-friendly or welcoming of SGM older adults. Based on characteristics of those who were out to less than all of their HCPs and who avoided asking for help from an aging service

provider due to concerns about coming or being out, Paper 2 offers recommendations for how aging service providers might address the unique needs of SGM clients.

Paper #3: How Do Sexual Minority Older Adults Disclose Sexual Orientation and Gender Identity to Health Care Providers?

Paper 3 used secondary qualitative data from the Health and Social Life of Boston-Area Elders that were collected by the Fenway Institute and members from the M'LANA coalition. Transcripts from interviews with 22 LGBT older adults (age 60 and older) were analyzed using constant comparative analysis in order to learn how participants in this study disclosed their SOGI to their primary health care providers. Coding procedures and memo writing were used to identify ways in which LGBT older adults either shared or concealed their SOGI with their providers. The goal of Paper 3 was to learn about SOGI disclosure from the perspective of LGBT older adults and to see what barriers or facilitators affected their willingness and comfort to disclose this information to their primary health care providers.

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CHAPTER II: PAPER I

The Invisibility of Sexual and Gender Minority Older Adults in Gerontological Social Work Assessment

Abstract

Objectives: Sexual and gender minority (SGM) older adults, those who identify as lesbian, gay, bisexual and transgender (LGBT), are a group that tends to be invisible in aging service settings. This 2-stage study sought to understand how gerontological social workers identify this population by learning about their clients' sexual orientation and gender identity (SOGI) while conducting biopsychosocial assessments.

Methods: Stage 1 is a content analysis of 32 assessment tools used by gerontological social workers in the Boston area and Stage 2 is a qualitative analysis of interviews with 10 gerontological social workers about how they ask clients about SOGI.

Results: None of the assessment tools asked clients about their sexual orientation; three provided a transgender option for gender identity. Social workers generally felt that it was not necessarily important to know about their clients' SOGI and they were concerned that their relationships with their clients would be negatively impacted if they asked questions about SOGI.

Discussion: This study reveals important implications for social work practice with older adults and suggests that future research efforts should be aimed at increasing cultural competency for social workers working with SGM older adults.

Keywords: LGBT older adults, gerontological social work assessment, intake process

Introduction

When older adults are admitted to an aging service, they typically meet with a social worker so that a biopsychosocial assessment may be conducted in order to give the social worker an appreciation of clients' presenting problems and strengths (McInnis-Dittrich, 2014). Assessments can be quite extensive and involve a combination of social workers asking questions directly from an assessment form as well as using their interviewing and engaging the client (O'Hare, 2009). Despite the thoroughness of gerontological biopsychosocial assessments, sexual orientation and gender identity (SOGI) are not regularly addressed in health and human services delivery (Fredriksen-Goldsen, Hoy-Ellis, Goldsen, Emlet & Hooyman, 2014).

Sexual and gender (SGM) minority older adults, those who identify as lesbian, gay, bisexual, or transgender (LGBT) may remain invisible to providers and practitioners when not asked about SOGI which, according to Stein, Beckerman, and Sherman (2010), may lead to "failure to receive adequate services; unaddressed needs for emotional, social and cultural support; failure to acknowledge and respect partners and close friends; and isolation from the wider residential community and other social support networks" (p. 422). Learning whether SOGI questions are part of initial social work assessments is important in determining how inclusive, supportive, and affirming gerontological social workers and agencies are of their SGM clients and their specific needs. Therefore, this 2-stage study investigated how gerontological social workers come to understand their clients' SOGI so that they may provide SGM older adults with appropriate and effective social work services. Assessment tools and practices among gerontological social

workers were evaluated to explore how cultural and institutional attitudes may affect social workers' ability to learn about adults' SOGI in aging services settings.

Literature Review

Health Disparities and The Life Course

Social determinants of health such as age, race/ethnicity and socioeconomic status are well-documented, yet the impact of SOGI on health outcomes for older adults is just beginning to be investigated (Fredriksen-Goldsen et al., 2013). There is concern over increased health disparities among LGBT older adults in the United States as compared to non-LGBT older adults of the same age (Fredriksen-Goldsen et al., 2011), such as increased risk of disability, poor mental health and higher rates of substance use (Fredriksen-Goldsen et al., 2013). It is important that gerontological social workers appropriately and sensitively inquire about their clients' SOGI during assessment in order to help identify possible health and social risk factors in this population. Culturally competent social work practice with older adults suggests that it is crucial for clinicians to be aware of historical, social, and cultural forces throughout their clients' life course (Council on Social Work Education Gero-Ed Center, 2008; Elder, 1998). Having an awareness of the effects of a lifetime of stigmatization and discrimination based on SOGI is an important first step in social workers being able to effectively support older adult clients.

Social Work Assessment With Older Adults

Gerontological social work biopsychosocial assessments are typically very thorough and include basic demographic information (such as name, address, age/date of birth, and marital status), employment history, military history, physical and mental

health, any difficulty with activities of daily living and/or instrumental activities of daily living, social functioning, spirituality, sexual functioning, financial resources, and environmental/home safety issues (McInnis-Dittrich, 2014). Comprehensive assessments require that social workers ask “very personal questions about health, social relationships, and finances that may be particularly uncomfortable for older adults to answer” (McInnis-Dittrich, 2014, p. 87). Despite the breadth of information collected during an intake assessment, clients are generally not asked about SOGI (Fredriksen-Goldsen et al., 2014).

There may be a number of reasons why gerontological social workers do not assess for clients’ SOGI. For example, SOGI information may not be included in assessment forms; social workers may not feel comfortable asking these questions; social workers may believe that SOGI information is irrelevant to their clients’ health care (Smolinski & Colón, 2008); or social workers may assume that when clients refer to a partner or spouse they must be heterosexual.

SOGI Non-disclosure

Gratwick, Jihanian, Holloway, Sanchez and Sullivan (2014) note that there are two main reasons why LGBT older adults may be invisible to aging service providers: (1) SGM older adults do not voluntarily disclose their identity and (2) aging service providers do not collect this information, even though it would assist providers in connecting LGBT older adults to appropriate services. Many LGBT older adults have gone to great lengths to conceal their SOGI from others, including health and human service providers, by using a variety of identity management strategies to protect themselves from discrimination or harassment (Fredriksen-Goldsen et al., 2014; Morrow,

2001). However, even those who have been “out” about their SGM identities in many areas of their lives (meaning that their friends, family, neighbors, faith communities, coworkers, etc. are aware of their SOGI) may be reluctant to share their SOGI with aging service providers for fear of judgment or rejection (LGBT Movement Advancement Project [MAP] & Services and Advocacy for Gay, Lesbian, Bisexual and Transgender Elders [SAGE], 2010). As they move into phases of their lives in which they become more dependent on formal aging and caregiving services, LGBT older adults may not disclose their SOGI to aging service providers out of fear that they may not receive adequate services (MAP & SAGE, 2010).

Silencing and Invisibility of SGM Older Adults

Instead of asking about SOGI directly, social workers tend to use language that assumes the heterosexual orientation of their clients (Greene, 2008). What is more is that heterosexism, the “dominant culture’s valuing of heterosexuality as the only natural, normal expression of human sexuality” (Fredriksen-Goldsen et al., 2014, p. 84) can manifest in social workers’ attitudes, beliefs, and values. LGBT older adults are more likely to live alone than their heterosexual counterparts (Fredriksen-Goldsen et al., 2011). Social workers may often assume that their clients are heterosexual if they report living by themselves or that they were never in a heterosexual marriage. LGBT older adults are also less likely than their non-LGBT counterparts to have children (Fredriksen-Goldsen et al., 2011), which may perpetuate their invisibility and a sense of shame if they are not asked about SOGI specifically. When social workers meet clients who were never in a heterosexual marriage and never had children, social workers may assume that these clients are heterosexual individuals who did not follow a “normal” aging trajectory,

when, in fact, they may identify as LGBT. Relying on clients' "self-disclosure, sex of the client's partner, or presenting concern to determine the client sexual orientation or gender identity" (Israel, Gorcheva, Burnse & Walther, 2008, p. 301) is not only unreliable, but also inappropriate, and an example of how heterosexual aging trajectories may influence social workers' perceptions of their clients' SOGI.

In response to Healthy People 2020's recommendation that health care providers should be "appropriately inquiring about and being supportive of a patient's sexual orientation to enhance the patient-provider interaction and regular use of care" (U.S. Department of Health & Human Services, 2014.), Cahill and colleagues (2014) pilot-tested SOGI questions in four community health centers in an effort to determine patients' attitudes and reactions toward answering such questions on registration forms in primary care settings. Although only 27% of the 251-person sample was 50 years old or older, the whole sample was racially diverse and mostly heterosexual; 18.4% of the sample identified as transgender. Seventy-three percent of respondents said that it was important for providers to ask about sexual orientation and 82% said it was important for providers to ask about gender identity on registration forms.

Most (81%) heterosexual respondents said that they understood the question when asked about sexual orientation, that it was easy to understand, that it accurately reflected their sexual orientation, and that they would answer it (Cahill et al., 2014). In addition, 78% of all respondents agreed that it was important for their medical providers to know about their sexual orientation. Similarly, 97% percent of respondents were able to answer a two-part gender identity question (sex at birth and current gender), although "heterosexual respondents were more likely than gay, lesbian, and bisexual respondents

to say they did not understand all the choices of responses in the gender identity question” (p. 15). Cahill and colleagues’ (2014) findings showed that patients were generally comfortable with and would respond to questions about SOGI, which is important given that the sample was mostly heterosexual.

Methods

Sample and Data Collection

Stage 1 consisted of a convenience sample of all 49 aging services agencies that had a Boston College School of Social Work MSW intern during the 2013-2014 academic year. The field placement office at Boston College provided contact information for the field placement supervisors at each of these 49 aging services agencies. Social work field supervisors at these agencies were initially contacted twice by email, then once by phone in order to obtain a copy of their agencies’ biopsychosocial assessment forms. Social workers were asked for a blank copy of their agency’s intake/initial assessments so that a content analysis of these documents could be conducted to determine the scope of demographic and social characteristics asked of new clients. Social workers e-mailed, faxed or mailed (after being provided a self-addressed stamped envelope) a copy of their agency’s forms to the author; the unit of analysis for Stage 1 was an evaluation form. Table 1 presents response rates by agency type and reasons for non-participation for Stages 1 and 2. For Stage 1, social workers from 12 agencies responded that they could not participate while 5 agencies responded neither to either e-mail nor voicemail. Social workers from 32 agencies provided biopsychosocial assessment forms used by their social workers when they conduct initial assessments, for a response rate of 65.31%.

Since not all biopsychosocial assessments adhere to a script and some gerontological social workers may ask their clients questions independent of a routine assessment tool, Stage 2 of the study involved interviewing 10 social workers from the aging services agencies that provided blank copies of their assessment forms to understand what is added to or omitted from their paper evaluations. Using a random number generator in Microsoft Excel and organizing agencies by ascending number, a random sample of the first 10 social workers in this list was obtained from the 32 social workers who provided their organization's blank assessment forms for Stage 1. Social workers were sent an e-mail inviting them to participate in one 30-minute semi-structured interview about their own experience regarding the assessment of their older adult clients' SOGI. Social workers were contacted twice by email, then once by phone. Of the first 10 randomly chosen social workers, 8 of the 10 agreed to an interview; 2 did not respond (one from a nursing home and one from a hospital service). Therefore, the next two social workers in the random sample were contacted (and so on) until a total of 10 social workers were interviewed. Two other non-responding agencies were Veteran's Administration Hospitals.

Table 1 also represents response rates by agency type for Stage 2. Of the social workers who participated in Stage 2, two were from different Aging Service Access Points⁴ (ASAPs), five were from nursing homes, one was from an ethnic/cultural senior

⁴ There are 27 Aging Service Access Points (ASAPs) in Massachusetts. ASAPs "provide private, non-profit agencies that provide the following direct services: Information and Referral; interdisciplinary case management: intake, assessment, development and implementation of service plans; monitoring of service plans; and reassessment of needs; and Protective Services: investigations of abuse and neglect of elders" (Commonwealth of Massachusetts, 2014).

services program, one was from a hospice, and one was from an adult day program. All interviews were conducted in private offices at social workers' agencies.

Participants for Stage 2 completed a brief six-question demographic questionnaire. Interview transcripts and demographic questionnaires contained no identifying participant information and all names used in this study are fictional. Participation in both the content analysis and qualitative interviews was voluntary. Informed consent was not required for Stage 1 of this study. For Stage 2, participants provided both verbal and written informed consent to be interviewed and recorded and to complete the demographic questionnaire. All participants were given a copy of the informed consent form and were provided a \$25 Visa gift card for their time. Both stages of this study were approved by the Boston College Institutional Review Board.

Stage 1: Content Analysis

A content analysis is a systematic description of “the symbolic content of any communication...to reduce the total content of a communication to a set of categories that represent some characteristic of research interest” (Singleton & Straights, 2010, p. 420). A content analysis of biopsychosocial assessments and/or intake forms is an appropriate and effective way to determine what is included or omitted from evaluation tools used by gerontological social workers. Here, the characteristic of research interest was whether assessments included questions about SOGI. Other items, such as marital status, relationship status, living situation, and family arrangement were also considered, since what constitutes “family” between LGBT and non-LGBT individuals can be quite different. LGBT older adults tend to have “chosen families,” mainly friends to whom they are emotionally close and consider to be family even though they are not

biologically or legally related (de Vries & Herdt, 2012). These items were also evaluated for whether they were open-ended, whether answer choices were provided and if so, what the response categories were. Although none of the assessments contained any client information, they are technically property of agencies and institutions, therefore were treated as semi-private documents, meaning that, for purposes of this study, they have been de-identified and there is no way to link a specific agency to its assessment tool (Singleton & Straits, 2010).

Stage 2: Qualitative Analysis

All ten interviews were conducted, recorded, and transcribed by the author. Constant comparative analysis of the interviews was used, with a focus specifically on similarities and differences among social workers and their practices for assessing for their older adult clients' SOGI. Descriptive and in vivo coding were used, as well as memo writing to draw comparisons between interviews (Bryant & Charmaz, 2007; Saldaña, 2013). First, descriptive coding was used to summarize general topics covered during the interviews. By using one word or short phrase, descriptive codes provided a categorized inventory of issues addressed both within and between interviews (Saldaña, 2013). In first-cycle coding, descriptive codes were identified and grouped according to relevance and similarity. Second, in vivo coding provided literal, verbatim coding of words or phrases from the language used by participants themselves (Saldaña, 2013). Codes were applied in order to condense data first into categories and then into themes (Saldaña, 2013). Third, memo writing was conducted simultaneously and constantly throughout each coding cycle in order to define categories and codes, make explicit

comparisons between them, compare across and within interviews, and identify gaps in analysis (Emerson, Fretz & Shaw, 2011).

A doctoral candidate in gerontology with expertise in topics regarding SGM older adults served as a peer reviewer for Stage 2 to enhance the accuracy of the qualitative interviews and researcher interpretation of findings (Creswell, 2009). The author used this strategy to ensure trustworthiness of the research process (Creswell, 2009). The peer reviewer read a subset of five transcripts and met with the author to compare, refine, and conceptualize findings. After comparing the peer reviewer's feedback to identified categories and themes, it was apparent that saturation had been achieved, that is, no new information was being added to the understanding of the categories and themes (Creswell, 2009).

Results

Stage 1

Table 2 provides information regarding the items included in assessment tools for Stage 1. The assessment tools ranged from 1 to 23 pages in length (mean number of pages=5.78, $SD=5.40$) and consisted of a combination of forms that could be filled out by clients themselves and/or by a social worker. This was determined by the wording of the questions on the forms (i.e., "What is the client's date of birth?" and "What is your date of birth?"). All assessments received were hard copies; 23 were paper copies that could be filled out with a pen or pencil and nine were printed electronic records. Table 1 provides information about the type and frequency of agencies that were included in Stage 1. Nursing homes and senior care services agencies were the predominant type of agencies in Stage 1. Although one agency was an ASAP with a specific focus on LGBT

older adults and one agency was an LGBT-focused senior service agency, none of the 32 assessments asked about sexual orientation.

With regard to gender identity, of the 32 agencies, four (13%) had “male” and “female” answer choices for gender, one (3 %) had “male,” “female,” and “transgender” choices for gender, two (6%) had “male,” “female,” “transgendered,” and “If transgendered, please explain” choices for gender, and one (3%) had an open-ended response for gender. Five agencies (16%) provided open-ended responses for sex, rather than gender. A total of 19 assessment tools (59%) did not collect information on sex or gender. Two agencies (6%) assessed clients for preferred names.

Marital and relationship status items were also included in the assessments. Eleven agencies (34%) provided choices for “marital status,” most of which included: single, never married, married, divorced, separated, widowed and remarried. One agency included “married-same-sex spouse” as an option for marital status and three agencies offered “significant other” as an option for marital status. Six agencies (19%) provided an open-ended response for marital status. Six agencies (19%) offered an open-ended response to “relationship status.” In addition to marital and relationship status, 11 agencies (34%) provided choices for “living arrangements,” some of which included: lives alone, lives with spouse, lives with friend or other family member, or lives with child(ren). Eleven agencies (34%) provided open-ended responses for living arrangements.

Stage 2

Table 1 shows the types of agencies that were included in Stage 2 of the study; five social workers were from nursing homes, two from ASAPs, one from an

ethnic/cultural senior service provider, one from a senior center and one from a hospice. Table 2 also shows the items included in assessment tools for agencies whose social workers were interviewed for Stage 2. Table 3 presents interviewee demographics. Interviews with social workers lasted between 10-25 minutes (mean=16.40, $SD=4.77$). All 10 participants were heterosexual females; 70% were white and 50% were Roman Catholic. Two social workers had no MSW; one of whom was in graduate school for social work and one had a bachelor's degree only. The remaining eight participants had their MSW for an average of 6.88 years ($SD=5.30$) at the time of the interview. All social workers had an MSW intern at the time of the interview; seven interns were from Boston College and three were from other local MSW programs.

For the remaining part of Stage 2 results, common themes that social workers addressed during their interviews are reviewed. The goal of Stage 2 was to learn about how gerontological social workers ask clients about their SOGI. Two themes emerged from descriptive coding, in vivo coding, and memo writing, which were (1) how inquiring about SOGI would impact the relationship between gerontological social workers and their clients and (2) social workers' perspectives on how asking about SOGI was or was not relevant their clients' care. Theme 1 was supported by four categories (a) "It's not something we're going to push," (b) concerns about clients' response to SOGI questions (c) assessment seen as an ongoing process and (d) creating a welcoming environment. Theme 2 was supported by the following three categories (a) perceived relevance to care (b) SOGI information is important if clients want social workers to know and (c) changing times.

Theme 1: How Asking About SOGI Would Impact Relationship With Clients

“It’s not something we’re going to push.” Since none of the agencies’ evaluation forms asked about sexual orientation, social workers were asked how they usually learned about this part of their clients’ identities. None of the 10 social workers directly asked and seven (70%) viewed asking about SOGI as an intrusive line of questioning. There was a general sense that asking about SOGI was too personal and that by asking, social workers would be invading clients’ privacy. Social workers said: “I know we ask intrusive questions, but how appropriate is it? We don’t fully push,” (Melanie, nursing home social worker); “We don’t really go in-depth about sexual orientation. It’s not in any of the paperwork we have, so we don’t,” (Josephine, ethnic/cultural aging service); “I haven’t taken it further, in, I guess the word, the way I can describe it is pushing, pushing, you know, like, what do I ask?” (Deborah, nursing home social worker) and “We’re not necessarily going after them to get that information,” (Colleen, ASAP social worker).

Concerns about clients’ reactions to questions about SOGI. Six (60%) social workers expressed concern about asking clients about SOGI and felt that they might confuse or offend their clients. Jennifer, a nursing home social worker said

I think that in the generation of people that work here and the generation of people that we have here, I think it sometimes is kind of one of those questions that people would look at you funny if you asked. So, if you asked a 90 year-old woman, “Oh, do you identify as straight, gay, lesbian, transgender, bisexual?” she’d probably go, “What the hell is that?” Having an older population makes this topic of conversation much more difficult because many of them are not, are either very, you know, religious, and

that was not something that was an option, they perhaps didn't explore their sexuality...so when you bring up something like this kind of topic, I think people will either have very strong opinions about it, or they are quiet.

Similarly, Rocelle, a nursing home social worker said

I think that to address it with an older adult, I think it's, I think they would find it very offensive. Um, you know, you can ask questions, try to probe, try to find out, but at the end of the day, what is the purpose of it if, um, they are not looking to talk about it and they're not looking for companionship? How is that going to feel to them?

Jennifer and Rocelle seemed to think that perhaps their non-LGBT clients would be offended or confused by the SOGI questions. Two other social workers took a different perspective, considering how SGM older adults might feel about SOGI questions.

Natalie, a nursing home social worker, said, "I don't know that it's something that they necessarily want shared with the rest of the population here," and Josephine, a social worker from an ethnic/cultural senior service, stated "This population, um, the way I see it, they would probably be reserved about it...I think they would be very reserved because in this type of environment they are afraid that people will judge them, so if they are [LGBT], they keep it very quiet."

Assessment as an ongoing process. Four (40%) social workers cited assessment as an ongoing process and suggested that information about their clients' SOGI is revealed during the course of their working together. Social workers said they either "figure it out," or clients will disclose their SOGI over time. Rocelle, a nursing home social worker

said that she meets with clients multiple times, “So it’s not just that first intake, it’s you know, we have a semi-term meeting, we’ll have a two week follow-up, we’ll have a discharge planning meeting, so in between that, I’m asking if there’s someone that wants to attend, is there anybody I need to call?” Perhaps these social workers make use of the ongoing nature of assessments to build trust and engagement with their clients over time. If their clients want to disclose their SOGI, social workers indicated that they would have established rapport and given their clients the opportunity to do so.

Creating a welcoming environment. Four (40%) social workers said that instead of asking about clients’ SOGI, they try to create a welcoming and safe environment, which they hope will encourage clients to share this information with them. Mary, a hospice social worker said

I think how I’ve actually gathered, um, about people’s sexual orientation comes much later after they’re comfortable with me and they feel they can share that information. I just try to emit a persona of acceptance and kindness, which I think I do well, and then people will be comfortable to share when they are ready.

Mary seems to value a non-judgmental attitude toward her clients. Similarly, Emily, a social worker from an adult day program said, “We’ll just create a comfortable space, a safe zone, and people can share what they need to share with us.” Jeanna, an ASAP social worker, was the only social worker who provided an explicit example of how she creates a welcoming environment. She noted that when she meets with people in their homes, she gives clients a diversity flyer that lists all the cultural and ethnic community services provided by the ASAP. This diversity flyer had a rainbow flag on it to “let people know

that we are uh, I guess, welcoming of any sexual orientation or culture, or language, or anything.”

Only one social worker’s agency had offered a workshop on working with LGBT older adults. Two agencies hosted workshops on inclusive work settings, which were intended for agencies to learn how to be affirming of their LGBT employees. Three social workers attended trainings on working with LGBT older adults on their own time, independent of their agency. Four social workers worked in settings where neither training on working with LGBT older adults nor training on working with LGBT colleagues were offered.

Theme 2: Perceived Relevance to Care

Relevance to care. Half of the social workers thought, unless clients’ SOGI were directly relevant to their care, they were not things social workers needed to know. For example, Jeanna, an ASAP social worker, said, “It’s not required that we ask, basically, because it’s not relevant to whether we’re going to serve them or not...there’s no program here where we, you know, where whether what services, of if they are going to get services is based on their sexual orientation.” In addition, Jennifer, a nursing home social worker said

That information isn’t a part of our social history; it’s not a question that’s asked on our assessment forms that we use to bill their insurance. I think that because it’s not on there, it’s not necessarily a question that is important for us to ask if someone’s here for a week and a half because they had their knee done.

Emily, a social worker from an adult day program, stated, “If it affects them here medically or socially, then, I think you know, it’s definitely something we have to work on in terms of social services, to make sure that we are being a competent service, that we are meeting their needs.”

SOGI information is important if clients want social workers to know. Eight (80%) of the 10 social workers addressed the notion of SOGI information being important to know about their clients only if their clients feel it is important to share with social workers. This answer was in response to the interview question “How important do you think it is, that as a social worker working with older adults, you know about your clients’ sexual orientation and gender identity?” Some examples of in vivo responses to the question of importance included the following: “Not important to know in this day and age. Not unless for the patient it’s important” (Rocelle, nursing home social worker) and “It’s only important as long it is important to them...it’s important as long, obviously, based on what the client wants me to know” (Deborah, nursing home social worker).

Changing times. Six (60%) social workers referred to the fact that, while there has recently been more awareness around LGBT issues, the older adult population will not really be affected by this change for another 10 or 20 years. For example, Melanie, a nursing home social worker, said, “In ten years, we’ll definitely see that question on a form,” and Emily, a social worker from an adult day program stated

It’s definitely something with the baby boomers aging, think we’re going to see a lot more folks going through this, and you know, having a hard time trying to

figure out whether or not they want to disclose, you know, who they are, and that's troubling.

Jennifer, a nursing home social worker said, "Probably in the next 20 or 25 years, that will probably change and we'll probably have to add that to our social history, 'What is your sexual orientation?'" but right now, with the type of people that we have, I don't think that's something they would feel comfortable being asked."

As for considering LGBT older adults who may not have come out to providers, Rocelle, a nursing home social worker, and Colleen, an ASAP social worker, suggested that the climate is too hostile now for them to come out. Rocelle said, "Right now, in this day and age, I think that it's, for these adults, it's still one of those negative connotations. It's something that's hidden and will always be hidden and they're never going to talk about it," and Colleen said, "It's hard for people to come out and just say it. Especially older adults, they lived in silence so long that you know, why come out now?"

Transgender Assessment

In addition to these two themes, gender identity was a topic addressed by social workers from the two ASAPs. The ASAP assessments had "transgendered" as an option for gender, asking clients to "please explain," if they identified as transgender. Colleen described her intake process:

A lot of times you're actually putting "male" and "female" by the voice you hear on the phone, versus you actually coming out and asking them. Um, and a couple of times, I have questioned, like I might have said "ma'am," and they're like, "it's a sir," or something like that, um, so, and I'll apologize, of course, and just put what they told me... And I think we

more go by eyesight too, unless they disclose to us that you know, whatever complexities of their lives and if that happened to be one of them in trying to meet their needs, they'll be the ones to tell us, we're not necessarily going after them to get that information.

Jeanna, the second ASAP social worker said

We do also ask gender, and people can answer "male," "female," or "transgendered," and we would indicate that on the form. And there's a space that says, "if yes, please explain," and we would, and if there's any other information besides transgendered, that you know, would need, that we know, we would put that there.

Discussion

This study found that among the sampled aging service providers in the Boston area, there was no consistent way in which gerontological social workers asked about their clients' SOGI. None of the biopsychosocial assessment tools included items about sexual orientation, and only two (both ASAPs) provided a transgender option for gender. Social workers were mainly concerned about how asking SOGI questions would impact their relationships with their clients and generally did not seem to think that this information was relevant to the services they provided.

Due to the heterogeneity of the older adult population, McInnis-Dittrich (2014) has suggested that "social workers' approaches to the assessment process should be unique to each older adult" (p. 85), which may mean asking private questions that clients may feel uncomfortable answering (McInnis-Dittrich, 2014). The 32 assessment tools reviewed in Stage 1 of this study asked about a wide range of issues, capturing variations

in ethnicity, culture, language, religion/spirituality, socioeconomic status, educational and work history, family composition, client strengths, substance abuse history and mental health history to name a few. Some of these questions are more comfortable to answer than others. The assessment tools were quite detailed and there was a lot of variability in asking about living situation, relationship status and marital status response items, yet none of the assessments asked clients directly about their sexual orientation. According to Fredriksen-Goldsen et al., (2014), “all assessment tools and standardized forms should be reviewed to ensure that they are LGBT-inclusive. For example, clients should not have to select between inaccurate or inappropriate choices, such as between married or single,” (p. 94). With regard to gender identity, some of the assessments did not include questions about gender on their forms at all.

Stage 2 of the study revealed a number of attitudes and beliefs surrounding social workers’ practice of directly asking older adult clients about their SOGI. The two themes that emerged from Stage 2 were (1) social workers’ concern about how asking clients about SOGI would affect their relationships with clients and (2) how they and/or their clients viewed SOGI information as relevant to care. These two themes beg the question as to whether or not these perspectives are somewhat contradictory, or at least confusing. The assessments used by social workers in this study asked a number of personal and detailed questions. If social workers relied upon their clients to tell them only what their clients think is important or relevant to receiving services, then social workers would not need to be trained in conducting thorough, competent, and sensitive assessments. Furthermore, based on this rationale, it could be argued that social workers should not ask any questions at all, instead leaving it up to clients to tell social workers only what they

think is important so as not to negatively impact the relationships between social workers and clients.

Although it has been suggested that social workers should avoid assuming the SOGI of their clients (Israel et al., 2008; Portz et al., 2014), those in this study generally thought that non-LGBT clients would be confused or offended if they were asked about SOGI items during an assessment. They thought that asking SOGI questions of their clients implied that they would be “pushing” a topic that their clients would either be confused or offended by. Their belief that clients would react this way suggests that the social workers who reported this concern may be likely to assume that clients are all heterosexual, or that this topic would be perceived as taboo or embarrassing. Only two social workers discussed this from the perspective of LGBT older adults; they thought LGBT older adults would feel uncomfortable disclosing SOGI information to a social worker. However, as previously stated, Cahill et al (2014) found that a sample of predominantly non-LGBT respondents said that they both understood and would answer questions regarding their SOGI.

When social workers ask their clients about SOGI items, they might increase their clients’ likelihood of discussing support systems, both traditional and chosen (Morrow, 2001). Additionally, when they are aware of their client’ SOGI, social workers can use correct pronouns and identifiers for their clients and their clients’ significant others, which would communicate the importance of these relationships and that these relationships are relevant to their care (Morrow, 2001). Social work assessment is considered to be an ongoing process (O’Hare, 2009); social workers who said that they “figure out” their clients’ SOGI over time cited the continuous nature of social work

assessment as being one of the reasons why they do not directly ask new clients about their SOGI. Instead of asking clients directly about SOGI, social workers in this study said that they tried to promote a safe, welcoming, and affirmative environment. Only one social worker described how she did this; her agency includes a rainbow flag on a diversity flyer and she has made a practice of pointing out LGBT-supportive services to all clients. This is an area in which social workers could benefit from trainings on working with LGBT older adults so that they could implement concrete efforts toward communicating an affirmative and supportive environment.

With regard to the second theme of perceived relevance to care, there are currently an estimated 1.5 million LGBT adults age 65 and older in the US and this number is expected to double to 3 million by 2030 (National Gay and Lesbian Task Force, 2014). Despite the current estimations of LGBT older adults in the US, social workers in this study thought that asking their clients about their SOGI would be relevant in the future, but they did not see it as being of particular importance to the current cohorts of older adults. Social workers approached this notion of “changing times” from two different perspectives. First, they did not think the current cohorts of older adults find SOGI to be important to their identity, while younger LGBT individuals see SOGI as relevant to their identities. Second, social workers believed that some SGM older adults are simply too afraid to share this information, citing the fact that clients may have lived in fear almost all of their lives without coming out, therefore, there is really no reason for them to do so in their later life. It was not clear whether social workers saw this shift resulting from a reduction in repression of SGM older adults or from an increase in social acceptance of LGBT older adults, or some combination of both.

Health disparities between SGM older adults and their non-SGM counterparts are well-documented (Fredriksen-Goldsen et al., 2011). If social workers are not aware of their clients' SOGI, they could be missing important information regarding risk factors for obesity, hypertension, depression and substance abuse among these clients (Fredriksen-Goldsen et al., 2011) and could fail to connect their clients to appropriate services to help address these issues. Biopsychosocial assessments serve "as an educational process to alert both the older adult and the appropriate support systems to high-risk areas that may threaten the older adults' well-being" (McInnis-Dittrich, 2014, p. 83). Just as risks for health disparities due to age, race/ethnicity and socioeconomic status are included in social work biopsychosocial assessments, SOGI should also be considered as well. It is also important that social workers be able to for explain to their client why they are asking such personal, and perhaps seemingly irrelevant, questions (McInnis-Dittrich, 2014). Social workers could take the opportunity to educate their clients about the health disparities between LGBT and non-LGBT older adults, and may find that the more they ask, the more they come to learn who their SGM clients are and what their specific needs may be.

Even though gender identity with a transgender option was provided on the two ASAP assessments, it is unclear how this item is addressed. In the first example from Colleen, she indicated that she does not ask clients at all, rather, goes by clients' voices if she conducts assessments over the phone and "by eyesight" when she meets with them in person. In the second example, Jeanna said that she asks people about their gender and acknowledges that they are then asked to "please explain," if they identify as "transgendered." However, this seems contradictory to her previous comment, when she

said that knowing clients' sexual orientation would not affect whether or not clients receive services. If this line of thinking is to be consistent with regard to gender identity, then why would it be important to have clients explain their "transgendered" gender identity?

Finally, even though there were two LGBT-oriented aging services in Stage 1 of the study, neither of their assessments asked about clients' SOGI. This suggests that even LGBT-specific services may also neglect to ask about these items. When LGBT-aging service providers do not ask their clients about sexual orientation, they may be further silencing those who are already quite stigmatized within the LGBT community, such as bisexual individuals (Witten & Eyler, 2012). If social workers do not know the SOGI of their clients, even social workers in LGBT-specific aging services, providers may be unaware of how marginalization and discrimination within the LGBT community may have contributed to health disparities.

Limitations

The main limitation of this study is that it did not consider any older adults' perspectives on the topic of intake assessment wording and social workers' interview practices. As noted earlier, client non-disclosure is also part of the reason why SGM older adults remain invisible in aging service settings. By not including the perspective of older adults, it cannot be concluded how older adults themselves might respond to questions about their SOGI. Further, this study had small sample sizes for Stages 1 and 2 and was limited to a convenience sample of gerontological social workers in the Boston area.

Implications for Future Research

Since social workers in Stage 2 of the study cited concerns about how asking their

clients about SOGI would impact the social work-client relationship, a social work research study could test such questions with older adult clients. Replicating Cahill and colleagues' (2014) study with older adult clients in a variety of aging services settings could give gerontological social workers insight into how their clients might actually perceive such questions and whether they would impact relationships with their social workers.

A second social work research effort would be an evaluation of gay-affirming senior services. Social workers in this study said that they try to create a safe and welcoming environment so their clients will feel comfortable sharing SOGI information. Though four social workers had at least some training on working with LGBT older adults, it was unclear how they incorporated knowledge from these trainings into their practice. A proposed study would involve multiple stages: (1) implementing cultural competency training for social workers on working with LGBT older adults, with an emphasis on how to create safe and affirming environments; (2) social workers following-through with recommendations on how to create safe and welcoming environments; and (3) surveying older adults about their perception of how welcoming/supportive they find senior service providers to be following LGBT cultural competency trainings. Such a study would require participation from both gerontological social workers and their clients; social workers' would gain skills in providing safe and affirming services and their clients would have the opportunity to evaluate the effectiveness of these efforts.

Policy Implications

As for policy-level implications of this study's findings, two important things

should be considered by individual agencies working with older adults: training and data collection. The Center for American Progress and The Fenway Institute (2013) recommended that the Centers for Medicare and Medicaid Services and the Office of the National Coordinator of Health Information Technology (within the Department of Health and Human Services) include SOGI questions in data collection procedures for the meaningful use of electronic health data. They stated that “training and data collection must go hand-in-hand” (Center for American Progress & The Fenway Institute, 2013, p. 2), which means that just asking clients about their SOGI is not sufficient; rather, clinicians who gather this information need to receive proper training on how to do so in an effective and supportive manner such that they understand the unique health needs of LGBT individuals.

Specifically with regard to aging service providers, agencies that serve older adults should not only change the wording and questions on their intake assessments to give clients an opportunity to identify their SOGI. While this is an important step toward making sure LGBT older adults become visible in aging service settings, social workers who ask such questions should also have sufficient cultural competency training in the historical, social, political, and health implications of what it means for older adults to have an LGBT identity.

Conclusion

Social work biopsychosocial assessments are one of the primary ways in which service providers learn about the social aspects of clients' lives. If SOGI questions are asked of older adults at the start of services, providers may be alerted to potential sources of support and barriers to care for SGM clients. LGBT older adults may not proactively

disclose their SOGI and agencies do not always make an effort to learn about these aspects of their clients' identities (Gross, 2007). Social workers could take on the responsibility of asking clients directly about their SGM status. Regardless of whether or not clients are forthcoming about this information, the obligation will lie with the clinician to initiate the question.

Social workers play a vital role in helping to empower their clients by advocating for social justice, assisting clients in health care decision-making and helping connect people to resources (Morrow, 2001) and they may miss valuable and informative parts of their clients' identity by not asking about SOGI. It would be useful for gerontological social workers to know about their clients' SOGI during a biopsychosocial assessment to determine whether their LGBT clients are connected (or want to be connected to) and are aware of their respective LGBT communities (Fredriksen-Goldsen et al., 2014, p. 90). Gerontological social workers should be aware of "how different historical events, social structures, and cultural factors intersect with developmental trajectories shape individual life experiences" (Fredriksen-Goldsen, et al., 2014, p. 86). They should also know about their SGM clients' resiliency and community connectedness, for when they are unaware of the populations they serve, they are probably also unaware of the unique challenges, strengths, and resources available to these populations (Portz et al., 2014).

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Appendix

Table 1
Response Rates and Final Samples by Agency Type, Stages 1 & 2

	Total Contacted	Stage 1			Stage 2	
		Non- responders	Reasons for not participating ^a	Final Sample	Non- responders ^b	Final Sample
Continuum of care facility	2	1	--	1	--	0
Affordable housing agency	2	0	a (2)	0	--	0
Hospice	2	0	b (1)	1	0	1
Nursing home	15	1	b (1), c (1)	12	1	5
Assisted living	1	0	a (1)	0	---	0
Hospital service	4	0	a (2)	2	1	0
Ethnic/cultural senior services program	4	1	a (1)	2	0	1
LGBT aging services	1	0	--	1	--	0
Senior care services agency	8	1	a (1) b(1)	5	0	0
Aging Service Access Point (ASAP)	4	0	c (1)	3	0	2
Outpatient medical provider	1	1	--	0	--	0
Senior center	1	0	--	1	--	0
Adult day program	2	0	--	2	0	1
Divisions of Veteran's Affairs	2	0	--	2	2	0
Total	49	5	12	32	4	10

Note. ^a Reasons for not participating include: (a) no social work assessment (b) could not print EMR (c) not permitted to participate. The number in parentheses indicates how many agencies did not participate because of reason (a), (b) or (c). ^b Agencies were chosen randomly from those who responded in Stage 1 and contacted twice via email and then once by phone. If one week passed without a response, the next agency on the random sample list was contacted until a total of 10 agencies agreed to be in Stage 2 of the study.

Table 2

Items Included in Assessment Tools, Stages 1 & 2

	Stage 1 (N=32)	Stage 2 (N=10)
Assessment Item	N (%) ^a or Mean (SD)	N (%) or Mean (SD)
Length of agency assessment (<i>Range</i> : 1-23 pages)	5.91 (5.33)	7.1 (6.9)
Sexual orientation	0 (0%)	0 (0%)
<i>Gender Items</i> ^b		
Male or female answer choices	4 (13%)	2 (20%)
Male, female, transgender answer choices	1 (3%)	0 (0%)
Male, female, transgendered with “please explain” choices ^c	2 (6%)	2 (20%)
Open-ended	1 (3%)	1 (10%)
<i>Sex Items</i>		
Male or female choices	0 (0%)	0 (0%)
Open-ended	5 (16%)	2 (20%)
<i>Marital Status</i>		
Choices provided ^d	11 (34%)	6 (6%)
Open-ended	6 (19%)	1 (10%)
<i>Relationship Status</i>		
Choices provided	0 (0%)	0 (0%)
Open-ended	6 (19%)	1 (10%)
<i>Living Arrangements</i>		
Choices provided	11 (34%)	3 (30%)
Open-ended	11 (34%)	3 (30%)

Note. ^a Percentages were rounded to the nearest whole percent and do not total 100. Only agency assessments that provided specific items on their forms are accounted for here. ^b “Male” and “female” are technically *sex* terms, but in some assessments, these terms were also used to identify gender. ^c Each of the agencies that offered “transgendered” along with “If transgendered, please explain” as a gender choice were ASAPs. ^d Common “marital status” choices included: single, never married, married, divorced, separated, widowed, remarried, number of marriages and number of remarriages. One agency included “married-same-sex spouse” as an option for marital status and three agencies offered “significant other” as an option for marital status.

Table 3

Stage 2 Interviewee Demographics (N=10)

	N (%) or Mean (SD)
Length of Interview (<i>Range</i> : 10-25 minutes)	16.40 (4.77)
<i>Agency</i>	
Aging Service Access Point (ASAP)	2 (20%) ^a
Hospice	1 (10%)
Nursing Home	5 (50%)
Adult day program	1 (10%)
Ethnic/cultural senior services program	1 (10%)
<i>Age</i> (<i>Range</i> : 24-49 years old)	32.7 (7.20)
<i>Gender</i>	
Female	10 (100%)
<i>Race and Ethnicity</i>	
Black or African American and Hispanic	1 (10%)
Cape Verdean	1 (10%)
Hispanic or Latino	1 (10%)
White or Caucasian	7 (70%)
<i>Religion/Spirituality</i>	
Episcopalian	1 (10%)
Protestant	2 (20%)
Roman Catholic	5 (50%)
Spiritual, no religious affiliation	1 (10%)
None	1 (10%)
<i>Sexual Orientation</i>	
Heterosexual or Straight	10 (100%)
<i>Current Supervising MSW student</i> ^b	
From BC	7 (70%)
From another university	3 (30%)
<i>Years since MSW completion</i> (<i>Range</i> : 2 to 19 years, <i>N</i> =8) ^c	6.88 (5.30)

Note. ^a Percentages were rounded to the nearest whole percent. ^b All respondents worked at agencies where MSW students were working for their internships. ^c All participants had an MSW with two exceptions; one will obtain her MSW in 2015 and one has a bachelor's degree only and is not pursuing an MSW.

CHAPTER III: PAPER 2

The Effects of Cumulative and Age-Specific Experiences of Sexual Orientation and Gender Identity-Based Discrimination and Violence on LGBT Older Adults' Attitudes and Behaviors Regarding Aging Service Use

Abstract

Objectives: Lesbian, gay, bisexual, and transgender (LGBT) older adults often avoid or delay needed care due to sexual orientation and/or gender identity (SOGI) concerns. They are also often reluctant to disclose their SOGI to providers for fear of discrimination, harassment, or inadequate care. This study sought to understand LGBT older adults' attitudes and behaviors regarding aging service use based on age-specific and cumulative experiences of SOGI-based discrimination and violence.

Methods: The sample consisted of 129 LGBT-identified adults age 60 and older who participated in the Care and Service Needs of Older Adults at Congregate Meal Sites survey between 2011-2013. Binary and ordinal logistic regressions were estimated, controlling for age, gender, income, and education.

Results: Sixty-two percent of participants reported an experience of SOGI-based discrimination/violence at least once in their lifetime. Having had such an experience at or after age 50 was associated with a significant decrease in the odds of being out to all health care providers and a significant increase in the odds of having not asked for help from a place that serves older adults due to concerns about coming or being out.

Discussion: Findings support educating aging service providers to be sensitive to the issues unique to LGBT older adults, with a focus on SOGI-based trauma history.

Keywords: LGBT older adults, aging service use, discrimination, and violence

Introduction

Lesbian, gay, bisexual, and transgender (LGBT) older adults are at increased risk of health problems as compared to their non-LGBT counterparts in the United States (Grossman, D’Augelli & Hershberger, 2000; Grossman, D’Augelli & O’Connell, 2001; Institute of Medicine [IOM], 2011; Services and Advocacy for GLBT Elders [SAGE], 2012; Fredriksen-Goldsen et al., 2011; Fredriksen-Goldsen, 2013b). Despite this increased risk, LGBT older adults are less likely than non-LGBT older adults to use aging services (IOM, 2011; King, 2009). They may avoid or delay needed care for fear of discrimination, harassment, or inferior care from providers (Brotman, Ryan & Cormier, 2003; Croghan, Moone & Olson, 2014; Hartzell, Frazer, Wertz & Davis, 2009; IOM, 2011). Those who do seek services may be reluctant to share their sexual orientation and gender identity (SOGI) with aging service and health care providers (HCPs) for these same reasons (Croghan et al., 2014; Espinoza, 2014; LGBT Movement Advancement Project [MAP] & SAGE, 2010).

LGBT older adults’ concerns are justified; aging service providers have discriminated against them due to their SOGI by either providing inferior care or denying care altogether (AOA, 2010; Johnson, Jackson, Arnette & Koffman, 2005; National Senior Citizens Law Center, 2011). These experiences, combined with other lifetime experiences of SOGI-based discrimination/violence⁵ have been shown to affect LGBT older adults’ use of care (Fredriksen-Goldsen et al., 2013a). The purpose of this study was to investigate how age-specific experiences of D/V and the cumulative effects of these experiences related to LGBT older adults’ attitudes and behaviors regarding aging

⁵ From this point forward, the abbreviation D/V will be used to refer to “SOGI-based discrimination/violence.”

service use. This study considered D/V at different points in time: before age 18, between 19-49 years old and at or after age 50.

Current Study

In this study, attitudes and behaviors were considered as independent outcomes. While LGBT older adults' attitudes and concerns about using aging services may affect their actual use of such services, the goal of this study was to understand how previous experiences of D/V affect both their attitudes toward and behaviors regarding aging service use. It is important to consider both attitudes and behaviors separately because at some point, older adults' need for aging services may be so great that regardless of how they feel about accessing services, they need to use them anyway. For those who have experienced D/V, this may be particularly salient since higher levels of stress related to concern about D/V have been shown to negatively impact both physical and mental health outcomes of people with an identity they attempt to manage out of fear of discrimination, prejudice, and rejection (Meyer, 2003).

As will be discussed, LGBT individuals' high rates of D/V may impact both their attitudes about and behaviors regarding aging service utilization. The number of times participants experienced D/V was one of the primary independent variables in this study, along with their experience of D/V at three different time periods in their lives: before the age of 18, between the ages of 18 and 49, and at or after age 50. D/V in later life may have an especially strong influence on LGBT older adults' attitudes and behaviors regarding aging service use due to conflicts that may arise out of their increased need for such services and their fear of further victimization.

With regard to attitude, this study explored whether cumulative and age-specific D/V experiences were associated with LGBT older adults' concern about sexual orientation discrimination and aging service use and their concern about coming or being out and accessing services for older adults. Therefore following attitude hypotheses were tested: (1) the cumulative experiences of D/V will be associated with both greater concern about sexual orientation discrimination and using aging services and greater concern about coming/being out and accessing aging services and (2) age-specific experiences of D/V will be associated with greater concern about sexual orientation discrimination and using aging services and greater concern about coming/being out and accessing aging services, specifically D/V experienced in later life.

With regard to behavior, this study explored whether cumulative and age-specific D/V experiences were associated with LGBT older adults' SOGI disclosure to all of their HCPs, having attended an event for older adults or having chosen an aging service provider because they were LGBT-friendly, and having decided against asking for help from an aging service provider due to concerns about coming or being out. Therefore, the following behavior hypotheses were tested: (3) cumulative experiences of D/V will be associated with respondents' being out to less than all of their HCPs, having attended an event for older adults or having chosen an aging service provider because they were LGBT-friendly, and having decided against asking for help from a place that serves older adults due to concerns about coming or being out and (4) age-specific experiences of D/V will be associated with respondents' being out to less than all of their HCPs, having chosen a service provider because they were LGBT-friendly, and having decided against

asking for help from a place that serves older adults due to concerns about coming or being out, specifically D/V experienced in later life.

Literature Review

The United States Department of Health and Human Services Administration on Aging (AoA) announced in 2012 that LGBT older adults were to be included in the Older Americans Act's (OAA) definition of people in the "greatest social need" (Services and Advocacy for GLBT Elders [SAGE], 2012). The OAA is specifically concerned with providing services to older adults who face vulnerability due to financial insecurity, social isolation, and increased health problems associated with aging. The OAA established the AoA, which "has historically funded organizations to serve as technical assistance resource centers for marginalized communities," and has focused on people of racial and ethnic minorities (National Resource Center on LGBT Aging, 2010). The AoA (2012) has recognized that people who are isolated due to their SOGI may face difficulty in performing normal tasks and may struggle to live independently because of limited biological family support, higher rates of living alone (as compared to non-LGBT older adults), and fear of using aging services due to their SOGI (MAP & SAGE, 2010).

By adding LGBT older adults to the definition of those in "greatest social need," the AoA has helped to make visible a group of older adults who tend to be hidden in aging service delivery (Tax, 2012). It takes into account the cumulative effects of a lifetime of stigmatization and discrimination, including exclusion for legal marriage, lack of recognition of same-sex partners, limited access to traditional family caregiving structures, and the insensitivity faced in health and long-term care settings (Wight, LeBlanc, de Vries & Detels, 2012). Mainstream aging service providers, those that are

not specifically targeted toward LGBT older adults, do not regularly offer training for working with LGBT older adults (Porter & Krinsky, 2014). For example, a national study that surveyed over 1,000 nursing home directors found that over the past five years, 75% had less than one hour of training on homophobia, heterosexism, and LGBT awareness (Bell, Bern-Klug, Kramer, & Saunders, 2010). When aging service providers and HCPs have little knowledge of the issues faced by socially and historically marginalized groups, they are less likely to be able to provide effective and supportive services to these groups (Morrow, 2001).

SOGI-based Discrimination and Violence

LGBT older adults are often hesitant to seek out formal aging services from paid professionals due to fear of discrimination or inferior care (MAP & SAGE, 2010) even when their access to familial support is limited (Fredriksen-Goldsen, 2012). Although they may be in need of more formal aging services because of fewer familial supports, LGBT older adults have been shown to be less likely to access formal aging services as compared to non-LGBT older adults (IOM, 2011; King, 2009). D'Augelli and Grossman (2001) suggested that a possible barrier to LGBT older adults' accessing aging services in later life might be the experience of D/V at least once in their lifetime. Many LGBT older adults either anticipate or have experienced discrimination based on their SOGI, which has been found to be associated with decreased likelihood of seeking services (Brotman et al., 2003; IOM, 2011). Fear of SOGI-based discrimination or harassment from providers can prevent or delay LGBT older adults' treatment (Croghan et al., 2014; Hartzell et al., 2009; IOM, 2011). Avoiding or delaying the use of needed services and treatment can have serious health and mental health consequences for older adults,

especially LGBT older adults who experience higher rates of social isolation as compared to their non-LGBT counterparts (Fredriksen-Goldsen et al., 2009; Fredriksen-Goldsen et al., 2013a; Fredriksen-Goldsen et al., 2013b; Wight et al., 2012).

What is not known, however, is when such experiences occurred and whether age-specific experiences of D/V influence LGBT older adults' attitudes and behaviors regarding aging service use. It is hypothesized that more recent experiences of D/V will affect LGBT older adults' attitudes and behaviors regarding aging service use, such that they: will have greater concern about sexual orientation discrimination and aging service use; will have greater concern about coming or being out and accessing aging services; will be out to less than all of their HCPs; will have attended an event for older adults or chosen an aging service provider because they were LGBT-friendly; and will have avoided asking for help from a place that serves older adults due to concerns about coming or being out.

Even if HCPs do not explicitly engage in discriminatory practices, heterocentric (heterosexually-oriented practices and roles) and gender-normative (aligned with society's expectations of gender) influences can affect providers' lack of knowledge about health disparities affecting LGBT individuals and therefore their overall treatment (IOM, 2011). Heterocentric and gender-normative influences in aging service settings and overt forms of discrimination in these settings influence LGBT older adults' willingness to disclose their SOGI (MAP & SAGE, 2010). While aging service providers may not directly discriminate against or harass LGBT older adult clients, LGBT older adults often fear discrimination and provider bias (MAP & SAGE, 2010). As such, LGBT older adults who use aging services can vary greatly in their level of "outness" with

providers, which may affect their quality of care overall (Croghan et al., 2014). A recently published SAGE report (Espinoza, 2014) found that of a nationally representative sample of 1,857 LGBT adults between 45 and 75 years old, 40% of LGBT respondents in their 60s and 70s reported that their HCPs were not aware of their SOGI. The psychological and physiological effects of managing one's identity have been shown to have negative health and mental health consequences over time (Pérez-Benítez, O'Brien, Carel, Gordon & Chiros, 2007) which is of particular concern for LGBT older adults when they may be in need of aging services, yet afraid to use them. They may struggle with concealing or disclosing their SOGI or decide to forego services altogether to avoid having to negotiate coming or being out with aging service providers.

Potentially Confounding Factors and Controls

Age. Age has shown to play a role in LGBT older adults' behaviors and attitudes regarding SOGI disclosure and health care utilization. Espinoza (2014) found that 40% of LGBT older adults ($N=1,857$) in their 60s and 70s said that their primary HCPs were unaware of their SOGI. Nineteen percent of LGBT older adults age 50-64 in Fredriksen-Goldsen and colleagues' (2011) sample ($N=2,560$) had fear of accessing services outside of the LGBT community as compared to 16.9% of LGBT older adults aged 65 and older. Though the current study does not explore LGBT older adults' comfort with accessing services inside versus outside of the LGBT community, age was considered to understand its effect on LGBT older adults' behaviors and attitudes regarding SOGI and aging service utilization in general.

Gender. Gay, bisexual, and transgender men have been shown to have greater concern about being judged by their HCPs (Fredriksen-Goldsen et al., 2011) as compared

to sexual and gender minority women, therefore, gender was considered to understand how it affects attitudes and behaviors regarding SOGI and using aging services.

Income. Total household income was considered as a factor influencing LGBT older adults' attitudes and behaviors regarding SOGI concerns and aging service utilization, as Fredriksen-Goldsen and colleagues (2011) found that LGBT older adults who had an annual income at or below 200% of the federal poverty line reported a “greater fear of accessing aging services both inside and outside the LGBT community,” (p. 33).

Education. Similar to income, education has been shown to affect LGBT older adults' concerns about using services, such that having a high school education or less was associated with greater fear of accessing services both inside and outside the LGBT community (Fredriksen-Goldsen et al., 2011). Therefore, education was also considered in analyses to understand its relationship to LGBT older adults' attitudes and behaviors regarding SOGI and aging service utilization.

Methods

Data

This study used secondary data that were collected for the Care and Service Needs of Older Adults at Congregate Meal Sites (MEALSITE) Study. Between November 2011 and February 2013, staff from the Fenway Institute (who were members of the Massachusetts LGBT Aging Needs Assessment coalition [M'LANA]) administered paper and pencil surveys to all adults aged 60 and older who attended one of 12 congregate meal sites in the Greater Boston area.

Sponsored by the AoA, congregate meal programs are funded “in part by Title III

of the Older Americans Act (OAA), provide meals and related nutritional services for individuals 60 years and older in group settings such as senior centers, places of worship, and other community venues” (Porter, Keary, Van Wagenen & Bradford, 2014, p. 2). In addition to promoting nutrition and reducing food insecurity, congregate meal programs also provide peer socialization for people age 60 and older. Meal are offered anywhere from once per month to once per day and attendees are free to attend as frequently or as infrequently as they would like.

During the time of data collection, there were six LGBT meal sites in the area, all of which were included in this study. LGBT meal sites were not limited to LGBT individuals; their allies and other LGBT-friendly attendees were welcome. Six non-LGBT (“mainstream meal site”) comparison groups were randomly selected from approximately 40 general population meal sites (Balkian, Sheeley & Chao, 2013). Study staff conducted data collection by visiting each meal site, explaining the project to participants, and distributing surveys immediately before the meals were served. If participants needed assistance completing the survey, study staff were available to help them upon request; large print versions of the surveys were also available for participants with vision impairment. Participants generally took about 20-30 minutes to complete the surveys. All participants were entered into a raffle for a \$50 Visa gift card that was drawn at the end of each meal.

Participants at LGBT sites were informed that the study was aimed at exploring aging experiences specific to sexual and gender minorities, while participants at mainstream sites were informed of the study’s general aging-related aims. The surveys administered at both types of sites were identical. LGBT meal site surveys included

instructions to complete a set of questions specific to LGBT aging, which included topics such as outness and D/V experiences. Non-LGBT meal site attendees were instructed to skip the sections specific to LGBT older adults. Both the LGBT and mainstream surveys included questions about how participants described SOGI. The total sample size was 300.

The study was reviewed and approved by the Fenway Health Institutional Review Board and the Massachusetts Executive Office of Elder Affairs. The Fenway Institute received funding from the Lesbian Health fund of the Gay and Lesbian Medical Association to conduct this study (Van Wagenen, Sass & Bradford, 2012). The present secondary analysis of the data was approved by the Boston College Institutional Review Board.

Study Sample

The original sample consisted of 300 participants (122 non-LGBT and 129 LGBT participants); the present study was limited to participants who identified as LGBT, though they did not need to attend an LGBT meal site to be included in the sample; 10 participants completed the survey at mainstream sites. Respondents reported their sexual orientation by answering the following question: “Which of the following best describes you?” with response categories (a) *heterosexual or straight* (b) *homosexual, gay or lesbian* or (c) *bisexual*. In addition, they were also asked in the following question, “Are you transgender or transsexual?” with response choices (a) *yes* (b) *no* and (c) *I don’t understand the question*. One participant did not understand the transgender question and was therefore coded as not transgender. Of the eight transgender participants, 5 of them

identified as heterosexual and completed the survey at mainstream sites; three of the transgender participants identified as LGB and completed the survey at LGBT meal sites.

Dependent Measures: Attitudes

Concern about sexual orientation discrimination and using aging services.

Participants were asked to report whether they were concerned about fear of discrimination or bias due to their sexual orientation when using aging services like in-home help with meals, housekeeping, or personal care. Response categories included (0) *not concerned* (1) *somewhat concerned* and (2) *very concerned*.

Concern about coming or being out and accessing aging services. Participants were asked, “If you are lesbian, gay, bisexual or transgender, on a scale of 1 to 10, how concerned are you about coming or being out and accessing services for older adults?” where 1=*not at all concerned* and 10=*very concerned*. To adjust for positive skew, this item was recoded to create a dichotomous variable such that 0=*a score* ≤ 5 (less concern, [reference]) and 1=*a score* ≥ 6 [more concern] on the 1 to 10 scale.

Dependent Measures: Behaviors

Out to HCPs. The following question was asked to gain a sense of the extent to which participants were “out” about their SOGI: “Please tell us about how open or ‘out’ you are or were about your sexuality or gender identity with your health care providers.” Response categories included (1) *not out to any* (2) *out to some* (3) *out to most* (4) *out to all* and (5) *not applicable*. LGBT participants who reported “not applicable” ($N=5$) were dropped from analyses including this variable. A dichotomous variable was created such that 0=*out to less than all aging HCPs* (reference) and 1= *out to all HCPs*.

Attended an event or chose an aging service provider because it was LGBT-friendly. Participants were asked, “Besides the community café/meal sites, have you ever attended an event for older adults or chosen a service provider for older adults because you knew the provider was LGBT-friendly?” where 0 = *no* (reference) and 1 = *yes*.

Decided against asking for help from a place that serves older adults because of concerns about coming or being out. Participants were asked “Have you ever decided against asking for help from a place that serves older adults because you were concerned about coming or being out?” where 0=*no* (reference) and 1=*yes*.

Primary Independent Measures

Age-specific experience of D/V. In order to determine respondents’ experience of SOGI-based discrimination, they were asked “Have you experienced discrimination or violence because you are LGBT...” (a) *before the age of 18* (b) *between the ages of 18 and 49* and (c) *after age 50*. Participants were instructed to “check all that apply” for each age group. Response categories included (1) *yes, I’m sure of it* (2) *I think or believe I have* and (3) *no, I have not*. Those who reported “yes, I’m sure of it” or “I think or believe I have” were collapsed into one category. Three separate dichotomous variables were created for each age group and used in analyses, where 0=*no experience* (reference) and 1= *experience*.

Cumulative D/V experience. Participant responses to the age-specific D/V questions were added following multiple imputation to create a cumulative measure of these experiences. Cumulative experience of D/V ranged from 0 (*no experience*) to 3 (*experience at three points in time*).

Independent Measures

Age. An ordinal variable for age was used in analysis, where 1=*60-64 years old*, 2=*65 to 69 years old*, 3=*70 to 74 years old*, 4=*75 to 79 years old*, 5=*80 to 84 years old*, and 6=*85 years old and older*. Age was treated as a continuous variable in all analyses.

Sex/gender. Participants were asked, “What is your gender?” and with responses (0=*female* and 1=*male*). Though these response categories are sex categories rather than gender categories, they are being used here to represent participants’ gender because of the terms used in the question.

Income. Participants were asked, “What is your annual household income from all sources?” and were provided the following response categories (1) *Under \$11,000* (2) *\$11,000-\$25,000* (3) *\$25,001-\$35,000* (4) *\$35,001-\$50,000* (5) *\$50,001-\$75,000* and (6) *\$75,001 or more*. Income was used as a continuous measure in all analyses.

Education. Participants were asked, “What is the highest level of education you completed?” and were provided the following response categories (a) *elementary/some high school* (b) *graduated high school or GED* (c) *some college* (d) *graduated college* and (e) *any graduate or professional school*. To adjust for negative skew, categories were collapsed so that some college or less was the reference category, compared to a college degree or higher.

Analytic Strategy

Missing data. Table 1 presents information on missing data for variables used in this study. Missing diagnostics showed 74 (57%) of 129 cases were complete; an additional 26 (20%) cases had one missing value. Having had an experience of SOGI-based D/V before age 18 had the most missing values at 27 (21%), followed by having had an experience of SOGI-based D/V at or after age 50 at 23 (18%) and having had an

experience of SOGI-based D/V between ages 19-49 at 21 (16%). Missing data were unpatterned, therefore multiple imputation by chained equations using Stata 12 (Royston, 2005) was performed. Twenty imputations were generated. Results present coefficients and standard errors that are aggregated across the twenty complete datasets (Rubin, 1987).

Statistical analyses. A correlation matrix containing all the variables considered in this analysis can be found in Table 2. For each dependent variable, two separate regressions were estimated. First, the three age-specific D/V experiences were tested as the primary independent variables, followed by the cumulative measure of D/V experiences as the primary independent variable.

Attitudes. Ordinal logistic regression was used to understand the relationship between independent variables and respondents' concern about sexual orientation discrimination and using aging services. Binary logistic regression was used to understand relationships between the independent variables and respondents' concern about coming or being out and accessing aging services.

Behaviors. Binary logistic regression was used to understand relationships between the independent variables and each of the three behaviors: a) being out to all HCPs v. out to less than all HCPs b) having attended an event or having chosen an aging service provider because it was LGBT-friendly v. not and c) having decided against asking for help from an aging service provider due to concerns about coming or being out v. not. A cluster correction was used in regression analyses to account for the fact that data were collected from respondents while they attended various meal sites.

Results

Descriptive Statistics

Descriptive statistics for the dependent variables can be found in Table 3. With regard to attitudes, 39% of respondents reported that they were “not concerned” about sexual orientation discrimination and using aging services, followed by 42% who indicated that they were “somewhat concerned,” and by 19% who said they were “concerned.” Seventy-eight percent of respondents scored less than 5 (less concern) on the question about level of concern about coming or being out and accessing aging services.

Regarding behaviors, 58% of respondents reported being out to all of their HCPs, 50% reported having attended an event for older adults or having used an aging services that they knew was LGBT-friendly, and 12% reported that they decided to not ask for help from an aging service provider due to concerns about coming or being out.

Bivariate analysis by attitudinal dependent variables can be found in Table 4. There was a significant association between respondents’ experiences of D/V at or after age 50 and concern about sexual orientation discrimination and using aging services ($\chi^2=8.82, p < .01$). There was also a significant association between respondents’ experiences of D/V at or after age 50 and having greater concern about coming/being out and accessing aging services ($\chi^2=8.44, p < .01$).

Bivariate analysis by behavioral dependent variables can be found in Tables 5 and 6. There was a significant association between cumulative D/V experiences and being out to less than all HCPs ($t=2.00, p < .05$) and between having experienced D/V at or after

age 50 and having decided against asking for help from a place that serves older adults due to concerns about coming or being out ($\chi^2 = 9.75, p < .01$).

Attitude Regression Results

Neither age-specific D/V nor cumulative experiences of D/V were significantly associated with odds of having greater concern about sexual orientation discrimination and using aging services in ordinal logistic regression (please refer to Table 7). Similarly, neither of the two primary independent variables were associated with the odds of having a higher (vs. lower) level of concern about coming or being out and accessing aging services (please refer to Table 8).

Behavior Regression Results

Regression results for behavioral dependent variables can be found in Tables 9 and 10. In binary logistic regression, neither age-specific D/V experiences nor the cumulative measure of D/V were associated with whether they had attended a program for older adults or used an aging service they knew was LGBT-friendly (vs. had not). Having had an experience of D/V at or after age 50 was associated with a decrease in the odds of being out to all HCPs (vs. out to less than all) ($OR=0.42, p < .05$) (please refer to Table 9) and with an increase in the odds of having not asked for help from a place that serves older adults due to concern about coming or being out (v. having asked for help) ($OR=8.95, p < .05$). Cumulative experiences of D/V were not associated with either being out to all HCPs or having not asked for help from an aging service provider due to concerns about coming or being out.

Discussion

The goals of this study were to explore how age-specific and cumulative experiences of D/V were related to LGBT older adults' behaviors and attitudes regarding aging service use. None of the hypotheses specific to cumulative effects of D/V on LGBT older adults' attitudes and behaviors regarding aging service use were supported.

However, age-specific D/V experiences showed a significant relationship between two behaviors regarding aging and health care service use, such that an experience of D/V at or after age 50 was significantly associated with (a) being out to less than all of one's HCPs and (b) having not asked for help from a place that serves older adults due to concerns about coming or being out.

SOGI-Based Discrimination/Violence Experiences as an LGBT Older Adult

Most studies that have explored the relationship between D/V and LGBT older adults' SOGI disclosure to their HCPs have considered such experiences at any point in one's life (Brotman et al., 2003; D'Augelli & Grossman, 2001; IOM, 2011). The current study contributes to the literature in that it differentiates such experiences by age when D/V was experienced. First, with regard to attitude, neither age-specific D/V experiences nor cumulative D/V experiences were significantly associated with either of the attitude outcomes. The hypotheses that age-specific experiences of D/V would be associated with behaviors using aging and health care services were partially supported.

Findings from this study support the idea experiences of D/V in later life may affect whether LGBT older adults use aging services, and if they do, whether they come out to those providers (Brotman et al., 2003; D'Augelli & Grossman, 2001; IOM, 2011). First, this study found that D/V experiences in later life were associated with a decrease

in the odds of respondents being out to all of their HCPs. Because of the limited LGBT-training received by aging service providers (Bell et al., 2010; Porter & Krinsky, 2014) and LGBT older adults' negative experiences with aging service providers (AOA, 2010; Johnson, et al., 2005; National Senior Citizens Law Center, 2011), it is not unrealistic that older adults who were victimized in later life would be less likely to disclose their SOGI to HCPs.

Next, with regard to having not asked for help from an aging service provider due to concerns about coming or being out, results from this study found that LGBT older adults' experience of D/V in later life was also associated with their not having asked for help from an aging service provider. As noted earlier, LGBT older adults may actually need to access formal aging support at higher rates as compared non-LGBT older adults due to limited family support, yet are less likely to access such services (IOM, 2011; Fredriksen-Goldsen, 2012; King, 2009). Perhaps some of the most vulnerable people among LGBT older adults are those who have experienced D/V in later life. This study has shown that such experiences later in life may impact whether or not LGBT older adults avoid or access needed aging services, regardless of D/V experiences before age 50.

Limitations

There are a number of limitations that must be considered when interpreting results from this study. The high percentage of missingness affected this study's ability to draw confident conclusions from the data. Missing data in aging research is a phenomenon that can have a number of causes, such as cognitive or physical impairments that may make it difficult for respondents to complete a survey, complicated questions

that may be confusing to participants, and length of the survey which can contribute to fatigue (Hardy, Allore & Studenski, 2009). Some possibilities for high rates of missing data in this sample could be that the surveys were administered during busy meal times when participants were likely to have been socializing, they may have been distracted and therefore provided incomplete information, or perhaps they thought certain questions were irrelevant to their experience. Though unpatterned, the missing data in this study could have affected statistical power needed to determine significant effects, therefore results should be interpreted with caution.

The use of cross-sectional data also presents a limitation in determining causality. Because these data were collected at one point in time, it cannot be determined whether participants' being out to less than all of their HCPs and not having asked for help from an aging service provider due to concerns about coming or being out came before or after they experienced D/V in later life. The sample was primarily white, therefore determining any racial/ethnic differences among LGBT and non-LGBT participants was not possible. Participants all lived within the greater Boston area and accessed the meal programs; results may have been different if a wider geographic region was captured and if people who did not make use of congregate meal programs were included in the study. Also, this study's consideration of HCPs is a major limitation of this study as "health care providers" is a broad category and may include any number and type of providers (i.e., physicians, nurses, physician assistants, social workers). In addition, the D/V question was collapsed into dichotomous variables and does not capture the severity or frequency of age-specific experiences.

A final limitation of this study has to do with the primary independent variable of age-specific experiences of SOGI-based D/V. Though the question was worded such that participants were given the option to state whether they were certain that they experienced SOGI-based D/V, thought or believed they had experienced SOGI-based D/V, or had not experienced SOGI-based D/V, there may be significant differences between those who thought they experienced SOGI-based D/V and those who were certain that they did or did not experience SOGI-based D/V. Research has shown that perceived discrimination has had significantly negative effects on adults' health and mental health outcomes (Pascoe & Smart Richman, 2009), however perceived LGBT discrimination and aging service utilization among older adults has not yet been studied. The fact that the SOGI-based D/V item used in this study relied on participants' self-report, their responses were essentially based on their perception of SOGI-based D/V. Future research is needed to understand experiences of actual versus perceived SOGI-based D/V among LGBT older adults and their effect on aging service utilization.

Conclusion

General aging concerns about finances, health and health care, and social isolation are among the issues that affect older adults as they age. LGBT older adults also experience concerns about these same issues, but with added minority stress regarding concerns about their sexual orientation and gender identity (Meyer, 2003). The issue of negotiating one's SOGI disclosure and accessing safe and supportive services is one of the ways in which minority stressors factor into older adults' general concerns about being unable to care for themselves, dependent on others, sick or disabled, cognitively impaired, and outliving their incomes as they age (MetLife, 2010; Wight, LeBlanc, de

Vries & Detels (2012) have noted the unique challenges faced by LGB older adults due to the combination of common aging-related stressors and those associated with their sexual minority status (p. 503).

In order to address the needs of current LGBT older adults, aging service providers and health care professionals need to know who among their clients and patients identify as sexual minorities. Therefore, it is important to consider Espinoza's (2014) recommendation about relationships between LGBT older adults and their providers:

if providers are not aware of their patients' sexual orientations and gender identities, and that lack of information is due in part to a fear of bias and discrimination from LGBT people themselves, the integrity of the patient- provider relationship has been compromised. Proper health treatment requires candid communication between patients and providers, and LGBT patients deserve professional interactions that affirm their sexual and gender identities at all ages. (p. 24)

The AoA's (2012) inclusion of LGBT older adults as those in "greatest social need" seems most appropriate in light of this study's findings. Older LGBT-older adults and those who have experienced D/V in later life may be among the most vulnerable of those in greatest social need. Being aware of their concerns about SOGI disclosure and using aging services could help aging service providers better serve this population who are among those who are most at risk for isolation and avoidance of aging services.

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Appendix

Table 1

Missing Statistics MEALSITE Study, 2013, LGBT Participants Only (N=129)

Measure	Total (N=129) N (%)
<i>Dependent measures</i>	
Attitude measures	
Concern about sexual orientation discrimination when using aging services	13 (10.08)
Level of concern about coming or being out and accessing services for older adults (1= <i>not at all concerned</i> to 10= <i>very concerned</i>)	17 (13.18)
Behavior measures	
Out to HCPs	18 (13.95)
Ever attended an event for older adults or chosen an aging service provider because the provider was LGBT-friendly	17 (13.18)
Decided against asking for help from a place that serves older adults due to concerns about coming or being out	17 (13.18)
<i>Primary independent measures</i>	
Experience of SOGI-based discrimination/violence	
Before age 18	27 (20.93)
Between ages 18-49	21 (16.28)
At or after age 50	23 (17.83)
<i>Independent measures</i>	
Age	18 (13.95)
Gender	0 (0)
Income	13 (10.08)
Education	0 (0)

Table 2

Correlation Matrix MEALSITE Study, 2011-2013, Multiply-Imputed Data (N=125)

	1	2	3	4	5	6	7	8	9	10	11	12
(1) out to HCPs	1.00											
(2) LGBT-friendly event/provider	-0.04	1.00										
(3) did not ask for help	-0.05	-0.02	1.00									
(4) concern	-0.03	-0.11	0.08	1.00								
(5) level of concern	-0.01	-0.07	0.32***	0.46***	1.00							
(6) D/V young age	-0.17	-0.04	-0.05	0.01	-0.09	1.00						
(7) D/V mid-age	-0.09	-0.06	0.01	0.18*	-0.06	0.62***	1.00					
(8) D/V older-age	-0.16	0.04	0.30***	0.19*	0.29***	0.22*	0.45***	1.00				
(9) cumulative ^a	-0.18	-0.03	0.10	0.16	0.05	0.79***	0.88***	0.70***	1.00			
(10) age	-0.05	0.25**	0.11	-0.18*	0.12	0.10	-0.02	-0.03	0.02	1.00		
(11) gender	-0.15	-0.04	-0.18*	-0.09	-0.18*	0.23**	0.06	0.02	0.13	0.07	1.00	
(12) income	0.11	0.02	-0.13	-0.05	0.08	-0.16	-0.08	-0.08	-0.14	0.14	-0.12	1.00
(13) education	-0.11	-0.02	-0.02	0.10	0.03	-0.03	0.10	-0.05	0.01	-0.02	-0.03	0.31***

Note. ^a *Cumulative* refers to the sum of respondent age-specific experiences of D/V.

* $p < .05$; ** $p < .01$; *** $p < .001$

Table 3

Descriptive Statistics for Dependent Variables, MEALSITE Study, 2013, Multiply-Imputed Data (N=129)

	Proportion or M (SD)
<i>Attitude measures (N=129)</i>	
Concern about sexual orientation discrimination and using aging services	
Not concerned	0.39
Somewhat concerned	0.42
Concerned	0.19
Level of concern about coming/being out and accessing aging services (1= <i>not at all concerned</i> to 10= <i>very concerned</i>)	
Level of concern ≤ 5	0.78
Level of concern ≥ 6	0.22
<i>Behavior measures</i>	
Out to HCPs (N=125)	
Out to all	0.58
Out to less than all	0.42
Ever attended an event for older adults or chosen an aging service provider because the provider was LGBT-friendly (N=129)	
Yes	0.50
No	0.50
Decided against asking for help from a place that serves older adults due to concerns about coming or being out (N=129)	
Yes	0.12
No	0.88

Table 4 *Descriptive Statistics by Attitude, Concern about Sexual Orientation Discrimination and Using Aging Services and Concern About Coming/Being Out and Accessing Aging Services MEALSITE Study, 2013, Multiply-Imputed Data (N=129)*

	Total	Concern About Sexual Orientation Discrimination and Using Aging Services				Concern About Coming/Being Out and Accessing Aging Services		
		Not concerned	Somewhat concerned	Concerned	Comparison	Level ≤ 5	Level ≥ 6	Comparison
	N=129	N=51	N=54	N=24		N=101	N=28	
SOGI-based discrimination/violence								
Before age 18					$\chi^2=0.35$			$\chi^2=0.50$
Yes	0.42	0.41	0.44	0.38		0.44	0.36	
No	0.58	0.59	0.56	0.62		0.56	0.64	
Between ages 19-49					$\chi^2=2.99$			$\chi^2=0.03$
Yes	0.56	0.47	0.59	0.67		0.55	0.57	
No	0.44	0.53	0.41	0.33		0.45	0.43	
At or after age 50					$\chi^2=8.82^{**}$			$\chi^2=8.44^{**}$
Yes	0.34	0.24	0.33	0.58		0.28	0.57	
No	0.66	0.76	0.67	0.42		0.72	0.43	
Cumulative (0 to 3)	1.32 (1.18)	1.12 (1.19)	1.37 (1.17)	1.63 (1.13)	$F=1.62$	1.27 (1.17)	1.50 (1.20)	$t=-0.92$
Age ^b	2.81 (1.33)	3.04 (1.34)	2.76 (1.30)	2.42 (1.32)	$F=1.87$	2.74 (1.31)	3.04 (1.40)	$t=-1.03$
Gender					$\chi^2=1.75$			$\chi^2=3.99^*$
Female	0.51	0.51	0.46	0.63		0.47	0.68	
Male	0.49	0.49	0.54	0.38		0.53	0.32	
Income ^c	3.27 (1.63)	3.16 (1.63)	3.52(1.58)	2.96 (1.76)	$F=1.19$	3.15 (1.55)	3.71 (1.86)	$t=-1.63$
Education					$\chi^2=0.40$			$\chi^2=2.60$
≤ Some college	0.30	0.33	0.28	0.29		0.34	0.18	
≥ College degree	0.70	0.67	0.72	0.71		0.66	0.82	

Note. ^a Means and standard deviations or proportions are reported; proportions may not add to 1.00 due to rounding. ^b Mean age between 2-3 corresponds to 65-69 years old; mean age between 3-4 corresponds to 70-74 years old. ^c Mean income between 3-4 corresponds to \$25,001-\$35,000 total household income.

* $p < .05$, ** $p < .01$, *** $p < .001$

Table 5

Descriptive Statistics by Behavior, Out to HCPs MEALSITE Study, 2013, Multiply-Imputed Data (N=125)

	Total	Out to HCPs		
		All	< All	Comparison
	N=125	N=73	N=52	
SOGI-based discrimination/violence				
Before age 18				$\chi^2=3.50$
Yes	0.44	0.37	0.54	
No	0.56	0.63	0.46	
Between ages 19-49				$\chi^2=1.11$
Yes	0.56	0.52	0.62	
No	0.44	0.48	0.38	
At or after age 50				$\chi^2=3.18$
Yes	0.35	0.29	0.44	
No	0.65	0.71	0.56	
Cumulative (0 to 3)	1.35 (1.17)	1.18 (1.10)	1.60 (1.22)	$t=2.00^*$
Age ^b	2.81 (1.32)	2.75 (1.38)	2.88 (1.25)	$t=0.54$
Gender				$\chi^2=2.82$
Female	0.51	0.58	0.42	
Male	0.49	0.42	0.58	
Income ^c	3.40 (1.67)	3.56(1.86)	3.17 (1.35)	$t=-1.29$
Education				$\chi^2=1.59$
≤ Some college	0.31	0.36	0.25	
≥ College degree	0.69	0.64	0.75	

Note. ^a Means and standard deviations or proportions are reported; proportions may not add to 1.00 due to rounding.. ^b Mean age between 2-3 corresponds to 65-69 years old. ^c Mean income between 3-4 corresponds to \$25,001-\$35,000 total household income.

* $p < .05$, ** $p < .01$, *** $p < .001$

Table 6 *Descriptive Statistics by Behavior, Attended an Event or Used an Aging Service Because it was LGBT-Friendly and Did Not Ask for Help from a Place that Serves Older Adults Due to Concerns about Coming or Being Out, MEALSITE Study, 2013, Multiply-Imputed Data (N=129)*

	Total	LGBT-Friendly			Did Not Ask For Help		
		Yes	No	Comparison	Yes	No	Comparison
	N=129	N=64	N=65		N=16	N=113	
SOGI-based discrimination/violence							
Before age 18				$\chi^2=1.83$			$\chi^2=2.13$
Yes	0.42	0.36	0.48		0.25	0.44	
No	0.58	0.64	0.52		0.75	0.56	
Between ages 19-49				$\chi^2=1.74$			$\chi^2=1.24$
Yes	0.56	0.50	0.62		0.69	0.54	
No	0.44	0.50	0.38		0.31	0.46	
At or after age 50				$\chi^2=0.00$			$\chi^2=9.75^{**}$
Yes	0.34	0.34	0.34		0.69	0.29	
No	0.66	0.66	0.66		0.31	0.71	
Cumulative (0 to 3)	1.32 (1.18)	1.20 (1.20)	1.43 (1.16)	$t=1.10$	1.63 (1.02)	1.27 (1.20)	$t=-1.11$
Age ^b	2.81 (1.33)	3.14 (1.38)	2.48 (1.20)	$t=-2.92^{**}$	3.00 (1.55)	2.78 (1.30)	$t=-0.62$
Gender				$\chi^2=1.31$			$\chi^2=0.94$
Female	0.51	0.56	0.46		0.63	0.50	
Male	0.49	0.44	0.54		0.37	0.50	
Income ^c	3.27 (1.63)	3.19 (1.51)	3.35 (1.75)	$t=0.58$	3.00 (1.86)	3.31 (1.60)	$t=0.71$
Education				$\chi^2=0.40$			$\chi^2=0.24$
≤ Some college	0.30	0.33	0.28		0.25	0.31	
≥ College degree	0.70	0.67	0.72		0.75	0.69	

Note. ^a Means and standard deviations or proportions are reported; proportions may not add to 1.00 due to rounding. ^b Mean age between 2-3 corresponds to 65-69 years old; mean age between 3-4 corresponds to 70-74 years old ^c Mean income between 3-4 corresponds to \$25,001-\$35,000 total household income and mean income between 2-3 corresponds to \$11,001-\$25,001 total household income.

* $p < .05$, ** $p < .01$, *** $p < .001$

Table 7

Ordinal Logistic Regression, Odds of Having Greater Concern about Sexual Orientation Discrimination and Using Aging Services, MEALSITE Study, 2011-2013, Multiply-Imputed Data (N=129)

	Odds of Having Greater Concern about Sexual Orientation Discrimination and Using Aging Services		Odds of Having Greater Concern about Sexual Orientation Discrimination and Using Aging Services	
	OR	95% CI	OR	95% CI
Young ^a	0.61	0.14-2.64	--	--
Mid-age	1.47	0.40-5.33	--	--
Older-age	2.68	0.75-9.63	--	--
Cumulative ^b	--	--	1.29	0.91-1.83
Age	0.74	0.48-1.13	0.75	0.46-1.22
Gender	0.71	0.27-1.87	0.67	0.25-1.75
Income	0.96	0.73-1.25	0.97	0.75-1.26
Education	1.42	0.40-5.04	1.29	0.46-3.62
<i>F; df</i>	3.38; 7		2.01; 5	
<i>N</i>	129		129	

Note. OR=odds ratio; CI=confidence interval. ^a *Young, mid-age and older-age* all refer to respondent experiences of D/V during these age periods. ^b *Cumulative* refers to the sum of respondent age-specific D/V (0 experiences, at least one experience, experiences during 2 age periods and experiences during all 3 age periods).

* $p < .05$, ** $p < .01$, *** $p < .001$

Table 8

Binary Logistic Regression, Odds of Higher Level of Concern about Coming or Being Out and Accessing Aging Services (vs. Lower Level of Concern), MEALSITE Study, 2011-2013, Multiply-Imputed Data (N=129)

	Odds of Higher Level of Concern about Coming or Being Out and Accessing Aging Services vs. Lower Level of Concern		Odds of Higher Level of Concern about Coming or Being Out and Accessing Aging Services vs. Lower Level of Concern	
	OR	95% CI	OR	95% CI
Young ^a	1.28	0.18-9.28	--	--
Mid-age	0.31	0.03-3.00	--	--
Older-age	8.30	0.68-100.67	--	--
Cumulative ^b	--	--	1.31	0.76-2.25
Age	1.15	0.63-2.09	1.13	0.66-1.91
Gender	0.38	0.10-1.43	0.42	0.13-1.35
Income	1.16	0.80-1.70	1.15	0.75-1.76
Education	1.69	0.27-10.46	1.38	0.31-6.10
<i>F; df</i>	5.02; 7		0.93; 5	
<i>N</i>	129		129	

Note. OR=odds ratio; CI=confidence interval. ^a *Young, mid-age* and *older-age* all refer to respondent experiences of D/V during these age periods. ^b *Cumulative* refers to the sum of respondent age-specific experiences of D/V (0 experiences, at least one experience, experiences during 2 age periods and experiences during all 3 age periods).

* $p < .05$, ** $p < .01$, *** $p < .001$

Table 9

Binary Logistic Regression, Odds of Being Out to All HCPs vs. Less than All, MEALSITE

Study, 2011-2013, Multiply-Imputed Data (N=125)

	Odds of Being Out to All HCPs		Odds of Being Out to All HCPs	
	vs. Less than All		vs. Less than All	
	OR	95% CI	OR	95% CI
Young ^a	0.44	0.13-1.49	--	--
Mid-age	2.35	0.53-10.37	--	--
Older-age	0.42*	0.17-1.03	--	--
Cumulative ²	--	--	0.82	0.53-1.27
Age	0.82	0.58-1.15	0.83	0.61-1.13
Gender	0.78	0.24-2.51	0.69	0.23-2.07
Income	1.25	0.89-1.75	1.25	0.90-1.73
Education	0.62	0.14-2.66	0.67	0.15-2.90
<i>F; df</i>	6.82; 7		4.13; 5	
<i>N</i>	125		125	

Note. OR=odds ratio; CI=confidence interval. ^a *Young, mid-age* and *older-age* all refer to respondent experiences of D/V during these age periods. ^b *Cumulative* refers to the sum of respondent age-specific experiences of D/V (0 experiences, at least one experience, experiences during 2 age periods and experiences during all 3 age periods).

* $p < .05$, ** $p < .01$, *** $p < .001$

Table 10

Binary Logistic Regression, Odds of Having Sought LGBT-Friendly Providers vs. Not, and Odds of Having Not Asked for Help from a Place that Serves Older Adults Due to Concerns about Coming or Being Out vs. Not, MEALSITE Study, 2011-2013, Multiply-Imputed Data (N=129)

	Odds of Having Attended an Event or Chosen an Aging Service Provider Because They Were LGBT-Friendly		Odds of Having Attended an Event or Chosen an Aging Service Provider Because They Were LGBT-Friendly		Odds of Having Not Asked for Help from a Place that Serves Older Adults Due to Concerns about Coming or Being Out		Odds of Having Not Asked for Help from a Place that Serves Older Adults Due to Concerns about Coming or Being Out	
	vs. Not		vs. Not		vs. Not		vs. Not	
	OR	95% CI	OR	95% CI	OR	95% CI	OR	95% CI
Young ^a	0.63	0.14-2.88	--	--	0.17	0.02-1.39	--	--
Mid-age	0.83	0.09-7.44	--	--	1.81	0.21-15.33	--	--
Older-age	1.40	0.38-5.08	--	--	8.95*	1.82-43.99	--	--
Cumulative ^b	--	--	0.88	0.59-1.32	--	--	1.41	0.80-2.50
Age	1.55*	1.16-2.08	1.54*	1.15-2.06	1.11	0.57-2.16	1.13	0.67-1.91
Gender	0.81	0.30-2.18	0.78	0.27-2.34	0.80	0.14-4.46	0.59	0.15-2.38
Income	0.91	0.67-1.24	0.91	0.67-1.24	0.74	0.41-1.34	0.80	0.50-1.29
Education	0.87	0.37-2.05	0.84	0.36-1.97	2.06	0.25-17.16	1.63	0.20-13.43
<i>F; df</i>	13.33; 7		17.25; 5		139.49; 7		3.44; 5	
<i>N</i>	129		129		129		129	

Note. OR=odds ratio; CI=confidence interval. ^a *Young, mid-age and older-age* all refer to respondent experiences of D/V during these age periods. ^b *Cumulative* refers to the sum of respondent age-specific experiences of D/V (0 experiences, at least one experience, experiences during 2 age periods and experiences during all 3 age periods).

* $p < .05$, ** $p < .01$, *** $p < .001$

CHAPTER IV: PAPER 3

How Do Sexual and Gender Minority Older Adults Disclose Sexual Orientation and Gender Identity to Primary Health Care Providers?

Abstract

Objectives: Health disparities among older adults based on sexual orientation and gender identity (SOGI) are well-documented, though SOGI information is rarely shared with one's health care providers (HCPs). HCPs do not regularly ask patients about SOGI and lesbian, gay, bisexual, and transgender (LGBT) older adults are often reluctant to reveal this information for fear of discrimination, harassment, or inadequate care.

Methods: Constant comparative analysis of interviews with 22 LGBT older adults was used to understand whether/how they disclosed SOGI to their HCPs and how their level of overall outness and LGBT community involvement may have affected disclosure.

Results: These participants were generally very out about their SOGI and at least moderately involved in the LGBT community. Sixteen participants indicated that they were out about their SOGI with their primary HCPs, though disclosure processes varied.

Discussion: While not synonymous to SOGI disclosure to HCPs, being out and connected to the LGBT community appeared to be related to disclosure. Results suggest that HCPs should appropriately and sensitively inquire about their patients' SOGI in order to identify risks for potential health disparities among LGBT older adults.

Keywords: LGBT older adults, outness, health care providers

Introduction

Health disparities among older adults based on age, race/ethnicity, and socioeconomic status in the United States are well-documented, (MacArthur Foundation, 2009) however researchers are just beginning to learn about disparities based on sexual orientation and gender identity (SOGI) (Ward, Dahlhamer, Galinsky & Joestl, 2014). Some population-based studies have investigated health disparities by SOGI, (Conron, Mimiaga, and Landers, 2010; Dilley, Simmons, Boysun, Pizacani, & Stark, 2010), but a major limitation of these studies is that they focus only on adults between ages 18 and 65 (Dilley et al., 2010; Conron et al., 2010). In 2013, the National Health Interview Survey (NHIS) became the first national survey in the United States to ask respondents about their sexual orientation, which has allowed researchers to begin comparing health indicators and health behaviors between sexual minority and heterosexual adults age 18-64 (Ward et al., 2014), yet still perpetuating the lack of attention to the health of older adults. Since national and statewide surveys do not typically ask respondents (particularly older adult respondents) about their SOGI, researchers have begun promoting the collection of this information in clinical settings (Cahill et al., 2014).

Lesbian, gay, bisexual and transgender (LGBT) older adults are among those in “greatest social need” (Administration on Aging [AoA], 2012), as they face disproportionate risk for vulnerability due to social isolation, financial insecurity, and aging-related health problems as compared to their non-LGBT counterparts (AoA, 2012). Despite their increased need for social and health supports as they age, sexual and gender minority (SGM) older adults often delay or avoid seeking care for fear of discrimination, inferior care or harassment from providers (Institute of Medicine [IOM], 2011;

Movement Advancement Project [MAP] & Services and Advocacy for GLBT Elders [SAGE], 2010). When they do access health care services, LGBT older adults are often reluctant to share their SOGI with providers (Croghan, Moone & Olson, 2014; Espinoza, 2014; MAP & SAGE, 2010).

Although disclosure of patients' SOGI to their medical providers has been shown to have a positive association with regular health care use (Steele, Tinmouth, & Lu, 2006), not all LGBT older adults share this information with their medical providers (Espinoza, 2014; Fredriksen-Goldsen et al., 2011). When primary health care providers (HCPs), such as physicians, nurses, physician assistants, and social workers who patients see regularly for care are unaware of their LGBT patients' SOGI, these patients remain invisible, (Fredriksen-Goldsen et al., 2011; Jackson, Johnson & Roberts, 2008), which affects providers' ability to facilitate appropriate care (Croghan et al., 2014). Being aware of SOGI would help primary HCPs identify their LGBT patients' increased risk for health disparities, such as higher rates of disability, poor mental health, smoking and substance use as compared to non-LGBT older adults (Fredriksen-Goldsen et al., 2013b). This would increase the likelihood that SGM older adults would receive effective preventive screening and proactive treatment given these health disparities. Since little is known about how SGM older adults come to share this information with primary HCPs, this qualitative study sought to understand whether and how LGBT older adults disclosed SOGI information to their primary HCPs.

Literature Review

Health Disparities Among LGBT Older Adults

There is a growing body of knowledge regarding health disparities between

LGBT older adults and their non-LGBT counterparts. In 2013, Fredriksen-Goldsen and colleagues found in a population-based sample of over 90,000 older adults in the state of Washington, that lesbian, gay, and bisexual individuals were more likely to have poorer mental health, higher rates of disability, and higher rates of excessive alcohol consumption as compared to heterosexual older adults (2013b). Additionally, lesbian and bisexual women had higher rates of heart disease and obesity, while gay and bisexual men were more likely to live alone and reported higher rates of poor physical health as compared to heterosexuals (Fredriksen-Goldsen et al., 2013b). Some studies have also indicated disparities among SGM older adults as well. Lesbian women were more likely to report higher rates of excessive drinking as compared to bisexual women, and bisexual men reported higher rates of diabetes and lower rates of HIV testing as compared to gay men (Fredriksen-Goldsen et al., 2013b).

Some explanations have been offered to help conceptualize these disparities. Actual experiences of, and fear of, experiencing future stigmatization, harassment, violence, and discrimination related to individuals' SOGI are understood to have profound effects on the mental and physical health of SGM individuals (Fredriksen-Goldsen et al., 2009; Fredriksen-Goldsen et al., 2013a; Wight, LeBlanc, de Vries & Detels, 2012). Chronic stressors have known effects on physical health (Juster, McEwen & Lupien, 2010), suggesting that "lifetime experiences of victimization may partially account for higher rates of disability" among SGM older adults (Fredriksen-Goldsen et al., 2013b, p. 1806). If primary HCPs were to regularly screen for their patients' SOGI, just as they do for racial/ethnic and socioeconomic (SES) characteristics, they could be alerted to important potential health risk factors, thereby improving the patient-provider

relationship and consistent use of care (U.S. Department of Health & Human Services, n.d. A).

It is widely accepted that social determinants of health, such as socioeconomic status (SES), social norms and attitudes (including racism and discrimination), exposure to violence, and access to health care and community-based services are related to health outcomes (U.S. Department of Health & Human Services, n.d. B). When primary HCPs ask their patients to identify their sociodemographic characteristics, such as race/ethnicity, they do so to have awareness of potential risk factors or barriers to treatment that may affect their patients' health outcomes and "to monitor health care processes and outcomes for different population groups, target quality initiatives more efficiently and effectively, and provide patient-centered care" (Hasnain-Wynia & Baker, 2006, p. 1501). Proponents of primary HCPs collecting SOGI information from their patients support the gathering of this data on all individuals in order to improve their patients' overall health care use (Steele et al., 2006).

The Importance of Collecting SOGI Information in Clinical Settings

In 2011, the Institute of Medicine (IOM) released a report highlighting health disparities among LGBT individuals in the United States. This report recommended that primary HCPs should collect SOGI information during regular routine care in order to better understand the health and well-being of their LGBT patients (IOM, 2011). The U.S. Department of Health and Human Service's Healthy People 2020 and The Joint Commission (2011) have also promoted the systematic collection of SOGI information from patients in clinical settings, primarily through the use of electronic health records

Two reports by The Fenway Institute (Bradford, Cahill, Grasso & Makadon,

2012a; 2012b) have outlined the importance of collecting SOGI data from patients and provided suggestions for how to collect this information from adult patients in clinical settings. In the first report, *Why Gather Data on Sexual Orientation and Gender Identity in Clinical Settings* (Bradford et al., 2012a) the authors promote the collection of this information so that providers would be able to “better understand LGBT health disparities, as well as to prevent, screen and early detect conditions that disproportionately affect LGBT people,” (p. 2). It is important for providers to know their patients’ SOGI in order to provide appropriate care and prevention screening (Bradford et al., 2012a) and those patients who share this information with their providers may be more inclined to disclose other health and risk behaviors with their providers as well (Klitzman & Greenberg, 2002). Including SOGI items as standard demographic questions would perhaps increase the likelihood that patients would share this information and would help guide providers’ approach to care (Bradford et al., 2012a).

The second Fenway report, *How to Gather Data on Sexual Orientation and Gender Identity in Clinical Settings* (2012b) and a recent study by Cahill and colleagues (2014) offer ways in which providers can obtain this information from their patients. Giving patients the opportunity to self-identify on patient registration/intake forms and during patient-provider interactions allows for patients to discuss privacy and confidentiality issues that may concern patients (Bradford et al., 2012b). Cahill and colleagues (2014) pilot tested a number of SOGI items in primary care settings with a sample of 301 geographically and racially diverse adults (51% were heterosexual and 33% were 50 years old or older) and found that respondents generally felt that it was important for their providers to know about their SOGI. The results showed that older

respondents were just as likely to agree that sexual orientation information was important for their providers to know, but less likely than younger age groups to agree that it was important for their providers to know about their gender identity. Respondents of all ages indicated that they would answer such questions in the future and felt that the questions accurately captured their SOGI (Cahill et al., 2014).

With regard to collecting SOGI information specifically from older adult clients, results from Paper I of this dissertation found that gerontological social workers did not think that asking clients directly was an appropriate way of learning about this information. These HCPs felt that they would either offend or confuse their older adult clients and were not convinced that knowing their clients' SOGI was relevant to the care they would provide. With regard to LGBT older adults' SOGI, Results from Paper 2 of this dissertation also found that just over half of a 129-LGBT older adult sample were out to all of their health care providers. Despite the increasing numbers of HCPs who are beginning to ask their clients about SOGI, there also seems to be resistance on the part of aging service providers to directly ask their clients about this information. Given aging service providers' reluctance to ask about and LGBT older adults' reluctance to disclose SOGI information, this study sought to understand facilitators/barriers to HCPs coming to learn this information about their clients.

SOGI Disclosure and Non-Disclosure to Primary HCPs

While there is some support for the collection of SOGI information in clinical settings, not all LGBT older adults regularly or consistently provide this information to their health care providers. In 2014, a SAGE report titled *Out and Visible: The Experiences and Attitudes of Lesbian, Gay, Bisexual and Transgender Older Adults, Ages*

45-75 (Espinoza, 2014) found that among 1,857 LGBT survey respondents, 36% stated that their primary HCPs were not aware of their SOGI, citing reasons such as reluctance to disclose this information for fear of “being judged or receiving inferior care” (Espinoza, 2014, p. 8), findings that are consistent with similar findings among LGBT older adults (i.e., Espinoza, 2014; Fredriksen-Goldsen et al., 2011).

There were also differences with regard to respondents’ living situations, age, gender, race and their SOGI disclosure to primary HCPs and concern about sharing this information with providers (Espinoza, 2014). Forty-three percent of single LGBT respondents and 40% of those in their 60s and 70s reported that their primary HCPs were unaware of their SOGI (Espinoza, 2014). With regard to gender differences, gay and bisexual men (25%) were more concerned about being judged by their primary HCPs than lesbian and bisexual women (18%); 35% of transgender respondents were concerned about being judged (Espinoza, 2014). Hispanic LGBT older adults (34%) reported higher levels of concern about the quality of care they would receive if their primary HCPs knew of their SGM status, as compared to 23% of African Americans and 16% of White respondents (Espinoza, 2014).

There is some research that has considered relationships between patient characteristics, provider characteristics and patient-provider relationship characteristics, and SOGI disclosure to primary HCPs. For example, Klitzman and Greenberg (2002) found that in their study of 96 lesbian, gay, and bisexual adults in their 30s and 40s, those who perceived their primary HCPs as being gay friendly and those who thought their primary HCPs were LGB, had higher rates of SOGI disclosure to those primary HCPs. In another study of 396 self-identified LGB individuals between the ages of 18-59, Durso

and Meyer (2013) found some differences between lesbian and bisexual women and gay and bisexual men and predictors of their disclosure to their primary HCPs. For women, Durso and Meyer (2013) found that having a bisexual identity, being a woman of color, being born outside of the US, not graduating from college and having children were some characteristics associated with non-disclosure to one's primary HCP. Lesbian and bisexual women who reported higher levels of internalized homophobia were also less likely to have disclosed their SOGI to their primary HCPs (Durso & Meyer, 2013).

For men, Durso and Meyer (2013) found that younger age, being bisexual, being born outside of the US, and higher level of internalized homophobia were associated with lower rates of disclosure to primary HCPs. Since nondisclosure of SOGI to HCPs may be a contributing factor to health disparities among SGM individuals (Durso & Meyer, 2013, p. 35) this study explored respondents' demographic characteristics, their level of overall outness, and LGBT community involvement in order to consider the process through which they shared SOGI information with their primary HCPs.

Overall Outness

Because one's overall level of outness, that is the extent to which others know about one's SGM identity, has been shown to be associated with SOGI disclosure to HCPs, it is considered in the present study. Steele and colleagues (2006) found that when lesbian women reported a higher level of overall outness, they had higher rates of disclosure to their HCPs. Similarly, Klitzman and Greenberg (2002) suggest being more out overall may contribute to LGB adults having closer bonds with their HCPs, therefore increasing the likelihood of disclosing their sexual orientation to their providers.

Level of LGBT-Community Involvement

In addition to overall level of outness, connection to the LGBT community has also been shown to have an association with disclosure to HCPs, such that a higher level of LGB community connectedness was related to higher rates of sexual orientation disclosure to their HCPs (Durso & Meyer, 2013). Therefore, this study also considered participants' involvement in the LGBT community to understand whether this was related to their SOGI disclosure to their primary HCPs.

The Durso and Meyer (2013) and Klitzman and Greenberg (2002) studies are important in that they both highlighted some of the factors associated with LGBT individuals' SOGI disclosure to their HCPs, though these studies were limited to middle-aged adults. Like the SAGE report (Espinoza, 2014), the current study focused only on LGBT older adults and sought to understand from a qualitative approach, what may help facilitate SOGI disclosure. The following section details how the sample of LGBT older adults was recruited and the methods used to analyze the interview data.

Methods

Data Source & Study Sample

This study used secondary qualitative data that was collected for the Health and Social Life of Boston-Area Elders study between December of 2009 and November of 2010. The original study was exploratory in nature and was developed as a community-based participatory research (CBPR) process in which researchers from the Massachusetts LGBT Aging Needs Assessment Coalition (M'LANA) and members of the LGBT older adult community worked together to identify the unique needs and strengths of this population (Van Wagenen, Driskell & Bradford, 2013). The primary

purpose of the original study was to learn about LGBT older adults' feelings towards participating in research and to gain insight into the composition of their social networks (Van Wagenen, Driskell & Bradford, 2013). A secondary aim of the original study was to "explore the health and social life experiences of LGBT older adults," therefore the "final interview guide included questions about coming out as LGBT, partnership histories, health, community engagement, and concerns related to growing older" (Van Wagenen et al., 2013, p. 4).

Participants were recruited through community-based outreach and snowball referrals and were asked to inform their peers about the study and provide information for how they could participate (Van Wagenen et al., 2013). Participants were required to be 60 years old or older, live in the greater Boston area, identify as lesbian, gay, bisexual and/or transgender *or* have been in a same sex relationship at some point in their lives (Van Wagenen et al., 2013). The three primary investigators for the original study interviewed participants using a semi-structured protocol. Most of the interviews were conducted in private study consultation rooms at a community health center; some were conducted in private rooms at congregate meal programs (where recruitment was facilitated); and a few were held in participants' homes in order to accommodate those with mobility restrictions (Van Wagenen et al., 2013). All participants provided written informed consent and all procedures were reviewed and approved by the Institutional Review Board of Fenway Health for the original study. The current study was approved by the Boston College Institutional Review Board.

The primary investigators used an interview guide that also had additional probing questions in order to elicit data from participants. In addition, all participants

completed a self-administered demographics questionnaire. All interviews lasted between one and two hours, were audio recorded and transcribed verbatim (eliminating any unique identifiers) and reviewed for quality assurance purposes (Van Wagenen et al., 2013).

Procedure and Analysis Plan

For the current study, constant comparative analysis of these data was used to explore the processes through which SGM older adults either share (or do not share) their SOGI with their primary HCPs (which could include physicians, nurses, social workers, or physician assistants). Constant comparative analysis is a qualitative research method that requires a researcher to examine individual pieces of data and compare them to other pieces of comparable data and to look for differences and similarities between them (Glaser & Strauss, 1967; Fram, 2013). By comparing across cases, individuals' experiences with disclosing or concealing their SOGI to others was thoroughly examined.

A series of coding procedures and memo writing (Bryant & Charmaz, 2007) was used to identify categories and themes across interviews. The three coding methods used include (1) descriptive coding, which was useful in gaining a sense of the scope of topics in the data, (2) in vivo coding, which allowed for identifying exact words or phrases used by participants, and (3) values coding, which yielded insights into participants' values, attitudes and beliefs (Saldaña, 2013).

Rigor

The current study involved secondary analysis of qualitative interviews; neither participant validation nor member checks were feasible, as so it was important to establish a plan to maintain credibility and rigor in this study. Therefore, peer debriefing

and consulting the community of practice were two strategies used to validate findings (Rossman & Rallis, 2012). One of the original study's primary investigators reviewed key findings and made recommendations on design decisions, provided feedback on possible analytic categories, and considered explanations for the phenomenon of interest, which was the process through which LGBT older adults share their SOGI with primary HCPs (Rossman & Rallis, 2012). In addition, as a member of the M'LANA research group, the author has had regular contact with other members. Having access to this community of practice has allowed for engagement "in critical and sustained discussion with valued colleagues in a setting of sufficient trust" to share ideas and tentative hypotheses and to apply relevant theory to the study's findings (Rossman & Rallis, 2012, p. 65).

Results

Sample Characteristics

Table 1 presents demographic and relevant participant characteristics pertaining current level of overall outness and level of LGBT community involvement for the entire sample ($N=22$) and for those who reported SOGI disclosure to primary HCPs ($N=16$). For two of the six remaining participants, it was unclear whether or not they were out to their HCPs; and four were not asked about being out to their HCPs. Eleven men and eleven women (one participant identified as having been born with a male sex assignment and now identified as female) were interviewed. All but two participants identified as lesbian or gay; there was one transgender participant who identified as heterosexual and one participant who identified as bisexual. Eighty-two percent of the sample was White, non-Hispanic and 14% were African American. The age range for the sample was 60 to 80

years old (Mean= 66.27, SD=5.50), 68% of the participants were partnered, and 55% lived alone.

Level of overall outness. Participants' level of overall outness was determined by considering two types of interview data (1) their response to the question "On a scale from 1 to 5, where 1=not out at all to 5=completely out, how out would you say you are?" and (2) their responses to questions such as "Would you say that you're a person who's out in most areas of your life?" "Are there certain places, when you would just not identify as a lesbian? And who knows about it, for instance?" "Can you tell me a little about how out you are about your sexual orientation?" "Can you tell me about how out you are in your life?"

Only eight participants were asked to report their level of overall outness using the scale. The fourteen who were not about the scale were asked questions about how out they are in their lives and with various people, including family members, friends, coworkers, community members, neighbors and primary HCPs. Based on one or both of these pieces of information, participants were categorized into a continuum of low, medium or high levels of overall outness. Participants who reported a 4 or higher on the outness scale, said that they were out to more people, and described fewer instances of concealing their identity were placed at the high end of the outness continuum. A score of 2 or lower on the outness scale, being out to fewer people, and describing more examples of managing their identity placed participants at the low end of the outness continuum. Based on this conceptualization of level of overall outness, 36% of the total sample was classified as having a medium level of overall outness and 64% had a high level of

overall outness. Of those who disclosed to their HCPs, 44% had a medium level and 56% had a high level of overall outness.

An example of a participant with a medium level of overall outness was Nancy, who was single and seemed to think that if she had a partner she would be more out. She said, “I guess I’d like it if I could be completely not guarded. And it’s a choice I make. I don’t have to be. And if I had a partner, I probably would just be totally out all the time.”

An example of a participant with a high level of overall outness was Elaine, who indicated that it was important for her to be out, that she was out to all of her immediate family, friends, and physician. She also stated that she does not make an effort to hide her sexual orientation, especially from men who try to flirt with her, stating that “it’s kind of fun to shock them.”

Level of LGBT community involvement. Participants’ level of LGBT community involvement was conceptualized in a way similar to how level of overall outness was captured. Eight respondents were asked “On a scale of one to five with one, not at all involved, three moderately involved five very involved, how involved would you say you are in the gay community?” Fourteen were not asked this directly, but were asked questions such as “Can you tell me about some of the gay community activities that you participate in?” “And so what about gay community, or LGBT community activity?” “Are you on any listservs or emailing lists for any organizations or different groups, in the gay community? Which ones?” and “Do you read any gay publications? Which ones?”

One or both of these pieces of information were used to place participants on a continuum of low, medium, or high levels of LGBT community involvement.

Respondents who reported a 4 or higher on the LGBT community involvement scale, said that they were participants in LGBT activities and groups, and were regular consumers of gay publications and online communities/listservs were placed at the high end of the LGBT community involvement continuum. A score of 2 or lower on the LGBT community involvement scale, little to no involvement in LGBT community activities, and no engagement with gay publications or online communities/listservs were placed at the low end of the LGBT community involvement continuum.

Based on this conceptualization of level of LGBT community involvement, 14% of the total sample were classified as having a low level, 36% had a medium level, and 50% had a high level of LGBT-community involvement. Of those who disclosed SOGI to their HCPs, 19% had a low level, 56% had a medium level, and 25% had a high level of LGBT community involvement. An example of someone with a low level of LGBT community involvement was Josie, a heterosexually identified transgender woman, who indicated that she had not been to an LGBT community event in the past year, did not consider herself to be a member of the LGBT community, received no LGBT publications, and reported that she did not participate in any online LGBT communities. Someone with a medium level of LGBT community involvement was Max, who participated in monthly Prime Timers meetings and congregate meal programs hosted by the LGBT Aging Project, a Boston-based non-profit organization focused on services and advocacy for LGBT older adults. Someone with a high level of LGBT community involvement was James, who not only attended LGBT community events and marched in the Boston Pride Parade, but also was a member of group whose mission is to educate the larger older adult community about the needs of older gay and lesbian caregivers.

Interview inconsistencies regarding overall outness and LGBT community

involvement scale questions. There were no prominent patterns for why some participants were asked to report their outness and LGBT community involvement on a scale from 1 to 5 and others were not. However, upon further investigation of similarities and differences between interviews in which participants were asked these questions, those who were asked the scale had interviews that lasted an average of 67 minutes, whereas those who were asked neither or only one of the scale questions had interviews that lasted an average of 86 minutes. There was no consistency in placement of these questions throughout the interview; at times the scale questions were asked near the beginning of the interview and other times were asked near the end. One possible explanation for why participants were not asked to report their outness and LGBT community involvement on a scale was that perhaps the interviewers felt that they had a clear understanding of the interviewees' general outness and LGBT community involvement based on additional questions and therefore did not ask participants to quantify these measures. Though this is only a speculation and the inconsistency in asking these scale questions is problematic, interviewers nevertheless were able to elicit participants' overall outness and LGBT community involvement by asking other direct questions about these two concepts.

SOGI Disclosure to HCPs

Table 1 presents frequencies for how SOGI disclosure was facilitated between the 16 participants who it was clear were out to their primary HCPs. Six respondents did not say how disclosure occurred. Of the 10 remaining participants, there were four distinct means through which they said their primary HCPs knew about their SOGI. Table 2

presents participants' sexual orientation, levels of outness, level of LGBT community involvement, and how SOGI disclosure occurred.

Health Status. Based on two participants' HIV status and one participant's experience with gender affirming surgery, these three indicated that their primary HCPs were aware of their SOGI because of these significant health needs. One of these participants had been with the same primary HCP for over 20 years, and though it was unclear how long the other two had been with the same primary HCP, all three felt that they had good relationships with their providers. When asked about being out to her physician, Camille⁶, a 62 year-old African American lesbian woman said, "When I introduce myself, I usually introduce myself as, Camille. And I'm HIV positive and I'm lesbian." Camille's overall outness level was high and her LGBT community involvement level was medium. Her response is an example of how in vivo and values coding were used to capture her perspective on being out with her HCP; the directness and intentionality she employs when introducing herself to new people suggests that she places value on others knowing these parts of her identity.

Disclosed without being asked directly about SOGI. Three participants said that they shared their SOGI with their providers without being asked directly. When asked about whether he was out to his doctor, Timothy, a 69 year-old White gay man, said

I told him, I've been with him now since, for a good 18 years I think, he's been in that position. And I came out to him the very first time I had an appointment with him. I wanted to let him know that I was gay.

⁶ All participant names have been changed to protect participants' identities.

Timothy had a medium overall outness level and a high LGBT community involvement level. Both in vivo and values coding were important in conceptualizing Timothy's experience with disclosing his sexual orientation to his HCP. He described telling his HCP about his sexual orientation at his first appointment because he wanted his provider to know this about him.

HCP asked about sex/love life. Three participants said that their HCPs asked about their sex/love lives, to which they responded by telling their providers that they identified as gay or lesbian. The interview excerpt that follows depicts the experience of Sam, a 60 year-old White gay, man (who had a high level of overall outness and a medium level of LGBT community involvement) when he told his provider about his sexual orientation:

Interviewer: Can you tell me a little bit about your relationship with your primary care doctors or nurses in terms of being out to them and information you share with them? *Sam:* This doctor I have now, have a really good relationship with. You know, he knows I'm gay. You know, it's very comfortable when I got to see him. *Interviewer:* Can you tell me a little bit more about what you mean by comfortable? Like, are there certain things that he's comfortable asking you? *Sam:* Yeah. You know, he'll ask me what my, I mean, he won't use the term, what's your sex life, but that's what he's asking, if I'm active or not active, you know, things like that. *Interviewer:* So he assesses sexual health. *Sam:* Yeah. And I feel comfortable talking to him. I don't feel like-he's straight. I assume he's straight. But, you know, he doesn't appear to be judgmental in any way.

Descriptive coding was used in understanding Sam's experience with telling his HCP that he was gay. Though his doctor did not explicitly ask him about his sex life, Sam said he felt comfortable telling his doctor he was gay and that he had a good relationship with his physician. Also, it cannot be determined whether Sam disclosed his sexual orientation before or after his physician asked about his sex life. Sam's presumably straight physician did not appear to be judgmental, which seems to be an important quality he valued in his HCP.

Doctor was gay. The one participant who said he specifically sought a gay HCP was Bernard, a 63 year-old White gay man. The following interview excerpt is of how this participant described his preference for a gay provider:

Interviewer: And what about your doctor? *Bernard:* My doctor was gay and that's how I chose him. *Interviewer:* OK. So that was important to you. *Bernard:* Yes. *Interviewer:* So you talk to your doctor about issues related to— *Bernard:* Yes. I said, "I'm looking for a gay doctor," and he said, "You found one."

Bernard had a high level of overall outness and a low level of LGBT community involvement and clearly prioritized finding a gay physician; his intentionality in identifying a gay HCP suggests that he valued having a provider with whom he could share this part of his identity.

Disclosure process unknown. There were 6 participants who reported being out with their HCPs, yet did not explicitly state how their providers became aware of this information. Four reported having a high level of overall outness and two reported a medium level of overall outness; three reported having a high level LGBT community

involvement and three reported a medium level of LGBT community involvement (Please refer to Table 2). Barbara, a 68 year-old White lesbian woman, with a high level of overall outness and a medium level of LGBT community involvement, said this when asked about being out to her doctor:

Interviewer: What about to your doctor. *Barbara:* Yes of course.

Interviewer: And you have been for a long time. *Barbara:* I can't remember when it was in fact. *Interviewer:* And do you ever talk about anything related to being gay with your doctor? *Barbara:* Yes. I don't know, but I mean we talk about my partner and how she's doing.

Later, when she was asked about aging as a gay person, Barbara said, "I live in the big city, when I tell my doctor that I'm lesbian, it's nothing to her, you know." Barbara had a high level of overall outness, a medium level of LGBT community involvement, and seemed to value being able to talk to her doctor about her partner was doing. Barbara also seemed to think that by living in an urban area, her doctor would not be judgmental regarding her sexual orientation.

Discussion

While some studies have explored rates of LGBT older adults' SOGI disclosure to their HCPs (Espinoza, 2014; Fredriksen-Goldsen et al., 2011), this study contributes to the research in that it sought to understand how disclosure occurred. The constant comparative method helped identify four ways in which LGBT older adults in this sample came to share SOGI information with their HCPs. These include: (1) health status, such as being treated for HIV by the same physician over time or experiencing gender affirming surgery and receiving care from the same physician before, during, and

after such surgery, (2) disclosure without being asked directly about SOGI, (3) HCPs asking about or discussing participants' sex/love lives or when asked explicitly about their partners and (4) choosing a gay HCP.

None of the participants in this study said that they disclosed their SOGI to their HCPs in response to being asked directly. Steele and colleagues (2006) found that lesbian women, when asked directly about their sexual orientation by their HCPs, disclosed this information 100% of the time. While this may have been true for a sample of 489 lesbian women with a mean age of 36 years old, (Steele et al., 2006) the current study could not speak to LGBT older adults' experiences with being asked about SOGI by their HCPs.

One participant in this study supported Klitzman and Greenberg's (2002) finding that when patients thought or knew that their providers were gay, patients had higher rates of disclosure. The results lacked evidence to support Klitzman and Greenberg's (2002) finding that patients' perceptions of their providers' level of gay-friendliness related to rates of disclosure. Additionally, this study was unable to determine what, if any other, HCP characteristics may have contributed to participants' SOGI disclosure.

Results from this study suggest that there are three malleable approaches through which HCPs can obtain SOGI information from their clients, and these approaches involve action on the part of HCPs, patients, and the environment. First, providers could use probing questions, such as inquires about sexual health and activity, followed by questions that ask directly about SOGI. Second, patients must be educated about being health disparities associated with aging as a sexual or gender minority person, which may help them voluntarily disclose SOGI information to providers. Third, an environmental change could be made such that patients would have access to an LGBT or LBT-friendly

friendly HCP network directory so that they would be able to intentionally seek out affirming and supportive providers.

LGBT individuals who are out to their HCPs about their SOGI have been shown to also be more open about other sensitive health issues (Klitzman & Greenberg, 2008), and perhaps the inverse is true. Three participants' HCPs inquired about their sex/love lives, which prompted participants to share information about their SOGI. There is no way of knowing exactly how HCPs phrased their questions about their patients' sexual functioning, sex partners, frequency of sexual intimacy, sex practices, or love lives, but for these three participants, this line of questioning may have helped facilitate their SOGI disclosure to their HCPs.

Connectedness to the LGBT community has been shown to be associated with higher levels of SOGI disclosure to HCPs (Durso & Meyer, 2013). Participants who disclosed their SOGI to their HCPs had relatively high rates of LGBT community involvement. In addition, participants also reported high levels of overall outness. High levels of overall outness tend to be associated with low levels of internalized homophobia or heterosexism, meaning that LGBT individuals may be more likely to disclose their SOGI when internalized homophobia or heterosexism is low (Durso & Meyer, 2013; St. Pierre, 2012).

Results indicated that these participants were generally very out, well connected to the LGBT-community, and out to their HCPs without being asked directly about SOGI, though these associations should be interpreted with caution. It should not be assumed that because older adults are out and connected to the LGBT community that they are always going voluntarily disclose their SOGI to their HCPs. By appropriately

and sensitively asking all older adult patients about their SOGI, HCPs increase the likelihood that their patients will share this information with them (Bradford et al., 2012a).

Limitations

This study has a number of limitations that must be considered when interpreting the results. First, as is the case with many studies of SGM individuals, convenience sampling was used to obtain a small sample of LGBT older adults age 60 and older. The intention of this study was not to produce generalizable findings, but rather to explore the ways in which LGBT older adults disclosed their SOGI to HCPs. Second, participants were recruited through community-based outreach and snowball referrals, primarily from LGBT congregate meal sites in one northeastern American city. Being that these participants were at least somewhat connected to the LGBT community and tended to have high levels of overall outness, their rates of SOGI disclosure to HCPs may be higher than those of people who are not as connected to the LGBT community or who have lower levels of overall outness. Third, this study did not consider other potential factors that might be associated with LGBT older adults' SOGI to their HCPs such as patient-provider congruence (similarities based on age, race, gender, sexual orientation), duration of patient-provider relationship, and "ethnicity, type of health care insurance, and disclosure of other potentially sensitive areas" (Klitzman & Greenberg, 2008, p. 67). The homogeneity of the sample posed another important limitation; there was only one transgender participant, one bisexual participant, and most of the sample was white.

Another major limitation of this study was the fact that what constituted a HCP was very broad. Most participants discussed relationships with their primary care

physicians, but some talked about relationships with their nurse practitioners, nurses and other specialty providers, such as cardiologists or endocrinologists. Future research should consider not only differences in types of HCPs, but HCP characteristics, such as their demographics and their knowledge of and comfort with treating SGM patients. In addition to considering HCP characteristics, future research could also include more detailed accounts of LGBT older adults' disclosure processes to their HCPs (i.e., whether disclosure occurred at the first appointment or over time) and how LGBT-friendly or knowledgeable they perceive HCPs to be and whether that affects their likelihood of SOGI disclosure.

Conclusion

LGBT older adults' risk for health disparities may go unaddressed if LGBT their HCPs are unaware of their SOGI, such as higher risk of disability, poor mental health, smoking, excessive drinking, cardiovascular disease and obesity (Fredriksen-Goldsen et al., 2013b). Over 70% of the LGBT older adult participants in this sample were out to their HCPs and most of them shared this information without being asked directly about their SOGI. The fact that participants who disclosed their SOGI to their HCPs generally had high levels of overall outness and LGBT community involvement should not be overlooked. In order to adequately address health disparities between LGBT and non-LGBT older adults, three recommendations were presented as to how obtaining this information might be facilitated: providers could inquire directly about SOGI after asking probing questions regarding sexual health and sexual activity; patients could gain knowledge and understanding of the importance of sharing SOGI information with HCPs, which would hopefully facilitate disclosure; and patients could have access to LGBT and

LGBT-friendly provider networks so that they may be aware of which providers who would be affirming and respectful for their SOGI.

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Appendix

Table 1

Participant characteristics by total sample (N=22), by known SOGI disclosure (N=16), and by unknown SOGI disclosure (N=6)

	Total (N=22)	Known Disclosure (N=16)	Unknown Disclosure (N=6)
	N (%) ^a or M (SD)	N (%) or M (SD)	N (%) or M (SD)
Gender/gender identity			
Female	11 (50)	8 (50)	3 (50)
Male	11 (50)	8 (50)	3 (50)
Sexual orientation			
Gay or lesbian	20 (90)	15 (94)	5 (83)
Bisexual	1 (5)	0	1 (17)
Heterosexual	1 (5)	1 (6)	0 (0)
Race/ethnicity			
Non-Hispanic White	18 (82)	13 (81)	5 (83)
Non-Hispanic African American	4 (18)	3 (19)	1 (17)
Age (Range: 60 to 80)	66.27 (5.50)	65.31 (4.47)	68.83 (7.52)
Partnered	15 (68)	10 (63)	5 (83)
Living Arrangement			
Alone	12 (55)	8 (50)	2 (33)
With partner	9 (41)	7 (44)	4 (67)
Shelter	1 (5)	1 (6)	0 (0)
Level of overall outness			
Low	0 (0)	0 (0)	0 (0)
Medium	8 (36)	7 (44)	3 (50)
High	14 (64)	9 (56)	3 (50)
Level of LGBT community involvement			
Low	3 (14)	3 (19)	0 (0)
Medium	8 (36)	9 (56)	3 (50)
High	11 (50)	4 (25)	3 (50)
Out to HCP			
Yes	16 (73)	16 (100)	--
Unclear	2 (9)	--	2 (33)
Missing ^b	4 (18)	--	4 (67)
SOGI disclosure to HCP			
Health status			
HIV treatment	--	2 (13)	--
Gender affirming surgery	--	1 (6)	--
Disclosed without prompting	--	3 (19)	--
HCP asked about sex/love life	--	3 (19)	--
Chose gay HCP	--	1 (6)	--
Did not say	--	6 (38)	--

Note. ^a Percentages may not add to 100 due to rounding. ^b Participants who were neither asked about being out to HCP nor shared this information were coded as missing.

Table 2

Participant characteristics by SOGI disclosure to HCP (N=16)

	Sexual orientation	Overall outness	Level of LGBT community involvement
<i>Health Status (N=3)</i>			
HCP treated respondent for HIV			
Camille	Lesbian	High	Medium
Marcus	Gay	High	Medium
HCP provided treatment during gender affirming surgery			
Josie	Heterosexual	Medium	Low
<i>Disclosed without being asked directly about SOGI (N=3)</i>			
Timothy	Gay	Medium	High
Max	Gay	Medium	Medium
Thomas	Gay	Medium	Medium
<i>HCP asked about sex/love life (N=3)</i>			
Sam	Gay	High	Medium
Edward	Gay	High	Low
Mary	Lesbian	Medium	Medium
<i>HCP was gay (N=1)</i>			
Bernard	Gay	High	Low
<i>Did not say (N=6)</i>			
Barbara	Lesbian	High	Medium
Elaine	Lesbian	High	High
James	Gay	High	High
Marla	Lesbian	Medium	High
Rebecca	Lesbian	High	Medium
Nancy	Lesbian	Medium	Medium

CHAPTER V: DISSERTATION CONCLUSION

The main contribution of this dissertation is its attempt to understand the multiple factors that influence LGBT older adults' invisibility and outness from the perspective of aging service providers and LGBT older adults. This dissertation has not only helped in understanding facilitators and barriers to LGBT older adults' sexual orientation and gender identity (SOGI) disclosure, but also has highlighted gaps in knowledge that aging service providers can begin addressing in their direct practice with older adult clients. In this concluding section, major findings, limitations, and implications for social work policy, practice, and research are discussed.

Major Findings

Together, these three papers have taken the issue of LGBT older adults' invisibility in aging services and approached it from three different perspectives: a content analysis of gerontological social workers' biopsychosocial assessment forms and a qualitative analysis of interviews with them regarding their intake practices (Paper 1); a quantitative analysis of LGBT older adults' attitudes and behaviors regarding aging service use and how they are influenced by age-specific and cumulative experiences of SOGI-based discrimination or violence (D/V) (Paper 2); and a qualitative analysis of interviews with LGBT older adults that explored level of overall outness and connection to the LGBT community and SOGI disclosure to health care providers (HCPs) (Paper 3). By including the views of gerontological social workers, LGBT older adults' responses to a quantitative survey, and qualitative interviews with LGBT older adults, this dissertation has attempted to capture the concerns and experiences of both clients and their providers.

Results from Paper 1 showed that gerontological social workers in the Boston area have no systematic way of assessing their clients' SOGI. These items are neither asked about on biopsychosocial assessment documents, nor are they generally addressed during interviews with new clients. Social workers in Paper 1 cited two main reasons for this: (1) they were concerned that asking about SOGI would negatively impact their relationships with their clients and (2) they generally did not see how asking about SOGI was relevant to their clients' care. Despite the fact that four of the ten social workers who were interviewed for Paper 1 had attended a training or seminar on working with LGBT older adults, none of them described concrete ways in which they had adapted LGBT-affirmative practice into their work. However, they did say that they try to provide a welcoming and supportive environment for LGBT clients to disclose their SOGI if clients felt it was important to share this information. Simply attending a training is not to be enough, just as simply adding questions about SOGI to assessment practices is not enough. Proper training and implementation of new practices must go hand-in-hand in order for providers to sensitively and effectively collect this information from their clients (Center for American Progress & The Fenway Institute, 2013).

Paper 2 results showed that being an LGBT older adult who experienced D/V at or after age 50 was significantly associated two behaviors regarding aging service use: (1) an decrease in the odds of being out to all of their HCPs and (2) an increase in the odds of having not asked for help from an aging service provider due to concerns about coming or being out. The analyses in Paper 2 did not confirm the hypotheses that cumulative experiences of D/V would affect LGBT older adults' attitudes toward and behaviors regarding aging service use. Given the high rates of isolation and increased

health disparities among LGBT older adults as compared to non-LGBT older adults (Fredriksen-Goldsen et al., 2011; Fredriksen-Goldsen et al., 2013; IOM, 2011; SAGE, 2012), having an experience of D/V in later life and the effect that may have on LGBT older adults' SOGI disclosure to their HCPs and choice of whether or not to use aging services due to concerns about coming or being out, may put them at even greater risk for these disparities especially since 61% of the total sample for Paper 2 reported at least one SOGI-based D/V in their lifetime.. The results are important considering the negative effects of minority stress, particularly managing a stigmatized identity over time (Grossman et al., 2001; Herek, 1996; Meyer, 2003; Miller & Major, 2000; Morris et al., 2001; Pennebaker et al., 1987; Ragins et al., 2007). Not sharing SOGI with one's HCP and choosing to not use aging services due to concerns about coming or being out could possibly increase stress in these individuals, which could lead to worse health outcomes in the future (D'Augelli & Grossman, 2001; MAP & SAGE, 2010; Pérez-Benítez et al., 2007).

Results from Paper 3 found that LGBT older adults who had high levels of overall outness and who were well-connected to the LGBT community were also out with their HCPs. The four ways in which LGBT older adults came to share their SOGI with their providers included: (1) health status (i.e., being treated for HIV by the same physician over time or having the same provider before, during, and after gender affirming surgery), (2) disclosing this information to their HCP without being asked directly about SOGI, (3) HCPs' inquiring about participants' sex/love lives, and (4) choosing a gay HCP. Various coding methods helped in conceptualizing participants' values regarding their HCPs' knowledge of their SOGI, especially since none of the participants indicated

that their HCPs asked them about SOGI directly. It is recommended in Paper 3 that provider, patient, and environmental changes be made to health care services such that HCPs are made aware of their patients' SOGI. These recommendations include: (1) that providers ask directly about SOGI after inquiring about their patients' sexual health (2) that patients understand the importance of disclosing SOGI information to HCPs and the potential health risks of not disclosing and (3) ensuring that LGBT older adults have access to an LGBT/LGBT-friendly provider network directory so they can be aware of LGBT-affirming providers. The participants in Paper 3 were generally very out and connected to the LGBT community, which introduces an unavoidable level of bias to the results. This and other limitations of each of the papers and the dissertation as a whole are discussed in the following section.

Limitations

The major limitation of Paper 1 was that it did not include the perspectives of any LGBT older adults as it focused only on gerontological social workers' biopsychosocial assessment practices. In addition, Paper 1 had a small sample sizes for both Stages 1 (content analysis) and 2 (qualitative analysis of social worker interviews). However, the limitation that Paper 1 focused only on aging service providers was countered in samples for Papers 2 and 3, as they both focused solely on LGBT older adults. Though Paper 2 consisted of a sample size of 129 LGBT older adults, it was not without its own set of limitations. The quantitative analysis for Paper 2 showed a high percentage of missing data, which certainly could have affected this study's ability to draw confident conclusions about the data. As with all cross-sectional data, it is not possible to ascertain causality, therefore it cannot be determined whether LGBT older adults' experiences of

D/V in later life actually caused increased concern about being out and accessing aging services.

A major limitation of Paper 2 is the measurement of the primary independent variable, SOGI-based D/V experiences at different points in time. Since Paper 2 relied on self-reports of SOGI-based D/V, it could be argued that participants could only respond to *perceived* SOGI-based D/V. To further complicate this measure, response categories included: “Yes, I have,” “I think or believe I have,” or “No, I have not,” indicating that perhaps those who answered “I think or believe I have” to the SOGI-based D/V question before age 18, between 19-49 years old, and at or after age 50 were different from those who responded “Yes, I have,” and those who responded “No, I have not,” to any of these items.

Papers 2 and 3 shared a similar set of limitations: they both consisted of mostly white, relatively out SGM older adults who were at least somewhat connected to the LGBT community as per their participation in LGBT congregate meal programs. The samples for both Papers 2 and 3 were conveniently obtained from meal sites in the greater Boston area, which prohibits generalization. It is important to note these limitations imposed by the sample selection processes and geographic region. The fact that Papers 2 and 3 included only those who were actively involved in an LGBT community aging service is undoubtedly a major limitation of this dissertation. The most isolated, vulnerable, and arguably the most invisible individuals in this population were not accounted for in any of the papers in this dissertation. Despite these limitations, this dissertation offers important policy and practice implications for aging service providers to consider when working directly with clients.

Implications

Policy Implications

There are two primary policy implications offered by this dissertation. First, aging service providers, social workers in particular, need to find a way to learn about the SOGI of their clients, and second, LGBT older adults need to share this information with their providers. While these two implications suggest a shared responsibility between aging service providers and LGBT older adults, aging service providers should begin educating their clients about why it is important to know clients' SOGI information and how this information will be protected. Even if clients do not seek treatment for sexual or gender-specific reasons, knowing about clients' SOGI will help providers understand the social context within which their clients live.

Support for aging service providers' knowing about their clients' SOGI has been thoroughly addressed throughout this dissertation (IOM, 2011; Morrow, 2001; U.S. Department of Health and Human Services, n.d.). Aging service providers would have more of an awareness of their SGM clients and would be able to begin understanding their unique needs in later life if they knew about their clients' SOGI. Providers would also be able to expand supportive services for their clients and refer them to appropriate LGBT-friendly or LGBT-specific services. Cahill and colleagues (2014) have already shown that people who agreed to participate in their study understood SOGI questions, felt comfortable answering such questions, agreed that such questions and answer choices accurately reflected their SOGI, and thought that it was important to answer such questions on health care registration forms. While mandatory training on the specific needs of LGBT older adults would increase aging service providers' understanding of

SGM older adults, without implementing a structured way of gathering this information from clients during intake assessments, LGBT older adults are likely to remain invisible when accessing services. Results from Paper 1 showed that, despite the fact that four gerontological social workers attended a training on issues regarding LGBT older adults, none of them had a systematic way of obtaining this information from their clients. Until SOGI information is made a required part of gerontological biopsychosocial assessment forms and documents, it cannot be expected that social workers will ask this information of all of their clients, regardless of whether or not they attended a training on working with LGBT older adults.

By including SOGI information as a regular part of demographic information on biopsychosocial assessments, gerontological social workers may be prompted to sensitively ask relevant questions regarding LGBT older adults' experiences with minority stress and SOGI-based discrimination and violence. When faced with the decision of whether or not to use aging services, older adults may know they need certain services, but may not feel comfortable using or accepting such help. However, if gerontological social workers were able to empathically inquire about their LGBT older adult clients' experiences with SOGI-related harassment, discrimination, or violence, particularly in health care settings and even more importantly, at or after age 50, (as indicated in Paper 2), they might be able to ease some of their clients' fears and apprehensions surrounding aging service use. Without addressing these possible concerns, LGBT older adults may continue to remain silent and invisible, even though aging service providers may see themselves as affirming and LGBT-friendly, as indicated in Paper 1. Without open and direct communication about SOGI information, LGBT

older adults may not feel safe disclosing this information, which brings this discussion to the second policy implication regarding the need for LGBT older adults to disclose their SOGI with aging service providers.

While it is important for LGBT older adults to share their SOGI with their aging service providers, they should not bear the responsibility of initiating this disclosure on their own, as indicated by results from Paper 3. Part of the reason why it is important to include SOGI information in social work biopsychosocial assessments is so that gerontological social workers can address confidentiality and privacy issues regarding this information. Making sure that LGBT older adults know that their SOGI information would be kept confidential, just as any of their other private health care information would be, is an important step in educating clients about their health care rights and protections.

It is crucial that LGBT older adults are made aware of their rights and protections within aging service and health care settings. In 2003, new federal regulations were added to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that changed how HCPs and health plans could use and disclose patients' private information (Lambda Legal, 2014). These rules pertain to when health plans and health care providers can and cannot share private patient information, and may require different levels of consent procedures depending on with whom the information is being shared and for what purposes. These include written consent, verbal consent, and no consent needed (Lambda Legal, 2014). These updated regulations expanded the established special safeguards that protect behavioral health, substance abuse, HIV/AIDS status, sexually transmitted diseases, and genetic information, all of which are classified as sensitive

health information and require that specific consent procedures be followed when sharing this information (U.S. Department of Health & Human Services, 2014).

In addition to the federal regulations, LGBT older adults may ask their providers to agree to additional protections concerning SOGI information. As an example, “if a patient elicits an agreement from a doctor that the doctor will not disclose the patient’s sexual orientation without the patient’s prior written consent, then the doctor generally must comply with the agreement” (Lambda Legal, 2014). Though health care providers are required to provide patients with a copy of their privacy rights during their first meeting (Lambda Legal, 2014), this is often done quickly and without much conversation; notices of privacy rights may also be technical and use legal terms that clients may find unfamiliar. Though clients may receive a copy of the provider’s HIPAA statement, this does not guarantee their understanding of their rights regarding protected private health information. Depending on how much they know about the protection of health information, LGBT older adults may not realize that their SOGI information falls under this classification among social service agencies and HCPs.

Section 1.07 (items *a* through *r*) of the National Association of Social Workers’ (NASW) (2008) *Code of Ethics* focuses solely on privacy and confidentiality of client information. The guidelines dictating ethical social work practice regarding privacy and confidentiality demand that social workers protect clients’ information in a number of circumstances. Client informed consent must be obtained before social workers can share information with an outside party, such as family members, insurance companies, or other treatment providers. With regard to privileged communication in legal settings, the *Code of Ethics* states

Social workers should protect the confidentiality of clients during legal proceedings to the extent permitted by law. When a court of law or other legally authorized body orders social workers to disclose confidential or privileged information without a client's consent and such disclosure could cause harm to the client, social workers should request that the court withdraw the order or limit the order as narrowly as possible or maintain the records under seal, unavailable for public inspection. (NASW, 2008)

Protection of privileged communication between social workers and their clients is an important aspect of client-social worker relationships. Privileged communication is one of the aspects that enhances trust between social workers and their clients. Social workers must be aware of their state's law on resisting subpoenas instructing them to disclose client information. Though there are special circumstances when privileged communication may be disclosed, such as when a client threatens suicide or harm to another person, has committed a crime, or shares private information in the presence of third party (Reamer, 2007), social workers are protected by privileged communication statutes.

In addition to having an awareness of privacy rights and privileged communication, it is also important that LGBT older adults receive adequate information regarding what their increased health risks may be as members of this population. This is where aging service providers have the opportunity to educate their clients about health concerns that disproportionately affect LGBT older adults as compared to non-LGBT older adults. While the LGBT older adults in Paper 3 of this dissertation shared their SOGI with HCPs, it is not clear whether they understood their risk for health disparities

as compared to non-LGBT older adults their same age. It is understandable that LGBT older adults may be reluctant to share their SOGI with HCPs, especially those who have experienced D/V later in life or have experienced discrimination or harassment in health care settings. However, if they had knowledge about risks they may face due to a lifetime of discrimination, stigma, and minority stress, they might consider sharing this information with their providers more readily.

Practice Implications

Aside from gerontological social workers' asking their clients about SOGI and LGBT older adults' sharing this information, two other ways that would help increase social workers' understanding of the importance of asking about SOGI of older adult clients would be to include LGBT life course trajectories in the older adults concentration in Council on Social Work Education (CSWE) schools of social work and to include questions about LGBT older adults on state licensure exams. These two approaches would provide a proactive approach in preparing social workers for working with LGBT older adults without relying on agency trainings to provide this information. Social workers could learn early on about the unique challenges, health disparities, historical context, and current policies regarding SOGI and the treatment of LGBT individuals in the U.S.

If aging service providers felt uncomfortable or were concerned about clients' negative reactions about their inquiring about their clients' SOGI, perhaps wording on intake forms could be changed to reflect LGBT life trajectories by including open-ended response categories for relationship status, family identification, and gender identity. While this would pose some challenge for data entry when using electronic medical

records, it would give clients the opportunity to describe their circumstances in a way that felt most accurate and authentic to them. Another issue to consider in using open-ended questions on biopsychosocial assessment forms is the time it takes to answer such questions, especially for older adults who may or may not have the physical endurance or cognitive capacity to participate in an elaborate assessment. However, this open-ended approach would give those aging service providers who felt concerned asking clients about SOGI another approach toward learning this information about their clients.

Aging service providers have substantial knowledge of the life course perspective and understand how life events over time affect people as they age. It is important that aging service providers begin to acknowledge LGBT life course trajectories in their practice by including wording on intake assessment forms that reflect the diversity of older adults' lives (i.e., changing "marital status" to "relationship status" in states that do not have marriage equality). Alternatively, assessment practices may also incorporate a biographical approach to obtaining data from clients. Asking clients to give a narrative account of important life events gives them an opportunity to discuss the major events in their lives, which for LGBT older adults may include, but are not limited to, first coming out, the role of important non-biological chosen families and support networks, LGBT-community connections, and any history of trauma related to SOGI-based discrimination and/or violence, especially in later life, as indicated by Paper 2 of this dissertation.

Comprehensive biopsychosocial assessments require that aging service providers consider the interpersonal, social, and environmental factors that affect individuals in later life. When aging service providers are aware of how minority stress due to SOGI

may have affected their clients over time, providers will hopefully be more effective in supporting their clients and connecting them to appropriate and supportive services.

Morrow (2001) noted that that social work intervention with LGBT older adults must understand the historical context of homophobia and heterosexism within which current cohorts of LGBT older adults came of age and that “it is important for social workers to respect the oppression and discrimination older gays and lesbians have endured and to honor their capabilities for survival” (p. 162). At the same time, the strengths perspective in social work requires that social workers also acknowledge the resilience of the current cohorts of LGBT older adults in the U.S. The social work role entails empowerment, advocacy, social justice, and resource development for our society’s most marginalized groups. By recognizing struggles and fortitude, social workers and aging service providers who work with LGBT older adults have the opportunity to educate and support this population as they navigate the complexities of aging services.

While practice changes are important, they are rendered completely ineffective if policy is not put in place to ensure that these changes will be implemented. It is impossible to separate social work policy and practice implications as they must simultaneously influence and be influenced by one another. Trainings must be offered, aging service providers must be required to attend, institutional changes must take place, and providers must be held accountable for implementing such changes.

In 2014 the *Journal of Gerontological Social Work* published a special issue that specifically addressed the needs of LGBT older adults and recommendations for how aging service providers could best prepare themselves for meeting these needs (Rowan & Giunta, 2014). In order to ensure that LGBT older adults are visible to aging service

providers, these providers (including home health care agencies, hospice and palliative care services, adult day programs, assisted living and long-term care facilities) should receive proper training from a certified LGBT aging education group, such as Services and Advocacy for Gay, Lesbian, Bisexual & Transgender Elders (SAGE), The National Resource Center on LGBT Aging, The National LGBT Health Education Center, The LGBT Aging Project (Massachusetts), and Project Visibility (Boulder County Area Agency on Aging). Aging service providers should make LGBT older adult competency training a requirement for all staff, especially those who are licensed practitioners in their state.

Future Research

A research agenda that looks at whether trainings, changes in documentation/forms, policy, and practice lead to improved outcomes for LGBT older adults is absolutely necessary in order to understand whether these proposed efforts would actually change the status of LGBT older adults' invisibility in aging service settings. LGBT older adults could evaluate their relationships with aging service providers to determine how well providers are meeting the needs of LGBT older adults. This would be a very large endeavor; however, it would be feasible by eliciting the help of medical, nursing, public health, social work, gerontology and physician assistant education programs. In addition, making sure that racially diverse samples of LGBT older adults are included in such studies must be a priority, as most studies focusing on LGBT older adults, this dissertation included, is limited to primarily white samples.

The intersection of multiple stigmatized identities, such as race, class, and immigration status is also an important issue to explore among LGBT older adults (IOM,

2011), given the fact that older adults are often excluded from the discourse of queer and LGBT studies (Brown, 2009). This becomes even more imperative given the high prevalence of D/V experienced by LGBT older adults, not only throughout their lifetime, but particularly in later life. Reaching LGBT older adults who are most vulnerable and isolated would be challenging, as they are less likely to be connected to LGBT aging services or the LGBT community as a whole. However, just because a group of people is difficult to identify should not stop competent and affirming aging service providers from trying to reach and understand the needs of these individuals.

Though an advantageous research effort, a study comparing separate interventions and their effect on identifying LGBT older adults in aging service settings could give providers a better understanding of what does and what does not aid SGM clients in disclosing their SOGI. One intervention would require that aging service providers attend a training on working with LGBT older adults, a second intervention would require that aging service providers use biopsychosocial assessment forms that include SOGI questions, and a third intervention would require that aging service providers attend a training on working with LGBT older adults *and* that they use intake documents that include SOGI questions. Outcomes from these three interventions could be compared against one another and against a control group that received no training and/or did not use biopsychosocial intake forms including SOGI information. Aging service providers could then compare a) their comfort and confidence in asking SOGI questions of older adult clients b) the rate of clients' disclosure of SOGI information c) their clients' understanding of the importance of SOGI information and how this can improve care and d) their clients' ratings of aging service providers' LGBT-friendliness/affirmativeness.

Such a study would incorporate policy and practice implications recommended by this dissertation.

Conclusion

This dissertation has presented findings from three separate studies that have all focused on LGBT older adults and their visibility/invisibility in aging service and health care settings. While older adults share similar concerns about aging, such as financial security, living arrangements, isolation, and increased health and cognitive problems, LGBT older adults also experience these concerns, but with the added stresses of being members of a group that still faces many forms of discrimination. LGBT individuals continue to experience marginalization in our society, such as lack of legal protections in anti-discrimination policies, legal relationship recognition, and religious condemnation. When it comes time for LGBT older adults to begin using aging services, they are faced with a decision that they have had to make countless times in their lives about whether to share or conceal their SOGI information. Since concealment and disclosure each have their own set of risks and benefits, it should be the responsibility of aging service providers to alleviate some of the pressure that this decision presents.

By having the knowledge about issues affecting LGBT older adults and the skills to appropriately and supportively learn about their clients' SOGI, gerontological social workers and health care providers working with older adults can begin changing LGBT older adults' experience of accessing aging services. If by inquiring about clients' SOGI, gerontological social workers could help increase LGBT older adults' rates of SOGI disclosure and aging service use, then it would be in our clients' best interest if we made this change. By doing so we would continue our commitment to enhancing the well-being

of the vulnerable and oppressed while paying “attention to the environmental forces that create, contribute to, and address problems in living” (National Association of Social Workers, 2008). If we fail to make this change, we may very well perpetuate the invisibility of an already vulnerable and oppressed group-LGBT older adults-which would go against our profession’s very mission.

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APPENDIX A

Paper 1

Interview Protocol 1

This interview protocol was used when agencies' biopsychosocial assessments included SOGI items.

- 1.) You have indicated that your agency's psychosocial evaluation forms include questions about clients' sexual orientation and gender identity. Can you tell me how long have those items been part of the assessment form?
- 2.) Since these items are on the evaluation forms, how often do you ask clients about their sexual orientation and gender identity?
- 3.) What has been your experience when asking older adult clients about their sexual orientation and gender identity?
- 4.) How have older adult clients reacted to being asked about their sexual orientation and gender identity?
- 5.) How important do you think it is, that as a social worker working with older adults, you know about your clients' sexual orientation and gender identity?
- 6.) Do you know if your agency/employer has had specific competency training regarding working with LGBT older adults?

Interview Protocol 2

This interview protocol was used when agencies' biopsychosocial assessments did not include SOGI items.

- 1.) You have indicated that your agency's psychosocial evaluation forms do not include questions about clients' sexual orientation and gender identity. Therefore, I am interested in how often you ask older adult clients about their sexual orientation and gender identity.
- 2.) How do you usually ask clients about their sexual orientation or gender identity? For example, do you ask something like, "Do you consider yourself to be gay, straight, bisexual or heterosexual? Do you identify yourself to be transgender?"
- 3.) If you do not usually ask clients about their sexual orientation or gender identity, how do you know about this part of their identity? For example, do people refer to same-sex or opposite sex partners from which you infer their sexual orientation?
- 4.) How do you know that other staff and social workers assess for clients' sexual orientation and gender identity if these items are not on the psychosocial evaluation forms?
- 5.) How important do you think it is, that as a social worker working with older adults, you know about your clients' sexual orientation and gender identity?
- 6.) Do you know if your agency/employer has had specific competency training regarding working with LGBT older adults?

Demographic Questionnaire

- 1.) What is your age? _____
- 2.) What is your gender?
 - a. Male
 - b. Female
 - c. Transgender
 - d. Other (if other, please specify if you feel comfortable) _____
 - e. Prefer not to answer
- 3.) What is your race and ethnicity? (Please select all that apply)
 - a. Black or African American
 - b. White or Caucasian
 - c. Hispanic or Latino
 - d. Native American or American Indian
 - e. Asian or Pacific Islander
 - f. Other (if other, please specify if you feel comfortable) _____
- 4.) What is your religious practice?
 - a. Muslim
 - b. Roman Catholic
 - c. Christian Scientist
 - d. Protestant
 - e. Seventh-Day Adventist
 - f. an Orthodox church such as the Greek or Russian Orthodox Church
 - g. Mormon
 - h. Jewish
 - i. None
 - j. Other (if other, please specify if you feel comfortable) _____
 - k. Spiritual, no religious affiliation
 - l. Prefer not to answer
- 5.) Do you consider yourself to be
 - a. Heterosexual or straight
 - b. Lesbian or gay
 - c. Bisexual
 - d. Other (if other, please specify if you feel comfortable) _____
 - e. Prefer not to answer
- 6.) In what year did you complete your MSW? _____

APPENDIX B

Project Title: Care and Service Needs of Older Adults at Congregate Meal Sites: A
Comparative Study of Sexual Minorities and Heterosexuals
Survey Instrument – General Population & LGBT Form Questions

1) Where do you live?

City/Neighborhood: _____

Zip code: _____

2) What year were you born? _____

3) What is your gender?

- ☐ Male
- ☐ Female

4) Are you transgender or transsexual?

- ☐ Yes
- ☐ No
- ☐ I don't understand the question

5) In a typical week, how many hours do you work for pay?

- ☐ None
- ☐ Less than 10 hours
- ☐ 10-19 hours
- ☐ 20-29 hours
- ☐ 30-39 hours
- ☐ 40 hours or more

6) What is the highest level of education you completed? (Check one):

- ☐ Some high school/elementary
- ☐ Graduated high school or GED
- ☐ Some college
- ☐ Graduated college
- ☐ Graduate/Professional School

7) What type of housing is your primary permanent residence?

- ☐ Room, apartment, or condominium in a building open to people of all ages
- ☐ Room, apartment, or condominium in senior housing
- ☐ Single family house
- ☐ Assisted living
- ☐ Nursing home facility
- ☐ No permanent residence/homeless
- ☐

8) With whom do you live at your primary residence? (Check all that apply):

- ☐ No one else -- I live alone
- ☐ Spouse or partner
- ☐ Child or children
- ☐ Other family members
- ☐ Other non-family members or roommates
- ☐ Pets: _____

9) Which best describes your current relationship status?

- ☐ Married
- ☐ In a relationship, but not currently married
- ☐ Single, widowed, or divorced/separated

10) Do you have any children who are living?

- ☐ Yes
- ☐ No

11) Which of the following do you consider yourself? (Check all that apply):

- ☐ White
- ☐ Black or African American
- ☐ Asian
- ☐ Native Hawaiian or other Pacific Islander
- ☐ American Indian or Alaskan Native
- ☐ Hispanic or Latino

12) Which of the following best describes you?

- ☐ Heterosexual or straight
- ☐ Homosexual, gay or lesbian
- ☐ Bisexual

13) What is your annual household income from all sources?

- ☐ Under \$11,000
- ☐ \$11,001 - \$25,000
- ☐ \$25,001 - \$35,000
- ☐ \$35,001 - \$50,000
- ☐ \$50,001 - \$75,000
- ☐ \$75,001 or more

14) Do you currently have any health problem that requires you to use special equipment, such as a cane, a wheelchair, a special bed, or a special telephone?

- ☐ Yes
- ☐ No

15) Compared with other people your age, would you say your health is...

- ☐ Better
☐ About the same
☐ Worse

16) With whom did you spend the past Thanksgiving? (Check all that apply)

- ☐ No one; I spent it alone
☐ Friends
☐ Partner or spouse
☐ Child or children
☐ Other family
☐ Attended a community gathering

17) How often do you feel...

	Never	Rarely	Some of the time	Often	Most of the time
...that you lack companionship?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
...left out?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
...isolated from others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

18) Think about the people in your life who are important to you, such as your partner or spouse, your friends, family, or neighbors you know well. How many people like this do you talk to in person or by phone...

...at least once a week?

...at least once a month?

...at least once a year?

Write in # of people

19) In the past 12 months, how often have you used the internet?

- ☐ Never
☐ Less than once a month
☐ Once or twice a month
☐ Once a week
☐ Several times a week
☐ More than once a day

20) How would you characterize your overall experiences using the following services for yourself? Select one answer for each statement.

	No experience	Positive	Neutral	Negative
Senior center	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In-home assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Volunteer helper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meals-on-wheels	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congregate meals/community cafes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Senior housing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assisted living	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nursing home care, including rehab	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental health counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Protective/elder abuse services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

21) What concerns you when you think about using aging services like in-home help with meals and housekeeping? (Select one answer for each statement.)

	Not Concerned	Somewhat concerned	Concerned
Feels like a loss of independence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Compromises my privacy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No control over who agency sends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fear disrespectful or unprofessional conduct	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cost will be too high	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Don't think they can provide services I need	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No control over schedule for help	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Fear discrimination or bias due to my...			
race/ethnicity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
religion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
sexual orientation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
gender	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
age	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

22) If you wanted to learn more about aging services for older adults, where or who would you go to for information?

23) Have you ever contacted an elder services agency or senior center in your local area?

- ☐ Yes
- ☐ No

24) How likely are you to contact an elder services agency or senior center for aging services in the future?

- ☐ Likely
- ☐ Somewhat likely
- ☐ Unlikely

25) If you are sick or not able to get around, who would you feel comfortable asking for help with an activity such as picking up a prescription, grocery shopping, or getting to an appointment? (Check all that apply):

- ☐ Spouse or partner
- ☐ Children
- ☐ Other family members
- ☐ Friends
- ☐ Neighbors
- ☐ Aging services providers or volunteer helpers
- ☐ I don't have anyone I feel comfortable asking for help

26) How many people in total can you think of who you would feel comfortable calling for help?

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5 or more

27) In the past 6 months, for how many days have you needed help because you were sick or not able to get around?

- ☐ 0 days
- ☐ 7 days or less
- ☐ 8-14 days
- ☐ More than 14 days

28) Do you agree or disagree with the following statements about this meal site/community cafe? Select one answer for each statement.

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
One reason I come here is to be with friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
One reason I come to here is to feel connected to my community	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel welcome here	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[LGBT only] I can be who I am here	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
This is one of the few places where I feel I belong	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
This is one of the few places I socialize with others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I enjoy the food offered here	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I enjoy the programs/entertainment offered here	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I would prefer that this meal site would meet more frequently	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The meal offered here is helpful for me because...					
...it is low cost	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
...it is nutritious	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
...I have a hard time buying or preparing food for myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

29) Do you go elsewhere for help with food? (Check all that apply):

- ☐ Other congregate meal sites/community cafes for elders
- ☐ Meals-on-wheels
- ☐ Food pantry/food bank
- ☐ Soup kitchen
- ☐ Family sometimes helps me out
- ☐ Friends sometimes help me out
- ☐ None of the above

30) (Check all that apply.) In the past 12 months, did someone in your life...

- ☐ insult you and put you down
- ☐ control your daily life or decisions too much
- ☐ take your money or belongings without your permission or keep them from you
- ☐ hit, kick, slap, push or throw things at you
- ☐ none of the above

Additional LGB Form

1) How frequently do you go to LGBT congregate meal sites/community cafes?

	Regularly	Sometimes	Never
Cafe Emmanuel (Back Bay/Boston)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Out to Brunch for Older LBT Women (Roslindale)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Monthly Brunch for LGBT Seniors (South Shore)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cadbury Cafe LGBT Monthly (Cambridge/Somerville)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Over The Rainbow Supper Club (North Shore)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2) Do you go to any other congregate meal sites for elders?

- ☐ Yes (Please name) _____
- ☐ No

3) If you are lesbian, gay, bisexual or transgender, please tell us about how open or “out” you are about your sexuality or gender identity with...

	Not out to any	Out to some	Out to most	Out to all	Deceased or N/A
Sibling(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child or children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other relatives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neighbors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health care providers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aging service providers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4) If you are lesbian, gay, bisexual or transgender, on a scale of 1 to 10, how concerned are you about coming or being out and accessing services for older adults?

(not at all concerned) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (very concerned)

5) If you are lesbian, gay, bisexual or transgender, have you ever decided against accessing services for older adults because you were concerned about coming out or being out?

- ☐ Yes
☐ No

6) If you are lesbian, gay, bisexual or transgender, have you ever attended an event for older adults or chosen a service provider for older adults because you knew the provider was LGBT-friendly?

- ☐ Yes
☐ No

7) Have you experienced discrimination or violence because you are LGBT...

	Yes, I'm sure of it	I think or believe I have	No, I have not
Before the age of 18	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Between the ages of 18 and 49	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
After age 50	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8) Has an experience of discrimination or fear of discrimination ever kept you from accessing services?

- ☐ Yes
☐ No

9) When you come here, do you feel like you belong and are welcomed? Please explain – tell us what makes you feel that way.

10) When you come here, do you feel like you are part of a community? Please explain.

11) What other places can you go to feel like you belong and are welcomed as a member of the community?

12) What do you like most about the experience of getting older as an LGBT person?

13) What are your greatest concerns about getting older as an LGBT person?

14) Have you taken this exact same survey before at another meal site?

Meal site observation/question survey for survey administrator

1) How many people were served at this meal site on the day that you visited? (Try to get an exact count for response rate):

2) What type of location is this meal site? (e.g. church, community center)

3) How often does this meal site meet?

4) What food was served on the day that you visited?

5) Did you hear any other languages spoken besides English? _____ If yes, please describe:

6) Describe the meal site setting – how large was the room, how many tables were set up, how was it decorated, etc.?

7) Describe interactions that you observed between participants. For example, did people greet each other with smiles, handshakes, or hugs? Did people chat with one another before the meal was served? Did you observe cliques? Did participants talk with a wide number of other participants or stick with their friends? Did the meal site coordinator facilitate social connections among participants?

APPENDIX C

Health and social life of Boston-area elders (HSLE) QUALITATIVE INTERVIEW GUIDE

Participant ID:	Visit Date:	Interviewer Initials:

As we talked about during the consent process, the purpose of this research study is to gain a deeper understanding of the health and social concerns for Boston-area elders. We want to hear your experiences and opinions to help us develop future research and services.

The interview will cover a variety of topics – including talking about your sexual orientation, your feelings about participating in research, your social networks and activities, and your feelings about aging. We'll ask for your feedback about what you think would help us to reach older homosexual, lesbian, gay, bisexual, or transgender individuals or other people who have had same sex romantic relationships in their lives.

I want to acknowledge that these are sensitive topics. If you don't feel comfortable discussing an issue, please say so and we can move on to the next question or pause the interview – I want to make sure you feel comfortable in this process.

Before we start, I just want to remind you again that everything we talk about today will be confidential, and we're just taping the interview to ensure accuracy to make sure that we get exactly what you said. Your name is not anywhere associated with this recording. Any questions before we start?

Interviewer Note: Turn on recorder.

Hello, this is [INTERVIEWER NAME] interviewing [PARTICIPANT ID] on [DATE].

For the record, do I have your permission to tape record this interview?

Thank you.

Opening

Will you start by telling me a little about yourself?

Are you currently in a relationship?

- If yes, tell me a little about it.

- If yes, do you live with your partner?
- If no, can you tell me a little about your most recent relationship?

What is the word or term that you feel best describes your sexual orientation?

- Is this the term you most frequently use to talk about your sexual orientation or sexuality?
- Has this changed over the course of your life?
- Are you open about your sexual orientation?

As you may know, some people describe themselves as transgender when are a different gender than their biological sex defined at birth. For example, a person born into a male body who feels female or lives as a women would be transgendered. Some transgender people change their physical appearance so that it matches the way they are inside. A transgender person may be any sexual orientation—straight, gay, lesbian or bisexual.

Do you consider yourself transgender?

- If yes, is this the term you most frequently use to talk about your gender identity?
- Has this changed over the course of your life?
- Are you open about being transgender [OR INSERT PARTICIPANT’S TERM]?

Reaction to sexual orientation questions on health surveys

We are interested in learning about the best ways to ask older people about their sexual orientation in research studies. We want to hear about how you would feel answering several different types of questions that have been asked in real health surveys of the general population.

This question is asked by the Massachusetts Department of Public Health in their annual survey of Massachusetts residents. Please think about how you would feel if you were called on the telephone by a representative of the Department of Public Health and asked this question:

Do you consider yourself to be:

- Heterosexual or straight
- Homosexual or [if respondent is male read “**gay**”; else if female, read “**lesbian**”]
- Bisexual
- **or**
- Other.

What would go through your mind if you were asked this question on such a phone survey?

- Would you hesitate to answer?
- Would you skip the question or not answer?
- How would you feel about saying that you were homosexual, gay/lesbian, or bisexual to a stranger on the phone?

- Is there anything that the interviewer could say that would make you feel more comfortable?
- Would your feelings about answering it be different if it was a survey you completed in pencil and paper and mailed?
- What about if you did it on the computer or Internet?

How do you think you would answer this question if you were called by someone from the department of public health and participated in the survey with this question on it?

How do you think other people who are about the same age as you are would feel about being asked this on a phone survey?

- Can you give me an example of someone you are thinking about?

Would you feel the same way if you were asked about the sex of your romantic partner?

- **(IF PARTICIPANT LIVES WITH A SAME-SEX PARTNER AND IS NOT SAME-SEX MARRIED)**, if you were asked who you lives with you in your house and were given a list of choices that included spouse, friend, partner, etc., would you say that you lived with a partner?
- **(IF PARTICIPANT LIVES WITH A SAME-SEX PARTNER AND IS SAME-SEX MARRIED)**, if you were asked who you lives with you in your house and were given a list of choices that included spouse, friend, partner, etc., would you say that you lived with a spouse? Would you be comfortable identifying your spouse as same-sex?
- What about other people who are about the same age as you?

Would you feel the same way answering questions about the sex of people that you have had sex with?

- What about other people who are about the same age as you?

Social networks, community participation

We are now going to shift gears and ask some questions about your social life and community activities.

Looking back over the past year, how many different people did you talk with about important things that were happening in your life? Think about people like friends, family members, colleagues or neighbors with whom you talked about your life.

- Can you tell me a little bit about these people? Who are they? How often do you talk or communicate with them?
- Are they mostly gay, lesbian, bisexual, or transgender? Mostly straight? A mix?
- How many of the people that you talk to do you consider close friends? _____

Next we are interested in learning about your experiences with the lesbian, gay, bisexual, and transgender community or the LGBT community. When we talk about the LGBT community, we could be talking about lots of things, including neighborhoods,

businesses, social groups, political groups, events, bars and clubs, newspapers or websites that cater to homosexuals or to lesbian, gay, bisexual and transgender people.

What does the term LGBT community mean to you?

- Do you usually use a different name for this idea?

On a scale of 1 to 5, with 1 not at all involved, 3 moderately involved, and 5 very involved, how involved/active are you in the LGBT community [OR INSERT PARTICIPANT'S TERM]?

- What kinds of LGBT [OR INSERT PARTICIPANT'S TERM] activities or organizations have you participated in the past 12 months? e.g., gay pride, social groups, political groups, visiting bars/other establishments
- (If any) Can you tell me a little bit about these activities? How often do you attend?
- (If any) What makes you feel comfortable in participating?
- (If any) What do you enjoy about participating?
- Is there anything that keeps you from participating?
- Has your involvement changed over the course of your life?

Do you feel like you are a part or a member of LGBT community [OR INSERT PARTICIPANT'S TERM]?

- Is feeling a part of LGBT community important to you? Was it more or less important to you at different points in your life?
- What makes you feel included/excluded?

(IF PARTICIPANT REPORTS LGBT FRIENDS) are your friends and acquaintances involved in LGBT community [OR INSERT PARTICIPANT'S TERM]?

- How involved are they?
- If not involved, why not?
- If they are involved, tell me about their involvement?
- If some are and some aren't, tell me about your friends who are involved? Tell me about your friends who aren't very involved?

Are you on any email or mailing lists from LGBT [OR INSERT PARTICIPANT'S TERM] organizations?

- If yes, which ones?
- If no, have you ever thought about joining a list and decided not to?

Do you read any LGBT [OR INSERT PARTICIPANT'S TERM] newspapers?

- Which ones?

Do you visit any LGBT [OR INSERT PARTICIPANT'S TERM] websites to get news or information?

- Which ones?

Do you visit any websites to meet or stay in touch with people? Which ones?

- Do you have any experience with Facebook?
- Do you have any experience with dating websites?

Besides LGBT community [OR INSERT PARTICIPANT'S TERM] activities, what other kinds of activities or organizations have you participated in the past 12 months?

- Eg., political, religious, civic, senior activities, volunteer work, cultural, sports
- Can you tell me a little bit about these activities? How often do you attend?
- Is there anything that keeps you from participating?

Outness

The next few questions are about “outness”. As you know, people vary in terms of how “out” or open they are about their sexual or gender identity.

Can you tell me about how open you are about your sexual orientation/gender identity.

- When did you first come out?
- Tell me about the process of coming out. Did you come out all at once or did it take place over time?
- Is being out important to you?
- Are you more out in some areas of your life than others?
 - Where are you most comfortable being out? What makes it comfortable?
 - Where are you less comfortable being out? What makes it uncomfortable?
- Are there some areas of your life where being out is more important than others?
- Has “outness” ever been a source of conflict with a partner?
- Are you out with your primary care provider?
 - What about your other medical care providers?

Next I am going to ask you to look at this outness scale [SHOW COPY OF SCALE]. I'm going to read each statement and ask you how you would respond.

	For each item, choose the number which most closely represents your response:				
	Never	Rarely	Sometimes	Often	Always
If a co-worker of mine asked me if I was gay/lesbian/bisexual/transgender, I would say “yes.”	1	2	3	4	5
I attempt to hide my sexual or gender identity from members of my family and friends.	1	2	3	4	5
I let my straight friends know that I am gay/lesbian/bisexual/transgender.	1	2	3	4	5
I make it a point to let everyone I meet	1	2	3	4	5

or work with know that I am gay/lesbian/bisexual/transgender.					
I attempt to hide my sexual or gender identity from my social acquaintances.	1	2	3	4	5
If asked outright if I am gay/lesbian/bisexual/transgender, I sometimes feel nervous and/or slightly embarrassed.	1	2	3	4	5
I feel comfortable discussing gay/lesbian/bisexual/transgender issues around my co-workers, family, and healthcare providers who are straight.	1	2	3	4	5
I am open with my medical or service provider about my sexual/gender identity.	1	2	3	4	5

What do you think about this scale? Looking at where your answers fall, do you think it did a good job reflecting your degree of “outness”?

Did any of these statements make you think a little more about your outness? Can you tell me about this?

Recruitment for Research Studies

We are planning a large scale survey of LGBT older people in Boston and we will want to recruit a large number of people to participate. We want to design the study so as many kinds of LGBT older people will participate as possible. Next I have a few questions about how you and your friends and acquaintances might respond to our research design ideas. Your feedback about our ideas will help us better design the study.

Participation in the study might mean filling out a paper and pencil survey and returning it by mail. The survey would include questions about your social networks, about your gay community connections, about your health, and about your sexual orientation and gender identity.

Do you think you would participate in such a study, filling out a survey and returning it by mail?

- Would you be concerned at all about participating in the study?
- Are there any questions you would not want to answer?
- How do you think your LGBT friends/acquaintances would respond?
- Is there anything that would make you or your friends more comfortable about participating?

If you could take the survey on-line instead of by paper and pencil, would you?

- Would you have any different concerns if you were to take the survey on-line?

- Do you think your LGBT friends/acquaintances would participate in an on-line survey?

What would you think if someone from the research team asked to take the survey by phone? Would you participate?

- Would you have any different concerns if you were to take the by phone?
- Do you think your LGBT friends/acquaintances would participate by phone?

What would you think if someone from the research team asked to interview you and administer the survey questions in person at your home? Would you participate?

- Would you have any different concerns if you were to be interviewed at home for the survey?
- Do you think your LGBT friends/acquaintances would participate in person?

Next I'm going to show you some text that we are thinking about using to recruit people like you to participate in a future study [SHOW MOCK UP]

What do you think about the way we have worded this?

- Do you think you would want to find out more and maybe participate?
- Would you have any worries about calling the number?
- What could we change to make it more likely for you to call?
- Would you be more likely to call if it said that participants would be compensated for their time?
- How much would you want to be paid?

Next I am going to show you a coupon that we are thinking about distributing to people to ask them to participate. [SHOW MOCK UP]

Participants needed for:

Health and Social Life of Boston Elders Study

Compensation for your time is provided.

To find out more: 617-927-6348 or

avanwagenen@fenwayhealth.org

Reference number: 131

If one of your friends/acquaintances told you about the study and gave you a coupon like this that would enable you to participate by calling the number, would you be likely to call?

- Would you have any concerns about participating?

Would you consider giving your friends/acquaintances these kinds of coupons to participate in the study?

- What if you received \$5 for every friend who you recruited to participate?

Perceptions of aging

What is the biggest fear or concern facing you as an *aging person*?

- What are your other fears?

What is the biggest fear or concern facing you as a [INSERT PARTICIPANTS SEXUAL/GENDER IDENTITY TERM] *person who is aging*?

What would you identify as the joys/positive aspects of aging?

Overall, how has being [INSERT PARTICIPANTS SEXUAL/GENDER IDENTITY TERM] affected your own aging process?

- Has it helped, hindered, both, or neither?

Recruitment of additional participants

We want to be sure that we include all kinds of people in this current study, including those who have been missed in previous research. In particular, we are interested in those who are not very out, don't go to LGBT community events, and don't have many LGBT friends.

Do you have any ideas about how we could find people like this and ask them to participate in an interview like you have?