Mount Saint Vincent University

Department of Family Studies and Gerontology

The Experience of Living in Long-Term Care for LGBT Individuals: Perspectives

from Residents and Stakeholders

by

Maureen Green

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Dedication

This thesis is dedicated to my incredibly supportive family, near and far:

Carol Green (mom), Ralston Green (dad), Jacqueline Green (twin), Rachel Green (sister), Carmel Smyth (nana), Carl Smyth (papa), Simone Smyth (cookie nana), Alphée Smyth (grampy), Doris Green (granny), and Norman Green (grampy)

Abstract

Because older lesbian, gay, bisexual, and transgender (LGBT) individuals face challenges due to ageism, homophobia/transphobia, and/or heterosexism, hiding their sexual identity may be a common coping mechanism to avoid discrimination. Due to these multiple forms of marginalization, sexual minority individuals are more likely to live alone than heterosexual individuals. They are also at greater risk of entering long-term care (LTC) facilities where they may feel they have no other choice but to hide their sexual identities, but little is known about their experiences.

This study used qualitative, descriptive methodology and was guided by the ecological perspective, minority stress theory, and intersectionality theory. In-depth, semi-structured interviews were completed with two LGBT residents, two LGBT activists, and two LTC workers. Interviews focused on their subjective, personal understanding of their experiences and the experiences of LGBT individuals in LTC.

Three themes emerged in the analysis. First, LTC residents were hesitant to reveal their sexual identity due to potential discrimination from residents and staff members in their facilities. Residents had heard of stories about other residents being maltreated on the basis of their sexual orientation, and their health-related vulnerability enhanced their fears. This feeling was validated by the stakeholders, who had also heard similar negative stories.

Second, fear of discrimination was buffered by positive relationships with others within and outside of the LTC facility. Support networks were important in

providing a positive environment for the residents, and this feeling was echoed by the stakeholder participants. Access to supportive services was important, and the participants worried about the availability of such services for those residing in smaller cities or rural areas.

Third, the environments with which LGBT participants interacted played a big part in their overall experience in LTC. Having to move from their home into an institution meant they had to give up control over the timing of day-to-day activities and who cared for them. The political climate of the LTC facility also factored into their experiences, where living smaller, rural areas (for example) made it more difficult to access supportive services. Finally, participants also felt positively about the idea of having an LGBT-friendly LTC facility available, though one had reservations about it, feeling it was unnecessarily contributing to segregation and not dealing with the root of the problem.

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CHAPTER 1: INTRODUCTION

The number of Canadians over the age of 65 will reach 10.4 million by 2036 (Statistics Canada, 2010a). Nova Scotia in particular has the highest percentage of seniors than any other province, totaling 16.5% of its population in 2011 (Statistics Canada, 2012a). By 2036, that number is expected to grow to 28.6%, more than a quarter of the total population.

In 2009, the Canadian Community Health Survey, became the first national survey in Canada to include a question on sexual orientation (Statistics Canada, 2010a). Approximately 1% of individuals between the ages of 18-59 reported they would consider themselves homosexual, while 0.9% reported considering themselves to be bisexual (Statistics Canada, 2010a). Though often rendered invisible, lesbian, gay, bisexual, transgender (LGBT) people exist in the growing population of older adults in Nova Scotia. They may face challenges due to multiple forms of marginalization as a result of ageism, homophobia/transphobia, and/or heterosexism, which may subsequently prevent them from making improvements in their physical and emotional wellbeing.

 LGBT individuals consists of both sexual and gender minorities. A "sexual minority" refers to a person whose sexual identity, orientation, or practices differ from the majority of the surrounding society (Gender Equity Resource Center, 2013b). This refers to people who identify as gay, lesbian, or bisexual. A "gender minority" is someone who has a gender identity that is different from the gender at which they were assigned at birth (Gender Equity Resource Center, 2013a). This includes people who identify as transgender.

LGBT older adults grew up in a time very different from today. For those who

grew up before the gay rights movements in the late 60s, learning to hide a part of their

identity became a common coping mechanism to avoid potential discrimination on the

basis of their sexual orientation (Bonneau, 1998; Cahill & South, 2002; Cook-Daniels,

1998; Kochman, 1997; Rosenfeld, 1999; Stein, Beckerman, & Sherman, 2010). They

experienced such discrimination and victimization because they fell outside of the

"norm" with regards to their sexual orientation. They were viewed as unusual, sexual

deviants, and disconnected from the majority of those around whom they lived (Hughes,

2006). In an effort to gain the same rights and treatment as those who identified as

heterosexual or "normal" in the eyes of others, a portion of the LGBT population became

active in the gay rights movement in the late 60s. Despite this involvement, identifying as

LGBT remained a stigmatized identity, and subsequently, many older LGBT adults still

remain fearful of discrimination, particularly those who enter long-term care (LTC)

facilities.

As age increases, so does the chance of requiring additional care due to chronic or

acute illnesses (Upshall, 2006). LGBT individuals face greater chances of such illnesses.

Due to living in environments that paint them as "abnormal" and "different"', they also

suffer from more mental illness than heterosexual individuals of similar ages (Butler,

2004; Cochran, Sullivan, & Mays, 2003; Fredriksen-Goldsen, Kim, Elmlet, Muraco,

Erosheva, Hoy-Ellis, …& Petry, 2011; Koh & Ross, 2006).

In the past, older adults relied heavily on family members for everyday care.

Today, changing factors within Canadian families may prevent loved ones from having

the resources to do so. For some older LGBT adults, accessing support from family

members is not an option, as they no longer have contact with their families of origin and

may not have children to rely on in times of need (Barranti & Cohen, 2000; Grant,

Koskovich, Frazer, & Bjerk, 2009; Grossman, D'Augelli, & Hershberger, 2000;

Grossman, D'Augelli, & O'Connell, 2002).

Furthermore, due to the fact that private care and homecare is neither fully

covered by Canada's Health Act nor covered under provincial health care policy, one of

the only options for older LGBT individuals may be public, 24-hour LTC (Health

Canada, 2011). Not being able to afford alternative forms of care means that older adults

have to rely on Nova Scotia's facility-based LTC system for their needs, creating an

additional strain on this already-burdened system (Canadian Institute for Health

Information, 2011). There are so many older adults requesting a bed in a LTC facility that

these facilities often have long lists of individuals waiting for a bed (Nova Scotia

Government, 2011a).

Once a bed becomes available in an appropriate LTC facility, entering the facility

might become a challenge for an LGBT individual as a result of the potentially hostile

environments with which they may soon interact. Many older LGBT adults residing in

care experience discrimination based on their sexual orientation from both staff and

residents (Brotman et al., 2007; Cahill & South, 2002; Fredriksen-Goldsen et al., 2011;

Hinrichs & Vacha-Haase, 2010; LGBT Movement Advancement Project & Sage, 2010).

They retreat to hiding part of their identity to avoid such consequences (Cahill & South,

2002; Cook-Daniels, 1998; Rosenfeld, 1999; Stein at al., 2010), which, in turn,

negatively affects their mental and emotional well-being (Brotman et al., 2007).

The reality of living in LTC is often perceived as a negative and overbearing

necessary move for older LGBT individuals (Brotman et al., 2007; Jackson, Johnson &

Roberts, 2008; Johnson, Jackson, Arnette, & Koffman, 2005; Porter, Russell & Sullivan, 2003; LGBT Movement Advancement Project & SAGE, 2010; Stein et al., 2010). Much of the literature about LGBT individuals in care is American-based, and no Canadian research has specifically looked at LGBT individuals' first hand experiences in Canadian LTC facilities. Decision-makers must better understand the subjective realities of older LGBT adults living in Canadian LTC facilities to ensure their health and well-being. My research question is: What is the experience of living in LTC like for people who identify as LGBT, from the perspective of residents and stakeholders?

In Chapter 2, the literature on LTC care in Canada, the experience of aging for older LGBT individuals, and LGBT individuals entering LTC is examined. I describe the theoretical frameworks (ecological, minority stress, and intersectionality theories) in Chapter 3. In the fourth chapter, which focuses on methodology, covering issues such as sampling, data collection, data analysis, and ethical issues. Chapter 5 presents the results, which are analyzed using the theoretical frameworks. The final chapter discusses the findings and draws conclusions about what types of strategies and practices can be used to maximize the quality of life for the future of all older LGBT individuals residing in LTC.

CHAPTER 2: LITERATURE REVIEW

This literature review focuses on LTC, with an in-depth look at the changes that have taken place in LTC, and the experience of entering, and living in LTC. The experience of aging for older LGBT adults will then be examined. Topics in this section include relevant historical contexts, LGBT health and well-being, mechanisms LGBT individuals use to cope with life stressors, and the types of support available to them. The final section focuses on being LGBT in LTC, examining their experiences with health-care practitioners, thoughts and fears regarding LTC, and actual experiences of living in LTC.

Long-Term Care

Due to the increasing health needs of older adults in Canada (such as increased rates of diabetes, heart disease, high blood pressure, mental health issues, and dementia), there has been an increase in the usage of facility-based LTC, subsequently increasing the demand for more LTC beds (Canadian Institute for Health Information, 2011; Canadian Union of Public Employees, 2009). In this section, I discuss Canada's changing family context, recent changes in Canada's LTC system, and the experience of living in LTC. This will help create a better understanding of the environments in which LGBT residents grew up, and what experiences they may have had.

Canada's Changing Family Context

One major change that has occurred over the past few decades is that older members are living longer. The average life expectancy of individuals in Canada increased from an average of 72.5 years in 1970 to 81 years in 2007 (Statistics Canada, 2012b). Reasons for this increase include greater access to healthcare, a better

understanding of disease, improvements in diagnosing ailments, and more health-conscious living (Rosenthal, 1997).

It was estimated that the number of Canadians over the age of 65 is expected to be 10.4 million by 2036 (Statistics Canada, 2010a). Nova Scotia has the highest percentage of seniors than any other province in Canada, totalling 16.5% of its population in 2011 (Statistics Canada, 2012a). By 2036, that number is expected to rise to 28.6%—over a quarter of the total provincial population. Considering this high population of seniors and the fact that chances of illness increase with age, Nova Scotia is confronted with a need to prepare for this development. This preparation needs to happen both in terms of the services that the province offers and in research that would help increase the general knowledge regarding the needs of this large population. Learning how to best care for all older adults must include minorities who may face greater challenges than others (Statistics Canada, 2010a).

The increased likelihood of having a parent alive has created a "sandwich generation" in which middle-aged adults are faced with task of caring for both their younger children and older parents (Rosenthal, 1997). Exacerbating this challenge is the fact that many families are now considered to be "beanpole families". These families often have fewer children, and as a result of increased life expectancy, they are also likely to include seniors (Bengtson, Rosenthal, & Burton, 1996). Divorce trends have also been increasing, meaning some older adults do not have a partner on which they can rely in times of poorer health (Statistics Canada, 2012a). This leaves fewer people available to care for the older generations and thus a gap in unpaid care (Rosenthal, 1997).

Another factor is that many people now have to relocate for jobs (Carrière, Keefe,

Légare, Lin, & Rowe, 2007). As unemployment rates have risen in Canada, individuals

are now forced to make the difficult decision to move away from their families to

increase their chances of earning a steady income (Carrière et al., 2007). Additionally,

women who have traditionally done and continue to do most of the caregiving (Pyper,

2006), are now often working full-time jobs, which means they no longer have the time

and resources to spend caring for their aging family members (Carrière et al., 2007). This

trend also contributes to the issue of older adults having less access to unpaid care,

increasing their need to access this care elsewhere.

Changes in Long-Term Care

Individuals who are responsible for the care of dependent family members may

seek help outside the family. Within this continuum of care, older adults can choose to

access many different services. These services include self-managed care, assisted living

facilities, residential-care facilities, enriched-housing projects, palliative/hospice care,

and home care. Some of these services are not covered by the province (e.g., assisted

living facilities). Others offer a lower level of care for those whose health does not

warrant 24-hour care (e.g., self-managed care, assisted living facilities, and home care)

(Nova Scotia Government, 2013; McNabney, Willging, Fried, & Durso, 2009). Also

included in this context of care is facility-based LTC (nursing homes), which provides

medical and social services to those unable to care for themselves (Health Canada, 2004).

As a result of the large population of older adults now living longer and requiring

care outside of the home, major changes have occurred within the context of facility-

based LTC (Calkins, 2002; Keefe, Standnyk, White, & Fancey, 2009; Rahman &

Schnelle, 2008; Wiersma & Pedlar, 2008). First, many homes have begun to approach the

care of their residents from a resident-centered perspective. Previously, tasks were staff-focused, placing greater importance on the time and efficiency of workers rather than the residents of the home (Calkins, 2002). In a resident-focused approach, emphasis is placed on "resident choice, autonomy and dignity, and encourages increased social interaction both among residents, and between residents and staff" (Keefe et al., 2009, p. 2). Using this approach also means having a focus on strengthening the relationship between family members of the resident and the staff members involved in the resident's care (Keefe et al., 2009). Strengthening such relationships allows the care of the resident to be team-based and inclusive, providing a basis for knowledge dissemination among all those involved in the care (Keefe et al., 2009).

Before this person-centered shift took place, many of the tasks carried out by staff were not necessarily done with the priority of the resident in mind. This sometimes meant that residents had little choice when it came to what they did and when. It also meant that many residents only had access to a limited number of activities that they enjoyed (Haran, 2006). Shifting these activities to reflect the desires and needs of the individuals living in the home means that the facility acknowledges the diversity of its residents. This change has occurred in Nova Scotia, which could mean moving towards more culturally-sensitive care. This might create a more open and accepting dialogue between LTC staff and residents who identify as being a sexual minority, which may positively impact their experience receiving facility-based care. Whether this changed has positively impacted older LGBT residents specifically is unknown.

LTC is not free for Canadians; accommodation fees are expected to be paid for by residents (Nova Scotia Government, 2012). Depending on which province a person

resides, an individual is subject to one of three models of policies regarding personal

financial contribution. The *daily-rate model* provides a daily rate for room and board,

which is determined by the individual's income or available finances. In this model, a

comfort allowance is also included for the individual's personal items (Stadnyk, 2002).

The *income-based model* provides a daily rate for room and board, and it is determined

and adjusted based on a person's income (Stadnyk, 2002). *The income/asset-based model*

provides a daily rate for room and board, and care costs are determined by nursing homes

and government agencies. In this third model, if a resident can afford to pay for their own

room and board in full, they are required to do so (up to $160/day) and in order to assess

whether or not the individual can afford to do so, their income and assets are examined

(Stadnyk, 2002). If they are unable to pay, they can then apply for a subsidy (Stadnyk,

2002). Nova Scotia falls under the third model, which means that individuals wishing to

move into LTC to meet their healthcare needs will have their finances examined to

determine how much they are required to pay for their care. As will be noted later, older

LGBT adults often face greater financial challenges than their heterosexual cohorts,

making it important to understand how differences in care facilities impact their

experience living within it (Gillow & Davis, 1987; Grant, 2009).

Despite being able to choose which nursing home in which to reside, the major

influx of older adults requesting a LTC bed means many will have a long wait-time

before a space becomes available. The wait-time in Nova Scotia is estimated to be

between 86 and 154 days (Nova Scotia Government, 2011a). Prospective residents are

only allowed to reject the first bed available at a facility for up to three months

(prideHealth, 2009). After this, their care coordinator may withdraw their application and

put them at the bottom of the list once again (prideHealth, 2009). Individuals may feel

pressured to choose whichever LTC facility first has a bed available instead of holding

out for their first choice. Complete freedom in choosing the best fit for a home, thus, does

not exist.

Entering and Living in Long-Term Care

In 2008-2009, 0.7% of Nova Scotia's population resided in LTC (Organization

for Economic Co-operation and Development, 2011). This number is expected to go up

as the population ages, which increases the chances of individuals requiring care (OECD,

2011). It is not simply the age of a person, however, that affects their chances of

requiring facility-based care. Other factors come into play.

Health status plays an important role. Having some form of physical or cognitive

impairment, and/or chronic or acute medical condition predicts entry into nursing home

care (Freedman, Berkman, Rapp, & Ostfeld, 1994; Osterweil, Martin, & Syndulko,

1995). The strongest predictor related to health status is a lack of ability to perform

activities of daily living (ADLs) (Keefe et al., 2009; Osterweil et al., 1995). Not being

able to perform daily tasks such as brushing one's own teeth, preparing meals, and

changing in and out of clothes create a need for 24-hour care.

Certain demographic characteristics are also related to the increased access of

LTC services. These characteristics are being female, being older, being unmarried,

living alone, being Caucasian, and having a lower income (Osterweil et al., 1995).

Although the gender gap is closing, women have traditionally lived longer than men,

resulting in greater use of LTC. Being unmarried and/or living alone is positively

associated with accessing paid services such as home and LTC (Grabbe, Demi,

Whittington, Jones, Branch, & Lambert, 1995). Not having a partner or family members

available to provide care means one has to rely more greatly on alternative forms of

receiving care, and if the individual's needs are great enough, it might contribute to their

admittance into a LTC facility (Choi, 1994). Those who are childless or living at a

relatively great geographical distance from their living children also show a greater

chance of entering LTC, as they too require care beyond their personal abilities (Choi,

1994).

Individuals who identify as LGBT have an increased chance of certain risk

factors. Some of these risk factors are having health issues, living alone, being childless,

having reduced access to one's given family, and having a lower income (Abatiell &

Adams, 2011; Barranti & Cohen, 2000; Butler, 2004; Fredriksen-Goldsen et al., 2011;

Grant, 2009; Grossman et al., 2000; Grossman et al., 2002). As a result, some LGBT

adults with health issues may have little other choice than to access facility-based LTC.

Exploring the experience of entering LTC for older LGBT adults from their perspective

is vital to make such an experience as positive as possible.

Although entering a LTC facility means that the basic needs of older adults are

adequately met, achieving a positive quality of life requires much more than this.

Assessing the quality of life of any individual is a complex task, making the discovery of

what factors are associated with quality of life a challenge. Some researchers have

attempted to do so and have highlighted factors associated with quality of life. Having

meaningful relationships, being respected by the staff of the nursing home, feeling safe

and secure (Hjaltadottir & Gustafsdottir, 2007; Kane et al., 2002), and having one's

unique identity recognized (Hjaltadottir & Gustafsdottir, 2007; Kane et al., 2002;

Robichaud et al., 2006) were found to be important. Having one's identity recognized and valued may be more difficult for older LGBT adults, especially for those who choose to hide part of their identity from others (Cahill & South, 2002; Rosenfeld, 1999; Stein et al., 2010).

A qualitative study that examined the experiences of residents in LTC and their family members in Canada found many indicators of resident quality of life (Robichaud et al., 2006). In this research, residents felt it was important to feel as though "they are still alive, growing, and part of community life" (p. 249), and family members felt that their loved ones' environments impacted their experience while living there. LTC residents also reported feeling concerned about not being treated with respect by those living and working around them. In addition, feeling autonomous played a major role in determining the resident's quality of life.

These factors may be managed with some of the new care facilities in Nova Scotia that are actively aiming to improve relationships between staff and residents. They are doing so by fostering autonomy and individuality, which provides the residents with opportunities with others. This also works to create a home-like and comfortable environment in which they can live (Robichaud et al., 2006). These steps are important when considering the possibility that older LGBT individuals may encounter difficulties in having relationships due to their fear of discrimination. Fostering autonomy and individuality will help connections be made with others (Stein et al., 2010; Brotman et al., 2007, Johnson et al., 2005; LGBT Movement Advancement Project & SAGE, 2010). No research has explored the effect of living within these care facilities in Nova Scotia from the perspective of those who identify as LGBT or concerned stakeholders.

When living in LTC, psychological health is an important factor in maintaining a good quality of life. Unfortunately, it has been noted that between 15 to 45% of LTC residents suffer from severe depression, while an additional 25% suffer from mild depression (Conn, 2002; Canadian Institute for Health Information, 2010). Although it is unclear whether these individuals were suffering from depression before their entrance into LTC, a high portion of those in LTC are experiencing mental health issues. Without any help in addressing these psychological issues, those with mild depression may see their symptoms worsen, warranting an urgent need for psychological intervention (Conn, 2002).

Compared to average rates of depression among seniors in Canada (2 to 4%), living in LTC correlated with negative psychological health (Upshall, 2006). Although some may have entered LTC with these mental health issues, exploring what might account for such high numbers of mental illness in facility-based care for those who did not helps researchers and decision-makers better understand why these disorders are present. For new residents, it may be the first time they have had to receive 24-hour care from strangers. This 24-hour care often includes having to accept help while bathing, using the washroom, eating, and performing other ADLs required to maintain a good quality of life. In addition, the unfamiliarity of the facility can be a source of anxiety, as some of the residents have moved from their home communities to an new environment and become geographically distanced from their family and friends. For those who identify as LGBT, it may also be a challenge to share all parts of their identity to others in the home, contributing to their risk of developing mental health issues (Hall & Havens, 2002), though little research has explored this.

To buffer the difficult transition into facility-based care, staff must be well-trained and prepared to encounter residents who might have trouble settling into their new home. A major research study headed by the Canadian Union of Public Employees found that having respectful staff was most important in determining the quality of life of the residents in LTC facilities (Canadian Union of Public Employees, 2009). As mentioned, residents in LTC facilities today have significantly greater health-related needs than individuals living there 15 years ago. Funding in some of these facilities has been inadequate leading to care that reflects that inadequacy (Canadian Union of Public Employees, 2009). Having overworked staff as a result of this lack of funding negatively affects the behaviours and moods of the residents for whom they care (McGregor et al., 2011). No longer are many of them able to work at a relaxed pace due to having to rush to be able to care for many other residents (McGregor et al., 2011).

Much of the existing research has focused on staff and family perceptions, or simply observation in order to gain an understanding of the residents' experiences. A more in-depth look at first-hand experience alongside the insights of others (E.g., LTC staff members and other stakeholders) is therefore necessary in order to better the transition into and living within care facilities, particularly for those who may encounter greater challenges, especially older people who identify as LGBT.

Experience of Aging for Older LGBT Adults

Considering prejudice still exists on the basis of sexual orientation and that older LGBT adults may encounter discrimination depending on their identity, they may face challenges throughout the aging process. This section of the literature review explores the historical context in which LGBT individuals grew up, their health and well-being, as

well as differences in their support systems when compared to heterosexual individuals of

similar ages. Some literature exists on the subject of older LGBT individuals, but the

numbers of published studies are relatively low and major gaps exist (Brown, 2009;

Christian & Keefe, 1997; Grant, 2009). Moreover, most of the research is American

(note: research reviewed in this section is American unless otherwise noted).

Although much of the literature seems to extend the conclusions of the studies to

all LGBT individuals, few studies have actually included bisexual and transgender

individuals, thus leaving their voices silenced (Grant, 2009). Some research also

unnecessarily generalizes all of the lived experiences of lesbian, gay, bisexual, and

transgender individuals, presuming that all sexual and gender minorities experience aging

in the same way, which is an unwarranted assumption (Grant, 2009). This can, in itself,

create issues in attempting to meet each of these groups' needs (Grant, 2009).

Historical Context

Much of the research relating to older LGBT individuals has suggested that sexual

and gender minorities have often been invisible in society (Brown, 2009; Butler, 2004;

Christian & Keefe, 1997; Esterberg, 1997; Grant, 2009; Kochman, 1997). Many LGBT

individuals grew up before the gay rights movements and were "labeled as sick by

doctors, unfit by the military, immoral by the clergy, and a menace by the police"

(Kochman, 1997, p. 2). This experience may have prompted them to use "invisibility",

hiding part of their identity, as a coping mechanism to avoid such judgment. Despite this

there have been many improvements with regards to the protection and inclusion of

LGBT individuals in society as marked by major LGBT-positive Canadian events. These

improvements provide create a very different environment with which to interact than

before these positive events took place.

In Canada, it was only in 1969, the same year the Stonewall Riots occurred in New York City, that homosexual acts were decriminalized for consenting adults over 21 (Canadian Lesbian & Gay Archives, 2010). This meant that for the first time they were legally able to have sexual relations with the person or people they choose. The next positive step towards acceptance occurred in 1973, when homosexuality was removed from the Diagnostic and Statistical Manual of Mental Disorders (DSM III). This change resulted in non-heterosexual sexual orientations no longer being diagnosed as disordered behaviour requiring psychological intervention (Canadian Lesbian & Gay Archives, 2010). Both of these events began to challenge the pervasive *homophobia* (the irrational fear of homosexuals based solely on their sexual orientation), *transphobia* (the irrational fear of transgender individuals based solely on their gender orientation) and *heterosexism* (discrimination or prejudice against homosexuals on the assumption that heterosexuality is the norm) existing in Canada. However, a major protective shield against discriminatory actions came in 1982 when the Canadian Charter of Rights and Freedoms guaranteed the "right to equal protection and equal benefit of the law without discrimination" (Department of Justice Canada, 1982, section 15). The Charter of Rights and Freedoms does not explicitly list "gender identity" in its text.

Another step in a positive direction for LGBT individuals occurred in 1992, when the ban on homosexuals in the Canadian Forces was lifted, allowing them to work in the military alongside heterosexual individuals (Canadian Lesbian & Gay Archives, 2010). Not only did it give them equal employment opportunity in this federal sector, but it also emphasized the fact that being LGBT in no way impacted one's ability to serve and

protect one's country (Canadian Lesbian & Gay Archives, 2010). Finally, Canada

became the fourth country in the world to officially sanction same-sex marriages in 2005,

providing equal spousal rights by recognizing the partnership by law (Canadian Lesbian

& Gay Archives, 2010).

Within the Canadian provinces there are different provincial policies in place to

protect citizens from discrimination, and the focus here will be on Nova Scotian policies.

Nova Scotia's Human Rights Code provides legal protection from discrimination by

affirming that public agencies and people in the province have a responsibility to ensure

that each person in the province is afforded their basic and fundamental human rights,

which includes being free from discrimination (Nova Scotia Government, 2011b). This

code explicitly states, in Section 5.1, that discrimination is prohibited on account of

sexual orientation, gender identity, and gender expression. If discrimination were to

occur, complaints can be made to the Nova Scotia Human Rights Commission, which

would then attempt to resolve the issue either through mediation, restorative measures, or

court (Nova Scotia Government, 2011b).

A different provincial policy that works towards protecting individuals from

discrimination is the Adult Protection Act. This legislation provides a means for adults

who cannot care for him or herself to be protected from abuse or neglect (Nova Scotia

Legislature, 1998). If a person was to encounter discrimination, the director of the Adult

Protection office would then be responsible for bringing the issue to court, as well as

providing a new safe environment for the person in which to live (Nova Scotia

Legislature, 1998).

When Nova Scotia's provincial Health Council was tasked with developing a

policy around the rights of LTC residents, the council concluded that it would pose too many legal problems that would take too long to resolve through the courts (Smith, 2002). Instead, there were expectations created that relate to the provision of health care, which outlined that LTC residents in the province should expect to be provided with services that respected values, culture, religion, and individual ability, and were free from abuse, neglect, and prejudice (Smith, 2002). These are simply promises that are not attached to the legal system, thus lacking any tangible penalty if a facility was to fail to meet those expectations (Smith, 2002).

Despite these important steps in achieving equal rights, many LGBT individuals still face discrimination based on their sexual orientation. Homophobia and heterosexism continue to exist and changes still need to be made in order to improve the overall social status of sexual and gender minorities (Butler, 2004; Dean, 2000; Fredriksen-Goldsen et al., 2011; Kochman, 1997; Van Wormer, Wells, & Boes, 2000). Given that LGBT elders not only have to deal with ageism but also with homophobia/heterosexism, they face a "double jeopardy" of discrimination (Butler, 2004). If these individuals are women and/or an ethnic minority, they may instead face a triple or quadruple jeopardy of discrimination. Having to deal with discrimination can have a major effect on the health and well-being of those discriminated against, which may in turn increase their chances of requiring 24-hour care in the future. Reviewing research on the overall health and well-being of LGBT individuals will aid in contextualizing their lives, and help guide future research.

Health and Well-Being

Many researchers and academics use the theory of "successful aging" to help

frame how good or bad a person's health is. This research also uses this concept as a way

to understand the health of LGBT individuals. Successful aging is defined as "low

probability of disease and disease-related disability, high cognitive and physical

functional capacity, and active engagement with life" (Rowe & Kahn, 1997, p. 433).

Though this concept has been widely promoted in the gerontological world, there have

been some recent critiques of the concept. For example, Dillaway and Byrnes (2009)

suggest there needs to be a shift towards a broader conceptualization of successful aging,

especially with regards to minorities, as the concept has been historically based on the

aging experiences of dominant societal groups. One might not need to be free from

disease and be fully active/productive in order to "age successfully", but instead, such a

process may be different for each individual based on their unique experiences (Dillaway

& Byrnes, 2009). Despite these critiques, however, aging successfully remains a widely

desired process to be involved in as an older adult; a process that may be denied to or

challenging to achieve for LGBT adults.

　　　　Health is traditionally defined as the absence of disease. When discussing health,

LGBT individuals may place a greater emphasis on the acceptance of one's self

(Brotman, Ryan, Jalbert, & Rowe, 2002). In other words, a shift away from the medical

model's definition of health seems to be taking place, as noted by Murray, Numer,

Merrit, Gahagan, and Comber (2011). Murray et al. (2011) also note that although

sexuality is known to have an effect on the health of an individual, it is often left out of

conversations related to health policies in Canada (Karlen & Maglia, 1995; Lindau,

Schumm, Laumann, Levinson, O'Muircheartaigh, & Waite, 2007). The participants of

one of the few notable and related Canadian studies defined health as incorporating "the

physical, psychological, emotional, social, and spiritual components that contribute to health and well-being" (Brotman et al., 2002, p. 86). This definition allows the incorporation of "issues such as coming out, locating community and managing oppression" to be included in the definition of health, as having a marginalized status can affect the health of LGBT individuals (Brotman et al., 2002, p. 86). These health issues arise not because the individual who identifies as LGBT is inherently sick by identifying as a sexual or gender minority, but because of a lack of supportive environments (Murray et al., 2011; Oswald & Masciadrelli, 2008). Despite these negative health outcomes, LGBT older adults may actually be better equipped to cope with these environmental challenges. This will be discussed in greater detail further in the chapter.

Successful aging and good health may be difficult to achieve due to the fact that many North American older LGBT individuals have had to face discrimination throughout the process of growing older (Butler, 2004; Dean, 2000; Kochman, 1997; Van Wormer et al., 2000). A study of 2,500 LGBT older adults found that 82% had been victimized at least once because of their perceived sexual orientation or gender identity and 64% of them had been victimized three or more times (Fredriksen-Goldsen et al., 2011). In Canada, 13% of all hate crimes in 2009 were motivated by sexual orientation (Statistics Canada, 2010b), with 74% of them violent in nature. The number of violent crimes motivated by sexual orientation was higher than those motivated by race/ethnicity (39%) or religion (21%) (Statistics Canada, 2010b). Not surprisingly, having such experiences can negatively impact the experience of aging for any individual, creating additional challenges in aging successfully while remaining in good health.

Experiencing discrimination or victimization has been linked to poor emotional

health issues such as depression, anxiety, and substance abuse (Butler, 2004; Fredriksen-Goldsen et al., 2011; Murnane, Smith, Crompton, Snow, & Munro, 2000). It also increases the frequency of feelings of loneliness, isolation, stress, and has been linked to suicidal thoughts and attempts (Fredriksen-Goldsen et al., 2011). Two in five older LGBT respondents reported that they had contemplated suicide at some point in their life, bringing to light the severity of these negative feelings for some individuals (Fredrikson-Goldsen et al., 2011). In the same study, 31% of respondents had reported symptoms of depression, 53% reported feelings of loneliness, and transgender older adults reported higher rates of loneliness and depression than their LGB peers (Fredriksen-Goldsen et al., 2011). This might be because transgender individuals have increased rates of disability, and often have smaller support networks available to them to buffer negative emotional feelings (Fredriksen-Goldsen et al., 2011). These consequences may also be due to the possibility that they are often misrepresented (or not represented at all) in media and the social world, leading to stronger and more frequent feelings of loneliness and depression (Fredriksen-Goldsen et al., 2011).

For those who identify as LGBT, additional challenges may be related to issues with substance abuse. Older lesbian adults experience a higher incidence of alcoholism, use of tobacco products, depression, and suicide attempts than the general heterosexual population (Murnane et al., 2000). Alcoholism may be high in sexual and gender minorities due to the possibility that they may feel gay bars make up the few places that provide feelings of belonging and security, as suggested by existing research (Cheng, 2003).

HIV positive gay and bisexual men experience even greater frequencies of

loneliness, isolation, and depression than the rest of their LGBT peers (Meris, 2002; Nokes, Chew, & Altman, 2003; Speer, Kennedy, Watson, Meah, Nichols, & Watson, 1999). Many of the men depicted with HIV/AIDS in LGBT magazines are young and attractive, which glamorizes the disease while simultaneously feeding into ageism already prevalent in gay male society (Brown, 2009; Dean, 2000). This is a vast misrepresentation of those who suffer with HIV/AIDS as it has been estimated that over half of the more than 1.1 million Americans living with AIDS will be 50 or older in 2015 (Fredriksen-Goldsen et al., 2011). Having HIV/AIDS at a later age may increase an individual's health needs, which may then warrant a higher level of care (Irving, Bor, & Catalan, 1995; Nakagawa et al., 2012). For some, 24-hour facility-based care is the most viable option. LTC facilities must thus prepare for the possibility of having to care for individuals with the disease.

LGBT individuals have higher rates of physical or disability. Due to their minority status, LGBT individuals may also see an increase in their risk of stroke, coronary heart disease, and lung cancer, thereby increasing the chances of requiring extra care in the future (Murray et al., 2011). Lesbians specifically have a greater risk of breast, ovarian, and colon cancer (Murray et al., 2011). Gay men also have specific physical health challenges, including gastrointestinal and sexually transmitted infections, as well as an increased chance of colon, anal, and hepatocellular cancer (Murray et al., 2011).

Older bisexual individuals have reported a lack of acceptance from both heterosexual groups and those who identify as lesbian, gay, and transgender, which often contributing to higher levels of stress than their lesbian and gay peers (Fredriksen-Goldsen et al., 2011). Understanding the role that social isolation plays a role in the

experience of growing older within different environments, including LTC, for the bisexual individuals is important. Very little research has examined the effects of the differences in health and well-being during the aging process (that is, of the previous environments that have affected experiences) for those who identify as bisexual within the context of LTC.

Transgender individuals, if involved in hormone treatments, see a greater risk for diabetes, heart disease, and liver problems (Blank, Asencio, Descartes, & Griggs, 2009). In one study, 62% of transgender older adults reported having a disability compared to 53% of lesbians, 51% of bisexual women, and 41% of gay men (Fredriksen-Goldsen et al., 2011). Only 12% of the general population are disabled (Fredriksen-Goldsen et al., 2011). Transgender individuals have an even greater rate of disability than those who identified as LGB, leading to the potential of facing greater challenges in later life (Fredriksen-Goldsen et al., 2011). This particular study was strong in its participant diversity, as it included a large number of participants: 2,560 lesbian, gay, bisexual, and transgender adults aged 50-95, with diversity in socioeconomic status, sexual and gender identity, and overall demographics (Fredriksen-Goldsen et al., 2011).

Coping Mechanisms

Developing coping mechanisms is imperative in preserving overall well-being for any individual, especially those who may face greater health challenges than others. Some ways LGBT individuals cope involve hiding part of one's identity (protective coping), reacting aggressively to discrimination (confrontational coping), simply ignoring discriminatory or derogatory comments (passive coping), or abusing substances (Nadal, Wong, Issa, Meterko, Leon, & Wideman, 2011). Unfortunately, many of these common

coping mechanisms prove to be ineffective in the long-term (Fredriksen-Goldsen et al., 2011).

Nevertheless, despite the challenging realities in the lives of some LGBT older adults, some researchers have found that gay men and lesbians may be better equipped to accept the process of aging compared to heterosexual individuals of similar ages (Adelman, 1990; Sharp, 1997; Quam & Whitford, 1992). One reason for this is related to the possibility that coming to accept one's LGBT identity (which is a continuous process) may aid overall self-acceptance. Some studies have validated this by finding a connection between being "out of the closet" and having higher life satisfaction and self-esteem (Adelman, 1990; D'Augelli & Grossman, 2001; Grossman, D'Augelli, & Hershberger, 2000; Grossman, D'Augelli, & O'Connell, 2002; Lee, 1987; Sharp, 1997). Building on this finding, other researchers found that the adjustment to aging for lesbians was linked to the successful management of their lesbian identity (Sharp, 1997). Having an ability to be critical of mainstream gender roles and stereotypes and having more inclusive criteria of what makes a person "beautiful" was also important (Thompson, Brown, Cassidy, & Gentry, 1999). In one study, older lesbian individuals felt more accepted than gay men in LGBT-related events and reported viewing aging more positively than gay males (Schope, 2005).

Another factor connected with the acceptance of the aging process for those who identify as LGBT is having an interest in spirituality (Quam & Whitford, 1992). Many LGBT older adults have reported developing their spirituality as a result of the stressors that come with being LGBT, providing them with another way in which they can cope with challenges throughout their lifetime (Quam & Whitford, 1992). This has provided an

outlet for worries that might otherwise create a great amount of stress and responsibility,

thus buffering any stressors they do encounter (Quam & Whitford, 1992).

In addition to focusing on spirituality, some older LGBT adults have developed

financial plans to better deal with potential economic challenges that come with the

process of growing old, as suggested by research findings suggesting that a higher

percentage of LGBT boomers have completed living wills, health care proxies, rights to

visitation and partnership agreements than compared to the general population (Myers &

Tucker, 2011; Quam & Whitford, 1992). Although this study was not representative of all

LGBT older adults, completing such documents may also help prepare to enter a LTC

facility.

LGBT older adults have developed coping mechanisms that help them handle

potential challenges they may face, but no research has focused specifically on examining

the coping mechanisms developed by this population of older adults in LTC. This leaves

a gap in the knowledge in how this group of individuals experience living within their

new home while accessing the care they require.

Support

Support is important to aging in a healthy way. Support consists of community

involvement/resources and a strong support network (Jones & Nystrom, 2002; Quam &

Whitford, 1992). One major contributing factor to LGBT life satisfaction and successful

aging is having a strong support network (Brown, 2009; Esterberg, 1997). A support

network is defined as "family, friends, romantic partners, pets, community ties, and

coworkers" who provide some form of support for an individual (Taylor, 2011, p. 189).

The source of this support can be informal (e.g., family and friends) or more formal (e.g.,

healthcare workers and community organizations (Taylor, 2011).

An important factor associated with aging positively involves the amount of support received from one's local community. Community is defined as a "group of people with diverse characteristics who are linked by social ties, share common perspectives, and engage in joint action in geographical locations or settings" (MacQueen et al., 2001, p. 1936). This makes it imperative that more organizations improve their ability to support the unique needs of older LGBT adults more broadly and broaden their accessibility to those in smaller cities and rural areas so that everyone gets the support they need (Beeler, Rawls, Herdt, & Cohler, 1999; Galassi, 1991; Nystrom & Jones, 2003; Orel, 2004; van de Ven, Rodden, Crawford, & Kippax, 1997).

Not every LGBT individual may truly feel as though they have a gay community in which they feel they belong, and some researchers have suggested that this community may instead be "imagined" and over-emphasized in research (Anderson, 1991). "Community" has been widely accepted as a means of support for individuals who have commonalities and shared interests, but often those who consider them a part of this community never actually meet each other. This further reduces the type of support to which LGBT individuals may have real access (Anderson, 1991).

Gay bars may provide some support for older LGBT adults, but being accepted even there may be a challenge, especially for gay men. Gay men in particular seem to face greater challenges with acceptance in the gay community as a result of gay society's alternate view of older gay men (Schope, 2005). Older gay men seem to be viewed in a negative light, making it difficult them to maintain a positive self-image (Schope, 2005). Linked to this is one finding that gay men consider "old" to begin at age 39, making the

"struggle against ageism" begin much earlier than the average older adult (Schope, 2005, p. 34).

LGBT older adults may find solace in their local gay community. Unfortunately, few organizations strive to meet the needs of LGBT elders. Those that do exist are often only located in large cities (such as SAGE- Service and Advocacy for Gay, Lesbian, and Transgender Elders, located in major cities in Canada and the US), which means that individuals living in rural areas may not have access to such support (Smith & Calvert, 2001). This type of support is important, and many older adults have indicated that they became comfortable with their own identity as a result of their local LGBT community (Orel, 2004). Older men have an especially strong attachment to the gay community, which allows them access to a network of individuals from which they can receive support (van de Ven et al., 1997). Only 8% of women in a study of 160 Chicago lesbians over the age of 51 were highly involved in their gay community (Beeler et al., 1999), contributing to a lack of cross-generational relationships between the members of these communities, and a gap in the support to which they might otherwise have access (Galassi, 1991). Having programs that are not sensitive to the needs of this particularly vulnerable group of older individuals may allow for many of them to be strained financially, further increasing their risk of mental health issues and poverty (Butler, 2004; Grant, 2009; Heaphy, Yip, & Thompson, 2004). Despite this concerning possibility, very little research has focused on how lack of support affects the experience of living within LTC for older LGBT adults.

Some existing research suggests that many LGBT older adults have reduced access to their given family members (Barranti & Cohen, 2000; Grant, 2009; Grossman

et al., 2000; Grossman et al., 2002), yet research has indicated that they are not always isolated and have various means of support available to them (Beeler et al., 1999; Whalen, Bigner, & Barber, 2000; Grossman et al., 2000; 2001; Jacobs, Rasmussen, & Hohman, 1999; Orel, 2004). Support can include partners, friends, some members of their family of origin, and the larger community (Brown, Alley, Sarosy, Quarto, & Cook, 2001; Whitford, 1997). Having these support networks may in turn enable individuals to age at home rather than in a facility (Van Houtven & Norton, 2004).

Friends play a crucial role in allowing older LGBT adults to age in a healthy manner; they are often referred to as *families of choice* or *fictive kin*. This terminology indicates that individuals who identify as LGBT have created their own perceived family networks despite the possibility of not being close with their families of origin (Beeler et al., 1999; Grossman et al., 2000, 2001; Heaphy et al., 2004). Highlighting this is a British study that suggested only 9% of LGBT elders would look to their relatives for support. This study, however, was a study done in the UK, only used a small number of participants, and did not include transgender individuals (Heaphy et al., 2004). In one study consisting of 26 LGB elders, 68% had "chosen families" (Orel, 2004). These "chosen families" mostly consisted mostly of friends, and provided a major means of emotional support to their loved one (Grossman et al., 2000, 2001; Heaphy et al., 2004). These families average six individuals, which is around the same number of people in many heterosexual individuals' family of origin (Grossman et al., 2000, 2001; Heaphy et al., 2004). In another study, 89% of older gay and lesbian respondents indicated that they had at least three friends that they could turn to in case of a serious problem (Beeler et al., 1999). These "chosen families" may then replace the support that they may have received

from their families of origin.

Older LGBT individuals may not only have a wealth of friends' support available to them, but also have that of their partner, as most older gay men and lesbians have indicated that they are in intimate relationships in their later life (Pope & Schulz, 1990; van de Ven et al., 1997). This may not be the reality for all LGBT individuals, however. Regardless, having a partner as a LGBT individual is associated with a higher physical and mental well-being compared to those living alone, emphasizing the importance of receiving this type of social support. This is especially important for older LGBT individuals who may require more social support as a result of their increased risk for mental and physical health issues due to the "sick" environments with which they interact (Grossman et al., 2000, 2001).

Healthy aging for sexual and gender minorities may be even more difficult to achieve as they often have lower incomes compared to heterosexual individuals (Grant, 2009). Gay men have been shown to earn between 15-25% less than straight men, reducing the combined household income of a gay couple (Grant, 2009). In one US study involving 142 lesbian participants, 10% of respondents indicated a lack of financial security (Gillow & Davis, 1987). Although lesbians do not earn less than straight women of similar education, women in general still earn less than men, meaning a household of two women would bring in a reduced combined income compared to heterosexual couples (Grant, 2009). Because LGBT individuals early less than heterosexual individuals of the same qualifications and similar ages, they have an even greater need for financial support to maximize well-being (Abatiell & Adams, 2011; Butler, 2004; Grant, 2009; Fredriksen-Goldsen et al., 2011). Not having access to this support can be

devastating.

Many LGBT elders may not even have the added support of an additional spousal or partner income, as sexual and gender minorities are more likely to live alone than heterosexual individuals (Grant, 2009). In one study, 65% of older lesbians and gay respondents lived alone compared to only 36% of heterosexual seniors in the same area (Abatiell & Adams, 2011). This study, however, was conducted in only one city, though, making the findings difficult to generalize to other locations.

Living alone means that it may be difficult for an older LGBT adult to remain in their home if they develop health needs that require extra help. Having to access outside care may mean relocating to a LTC facility. Older sexual and gender minorities who lived alone were shown to have a higher risk of institutionalization than those who lived with others (Blank et al., 2009; Shapiro & Tate, 1988).

Another factor associated with healthy aging includes the support one can receive from offspring. Individuals who identify as LGBT are more likely to be childless than the general senior population, reducing the monetary support (as well as other types of support) that some older adults may have access to via their children (Abatiell & Adams, 2011). This can also play a role in determining whether or not an older adult needs to go into LTC to have their needs looked after, as fewer LGBT seniors have the social support networks required to access care outside of these facilities.

LGBT: Accessing Care

As discussed, LGBT individuals may experience the process of aging differently than the average heterosexual individual. Not only do they have to deal with ageism in Canada, but they also have to deal with the homophobia and heterosexism that continues

to be prevalent in the attitudes of many Canadians today. This can contribute to poor

health and well-being for older LGBT individuals. Moreover, there may not be enough

support for them to access in times of need (Butler, 2004; Dean, 2000; Fredriksen-

Goldsen et al., 2011; Kochman, 1997; Van Wormer et al., 2000).

       Discrimination can come from the general public as well as health care providers,

and this is an issue that must be examined. Aging populations (especially in Nova Scotia,

which has the highest population of seniors in Atlantic Canada) (Statistics Canada,

2010a), are associated with higher incidences of chronic and acute diseases (Upshall,

2006). This may warrant the need to access 24-hour care, and for some, that means

entering a LTC facility. In this section, I explore the literature on LGBT experiences with

the general health-care system, thoughts and fears of entering LTC, and the realities that

exist in these facilities.

Experiences with Health-Care Practitioners

       Some LGBT individuals interact with the health care system differently than the

general population by hiding their gender identity/sexual orientation from health care

practitioners, delaying accessing care they need, or refraining from accessing care

altogether (Brotman et al., 2007; McKay, 2011; Metlife Mature Market Institute, 2006;

Senn & Bergeron, 2003; Simpson, Balsam, Cochran, Lehavot, & Gold, 2013; Steele &

Tinmouth, 2006; Stein & Bonuck, 2001; Tjepkema, 2008). This is alarming considering

their increased health needs, as they are more likely to likely to suffer from mental health

issues (Butler, 2004; Fredrikson-Goldsen et al., 2011; Meris, 2002; Nokes et al., 2003),

have greater chances of disability (Fredriksen-Goldsen et al., 2011), and have increased

overall health issues (Brotman et al., 2007).

Researchers have looked into this issue and suggested that many older LGBT adults may be afraid to encounter discrimination within the health care system (McKay, 2011; Metlife Mature Market Institute, 2006; Simpson et al., 2013; Stein & Bonuck, 2001). They may have already encountered discrimination in the past, which may then have caused them to expect it to continue to occur while accessing care (Brotman et al., 2007; Metlife Mature Market Institute, 2006; Stein & Bonuck, 2001).

The anxiety of encountering discrimination was prominent in 19% of the respondents in one study, in which they reported having low expectations that health care workers would treat them with dignity and respect as an older LGBT individual (Metlife Mature Market Institute, 2006). Older lesbians were especially anxious about encountering prejudice based on their sexual orientation, with 12% reporting they did not believe they would receive appropriate and unbiased treatment. Lesbian individuals may have an increased fear of discrimination because they are female living in a North American, male-dominated society, resulting in feelings of diminished empowerment and fear (Johnson et al., 2005).

Researchers have documented the fear of encountering discrimination within the health-care system for LGBT individuals (Brotman et al., 2007; Burgess, Tran, Lee, & van Ryn, 2007; Durso & Meyer, 2013; Jackson et al., 2008; Johnson et al., 2005; McKay, 2011; LGBT Movement Enhancement Project & SAGE, 2010; Porter et al., 2003; Simpson et al., 2013; Stein et al., 2010). In one study involving HIV-infected individuals, 54% reported encountering discriminatory behaviours from physicians, and 39% reported experiencing it from other healthcare staff (Schuster, Collins, & Cunningham, 2005).

One study analyzed the implicit (outside of conscious awareness) and explicit

attitudes of healthcare providers towards lesbian and gay men (Sabin, Risking, & Nosek, 2015). It used a sample of over 2000 healthcare practitioners (including nurses, physicians, mental health providers, and other practitioners) who had completed the Sexual Implicit Association Test (Cochran, Peavy, & Cauce, 2007) and answered one question about their explicit preference of sexual minorities versus heterosexual individuals. The data revealed that providers who identified as heterosexual themselves favoured treating other heterosexual individuals over lesbian and gay individuals (Sabin et al., 2015). These preferences ranged from moderate to strong when treating straight women over lesbian woman (Sabin et al., 2015). Gay men were the least preferred patient, especially among heterosexual nurses (Sabin et al., 2015). In another study of Health Professionals Advancing LGBT Equality members, 34% of physicians who identified as LGBT reported observing discrimination towards LGBT patients (Eliason, Dibble, & Robertson, 2011). Similarly, 50% of healthcare providers in one Australian study reported feeling uncomfortable when treating LGBT individuals (Khan, Plummer, Hussain, & Minichiello, 2008).

Fearing encountering discrimination can result in "felt stigma", meaning though there have not been any explicit behaviours of discrimination as a result of someone's sexual or gender identity, an individual still feels stigmatized (Herek & Garnets, 2007; Herek, Gillis, & Cogan, 2009). Living with this felt stigma can influence LGBT individuals' health by not revealing their sexual orientation to providers (Durso & Meyer, 2013), which can complicate healthcare needs (Harrison, 1996). Despite the dangers and consequences of such avoidance, many LGBT individuals have failed to seek this care when in need. This was shown in one of Brotman's Canadian studies completed in

Halifax, Montreal, and Vancouver, in which lesbian individuals consulted their family

doctors far less often than heterosexual women in a year's time (Brotman et al., 2007). It

is therefore not surprising that one survey found that over one-third of their 60+ year-old

respondents (38%) refused to disclose their sexual orientation to their health care

provider, with 30% of them reporting concerns about encountering negative reactions if

they were to do so (Stein & Bonuck, 2001). Stein and Bonuck's study was conducted

over ten years ago in New York and New Jersey and did not include a great diversity of

participants, leaving much to be learned within the Canadian context.

Not all LGBT individuals may be fearful of encountering discrimination while

accessing care. Some of the studies on the subject are outdated and have methodological

issues. For example, one study's survey (Dardick & Grady, 1980) was distributed in the

Gay Community News, which may have attracted participants who were more

comfortable and open about their LGBT identity. Given that this research focuses on

interactions with the health-care system, the need for Canadian research becomes even

greater. The Canadian health-care system and the broader environment differs from its

American neighbour in many ways. Despite this, these findings still provide important

information regarding the experiences of LGBT older adults in accessing care, as the

disclosure of sexual orientation can be vital in receiving appropriate care with regards to

gynecological care, screening for STIs, and counseling (Simkin, 1993).

Long-Term Care: Thoughts and Fears

Many older LGBT adults have developed a fear of encountering discrimination

within general society and the health-care system. Unfortunately, this fear also surfaces

when considering the possibility of entering LTC (Brotman et al., 2007; Jackson et al.,

2008; LGBT Movement Advancement Project & SAGE, 2010; Stein et al., 2010), where

administration, staff, and residents in these facilities are all potential sources of

discrimination in the eyes of older LGBT adults (Stein et al., 2010; Brotman et al., 2007;

Johnson et al., 2005). In a Washington-based survey, 73% of LGBT participants believed

discrimination occurred in retirement care facilities (Johnson et al., 2005). Women were

more suspicious of discrimination than men, which may be their societal

disempowerment translated into suspicion (Johnson et al., 2005). It is, however,

important to consider that the participants of this study were not in LTC. One study's

respondents who were from small communities as well as the participants who identified

as being transgender spoke directly about the fear of leaving their community to enter a

retirement community—albeit a different environment (Johnson et al., 2005). Although

this study was a reflection of fears associated with retirement communities and not a LTC

facility, many of the same social factors come into play in both types of environments.

This makes the study relevant when exploring the potential challenges faced by those

moving to a new healthcare facility. Additionally, the participants were of a broad age-

range, which may not accurately reflect the beliefs of older LGBT adults. This is

especially notable since younger LGBT participants of the study were more optimistic

about receiving unbiased care compared to older LGBT individuals (Johnson et al.,

2005).

The fear of leaving one's community may be greater to LGBT Nova Scotians due

to the fact that few LTC beds are available in the province. Individuals living in rural

areas or smaller cities may have to travel even further outside of their community to

access care and/or support, which may impact how they experience living in LTC.

Moreover, prospective residents are only allowed to reject the first bed available at a facility within the first three months. After rejecting that bed, their name could be put back at the bottom of the waitlist, meaning they may not have a great variety of choices with regards to which facility they would like to call "home". There is a need for research focusing on entering and living in LTC not only for LGBT individuals in larger cities, but also including those who live in rural areas and smaller cities to reflect the varied experiences of individuals across Nova Scotia.

Much like sexual and gender minorities in the general population, using invisibility is expected to be a common coping mechanism within LTC facilities for older LGBT adults (Bonneau, 1998; Cahill & South, 2002; Cook-Daniels, 1998; Kochman, 1997; Rosenfeld, 1999; Stein et al., 2010). In the Washington survey just mentioned, one third of LGBT participants reported that they would choose to go back "into the closet" to avoid potential discrimination if they were to enter a retirement community (Johnson et al., 2005). Older adults are more fearful of discrimination than their younger cohorts, and researchers theorize that this is because they are aware they might have to share their home with the same people who kept them from exercising their rights in earlier days (Stein et al., 2010). Despite the important information this study revealed, it only examined how participants cope with entering a retirement facility rather than speaking to those already in them, which makes it difficult to make assumptions regarding what type of behaviour might really occur in such a situation.

This fear and invisibility has implications not only for individuals but also for their families and health care practitioners who might need to compensate for the potential unmet needs of the older adult (Brotman et al., 2007). Without adequate care,

these LGBT individuals may have a reduced quality of life, becoming further isolated and

suffering a decrease in their social, psychological, and physical health (Brotman et al.,

2007). Nevertheless, though most studies have indicated that older adults do consider

concealing their sexual identity upon entering care, one study found that 66% of its 127

participants would refuse to become invisible upon entering 24-hour care (Johnson et al.,

2005). This study only used participants who were not yet in care, looking only at the

potential behaviours if they were to enter such a facility. Additionally, this study did not

focus on older LGBT adults, and therefore its conclusions are not specific to those who

are in an older age-bracket, creating a gap in understanding of those individuals regarding

their perceptions of being in LTC (Johnson et al., 2005). Finally, these participants had

already been open about their sexual orientation, which may have had an effect on their

lack of a desire to go back "in the closet" in LTC (Johnson et al., 2005).

Given that growing research about the many thoughts and fears that LGBT older

adults may have, several community-based initiatives have highlighted the importance of

understanding the realities of LGBT aging and challenge health care practitioners to

adapt their services to be more considerate of this population (Brotman et al., 2007).

Recognizing this need is one Halifax-based social group called the "Elderberries", whose

goal is to provide social support for local LGBT adults over 50 years of age (Thibault,

2011). This group has more than 100 members, and meets monthly, providing

educational and recreational programs (Thibault, 2011). Two other Canadian community

organizations are the 519 Community Centre and the Community One Foundation, and

the largest LGBT human rights organization in Canada, EGALE Canada (Equality for

Gays and Lesbians Everywhere), both located in Toronto but offering services to LGBT

individuals and their families across Canada (EGALE Canada, 2011; Toronto Digital

LGBTies, 2003). Despite focusing on all ages of sexual and gender minorities, both of

these organizations have programs that provide support to LGBT seniors and their

caregivers, which may protect against caregiver burnout (a state of physical, emotional,

and mental exhaustion) and increases the quality of life of both the seniors and their

caregivers (Brotman et al., 2007). Some even go one step further by developing LTC

facilities that are gay-friendly, such as the Rekai Centre, Fudger House, Kipling Acres,

and Wellesley Central Place, all of which are located in Toronto (Toronto Nursing

Homes, 2012). These homes are often modified to reflect the cultural backgrounds of

their residents, and provide services specifically designed to meet the needs of LGBT

adults with staff who are trained in meeting those needs (Toronto Nursing Homes, 2012).

No such institutions exist in Nova Scotia.

Older gay men and lesbians prefer to utilize services that are sensitive to their

needs specifically marketed toward them (Lucco, 1987; Quam & Whitford, 1992;

Johnson et al., 2005; Orel, 2004; Rivera, Wilson, & Jennings, 2011). Though some of

these studies are much older, they provide support for the development of LGBT-specific

organizations and facilities. For example, Quam & Whitford's (1992) study involving

lesbians and gay men over the age of 50 revealed that many of its participants would

prefer to live in gay-only facilities, with women (54%) having a stronger preference than

men (24%). In another study, 87% of the gay and lesbian participants reported they

would move far away from their home community to access housing that was exclusively

designed to meet their needs as older LGBT individuals (Lucco, 1987). This high

percentage might once again be a manifestation of the generation of its participants,

because they were born before the baby boomers and likely endured realities that were

less accepting of sexual and gender minorities. This may have made them less open to the

general population about their sexual identities and increasing their fears of

discrimination. Moreover, developing and providing such services could be more

challenging in rural areas, as there is inevitably a smaller population of individuals who

would utilize these services relative to much bigger cities. This may leave some of their

needs unmet, potentially complicating their care in the future.

Experience of Living in Long-Term Care

The reality that many LGBT older adults have encountered discrimination

throughout their life (whether obvious or in more subtle manners) seems to have

translated into fears and apprehensions about encountering such behaviour if they were

ever to have to enter a LTC facility. Examining the reality of living in LTC as a LGBT

individual is important in understanding whether these thoughts and fears are justified.

As outlined earlier, the NS Human Rights Code and the Adult Protection Act

provide legal protection from discrimination to ensure individuals feel safe from neglect

or abuse in their environments (Nova Scotia Legislature, 1998). Unfortunately, there are

gaps in the protection of LGBT older adults in LTC, as they do still encounter

discrimination. Some studies that explored the attitudes of health care practitioners found

that many of their attitudes were prejudiced towards sexual and gender minorities (Coon,

2003; Hash, 2002; Hash & Cramer, 2003; Moore, 2002; Cahill & South, 2002). Other

studies suggested that homophobia and heterosexism are even more common in LTC

settings than within the general health care system, and provided examples of

maltreatment in these facilities on the basis of these homophobic attitudes (Daley, 1998;

Krauss-Whitbourne, Jacobo, & Munoz-Ruiz, 1996; Peterson & Bricker-Jenkins, 1996).

One study involving 769 individuals (approximately half being LGBT older adults in

LTC, and the rest being family members, friends, social service providers, or legal

service providers of these individuals), found that 43% of LGBT people in LTC had

personally experienced mistreatment based on their sexual orientation (LGBT Movement

Advancement Project & SAGE, 2010). In other studies, staff members in care facilities

reported negative perceptions of same-sex sexual contact and overall discomfort with

residents who were LGBT (Cahill & South, 2002; Hinrichs & Vacha-Haase, 2010)

Little literature has focused on staff perceptions of same-sex contact in Canada,

though one Canadian study suggests that there are similarities between the US and

Canada in this regard (Brotman et al., 2007). In this study, caregivers of LGBT seniors in

Halifax, Montreal, and Vancouver were interviewed about their perceptions of the quality

of care that the LGBT individual they cared for received. They reported that although

discriminatory behaviour against LGBT individuals was more subtle in nature, these

behaviours remained an issue for the individuals they cared for, just in more subtle forms

such as negative attitudes or comments (Brotman et al., 2007). The study concluded that

many of the LGBT adults were reluctant to access some of the care they required, as a

result of encountering this discriminatory behaviour, increasing the burden on their

caregivers and decreasing their quality of life (Brotman et al., 2007). A caveat of this

study is that it did not interview the actual people involved in the care, and failed to

include participants or care recipients from rural areas. This is an important group to

include, considering that Atlantic provinces have a greater proportion of people living in

rural regions compared to other parts of Canada.

Unfortunately, negative attitudes may be exhibited both by staff *and* residents (Brotman et al., 2007; Fredriksen-Goldsen et al., 2011). Having to share a home and possibly a room with residents who are not comfortable with sexual and gender minorities can be an inescapable reality for some older adults. Lesbian and gay people have increased fears about being open with other residents, as evidenced in various research studies (Brotman et al., 2007; Cahill & South, 2002; Stein et al., 2010). Some have reported feeling unable to speak openly about their partners, while others felt they were unable to participate in shared grieving over the loss of their spouse (Brotman et al., 2007). Feeling an apprehension to be open to other residents regarding one's sexuality is understandable. In one survey, 60% of residents in eight US LTC facilities agreed that "homosexuality is a sin" and 64% believed that "homosexuality is unnatural" (Walker & Ephross, 1999, p. 100). With attitudes like this, forming friendships could be justifiably difficult, thus creating a gap in readily accessible social support from those surrounding the individual. As explored previously, having a lack of social support can contribute to feelings of loneliness, isolation, and stress, subsequently increasing the possibility of becoming clinically depressed, a problem already too prevalent for residents of LTC facilities today (Conn, 2002; Canadian Institute for Health Information, 2010; Fredriksen-Goldsen et al., 2011). LGBT older adults are therefore potentially in even greater vulnerable positions than the average resident in LTC, complicating their health-related needs and placing a greater responsibility on family and friends in ensuring their loved-one's well-being.

Staff training programs can seek to address issues of discrimination (Brotman et al., 2003; Stein et al., 2010). Québec, for example, has one of the most comprehensive

training programs in Canada, which specifically addresses issues of discrimination due to

factors such as sexual orientation and ethnic origin (Brotman, Ryan, & Cormier, 2003).

Developed in 1992, it is used in work environments (including LTC) to correct

prejudicial attitudes that may exist towards sexual and gender minorities, and trains

workers to adapt their services specifically to the needs of these LGBT individuals

(Brotman et al., 2003). Training programs like this have been recommended both

provincially and federally to address issues of discrimination, but there remains a lack of

staff members who have actually gone through related training (Brotman et al., 2003;

Kochman, 1997; LGBT Movement Advancement Project & SAGE, 2010; Stein et al.,

2010). For example, a New York-based study found that only 13% of staff in LTC

facilities received same-sex sensitivity training, whereas 65% of them had received

cultural-diversity training, which did not include sexual orientation (New York City

Department of Health and Mental Hygiene, 2008). The impact that this training has on

LTC staff interactions with LGBT residents is unknown. To meet the complex

psychosocial and medical needs of these older LGBT adults, these gaps need to be

acknowledged.

Conclusion

Although there are many positive aspects about growing old as an LGBT

individual, these people may encounter greater challenges compared to heterosexual

older adults. The context in which these individuals live has been in constant change;

changes that affect the amount of support available to them if they are to require 24-hour

care. These changes, among many other factors in the lives of LGBT older adults

(including economic, physical, and mental health, as well as the community support they

have access to), may increase the need for facility-based LTC. Having to potentially access such care has been a source of anxiety for many older sexual and gender minorities, as many fear encountering residents, staff, and administration who display heterosexist and homophobic behaviours. Previous research has provided reasoning for those who are fearful of encountering discrimination in LTC, as many LGBT older adults and their caregivers have reported instances of such negative behaviour. Subsequently, many of these older adults have reported a preference in accessing LGBT-specific organizations and facilities. Unfortunately, Nova Scotia has no such facilities, and it may be that older adults are less likely to leave this province later in life to move to bigger cities like Toronto. Aging in place is the ability to live in one's own home and community safely, independently, and comfortably, regardless of age, income, or ability level (American Planning Association, 2014), and it is preferred over having to change communities to access care (Pynoos, Caraviello, & Cicero, 2009; Ball et al., 2004).

There are gaps in the existing literature on older LGBT individuals and their experience with aging and LTC. Few Canadian-based studies exist, as only three projects in total have been completed in Canada. Canadians live in a different context, with beliefs and attitudes that may not be parallel to those of Americans. For example, Canadian policies are different, making the practice of caring for LGBT older adults and their protection from discrimination different from the US context. Though the three research projects headed by Brotman (Brotman et al., 2002, 2003, 2007) have provided vital information on the subject of LGBT and care, they looked at the fears that LGBT people may have in entering LTC and their experiences with health care practitioners outside of LTC settings. Subsequently, research could include the voices of those who have first-

hand experiences being a LGBT individual in a LTC facility and concerned stakeholders. This would bring in multiple perspectives in order to better understand what that experience may be like. Lastly, only one of these projects have specifically included older Canadians (Brotman et al., 2003). There is a need for more Canadian literature on experiences of older adults rather than those of broader age ranges.

Methodologically, there has also been a general lack of diversity within the participants of the studies that have been done, which particularly lack bisexual older adults. Much of the literature seems to assume that their findings based on lesbian and gay older adults apply to all other sexual and gender minorities. Moreover, the research needs to include older LGBT individuals who live in smaller cities and rural areas, as their needs and desires may be different than those living in larger cities.

Finally, many of the existing studies on older LGBT individuals' experiences of living within a LTC facility have used focus groups and surveys as a method for gathering information. Focus groups can create a group bias, preventing some voices from being heard. Using surveys does not allow for the detailed translation of subjective experience. Although these methods can be useful in acquiring data from a greater amount of individuals, in-depth interviews would gain a deeper understanding of residents' experiences and stakeholder understandings. Interviews provide each individual with their own voice, and considering the diversity and unique challenges and experiences that each of these LGBT older adults can have, in-depth interviews provide a better a more relaxed and allowing context in which to share detailed information.

As this population of older adults continue to age, increasing their chances of requiring 24-hour care, the gaps in the literature must be addressed. Some of these gaps

are the lack of diversity in LGBT participants and the lack of Canadian studies. To

address these gaps, this thesis explores the perspectives of both residents and various

stakeholders about the older LGBT individuals' experiences of living in Nova Scotian

LTC facilities.

CHAPTER 3: THEORETICAL FRAMEWORK

This research used the ecological theory (Bronfenbrenner, 1977), minority stress

theory (Meyer, 1995, 2003), and intersectionality theory (Collins, 2000; Crenshaw, 1989;

Symington, 2004). Ecological theory began within the biological sciences, where

organisms, in their own ecosystems, interrelate with one another. It was then applied to

the social sciences by beginning to frame individuals and multiple levels of their social

environment, as a social ecosystem (Bronfenbrenner & Morris, 1998; Ungar, 2002).

Researchers have described how this particular theory is helpful for both gerontological

work (Greenfield, 2012) and research focusing specifically on LGBT individuals'

experiences (Mishna, Newman, Daley, & Soloman, 2009).

Ecological theory places an emphasis on individuals' surrounding environments,

both at the micro and macro level. It broadens the context through which an individual's

issues are understood (Bronfenbrenner & Morris, 1998). Much like biological

ecosystems, this theoretical framework views environments as interacting with each

other, influencing broad societal values, and subsequently shaping the experiences of

each individual within that "ecosystem" (Bronfenbrenner & Morris, 1998). This theory

involves "mutually influential and dynamic transactions" between individuals and their

multiple contextual environments (Greenfield, 2012, p. 2). According to this theory, if an

individual's environmental needs increase (whether they be social and/or physical in

nature), the environment(s) are no longer appropriate for them (Lawton, Weisman,

Sloane, & Calkins, 1997). Older adults may not be able to age in place— that is, to grow

older in one's own community or home despite health limitations— if their environment

is inappropriate. For example, if an older gay man living with HIV/AIDS is no longer

able to provide meals and maintain his home himself and has no partner, children, or

family on which he can rely, he may need to find a different environment that will be able

to meet these needs, thus preventing him from being able to age in place.

There are four levels of environmental contexts or systems within which

individuals interact: the *microsystem*, *mesosystem*, *exosystem*, and *macrosystem*. The

microsystem includes interactions between an individual and their "immediate setting"

(Bronfenbrenner, 1977, p. 514). A setting is a specific place in which an individual takes

on a particular role and carries out distinct activities (Bronfenbrenner, 1977). This level

of environment involves direct contact, and is the level that is closest to the individual

(Bronfenbrenner, 1977). It might include an older lesbian woman's home, where she is in

the role of a parent, or in church, where she takes on the role of a clergy member. The

mesosytem is the part of their environmental known a "major setting" where interactions

can occur. This level connects the individual's microsystem with other systems. Under

the mesosystem, a LGBT individual's church would connect with his neighbourhood, or

his partner might connect with his nursing home caregiver. Stated simply, "a mesosystem

is a system of microsystems" (Bronfenbrenner, 1977, p. 515). The next system involved

in the social ecosystem is the *exosystem*, which focuses on the settings of one's

community (Bronfenbrenner, 1997). This level might involve one's workplace or their

neighbourhood (Bronfenbrenner, 1997). The individual is indirectly affected by the

forces of these structures or settings. For example, a man, while living in a nursing home,

is affected by the staff nursing schedules of the care facility. Finally, the *macrosystem*,

which is the most generalized system, refers to broad societal factors such as political,

economic, and social forces that interact and inevitably affect the rest of an individual's

environments, and therefore experiences (Bronfenbrenner, 1997). For an older LGBT

individual living in Canada, this might include homophobic/transphobic and heterosexist

social norms, as well as conservative political forces that work to prevent LGBT rights

from being at the forefront of political examination.

In examining the systems that impact the individuals with which they interact, the

ecological theory also places great importance on the quality of activities involved in the

lives of these individuals. It is conceptualized that these activities affect and influence

those within that environment, as well as the surrounding ones (Engelhard & Sullivan,

2011). Individuals interacting with these environments are both being affected by and

affecting these environments; these interactions are mutual.

Ecological theory helps frame the experiences of those who identify as LGBT in a

meaningful way by allowing researchers to view their experiences as an outcome of the

many unique contexts and environments within which they have grown up and interacted.

This means that older LGBT individuals' experiences are not solely viewed as a result of

their personal characteristics (such as identifying as LGBT or being an older adult), but

rather as a complex consequence of living and interacting with many different systems

that come with their own norms and beliefs. This approach allows researchers to position

an individual's experiences based on the many unique environments and contexts that

frame them (Coates & Sullivan, 2005). The ecological theory also examines both the

environment and the individual to understand the interaction between the two, allowing

for the environmental needs of an individual to be included in the understanding of their

experiences. This deeper understanding includes both physical and social aspects of these

environments (Greenfield, 2012). For example, although one may be able to have their

physical needs met in a LTC facility, the social aspect of the nursing home may not be appropriate for the individual. A social environment may be very different than the environments to which the resident is accustomed.

Ecological theory additionally incorporates a critical perspective (Greenfield, 2012), placing importance on having research that works to change and improve certain aspects of these ecological systems. For example, an older lesbian may have lived most of her life after the gay rights movement in an urban place, and for much of her life was involved in LGBT support groups. In her later life, she might make the difficult decision to move into a LTC facility and have to live with other individuals who view lesbianism as abnormal, or worse, wrong and bad. This may then influence her life due to the negative perceptions of her identity by those with whom she lives. Having to move from one accepting microsystem to one that may not be so accepting, thus, may affect her experiences from then on. Other gerontological research has used the ecological theory, lending support for the decision to incorporate this theory in the current study (Haley, West, Wadley, Ford, White, Barrett, … & Roth, 1995; Kim & Moen, 2002; Schiamberg & Gans, 1999).

I also used minority stress theory in this research. Some gerontologists have used this theory as a lens with which to examine older individuals' experiences (e.g., Bos, van Balena, van den Boom, & Sandfort, 2004; Kelleher, 2009). Other researchers have combined this perspective with the ecological model, such as Kinkler and Goldberg (2011).

Minority stress theory emphasizes the idea that living within an environment in which a person is stigmatized can negatively affect their psychosocial health (Meyer,

1995, 2003). An individual's health is greatly impacted by the stressors in their life. A combination of stressors without enough support can lead to negative health outcomes. Researchers continue to find that individuals who identify as LGBT face a greater risk of physical and mental health issues (Cochran et al., 2003), and that some of these individuals have used unhealthy coping mechanisms, such as substance abuse, to cope with these issues (Kalichman & Cain, 2004; Kashubeck-West & Szymanski, 2008). Multiple factors in one's environment can buffer these stressors, including the social support received from friends and family, or specific policies that protect individuals against discrimination based on their minority status (Kinkler & Goldberg, 2011). Minority stress theory helps explain why LGBT individuals have increased health risks later in life. Rather than attributing these risks to flaws within the individual, it acknowledges the impact of their environments, demonstrating, for example, that the dominant values of these environments conflict with their own beliefs and norms (Meyer, 1995, 2003).

Living in a hostile, homophobic/transphobic, and heterosexist environment can induce major stressors for someone who fits these "abnormal" characteristics, separate from the "average" Canadian. The minority stress theory conceptualizes that the stressors that many LGBT individuals face are unique to their minority status and are based in the social aspect of their lives, consequently affecting their physical and mental well-being (Meyer, 1995, 2003). These negative attitudes can be internalized by those who are stigmatized, thus increasing the negative psychological effect originally induced by the conflict between one's beliefs and the beliefs of the society in which they live (Meyer, 1995, 2003). Many LGBT individuals may have conversely developed healthy coping

mechanisms to deal with their unique stressors as marginalized individuals, and thus have adapted and become resilient to them (Consolacian, Russell, & Sue, 2004).

This theory fit well with this study as the resident subjects being studied involved individuals who were of minority status and lived in Canadian social environments that generally include homophobic/transphobic and heterosexist beliefs and norms. The other stakeholder participants also lived in similar macro-level environments and had unique opportunities to better understand what life is like for residents of LTC. Dealing with the stressors induced by the conflict between their norms and the norms of some of their environments were unique to each individual. This also holds true for the stakeholder participants, whose experiences and reflections are just as unique as their own lives. This theory aided me in exploring how the LGBT residents coped with their potential stressors, how their experience was perceived by the stakeholders, and provided valuable insight into how their minority status impacted their experiences in a LTC facility.

The data was also analyzed using intersectionality theory, which helps frame an understanding of how multiple layers of identity/minority statuses can lead to unique experiences. Developed as a way to understand the experiences of black women in the United States and how their experiences are affected both by their race and their sex (Collins, 2000; Crenshaw, 1989), intersectionality holds that each person's experiences is affected by many other factors relative to that individual, such as one's historical, social, and political context (Symington, 2004). This helps explain why some LGBT residents might simultaneously experience discrimination and privilege due to their multiple statuses. For example, one resident might be a white, lesbian, older adult living in an urban LTC facility due to a disability. Though they may experience discrimination based

on their sexual identity, age, and disability, they might also experience privilege based on

their race and location, which allows them to access high-quality care.

CHAPTER 4: METHODOLOGY

This study used qualitative description, which is a qualitative method emphasizing the importance of having a researcher be close to their data (Sandelowski, 2000, 2010). This method acknowledges the fact that describing data involves interpretation, and while that means the perception of the researcher inevitably frames the description of the data, it emphasizes "descriptive validity" (Sandelowski, 2000, p. 336). "Descriptive validity" signifies the description will most likely be agreed upon by other researchers as fact. While other researchers may describe the data using different terms, they are able to agree that each of their interpretations are valid (Sandelowski, 2000, 2010). In other words, the interpretation is "low-inference" and has researchers tend to agree with each other when it comes to coding, as it focuses on the "facts" while leaving the description of those facts up to each individual researcher (Sandelowski, 2000, p. 335). Qualitative description also encourages the use of participants' language in describing the data (Sandelowski, 2000).

The method of qualitative description emphasizes the use of "everyday language" in describing the data (Sandelowski, 2000, p. 336). This is different than other types of qualitative methods, such as phenomenological, theoretical, or narrative descriptions, which encourage the researcher to move beyond the data using abstract terms (Sandelowski, 2000). In contrast, qualitative description does not transform the data as much as other qualitative methods and works within the limits of the facts to summarize the data.

Unlike quantitative research, qualitative research requires neither the rigid use of variables nor structured settings to control variables (Denzin & Lincoln, 2005). Given the

fact that an individual's experiences are all subjective and an outcome of the environments with which they have interacted throughout their lifetime, it was not important for this research to be representative or generalizable to all individuals involved in the LGBT population. A qualitative approach provided me with rich and detailed data from which I could better understand the subjective experiences of the LGBT individuals living in long-term care (Denzin & Lincoln, 2005). It is also worth noting that, given the lack of data on the subject of being LGBT in LTC, this research was exploratory and encourages more research to be done on the same topic.

The research question I posed was, "*What is the experience of living in LTC like for those who identify as LGBT?*" The goals of this research were to (a) understand what factors are involved in determining what the experiences are like for those who identify as LGBT and live in LTC, (b) understand how an individual's sexual and/or gender identity frames the way they interact with their environments, and (c) provide suggestions of action that decision-makers can take to make the experience as positive as possible for LGBT LTC residents

Sample

Six individuals participated in this research: two LGBT older adults, two older LGBT activists, and two LTC workers (see Table 1). I aimed to recruit six to eight LGBT residents, but expanded participant qualification to include shareholders due to recruitment challenges. Stakeholders were employees or activists who had special understandings, based on their own personal experiences and understandings, of what life might be like in LTC for people who identify as LGBT. Several of them were also LGBT themselves, and had a particular interest in maximizing their own quality of life if they

were to ever require 24-hour, facility-based care. Given the subjective and exploratory

nature of this research, their voices were welcomed and poignant. It was especially

helpful to have stakeholder participants because I was unable to recruit any transgender

LTC residents. Samantha (W2) had received special transgender-related training, which

provided valuable insight into what the experience of living in LTC might be like for

someone who identified as such.

To be eligible as an LGBT resident of LTC for this research, individuals must

have lived in LTC in Canada for at least one month to ensure they had enough experience

in the environment to speak in detail about it. Participants did not need to have the

permission of an adult child or power of attorney to participate in the study. This was

done to reduce the chances of "outing" the individual to those who may not have been

aware of their sexual orientation (this will be further discussed in the section on ethical

considerations). Thus, it was important that they have the full mental capability to recall

experiences and to have provided their own consent to participate. As a way to ensure

that their experience was well-translated, participants with middle or late-stage dementia

were excluded from the study.

To qualify as a stakeholder participant, the individual needed to feel they had

specific insight into the experiences of LGBT individuals who live in LTC. This meant

they had experience with LGBT individuals in nursing homes or special knowledge of

what it might be like for that population in LTC. Activists were included in this

participant group as people who had campaigned for social change in the area of LGBT

equality.

Table 1

Summary of Participants

Participant Pseudonym and Type of Participant[a]	Description of Participant	Location of Interview
Brenda (R1)	57 year-old bisexual woman, living in LTC for 10 years	In LTC facility with care coordinator/next-of-kin
Carol (R2)	62-year old lesbian woman, living in LTC for 5 years	In LTC facility
Mrs. Pealm (W1)	Lesbian woman over 50 years-old. Experience as a Personal Care Worker (PCW) in LTC.	Over the phone
Samantha (W2)	Adult psychiatrist for 7 years with special interest in geriatrics	Over the phone
Jerry (A1)	73 year-old gay man, activist for LGBT equality and equal treatment	In person over lunch with David
David (A2)	Older gay man, activist for LGBT equality and equal treatment	In person over lunch with Jerry

[a] R = Resident, W = Worker, A = Activist.

Data Collection

This study used selective sampling to find participants. Snowball sampling (that is, using informants as a way to access to other individuals/participants) was also used. A list of LTC facilities in Nova Scotia was obtained from the online database of nursing homes and homes for the aged in Nova Scotia, found on the government of Nova Scotia website. I used this list to find and contact LTC facilities in different parts of the province (both rural and urban). Each home administrator was asked if they could be sent a poster

to be put up in the care facility. At the same time, I also inquired about their policies

regarding conducting research involving residents. Some of these facilities required a

copy of the MSVU ethics approval form or their own, in which case, I either sent them a

copy of the approved ethics form, or completed an additional form. Recruitment ads were

posted in LTC facility newspapers and popular LGBT-friendly shops (coffee shops, book

stores, etc.) both in rural and urban areas in Nova Scotia. An electronic advertisement

was also submitted to the "Wayves" magazine—a non-profit magazine that informs

LGBT individuals in Atlantic Canada of community events and activities (Wayves,

2013). I also presented my research to decision-makers in one nursing home, and was

interviewed by the Chronicle Herald and a Halifax-based radio station to expand the

knowledge of my research to individuals across the province.

      I also contacted LGBT associations in Nova Scotia (such as the Rainbow Action

Project, an association that seeks equality for all people of sexual orientations and gender

identities) to have them inform others who might have fit the requirements of the

research. Additionally, ads were shared and posted on LGBT webpages, forums, and

other internet sites (e.g., reddit.com and thecoast.com). This provided me with a way to

reach out to a larger number of individuals, which I had hoped would increase the

chances of gaining transgender and bisexual participants.

      Prospective participants contacted me and were given more information about the

research. Upon doing so, if the potential participant decided that they would like to be

interviewed, we decided on a convenient time and place for this interview to take place.

Two participants opted to be interviewed with others present. Brenda was interviewed

with her care coordinator, who is also listed as her next-of-kin. Her comments were not

included. David and Jerry were interviewed together, and both of their comments are included in the data. Both Mrs. Pealm and Samantha's interviews were over the phone.

Interviews were semi-structured and digitally recorded. Semi-structured interviews are flexible and fluid in structure while still having an interview guide involving questions that all participants will be asked (Whiting, 2007). Using open-ended questions, that is, questions that require a detailed response rather than a simple 'yes' or 'no' answer, allows for meaningful dialogue. The prepared questions were only guidelines, and allowed the questioning to change and evolve based on the participants' answers. New questions can arise naturally during the interview based on new information learned. This meant that the participant had some freedom to discuss what they wanted to talk about, how much they wanted to discuss, as well as how they wanted to express it. To avoid asking any questions that might encourage participants to answer in a certain way, I ensured most of the questions were open-ended and allows participants to answer in any way, given their subjective experience.

Rapport building was also important within this method, allowing conversation to flow in a respectable, stress-free way. Doing so allowed for experiences were discussed in greater detail and depth.

Using this method of data-gathering allowed me to explore the subjective experiences of the participants, providing me with a better understanding of how their environments played a role in their life in LTC, as well as how their minority status influenced and interacted with their everyday experiences. Having an open dialogue allowed the participants' own subjective reality to be highlighted in conversation. There were prompts to discuss certain topics related to their experience or understanding or

opinion of living within the care facility.

Resident interview questions were guided by the minority stress theory and ecological theory by emphasizing the environments in which they experience, their subjective, personal understanding of their experiences, and what elements they felt impact their experiences in LTC. These questions focused on the impact of social environments (ecological theory) and how they impacted the individual's experience interacting with them (minority stress theory).

The main topics (see Appendix A) that were discussed with resident participants were life before entering the facility, deciding to move into the facility, initial entrance/first few days, life in the facility, individuals in the home, being LGBT in the facility, health, recommendations, and general information about the participant. Each of these topics served a purpose and drew on ecological, minority stress, and intersectionality theories. For example, asking questions on the topic of "life before entering the facility" helped gain a better idea of what kind of environments the individual interacted with before moving into a completely new environment—that is, the LTC facility. It also provided insight into how living as a LGBT individual has interacted with their experiences in different environments. Questions about life before the facility included "can you tell me about your life five years prior to entering this facility?" with probes such as "can you tell me about your work life?" and "what were your favourite activities?".

The purpose of asking questions on the topic of "life in the facility" was to better understand what changes had occurred in their experiences after moving into the facility. It also allowed me to better understand how their minority status had interacted with their

new environment, framing their experiences within it. Questions asked on the topic of life in the facility included, "what kind of support do you have now?" with probes such as, "what support do you receive inside the facility" and "what support do you receive outside of the facility".

Asking questions on the topic of "being LGBT in the home" gave me further insight into how their experiences were shaped by their minority status. This also allowed me to understand how their different systems/environments interacted with each other to shape these experiences. Questions included in the topic of being LGBT in the home were "do you feel that identifying as LGBT has affected your experience living in the home?" with follow-up probes such as "why" or "why not?" Finally, I asked questions about of health in order to gain a detailed understanding of how their macrosystem had framed their view of health and subsequently their experience in the LTC facility. It also allowed me to better understand how their definition of health differed from other widely used definitions, which provided insight into whether their minority status had interacted with their own beliefs regarding health.

The main topics (see Appendix B) discussed with stakeholder participants were why they had insight into the experiences of LGBT individuals living in LTC, how sexual/gender identity may impact residents' experiences, and any stories/experiences they have had relating to LGBT individuals accessing care. Questions were also asked about what kinds of recommendations they had to maximize the experience of living in LTC for individuals who identify as LGBT, given their specialized insights.

Stakeholder interview questions were guided by the minority stress and ecological theories by emphasizing the environments in which they have experience and how that

might impact their understanding of what it was like to live in LTC as an LGBT resident. The questions also emphasized the stakeholders' own experiences with LGBT individuals as well as their experience as someone who identified as LGBT (if applicable). These questions highlighted the impact of social environments (ecological theory) and how they impacted the experience of minorities living within them (minority stress theory).

After each interview, I took field notes related to the context of the interview, including details about the participant's disposition, any emotional reactions they may have, their body language throughout the dialogue, as well as their perceived interest in certain topics after the interview. Taking field notes created a more detailed and complete picture of the collected data, which helped prevent me from forgetting any interesting and/or important details regarding the interview.

Analysis

Interviews were also analyzed using *directed content analysis* (Hsieh & Shannon, 2005). Directed content analysis involves finding emerging themes and codes within the data (in this case, the in-depth interviews) and then sorting the codes into categories depending on how they relate and are linked to one another (Hsieh & Shannon, 2005). It also involves using the three theories and previous relevant research on which to base the research question, making the approach deductive in nature (Hsieh & Shannon, 2005). Using theories and knowledge from previous relevant research allowed me to create initial coding categories/themes, while remaining open to new data coming out of the data analysis to ensure that a broad and accurate understanding of each participant's experiences.

All the transcriptions were first read several times to become familiar with the data. The data was then analysed using "open coding" and then "axial coding" (methods borrowed from grounded theory) (Given, 2008). Open coding helps with findings and labeling concepts, and helps subsequently develop themes based on the conceptual categories and properties (Given, 2008). Axial coding identifies relationships between the themes identified while using open coding (Given, 2008).

MAXQDA software (version 11) was used in the data analysis and management in several ways. First, the program allowed me to create multi-level coding for each interview. In doing so, I was able to link codes to relevant portions of each interview, thus providing me with a way to compare and contrast them. This also provided me with a well-organized platform on which to develop the themes based on the conceptual categories that were created using open coding, and then helped me identify the relationships between these themes using axial coding.

I also used MAXQDA's visual tools (such as the "Code Matrix Browser", where the distribution of codes in sections of the data are visually mapped) for the purpose of analyzing coding patterns. Although software programs such as MAXQDA are helpful with the organization of the interview data (transcripts, codes, and themes), the interpretation resided with the researcher (Humble, 2012). Thus, ultimately, although MAXQDA helped facilitate the analysis and management of the data, the interpretation of the data was performed by me.

I kept an audit trail throughout the analysis process, which is a technique used by researchers to record "the decisions, analytical processes, and methodological decisions", while "remaining separate from the study" (Cutliffe & McKenna, 2004, p. 127). This

helped to prevent any information from being lost or forgotten and allowed me to re-examine the sequence of events that took place (such as notes that were taken during the interviewing, or any thoughts/ideas that had been deleted in the research paper itself (all drafts of the paper as well as analysis were kept).

I practiced disciplined subjectivity by attempting to identify all my potential biases about the topic at hand before doing the interviewing through keeping a reflexive journal of all my feelings and insights. Reflexivity is important in qualitative research as it increases one's awareness about the preconceptions, thoughts, and feelings they have regarding the research process (Gilgun, 2010). Reflexive notes included emotions, feelings, biases, and any other relevant thoughts (Gilgun, 2010). These notes were taken before, during, and after interviews (including during analysis) so a complete understanding of my reflections was collected.

Ethical Considerations

Due to the fact that this research involved discussing potentially personal information with individuals who are marginalized, it was important to be considerate of ethics in every aspect of the study. The most major risk in this study involved a participant being potentially outed as an LGBT individual to other within their nursing home. There were also privacy issues and possible negative mental/emotional consequences.

Informed consent was, first and foremost, extensively examined. To test comprehension, participants were asked a few questions regarding their rights as a participant after reviewing the consent form (see Appendix B). These comprehension questions consisted of questions such as, "If you do not want to answer a question, what

do you do?", and "What will you do if you no longer want to participate in the study and the interview is only halfway completed?"

As a result of potentially discussing personal information during the interview process, it was possible that someone might have overheard information leading them to discover that the participant identifies as LGBT. Being outed can be a fearful and detrimental experience for the individual living in LTC, especially if they live in the presence of individuals who hold homophobic or heterosexist opinions. Thus, to ensure that stress was minimized and that they were as comfortable as possible, as some participants might have been apprehensive about discussing certain topics around residents or staff members, they were provided with the choice of having the interview take place over the phone, which could lessen the risk of outing the participant. No residents chose this method of interview, though one stakeholder did. Moreover, as an attempt to protect the participants from potentially being outed, individual who required the consent of an adult child or power of attorney to participate were excluded from the study.

Another consideration that was examined due to the possibility of discussing personal information was privacy. A breach of privacy is possible when people are revealing information they often do not share with others, and although risk was minimized as a result of the protocols that were followed to ensure that the participant's identity was concealed (Corbin & Morse, 2003). For example, the actual names of the participants were neither shared nor used when doing any writing with regards to the interview itself. In the transcription, pseudonyms were used, and all identifying characteristics were removed, such as the home in which the person was living. Mrs.

Pealm chose her own pseudonym, while the rest of the participants' pseudonyms were chosen for them. Informed consent forms were kept in a separate place from interviews as well in order to further protect the participants' privacy.

Emotional harm was a risk of the study as a result of the sensitive issues that may be discussed during the interviews (making it emotionally intense for some participants). Participants were given the contact information of local therapists and counselors if they wished to seek additional help. They were also advised of the option of accessing psychological care through a local hospital, which, in emergency situations, is free. Again, they were given information regarding the informed consent process, and it was discussed and further reiterated during the interview process to remind participants of their rights and ability to withdraw their participation at any time or to refrain from answering certain questions. In doing so, informed consent was a continuous process, which allowed the participant full freedom of whether or not they would like to participate and how they would like to participate, regardless of when this decision is made. Other information that was provided included the fact that hard copies of the data from their interviews were locked in a cabinet and electronic copies stored on my personal, password-protected laptop, for up to five years, to which only myself and my thesis advisor, Dr. Áine Humble, had access to. Copies of the MAXQDA file, which was password-protected, were also sent to Dr. Humble.

Although there were potential risks involved in taking part in this research, there were also potential benefits. These benefits included issue self-awareness, catharsis, self-acknowledgement/validation, a sense of purpose, self-empowerment, and having their voice heard (Corbin, & Morse, 2003; Hutchinson, Wilson, & Wilson, 1994). Being

involved in research involving sensitive topics may have allowed participants to be more

mindful and aware of their issues, as they may then have moved forward and sought

support to resolve these issues (Corbin & Morse, 2003). This always depended on the

level of distress that was experienced by the individual. Having their own voice heard

and understood might then have allowed them to make positive changes in their own life,

feeling an increased sense of power and acknowledgement, as well as the ability to make

real changes (Huchinson et al., 1994). Becoming more self-aware of their personal issues

may have provided them with a long-term benefit from their participation.

       Catharsis, which is thought to provide a sense of relief from having shared

those feelings, thoughts, and problems with an open, interested, and accepting was also

potential benefit of this research as participants shared personal experiences with

someone open and accepting to hearing whatever the participant wanted to discuss. Being

involved in this research might have also allowed participants to experience some

personal validation, as they were able to share their inner thoughts and feelings. In other

words, they may have also felt a sense of worth through having these thoughts and

feelings validated during the interview, giving their personal experience meaning

(Hutchinson et al., 1994). In a related sense, they may have also gained a sense of

purpose from having someone be genuinely interested in their experiences living in LTC

or their perceptions of it, given the shareholder participants' special insight into the

matter. Knowing that the information they shared with me would in turn be disseminated

to others, which might subsequently improve the life of others if this information used by

professionals, might have been a benefit of taking part in the research. Helping others is

an intrinsic desire in many human beings and provides powerful and positive emotional

feelings (Post, 2005; Schwartz, Meisenhelder, Ma, & Reed, 2003), thus potentially

benefiting the participants who were involved.

Finally, the participants may have also felt empowered (Hutchinson et al., 1994).

As mentioned, there is very little research that has been none conducted in Canada, and

specifically Nova Scotia. As a result of this research, individuals involved in the study

may have, for the first time ever, been provided with an opportunity to formally share

their thoughts, opinions, and experiences about to LGBT individuals living in LTC.

CHAPTER 5: FINDINGS

Living in LTC can be both a positive experience and a challenging one. Upon

entering LTC, one hopefully receives the care they need in order to maximize their

quality of life. This includes having LTC staff help them with their activities of daily

living, such as eating, dressing, bathing, and creating support networks within the home

with new friends and confidants. The process of accepting care and making friends,

however, is more difficult for LGBT residents for several reasons, some of which

emerged from speaking with the participants of this research. Three themes emerged in

the analysis: (a) LGBT residents being "in the closet" while living in LTC, (b) the impact

of LGBT residents' relationships with others within and outside of the home, and (c) how

changing environments impacted the residents' experiences in LTC. Participant quotes

are provided for each of them, and each participant is identified as a resident (R), worker

(W), or activist (A).

In the Closet

Upon entering LTC, all participants agreed that LGBT residents have difficulty

showing others all aspects of their identity within their new home. Hiding part of one's

sexual identity can be a way of coping with fears that one has about being a victim of

discrimination. Reasons for choosing to go "into the closet" included being fearful of

discrimination, stories being passed around about this discrimination occurring, and being

in a vulnerable position based on other life factors such as age and health status.

Fear of discrimination

One reason why residents chose to go "back in the closet" upon entering LTC is

because they were fearful of being discriminated against based on their sexual

orientation. Although there has been some positive national social movement for those

who identify as LGBT (such as gay marriage becoming legal and transgender surgery

being paid for by the province of Nova Scotia), Jerry (A1) argued that the fear of being

mistreated was still strong for many people. As a collective, society has systems in place

to protect many groups from discrimination, and yet individuals can still be threats. He

said,

> I'm told in Canada about 80% of people think that rights should be there, and
>
> equal marriage should be there, and so-on, that's a good percentage, 80%!
>
> However, that doesn't necessarily mean that, especially older people that will get
>
> cranky in their old age, and that's realism—I mean, I know some people who get
>
> old and cranky, right David [laughing at David, who was interviewed with him]?

Certain environments come with different amounts of safety and fear within

residents. In one place, a LGBT older adult may have felt very accepted and safe, while

in others, they may feel vulnerable to discrimination. Carol (R2) mentioned she lived

"out" most of her life, but went back in the closet when she entered LTC. She had been

out to most people in her life before entering the facility as she had become accustomed

and comfortable with her environment and those in it. Carol alluded to this feeling:

> Well, the people I hung out with were my friends, of course, and it was all by
>
> choice. And so I, I hung around with people I wanted to be with, and, you know,
>
> they knew me well. So I was fine with being "out" with them.
>
> Carol was "out" to family members as well. She described the process of coming

out to those she was closest to.

> Oh, fine! But at that point my life I was, and I, you know, it was so long ago and

so natural I don't remember. It was not a big thing.

Describing herself as a naturally private person, however, she felt her need for privacy "intensified" upon entering LTC. Upon becoming a new resident of LTC, her uncertainty about whether she would be accepted manifested as her going "back in the closet".

Evidently, Carol's new environment seemed to have a major impact on her behaviours involving sharing her identity. She had lived at a time where gay rights were not a political priority. Despite this, she never really had to worry about those closest to her judging her harshly based on her sexual orientation. Now, the impact of moving into a closed LTC facility created the fear of discrimination for what seemed like the first time. Thus, the factor of being in a new environment—a new home—had a bigger impact on her ability to live openly gay than all her previous, positive experiences.

Brenda (R1), in contrast, had negative experiences when first coming out to her sons before she moved into the LTC facility. She did not feel they accepted her bisexual identity, and they "want[ed] nothing to do with" her afterwards. Perhaps that negative experience played a part in her decision to only reveal her sexual identity to those closest to her—both being nurses—within this environment, rather than her home before the facility. She feared she "might lose friends" if she did reveal her sexual orientation.

Stories being passed around

Some LTC residents encountered discrimination outside of the home in other areas, and the consequence of those experiences framed their idea of what could happen in their facility. Because they had endured maltreatment on the basis of their sexual orientation outside of the home, it was possible to be subjected to such treatment within

it, too. Some who were fearful of this maltreatment had personal, first-hand experiences

with discrimination, but for many others, hearing stories being passed around of others

being discriminated against was enough to be afraid.

Samantha (W2), for example, recalled being told a story about a person who was

"laughed" at because they were transgender:

> Sometimes staff who were doing intimate/personal care for transgendered people
>
> have not been terribly sensitive about the fact that, you know, surgery makes
>
> things look different than you would expect.

They laughed at the resident, she went on to say. This resident had late-stage

dementia, and she found solace in the idea that the resident may not have been aware

enough to know that she was being mistreated. Despite this, the story deeply disturbed

her.

Mrs. Pealm (W1) also heard second-hand stories regarding discrimination on the

basis of sexual orientation, but this time, it was based on other people's misperception.

She explained that she heard about a woman being treated in a hospital who was thought

to be a lesbian because of her close female friendship. It broke her heart:

> A person, who was like a long-term care kind of person, needed continual care
>
> even outside of the hospital, and she had a female friend come to be with her to
>
> help her do whatever. And apparently when somebody was giving care, they
>
> shoved a face-cloth in her face and made comments about her being a dyke or
>
> something like that. The woman wasn't gay.

To hear stories like these, where even suspicion of having a non-heterosexual

identity subjected someone to abuse, is one of the reasons so many residents are fearful of

expressing their sexual identity to others. If stories about discrimination are being passed

around, and if there is a lack of sensitivity training for care staff, LGBT residents might

be more apt to hide their sexual identity due to fear. Jerry (A1) mentioned residents may

feel more afraid in one area of Nova Scotia than another. He recalled, for example, the

violent attack of a prominent gay activist who lived near the Annapolis Valley:

> [An LGBT activist] was stabbed there, but that's not indicative of the area. I've
>
> never seen so many churches in one place as in [small town in NS] so it's a very
>
> religiously-minded area. But having said that, there's so many wonderful people,
>
> [turning to David] right David? They're very accepting and they've been very
>
> welcoming, they've offered me a column in their paper, and now it's gone to the
>
> [name of town] Daily News, and it's gone to Sackville in New Brunswick, 5
>
> papers in Newfoundland, and in Saskatchewan, and God knows where else it is!

Residents living around the area might feel afraid that they might endure the

same treatment, even despite the other supportive and accepting individuals in the area.

The negative experiences, it seems, may speak louder than the positive ones. After all, if

one person can engage in violent, homophobic behaviour, is it not possible for others to

do the same? This fear is especially strong when residents, like Carol and Brenda, relied

on strangers to provide the care they needed to have a good quality of life. Jeopardizing

one's care while living in LTC by outing themselves as LGBT is not an option for

everyone. Living a good quality of life can be difficult if one feels the need to hide part of

their identity from others.

Vulnerable position

Sexual orientation may not be the only reason the resident feels they are

susceptible to discrimination. Additional factors that could play a part are age, health, and geographical location, especially if they point to vulnerability. Being younger than most others in the home while also having poor health and living in a rural area can make someone feel like an outsider. This can compound the effects of already feeling like a minority. The greater the amount of differences one may have from those around them, the greater the fear of discrimination.

Brenda (R1), for example, was younger than the majority of those in her care facility, and felt less able to connect with others because of this:

> I feel sometimes that, where I'm not of the age of many of these people here, they don't know what to do with me, or how to react with me. In some sort of ways it feels like I'm discriminated against. I mean, I even found out years ago that my doctor didn't want to have me. The nurse told me he didn't want to see me; he didn't want to be my doctor anyway.

Brenda already felt different from the others based on her age, and experienced what she felt was discriminatory behaviour because of it. Experiencing discrimination on the basis of her age might not have even been a thought, and so, she might not feel safe in sharing her sexual orientation with others.

Carol (R2) was also "extra" vulnerable, and mentioned how her health status and inability to care for herself played a big part in her experience within the home. Although already describing herself as a private person, her poor health made her keep to herself even more. This prevented her from confiding in those around her and accessing emotional support. Carol said, "I mean, I'm open but I'm not active. I can't move, and I don't talk with anyone about private issues, or barely even any issues". She described

how her ability to confide in others changed upon entering the home, "It's intensified. I've been somewhat private, but my body spoke. I mean, I couldn't and never was a big talker. I didn't have to be, as they say. My body did the talking." She agreed that being open about her sexuality might impact how the staff members care for her. Without knowing for sure, Carol said, "I hear things said and I know they would frown about [my sexuality]."

Living in a big city, Carol had quite a bit of access to LGBT support groups, with one even meeting in her care facility on a monthly basis, open to the public. She still never felt comfortable enough to attend these meetings, which was a factor of her disabilities. "I don't choose to go there every time. It was largely about eating, and again, when your arms and hands don't work, [I would have to have] somebody to put food in my mouth, and it's often [too much] trouble". Carol did mention actively taking part in the gay pride parade by representing her care facility. She alluded to feeling more comfortable doing so because there were so many people that no one would know it was her. She therefore remained "in the closet" during even the most seemingly "out" events. Her privacy, and thus safety, was maintained.

Another factor that can play a major role in fearing discrimination is someone's geographical location of their care facility. In smaller, rural areas, where belief systems may be more orthodox or traditional, a story of someone being discriminated against on the basis of their sexuality may be enough to create fear, as Jerry spoke of in the previous theme. In addition, living in a smaller town or area can also limit one's access to support and understanding outside of the care facility, which can affect how vulnerable a citizen may feel. Brenda (R1), for example, spoke of wanting to connect with an LGBT group

outside of her small, rural location. "Before I accepted being bisexual, I always wanted to get into contact with a group from Truro called "gay pride", but I never did". Not having anyone with whom to connect on the basis of certain similarities such as sexuality may have prevented Brenda from feeling comfortable enough to come "out of the closet" to all those around her.

In summary, three factors that played a part in a resident's decision to hide their sexual identity from others, or go "back into the closet". These factors were fearing discrimination, hearing stories of discrimination being passed around, and being in a vulnerable position. Feeling the need to hide part of one's identity can be detrimental to one's health over time. One may not be able to access the kind of emotional support they need to buffer the effects of stress because they are unable to open up to others, as was the case for Carol and Brenda. And, after all, one should be able to feel comfortable expressing themselves completely in the place that is supposed to be "home".

Relationships with Others

For LTC residents, relationships can be established with staff, residents, and loved ones outside of the home. Having positive relationships can help lessen the effects of stress caused by the aforementioned fear of discrimination by providing a strong emotional support network. These relationships, however, do not always end up being beneficial. Poorly-formed or maintained relationships can be a source of stress due to differences in personal belief systems and experiences. Additionally, other factors may simply prevent bonds from being maintained, such as, in the case of loved ones outside the home, the inability to visit the LTC facility or feeling uncomfortable visiting a LTC facility.

Staff

Staff played an important role in framing the experience that LGBT residents have within the home. Their personal beliefs, the friendship they can provide, and their stress levels were a major factor in the experience of residents within their LTC facility. Staffs' personal belief system can affect whether or not the residents are able to connect with their care providers. For example, a staff member may be very accepting regarding LGBT sexual and gender identities, and therefore there is a possibility for friendship between the resident and the caregiver. Brenda (R1) demonstrated this, as she felt her closest friend in the home was a staff member, and even listing the woman as "next of kin". This staff member was one of the very few people within the home who knew of her sexual identification. "I'm scared to tell people", Brenda admitted. The only two people who knew of her sexual orientation were nurses. She quickly learned, in opening up to the staff members about her bisexual identity, that they were accepting and non-judgmental, which gave her a feeling of security. Interacting with these staff members so often, as they helped her with many of her daily living activities, strengthened their bond and friendship. She still felt afraid of what might happen if she opened up to other residents because she feared she "might lose friends".

Given the high degree of variability of workers who cared for her, Carol (R2) wondered who might be her care provider each day. In response to this stress, she opted to hide her sexual identity from them due to the fear of discrimination and judgment. Before entering care, Carol was part of a program that allowed her to interview and then choose who her home care workers would be. Having to relinquish that control was stressful to her. She described herself as a "lesbian who wants privacy", and explained

why she chose to hide part of her identity from others:

> [I am someone] who knows what side her bread's buttered on, and so I shut up.
> And I realize that that's kind of, that might be hiding, and I'm OK with that. I'd
> rather hide than, you know, jump up and down. I don't know who's gonna walk in
> the door the next morning to get me up, and they can do anything, right?

She was asked if she had encountered discrimination with others in the home that might have contributed to her decision to remain "in the closet":

> Well, not certainly physical. No assault or nothing like that. But I hear them talk.
> The staff talk. And I know how the situation is seen by certainly not everybody,
> but by a few, and like I say, I have no control or idea who's gonna get me up the
> next day, so, so I shut up.

Not knowing what their belief system was, and thus how accepting they would be of someone who identified as lesbian, prevented Carol from forming friendship bonds with the staff members. For others, they may feel incapable of connecting with these care providers because they of their stress levels. As mentioned, staff members may feel the need to rush through their tasks due to being overworked and understaffed, which can create these high stress levels, and can manifest as frustration in their interactions with residents. Staff stress levels also make residents feel similarly stressed. Samantha (W2) spoke of this:

> The nursing homes in which the staff are the most stressed, it seems like the
> patients are the most stressed, and that causes the staff more stress because the
> patients—you know what I mean? That cycle just goes around.

Stress can also be created in residents if they, like Carol, do not completely trust

their care providers, and feel especially vulnerable when having to rely on them for their

activities of daily living, especially those who may be forced to give up some privacy due

to their high care needs. Ms. Pealm (W1) spoke of the vulnerability a lesbian woman

might have in this situation:

> I think in some cases, for example, if you are a lesbian woman who has never been
>
> with a man, and you've never even maybe had a PAP smear, cause it's just not
>
> something you've ever been comfortable with, and you go into a nursing home and
>
> you have a male CCA coming to care for you; If you need [that kind of] care, that's
>
> going to be earth-shattering for you.

Carol (R2) was fortunate to have been able to choose who her care providers were

at one point. Unfortunately, many residents of LTC are not afforded that option, and may

have to deal with situations such as the one Mrs. Pealm (W1) described. Instead of staff

members becoming friends whom can buffer the effects of stress, they may therefore

become the source of stress.

Staff, therefore, can play both a positive and negative role in residents' lives, as

described by the two residents and two workers. Whereas some residents may feel

trustworthy of their care providers due to factors such as well-developed empathy and a

non-discriminatory belief system, and are thus able to foster friendships with these

individuals, others may feel unable to bond positively due to fear of maltreatment,

brought on by a lack of trust. LGBT residents may then turn to their LTC peers—other

residents—for that support.

Residents

Other residents can serve as important support in older LGBT adults' lives

through their friendship. Like staff, other residents' personal belief system can affect their connection to other residents in the home. They may also be a part of tight-knit social circles, which can make other residents feel rejected.

Carol (R2) explained that she shared stories and spent time with other residents. Those residents were friends with whom she could—and often would—play bridge, an activity she very much enjoyed within the care facility. She did not reveal her sexual orientation to them:

> I don't confide in them. If they were in a similar situation that I am, then I would talk to them more, and they would be mutual, and that would be nice. But I don't long for that. It hasn't come up. That's OK.

> She was then asked about whether she chose to go back in the closet to protect

herself from discrimination, and she explained that she had, but that it was not an active decision. "It's just more quiet than usual. I talk to less people about that particular situation".

Carol felt different from others due to her sexual orientation and her lack of physical ability relating to her health status. Similarly, Brenda (R1) also felt a lack of connection with other residents due to her age; she was much younger than everybody else. Additionally, she was put into her current care facility in an "emergency situation", thus preventing her from being able to wait to get a bed at her facility of choice. Despite this, Brenda chose to stay in the same facility when a bed in her "preferred" facility became available. She explained that despite her differences, she had managed to connect with some people in the home. Even though she was only open to two nurses, she said, "I liked the people here and I thought it's time for a fresh start!"

Unfortunately, like staff members, residents can also be a source of stress, as Jerry (A1) explained:

They play a big part in this. Because, say you're with someone as a gay couple, you know, somebody may give you a kiss or something, as straight couples do without any consequence, but can we do that? And the answer is no. Not presently.

Knowing that others could witness the acts of affection and may not feel comfortable with it can, therefore, prevent residents from being able to express themselves authentically with their loved ones. They may perpetually question whether they are safe around other LTC residents, and without being able to trust those around them, they may not feel like those around them are potential friends.

Samantha (W2) felt similarly, feeling that it might be hard for residents with differences such as a non-heterosexual identification to feel accepted within resident "cliques" within the home:

I'm wondering about the discrimination that they would experience from other residents. Cause honest to God, nursing homes are like little junior highs sometimes. They have their little cliques, they have their little gossips, and there's the cool people—you know what I mean? That's a difficult thing.

LGBT residents may or may not find social support amongst other residents in the facility due to several factors. Fearing discrimination due to others' personal beliefs can prevent one from facilitating said friendships, or there simply may not be "room" for them within the already-formed cliques. Carol and Brenda, both developed friendships with residents in their facilities, but they still chose not to share their sexual identity with

them.

Loved ones outside the home

Living in a nursing home can affect residents' relationships with loved ones outside of the home, including family and friends. Sometimes those with friends and family who reside in LTC are uncomfortable visiting the facility due to its institutional nature, among other things. Other times, their ability to visit is a factor of geographical distance and lack of access to transportation. Both Carol and Brenda spoke of this.

When Brenda (R1) moved in to the care facility, she felt discouraged numerous times by her friends, who promised they would see her. One friend, despite being close by, never visited:

> She promised she'd come see me adamantly, and she called me up one day from [nearby town] and told me she'd been at the [hospital across the street from the nursing home] a week ago. I go, "well why didn't you come over to see me? I'm only opposite!" and she goes, "Oh, just wanted to get home!" We've hardly spoken since.

Whatever the reason for the lack of visits that Brenda received from friends and family outside the home, it was clear that it was upsetting to her. Maybe the truth was that she did not feel comfortable visiting because she would have to come to an institutional facility to do so. Perhaps this friendship simply was not strong enough to survive Brenda's move from her home to the facility. Brenda already had a small group of friends, and now, upon moving, it was much smaller.

Carol (R2), in contrast, had found no difficulty seeing friends who resided outside of the home. Her old roommate and best friend still visited often:

Before that, I lived in a condo. I shared it with my friend who still lives there and

comes to visit, but I'm here, we go out. In fact, we did yesterday. Went to a pub

up on the corner, a little bar down that way. That was good.

Location seemed to be a factor contributing to whether or not the loved ones of

LTC residents such as Carol visited. Although this factor is not specifically LGBT-

related, it affected their ability to access social support, which subsequently impacted

their quality of life while residing in the facility. Having this social support outside of the

facility was especially important to those who were not comfortable or did not feel safe

enough to fully express themselves to those within it.

Relationships with others can have a major impact on LGBT residents'

experience living in LTC. Staff, residents, and loved ones outside the home can increase

the residents' quality of life by being accepting, present, and supportive. On the other

hand, if these groups are stressed, discriminatory, or unavailable, the LGBT resident's

quality of life may be compromised, especially when other stressors, such as changing

environments, are present in their life.

Changing Environments and their Impact

When someone moves from one environment to another, many changes take place

which can be both positive and negative. This was true for the research participants,

where they all felt changing environments had a powerful impact on the quality of life of

LTC residents. Some of the changes that were mentioned were relinquishing control of

many things, such as which home they would become residents at and who their care

providers would be. As mentioned earlier, the location of their LTC facility can also have

a large impact on their quality of life, as, for example, homes in urban locations might

have greater access to supportive services due to its bigger and more versatile location.

Additionally, a facility's location can also impact loved one's ability to visit the residents

within the home, decreasing their access to social support. Finally, the location of the

home, complete with its shared stories, experiences, and political climate can impact how

safe and comfortable residents feel within the home. Feeling unsupported by the

community at-large can increase fear of discrimination, and fail to provide adequate

needed resources. The idea of having an LGBT-specific LTC facility was also discussed.

From home to institution

Having to transition from living at home to living in a LTC facility can be both

positive and challenging. The new facility may not feel like home for quite a while, as

residents may be forced to purge many of their sentimental personal items while moving

into their new room. They may also have to share a room with another resident, which

may mean being subjected to different opinions and beliefs, which could, as mentioned,

bring up fears about views other may have about their sexual orientation. Despite this, the

new environment may prove to be more suitable and thus conducive for good health,

providing care and meeting needs that the individual's previous environment was

incapable of providing.

Being a psychiatrist who regularly worked in LTC facilities, Samantha (W2)

explained that the transition from the individual's home to a care facility can be very

emotionally and psychologically challenging. Having a difficult time with this transition,

known as "adjustment disorder", is found in many residents, not only those who identify

as LGBT.

She mentioned some of the strategies that can be put in place to help the resident

cope with the transition:

> We don't usually use medication, it's more trying to help deal with the situation,
> so helping with coping strategies, and then working with the nursing home to try
> to make the transition easier. For example, there was one patient I remember who
> was so not used to the nursing home environment. It was sort of around making
> sure she had stuff from home, and one thing that [LTC staff member] talked
> about, is taking a picture of the person's favourite room at home and setting up
> their room that same kind of way, and then working with the nursing staff around
> what they feel and what they feel would be helpful, trying to make it as homelike
> as possible within these institutional-type settings.

Making this resident's new room more comfortable by setting it up like her previous home helped with the transition. Like all residents, this may be an important step in reducing the stress of moving for LGBT residents, especially if they are already dealing with their other identity-based stressors.

Some residents may have to share a room, which, as suggested by David (A2), can make the transition especially stressful. David said,

> I think that when you're speaking about the nursing homes you would want
> perhaps people who are more open in their philosophies of life to be, because
> there is more than one bed per room, so that you would want more understanding
> because you wouldn't want to have to go back in the closet again.

For LGBT residents who have to share a room, fearing discrimination may be an even more common feeling. They may not feel safe enough to fully express themselves, nor invite their romantic partners to come visit. Perhaps they may have to change the

pronouns of their partners to keep their sexual or gender identity hidden. The stressors of

such potential situations can be powerful.

Moving into a care facility can be positive, too. Although Brenda (R1) "fought"

having to transition into a long-term care facility for years, once she adapted to her new

home, she realized the environment was much more suitable for one reason in particular.

Brenda said, " I never felt safe wherever I was. I feel safe here". For her, the move was

worth it for that peace of mind. In her old home, she became almost obsessive about

having someone break into her home, and spent much energy worrying about it. In the

care facility, she knew the doors were locked in the evenings and that there were staff

members who ensured threatening individuals could not enter.

Lack of control

Losing control over many decisions may be a massive source of stress for LTC

residents. For example, they have very little choice over the food they eat, their care

providers, and how their time is spent. This can make the transition from home into

institution particularly difficult for some residents, especially those who identify as

LGBT, as they also have to deal with other unique stressors. All participants spoke of

specific factors that made the transition difficult, such as not being able to choose how

care is delivered, what personal items they could keep in their new room, whether they

had a roommate or not, and which care facility in which they are placed.

Samantha (W2) recalled some of the unique challenges she learned about that

transgender individuals may face in a LTC facility during her voluntary World

Professional Association for Transgender Health (WPATH) training:

One of the statements that the person who did the WPATH training with me said

was that when transgendered people start to develop dementia, it's really difficult

in nursing homes because they're not able to be as attentive to some of the things

that kept them congruent with their self and their lived gender. The example was

about someone who was transitioning [from] male to female, and they're not

shaving every day, so all of the sudden they're looking like a [man].

Without specific training, staff members may not know how best to care for

transgender individuals, especially for those who can no longer express themselves due to

their illness. What would happen to a transgender individual who is able to express

themselves, but who encounters staff members who are uncomfortable with caring for

them? Some staff members may actually be very accepting and open to that sexual

identity, but may not know how to sensitively ask questions regarding how best to care

for them.

When asked about reasons why individuals may have difficulty transitioning into

a care facility from their home, Samantha (W2) said there were specific aspects of the

transition that can be a source of stress for all residents, not only those who identify as

LGBT. Some of these factors included having to make tough decisions about their

possessions, and being subjected to a lack of control regarding their everyday activities:

I think part of it is the abruptness. Because a bed becomes available and you have

to decide immediately. Having to give up your possessions, and the lack of

autonomy, even about when you eat your supper or what you eat for supper, or

when you go to the bathroom, when you have your bath—that's very difficult.

Having a roommate is huge for people I'm sure you've seen too, it's very very

difficult. Separation from a spouse—if one needs more care than the other,

adjusting to a whole new group of people and having different caregivers every day.

As previously discussed, Carol is an example of a resident who disliked not having the ability to decide who cared for her on any given day. It seemed almost more difficult for her in particular due to the fact that she had previously been able to do so when she received home care.

Although there is some degree of choice when it comes to choosing a facility, a resident's poor health may mean they are forced to choose the first bed that becomes available. This happened to Brenda (R1), and she found the process to be quite stressful:

It was hard! The first day I got here, the menu board said "Fish". I hate fish. So I arrived here at dinner time, and they kept trying to feed me, and I just said, "No!" I was too embarrassed to say "I don't want fish". I wouldn't stand up for myself. I thought to myself, "What have I gotten myself into?"

After about a month, however, Brenda felt much better about her new home, and even decided to stay upon being given the opportunity to move into the facility she initially listed as her first choice:

I realized a week later that I could have the first pick to go back to [nearby home town], and I said "No!" I decided to stay here rather than leave […] because I liked the people here and I thought, "It's time for a fresh start!"

Brenda had evidently successfully worked through the transition, and now felt comfortable and happy with where she was. Perhaps this decision was partially made because she now had her safety and care needs met. A definite deciding factor, however, related to the friends she now had within the facility.

Though this transition can be stressful for all new residents, it can be especially stressful for those LGBT residents who are already fearful of discrimination. These residents may therefore rely on other factors to feel safe, such as an accepting population or overarching care facility philosophy of their environment and additional training for care workers.

Political climate

The political environment or climate can have an impact on the experience of an LGBT resident. Stories of discrimination may be more common in some areas than others, making those who move into homes in those locations more fearful of maltreatment.

Nursing homes are influenced by the political climate or environment of its location. This can mean stories of discrimination are more common in more conservative places, and such stories can play a big role in the experience of LGBT residents in long-term care. Jerry (A1) spoke of this, and specifically mentioned some of the ways in which anecdotes relating to that location may impact residents living in the area:

> You read all these stories about people who discriminate in other parts of Canada, who are, you know, paying attention to this, how much has happened to them. I haven't heard of anything in Nova Scotia, uh, about any particular residents who have been involved in that, but um, but then again, we live in Eastern Canada. Sort've like a small area, population wise, by ourselves, and I think most of the gays and lesbians decide to stay around their own homes or apartments and to try not to go into these long-term care facilities. But if they do, they're still afraid, you see and they're petrified of being found out, of being discriminated against,

and I think that's the main issue.

Living in a smaller area may mean stories get passed around more quickly, and may, as Jerry suggested, prompt LGBT individuals to remain at home, avoiding facility-based care in order to protect themselves from discrimination. Living in their own home in fear, may simply be less stressful than living in an institution in fear.

Having an environment that actively works to protect the lives of those who identify as non-heterosexual can make LGBT people feel safer no matter where they reside. The broader political climate (i.e., the macro environment) was also important. For example, the Health and Wellness Department of the Nova Scotia government showed their acceptance and compassion for LGBT individuals needing care by showing 'Gen Silent', a touching documentary to several places across the province. Mrs. Pealm (W1) was involved in this governmental activity. She felt the activity itself was encouraging, but found the low attendance at the film disappointing:

> They brought it in one of the managers of the largest nursing home here, [she
> was] very supportive. We showed it in the nursing home, [but] not one staff
> member attended.

She felt that the low attendance spoke to the lack of concern and understanding that staff had about the health of LGBT individuals:

> It's not something people put as a priority to learn anything about—'cause, you
> know, "there's only a few and really, everybody's treated fairly, they're all equal,
> and, yeah…not that important"

Ms. Pealm also felt that having training for staff that allowed them to know how to approach sensitive issues such as sexual orientation might be beneficial. Currently,

there was no known required training that aimed to approach this issue:

> For government employees they had a mandatory diversity-type training when I
> started. But when I started with the Department of Health years ago as part of our,
> you know, "you're new with government!", you had to take that, and that was
> around culture as well, not just GLBT, but culture and a bit around
> homosexuality. Then we had further training which delved a little bit more into
> sexual orientation so, that's the only thing I'm aware of.

Mrs. Pealm felt that sensitivity training specific to LGBT issues would be beneficial for all staff members. Samantha (W2), as mentioned, felt the same, especially when having to care for transgender individuals, which are an even less common subgroup of individuals who arguably require greater sensitivity when dealing with their personal care. I then asked about whether Mrs. Pealm (W1) felt the diversity training she received as a government employee was sufficient:

> No, I don't think so—but I think it opened the door. Nothing is going to be
> sufficient in a day. I think it was a really good "open the door" and you're given
> paths that you can take on yourself to enhance your understanding and such, like,
> opportunities have been available whether people take them or not.

Given her interest in supporting LGBT individuals, Samantha (W2) opted to do elective psychiatric training, which involved doing assessments of transgender people for their readiness for hormone therapy. This training was provided by the province of Nova Scotia alongside prideHealth, a program of Capital Health, in partnership with the IWK Health Centre, which aims to improve the health and wellness of LGBT community members through education and providing services. Additionally, she did elective

training around LGBT individuals in LTC, and felt this training should be required as a

preventative measure for staff to sensitively care for LGBT residents, instead it being an

after-thought:

> I think it would be important to have sessions and teaching with staff about LGBT
>
> issues in the nursing home, and to have it as sort of the standard thing, so that it's
>
> not "oh, we've got an LGBT resident, now we have to do this training". It sort of
>
> points the finger at weird or different in their eyes, so I think if it was part of a
>
> standard, even part of the orientation or a part of the yearly update that people do,
>
> I think that would be really helpful. Just to sort of raise an awareness and to make
>
> it not, not so hidden, or not so have to be hidden.

Mrs. Pealm (W1) expressed a similar opinion, and added that the training should

involve actual LGBT individuals, especially when it related to caring for those who

identify as transgender:

> I think a lot of it comes to education, and with education, putting a face on it, I do
>
> still believe that there are still people working in the system, be it CCAs, LPNs,
>
> RNs, whoever, um, administrators, who don't have a face to a lesbian, or a gay
>
> man, or a transgender person—transgender persons perhaps moreso now than
>
> gay—everybody seems to know somebody gay or lesbian, but um, I think the
>
> education needs to be very hands-on and, and really creative in the sense that
>
> bringing it to the homes, and as leadership, like having some leaders who are
>
> willing to, and seniors, who are GLBT and some who aren't and bring that to the
>
> education so that people learn like, "Oh, I get it, they're people".

Jerry (A1) also agreed:

It's important to get maybe two or three people of us, you know? Gay men,

lesbians—three that'd be perfect to go in and, you know, and it has to be

organized in the proper manner […] and just have discussion. You know, you

have to have discussions, you can't just have a talk, but you have to get people

involved, you know, "what do you think?" "what's your idea on this?" and I think

that's what's important. People have to become involved, because you have to

know what's in their minds. You can't just set it up—it doesn't help.

Recognizing the importance of this training, Jerry actually went around his

community LTC facilities and tried to offer it himself, or at least gently introduce the

idea. But, despite being a very well-known LGBT activist in his small community, Jerry

had never been able to contact LGBT residents themselves. At the time, he also had not

been able to provide preliminary training/understanding to staff members of LTC

facilities in his area. He mentioned that prior to the interview, one LTC administrator had

expressed a lot of support for his desire to speak with nursing home residents and staff

about better supporting people LGBT residents and to promote their rights. She invited

him to set up a booth during the following spring to help him achieve that goal. Whether

or not this is successful in allowing him to speak with the LGBT residents remains to be

seen. The more common inability to get in touch with these residents was, he felt, a factor

of the beliefs of certain individuals of the home. "If I can do something like [talking

about LGBT residents' rights at LTC facilities], I'm quite willing to do it. But it's what

the administration will agree to do". For many, their LTC environment was "protected"

by the administrators and other higher-up staff, acting as gatekeepers, another way in

which the smaller environment can prevent one from feeling accepted and safe.

Changing environments can mean being in a completely new political climate,

which can have a positive or negative impact. Certain locations may come with stories of

discrimination, unfortunately a reality for the two resident participants. Heteronormative

political frameworks can also mean the resident's new home's activities, policies, and

staff training is reflective of that, as validated by several participants. Some of these

participants felt that more training amongst care staff was required, and suggested that the

training involve LGBT individuals themselves so that care providers could get to know

actual LGBT individuals, rather than simply speaking about them.

LGBT homes

While discussing the unique challenges involved for an LGBT person living in

LTC, having a home designed for LGBT individuals was mentioned, and there were

mixed opinions about it. Jerry (A1), Samantha (W2), Brenda (R1), and Carol (R2) felt

positively about the idea, whereas Mrs. Pealm (W1) was less sure. Samantha, similar to

Jerry, felt an LGBT-friendly home would allow residents to feel safe:

> I think it would be fantastic. It would take a lot of the fears and pressures off the
>
> LGBT person if they knew they were going somewhere safe. Where they weren't
>
> going to encounter discrimination, they weren't going to encounter staff who were
>
> whispering, or anything like that.

When first asked, Brenda (R1) felt she would rather stay in her current home than

move into a new one, as she had become accustomed and close to the people with whom

she lived. She had already described having a hard time becoming used to the new

environment, and the anticipated stress that would come from moving locations once

again seemed to be the determining factor in her feelings about the LGBT-friendly home.

Two days after interviewing her, I received a call from her, and she stated that she

changed her mind; she would move to such a home if she was given the opportunity.

Although Carol (R2), the self-described "private person", mentioned feeling

satisfied with her openness with those around her, she did suggest she would feel

positively about being around others who were more similar to her. She felt that an

LGBT home might be positive for her. "If [other residents] were of a similar situation

that I am, then I would talk to them more, and they would be mutual, and that would be

nice".

When asked directly, Carol (R2) mentioned that if the location of the home were

near where she resides currently, the idea of entering an LGBT-specific home was more

amenable to her:

> Well because it speaks about being friendly, and being accepting and that's
>
> mostly why. But you know what I really like about this is? The neighbourhood.
>
> The location. So, if that was somewhere in the [location in the city] then, big-time
>
> yes.

Ms. Pealm (W1), as a lesbian woman herself, felt that creating such a facility might

not speak to the real issue of discrimination, and simply provides a temporary solution.

The solution should instead aim to be long-term:

> I mean, I'm of two minds with it, because on the one hand I think "Wow, wouldn't
>
> that be nice" and on the other hand I think "segregation". Because, honestly, if I sat
>
> down and thought of all my friends, you know, most of them are straight if I, if I
>
> ended up—which I don't, probably wouldn't—but if I ended up in a home with my
>
> friends, you know, would I have to not be near my straight—I know it's gay-friendly

as in, well probably the straight friends I have would probably prefer to live in

GLBTI-friendly [homes], just the kind of people they are. But you know, I'm really

torn because the other part of it feels to me like all the homes that aren't, that they're

unwelcoming and yet they're in the communities that people would like to live in, so

I almost, like, I'm supportive of it, but at the same time, I don't think it's the answer.

Additionally, like Carol (R2), she felt the location of the home would have an impact

on its success. For example, because Halifax is a big city, she felt there were enough

LGBT individuals needing care that it would make sense to create a home specifically

designed for them. For more rural NS locations, it might not be as successful due to the

lower numbers of LGBT individuals in those areas.

She was then asked if she felt there should be different approaches taken based on

the specific population of an area:

> Well I think they have the ability to have that kind of approach. Because there'd
>
> be the numbers to substantiate that, but even in our process, the way the
>
> government works, that's not even, you know, single-entry access wouldn't even,
>
> that doesn't even fit the process now. Not saying that it shouldn't, because maybe
>
> even something like a francophone home, or a—which there are some—or you
>
> know, there will be other cultures that would probably, it would benefit them
>
> greatly to have their own home.

When considering the possibility of an LGBT-friendly home, it is clear that many

factors should be taken into consideration. In Jerry (A1), Samantha (W2), and Carol's

(R2) eyes, safety and being around similar individuals would be a positive impact of

being in such a home. In contrast, the perpetuation of segregation as resolution to

discrimination was not the right way move forward according to Mrs. Pealm (W1).

Having to change one's environment can be challenging for many reasons, especially to those with greater vulnerabilities. It can also be a very positive move, however, when the new environment provides a better quality of life to the residents. Relinquishing control over daily decisions, the location of the care facility, and the political climate of the environment can have a major impact on the residents' experience within the home, as validated by the participants. It is possible that creating a LGBT-friendly home might be a positive experience, especially if all factors are taken into consideration, though there were still some reservations regarding this idea. Obviously, there is not one simple answer to helping cope with the stress of changing environments.

Conclusion

Three themes emerged from the data. First, according to the participants, hiding part of one's identity was a way to protect one's self from discrimination on the basis of sexual orientation within the home. The source of the discrimination could be from residents or staff members of the home. The stories that were passed around within the facility was also a source of fear for the LGBT residents, as was being in a vulnerable position for other life factors, such as age and/or compromised health status. Within the second theme, relationships with others, the connections residents had with the LTC staff, other residents, and loved ones outside the home was discussed. Finally, the third theme, changing environments and its impacts, prompted discussion regarding moving from their home into institutional care, the effect of losing the ability to control their everyday activities and care, the geographical location of their care facility, and the political climate of that location. It is clear that one's sexual identification can impact their

experience in LTC, and better understanding how it impacts their experience can help

decision-makers develop a better plan with the goal of maximizing the quality of life of

these residents in the future. The next chapter analyses these themes through the lenses of

the minority stress, ecological, and intersectionality theories, allows for an in-depth look

at how these factors impact the lives of LGBT residents of LTC.

CHAPTER 6: DISCUSSION

After speaking with LGBT LTC residents, LTC-related staff members, and LGBT

activists, it became clear that this research was consistent when compared to the small

amount of existing research on the subject. The participants agreed that LGBT

individuals would find it difficult to openly express their sexual orientation within LTC.

This was due to aspects of their experiences that created fear, such as negative stories

being passed around within the home that related discrimination on the basis of sexual

orientation. Even though the resident participants did not have first-hand experiences

with discrimination within the home, they did not feel safe. All participants understood

feeling fearful of discrimination. Some of the consequences of not being open regarding

sexual orientation were loneliness and isolation. In order to mediate these effects,

residents received support from friends both inside and outside of the facility, as well as

from staff members. Most participants discussed the benefit of providing sensitivity

training for LTC staff members so they could be prepared to adequately care for LGBT

residents. The idea of LGBT-specific homes was also discussed, and most participants

were in favour of such a facility.

Each participant perceived the difficulty a LGBT resident might have in openly

expressing their sexual orientation and/or gender identity within the LTC environment,

which is consistent with prior research finding that many LGBT residents coped by

hiding their sexual identity (Bonneau, 1998; Cahill & South, 2002; Cook-Daniels, 1998;

Kochman, 1997; Rosenfeld, 1999; Stein et al., 2010). With regards to the resident

participants, this finding was particularly interesting because they each had different

experiences growing up. Their different experiences did not seem to impact their decision

to remain closeted while in the nursing home. Both residents still had fears about encountering discrimination from those within the home, and decided to keep quiet about their sexual identification.

One explanation for this finding might be that the residents' experiences with immediate environments have had a great impact, and might influence them presently more than any of their past experiences. The combination of the ill-fitting environment as well as their minority-related stress affected the way in which they experienced the LTC facility. It muted their self-expression.

Aspects of their experiences, such as stories being passed around, created fear and/or apprehension about expressing their sexual orientation in an open manner. All participants in this study had heard negative stories regarding LGBT LTC residents experiencing discrimination on the basis of their sexual orientation, and felt that hearing about these stories might lead to feeling unsafe within their so-called "home".

Regardless of the fact that none of them had first-hand experiences with discrimination on the basis of their sexual orientation, the stories still prevented them from feeling completely safe. Residents might have felt unsafe due to the anticipated stigma, that is, the stress associated with their sexual identity (Meyer, 1995, 2003). This also makes sense when highlighting the fact that each environment or level of social ecosystem interacts with each other. In this case, the interactions were at the level of the mesosystem, where the stories being passed around within their neighbourhood and within the larger social environment were the determining aspects of their environment which shifted the way they behaved within it. These interactions created forces that prevented the individual from feeling completely comfortable within their own home,

indirectly altering their ability to share openly without fear about anything related to their

sexual orientation or gender identity. Though there had not been evidence of these

discriminatory acts happening within their home, their behaviours were no different than

if they had.

All participants agreed that LGBT residents would not feel safe expressing their

sexual orientation or gender identity to others within the home, including the LGBT

residents. It only takes one person to make a discriminatory comment, or subtle facial

expression to make the resident feel uncomfortable in fully expressing themselves within

their facility. The residents' choice to keep this information private contributed to some

loneliness, which is congruent with prior research on the subject which suggests that

having a lack of social support can contribute to feelings of loneliness, isolation, and

stress, increasing the possibility of becoming clinically depressed (Conn, 2002; Canadian

Institute of Health Information, 2010; Fredriksen-Goldsen et al., 2011). Compounding the

effects of lacking connection with other residents in the home, residents might also not

have a close relationship with their blood-related family members. Having a lack of

connection with one's given family is also found in existing research (Barranti & Cohen,

2000; Grant, 2009; Grossman et al., 2000; Grossman et al., 2002).

Despite the lack of support the resident participants felt from certain others due to

their sexual identification, they both filled the gap elsewhere (e.g., friends outside the

home, support from staff members), thus appropriately coping with their unique stressors

in a healthy way despite challenges. This is congruent with research that found that

LGBT residents do find additional means of support, especially from friends (Beeler et

al., 1999; Whalen et al., 2000; Grossman et al., 2000; Grossman et al., 2002; Jacobs et al.,

1999; Orel, 2004), or, more specifically, "chosen families", which consisted mostly of

friends and provided major means of emotional support (Grossman et al., 2000, 2001;

Heaphy et al., 2004). Important, supportive friendships can also be made with staff

members of nursing homes. Unfortunately, LTC staff deal with stressors of their own,

some of which are factors of their personal lives, while others stem from their work.

Being overworked and/or working in an understaffed facility can be one of these

stressors. Being overworked or understaffed can also mean not having the time to

properly care for residents in the home, and may mean they need to rush in order to finish

all their given daily tasks. This leaves little to connect on an emotional level with

residents, which can be devastating to those who do not have friends or family outside of

the home who visit regularly. Having to rush also means having little time to build trust

between the residents and care providers, thus perpetuating the potential fear some

residents may have about being mistreated.

Receiving other means of support might not always be possible for all residents,

as suggested by the LGBT activist participants. Prior research has shown that residents in

smaller communities, rural communities might have less access to supportive services

(Beeler et al., 1999; Galassi, 1991; Nynstrom & Jones, 2003; Orel, 2004; Smith &

Calvert, 2001; van de Ven et al., 1997), services that could vastly improve their quality of

life in LTC. This provides additional evidence for the unique stressors that LGBT

individuals are faced with, as suggested by the minority stress theory. Being able to

access supportive services available to them could act as a healthy buffer for other

stressors, such as being fearful of discrimination and not having access to their given

family members. Accessing these supportive services would fill the gap of needs that

LGBT residents might have, and it is unfortunate that the environment in which they live prevents them from accessing those supports. Here, like many other aspects of this research, the minority stress theory and the ecological theory work quite well together to explain this group of individuals' unique challenges.

Having an environment that actively worked to protect the lives of those who identify as non-heterosexual could make LGBT people feel safer no matter where they reside. The broader political climate impacted the macro environment, where showing acceptance of LGBT older adults in LTC (by, for example, screening the "Gen Silent" film as mentioned earlier) gave others insight into their experience. This was an example of how activity in a macro environment could have trickle-down effects into micro environments, even for those in smaller, rural communities.

This research found that living within smaller communities not only meant that LGBT residents had less access to support groups and supportive services, but it also meant that stories of discrimination were more quickly passed around, making residents even more fearful of encountering the same treatment. Hearing these stories meant that the fear/stressor the residents already had were echoed throughout their environment, both at a macro level, within their country and province, and at the micro level, within their LTC facility. This is why it takes time for some residents to open up to others about their sexual orientation, why some chose to remain closeted, and why some individuals are not able to access the care they need. In order to avoid the stress of being discriminated against, they might remain at home, where they are potentially unable to receive the type of care they need in order to maximize their quality of life. Perhaps, however, lessening that fear-based stress is more helpful to one's overall health than it

would be to receive the 24-hour care. Though difficult to truly know without research in this area, it is clear that deciding which environment is most suitable while navigating their diverse and sometimes complex health needs is challenging at best.

The residents' decisions not to share their sexual orientation with others may also be related to their fear of maltreatment when receiving care from staff members. This is shown in prior research that found that staff members were potential sources of discrimination (Stein et al., 2010; Brotman et al., 2007; Johnson et al., 2005). These staff members held heterosexist/heteronormative attitudes. (Daley, 1998; Krauss-Whitbourne et al., 1996; Peterson & Bricker-Jenkins, 1996). In this research, LTC workers interviewed expressed being accepting of LGBT residents. This finding was not surprising given it was unlikely that staff members who felt uncomfortable or unsupportive of LGBT individuals would have volunteered to be interviewed on such a topic. Not only might it have brought up challenging feelings, but it also might have put their job at risk. LTC staff members can have negative attitudes of LGBT residents (Cahill & South, 2002; Hinrichs & Vacha-Haase, 2010), so the residents' fears about encountering homophobic staff members, or at least staff members who did not feel comfortable caring for individuals such as themselves were reasonable. All participants agreed that this was a source of fear for LGBT residents.

Most participants felt that providing additional training to staff members as well as residents would help lessen the impact of their negative attitudes or lack of understanding when it came to dealing with residents who identified as LGBT, providing a safer and a more fitting environment for those LGBT residents. Recent research studies support the training recommendation by addressing the possibility that many LGBT older

adults feel unsafe when accessing community services. Healthcare services with workers who have gone through LGBT-sensitivity training helped LGBT individuals feel more welcome (Croghan, Moone, & Olson, 2015; Fredriksen-Goldsen, Hoy-Ellis, Goldsen, Emlet, & Hooyman, 2014). Building on this recommendation, the participants of the current study felt that there should be mandatory LTC staff training that includes actual LGBT individuals so that staff members can gain empathy and compassion for this diverse group of people. This would also allow staff members to be prepared to interact with LGBT residents, as opposed to having to figure it out in the moment, which might not be a comfortable or appropriate process.

Offering sensitivity training would help the staff members interact with LGBT residents within the staff members' microsystem; their work environment. It would also work to help lessen the negative impact of the residents' minority status relating to their sexual orientation by providing a buffer—that is, a more empathetic understanding of who these LGBT individuals are and who they are not. This would provide a space for appropriate emotional support if the residents were to ever request it from staff as well, thus additionally buffering their other unique stressors.

Training programs for LTC staff have been recommended both provincially and federally to address the issue of discrimination, though, as suggested by past research as well as some of the participants, few staff members have actually gone through this training (Brotman et al., 2003; Kochman, 1997; LGBT Movement Advancement Project & SAGE, 2010; Stein et al., 2010). Fortunately, in Nova Scotia, the organization 'prideHealth' (a partnership of Capital Health and the IWK Health Centre) offers individual and group training for professionals who work with people who identify as

LGBT (para. 5). This training includes information regarding "safe and inclusive

environments", as well as more in-depth training on how to provide healthcare with those

who identify as transgender, among other LGBT-related topics (para 5).

As mentioned, training should be mandatory for all staff members, because if not,

it is possible that few staff members may elect to do it. Making the training mandatory

would also mean the staff members would have adequate time and space for this training

to be administered, and would undoubtedly improve feelings of openness and acceptance

among non-heterosexual residents.

Deciding to remain in the closet in LTC was also a factor of the residents'

vulnerability, as suggested by the residents' experiences. Having to rely on staff members

for basic activities of daily living increased feelings of vulnerability, especially not

knowing which staff member might walk through the door to provide care on any given

day, any given moment. For residents who were once able to choose who cared for them

within their own home, coping was especially challenging. The shift of environment,

therefore, added to the stress. This suggests that one's minority status is enhanced. Not

only is one a sexual minority, but a minority in health, too. Autonomy and feelings of

choice are compromised, and one therefore might not want to also compromise their

safety by opening up about their sexual orientation.

Intersectionality helps explain why some LGBT residents might simultaneously

experience discrimination and privilege due to their multiple statuses. Though she was

privileged enough to access care in her LTC facility, one resident felt extra vulnerable

due to differences in age from other residents within the home. Her age acted as one of

their layers of identity. Residents who are much younger than the majority of others in

the home might feel unable to connect with many of the other residents due to their age

difference. Even care professionals might exhibit some discrimination due to these

differences, and may make residents feel unwelcome to receive the help they want to ask

for and need. As past research has suggested, not being able to receive the support one

needs compromises overall health (Murray et al., 2011; Oswald & Masciadrelli, 2008).

Finally, most of the participants supported creating an LGBT-friendly facility,

which is consistent with past research findings (Lucco, 1987; Quam & Whitford, 1992;

Johnson et al., 2005; Orel, 2004; Rivera et al., 2011). Most of them felt that having a

home designed to specifically meet their needs as LGBT individuals would provide

needed feelings of safety for self-expression in its fullest. It would allow them to interact

with staff members who are aware of their unique needs as LGBT people and thus know

how to properly and sensitively deal with them. The staff of these facilities would be

accepting, and the residents would know this, which would vastly lessen their fear of

discrimination within that care facility. Also working towards that goal would be

knowing that other residents are also accepting, and likely also LGBT. This might make

residents feel able to talk more openly with more people, and thus be able to access a

greater amount of social support from others in the home, creating a better, more suitable

environment to appropriately deal with their unique stressors.

Not all participants felt so confident about supporting LGBT-specific care

facilities, however. Taking into account intersectionality and thus the unique experiences

of each LGBT resident also helps explain why there is no "one-size-fits-all" solution to

help maximize the quality of life for LGBT residents in LTC, not even a LGBT-specific

care facility. Decision-makers must take into account the variety of experiences of this

diverse group in order to foster change. This is also consistent with past research

indicating that, although most LGBT individuals are supportive of these "LGBT"

facilities, not all of them are (Lucco, 1987, Quam & Whitford, 1992). These facilities

might not always be accessible to those in smaller regions, either, because of the low

number of LGBT Nova Scotians living in these areas. Their numbers might not be great

enough to warrant such a facility. Given this finding, it is even more important to

emphasize the need for mandatory LGBT-sensitivity training for all LTC staff members.

Recommendations

Based on the findings, the following are recommendations for changes to occur in

order to best support the quality of life of LGBT individuals in LTC:

First, cultural sensitivity training should be provided to LTC staff members, and

would include actual older LGBT individuals. During these training sessions,

fundamental information regarding sexual and gender minorities would be discussed,

including common definitions and terms used within the LGBT community. In addition

to knowledge, the training would also include opportunities to reflect on attitudes and

learn and practice new behaviors (Fredricksen-Goldsen et al., 2014). A portion of the

training would also be dedicated to educate attendees about the unique challenges and life

situations LGBT individuals face, as well as common healthcare issues they may have.

Hypothetical situations involving various sexual and gender minorities would be given to

those attending. The staff members would discuss how they might deal with these

hypothetical situations, and then the attending LGBT individuals would discuss how they

would prefer care be given in each circumstance.

This training is consistent with suggestions made by Fredriksen-Golsen et al.

(2014) regarding potential strategies that would improve the well-being of older adults

accessing healthcare. One of these suggestions was to critically analyze the attitudes of

professionals towards sexual and gender identity. Specifically, the authors felt that

presenting the staff with hypothetical sensitive care situations involving an LGBT

individual and having the staff write down their thoughts and feelings would be

beneficial. The staff would also discuss how they might take action in response to such a

sensitive situation. This could help bring their potential biases into their awareness,

allowing them to address them and find appropriate ways to deal with these biases while

providing adequate care for the LGBT individual. Other suggestions could be made by

those providing the training as well as the LGBT individuals participating as to what

alternative methods could be used to cope with this sensitive situation while still

respecting the rights and dignity of the person being cared for.

   Having LGBT individuals share their unique stories about growing older as a

sexual and/or gender minority would help attendees gain compassion for these

individuals. This is consistent with the suggestion Fredriksen-Goldsen et al. (2014) made

about having others understand how the LGBT individuals' environmental contexts may

have had negative impacts on them. It is also consistent with their suggestion to make

distinctions within the subgroups of LGBT older adults and their other identities, such as

their age, gender, race, and health status. Those attending the training would hear various

stories from individuals who identify as part of the subgroups, and those stories would

inevitably vary based on their unique identities.

   This training would provide staff the opportunity to have positive experiences

with sexual and gender minorities. It could also help staff cope with any anxiety or

confusion they may have related to working with LGBT individuals in LTC by providing examples of what they may expect during their caregiver duties, such as what a post-operation transgender individual's body may look like, or how to sensitively care for an individual who may never have been cared for by a member of the opposite sex.

Parts of this training could be offered to LTC residents too, such as the portion dealing with fundamental knowledge about LGBT individuals, as well as related basic terminology and definitions. They could also listen to the stories and experiences of LGBT individuals, which may detail any challenging times they have had facing or fearing discrimination from strangers and healthcare practitioners. This would allow them to gain compassion and empathy for sexual and gender minorities with which they may live in the nursing home.

Fredriksen-Goldsen et al., (2014), also suggest being cognizant of the language staff use while providing care for LGBT older adults, as their biases and/or stereotypes might be subconsciously conveyed within it. For example, using the proper pronouns for individuals who are transgender, or understanding the basic difference between sex and gender, would help build rapport between the staff member and the person receiving care.

Also consistent with Fredriksen-Goldsen et al.'s (2014) article is my next recommendation of providing supportive services specifically for LGBT individuals. Such services would provide social support in the form of leisurely community events, group talk-therapy, and dinner groups geared towards LGBT individuals. There could also be online and telephone support provided for those living in smaller cities and rural areas, or for those who are unable to access the support in person.

A second recommendation relates to a Resident Bill of Rights. The province of

Ontario has a Resident Bill of Rights to which every LTC facility and those in it must

adhere (Advocacy Centre for the Elderly & Community Legal Education Ontario, 2015).

Each LTC facility must have it on display and provide a copy for each of its residents.

The document reminds everyone that each resident is a valued member of the

community, and must have their rights respected while in the home. Along with 13 other

items, this document details that each resident has the right to: (a) have their dignity and

individuality respected, while being free from abuse; (b) be provided shelter, food,

clothing, grooming, and care in a manner consistent with their needs; (c) communicate in

confidence, receive any visitors, and consult in private with anyone without interference,

(d) raise concerns or recommend policy-changes on behalf of themselves or others

without fear of restraint, interference, or discrimination, (e) form friendships, enjoy

relationships, and participate in the residents' council, and (f) meet privately with their

spouse in a private room, as well as share a room with their partner if such a room is

available.

As previously discussed, Nova Scotia's Health Council was tasked with

developing a similar bill of rights for the province, but they concluded that it would lead

to too many complex legal problems. They instead created a document outlining

expectations related to the provision of healthcare. A lack of adherence to these

expectations, however, does not have legal ramifications. Nova Scotia must examine in

greater detail the operational details of Ontario's Resident Bill of Rights, and learn from it

in order to successfully implement a similar bill in Nova Scotia. In doing so, a greater

sense of environmental safety, dignity, and privacy will be created for all residents,

regardless of their differences. They would also know what is expected of them while

living in the LTC facility and understand the potential consequences of not respecting the

rights of others.

Limitations

Due to having significant difficulty in gathering participants for this research, I

was only able to recruit two LGBT residents. Although I expected the recruitment

process to be challenging, I did not anticipate the amount of difficulty I encountered. This

lack of ability in gathering older LGBT LTC residents was partially influenced by my

"outsider" status within that age-group.

In the beginning, I sent out information packages to approximately 80 nursing

homes across Nova Scotia, which included a brief description of my research, why I felt

the research was important, and why I was conducting it. I also included some

recruitment ads in the package and asked the administrators of the home to put one up on

the bulletin board for the residents to see. To my surprise, several administrators called

me to say that they did not have any LGBT residents in their home. I encouraged them to

put up the ad anyway, noting to them that although it was very possible there were some

of their residents who were LGBT but simply did not let their sexual orientation be

known among those within the home. I received one call from an administrator saying

not only did she not have any LGBT residents in the home, but she also felt that putting

up the recruitment ad would make residents feel uncomfortable. Because she wanted to

avoid this potential consequence, she did not put up the ad. Perhaps it was true that the

residents of her LTC facility were all heterosexual, however, in the event that there were

some who did identify as LGBT and simply did not make that known to others, this

administrator was preventing their voices from being heard. Their opportunity for

vocalization regarding their experience in LTC was being prevented before they even

knew about it. Yet, I also received phone calls from several administrators thanking me

for doing the research as they felt it was important as well. They agreed, however, that if

they had any residents who identified as LGBT, they were not aware.

Although I was able to recruit two LGBT residents of LTC, after several months

of waiting for more responses, I decided to expand my search to the rest of Canada. I e-

mailed and phoned additional nursing homes across all the provinces, without any results.

I decided, therefore, to seek the opinions of stakeholders of the issues, which is when I

connected with the additional four research participants. Though I initially hoped to

solely interview the LGBT LTC residents themselves about their experience, the

information and opinions gathered by the shareholders was valuable. They were able to

speak from similar perspectives as the residents, given all but one were also LGBT, and

felt they had a lot to share about the issue, including strategies to improve the experience

of living in LTC for future residents. The variety of perspectives, I found, brought a new

life to the research.

Another limitation of this study was that I was unable to speak to a transgender

participant, which limited my understanding of the experience a transgender individual

might have within LTC. One of the participants working in the LTC field, however, had

completed training related to caring for transgender individuals, and was thus able to

share her perspective with regards to a transgender person's experience. Though I would

have loved to hear the perspective of the individuals themselves, I felt this was a good

compromise, and was grateful for this person's perspective.

Given the fact that this research was qualitative in nature, the findings of the study

are not representative of the population of older LGBT individuals across Canada, and

represents only the experiences of a small number of Nova Scotians. I am not concerned

about this limitation, because every individual's experience is subjective and different

from any one other person. Their environments and experiences as minorities are unique

and subjective. These subjective experiences, therefore, are valuable regardless of the

lack of generalizability and representativeness they provided. Moreover, it was important

to examine what is happening in Nova Scotia, given that many health related policies are

at the provincial level.

Another limitation of this research involved the fact that I, the researcher, may

have been prone to bias as a result of my past experiences and familiarity with the related

existing literature. Any potential biases were minimized by practicing disciplined

subjectivity, as well as by maintaining a reflective journal to increase my own awareness

about these biases.

Future Research

Although this research did, for the first time in Canada, include the perspectives

of the LGBT residents themselves regarding their experience in LTC, a greater number

and variety of LGBT participants living in LTC would provide valuable information.

Future research projects should therefore aim to recruit a greater number of LGBT

participants who are LTC residents.

Given that the baby boomers are widely known to be those who have lived more

openly than any previous cohorts regarding their sexual orientation, it will be important

to gain their perspective on how they might experience receiving LTC services if they

were to ever require that level of care. Baby boomers might not be so willing to use

protective coping to deal with potential discrimination and might push for change rather than use invisibility, for example. Understanding their perspective will help decision-makers make changes within the LTC and political system to best care for them and thus maximize their quality of life while accessing LTC.

Related to this, it would be interesting and helpful to know and compare the impact that the stress caused by fear of discrimination based on sexual orientation with the impact of postponing 24-hour healthcare needs. Avoiding fear-based stress might lead to a better health outcome than receiving facility-based care while fearing discrimination.

Given the fear of discrimination among LGBT residents was acknowledged by all the participants of this research, it would be interesting to better understand the health outcomes of LGBT residents living in a traditional LTC facility compared to those living in a LGBT-friendly facility. This research could also question the family members and loved ones of these LGBT residents living outside of the home with regards to their perceptions of their loved one's health and their comfort level in visiting their facility. This would allow decision-makers to better understand how the choice of facility (both in location and in philosophy) impacts the way residents interact with others outside of the home.

A more in-depth look into the perceptions of LTC staff members and residents regarding their perception of caring for and living with LGBT individuals would be helpful. Very little research has been done on this within Canada, which would help share the reality of how staff and residents feel today. In doing so, the stories being passed around regarding discrimination might fade away in comparison to the positive stories of acceptance for those who identify as LGBT within LTC. This understanding would also

allow training programs to be curated for Canadian staff members and residents, and thus

might be more successful in creating proper support and understanding for LGBT

residents in the future.

Finally, future research could focus on potential training programs for LTC staff

members across Canada. Doing a cost-benefit analysis would help determine how

realistic this training would be if it were to be mandatory. Perhaps the improved health

outcomes for LGBT residents end up lowering the cost of their care in the long-term.

There may also be many other helpful training programs that could help support LGBT

residents as well as other heterosexual residents in the home.

There are many questions that could be explored through future research, and

simply not enough academics aiming to do this type of research, especially given the

numbers of LGBT baby boomers who might require care in the very near future. The

more quickly researchers focus their attention on better understanding the experience of

these LGBT individuals, the sooner their health and quality of life can be maximized no

matter their health needs. LGBT individuals certainly deserve to receive competent care

without expectations or fears of discrimination.

CHAPTER 7: CONCLUSION

Nova Scotia houses the highest percentage of seniors of any province in Canada, which means that this province in particular needs to prepare for the possibility of having a large amount of individuals needing to access 24-hour, facility-based care. Given the context of today's Canadian family, acquiring this care may mean entering a LTC facility, and these facilities need to be prepared for a population of older adults who identify as LGBT. Although there has been some research done on the subject of LGBT individuals' thoughts, fears, and experiences in such facilities, gaps in the literature remain.

Guided by ecological, minority stress, and intersectionality theories, this study explored the LTC experiences of LGBT individuals living in Nova Scotia. In-depth, semi-structured interviews were completed with six individuals: two LGBT older adults, two older LGBT activists, and two workers in the LTC field.

Highlighted in the findings is the suggestion that regardless of whether or not LGBT LTC residents have endured maltreatment on the basis of their sexual orientation, the fear of encountering such treatment still exists and impacts their experience while living there. Based on the experiences of the LGBT residents, as well as the experiences and understandings of individuals working in the LTC field and gay activists, it did not seem to matter whether discrimination had been a first-hand experience for LGBT residents. Simply the possibility that discrimination was possible prevented them from interacting with others within the home for fear of being "outed"—for their sexual identity to be discovered. Had this happened, they might lose friends, be subjected to poorer care by the staff members, or be the topic of gossip among other residents. This

would not be a comfortable microsystem in which to live. This is a cruel irony given the LTC facility is meant to support health-related needs. Evidently, their minority status affected their experience. As discussed in previous chapters, the health-related needs of any individual, but especially those who are already in a vulnerable position, are impacted by a person's social and emotional states. That is, if one's social and emotional needs are met, it positively affects their physical health. All these aspects of an individual's experience in LTC need to be acknowledged and identified to provide the best care possible.

Though this research has been able to, for the first time, speak to the LGBT individuals themselves who are living within LTC, there is still much to be understood. It is thus important to continue doing research on this subject to better understand the diversities of experience among this vast, unique group of LGBT individuals, thus allowing key decision-makers to create plans to best support such individuals in LTC. Individuals working and living with LGBT residents must develop compassion and understanding for them. Research focusing on what actions and tools would encourage this would be helpful. As reflected in this research, residents should to feel safe and supported within their LTC home.

In conclusion, the current research lends support to findings of existing research in that LGBT residents in LTC used invisibility to protect themselves from potential discrimination from staff and residents, and they had less access to support than their heterosexual peers and created their own unique social support networks to bridge that gap. Suggestions made by participants were consistent with existing research in that mandatory staff training was thought to be a good, and perhaps necessary, way to help

staff navigate caring for LGBT residents, as well as the positives and negatives of the

idea of a LGBT-friendly LTC facility. For the residents, their experience in LTC was a

factor of their minority status as well as the ecosystem/environments with which they

interacted both throughout their lifetime and in the present days. Thankfully, these

environments are changing, and more than ever there are potential avenues that can be

taken both at the micro and the macro level. If stakeholders of this issue remain focused

and diligent, as proposed by the LGBT activist participants, change will come.

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Appendix A: Resident Interview Guide

Life before facility
1. This interview is focusing on your experiences in here in this facility, but to provide a bit of context to start with, can you tell me about your life 5 years prior to entering this facility?
    Probe: Work, friends, favourite activities…
2. What kind of support did you have before entering the facility (financial, social, etc)?
3. Can you describe how "out" you were?
    Probes: Were you "out" (sexual orientation known) to others in your life? Who were you out to? If you were not out to certain people, why or why not?

Deciding to move into the facility
4. When did you move into this facility?
5. How long have you lived here?
6. Can you tell me about your decision/reason to enter this facility?
    Probe: What was the reason?
7. Did you look at any other places, and if so, why did you choose this one over another one?

Initial entrance/first few days
8. What it was like to first enter the facility?
    Probe: Did you come out to anyone? If so, who, and how did that go?
9. What was the first week like?

Life in facility
10. What do you enjoy the most about being in the home?
    Probe: Why?
11. What do you least enjoy about the home?
    Probe: Why?
12. Are there any activities/events you wish happened in the home?
    Probes: What are they? Why?
13. What kind of support do you have now?
    Probe: inside the facility, outside the facility
14. Do you feel the need for more support?
    Probes: Why or why not? What kind?
15. Have you requested or thought about transferring facilities?
    Probes: Why or why not?
16. Has being in here changed you in any way?
    Probes: If so, how, and for what reason?

Individuals in the home
17. Who are the people who are most important to you in the home?
18. Why are they important to you?

19. Which person (or people) do you interact with the most?
    Probe: Why?
20. How do you feel about your level of interaction with them?
21. Are there people you wish you would have more interaction with?
    Probe: If so, who are they, and what would you like to change?

Being LGBT in the facility

22. Is your sexual orientation known to people in the facility? If so, who, and why or why not?
23. Do you feel that identifying as LGBT has affected your experience here in the home?
    Probe: Why or why not?
24. Do you feel your needs are different because of your identification as LGBT?
    Probe: Why or why not?
25. Do you think the policies that are in place in this home are adequate?
    Probe: Why or why not?
26. Are there any you wish they had in place?
    Probe: Why or why not?

Health

27. How do you define "good health"?
28. Would you consider yourself to be in good health?
    Probe: Why or why not?
    Probe: physical (such as mobility), mental, spiritual health, etc.
29. Does the facility help you remain in "good health"?
    Probes: How, and why or why not?

Recommendations

30. Are some things you wish you could change about the home to improve your experience here?
    Probes: If so, what are they? Why or why not?
31. If a nursing home built specifically to be LGBT-friendly, would you consider moving in?
    Probe: Why or why not?
32. Is there anything that we haven't talked about that you think would be helpful or important for me to know about?

General Information

33. What is your relationship status?
    Probe: What is your mobility like? (lots of issues, moderate issues, no issues)?
    Probe: Level of anxiety and/or depression? (lots, moderate, none)?

Appendix B: Stakeholder Interview Guide

I'd like to hear your thoughts about individuals living in long-term care (LTC) facilities (nursing homes) who identify as lesbian, gay, bisexual, transgender, or LGBT (LGBT).

Could you tell me what you do as a hobby/job that relates to the subject of LGBT individuals in long-term care, and why you feel you might have information/stories that could be helpful?

1. Has a resident ever confided in you or another staff member about their sexual identity/orientation?
    a. *Probe*: (If yes) Why do you feel they confided in you/the staff member? Do you think this is common?

2. Do you feel that the experiences of residents are different based on their sexual/gender identity? *Probe*: Why/why not? In what ways?

3. What are the issues you think these residents would face if they were living in a LTC facility?

    a. *Probe*: Are there issues of discrimination?
          i. If so, in what ways? From whom?
          ii. Do you feel this is common? Why or why not?
          iii. How could administration approach these potential issues?

    b. *Probe*: Do you believe residents who identify as LGBT hide their sexual orientation upon entering long-term care? Why/why not?

    c. *Probe*: Do you feel that a resident identifying as LGBT might live differently upon entering long-term care? *Probe: Relationship with* Friends and confidants, frequency/details regarding partner visitations, etc.
          i. Why/why not? In what ways?
          ii. (If yes) Do you feel this might affect their quality of life? *Probe*: Why/why not?

    d. *Probe*: What are staff members'/government employee perceptions of LGBT individuals? Please explain.
          i. (If yes) Do you think that affects the way they care for/interact with the residents? How so?

4. Have you heard of any specific positive experiences of LGBT residents living in LTC stemming from their sexual/gender identity? If so, can you share those with me (without identifying the person)?

5. Have you heard of any specific negative experiences of LGBT residents living in LTC stemming from their sexual/gender identity? If so, can you share those with me (without identifying the person)?

6. In your work as a government employee or LTC worker, what kind of comments have you received from others (e.g., LTC residents, other government workers or LTC employees, the general public) about this topic?

7. What is currently in LTC homes in terms of support for those who identify as LGBT? *Probe:* policies, staff training, resident education, activities, etc.

8. What changes in LTC facilities do you feel would benefit those who identify as LGBT? *Probe:* policies, staff training, resident education, activities, etc.

9. What are your thoughts on LTC facilities built specifically for LGBT individuals?

10. Do you believe identifying as a LGBT resident in LTC, is an issue that should be explored by:
> i. LTC facilities?
> ii. The government?
> iii. *Probes*: Why/why not, and in what ways?

11. Is there anything that we haven't covered that you think would be helpful for me to know about? Please explain.

Appendix C: Informed Consent Form

The Experience of Living in Long-Term Care as an LGBT (lesbian, gay, bisexual, transgender) Individual

Principal Investigator: Maureen Green, MA student; Department of Family Studies and Gerontology, Mount Saint Vincent University; 902-448-0022, mgreen2@msvu.ca

Co-Investigator: Dr. Áine Humble, PhD, CFLE; Associate Professor, Department of Family Studies and Gerontology, Mount Saint Vincent University; 902-457-6109, aine.humble@msvu.ca

Dear Participant,
You are invited to take part in an in-depth interview. This study is being completed as part of my Master of Arts degree in Family Studies and Gerontology. The purpose of this study is to better understand what it is like to live in a nursing home for people who identify as lesbian, gay, bisexual, or transgender. This research is being conducted out of Mount Saint Vincent University and has received funding from the Nova Scotia Health and Research Foundation.

You are eligible to participate as a resident if you:
- live in Canada;
- are lesbian, gay, bisexual, or transgender;
- are 50 years or older;
- have lived in a licensed nursing home for at least one month;
- do not have dementia;
- do not need the permission of an adult child; and
- are able to give insight about your experience so far.

You are eligible to participate as a stakeholder if you:
- Work in an area of the government or long-term care (LTC) system and feel you have insights into the experiences of LGBT residents in LTC.

What will happen if I participate?
I will have a conversation with you about your experience in the long-term care facility. If you decide that you would like to take part in the study, I will contact you (via phone or in person) regarding where you would like the conversation/interview to take place. You may choose to have the interview in your room, in the nursing home, or by telephone (the cost of any long-distance phone call will be covered by me). Conversation topics will include privacy, your relationship with staff members, family members, and other residents, the things you like about the home, and the things you dislike. The interview has no time limit, but will take approximately one hour to complete. You may take a break at any time during this process.

What are the risks of taking part?

Despite the fact that the ethical components of this research study have been reviewed by the University Research Ethics Board, as with any research study, there is a possibility that privacy may be breached (e.g., someone may overhear our conversation). If you are not out to others within the home, this may lead to the discovery of that fact. However, this risk will be minimized by having you choose the location of the interview or, if you prefer, being interviewed over the telephone (I will cover the cost of this). I will also use a pseudonym in transcription and remove any identifying information.

Another risk is that you may find some of the interview topics upsetting or distressing. You do not have to talk about anything you do not want to, and you are able to stop your participation at any time if you wish without penalty.

What are the benefits of taking part?

Taking part in the interview may be beneficial as you will be able to talk openly to someone who is accepting and non-judgmental. You will be able to share your experiences and have someone provide support for them. Also, contributing to research that is funded and seen as meaningful by the Nova Scotia Health Research Foundation means that what you share will also be seen as meaningful and important. My hope is that the information gained in this study will be able to influence long-term care practices and policies in the future.

What about privacy?

I will only use information that you share with me that I need for the study. I will remove any identifying information from the transcripts in order to maintain confidentiality (such as your name, the location of the nursing home, and the names of family members and friends). However, under provincial law, I am required to report any instances of abuse (either to self or others) under the Protections of Persons in Care Act of Nova Scotia and other provincial policies (such as BC's Residents' Bill of Rights, New Brunswick's Nursing Homes Act, and Newfoundland and Labrador's Operational Standards of Long-term Care).

The audio recording, files, and documents relating to the study will be kept in a locked cabinet, and stored files on a computer or USB drive will be password protected. Dr. Áine Humble and I will be the only individuals who will have access to them. The audio files will be deleted once I have completed my Master's degree. The paper transcripts as well as the consent forms will be deleted and destroyed after 5 years.

What if I do not want to participate anymore?

If you want to stop participating, you may do so at any time without penalty. You will be asked if you would still like the information collected so far to be used in the study. If you decide that you would not like it to be used, the information will be destroyed.

How will the interview data be used?

After my thesis is completed, I will attempt to publish the findings in a variety of ways (e.g., conference presentation, journal article, article in local publications). Quotations from your interview may be used in any of these publications or presentations.

What if I have any questions or problems?
If you have any questions or problems relating to the research, you may contact me by telephone at 902-448-0022, or by e-mail at mgreen2@msvu.ca or my thesis advisor, Áine Humble, at 902-457-6109, or by e-mail at aine.humble@msvu.ca.

If you would like to speak with someone not involved with the study, you may contact the chair of the Mount Saint Vincent University's Research Ethics Board c/o MSVU Research and International Office, at 902-457-6350 or by e-mail at research@msvu.ca

Statement of Consent
I have read and understood the information above related to my participation in the research study, "The Experience of Living in Long-Term Care as an LGBT Individual", and have had any questions answered. I consent to the use of non-identifying quotations from my interview in the student's thesis and in future reports, publications, or presentations.

Participant's name (please print) _____

Participant's signature
_____

Date _____

I consent to being audio-recorded for the interview.

Participant's signature
_____

Date _____

Principle Investigator's Signature
_____

I would like to receive a copy of the results by e-mail or mail

□ Yes
□ No

E-mail address: _____

Mailing address: _____

_____

_____

I would like to review or receive a copy of my transcript

□ Yes
□ No

E-mail address: _____

Mailing address: _____

_____

_____