

The Health and Social Service Needs of Gay and Lesbian Elders and Their Families in Canada

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Purpose: This article reports the findings of a study, undertaken in 2000, whose purpose was to gather information about the experiences and realities of gay and lesbian seniors and their families from across Canada in accessing a broad range of health and social services in the community, and to examine the role of health care and social service organizations in shaping access and service delivery. **Design and Methods:** This study used a qualitative exploratory design based on focus group interviews. Perspectives of older gay men and lesbians and their families involved in organizations addressing these issues, as well as professionals from both gay and lesbian health organizations and mainstream elder care organizations were sought. **Results:** Specific reference was made to the impact of discrimination on the health and access to health services of these populations. Issues relating to invisibility, historic and current barriers to care, and the nature of service options are identified. **Implications:** Recommendations for change are highlighted, including those related to best practice programs and policies in the long-term care sector.

Key Words: *Sexual orientation, Aging, Health care, Access, Long-term care*

It has been well documented that gays and lesbians of all ages face considerable discrimination in health and social service systems. This discrimination has been identified as homophobia (fear or hatred) and heterosexism (assumption of all forms of sexuality other than heterosexuality as deviant). Because gay men and lesbians have historically been socially defined within medical terms as mentally ill,

the health care system has been one of the primary arenas through which control over their lives was exerted. As such, health professionals were often charged with the task of “healing” gay and lesbian people from their so-called unhealthy same-sex attractions through such means as electroshock therapy or aversion therapy (Daley, 1998; Dunlap, 1994). Although the American Psychiatric Association removed homosexuality from its classification of mental disorders in 1973, many health care providers continue to consider homosexuality as a mental disorder (Harrison & Silenzio, 1996; Jones & Gabriel, 1999). Gay and lesbian patients of all ages still report negative reactions from service providers. These include embarrassment, anxiety, inappropriate reactions, direct rejection of the patient or exhibition of hostility, harassment, excessive curiosity, pity, condescension, ostracism, refusal of treatment, detachment, avoidance of physical contact, or breach of confidentiality (Aranson, 1995; Berkman & Zinberg, 1997; Dardick & Grady, 1980; Harrison, 1996; Harrison & Silenzio, 1996; Kaufman, Ford, Pranger, & Sankar-Mistry, 1997; Morrissey & Rivers, 1998; Nystrom, 1997; Peers & Demczuk, 1998; Randall, 1989; Schatz & O’Hanlon, 1994; Smith, 1993; Stevens, 1992; Stevens & Hall, 1990; Tievsky, 1988; Van Soest, 1996).

Discrimination in health care is particularly salient for today’s gay and lesbian elders (Beeler, Rawls, Herdt, & Cohler, 1999; Boxer, 1997; Cahill, South, & Spade, 2001). Many of these people lived their youth and young adult lives in very hostile environments, prior to the development of the modern day gay liberation movement that began in the late 1960s in Canada and the United States. The current cohort of gay and lesbian elders is commonly referred to as “preliberation” as a means of calling attention to their particular reality. It cannot be understated that gay and lesbian elders who grew up prior to the era of gay liberation face considerable obstacles to accessing health care. Many have lived through enforced medical interventions and/or have experienced overt discrimination on the part of professionals and the public. This has resulted in feelings of great stigma and shame (Chamberland,

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1996; Kaufman & Raphael, 1996), which continue to shape their lives, often requiring them to keep their sexual orientation hidden as a strategy of survival. This need to stay hidden for fear of discrimination has remained a prominent coping mechanism in the lives of many older gay men and lesbians (Bonneau, 1998; Cook-Daniels, 1997; Harrison, 1996; Harrison & Silenzio, 1996; Kochman, 1997; Krauss Whitbourne, Jacobo, & Munoz-Ruiz, 1996; Rosenfeld, 1999; Saunders, Tupac, & MacCulloch, 1988).

Older gay men and lesbians who have come out to others often find themselves having to go back into hiding when they begin to require health care services. *Coming out* is a term used to describe the process of identification as a gay or lesbian individual. Some research has documented that homophobia and heterosexism are even more common in elder care systems than within the health care system generally. This is partially because the aging network has largely gone unchallenged with respect to its attitudes and practices toward gay and lesbian elders. In addition, sectors of the aging network in which elders work (voluntary or social support organizations), or live alongside each other (congregate housing), often expose gay men and lesbians to further marginalization from contemporaries who continue to hold discriminatory attitudes reminiscent of the preliberation era (Daley, 1998; Krauss Whitbourne et al., 1996; Peterson & Bricker-Jenkins, 1996).

The health impacts of exposure to discrimination are far-reaching (Appelby & Anastas, 1998; Brotman, Ryan, & Rowe, 2001; Cabaj & Stein, 1996). The risks of coming out in hostile or intolerant environments cause significant stress on gay men and lesbians, and often forces them to focus more on assessing the safety of environments rather than on developmental achievements (e.g., education, employment, family, social networks, etc.; Appelby & Anastas, 1998; Brotman et al., 2001; Demczuk, 1998). It also contributes to lower life satisfaction and self-esteem. Research has also documented that managing stigma over long periods of time results in higher risks of depression and suicide, addictions, and substance abuse (Bradford & Ryan, 1989; Gillow & Davis, 1987; Rothblum, 1994; Russel & Joyner, 2001). Because of the length of time that elderly gay men and lesbians have been managing stigma, health care professionals should be particularly concerned about potential effects on their health status. This is made more problematic because older gay men and lesbians are less likely to seek out health care services or identify themselves as gay or lesbian to health care professionals when they do (Harrison & Silenzio, 1996; Owen, 1996; Risdon, 1998; Robertson, 1998). This makes outreach efforts and adapting practices to meet their needs more challenging (Conolly, 1996; Jacobs, Rasmussen, & Hohman, 1999).

Another major area of concern for gay and lesbian

elders is the way in which notions of “the family” are constructed in elder care services. From the perspective of heterosexual elders, families have become an increasingly visible and important partner in the elder care network over the past decade. Health care professionals, policy makers, and researchers have pointed to the essential role of families in providing care and support and in participating in decision making with regard to care plans. However, prioritizing of the “biological family” has reinforced the experience of marginalization and exclusion among gay and lesbian elders. First, gay and lesbian elders may be less linked to their biological families or families of origin. Although many do receive support from their biological families (siblings, parents, etc.), many do not. In addition, although many older gay men and lesbians have children and grandchildren, largely through previous heterosexual relationships experienced prior to coming out, many do not (Barranti & Cohen, 2000). In these instances, health care professionals who come into contact with gay and lesbian elders with few or no ties to biological family simply assume that they have no one to support them. This is not true in most cases. Research on gay and lesbian elders have demonstrated that often these elders have larger social networks than their heterosexual counterparts. Having faced rejection from the biological family, gay and lesbian people have often had to seek out friends with whom they can be themselves, be out, and be affirmed. These friends become family, or “fictive kin” (Barranti & Cohen, 2000). The “myth” of the older gay man or lesbian as isolated and lonely is simply a myth (Ehrenberg, 1996; Friend, 1990). Older gay men and lesbians often have “fictive kin” networks made up of partners and friends who act as family (Barranti & Cohen, 2000). It is not that these families do not exist, it is that they are unrecognized by health care professionals and systems. In the health care field, partners and friends of gay and lesbian people requiring health care services have pointed time and again to the lack of rights/recognition given them in relation to visiting, decision making, and caregiving for their loved one (Irving, Bor, & Catalan, 1995; Kaufman et al., 1997; Ryan, Hamel, & Cho, 1998; Simkin, 1993; Turner & Catania, 1997). To make matters worse, health care professionals will often call on biological family to make health care decisions because of a lack of rights/recognition afforded to “fictive kin.” However, these family members may have little support for the elder’s identity and may even exhibit hostility toward the elder and/or his or her partner (Barranti & Cohen, 2000). These practices result in further isolation of the gay or lesbian elder. That isolation may be a factor in the lives of older gay men and lesbians, and must be taken into consideration in outreach and care plans.

Unfortunately, because of invisibility and discrimination, there continues to be almost no recogni-

tion of the specific needs of gay and lesbian elders and their families in health and social services (Auger, 1992; Berger & Kelly, 1996; Slusher, Mayer, & Dunkle, 1996). This is reinforced by a lack of affirmative research (Berger, 1984; Cook-Daniels, 1997; Cruikshank, 1991; Hamburger, 1997; Humphreys & Quam, 1998; Kochman, 1997). This enforced invisibility both results from and has contributed to a continued lack of exposure to gay and lesbian issues and experiences, and the lack of commitment to developing gay-positive policies and practices directed toward elders themselves (Kochman, 1997; Metz, 1997) and their caregivers (Aranson, 1998). It has also resulted in increased stress on both elderly gay or lesbian people and their families (Fredriksen, 1999).

This article reports the results of a Phase 1 exploratory study undertaken between 2000–2001 in Canada on the experiences and realities facing gay and lesbian seniors in accessing the health care and social service system. The aim of the study was to generate understanding about the health and social service needs of gay and lesbian elders and their caregivers through an exploration of the perceptions of various professional and activist stakeholders in the community—namely those representing gay and lesbian health community organizations, gay and lesbian seniors organizations, community health and homecare organizations, and elder care policy bodies. The study examined how key informants from both the gay and lesbian network and the mainstream elder care network understand and talk about need and current responses. The project investigated an area of health equity studies that has been, to date, largely unexplored. Also, this study supported building partnerships between key stakeholders to facilitate development of a large national study on access and equity among gay and lesbian elders and their families.

This study is limited to analyses based on gay and lesbian sexual orientation, meaning that the experiences of bisexual and transgender people are not included in the current study. Although the issues facing these communities are essential to address and have often been identified alongside those of gay men and lesbians, the points of view of both bisexual and transgender people are unique enough to warrant a distinct and separate enquiry. Often times, research that claims to include bisexual and transgender populations alongside gay and lesbian populations is actually focused almost entirely on the experiences of the latter groups. This reinforces the marginalized and invisible status of bisexual and transgender people. Given the limited funding available for this study, emphasis was placed on exploring the issues facing gay men and lesbians, both with respect to review of the literature and participant identification. In this context, including bisexual and transgender issues would contribute to a process of tokenization. This study was preliminary in nature,

and it is hoped that additional funding can be sought to expand our exploration with bisexual and transgender people in the future.

Methods

A focus group design was used to explore the perceptions and understandings of the experiences and realities facing gay and lesbian seniors in Canada from the perspectives of a variety of community stakeholders. Four focus groups were undertaken in three locations across Canada to ensure a national scope to the project: One in Quebec, one in Nova Scotia, and two in British Columbia. Focus groups were composed of gay and lesbian activists working within the community, namely those representing organizations made up of gay and lesbian seniors and their families, health care providers and policy makers within the public health system, and members of various mainstream senior groups, including those representing caregivers.

Current research aimed to develop relationships with local organizations to advance a partnership agenda for future work in the area. Intended as a Phase 1 endeavor, only those people with organizational or group affiliation were invited to attend the focus group discussions. The discussions that resulted were based both on participants' own experiences and perspectives, and those of organizations, agencies, or groups in which they were involved. Participants were recruited in each location using a snowball sampling technique (Neuman, 1997). Those representing gay and lesbian organizations, including gay and lesbian seniors groups, were identified through contact with key informants reinforced through identification in local and national gay and lesbian directories. The researchers, themselves active in local and national gay and lesbian research and activist projects, had had much prior contact with many of the individuals approached, which expedited trust-building. Participants representing mainstream long-term care and other health care organizations—including public health departments, homecare agencies, seniors groups, and voluntary sector aging and caregiver organizations and institutions—were identified through key informants in each local setting. Key informants from gay and lesbian sectors, both locally and nationally, have had much contact with policy and public health bodies, and these contacts were used to identify those who might be willing to participate in focus groups on gay and lesbian aging. Once these “publicly supportive” people were contacted, researchers used snowball techniques to identify others who, key informants felt, could make an important contribution or who would be open to discussing these issues. All potential participants in focus group discussions were provided with a letter of introduction and information about the project. A number of organizations did refuse to

participate, mostly sighting that they did not work with gay or lesbian elders or that sexual orientation was not an important consideration for their agency.

Focus group theory asserts that disparate groups need to be separated out, one from the other, when undertaking focus group discussions. This is particularly important when there is a power differential between these groups that might lead to exposure of marginalized people to further discrimination by those people with more power or control (Bryman, 2001). At first glance, one might conclude that the design undertaken in the current study is problematic. Two issues are important to consider in response to this concern. First, although participants from the mainstream elder care sector might have had little familiarity with the issue, these individuals had at least recognized that the issue of accessibility was an important and often ignored issue that needed to be addressed. This suggests some openness to rethinking their particular positions. Second, because organizational representation was a necessary precursor to inclusion in the study, those gay and lesbian people who participated were already identified as willing and able to speak publicly about their experiences in a wide range of environments. This considerably diminished the risk of exposure in the context of this study. In fact, gay and lesbian participants were eager to have the opportunity to engage in discussion across groups, both to exchange information and broaden understanding. All of the gay and lesbian groups or organizations that researchers contacted for inclusion in the study identified a representative to participate. Informal feedback from participants suggested that they were satisfied with the model used. However, there are still several limitations to the mixed-group study design. The potential exposure inherent in mixing gay and lesbian people with people from mainstream elder care sectors might have resulted in a refusal to participate by those who might feel risk in speaking out. This includes gay and lesbian elders or their caregivers who fear being remarginalized or oppressed by professionals or policy makers from the mainstream elder care network and also professionals who are less aware or who harbor negative feelings about the subject matter who fear being challenged by gay and lesbian activists. Second, the content of the focus groups may have been limited because of the mixed nature of the groups so that, even though people agreed to participate in the mixed setting, they may have shaped their responses in consideration of the safety of the environment. Still, given these limitations, the substance of the discussions were rich and complex.

Overall, 32 people participated in all four focus groups [8 in Quebec, 6 in Nova Scotia, 9 in Location 1 (midsized center) in British Columbia, and 9 in Location 2 (large urban center)]. Within the four focus groups, 7 participants were from gay and lesbian seniors groups (being seniors them-

selves), 9 were from gay and lesbian health organizations, 3 were from voluntary mainstream organizations (including caregiver groups), 8 were from public sector service delivery organizations or institutions, and 5 were from governmental policy bodies. Twenty-one were identified as gay or lesbian. Other demographic data were not collected in this study, and we are not able to identify any other information about participants aside from what is described. At the time, the focus of analysis was limited to organizational representation as the main interest of this study. This was justified because the goal of the project was to build understanding of organizational or professional perceptions of the issues to substantiate the need for further inquiry. Stemming from this focus on representation, it was decided that identification of sexual orientation would be entirely voluntary.

Participants engaged, with investigators, in a tape-recorded group discussion of approximately 2 hr. Informed consent was received from all participants in the study. The discussion questions were semi-structured and designed to cover specific aspects of gay and lesbian elders' experience of health, their particular health needs, and access/service delivery issues. The focus group questions and emerging themes were designed to be broad-based and exploratory at this stage. These questions included what services are needed by gay and lesbian elders and their families, how they go about finding these services, what stops people from getting services, and whether or not services meet their needs. Focus group discussions centered on: (1) the perspectives of allies and activists as to the needs and issues facing gay and lesbian seniors and their families, (2) the perspectives of mainstream policy and practice organizations with respect to their knowledge about or current practice with gay and lesbian seniors, and (3) the sharing of gay and lesbian elders' and their families' experiences of care. This final theme emerged out of discussions and was not pursued directly by research interviewers. This attests to the level of comfort within focus groups that facilitated disclosure of personal experiences.

Data collection and analysis were consistent with that developed by Morgan (1997), who articulates a distinctive qualitative methodology for focus group inquiry. Focus group discussions were transcribed and then analyzed with the intent of developing common and divergent themes. This analysis proceeded through an iterative process, beginning first with a reading of each full transcript independently to uncover overarching themes that emerged from the text. Then, each transcript was analyzed section by section, maintaining the integrity of the speakers' comments to code the data. A final run-through, moving line by line, allowed the researchers to uncover both locations of connection and divergence of themes/codes within the text. Once themes were explored to their fullest and sections from the text

identified that highlighted these themes, all four focus groups were compared and contrasted in an iterative process of identification and analysis, in Phase 3. This was done to ensure that findings were grounded first in local and then in national perspectives. This was also done to facilitate feedback from participants with respect to the local focus groups in which they were involved. Intercoder reliability testing was undertaken throughout these phases of analysis. At each phase, at least two members of the research team reviewed transcripts and data coding. The research coordinator undertook preliminary data coding, which was reviewed and verified by at least one of the principal investigators on an ongoing basis. This included having the principal investigators reread the original transcripts to verify the coding and analysis process. This ensured consistency and reliability. Finally, preliminary description of themes were brought back to participants for validation and reflection. Each participant was sent a draft document of the analysis (including theme areas, comments on those themes in bullet form, and quotes that related to these themes) from their particular geographic region for feedback. Feedback suggested that the themes emerging and quotes identified to justify these themes were accurate. This process of member-checking was important to ensure authenticity.

Results

Although several issues arose from the four focus group discussions, the one theme that emerged repeatedly and most frequently was the profound marginalization experienced by older gays and lesbians in all aspects of social and political life. From this theme of marginalization emerged five critical issues that help to deepen our understanding of gay and lesbian seniors, including: (1) historical experiences of discrimination; (2) homophobia within present-day context; (3) the profound invisibility of gay and lesbian seniors in all segments of society; (4) long-term care services; and (5) gay and lesbian support networks. The final section of this analysis will include several recommendations that were brought forward by participants in an attempt to address the present health care and social service needs of these aging populations.

Historical Experiences of Discrimination

Participants in this study confirmed that older gay men and lesbians often mistrust the health and social service network as a result of life-long experiences of marginalization and oppression. Many gay and lesbian elders who experienced the pervasive social stigma that existed prior to the advent of the gay liberation movement maintain a sense of extreme caution with respect to whether or not societal attitudes have really changed.

... we're coming out of an experience of being badly treated in society, and there's no sense that that treatment is going to get any better when you get older and more vulnerable within the system ...

... for most people who didn't have the support of various organizations or were part of some kind of social movement, the scarring is pretty deep ...

The painful wounds of being socially marginalized and the deep scarring that resulted from these experiences remind older gays and lesbians that it is unwise to place trust in individuals and social systems that have historically persecuted them, particularly as they confront the potential of becoming physically dependent on others as they grow older. In this regard, the historical experiences of oppression and related trauma continue to figure importantly in the lives of many lesbians and gay men of older generations.

Homophobia Within the Present Social Context

Although gay and lesbian seniors are deeply affected by their historical experiences of discrimination, they continue to be victims of discrimination within their present social environments. Despite recent changes in social policy in Canada that have resulted in increased recognition of the rights of gay men and lesbians (the most important of these is the passing of federal and provincial legislation recognizing same-sex couples as equivalent to common-law couples outside of family law), discrimination continues to be apparent in many social and institutional environments. This represents an important threat to the health and well-being of gay and lesbian seniors and their families. Whereas many focus group participants acknowledged that attitudes had changed in recent years for gays and lesbians living in Canada, many reported incidences of overt homophobia directed toward the elderly lesbian and gay male populations.

In light of this reality, the possibility of one day having to be reliant on the health care system, on a nursing home facility, or any other social institution understandably provokes anxiety and fear in aging lesbians and gay men. Many gay and lesbian elders who fear being victimized or discriminated against in these systems may avoid accessing services all together, even when their health, safety, and security depend on it.

... but their fear is where they are at, and until they see that the system is inclusive, I think there are some people who are not going to access services when they really could benefit from them until it may be too late.

Profound Invisibility of Older Gays and Lesbians

Past and current experiences of stigma reinforce, in the minds of many lesbian and gay seniors,

a vigilance in maintaining secrecy over their sexual orientation. Other seniors may feel it necessary to deny a same-sex relationship for fear of being badly treated in the long-term care network. Many seniors are very cautious about disclosing their sexual orientation. Consequently, they remain profoundly invisible in most segments of society. Older gays and lesbians are hardly ever seen in mainstream senior networks, in health care institutions, and in society.

What I am hearing around the table is that the word invisibility keeps coming up in one way or another . . . in the network, in workers' caseloads, all around us . . .

Because of the absolute invisibility of gays and lesbians in senior care networks, physicians, nurses, psychologists, social workers, and volunteers working within the health care system often overlook the possibility that some of their aging clients may be gay or lesbian. This oversight promotes and further marginalizes these seniors and their care providers.

The invisibility of older gays and lesbians in the health care and social service systems not only helps keep these seniors marginal within social systems, but also creates important barriers to the development of a social and political voice. Historically, gay and lesbian seniors have been excluded from all discussion, planning, and programming processes both in mainstream senior networks, as well as in gay and lesbian organizations. When the needs of gay and lesbian seniors are raised at national seniors' meetings and conferences, the most prominent reaction is one of discomfort. Most often, there is a lack of willingness to place the issues of gay and lesbian seniors on the agenda for discussion.

There was a consensus among focus group participants that the issues of gay and lesbian seniors are poorly understood by academics, lesbian and gay communities, and by health care professionals. Their needs are hardly ever addressed, and their profound invisibility obstructs any possibility of developing sensitive and appropriate health, social service, and long-term care alternatives for them.

Long-Term Care Services for Older Gays and Lesbians

The question remains as to how gay and lesbian elders can begin to trust in a system in which their needs are not clearly expressed or understood. Older lesbians and gay men have learned to survive negative social climates by being cautious and suspicious of public health care services and of professionals working within these systems. When professionals conduct assessments with these seniors, important aspects of their social lives are often overlooked. Most health care professionals are completely unaware of the specific needs of this population.

Issues of sexuality are often overlooked when these clients are assessed by health care providers.

The discomfort that many professionals experience around discussing issues of sexuality with their aging clients, coupled with these clients' need to remain invisible to protect themselves from discrimination, promotes and reinforces a vicious cycle of oppression for aging gay and lesbian populations. For example, outward expressions of affection may represent major impediments to the health and well-being of older lesbians and gay men who reside in long-term care facilities.

One woman told me that she would just like to know that if she ever has to go into a facility, that she can hold hands with her partner in the tv room.

Given the discomfort exhibited by health care professionals with respect to addressing issues of sexuality, even the simplest outward signs of affection between gay or lesbian couples living within long-term care facilities would cause conflict within most institutions currently operating in Canada.

Seniors who require care need to be assured that the values of agencies, institutions, and professionals respect and reflect who they are and their unique needs. Relying on others for health care as a result of failing health is a profoundly frightening experience for most seniors. For lesbians and gay men, the fear is even greater because they are forced to depend on networks and social institutions that have traditionally been known to be intolerant of them.

Most people are terrified of going into any of the care facilities, and having to be hidden, losing their lovers, their partners, their friends . . . so it is a huge question and a tremendous loss of power when you're not mobile anymore.

The profound lack of visibility and awareness of the needs of older gays and lesbians within the health care system has sometimes resulted in tragic situations for these seniors. For example, one participant recounted the story of a lesbian couple who, after living together for several decades, were separated with the help of health care professionals and family members who were unaware of the nature of their partnership.

Finally, it must be stressed that remaining invisible has been a strategy of survival for today's older gay men and lesbians—a strategy that has often resulted in an increased capacity for resilience against the onslaught of additional forms of discrimination they experience as elders. Historical experiences of victimization have led many older lesbians and gay men to develop skills that keep them safe from or help them deal with all kinds of hostile environments.

I heard a story once that one lesbian couple . . . one of the partners changed her last name to her partner's last name so that they would be taken for sisters. To be put in the same room.

Gay and Lesbian Communities and Their Aging Members

Older gays and lesbians not only confront obstacles when accessing services from mainstream senior networks, but also face important barriers within lesbian and gay communities. Even though gay and lesbian organizations are well positioned to develop and provide advocacy and support services for their aging members, the needs of seniors are poorly understood within these networks and are now only beginning to be addressed.

In recent decades, gay and lesbian communities have spent a lot of energy articulating and responding to the needs of its younger members, but have done much less in an effort to develop services for its senior members. Few services or programs presently exist in Canada for older gays and lesbians, despite the potential benefits they could bring to this profoundly marginal population.

For gay and lesbian communities that have been willing to develop and offer services to senior members, one important challenge for them has been to access these older members and to entice them to come out and participate in various activities. The high degree of invisibility that currently characterizes these populations makes the challenge even greater.

Another important challenge for these communities is to change their youth-focused image, which makes it troublesome for groups to reach out to its aging members and, more importantly, makes it difficult for seniors to reach out to gay and lesbian organizations. As one participant emphasized, the youth centered culture of many lesbian and gay communities represents an important impediment for senior members. Older lesbians and gay men feel they cannot relate to the younger members of these communities.

Older gays and lesbians are often confronted with negative attitudes toward them because of their age. Several participants raised concerns about ageist attitudes that dominate gay and lesbian communities and culture. Ageism, beauty, and youthfulness are values that reign supreme within most gay and lesbian communities, making it difficult for older members to feel like they belong.

Perhaps it is worth the effort to underline the ageism that we find in the gay community. And perhaps it is an additional reason that older gay men and lesbians are so invisible . . . it's the ageism within our community. Because in the community, one has to also say, as in society at large . . . beauty, youthfulness, these are the primary values . . . there was an older lesbian who told me "Look, I've gained weight, I've gotten older, I'm not visible anymore!" and she no longer goes out . . .

Recommendations: Education and Raising Awareness

Some participants questioned whether senior-serving organizations and caregiver networks are in a state of readiness to be offering services to aging lesbians and gay men. People are having to adjust their views and thinking about these marginalized populations. Other participants believed that education and awareness-raising campaigns are critically important in terms of improving services and service access for aging lesbians and gay men.

Educating health care professionals has also been identified as an important way of raising awareness and improving services for aging gays and lesbians. Participants addressed a variety of issues related to educational initiatives and adapted practice. The most frequently mentioned issues were those related to the development of supportive and safe environments and improvements to the ways in which professionals collect information. It was felt that improving communication and support would best facilitate trust-building for gay and lesbian seniors.

Finally, it was suggested that older lesbians and gay men would benefit immensely from the added protection of policy initiatives that incorporate homophobia as a grounds of elder abuse. One participant suggested that the time has come to expand the definition of elder abuse to include sexual harassment based on sexual orientation, because the knowledge of one's same-sex orientation could easily be used to intimidate, harass, humiliate, or shame an elderly individual living within a long-term care institution.

I think that what a lot of people feel is that fear that they can't be out, that it won't be safe to be out, that what is required in order to create a kind of safety is some proactive reassurance that this is an open climate.

A policy initiative that incorporates homophobia as a grounds of elder abuse could benefit gay and lesbian seniors greatly by entrenching it as a category of potential discrimination within the elder care network. This would provide impetus for embedding the notion of freedom from harassment or injury based upon sexual orientation as a legitimate right. This would, in turn, force institutions and organizations to prepare themselves better to work with gay and lesbian elders and respond proactively to potential threats of discrimination against them.

Discussion

Several issues have been identified in this study. First, there is the profound invisibility of gay and lesbian seniors, both within gay and lesbian communities and mainstream long-term care services. This finding was consistent across all geographic

regions and within both mid-sized and large urban centers. Even in locations in which there are high proportions of seniors and/or a sizeable infrastructure of gay and lesbian organizations and services, gay and lesbian elders remain invisible. The reasons for this are complex and directly related to the experiences of homophobia and heterosexism faced by gay and lesbian elders across the life span. Gay and lesbian elders have learned to cope with discrimination by hiding their sexual orientation. They do this in a variety of ways, including: (1) avoiding identification of their sexual orientation to others; (2) avoiding identification of their partners to others; (3) avoiding identification with gay and lesbian communities; and (4) avoiding services altogether. In light of the overt homophobia that they faced throughout their lives, particularly during the years prior to the advent of the gay liberation movement, this strategy of hiding must be seen as an important coping mechanism for survival.

Developing resilience in the face of discrimination has helped many gay and lesbian seniors become expert in dealing with adversity, facing change, and learning how to take care of themselves. This adaptive capacity follows them into old age so that, although unable to rely on public services, elderly gays and lesbians have developed a unique capacity to do for themselves and for each other. These adaptive coping strategies, as forms of resilience and resistance, have been well documented in the research (Barranti & Cohen, 2000; Berger, 1980; Berger & Kelly, 1986; Friend, 1980, 1990; Humphreys & Quam, 1998; Kimmel, 1978). This research suggests that older gay men and lesbians adjust to age more successfully than their heterosexual counterparts.

Older gay men and lesbians' ability to cope and survive on their own in hostile environments does have a downside, however. These populations have learned to adjust to loss and stigma so well that they may delay seeking medical attention even though they need it, relying on their own resources far beyond the limits of their functional capacity because this is what they have always had to do. This means that older gays and lesbians may arrive at the doors of the health care system and long-term care network in a more advanced state of risk than their heterosexual counterparts, or not at all.

It is important to emphasize that discrimination continues to be present in health care and social services in the field of aging. This contributes to a continued discomfort with and lack of trust in the system. Older gays and lesbians, their families, and allies have identified the incredible fear experienced by gay and lesbian elders when confronted with these services and systems. At worst, the system continues to be hostile. At best, there is a pervasive ignorance about gay and lesbian elders and their unique needs in the elder care network.

Given the current reality, health and social service

providers must begin to ask themselves profound questions about how to transform the system to enhance equity. The participants made several suggestions in this study that are important to highlight. First, we must not blame seniors for their lack of visibility in the system. Health care professionals must understand the roots of gay and lesbian seniors' mistrust and must see the strategy of hiding as an understandable outcome of facing ongoing and pervasive discrimination. Health care providers must also be able to identify this and other coping mechanisms as signs of resilience and capacity. This invariably means understanding and identifying the role of the health care system in the oppression of gay and lesbian people. Institutional practices must reflect this understanding through the development of unique programs designed to redress discrimination. Developing outreach strategies, adapting assessment tools, improving communication, and creating open and supportive environments are all necessary changes to better meet the needs of gay and lesbian seniors within the current system. Entrenching homophobia as a category of elder abuse in aging policy would go a long way to enforce institutional change. The difficulty in undertaking change in an environment in which older gays and lesbians are profoundly silent cannot be underestimated.

It is inherently difficult to reconcile the silence of older gays and lesbians because of their historical and current realities with the need to engage with these elders so that they can be seen and heard. This conflict will not change overnight. Making room for older gay men's and lesbians' voices to be heard in elder care sectors will require beginning the change process from within, sometimes without their inclusion, as a beginning phase. Institutions and organizations that have been historically oppressive to these individuals will not be able to simply invite participation without first engaging in a trust-building process. Trust-building takes time and great effort. Once again, outreach programs are essential, as is beginning with where individuals are in the process. Elder care organizations, including voluntary sector ones, must begin by learning about the issues facing older gay men and lesbians and their families through the development of staff and volunteer training, inviting gay and lesbian organizations to speak to them, sitting on boards and committees and to review methods of practice, and evaluating their own values and assumptions about gay and lesbian people. Institutional policy changes, such as recognizing and supporting the rights of partners and fictive kin to participate in care plans, are another way to create a welcoming environment for gay and lesbian elders. Finally, once the transformation work is done, organizations and institutions must advertise the gay affirmative nature of their settings by reaching out and participating in gay and lesbian community events, posting informa-

tion, and opening their doors through such events as open houses to invite gay and lesbian communities into their settings. Although this may only reach those that are already out, it would create an atmosphere of partnership with gay and lesbian organizations and people that would help facilitate spreading the word. Finally, it cannot be understated that part of the job of creating a gay affirmative elder care sector includes making these spaces affirmative for gay and lesbian professionals working in them. Whereas these people should not be the only ones involved in the change process in these settings, they must be included as essential participants. After all, if gay and lesbian employees and volunteers are not visible, it is more likely that elders will not be comfortable in being visible. Once environments are made more open, then older gay and lesbian populations, as well as their families, are more likely to trust, find space, and make their voices heard.

Another important aspect addressed briefly by participants in this study is the importance of rendering the issue of sexuality more open in elder care sectors. It is less likely that sexual orientation will be addressed in environments in which discussions of sexuality in general remain taboo. Many myths currently exist surrounding sexuality in old age. Despite the fact that research has shown that elders can and do participate in sexual activity and that desire continues throughout our lives, ageism has reinforced the perception that sex is only for the young; that older people lack the interest or capacity to be sexually active (Gibson, 1992; Kaye, 1993). Prejudicial beliefs about elders' experience of sexuality, as well as repressive attitudes that make discussions about sex and sexuality uncomfortable for workers, contribute to making sexuality an ignored and often feared subject in elder care settings (Scrutton, 1999). This also filters up to the level of policy. Many organizational settings, for example, place little significance on privacy, and actively discourage sexual activity between residents or clients. Although enabling discussions of sexuality does not guarantee increased openness to the issues and needs of gay and lesbian elders, it certainly will not do harm. Where sexuality is understood as a normal and healthy aspect of older people's lives, arguments for the inclusion of sexual orientation gain credibility. Making the sexual needs and identities of older people a mandatory part of assessment and care plans will facilitate understanding of the concerns facing older gay and lesbian clients.

The role of gay and lesbian communities in change efforts cannot be understated. Gay and lesbian community activists would be well placed to advocate for changes to the health, social service, and long-term care systems and to provide education. They have worked for decades on documenting and addressing homophobia and heterosexism in society and can advance an agenda for institutional change, particularly in light of the current appre-

hension of gay and lesbian seniors to identify to the system because of increased vulnerability. However, before community organizations and activists can adequately and appropriately take on this advocacy role, they need to engage in more dialogue with gay and lesbian elders themselves. This means addressing ageism within the gay and lesbian community so that space can be opened for gay and lesbian elders to identify themselves and participate as equals in change efforts. In doing so, gay and lesbian communities will also be better placed to provide gay- and lesbian-specific services across the long-term care network. Although efforts must be made to create equity in the public system, gay- and lesbian-specific services need to be available as an option for those people who are more comfortable in culturally specific environments.

Finally, a brief discussion on possible cohort differences between the current population of gay and lesbian elders and those who will be coming of age over the next 15–20 years is warranted in the current context. Although gay and lesbian elders today grew up in harsh conditions of discrimination that existed before the advent of the gay liberation movement, resulting in particular strategies of hiding to survive, tomorrow's gay and lesbian elders have potentially had a quite different experience. Tomorrow's elders will have grown up in an environment of political and social solidarity that emerged out of the gay liberation movement. This cohort will have more likely identified themselves with a cultural community and had the opportunity to participate in a variety of organizations designed to promote their health and well-being, challenge discriminatory law and policy, and celebrate a sense of pride in their identity. This is, of course, more likely in larger urban centers, in which a critical mass of gay and lesbian people have been able to come together. The past few decades in Canada have seen major changes in attitudes toward and law protecting the rights of gay and lesbian people. All jurisdictions in Canada have included sexual orientation as a grounds of discrimination under federal and provincial charters of rights, and this has led the way for challenges to many aspects of legislation, including family, insurance, and pension law in favor of same-sex couples. In light of this, gay and lesbian people growing old with the experience of solidarity and community, and who have a sense of their rights and entitlements, will be less likely to accept going back into invisibility to receive elder care services. They will also be less likely to stand back while services are designed and delivered without their interests in mind, whether this be done within the mainstream elder care sector or the gay and lesbian community sector. This cohort of gay and lesbian people are already beginning to identify the need to re-examine and address the interplay of ageism and homophobia that may hinder their visibility and participation in the future. There are also several informal projects

underway across Canada, made up of middle-aged gay men and lesbians, to develop residential services that are gay and lesbian exclusive or affirmative.

Engaging in advocacy strategies, training, and outreach will ensure that today's gay and lesbian elders, as well as tomorrow's gay and lesbian elders, will be able to locate appropriate and adequate services to meet their needs in environments of safety and security. Providing gay- and lesbian-affirmative services must be seen as a priority to ensure that gay and lesbian elders can live out their latter years free of the discrimination and exclusion they have been forced to manage for most of their lives.

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