Diversity through Inclusive Practice: An Aging LGBTQ Perspective

by

Jess Boulé

A Thesis presented to The University of Guelph

In partial fulfillment of requirements for the degree of Master of Science In Family Relations and Applied Nutrition

Guelph, Ontario, Canada © Jess Boulé, August, 2018
ABSTRACT

DIVERSITY THROUGH INCLUSIVE PRACTICE:
THE PERSPECTIVES OF OLDER LGBTQ ADULTS

Student
Jess Boulé
University of Guelph, 2018

Advisory Committee
Dr. Kimberley Wilson
Dr. Robin Milhausen

This research project investigated the health and aging experiences of 21 lesbian, gay, bisexual, trans, and/or queer (LGBTQ) adults, between 60 and 79 years of age, so as to identify the perceived service and support needs of this population. Participants engaged in focus group discussions. An inductive theoretical thematic approach was used to analyze the data. Participants described a desire to be included and safe within Canadian society. Participants anticipated age-related losses and as such, expected a greater use of and dependence on health and social care services. Despite greater LGBTQ visibility and inclusive care, participants perceived care services and facilities to not be prepared to offer safe and competent support. Participants, described employing positive aging strategies to overcome discrimination and support the health of LGBTQ seniors living in Ontario.

Recommendations for inclusive practice, related to community, health and social care and directions for future research are discussed.
Acknowledgements

I would like to thank…

My thesis advisor and mentor, Dr. Kim Wilson who has fully supported me (probably more than she ever anticipated she would) throughout these past two years. I feel so fortunate to have had an advisor that genuinely cared and prioritized my own health, especially during times when I would forget, or neglect, to do so. Every meeting I left with a new lesson learned and an even greater understanding and acceptance of alternative perspectives. I am beyond appreciative for her surplus of kindness, patience and openness. Kim has always gone out of her way to offer a solution and to lend an ear, as well as her time. But most importantly, I have always felt that she accepted me for being me. Thank you Kim for giving me a chance. I am really looking forward to spending the next ~four years working with you again!

Dr. Robin Milhausen, my thesis committee member, who has offered invaluable feedback and guidance throughout the thesis process. Thank you for being so flexible and open to reading this (enormous!) thesis. Your perspectives and suggestions really strengthened this paper!

Dr. Hannah Tait-Neufeld for stepping in to be the internal/external examiner during the defence. Thank you for offering your time on such short notice and your unique take on this project. I look forward to learning more about cultural safety and finding ways to incorporate such knowledge into my future work.

Drs. Kathy Kortes-Miller and Arne Stinchcombe. By taking part in this study, I really learned the benefits of collaborating with other researchers and across Universities. Thank you for being so kind to me, for really taking me in on your project(s), for considering my future success as a student researcher, and for teaching me everything you could in terms of the research process. Being a part of this project taught me some incredible lessons and I’m so grateful that I got to share this experience, as well as learn, from all three of you.

My partner for being a complete pillar of support throughout the past two years. Thank you for not treating me like a potato, and throwing me out the window as soon as I got a bit sour. Honestly, I’m not sure if this thesis would have made it to the Atrium without your tech help. Aren’t you excited for ~four more years of this? Ha!

Lastly, I want to share my absolute appreciation for the folks who volunteered to participate in this study for so generously giving their time and sharing their personal life stories and perspectives with the research team.

Without all of these people assisting in or supporting me throughout the research process, I feel there would not be a thesis to submit.

Thank you all.
Disclaimer on Language

Using language that is inclusive and non-assumptive, is an ever evolving process. For instance, in 1967 there was an article entitled “Homosexuality Among Women,” published in the *Canadian Nurse.*\(^1\) The authors of the article, Rancourt and Limoges, defined lesbianism as an “addiction” and a “retarded social development” (as cited in Brotman et al., 2015 p.113). The terms used in this sentence are riddled with language which we would consider in the current context, to be quite offensive, ignorant, and prejudice. However, within the context of history, this was the language and the perspective that was shared by researchers and medical professionals. I recognize that this language exemplifies the negative attitudes that continue to medicalize and pathologize sexual and gender diverse people and to “other” people who do not fit within the structural norms (among other things). My point in including this reference, is that even today we continue to question the language, and the meaning given to certain terms, used within this field of research, (e.g., “minority”, “marginal,” etc.). Health equity experts have suggested that instead of using the term “vulnerable,” researchers and care providers, alike, use “populations we oppress through discriminatory, racist, policies and stereotypes” (as tweeted by @LauraCaitlyn, March 23, 2018).

Language is complicated, powerful, laden with individual meaning and driven by the social contexts of its time. Therefore, I hope that the person(s)—if any—who read this thesis, read it with an understanding of the context in which it was written. I further hope that you are able to empathize with the circumstances of its writing, in that I am budding researcher and as I continue to engage in reflexive practice, I hope to continually challenge myself to evolve the language and terms that I use and to re-define their meanings. As one of the participants stated during this

project, “[…] if something is worth doing […] it’s really worth fucking it up in order to get good at it and allow that process the time that it needs.”
Table of Contents

ABSTRACT ............................................................................................................................................................ ii

Acknowledgements ............................................................................................................................................... iii

Disclaimer on Language ........................................................................................................................................ iv

Table of Contents ................................................................................................................................................... vi

List of Tables ......................................................................................................................................................... ix

List of Figures ........................................................................................................................................................ x

List of Abbreviations .......................................................................................................................................... xi

Chapter 1: Introduction .......................................................................................................................................... 1

Chapter 2: Critical Literature Review .................................................................................................................. 5

Defining Sexual Orientation and Gender Identity within an Aging Cohort ................................................. 5

The history of oppressive language .................................................................................................................. 5

The evolution of language .................................................................................................................................... 5

The meaning behind language ............................................................................................................................ 6

Demographic Data on Aging LGBTQ Adults in Canada .................................................................................. 7

The aging population ............................................................................................................................................ 7

Aging LGBTQ populations ................................................................................................................................. 8

Surveys .................................................................................................................................................................. 8

The limitations of quantitative methodologies ................................................................................................. 9

An estimation of the LGBTQ population in Ontario ...................................................................................... 10

The Theoretical Approaches to Studying Aging LGBTQ Populations ......................................................... 10

Social ecology ...................................................................................................................................................... 11

Minority stress theory ......................................................................................................................................... 11

Life course theoretical perspective .................................................................................................................. 12

Intersectional framework .................................................................................................................................. 12

Blending theories .................................................................................................................................................. 13

The health equity promotion model (HEPM) ................................................................................................. 13

The Emerging Themes and Gaps within the Evidence-Base ............................................................................. 15

Background .......................................................................................................................................................... 15

Physical and mental health disparities and needs ............................................................................................ 16

Social supports and connectedness .................................................................................................................. 18

Service provider perspectives .......................................................................................................................... 28
Cultural competency and inclusive practice as a solution to accessible care .................................................. 30
Stigma as a health promoting pathway ........................................................................................................ 31
The Rationale for this Research Project ......................................................................................................... 32
Limited research in Canada .......................................................................................................................... 32
Intersectional research .................................................................................................................................. 33
Qualitative experiences .................................................................................................................................... 33
Purpose Statement and Research Questions .................................................................................................. 34

Chapter 3: Methods .......................................................................................................................................... 36

Study Design ................................................................................................................................................ 36
Ethical considerations .................................................................................................................................... 36
Eligibility criteria ........................................................................................................................................... 38
Recruitment of participants ........................................................................................................................... 39
Study procedures ........................................................................................................................................... 40
Reseacher Positionality ................................................................................................................................. 43
Data Analysis ................................................................................................................................................ 45
Thematic analysis ........................................................................................................................................... 45

Chapter 4: Results ........................................................................................................................................... 56

Participant Characteristics ............................................................................................................................ 56
Thematic Interpretations of the Data ............................................................................................................... 57
Living (in)visibly: Exposure to discrimination across changing social systems and identities .......................................................................................................................... 57
(Dis)connections from the community: Finding inclusive and safe supports as a marginalized person and/or socially repressed group ........................................................................................................ 82
Power(lessness) and (de)energization: The fight for choice and autonomy ................................................. 107
Requests and Recommendations for Inclusive Care Provision ..................................................................... 120

Chapter 5: Discussion ................................................................................................................................... 127

The Implications of the Study ......................................................................................................................... 127
Past discrimination and invisibility .................................................................................................................. 127
Anticipating health disparities ......................................................................................................................... 135
Dependence on home, community, long term care and retirement homes ..................................................... 137
Anticipatory coping ....................................................................................................................................... 142

Application of the Research: Recommendations for Community, Health and Social Care Services and Providers ......................................................................................................................... 144
Recommendation 1: Develop an understanding of how past oppressions continue to influence the invisibility and the health of LGBTQ individuals and communities .............................................. 144
Recommendation 2: Ask questions and avoid making assumptions ................................................................. 146
Recommendation 3: Communicate and use meaningful terms effectively ....................................................... 146
Recommendation 4: Use symbols to signal safety to older LGBTQ adults ...................................................... 147
Recommendation 5: Adopt trauma informed approaches to care ................................................................. 149
Recommendation 6: Foster community by developing outreach strategies ..................................................... 149
Recommendation 7: Include the voices of older LGBTQ adults, and their allies, in educational trainings and in the planning of inclusive practices and policies ..................................................... 150
Recommendation 8: Critically reflect on normative structures and discourses and the implications of care providers’ identities and values on older LGBTQ health. .................. 151
Recommendation 9: Promote capacity among older LGBTQ adults........................ 152
Recommendation 10: Continue providing care to older LGBTQ adults by advocating on behalf of their health needs. ................................................................. 153
Recommendation 11: Co-ordinate and regulate inclusive care practices across staff, sectors and institutions. ................................................................. 154
Recommendation 12: Promote kindness, acceptance, and empathetic understanding when working with LGBTQ communities. ......................................................... 155
Recommendation 13: Provide equitable care and treatment to a spectrum of identities and sub-communities. ................................................................. 156

Summary of the Findings and Recommendations ................................................. 158
Power(lessness) and (de)energization. ................................................................. 160
The Strengths of this Study .................................................................................. 163
The Limitations of this Study .............................................................................. 164
The sample ........................................................................................................... 164
The study design, procedures and analysis. ............................................................ 165
The health equity and promotion model ............................................................... 167

Areas for Moving Forward in Future Research ...................................................... 168
Recruitment and working in collaboration with community partners ................. 168
Incentive to participate. ......................................................................................... 170
Inclusive language and questionnaires. ................................................................. 170
Narrative interviews. ............................................................................................. 172
Mixed research methods. ..................................................................................... 173

Conclusion ........................................................................................................... 174

References ........................................................................................................... 175

Appendices .......................................................................................................... 187

Appendix I: Tri-Council Policy Statement 2—CORE Certification ...................... 188
Appendix II: Ethics Approval—REB#16NV050, H05-17-19, REB#026-17-18 ......... 189
Appendix III: Recruitment Materials ................................................................. 193
Appendix IV: Research-Designed Demographic Questionnaire .......................... 196
Appendix V: Information Letter ........................................................................ 201
Appendix VI: Inductive Thematic Analysis ......................................................... 207
Appendix VII: Summaries of Participant Characteristics .................................... 219
## List of Tables

<table>
<thead>
<tr>
<th>Table</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Focus Group Questions</td>
<td>41</td>
</tr>
<tr>
<td>2</td>
<td>Initial Themes and Subthemes</td>
<td>48</td>
</tr>
<tr>
<td>3</td>
<td>First Revision of Themes and Subthemes</td>
<td>51</td>
</tr>
<tr>
<td>4</td>
<td>Second Revision of Themes and Subthemes with Codes</td>
<td>52</td>
</tr>
<tr>
<td>5</td>
<td>Final Revision of Themes, Subthemes and Sub-Subthemes with Codes</td>
<td>54</td>
</tr>
<tr>
<td>6</td>
<td>Original Table of Themes, Subthemes and Codes</td>
<td>211</td>
</tr>
<tr>
<td>7</td>
<td>Participant Identities</td>
<td>219</td>
</tr>
<tr>
<td>8</td>
<td>Participant Education, Occupation, and Socioeconomic Status</td>
<td>221</td>
</tr>
<tr>
<td>9</td>
<td>Participant Health</td>
<td>223</td>
</tr>
<tr>
<td>10</td>
<td>Summary and Impressions of Participant Responses to the Social Convoy Model</td>
<td>227</td>
</tr>
</tbody>
</table>
## List of Figures

<table>
<thead>
<tr>
<th>Figure</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>A Guiding Map of the Health Equity and Promotion Model (HEPM)</td>
<td>15</td>
</tr>
<tr>
<td>2</td>
<td>Why Does Only Half of my Maple Tree have Leaves?</td>
<td>207</td>
</tr>
<tr>
<td>3</td>
<td>Original Thematic Map</td>
<td>208</td>
</tr>
<tr>
<td>4</td>
<td>Evolution of Thematic Map</td>
<td>209</td>
</tr>
<tr>
<td>5</td>
<td>Final Thematic Map</td>
<td>210</td>
</tr>
</tbody>
</table>
## List of Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>APA</td>
<td>American Psychiatric Association</td>
</tr>
<tr>
<td>ARCH</td>
<td>HIV/AIDS Resources and Community Health</td>
</tr>
<tr>
<td>CCHS</td>
<td>Canadian Community Health Survey</td>
</tr>
<tr>
<td>CPP</td>
<td>Canadian Pension Plan</td>
</tr>
<tr>
<td>DSM</td>
<td>Diagnostic Statistical Manual</td>
</tr>
<tr>
<td>FTM</td>
<td>Female to male</td>
</tr>
<tr>
<td>GIS</td>
<td>Guaranteed Income Supplement</td>
</tr>
<tr>
<td>HEPM</td>
<td>Health Equity Promotion Model</td>
</tr>
<tr>
<td>IOM</td>
<td>Institute of Medicine</td>
</tr>
<tr>
<td>LGB</td>
<td>Lesbian, gay, bisexual</td>
</tr>
<tr>
<td>LGBTQ</td>
<td>Lesbian, gay, bisexual, trans, and queer</td>
</tr>
<tr>
<td>LGBTQI2S+</td>
<td>Lesbian, gay, bisexual, trans, queer, intersex, two-spirited, plus</td>
</tr>
<tr>
<td>LHINs</td>
<td>Local Health Integration Network</td>
</tr>
<tr>
<td>LQIP</td>
<td>Long term care quality inspection program</td>
</tr>
<tr>
<td>MAiD</td>
<td>Medical assistance in dying</td>
</tr>
<tr>
<td>MTF</td>
<td>Male to female</td>
</tr>
<tr>
<td>NCCPH</td>
<td>National Collaborating Centres for Public Health</td>
</tr>
<tr>
<td>NSAC</td>
<td>National Seniors Advisory Council</td>
</tr>
<tr>
<td>OAS</td>
<td>Old Age Security</td>
</tr>
<tr>
<td>ODSP</td>
<td>Ontario Disability Support Program</td>
</tr>
<tr>
<td>OSPN</td>
<td>Ottawa Seniors Pride Network</td>
</tr>
<tr>
<td>OSS</td>
<td>Ontario Senior’s Secretariat</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td>RHRA</td>
<td>Retirement Homes Regulatory Authority</td>
</tr>
<tr>
<td>SDoH</td>
<td>Social determinants of health</td>
</tr>
<tr>
<td>SSHRC</td>
<td>Social Sciences and Humanities Research Council</td>
</tr>
</tbody>
</table>
Chapter 1: Introduction

Within the Canadian aging population, there are many distinct identities and subgroups of communities, each of which contain their own experiences, challenges, and characteristics. These characteristics are often referred to as social positions and include factors such as race (or ethnicity), culture, (dis)ability, socio-economic status, age, sexual orientation, and gender identity (or expression—Haber, 2009; Fredriksen-Goldsen, 2016). Social positions inform an individual’s position of power, or, specifically, the level of privilege or marginalization experienced within a society (e.g., Fredriksen-Goldsen et al., 2017a). Social positions often intersect, compounding the effects of discrimination or disadvantage to ultimately determine an individual’s health status2 (Mikkonen & Raphael, 2010; National Collaborating Centres for Public Health [NCCPH], 2012; World Health Organization [WHO], 2017). This becomes especially evident in aging lesbian, gay, bisexual, trans, and queer (LGBTQ)3 populations where the intersections of age, sexual orientation, and/or gender identity have revealed multiple forms of oppression that contribute to the health disparities4 and social exclusion of this community (Hatzenbuehler, et al., 2014; Wilson, Kortes-Miller, & Stinchcombe, 2018).

Similar to their heterosexual counterparts, LGBTQ adults face physical, mental, and social challenges to aging (Hughes, Harold, & Boyer, 2011). Ageism,5 for instance, is prominent in Canada (Carstairs & Keon, 2009) and has been shown to lower the life satisfaction and self-esteem of aging heterosexual, gay, and lesbian adults (Bradway & Beard, 2015; Brotman, Ryan, &

---

2 As such, various social positions are often referred to as the social determinants of health (SDoH).
3 Throughout this research project, the acronym LGBTQ will serve as an umbrella term in order to refer to the many unique populations and intersections of identity within the spectrum of orientation and gender identity. See section entitled, “Defining Sexual Orientation and Gender Identity within an Aging Cohort” for the rationale.
4 Health disparities refer to the adverse gaps between individuals of varying social positions (Fredriksen-Goldsen, 2016).
5 Ageism is the discrimination or prejudice based on a person’s age. According to Bradway & Beard (2015), “[a]geism is a problem that is both reflected and reinforced by projections of older people in mass media, perceptions held by social others, and the views and values we ourselves hold” (p. 504).
Cormier, 2003, MAP & SAGE, 2010). For sexual and/or gender minority individuals, though, ageism becomes an added burden to the many stressors already being faced (Brotman, Ferrer, Sussman, Ryan, & Richard, 2015; Fredriksen-Goldsen et al., 2014b). Despite Canada’s political advancements in terms of acknowledging the tumultuous histories of LGBTQ communities, researchers have found that older LGBTQ populations continue to experience substantial health inequities due to a lifetime of discrimination imparted by health and social care services (e.g., Brotman et al., 2015). Canadian social justice researchers (e.g., Brotman, Ryan, Jalbert, & Rowe, 2002b; Daley, 2006; Giwa & Greensmith, 2012; Mulé et al., 2009; Mulé & Smith, 2014) have documented the ways in which institutional policies have reinforced dominant assumptions of normativity regarding gender, sexual orientation, and age, as well as regarding race/ethnicity or culture; even within LGBTQ run organizations themselves (Brotman et al., 2002b; Giwa & Greensmith, 2012). As a result, many older LGBTQ remain hidden, or “in the closet” (Brotman et al., 2003, p. 19), unable to access much needed resources and supports (Brotman et al., 2003; Brown & Grossman, 2014; Espinoza, 2014; Gendron et al., 2013; Grant et al., 2011; Hughes et al., 2011; Ottawa Senior’s Pride Network [OSPN] & Ipsos Reid, 2015); while others may even consider suicide (Alzheimer’s Australia, 2014; Cooks-Daniels, 1997; Rivers, 2006; Tully, 1989).

The Ministry of Health and Long Term Care and Ontario Senior’s Secretariat (OSS) have recognized the increased fiscal realities of an aging population (e.g., Ontario Long Term Care Association, 2016; OSS, 2013), as health problems and the use of health and social services tend to increase with age (National Research Council Panel on a Research Agenda and New Age Data for An Aging World, 2001). However, barriers to accessing such services, especially among those who

6 Stressors may include both structural and individual level stressors. Structural level stressors include: social exclusion, social stigma, institutional heterosexism and/or racism. Individual level stressors include: micro-aggressions, discrimination, victimization and abuse. (Fredriksen-Goldsen et al., 2014).
identify as LGBTQ, have resulted in greater health disparities (Fredriksen-Goldsen et al., 2013a; Fredriksen-Goldsen, Kim, Bryan, Shiu, & Emlet, 2017b) thereby increasing health expenditures (Healthy People 2020, 2017). As a result, Ministries across Ontario have been stressing more inclusive, respectful and equitable access to quality care (e.g., Health Quality Ontario, 2016; Health Quality Ontario, 2015) through healthy aging strategies, such as those outlined within the Ministry of Seniors Affairs report on Age-Friendly Community Planning (2013) and the OSS’ Ontario’s Action Plan for Seniors (2013). While such reports acknowledge the importance of facilitating environments that promote continued independence and community engagement for all older adults, no matter their health or social status, there are no explicit recommendations regarding the needs of LGBTQ populations in particular. Therefore, the unique needs of those in the LGBTQ community must continue to be explored and the gap between the knowledge of these needs and the services being provided must be closed (Anderson, Um & McKenzie, 2016).

Although research has been conducted on the topic of aging, sexual orientation, and gender identity, the data originating from Canada is limited. Often, the experiences of LGBTQ populations are generalized as one community (Brotman et al., 2015; Fredriksen-Goldsen & Muraco, 2010) and as a result, the unique individual and subgroup needs are overlooked in order to serve more general research and advocacy aims (Brotman et al., 2015; Davidson, 2015). Though research trends regarding LGBTQ populations depict a central narrative of poor health, unmet needs, isolation, and despair, several studies have also recognized samples of older LGBTQ adults where stressors have contributed to successful aging strategies and resilience in later life (e.g., Fredriksen-Goldsen, Kim, Shiu, Goldsen, & Emlet, 2014a; Kimmel, Rose, & David, 2006; Meyer, Ouellette, Haile, & McFarlane, 2011). Therefore, the aims of this Masters’ thesis project will be to generate an
understanding of the health and aging experiences of older\textsuperscript{7} LGBTQ adults living in Ontario so as to inform inclusive practice among care service\textsuperscript{8} providers.

\textsuperscript{7} The term older refers to any individual over the age of 60.
\textsuperscript{8} The use of the term care services is derived from the works of Swartz, Bunter, Fruhauf and Orel (2015), and as such, will include any community-based health and social supports that aims to reduce health disparities and optimize the quality of life of older LGBTQ adults.
Chapter 2: Critical Literature Review

Defining Sexual Orientation and Gender Identity within an Aging Cohort

The history of oppressive language. Within the field of gerontology, the terminology used to describe the intersection of aging, sexuality, and gender identity has and will continue to change as it reflects the shifting cultural attitudes of a society (Fredriksen-Goldsen, 2016). From a Canadian perspective, homo/bi/trans-phobia and hetero/cis-sexist attitudes have prevailed since its colonization (Hunt, 2016). Terms such as homosexual or transsexual (Fredriksen-Goldsen, 2016; Rossi & Lopez, 2017) were the standard language used to contextualize a non-heterosexual experience of sexuality. The American Psychiatric Association’s (APA) Diagnostic and Statistical Manual’s (DSM) use of such terms designated individuals who engaged in same-sex behaviours or expressed a gender outside of the binary as pathological (Brotman et al., 2015; Rossi & Lopez, 2017); ultimately stigmatizing the identity of many of these communities (Rossi & Lopez, 2017). Within the past 20 years, differences among sexually diverse and gender variant populations and individuals have become more apparent (Rossi & Lopez, 2017). Since the removal of the term homosexuality from the DSM in 1973 and the complete removal of same-sex behaviours as a mental disorder (i.e., sexual orientation disturbance) in 1987 (De Block & Adriaens, 2013), LGBT has become the most widely used acronym within aging research in order to account for the varying experiences of lesbian, gay, bisexual, and transgendered individuals (Brown & Grossman, 2014; Cronin & King, 2010).

The evolution of language. Many new and distinct identities continue to surface though. As an umbrella term, queer, recognizes the many communities that exist beyond LGBT, whereby Two-Spirit, pansexual, intersex, asexual, and numerous gender variant and nonconforming
identities are becoming increasingly common extensions (Cronin & King, 2010). Fredriksen-Goldsen (2016) noted from the Aging with Pride: National Health, Aging, Sexuality and Gender Study that adults over the age of 50 are increasingly identifying with terms such as queer or genderqueer however, other resources (e.g., Averett, Robinson, Jenkins, & Yoon, 2014; The National Resource Centre on LGBT Aging, 2010) have indicated the use of the term queer remaining offensive with older cohorts, despite its reappropriation by the younger generation in the 1990s (Galinsky, Hugenberg, Groom, & Bodenhausen, 2003).

The meaning behind language. Likewise, controversies remain over the use of the term homosexual. Some research findings suggest older adults appear more likely to self-define as such (e.g., Kim & Fredriksen-Goldsen, 2013; Fredriksen-Goldsen, Hoy-Ellis, Goldsen, Emlet, & Hooyman, 2014c; Rawls, 2004), while others prefer to self-identify with labels such as lesbian and gay (Fredriksen-Goldsen, 2014c; MacFarland & Sanders, 2003) or to not identify with any labels at all (Brotman et al., 2007; Fredriksen-Goldsen, 2014c; Wilson et al., 2018). Distinct differences also tend to arise when race, or ethnicity, is taken into consideration. Fredriksen-Goldsen (2016) described the use of terms such as same-gender loving and down-low among certain African American populations. The language that will be used throughout this research project therefore, becomes not only important in validating participants’ right to self-define their identities; but also acknowledges that sexual and gender identity are situated within the specific contexts of time,

9 For more information regarding the extensiveness of these acronyms, please view a clip released by Equinox, in collaboration with the LGBTQ Community Centre, entitled “LGBTQAlphabet: Six Letters Will Never Be Enough.” The video explores the meanings of various identities based on the letters of the alphabet in order to expand the definition, and provide a wider representation, of the diverse experiences that subgroups within the LGBT community may have: <https://www.youtube.com/watch?v=KQ0D5W5Htc0>

10 The term reappropriation, within this context, refers to the cultural reclamation of the stigmatizing label queer.

11 The use of the term homosexual has been met with negativity from many individuals within LGBTQ communities. This is due to the American Psychiatric Association’s (APA) Diagnostic and Statistical Manual’s (DSM) use of the word to designate a mental disorder (APA, 1952—as cited in Rossi & Lopez, 2017). As such, the use of the term homosexual became stigmatizing to many communities.
place, culture, race and ethnicity. A body of literature exists acknowledging the importance of using inclusive language\(^{12}\) and cultural competency in service provision and practice (e.g., ARCH, 2017; Croghan, Moone, & Olson, 2015; Rossi & Lopez, 2017), however the same must be considered when conducting research with populations that have experienced a history of marginalization.

Throughout this research project, the acronym LGBTQ will serve as an umbrella term in order to refer to the many unique populations and intersections of identity within the spectrum of orientation and gender identity. Other acronyms, such as LGB (lesbian, gay, bisexual), along with specific labels (e.g., trans) will be incorporated when referencing the literature that acknowledges these subgroups in particular. The term “participants” will also be used in the results section, when referring to the older LGBTQ adults that volunteered for this study.

**Demographic Data on Aging LGBTQ Adults in Canada**

**The aging population.** For the first time in Canadian history, the number of people aged 65 years and older has surpassed the number of children aged 14 years and under\(^{13}\) (Statistics Canada, 2016a; 2016b). The nation’s most populated region, the province of Ontario,\(^{14}\) holds the largest proportion of aging individuals, with approximately 2.2 million\(^{15}\) adults over the age of 64 (Statistics Canada, 2015b; 2016b). Population projections suggest that between the years 2010 and 2031 Canada’s Baby Boomers\(^{16}\) will have reached the age of 65 and that by the year 2036, they will represent between 23% and 25% of the total population (Statistics Canada, 2015).

\(^{12}\) Inclusive terms within this context involve the use of a common language that is reflective of an aging LGBTQ identity and evidenced within the literature (Croghan et al., 2015; Fredriksen-Goldsen et al., 2014c; Rossi & Lopez, 2017).

\(^{13}\) Approximately 5.9 million Canadians aged 65 and older, accounting for 16.6% of the national population in comparison to approximately 5.8 million children aged 14 and under, or 16.1%, of the national population (Statistics Canada, 2016a).

\(^{14}\) Ontario has approximately 13.9 million residents (Statistics Canada, 2016b)

\(^{15}\) Ontario accounts for 38.2% of the total aging (65+) population in Canada (Statistics Canada, 2016b)

\(^{16}\) The term Baby Boomer designates a person born during the years that followed World War II. This period is marked as a temporary increase in birth rate.
**Aging LGBTQ populations.** As the aging population continues to grow, so too will the number of LGBTQ adults. Demographic data concerning LGBTQ individuals in Ontario—and Canada more broadly—represents only an approximation of the number of individuals identifying within these groups because of measurement and methodological limitations. For example, much of the data is not representative as the majority studies are based out of small, local, nonprobability samples that lack generalizability (Brotman et al., 2015; Brown & Grossman, 2014) or biased population-based surveys. Further, what little is known about LGBTQ communities often originates from the data collected by researchers, local organizations, or Statistics Canada and may not always be readily, or publicly, available for researchers (Bauer, 2012).

**Surveys.** In 2001, the Canadian Census became the first data collection system to acknowledge same-sex couples. Since the legalization of marriage in 2005, the Census now recognizes both common-law and married same-sex dyads, though, it continues to exclude those LGBTQ individuals who are living with multiple partners or alone. In 2003, the *Canadian Community Health Survey* (CCHS) became the first Statistics Canada survey to incorporate sexual orientation into its cross-sectional analysis of the Canadian populations’ health status, determinants of health, and access to health systems within certain health regions (Statistics Canada, 2015c; WDG-Public Health, 2015). Limitations of the survey are evident; in that (1) the survey question only measured sexual orientation as a single variable\(^\text{17}\) and used terms that may have been considered offensive to some and may have instilled an unwillingness to respond (WDG-Public Health, 2015); (2) the findings only accounted for people between the ages of 18-59\(^\text{18}\); (3) questions

\(^{17}\)“Do you consider yourself to be: 1. Heterosexual (sexual relations with people of the opposite sex), 2. Homosexual, that is lesbian or gay (sexual relations with people of your sex), or 3. Bisexual (sexual relations with people of both sexes)” (CCHS, 2003, p. 230).

\(^{18}\)This has shown to be an increase in self-identification from the 2003 CCHS, which demonstrated only 1% of individuals self-designating as lesbian or gay and 0.7% as bisexual (Statistics Canada, 2004—as cited in Baur, 2012).
regarding gender identity or a history gender related medical treatments were not included; and (4) data collection was only conducted in English or French. Such survey data findings, therefore, do not reflect the health related needs of the many identities and intersections of social positions that exist within the spectrum of sexual orientation and gender identity. For instance, those respondents who may be experiencing sexual encounters with the same sex or gender, but may not consider themselves to be lesbian, gay, or bisexual\(^{19}\), those who identify as trans, non-binary, or gender variant, those from varying cultural, ethnic and language backgrounds\(^{20}\), those living in Canada who are homeless, transient, in a group home setting, or without status (WDG-Public Health, 2015), or LGBTQ adults over the age of 60.

**The limitations of quantitative methodologies.** It is important to also recognize that issues surrounding underreporting impact the accuracy of the population data concerning LGBTQ identities (Fredriksen-Goldsen & Muraco, 2010). Many LGBTQ individuals choose not to disclose their sexual identities out of the fear that confidentiality and/or anonymity may be breached (Bauer, 2012; WDG-Public Health, 2015). The current cohort of older LGBTQ adults, in particular are less likely to self-identify (Fredriksen-Goldsen & Muraco, 2010) to government officials and researchers (Hart, 2012). This may be due to a history of systemic oppression and discrimination perpetuated by the criminalization and medicalization of sexuality and gender identity; while unethical research practices\(^{21}\) have established a sense of distrust and reluctance to participate in studies. For those older adults who have lived through times when universal health care coverage

\(^{19}\) E.g., men who have sex with men (MSM—Brennan, Ross, Dobinson, Velhuizen, & Steele, 2010).

\(^{20}\) E.g., people who do not speak English or French or individuals of Indigenous background who identify as Two-Spirit. Even if Two-Spirit individuals felt inclined to respond to a Westernized definition of sexual orientation (e.g., LGB), the survey did not include Canadians living on reserves or in other Indigenous settlements, or the more remote areas of Nunavut (Statistics Canada, 2016d).

did not exist in Canada, fears concerning the consequences of having their sexual and/or gender identity outed within their community, or the possibility of losing a much needed service, become profound barriers to self-identifying in research (Brotman, et al., 2002b; Brotman et al., 2015).

An estimation of the LGBTQ population in Ontario. While the 2014 CCHS demonstrated that 1.7% of the Canadian population identified as gay or lesbian and 1.3% as bisexual (Statistics Canada, 2015c), several Canadian research studies and organizational reports conclude that the LGBTQ community, inclusive of individuals varying in social positions, comprises between 5-10% of any given population (OSPN & Ipsos Reid, 2015; Toronto Long-Term Care Homes and Services, 2008; WDG-Public Health, 2015). Due to the fact that the most recent CCHS only accounted for LGB individuals up to the age of 59, the number of LGBTQ adults 60 years of age and above must be approximated. Estimations were therefore derived from the Ontario Ministry of Finance’s Ontario Population Projections Update, 2016-2041 (2016), whereby the total number of individuals aged 60 and above was found to account for 3,151,434 of the total provincial population. As such, it may be estimated that between 157,571 and 315,143 LGBTQ adults over the age of 60 may be experiencing health inequities as a result of the barriers encountered when accessing care services in Ontario. Therefore, further research is required in order to better understand the health implications of a diverse sample of older adults so as to influence more inclusive practice and policy.

The Theoretical Approaches to Studying Aging LGBTQ Populations

Much of the body of literature on aging, sexuality, and gender identity is not explicitly grounded in theory. In Fredriksen-Goldsen and Muraco’s (2010) 25-year review of 58 Canadian and American journal articles on aging and sexual orientation (1984-2008), the majority (i.e., 75%) of articles did not include a guiding theoretical approach. When a theoretical perspective was
applied though, the following were utilized: “Life Course Perspective (10%), Crisis Competence (5%), Grounded Theory (3%), Stress and Coping (3%), Systems Theory (2%) and Queer Theory (2%)” (p.396). After this article was published, the Institute of Medicine’s (IOM) report on LGBT health (2011) suggested four theoretical lenses in order to understand the influences that impact aging LGBTQ health and access to social care: (1) Social Ecology (Bronfenbrenner, 1979); (2) Minority Stress Theory (Meyer, 2003), (3) the Life Course Perspective (Elder, 1998), and (4) an Intersectional Framework (Crenshaw, 1989).

**Social ecology.** An extension of Bronfenbrenner’s (1979) ecology of human development framework, social ecology (McLeroy, Bibeau, Steckler, & Glanz, 1988) acknowledges that there are larger social influences on individual development apart from their immediate environments. The model, as such, is comprised of multiple environmental levels that impact an individual beyond their control, such as relationships (e.g., family), community services, and socio-cultural and political norms (IOM, 2011). The use of the social ecology model is most evident within national and international public health initiatives (e.g., Age Friendly Communities—Government of Canada, 2011; Ministry of Seniors Affairs, 2013; WHO, 2017) as the interrelated effects of social, economic, physical, and individual characteristics and behaviours are recognized as influencing the overall health of a population or individual. The Canadian federal government, for instance, uses this model to inform the social determinants of health (SDoH) and promote individual and community-based health interventions (Government of Canada, 2011).

**Minority stress theory.** Originally the minority stress theory was developed for lesbian women (Brooks, 1981), then it expanded to include gay men (Meyer, 1995) and bisexual individuals (Meyer, 2003). Since then, the minority stress theory has been applied to the unique stressors and health disparities experienced by sexually diverse and gender variant individuals. By
definition, the minority stress theory dictates that stigmatized social and environmental contexts create two forms of chronic stress: distal and proximal. Distal stress processes do not rely on an individual’s perspective; such as events where actual, overt discrimination, verbal harassment, or violence occur. Proximal stress processes, however, are dependent on the individual’s perception of the stigma. This would include events where homophobia or transphobia is internalized, whereby the individual adopts and applies negative attitudes toward themselves regarding their sexual orientation and gender identity. Proximal stress processes can also include instances of perceived stigma, that is, the ongoing expectation of rejection and discrimination and the resulting concealment of sexual orientation or gender identity (IOM, 2011).

**Life course theoretical perspective.** Similar to the social ecology model, the life course theoretical perspective provides an understanding of both the structural and individual transactions that influence health needs over the course of a life-span (Fuller-Iglesias, Smith, & Antonucci, 2009; IOM, 2011). The life course theoretical perspective recognizes that every stage, or event, in an individual’s life is informed by their past experiences. Central themes in the life course theoretical perspective include: linked lives, human agency and life trajectories, resilience and strength, as well as the socio-historical context in which a person has developed (IOM, 2011).

**Intersectional framework.** An intersectional framework acknowledges the layering of social positions within an individual identity and helps in better understanding the diversity of issues related to age, sexual orientation, and gender identity. The intersectional framework, as such,

---

22 Linked lives acknowledges the interdependence experienced between individuals, that is, social connections or networks.
23 Life trajectories are in reference to the transitions between life stages that link over time to create adverse or resilient pathways. Human agency is associated with life trajectories as it refers to the choices that are influenced by the social contexts, in which an individual lives.
24 The historical context is the understanding of the underlying socio-cultural forces that have shaped, or continue to shape, an individual’s development. This could include major events at the systemic-level or individual-level and ultimately influence cohort effects.
challenges the dominant group culture in order to acknowledge marginalized identities and social inequality (IOM, 2011).

**Blending theories.** Experts within the field of LGBTQ aging (e.g., Brotman et al., 2015; Fredriksen-Goldsen & Muraco, 2010) have acknowledged the importance of combining conceptual models in order to more fully understand the intersecting systems of structural oppression and the related impact on health equity and access to quality care. Recommendations to combine theoretical lenses, such as life course and intersectionality perspectives, have been suggested in order to understand the unique needs and diverse realities of aging LGBTQ populations. For example, the emerging works of Fredriksen-Goldsen and colleagues (e.g., 2014b; Emlet, Shiu, Kim, & Fredriksen-Goldsen, 2016; Hoy-Ellis & Fredriksen-Goldsen, 2014; Fredriksen-Goldsen, Jen, Bryan & Goldsen, 2016; Fredriksen-Goldsen & Kim, 2017; Fredriksen-Goldsen, 2017b; Kim & Fredriksen-Goldsen, 2016; Kim, Fredriksen-Goldsen, Bryan & Muraco, 2017; Kim, Jen, & Fredriksen-Goldsen, 2017; etc.) have suggested the Health Equity and Promotion Model (HEPM) to be a cohesive framework that is inclusive to the multiple theoretical approaches mentioned here within (i.e., social ecology, minority stress theory, life course theoretical perspective and an intersectionality framework).

**The health equity promotion model (HEPM).** The HEPM is a strengths-based conceptual model that connects the many theoretical, disciplinary, and epistemological approaches to studying LGBTQ communities (Fredriksen-Goldsen, 2014b—see figure 1). Grounded in the promotion of health equity\(^{25}\), the HEPM differs from past, “deficit-driven,” conceptual models as there is a recognition of LGBTQ populations maintaining varying levels of resources and risks that contribute to optimal health outcomes, in spite of marginalization (Fredriksen-Goldsen, 2014a, p.s2). Designed

\(^{25}\) Health equity is an individual’s ability to achieve their full health potential, no matter their social position (Hyun-Jun Kim, Jen, & Fredriksen-Goldsen, 2016).
as a guide, rather than an exhaustive theory for categorizing the determinants of LGBTQ health, the HEPM recognizes the intersection of multiple influential factors that impact health outcomes among LGBTQ populations across the life course. The HEPM considers the impacts of socio-historical, cultural meanings, and environmental contexts as well as structural and individual factors that influence the unique needs of aging LGBTQ populations. In doing so, the HEPM recognizes the layering of additional social positions onto an aging LGBTQ identity, and the resulting challenges or opportunities that influence heterogeneity in health outcomes. By integrating a developmental assessment, the HEPM is able to distinguish the similarities and differences that exist within individual and parallel group experiences in order to determine variations in life trajectories, such as the ability to process and adapt to change (Fredriksen-Goldsen & Kim, 2017). The HEPM therefore, provides a better understanding of how older LGBTQ adults may be aging so as to translate any identified strengths into interventions that may promote the health and well-being of others who may not be aging successfully (Emlet et al., 2017). As such, this conceptual framework is in line with my own positionality as a critical social justice researcher and has been chosen as the guiding conceptual framework.
The Emerging Themes and Gaps within the Evidence-Base

**Background.** In 2010, American researchers Fredriksen-Goldsen and Muraco conducted a 25-year scan of the literature on aging and sexual orientation and determined that it was characterized by four “waves.” Within the first wave, the literature challenged the stigma and negative assumptions often associated with a lesbian or gay sexual orientation. Researchers within this wave were primarily concerned with dispelling the preconceptions that older lesbian and gay adults were at a higher risk for depression, social isolation, or experienced any more maladjustments to aging than their heterosexual counterparts (e.g., Dorfman et al., 1995; Grossman, D’Augelli, & Hershberger, 2000; Nystrom & Jones, 2003; Pope & Schulz, 1990, Whitford, 1997). The second wave marked the positive psychosocial functioning of older lesbian and gay adults in spite of the accumulation of systemic stressors (e.g., Adelman, 1990; Berger, 1984; Berger & Kelly, 1986; D’Augelli, Grossman, Hershberger, & O’Connell, 2001; Gray & Dressel, 1985; Grossman et
al., 2000; Lee, 1987; Pope & Schulz, 1990; Sharpe, 1997; Whitford, 1997); while some findings even suggested that older gay men and lesbian women established strategies, known as crisis competence (Friend, 1980; Kimmel, 1980) and mastery of crisis (Berger, 1980) in order to successfully age (Adelman, 1990; Kehoe, 1986, 1988; Quam & Whitford, 1992; Sharp, 1997). The third wave discussed lesbian, gay and bisexual (LGB) identity development as an experience that shifts over time and social contexts (e.g., Chapple, Kippax & Smith, 1998; Floyd & Bakeman, 2006; Herdt, Beeler, & Rawls, 1997; Parks, 1999; Rosenfeld, 1999; Sharp, 1997; Van de Ven et al., 1997). It is within the final wave that the most current literature predominates, as researchers continue to explore the social support and community-based needs (e.g., housing, health, caregiving, etc.) of aging LGBTQ individuals and populations. More specifically, researchers have been focusing on the relational influences (e.g., social networks) of older LGBTQ adults and how these may impact access to service provision and inclusive practice.

**Physical and mental health disparities and needs.** Although older LGBTQ adults may face similar barriers to their heterosexual counterparts when accessing quality care26 (Age Friendly Ontario, 2013; Horton & Johnston, 2010), the evidence-base suggests that LGBTQ seniors face additional complexities that result in greater health disparities. That being said, research has demonstrated higher rates of physical limitations, such as disability, chronic illness, substance use, and sexually transmitted infections (Addis, Davies, Greene, MacBride-Stewart, & Shepherd, 2009; Brennan et al., 2010; Fredrisken-Goldsen, Kim, Barkan, Muraco, & Hoy-Ellis, 2013c; Grossman, D’Augelli, & O’Connell, 2001; Wallace, Crochran, Durazo, & Ford, 2011); in addition to adverse mental health experiences, including symptoms of depression, anxiety, and suicide ideation within

---

26 Barriers in accessing care services among the general aging population have included: a lack of transportation, insurable coverage, finances and informal caregiving supports, difficulties in navigating health care systems and issues concerning effective communication in regards to available and accessible programs or services, as well as ageist attitudes (Age Friendly Ontario, 2013; Horton & Johnston, 2010)
an aging LGBTQ population (Bockting, Miner, Swinburne Romine, Hamilton, & Coleman, 2013; Davidson, 2015; Fredriksen-Goldsen et al., 2011; Fredriksen-Goldsen et al., 2013a; Fredriksen-Goldsen & Muraco, 2010; Rawls, 2004). Older lesbian and bisexual women, for instance, demonstrate higher risks for cardiovascular disease, obesity, disability (Fredriksen-Goldsen, 2013b) and reproductive cancers (Valanis et al., 2000) relative to their heterosexual counterparts. Gay and bisexual men have exhibited greater risks for hypertension, diabetes (Wallace et al., 2011), and overall poor health (Fredriksen-Goldsen, 2013b) when compared to heterosexual males. Moreover, aging gay and bisexual men, as well as trans women, have shown a greater prevalence of HIV (Fredriksen-Goldsen et al., 2011, Herbst et al., 2008).

Additional layering of needs: trans, race/ethnicity and culture. It is important to acknowledge that trans, Two-Spirit, intersex, genderqueer, and other gender nonconforming, individuals may identify as lesbian, gay, bisexual, queer, or another identity within the spectrum of sexual orientation. As such, these groups face additional difficulties based not only their age and sexual orientation, but their gender identity and race, or ethnicity, as well (Fredriksen-Goldsen et al., 2014b; Johnston, 2016). Physical and mental health disparities, therefore, are often even more exacerbated among trans populations than their LGB counterparts (Cook-Daniels, 2006; Cook-Daniels, 2015; Fredriksen-Goldsen et al., 2011; Fredriksen-Goldsen et al., 2013b). For instance, older trans individuals demonstrate an increased likelihood of developing a chronic health condition due to the cumulative effects of hormone-use and normative age-related changes (Mahan, Askins-Bailey, Bibb, Fenney, & Williams, 2016). In a study that compared the perceived mental health of older lesbian women, bisexual women and men, gay men, and trans adults, it was found that older trans adults rated the worst mental health, especially in terms of depressive symptoms (Fredriksen-Goldsen et al., 2011). While there is limited information regarding older trans adults, one study by
Mahan et al. (2016) found subgroup differences in chronic illnesses between male to female (MTF) and female to male (FTM) transitions, as being associated with long-term hormone use. Less research has been conducted on the intersection between age, sexual orientation, gender identity, race/ethnicity, and culture (Fredriksen-Goldsen et al., 2014b; Mulé & Smith, 2014; Van Sluytman & Torres, 2014). For instance, through the content analysis of 64 articles from an international gerontology literature base, only two documents addressed the specific health needs of aging LGBT adults from various racial, ethnic, or Indigenous backgrounds (Van Sluytman & Torres, 2014).

**Social supports and connectedness.** Both heterosexual and LGBTQ older adults rely on varying social network resources, such as friends, family or partners to provide social support (MAP & SAGE, 2010). However, some older LGBTQ adults express less dependency on their family of origin27 (de Vries, 2009; Grossman et al., 2000; Hughes et al., 2011, MAP & SAGE, 2010; OSPN & Ipsos Reid, 2015) and instead turn to their families of choice28 for care and support (de Vries, 2011; Grossman, et al., 2000; Hughes et al., 2011; OSPN & Ipsos Reid, 2015; Stinchcombe, Smallbone, Wilson & Kortes-Miller, 2017). Social connectedness is an important factor in developing positive mental and physical health outcomes (Hughes et al., 2011; Kim & Fredriksen-Goldsen, 2016; Lyons, Pitts, & Grierson, 2013). However, older LGBTQ adults are more likely to be living alone, or living with fewer social network resources (Brennan-Ing, Seidel, Larson, & Karpiak, 2014; Cantor & Brennan, 2000; Kim & Fredriksen-Goldsen, 2016; Rosenfeld, 1999; Rosenfeld, 2003; Wallace et al., 2011). As evidenced in the OSPN (2015) housing survey, older LGBT adults were four times more likely than the general Ottawa population to respond as single or never married; in addition to reporting lower rates of living in a relationship (55%)

27 Family of origin refers to an individual’s biological family which may include: children, parents, siblings, etc.
28 Families of choice may also be referred to as chosen families, or lavender families, and typically include friends and other members of the LGBTQ community that provide support and companionship, especially near the end-of-life (Stinchcombe, et al., 2017).
compared to 68%, respectively) and having no children (67%). Similarly research conducted in America found that older gay and bisexual men have shown the highest prevalence of living alone and having fewer children (Fredriksen-Goldsen et al., 2013b).

**The impacts of social health disparities.** Under such circumstances, isolation and loneliness become detrimental threats to health and well-being (Brotman et al., 2015; Fredriksen-Goldsen et al., 2011), especially in respect to older cohorts (Whitford, 1997), those living with physical or cognitive limitations (Brotman, et al., 2003; Brotman, Watkins, & Ryan, 2010; Rivers, 2006; Fredriksen-Goldsen et al., 2014a; Fredriksen-Goldsen et al., 2016; Price, 2011), and those residing in rural settings (Butler & Hope, 1999; Comerford, Henson-Stroud, Sionainn, & Wheeler, 2004; Furlotte, Gladstone, Cosby, & Fitzgerald 2016). There is also indication that aging bisexual and trans people may have even fewer social supports (Fredriksen-Goldsen et al., 2011; MAP & SAGE, 2010; SAGE & National Centre for Trans-Gender Equality, 2012) especially within the LGBTQ community itself (Davidson, 2015; Factor & Rothblum, 2008; Fredriksen-Goldsen et al., 2011).

**The barriers to accessing care.** As part of the normative aging process, many older LGBTQ adults develop health challenges that require accessible care services. Older LGB adults, in particular, expect their health to increasingly worsen with age (Brotman et al., 2015; MacFarland & Sanders, 2003; Orel, 2004; Rivers, 2006). Though preventative care is important for all individuals (WHO, 2017), aging LGBTQ often delay seeking care services until there is significant distress (Brotman et al., 2003; Cook-Daniels, 2015; Fredriksen-Goldsen et al., 2013a; Fredriksen-Goldsen et al., 2013b). Barriers such as a life time of oppression and disparate treatment from care providers toward LGBTQ adults, manifested in negative attitudes (Brotman et al., 2003), informational and
institutional erasure\textsuperscript{29} (Bauer et al., 2009; Giwa & Greensmith, 2012; Johnston, 2016), as well as an atmosphere of silence\textsuperscript{30} (Furlotte et al., 2016; Kia, 2016) impact older LGBTQ adults’ access to care resources and supports. Due to a lack of culturally competent care and inclusive practice within service provision and policies, older LGBTQ adults limit their use of formal social supports, making this group “the most invisible of an already invisible minority group” (Blando, 2001, p.87).

\textit{A lifetime of discrimination.} In a study conducted by Fredriksen-Goldsen et al. (2011), 82% of older LGBT adults reported having been discriminated against at least once in their lifetime, while 64% experienced discrimination three times or more. While the legal rights and equal treatment of certain LGBTQ populations are ever progressing in Canada, unique generational experiences continue to impact this group’s health and the manner in which they seek care (Averett, Yoon, & Jenkins, 2011; Barrett, Whyte, Comfort, Lyons & Crameri, 2015; Detanto, Orwat, Spira, & Walker, 2014; Furlotte et al., 2016; Haber, 2009; Kimmel, 2014). Consider, for instance, the conservative socio-political climates that some older LGBTQ populations experienced prior to the passing of Bill C-150; to remove the criminalization of homosexual behaviours from Canada’s Criminal Code in 1969. During this time, homosexuality in Canada had been equated to deviancy, illness, and shame (Fredriksen-Goldsen et al., 2014b), often resulting in legal, medical, social and religious ramifications that threatened personal safety (e.g., Barrett, et al., 2015; Brotman et al., 2003; Brotman et al., 2015; Detanto, et al., 2014; Haber, 2009). Until the removal of homosexuality in 1973 from the DSM, same-sex orientation was considered to be a sociopathic personality disorder (Fredriksen-Goldsen et al., 2014b). Experimental procedures known as conversion

\textsuperscript{29} Erasure within this context refers to the disregard of LGBTQ identities, thus, reinforcing the notion that individuals outside of these norms are an irregularity.

\textsuperscript{30} Silencing refers to more specific practice whereby service providers assume the heteronormativity and cisnormativity of clients. Within these contexts there is no affirmation or acknowledgement of sexual orientation or gender identity.
therapy, were often endorsed by health care professionals and religious groups to ‘normalize,’ or revert LGBTQ individuals to heterosexual status, using techniques such as lobotomy, genital mutilation, and shock therapy (Beagan & Hattie, 2015; Detanto, et al., 2014).

**Cohort effects.** Families, friends, educators, and religious congregations have become increasingly accepting and supportive toward the younger cohort of LGBTQ since the legal protections of LGB human rights in 1998 and the passing of the Civil Marriage Act in 2005 (Brotman et al., 2015; IOM, 2011). As such, differences between the life trajectories of even the LGBTQ adolescents from a decade ago have become apparent (Martin & D’Augelli, 2009). Similarly, Rosenfeld (1999) and Parks (1999) discovered age differences within the greater cohort of older LG adults, especially in terms of the strategies used to disclose sexual orientation.

Contingent to the historical milestone and the corresponding age of the individual, various degrees of stigma were experienced. For instance, the oldest (aged 75 years and older) of the aging LGBTQ cohort lived during the pre-liberation era, and as such, faced the greatest exposure to harassment, violence, and refusal of services. Therefore, this generation of older LGBTQ adults may demonstrate the most apprehension when disclosing their sexual or gender identity to care providers. Their younger counterparts (aged 50-65 years), who were born near the end of baby boom and grew up during the civil rights movements, would be less likely to keep their identities hidden, especially when accessing programs that could benefit health and care needs (Brotman & Ryan, 2008; Brotman, et al., 2003; Cahill & South, 2002). Thus, Brotman and colleagues (2015)

---

31 June 15 (2015) the Affirming Sexual Orientation and Gender Identity Act (Bill-77) had been enacted in the province of Ontario to no longer fund—through the Ontario Health Insurance Plan—conversion therapy on any individual at any age. Amendments to the Health Insurance Act and Regulated Health Professions Act, thereby prohibits “the provision, in the course of providing health care services, of treatment that seeks to change the sexual orientation and gender identity of patients under the 18 years of age and make it an offence to do so,” while also ensuring that no such services be insured or offered (Legislative Assembly of Ontario, S.O. 2015 C. 18).

32 That is, pre-Stonewall—over 45 years of age—the gay liberation era—between the ages of 30 and 44—and the gay rights era—under the age of 30),
propose that the type of support being accessed will not only depend on the cohort, but also the region that the person is residing in and personal preference. For instance, LGB seniors who developed in urbanized, liberal environments with active LGBTQ communities are more likely to approach supports from within these communities, while those from rural or conservative upbringings may prefer to engage in formally organized and mainstream systems of support (Brotman et al., 2007).

**Are older LGBTQ adults seeking-out health care?** In spite of the standards put in place by the Canada Health Act (1984) regarding the universality and accessibility of health care services in Canada (Government of Canada, 2017), research suggests accessing quality medical care remains challenging for older LGBTQ adults. Probability-based studies in the U.S. have demonstrated that there are no significant statistical differences between older LGB adults and their heterosexual counterparts regarding accessibility to healthcare (Fredriksen-Goldsen et al., 2013c; Wallace et al., 2011). However, several non-probability studies have demonstrated that many older LGBT adults are distrustful and feel reluctant toward seeking health care due to past and current experiences of systemic and institutional oppression (Brotman et al., 2003; Cahill, South, & Spade, 2000; Cook-Daniels, 2006; Croghan, et al., 2012; Wallace et al., 2011).

**Invisibility as coping strategy.** Maintaining a hidden sexual or gender identity has been a survival strategy employed by many older LGBTQ adults in order to prevent discrimination or other threats to safety. Espinoza (2014) established that 40% of LGBT respondents aged 60-70 years, concealed their sexual identity from their health care providers. The effort to conceal one’s identity requires constant cognitive efforts and energy, and has demonstrated adverse health effects

---

33 As indicated by a delay in or refusal of a medical service or prescription, the number of emergency and non-emergency related visits within the past year (Wallace et al., 2001), as well as whether the participant had been assigned a health care provider (Wallace et al., 2011; Fredriksen-Goldsen et al., 2013)
among LGBTQ populations (Furlotte et al., 2016; Fredriksen-Goldsen et al., 2013a; Fredriksen-Goldsen et al., 2013b; Fredriksen-Goldsen et al., 2016). Ramirez-Valles, Dirkes & Barret (2014) found that when older gay and bisexual adults disclosed their sexual identity to care providers, depression scores lowered and perceived health scores demonstrated better outcomes when compared to those who had not. Though LGB adults may perceivably demonstrate the choice to disclose their sexual orientation, many trans individuals may not have the option to conceal their gender history from health professionals and, as a result, may be more susceptible to overt and covert forms of discrimination (Cook-Daniels, 2006; Cook-Daniels & Munson, 2010; Cook-Daniels 2015).

The medicalization of trans identities. While equivalent amendments on the basis of gender identity and expression have recently been revised in the Canadian Human Rights Act (Bill C-16, 2016), policy development and the equitable treatment of gender variant individuals continue to lag (Brotman et al., 2015). Gender dysphoria remains a mental health disorder in the most current DSM-V. Gender dysphoria underwent revisions in 2013, concerning the diagnostic labelling and classification criteria34, and arguably, these changes reflect a shift in cultural values towards social acceptance (Rossi & Lopez, 2017; Davidson, 2015; Fredriksen-Goldsen et al., 2014b). Diagnosing, or labelling, gender identity as a mental illness has been shown to have lasting stigmatizing and prejudicial effects, often resulting in higher rates of mental health problems (Alzheimer’s Australia, 2014; Davidson, 2015; Dentato et al., 2014; Fredriksen-Goldsen et al., 2014b; Witten, 2014). Recent changes in the funding criteria for gender-confirming surgeries (Ontario Ministry of Health

34 As a mental illness previously referred to as Gender Identity Disorder (GID), emphasis on the diagnosis had been placed on the incongruency between a person’s biological sex and their preferred gender. Now, a diagnosis of gender dysphoria refers to the mental or emotional distress that is associated with this lack of congruency.
and Long Term Care, 2016) now allow any qualified health care provider throughout the province to refer clients for surgeries. However, due to past discrimination and continual experiences of pathology, abuse and fear of rejection, many older trans individuals resist accessing care services, especially from health care professionals (Cook-Daniels, 2015; Davidson, 2015). In the Aging and Health Report, 8% of older trans adults aged 65 and older, as well as 20% of those aged 55-64 had disclosed at least one instance where they had been refused a health care service, while approximately 12% were treated with disrespect or verbally harassed in a doctor’s office or hospital (Cooks-Daniels, 2015; Grant et al., 2011). Correspondingly, the majority (65%) of aging trans adults anticipate substandard healthcare as they grow older (Espinoza, 2014). Even when certain sub-populations, such as a sample of elderly trans-lesbians (Witten, 2015) described having successfully aged, they remained fearful of the future and apprehensive of the quality of treatment they would receive.

Financial instability. Financial instability and poverty are of concern to older LGBTQ adults as well (deVries, 2009; Jacobs, Rasmussen, & Hohman, 1999; OSPN & Ipsos Reid, 2015), since approximately 70% have indicated that they are not fiscally prepared to age (MacFarland & Sanders, 2003). According to the OSPN and Ipsos Reid Housing Survey (2015), older LGBT adults living in the Ottawa area have lower incomes. Incomes are likely even lower for those who identify as women, lesbian, Two-Spirit and trans, those who have immigrated and cannot speak either French or English, and those living with a physical or cognitive limitation that has impaired their ability to maintain consistent income (Brotman et al., 2015; Cartwright, Hughes & Lienert, 2012; Cook-Daniels, 2015; Nystrom & Jones, 2003; Orel, 2004). Only recently have older same-sex couples been treated to the same federal benefits as their heterosexual counterparts, such as the

35 Opposed to only the one facility that was located in Toronto, CAMH (Ontario Ministry of Health and Long Term Care, 2016).
Guaranteed Income Supplement (GIS) and the Allowance and Survivor’s Pension (Government of Canada, 2016a; Government of Canada, 2016b), which may place these populations at a financial deficit when compared to their heterosexual counterparts. It has also been suggested that LGBTQ seniors may be living without regular benefits, such as RRSPs or other pension plans due to varying employment statuses, such as higher rates of unemployment, part-time or contract work (Cook-Daniels, 2015; Fredriksen-Goldsen et al., 2017; Grant, et al., 2011) and higher rates of self-employment in Ottawa (OSPN & Ipsos Reid, 2015). The lack of a disposable income for LGBTQ older adults has also led to barriers to accessing certain health and social support programs (Greene, 2002; Porter et al., 2003) such as the affordability of in home-care (OSPN & Ipsos Reid, 2015) and private seniors’ residences (Cahill & South, 2002; Rivers, 2006); in addition to the need for more inclusive employment services (Jacobs, et al., 1999).

Access to aging programs and services. Canadian Census data (2011) indicated that only 7.1% of seniors, 65 years and older, were living in special care facilities such as a nursing home, chronic care centre, or long-term care facility (4.5%) or in a residence for seniors (2.6% — Statistics Canada, 2015c). As such, it is relevant to identify the remaining formal care resources that older LGBTQ adults may be leveraging in the community. In the OSPN and Ipsos Reid’s Housing Survey (2015) only 1/3 of respondents were able to name a community-based service for seniors in Ottawa, whether they were LGBT-friendly or not. The most known community resources included, seniors’ clubs, or centres (24%), health services (14%), community centres (14%), seniors’ residences or nursing homes (13%), in-home care (7%), Meals-on-Wheels (7%), Para-Transpo (6%), the Community Care Access Centre (CCAC—6%), with commercial seniors’ discounts, activity clubs, church, the food bank, emergency call, and other accounting for the remaining 8%. Almost one half of participants, 42%, did not know or did not specify a response. Likewise, 57% of
respondents mentioned that LGBT-friendliness among service providers was of significant importance and that they would be willing to switch providers in order to receive such amenities. The majority, 86%, reported a higher likelihood of using such services over the alternative.

Cantor and Mayer’s (1978) hierarchical compensatory theory, suggests that community-based services are accessed to a greater extent when social network resources are unable to meet the health needs of older adults (Cantor & Brennan, 2000, as cited in Brennan-Ing et al., 2014). Social supports have demonstrated to be protective factors among older LGBT adults (Fredriksen-Goldsen et al., 2013a; Fredriksen-Goldsen et al., 2013b; MAP & SAGE, 2010; Ramirez-Valles et al., 2014). Having more social network resources have shown to assist with successful aging as well as positive coping with issues of lifelong discrimination and stigma (D’Augelli & Grossman, 2001; D’Augelli, Grossman, Hershberger, & O’Connell, 2001). In a study conducted by Grossman et al. (2000), it was noted that older adults who have disclosed their sexual orientation to social supports have felt more in control of their loneliness in comparison those who kept their sexual identity concealed. As such older LGBTQ individuals often find solace in accessing LGBTQ specific organizations, programs and activities than those provided by mainstream aging and recreation facilities for the general population (Quam & Whitford, 1992).

**Access to LGBTQ organizations.** Although 89% of LGBT seniors have reported feelings of pride when they are part of a larger community, MAP and SAGE (2010) uncovered divergent results whereby certain subgroups of older LGBT adults felt unwelcomed within the greater LGBTQ community and the accompanying organizations. Ageism from within the broader LGBTQ community is most evident within the gay community, as older men report feelings of rejection, loss of social value and exclusion from social events on account of their diminished physical attributes. Conversely, older lesbian women continue to socialize with their younger counterparts.
through political contributions and mentorship, displaying little fluctuation in their inclusion as they age. Due to the negative messages surrounding bisexuality as a ‘choice’ and matter of convenience, older bisexual adults often feel excluded from both heterosexual and LGBTQ communities (Donaldson & Vacha-Haase, 2016) and worry about becoming isolated (Teaster & Harley, 2016). Similarly, while some older trans may align themselves with the LGBTQ community, others feel excluded and turn to online support groups instead (Teaster & Harley, 2016). While people of colour may encounter acceptance within their communities, others may be forced to remain hidden in order to maintain their own safety and that of their families. Some people of colour may also feel as though they must choose between their cultural heritage and their sexual or gender identity. Such feelings have been reflected in Giwa and Greensmith’s (2012) study of racism in Toronto’s LGBTQ community, albeit with younger participants (n=7, aged 25-56). As one older participant shared the following:

*Events like Gay Pride [...] give a false sense of community cohesiveness (p.163) [because it is difficult for the LGBTQ community to talk about racism; for White individuals, it is the fear of being perceived as racist [...] Racism] pushes people away.... Which leads to the issue not being resolved [...]or people of color, the topic is difficult to broach because of the fear of upsetting someone in the process (p.167-168)*

**Access to religious and spiritual networks.** Though charged with tensions, emerging works have acknowledged the importance of accessing spiritual or religious services among LGBTQ adults in later life (Beagan & Hattie, 2015; Brotman & Ryan, 2008; Comerford, et al., 2004; Fredriksen-Goldsen et al., 2011; Orel, 2004; Rivers, 2006; Swartz et al., 2015). Some religious-based messages continue to imply that same-sex orientation and gender transition is deviant, and as such, continue to influence concealment of identity and internalized stigma among LGBTQ
communities (Beagan & Hattie, 2015, Swartz et al., 2015). In order to access such resources, some older LGBTQ may continue to conceal their identity or engage with LGBTQ-friendly institutions (e.g., Christianity-based churches—Levy, 2012). In 2004 Orel held focus groups and in-depth interviews to address the needs and concerns of gay, lesbian, and bisexual adults as they aged. For many of the older LGB adults, organized religion brought up painful memories of rejection. However, all of the participants shared that they would be more active within such organizations, should the bias toward same-sex orientation discontinue. Similarly, Beagan and Hattie (2015) conducted 35 interviews in Canada with participants varying in age (i.e., 20-61 years old), gender identities (i.e., man, woman, trans/queer, and other), sexual orientations (LGBT2Q+), and current and past belief systems (i.e., none, spiritual, Christian, Jewish, Buddhist, Pagan, and other). The findings suggested that traditional religious institutions have created conflicts regarding some older LGBT2Q+ adults’ spiritual involvements, as well as their sense of identity as an LGBT2Q+ person. Additionally, the loss of a traditional religious affiliation as a result of their sexual orientation or gender identity left some LGBT2Q+ participants with a sense of emptiness and longing for a metaphysical connection. Others, however, described instances where they could access their own meanings of spirituality by leaving traditional systems of the Church and connecting with their beliefs on their own terms.

Service provider perspectives. The access and invisibility of older LGBTQ in care services has been a recognized theme within the community and among care providers (Brotman et al., 2003; Knochel, Croghan, Moone, & Quam, 2010; EGALE, Plante, Filipenko, Bontje, & NSAC, 2017). Under the supervision of the National Senior’s Advisory Council (NSAC)36, Egale: Canada Human Rights Trust (2017) held a forum in Toronto to address various manners in which

36 NSAC comprises of a committee of aging lesbian, gay, bisexual, trans, intersex, queer, Two-Spirit adults and allies from across Canada (Egale, 2017).
government, institutions and communities could improve the health and well-being of older LGBTQI2S adults. The data were collected through forum discussions and then expanded to nation-wide online consultations. The responses, from 192 adults aged 65 and older and 33 allies and service providers, originated mostly from Ontario. LGBTQI2S seniors, service providers, and allies most commonly agreed that the fear of going “back into the closet” in extended care is the greatest concern. However, differences emerged as older LGBTQI2S adults reported more concerns regarding their personal well-being\textsuperscript{37}, while service providers and allies indicated issues with institutional practice\textsuperscript{38}. In terms of policy recommendations, there was significant overlap between several strategies for adoption such as the development of inclusive LGBTQI2S policies in all organizations, shared housing for LGBTQI2S seniors and the promotion of inclusive and culturally competent training for residents and community members in extended care (EGALE et al., 2017).

A continued disconnect between needs and provision. In a study conducted by Brotman et al. (2003), the authors concluded that those working in mainstream elder care avoided, or ignored LGB issues that needed to be attended to. Survey data from the U.S. assessing care providers’ readiness, attitudes and experiences of working with older LGBTQ adults however, indicated that care staff were aware of the various and additional challenges LGBTQ older adults’ faced and for the most part, responded optimistically to receiving cultural competency training (Hughes, et al., 2011; Knochel, et al., 2010). Most providers reported that they felt as though their current provision

\textsuperscript{37} Concerns regarding personal well-being included, “concerns about end-of-life decision making rights; lack of guidance for the care of LGBTQI2S seniors experiencing dementia, Alzheimer’s who have transitioned/come out; lack of residential care staff who are open about their own LGBTQ12S identities; concerns about limited definition of “family” in legal and medical settings”, in their respective order (EGALE, Plante, Filipenko, Bontje, & NSAC, 2017, p. 2).

\textsuperscript{38} Issues regarding institutional practice included, “the lack of designated spaces for trans and/or Two-Spirit seniors; difficulty assessing health services that are accepting and knowledgeable about all the parts of a senior’s identity; feelings of exclusion due to intakes and sign-up forms not inclusive of LGBTQI2S identities; lack of guidance for the care of LGBTQ12S seniors experiencing dementia/Alzheimer’s who have transitioned/come out,” in their respective order (EGALE, Plante, Filipenko, Bontje, & NSAC, 2017, p.2).
of services offered a welcoming environment for older LGBT adults. However, within the same study, few agencies indicated that they connected LGBT adults with outreach programs or even collected the sexual or gender identity demographics of their clients (Knochel et al., 2010). These findings are consistent with those of Johnston (2015), who suggested that just by offering older adults—especially bisexual older adults who are more commonly assumed to be heterosexual—the chance to self-identify can signal that the organization is a safe, respectful, and non-judgmental environment. While Donaldson and Vacha-Haase (2016) aimed to explore the manners in which LTC staff understood their knowledge, skills and attitudes in their own practice in order to develop a culturally competent framework to caring for LGBT residents. Focus groups with participants from three LTC facilities in Colorado indicated that the staff had difficulties in demonstrating sensitivity toward LGBT residents, without it being deemed as “favouritism” or “unprofessional” (p. 401). Such findings echo a universal theme of cultural blindness as privileged individuals tend to advocate for all individuals to be treated as equals. Rather than encouraging cultural competency, differences in social positions and the associated experiences of disadvantage are minimized, and ultimately, contribute to the increased invisibility of LGBT older adults (Donaldson & Vacha-Haase, 2016; Hardacker, Rubinstein, Hutton & Houlberg, 2014; National Collaborating Centre for Aboriginal Health & Reading, 2013)

**Cultural competency and inclusive practice as a solution to accessible care.** Within the evidence base of scholarly articles (e.g., Croghan et al., 2015; Detanto, et al., 2014; Donaldson & Vacha-Haase, 2016; Gendron et al., 2013 Fredriksen-Goldsen et al., 2014c; Fredriksen-Goldsen et al., 2016; Hardacker et al., 2014; Johnston, 2016; Leyva, Breshers & Ringstad, 2014; Porter &

---

39 For example, similar tactics have been used with individuals of colour, especially within the Indigenous communities in Canada, whereby the cultural hardships that have been faced are erased (e.g, National Collaborating Centre for Aboriginal Health & Reading, 2013; Hardacker et al, 2014)
Krinsky, 2014) there have been significant efforts assigned to developing educational materials to increase such inclusive practice in relation to LGBTQ aging. Despite the significant barriers LGBTQ older adults’ face to accessing care, research indicates that trainings in inclusive and culturally competent practice can facilitate older LGBTQ adults’ access to quality care (Fredriksen-Goldsen et al., 2014c; Knochel, et al., 2010; Portz, et al., 2014); especially related to developing open communication and comfort between the care recipient and provider (Portz et al., 2014). However, the training of front line staff is only one part of promoting an inclusive environment. Successive measures have been identified as the inclusion and use of meaningful images, inclusive intake forms, visible and inclusive organizational mission statements and goals, and policies that enforce the rights of aging LGBTQ clients within all care programs, services and organizations (Brotman et al., 2015; Croghan, et al., 2015).

**Stigma as a health promoting pathway.** An increasing body of literature has been recognizing that LGBTQ individuals who have experienced a lifetime of marginalization may actually demonstrate a greater resistance towards stigma (e.g., ageism) or implement positive aging strategies in later life, especially when compared to their heterosexual counterparts (deVries, 2015). For instance, Meyer and colleagues (2011) conducted a study that included 57 LGB, between the ages of 18-59, and various races/ethnicities—Black (22), Latino (19), and White (16). Without the use of probes, researchers posed the question, “*What do you think your life would be like without homophobia, racism, and sexism?*” (p.206). Initially, participants considered the implications of living in a world without inequalities; reflecting mostly on how oppression, lack of safety and unacceptance have cost them crucial resources, as well as the loss of possibilities. However, upon further reflection, several older participants distinguished that without stigma they would have also lost their core identity, as the continuous confrontations across their lifespan enhanced their identity.
and gave them strength to overcome challenges. Despite the significant adversities that have been described throughout this literature review, findings from additional studies suggest that older LGBTQ adults lead healthy and satisfied lives, where they successfully age into later life with strong personal social connections (Fredriksen-Goldsen et al., 2014a). However, these findings should not be interpreted as though the entire community is equally prepared to age. Rather, special attention must be paid to the individual, and the intersections of identity experienced in order to determine the health and social care needs of these populations (Brotman & Ryan, 2008).

The Rationale for this Research Project

Limited research in Canada. From the evidence base, the research emerging from the United States—particularly that of Fredriksen-Goldsen and colleagues (1988-2018) has led to incredible progress in the consideration and mobilization of knowledge on the health and social needs of LGBTQ seniors. Although Canada and the United States may share certain similarities, significant differences prevail within political, economic, socio-cultural, and health care spheres, preventing the legitimacy of generalizing such findings to Canada. Research has been conducted on the topic of aging, sexual orientation, and gender identity. However, most of the research has focused on, for example, the experiences of older gay men and lesbian women, without much exploration into the experiences of bisexual or trans persons, or, the intersections between the intersections of sexual orientation, gender and other social locations. Research that may provide further insight into the diverse experiences of LGBTQ individuals, therefore, has been identified as a need within the evidence-base (e.g., Brotman et al., 2015; Fredriksen-Goldsen et al., 2014c; Wilson et al., in press) so as to better inform culturally competent practice and inclusive policies among service providers.
**Intersectional research.** Experts and advocates alike, have suggested future research projects incorporate an intersectional framework (e.g., Brotman et al., 2015; Van Sluytman & Torres, 2014) and life course theoretical perspective (e.g., Brotman et al., 2015; Fredriksen-Goldsen & Muraco, 2010; Orel & Fruhauf, 2015) in order to account for the diversity of experiences in the provision of inclusive care; especially when conducting research with individuals who have face multiple forms of oppression. By incorporating the HEPM (Fredriksen-Goldsen et al., 2014b) as a guiding theoretical framework, this research project will be strengthened as it provides a comprehensive lens to understanding both positive and negative health outcomes from various disciplinary perspectives (i.e., behavioural, social, psychological, and biological) as a result of both structural and individual-level contexts of discrimination. The HEPM also acknowledges the importance of intersecting social positions on health outcomes across the life course and ultimately accounts for the variations in life trajectories among similar subgroups and individuals throughout history and under diverse sociocultural factors. Therefore, the HEPM is inclusive to the four theoretical frameworks outlined by the IOM (2011) to be used when researching LGBTQ populations (i.e., social ecology, minority stress theory, life course theoretical perspective and intersectionality framework) and provides a greater understanding of the phenomena impacting the health outcomes of older LGBTQ adults, than any one framework alone. Although the intentions of this research project are not to focus on the specific health statuses of aging LGBTQ adults in Ontario, the differences in their health needs must be addressed in order to establish an appropriate comprehension of this community’s care service and support needs.

**Qualitative experiences.** Although large quantitative, probability-based, studies with representative samples are often requested in order to provide more generalizable data, difficulties surface in accounting for the fluidity of sexual and gender identities and accessing potential
participants outside of the normative discourse. Sexual, gender, and social identities, or positions within a society are dynamic and continually changing. There is no homogenous or singular way of understanding the diversity between members of a community, especially when such identities are, by definition, in contrast to socially constructed terms. Qualitative research, as such, offers profound insights into the range of lived experiences and perspectives of aging LGBTQ populations and offers drastically different, yet complimentary, information that cannot necessarily be accessed through quantitative studies (Braun & Clarke, 2014). Qualitative approaches have the additional benefit of enriching the relationship between researchers and participants from the community. Due to a lifetime of oppression, stigmatization and social exclusion, older LGBTQ adults are increasingly more difficult to approach and include in research. As such, Canadian experts (e.g., Brotman et al., 2015) have suggested that future research incorporate qualitative methodologies and a social justice lens so that the voices that have been silenced over multiple generations may be heard.

**Purpose Statement and Research Questions**

The purpose of the current research project was to investigate the lived experiences of older LGBTQ adults living in Ontario, in relation to their health and perceptions of aging. From these findings, the current research project also aims to identify the perceived care service and support needs of this population in order to make recommendations that may inform practice among aging care service providers in Ontario. The following research questions were explored in order to fulfill the purpose of the thesis project:

1. What are the health and aging experiences of older LGBTQ adults in Ontario?
2. How do older LGBTQ adults envision ideal care service provision in Ontario?
3. How might the identified experiences and ideal visions for care service provision of older LGBTQ adults inform inclusive practice in Ontario?
Chapter 3: Methods

Study Design

This research project was embedded within a broader, nationwide research project that received funding through the Social Sciences and Humanities Research Council (SSHRC) in order to understand the barriers and facilitators that impact older LGBT adults’ experiences of aging and fully participating in society. The principal investigators collected qualitative and demographic data from ten (10) focus groups located across Canada; four (4) of which were based out of Ontario. In order to ensure the feasibility, quality, and appropriateness of scope for this project and the parameters set by the existing research project, I was tasked with the recruitment of participants and collection of all Ontario-based focus group data, between the months of June 2017 and April 2018. Although this research project is limited to the focus group locations and questions set within the objectives of the broader, Canada-wide project, my thesis has been informed by a unique set of research questions and more narrow geographical focus.

Ethical considerations. Given that the team of principal investigators originated from three institutional bodies, clearance of all research involving human subjects was obtained from the research ethics committees at the University of Guelph, the University of Ottawa, and Lakehead University prior to the commencement of the project (see Appendix I for the Tri-Council Policy Statement 2: CORE Certification Completion & Appendix II for the Research Ethics Boards’ Approval of the study). Due to the nature of conducting focus groups, anonymity of participants


41 The primary research study involved an interdisciplinary team of investigators from multiple universities and institutions: Dr. Arne Stinchcombe is an Assistant Professor in the Faculty of Human Sciences, at Saint-Paul University and the principal investigator on this project. Dr. Kimberley Wilson is an Assistant Professor in the Department of Family Relations and Applied Nutrition, at the University of Guelph. Dr. Wilson is advising this Master’s thesis and a co-investigator of the larger project. Dr. Kathy Kortes-Miller is an Assistant Professor in the School of Social Work and Palliative Care Division Lead at the Centre for Education and Research on Aging and Health (CERAH), at Lakehead University and is a co-investigator on this project.
was not made possible. Participant names and contact information were collected for the purpose of organizing the focus groups. While the names and signatures of the participants were collected during the administration of consent, they were kept separate from the research-designed demographic questionnaire and focus group data. The focus group recordings were de-identified upon transcription and prior to the release of any findings.

**Maintaining confidentiality in focus groups.** Confidentiality among the focus group participants was an ethical consideration that was addressed prior to the commencement of each focus group. Participants were asked in the consent form to avoid disclosing the identity of others in the group, or any other specific details, as per Braun and Clarke’s (2013) guidelines. Participants were also given the opportunity to withdraw from the focus group at any given time without penalty and encouraged to decline responding to any focus group or demographic questions that they did feel comfortable responding to. As outlined within the information letter and consent form, if a participant wished to withdraw from the study, we would not have been able to destroy the audio recordings. Rather, when possible, the data, specific to said participant, would be removed from the transcription and any analysis. No participant requested to withdraw from the study, nor did any participant request that their all of their data be removed from the transcription or analysis.

**The benefits of focus groups.** Despite the potential ethical risks and lack of privacy associated with focus groups, this method of eliciting data was selected over conducting interviews, as it allowed: (1) more participants the opportunity to contribute to the study, (2) the participants to interact with others from the community, as well as (3) the participants the opportunity to provide more detailed accounts as to the similarities and differences of their lived experiences or understandings of certain social issues. Given that the participants were expected to be over the age of 60 and identify as LGBTQ, their perspectives may be considered to be those of an
underrepresented group in Canada. Therefore, it was assumed that participants would have felt more comfortable discussing life experiences with other members of the LGBTQ communities, rather than independently with the researchers. Furthermore, from a social justice perspective, focus groups offer additional benefits to the participants as they: (1) foster and enhance social network resources, (2) reduce feelings of isolation when certain views are shared and normalized within the group and (3) create opportunities for advocacy outside of the focus group sessions (Braun & Clarke, 2013). The focus group discussions were moderated by the one facilitator, in order to allow for the equal dispersion of talk-time among participants and the opportunity for heterogenic views to be articulated without the added pressure to respond in socially desirable ways (Braun & Clarke, 2013). Each focus group was inclusive to all voluntary participants who identified along the spectrum of the LGBTQ identity. This was an intentional decision, as we felt that the diversity of the data would be enhanced, as it would clarify the similarities as well as the unique distinctions in individual and subgroup life experiences.

**Incentives to participate.** The incentives used to compensate participants included $10.00 to cover their travel costs (i.e., parking, public transit, gas, etc.) in addition to snacks and non-alcoholic beverages provided throughout the focus group session. It was assumed that participants would also benefit from the opportunity of having their voices heard, their experiences and knowledge documented, as well as the chance to meet, engage and network with other individuals from similar social groups. Additionally, once the data was transcribed and analyzed, the participants who agreed to be re-contacted and the collaborating partners were sent a summary of the national findings.

**Eligibility criteria.** For the purpose of meeting the nation-wide project’s objectives, participants were required to meet the following eligibility criteria at the time of data collection: (1)
aged 60 years or older, (2) self-identified within the spectrum of sexual orientation and/or gender identity, (3) lived in Canada, (4) spoke English, (5) demonstrated sufficient cognitive capacity. For ethical reasons, the cognitive functioning of participants was required in order for participants to provide informed consent. Cognitive capacity was assumed by the principal investigators so long as, the participants were able to arrange their own transportation to and from the focus groups, as well as be oriented to time and place.

**Recruitment of participants.** Focus groups were organized in urban centres in Northern (one focus group), Southern (two focus groups) and Eastern (one focus group) Ontario as a way to enhance the diversity of the Ontario-based research findings and to capture the range of services, resources and supports that older LGBTQ adults may encounter within their community. Recruitment for the focus groups followed a systematic procedure that used community-based agency contact lists and social network chain referral (Fredriksen-Goldsen & Kim, 2017). Social network chain referral is a recruitment procedure, which has demonstrated efficacy in connecting with underrepresented racial, ethnic, sexual and gender minority communities (e.g., Walters, 2011, as cited in Fredriksen-Goldsen & Kim, 2017). This snowball sampling procedure accounts, in part, for the non-coverage bias, as it connects potential participants to the study who may not have an affiliation with community-based programs and services (Fredriksen-Goldsen & Kim, 2017). Additionally, the research team had permission to re-contact participants from a previous study and these individuals were sent recruitment materials.

Contact lists were created by conducting environmental scans of LGBTQ organizations (e.g., support groups and health services) by geographic region and included information such as the name, location, website, email address, name and role of contact and type of social media presence (e.g., Facebook, Twitter, Instagram, etc.). The contact list comprised a total of 77
community-based LGBTQ agencies across all four focus group: 24 agencies from Southern-Ontario (Focus Group 1); 18 agencies from Eastern-Ontario (Focus Group 2) and 13 agencies from Northern-Ontario (Focus Group 3) and 22 agencies from Southern-Ontario (Focus Group 4). In the initial survey for community partnerships, I contacted LGBTQ organizations, such as pride networks, advocacy group, as well as trans-inclusive health care services and HIV/AIDS clinics by email as a request to support the broader research project (see Appendix III for the Recruitment Email Script and Recruitment Materials). The community-based organizations that wished to participate in the research project did so by sharing the recruitment materials that were attached to the original email through their own social media accounts and/or membership lists. This was done at the discretion of and in accordance with organizational policies regarding social media and information sharing. An affiliation with collaborating community organizations, support groups and/or health service agencies were not requirements for participation in the larger research project. In fact, some participants disclosed that they had been recruited through the social network clustering chain referral, as other participants shared the recruitment materials and contact information of the research team with their social networks. Volunteers who saw the recruitment materials and wished to participate in the study were asked to contact one of the investigators by either phone or email. Once a participant contacted the investigator, they were emailed a copy of the Letter of Information and Consent (see Appendix V for the Letter of Information and Consent) and were screened for eligibility.

**Study procedures.** The data were collected through a researcher-designed demographic questionnaire and focus group discussions, with approximately 5-6 other participants. The first thirty minutes of the focus groups were focused on project orientation, which included the reading and comprehension of the information letter, the participants’ signing of the informed consent
forms and the option to respond to a 22-item research-designed demographic questionnaire (See Appendix IV for the Demographic Questionnaire). Participants were then offered the opportunity to have any of their questions and concerns regarding the purpose and intentions of the larger research project answered during this time. Once these tasks were completed the focus group discussion began. The focus group questions followed a semi-structured format that comprised of approximately 1.5 hours of discussion. Focus group questions were devised within the parameters of the nation-wide project’s research questions (see Table 1).

**Table 1: Focus Group Questions**

<table>
<thead>
<tr>
<th>Source Order</th>
<th>Researcher-Designed, Semi-Structured, Focus Group Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Some people are not comfortable with certain terms used to describe their sexual orientation, gender identity, and/or age. Could you please tell us which terms you use to identify yourself and why?</td>
</tr>
<tr>
<td>2.</td>
<td>When you think about growing older, what do you consider or think about?</td>
</tr>
<tr>
<td>3.</td>
<td>What kind of unique needs do older LGBTQ adults have?</td>
</tr>
<tr>
<td>4.</td>
<td>What rewards do you anticipate around aging?</td>
</tr>
<tr>
<td>5.</td>
<td>What challenges do you anticipate around aging?</td>
</tr>
<tr>
<td>6.</td>
<td>What policies (social, government, financial) are you aware of that support aging individuals? Do you feel as though you would seek out these supports? Why or why not?</td>
</tr>
<tr>
<td>7.</td>
<td>Could you please describe how you are currently using services in the community?</td>
</tr>
<tr>
<td>8.</td>
<td>What resources/services are you aware of for LGBTQ older adults?</td>
</tr>
<tr>
<td>9.</td>
<td>When you are in need of support, who do you turn to (e.g., friends, family, community groups)?</td>
</tr>
<tr>
<td>10.</td>
<td>If you had one wish regarding your experiences around services in the community, what would that be?</td>
</tr>
<tr>
<td>11.</td>
<td>Is there anything else you would like to share with us?</td>
</tr>
</tbody>
</table>

The semi-structured focus group questions were designed following Braun and Clarke’s (2013) suggestions by including opening and closing questions to introduce and conclude the focus group, while ensuring to maintain a sequential, or logical, order. Prompts and probes were not included in
the focus group question guide, as the focus group lead (Dr. Kathy Kortes-Miller) included them naturally during the focus group sessions.

*The researcher-designed demographic questionnaire.* The demographic questionnaire was developed in order to provide a more complete understanding of the participants' lived experiences in relation to the intersection of multiple social locations (see Appendix IV for the Demographic Questionnaire). Previous research has shown that the social determinants of health may influence an individual’s experience of aging (e.g., Mikkonen & Raphael, 2010; WHO, 2017). Therefore, the questionnaire has been designed in order to address participants' social positions including: age, gender, sex assigned at birth, sexual orientation, relationship status, employment status, education status, health status, financial status, living environment, as well as race and ethnicity. To meet age-friendly standards for optimal communication with older adults, the guidelines presented by the Public Health Agency of Canada (2010) were incorporated into the layout, such as larger and clearer font and more white (negative) space. The language integrated into the demographic questionnaire originates from past evidence (Kim & Fredriksen-Goldsen, 2013; NSAC, 2013) that predicts higher rates of response in terms of self-identification of older LGBTQ adults. In order to understand the quality and quantity of social network resources of potential participants the Social Convoy Model was included in the demographic questionnaire (see Appendix IV for the Demographic Questionnaire, Question #22—Antonucci, Ajrouch, & Birditt, 2014, as cited by Kim, 42

42 Employment status includes hours level of paid work, as well as time spent volunteering and providing informal care (see Appendix IV for the Demographic Questionnaire, Questions 6-9).

43 Health status includes aspects of mental, physical, spiritual and social well-being.

44 According to Kim and Fredriksen-Goldsen (2013), the National Survey of Family Growth (U.S.) revised their questionnaire to include the term “homosexual” when referring to gay and lesbian identities, which led to a noticeable decline in the non-response rate (from 6.2% to 1.6%). Other categories that were left unchanged on the questionnaire remained the same (i.e., the use of the term “Hispanics” scored a non-response rate of 9% before and after the inclusion of the term “homosexual”). Accordingly, Question 4 (regarding sexual orientation) has been worded in order to be consistent with Kim and Fredriksen-Goldsen’s (2013) findings (p. 1; see Appendix IV for the Demographic Questionnaire).
Fredriksen-Goldsen, et al., 2017a). Since the evidence informing these questions is based out of the United States and has not demonstrated external validity in Canada, participants were given the opportunity to leave comments regarding their experience of the demographic questionnaire and encouraged to clarify the language they might prefer throughout the duration of the focus group session.

**Researcher Positionality**

Following the tenets of qualitative methodology, I believe it is essential to include a reflexive statement that attends to the construction of my own knowledge, values and research orientation. Prior to my acceptance at the University of Guelph, I subscribed to a positivist epistemological approach. I was an essentialist, believing that there was a singular truth to explain the process of aging and the developmental changes surrounding one’s sexuality and gender expression. While I still believe that quantitative and post-positive studies establish reliable and valid evidence, I have since realized that certain aspects of aging are associated with a time and place; and that culture, past experiences, and the socialization that individuals receive throughout their lifespan can also impact one’s interpretation of reality. I am now aware that depending on the context of a situation, there could be one truth or there could be many truths, and as such, subscribe to a contextualist research identity.

As a researcher with a history of LBGTQI2S+ activism, I find that I am drawn to conducting research as a means for social justice and change, and as such, view research as a tool for voicing the individuality and concerns of populations that have been rejected and pushed toward the margins of Canadian society. I have come to value research, as I consider it to offer a platform to discuss diverse perspectives, including those that are often unknown or ignored and could promote solutions to real world problems. I, however, have also come to recognize that research is
also discouraging, as it is often a long and tedious process toward change. One, which, as a result, may leave research participants feeling, exploited, resentful, and less inclined to participate in the future. Although I recognize how my interests in research came to be, I continue to contemplate my own duality as “insider” and “outsider” to the greater LGBTQI2S+ community and how the assumptions regarding my own sexual orientation and upbringing, may also impact the research process.

As a queer person who subscribes to intersectional feminism, I recognize that my identity and past experiences working and communicating with aging LGBTQI2S+ communities have shaped and biased my research interests. For most of my life, I lived in a very small, very privileged, rural town in a southern Ontario, where most of the community members exhibited very similar social locations. Although I shared my white skin colour with most of the locals, I maintained the position of an “outsider” as I did not share a similar economic status or sexual orientation, nor did I relate to their heteronormative, and at times homophobic, views. It is difficult for me to explain, but I always knew that I never “fit in” with this community, even though it may not have been as evident to everyone else. Since I never came out to my family or friends, my orientation and gender were assumed as heterosexual cis-female, and therefore I experienced many of the same privileges and safety as those who identified within the straight and cis-gendered community. Yet, as a bisexual tomboy (at the time), I felt the discrimination in my community, among my friends and even within my family. So, despite federal laws and policies telling me that I was equal and that I could publicly share my whole sense of self, the attitudes of my social networks, and a lack of LGBTQI2S+ visibility, suggested otherwise. Presently, I identify with both gender and sexual fluidity, but continue to be assumed by both the queer and straight communities as cis-female and straight because of my own, and my partner’s, outward appearance. Such
experiences have led me to believe that social scripts of normativity in general, whether normative-queer or straight discourses, negatively impact all communities and individuals, alike, as they contribute to feelings of exclusion and rejection. So while I have come to accept and understand the context of my own identity, I do recognize that my grey, insider-outsider status influenced this research.

Parts of my queer identity and past experiences allowed me to empathize with the participants, as I too have felt the prejudicial social attitudes and isolating effects of a ‘closet’, as well as a sense of exclusion and resentment toward the greater community itself. However, as a member of the younger generation and as a person who values sexual and gender fluidity (as it helped me to expand and accept my own identity) my presence during the focus groups may have inadvertently affected how the participants interacted with each other and discussed various topics. I am also a white person conducting research out of an institution that historically has oppressed and discriminated against people of colour and Indigeneity. Although three people of colour and one Métis person participated in the focus groups, I became quite aware of the negative impacts my being an outsider to this population had on the research, but also the harmful impacts it had on the participants as they did not see themselves represented within the room. So, in spite of considering my own identity to be within the spectrum of the queer umbrella, I cannot claim to understand all of the diverse experiences, identities and populations that seek its shelter. Accordingly, I have given special consideration to my biases so that I might provide the most authentic findings possible, while ensuring to respect the wishes and voices of those who participated in this study.

Data Analysis

Thematic analysis. According to Braun and Clarke (2006), thematic analysis (TA) is qualitative methodology and tool used for “identifying, analyzing and reporting patterns (themes)
within data” (p.79). The flexibility of thematic analysis is, therefore, appealing as it may be applied to a variety of research questions, sample sizes, methods of collecting data, and most importantly, the manners in which meaning may be derived. TA is a foundational method, and as such, is an appropriate methodology for a Masters’ of Science thesis project, as it provides the most basic skills that may be transferrable to other forms of qualitative analysis. By using coding frames, thematic analysis provides a systematic framework to identify patterns and themes across a data set relative to the research questions. TA has proven to be useful when conducting applied research, that is, research that acknowledges policy and/or practice (Braun & Clarke, 2014) and has been applied within the qualitative body of literature concerning aging, sexual orientation and gender identity (e.g., Meyer et al., 2011; Wilson et al., 2018). An inductive thematic analytical approach was chosen as the guiding methodology for analyzing the data.

**Step 1.** Guided by Braun and Clarke’s (2006) six-phases to TA, I began the analysis by familiarizing myself with the data. The familiarization process included recruiting community partners and participants, as well as attending all of the Ontario-based focus groups.

Approximately, 24-48 hours after the focus groups had been completed, I wrote extensive field notes that attended to environmental observations, as well as the attitudes, feelings, vocal, and facial expressions of the participants during the focus group session. Chiseri-Strater and Sustein (1997) developed a list of observations, which I used as a template to guide my own field notes.45 Then, between two weeks to four months after the focus group sessions took place, I transcribed all

---

45 As per Chiseri-Strater and Sustein (1997), I used the following observations to guide my written field notes: (1) the date, time and location of the focus group, (2) the number of participants present at the focus group, (3) sensory impressions (i.e., sounds, sights, textures, tastes, smells, etc.), (4) the responses of participants when recording field notes, (5) participants’ use of insider language (i.e., specific words, acronyms, phrases, people, places, or summaries of conversation), (6) my own questions regarding participants, behaviours, or the focus group location, (7) an analysis of the setting, focus group questions and moderator style, as well as the themes or patterns that emerged from the discussion, and (8) a reflection on what was learned from the experience (e.g., what felt comfortable, or uncomfortable and why).
of the Ontario-based focus group dialogues using iTunes Player. Audio data were transcribed using an encrypted laptop and onto password protected Microsoft Word documents and included all of the filler words (e.g., *you know, uh, um, mhmm*, etc.) as well as the participants’ and researchers’ laughter, pauses, and interruptions. For each focus group, the data were recorded onto two devices resulting in two audio files that required transcription. The process of transcription followed the same pattern for each focus group: I would listen and transcribe one recording first, as a rough draft (as there were always issues with deciphering certain discussions) and then, I would listen to the second recording of the same focus group session, following along with the rough draft of the transcript, while filling in the gaps and ensuring the accuracy of the transcribed data. I then, immersed myself in the data through repeated and active readings of the transcription. During these active readings, I often made summaries of my thoughts, noting recurring concepts and limitations of the data across all four focus groups.

**Step 2.** Second, I generated a list of initial codes and interesting findings within the data regarding the health and aging experiences of older LGBTQ adults and their specific visions for service provision in Ontario. I then coded the transcripts at the semantic level, identifying explicit themes that did not go beyond what the participants shared. This process involved creating keyword descriptors, that is, short-hand words or concepts that served to refer to “the most basic segment, or element, of the raw data or information [so that it could] be assessed in a meaningful way” (Braun & Clark, 2006, p.88). Following the advice of Braun and Clark (2006), I coded for as many patterns as possible, while ensuring to maintain the context of the extract. Throughout this process I used the electronic software MAXQDA to organize my analyses and interpretations of the data. During this step of the analyses, I generated 2694 codes across all of the focus group data.
Step 3. Once I had my initial list of codes I began the third phase by searching for themes. While I was collating a list of codes, I had been keeping notes of some preliminary themes and meaningful patterns across the individual transcripts in a Microsoft Word document. I then repeatedly returned to the initial list of codes, on MAXQDA, collapsing recurrent or synonymous codes (e.g., “Lack of Service” and “Gaps in Services”) and performed checks to ensure that the data were appropriately coded and no phenomena were missed. I then began to sort the codes into potential themes by organizing similar or related coded extracts by colour. Initially, I had five colours, or categories, which represented: (1) Perceptions of Social Attitudes and Systems, (2) Social Supports and Community, (3) Individual Identities, (4) Recommendations for Inclusive Practice and (5) Miscellaneous. This became a cyclical process, as I continued to collapse and organize codes that seemed to be connected and refer back to the extracts and transcripts, for additional clarification. I sorted the remaining 1467 codes by colour again, which represented the themes and subthemes in Table 2.

<table>
<thead>
<tr>
<th>Theme</th>
<th>Subthemes</th>
</tr>
</thead>
</table>
| We are unique and our experiences are diverse | • Unique compared to the older cis/straight community  
• Narratives and social positions  
• The “coming out” experience  
• “It’s just a very different world… different culture at that.”  
• Living invisibly for safety  
• An underground culture  
• The quieted, not the closeted |
| Tensions between inclusive/exclusive attitudes within society | Types of discrimination being experienced  
| --- | --- |
|  | o Heteronormativity/cisnormativity  
|  | o Classist/ableist  
|  | o Stigma  
|  | o Abuse (physical, verbal, hate crimes) & neglect  
|  | o Victimization (i.e., bullying)  
|  | o Prejudice (homo, trans, bi-phobias)  
|  | o Colonization & racism  
|  | o Marginalization/rejection/exclusion  
|  | o Ageism  
| Inclusive social structures and attitudes | Exclusive structures and attitudes  
|  | o The experience of discrimination  
| Intersectionality and the recognition of privilege  
| Polarized attitudes  
| Canada’s discrimination is coming from the US  
| Living authentically versus living a duplicitous life  
| Evaluating the safety of an environment/person  
| Topic du jour  
| Ability to maintain LGBTQ identity  
| Tensions between policies and social attitudes  
| How we label and define ourselves is meaningful across systems | Language as a form of victimization or reclamation (queer, homosexual, dyke)  
| Who can use which terms (insider vs. outsider)  
| Perspective taking  
| There are many labels for identifying as LGBTQ  
| How do others perceive me/us  
| Offending others  
| Categorical divisions between LGBTQ communities  
| Sexual and gender fluidity  
| Generational differences and conflicting ideologies  
| What is our root and who should be included in the LGBTQ community?  
| Black lives matter  
| The fears and joys of aging | Losses in health ability and support  
<p>| Losses in human rights, choice, autonomy and |</p>
<table>
<thead>
<tr>
<th>Category</th>
<th>Themes</th>
</tr>
</thead>
</table>
| safety                                                                  | • Who will support me/advocate for me?  
  ○ Types of informal supports discussed  
  ○ Distinguishing loneliness vs living alone  
  ○ The importance of having circles of support  
  ○ Changes in behavior and end-of-life planning to overcome fears  
  ○ The hopes and joys of aging  
    ○ generativity  
    ○ patience  
    ○ accumulated experiences  
    ○ time  
    ○ choice and autonomy |
| Valuable members of our community                                        | • Why volunteerism is a support  
  • Current Activism  
    ○ I no longer wish to advocate, I need a break  
  • Types of volunteer involvement |
| The facilitators and barriers to service provision                      | • Types of formal care services discussed (community/social services, health care services, housing/housing supports/assisted living)  
  • Culturally competent, inclusive, accessible and safe  
  • Visibility and representation  
  • Intersectional barriers and facilitators  
  • Collapsed programming and groups  
  • Reaching out to isolated individuals and building community |
| Wishing and hoping for inclusive practice                                | • Greater social inclusion and equality of rights  
  • Choice and autonomy over the decisions being made  
  • Resources specifically tailored for older LGBTQ adults  
  • Cultural competency trainings and dissecting systemic norms |

In recognition that many of the themes, subthemes and codes intersected, I tried to make sense of my interpretations by drawing a visual representation that summarized the data (see Appendix VI for “Why Does Only Half of My Maple Tree Have Leaves?”). At this point during the
analysis, I met with my advisor, Dr. Kim Wilson, to discuss this list and the visual representation as potential themes through a process known as triangulation (Gilson et al., 2011). Triangulation is a social science and health policy technique, which facilitates the validation of qualitative data by comparing results, or patterns generated from the data, across several sources of evidence (e.g., between researchers or across methodological approaches and/or theory). In this case, Dr. Kim Wilson and I reviewed the themes and the related codes for connections and created subthemes (See Appendix VI for the Original Thematic Map). I then continued the analysis independently, reviewing and collapsing the themes and subthemes that intersected, until I established three (3) themes and twelve (11) subthemes from the remaining 1,173 codes (see Table 3: First Revision of Themes and Subthemes).

Table 3: First Revision of Themes and Subthemes

<table>
<thead>
<tr>
<th>Themes</th>
<th>Subthemes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living (In)Visibly: Exposure to Discrimination across Changing Social Systems and Identities</td>
<td>(1) Maturing under Extreme Conditions (LGBTQ only)</td>
</tr>
<tr>
<td></td>
<td>(2) Changing Climates: Shifting policies, attitudes and status (LGBTQ + Old)</td>
</tr>
<tr>
<td></td>
<td>(3) Anticipatory Aging</td>
</tr>
<tr>
<td>(Dis)Connections from the Community: Finding Inclusive and Safe Supports as a Marginalized Person</td>
<td>(4) Coming out and Finding Community Underground</td>
</tr>
<tr>
<td></td>
<td>(5) Language is Meaningful to Individual Identity and Community Belonging</td>
</tr>
<tr>
<td></td>
<td>a. Language as a Form of Victimization and Reclamation</td>
</tr>
<tr>
<td></td>
<td>(6) The “LGBTQ Community” Doesn’t Always Mean Community</td>
</tr>
<tr>
<td></td>
<td>(7) Girdling Roots and Hardy Supports</td>
</tr>
<tr>
<td></td>
<td>(8) Anticipatory Coping</td>
</tr>
<tr>
<td></td>
<td>(9) The Experts of Aging and LGBTQ Care Provision</td>
</tr>
<tr>
<td>Power(lessness) and (De)Energization: Declining Power and Energy over Time</td>
<td>(10) The Fight for Human Rights and Visibility in Canadian Law</td>
</tr>
<tr>
<td></td>
<td>(11) The Fight to Change Policies and Social Attitudes</td>
</tr>
<tr>
<td></td>
<td>(12) Our Youth Need a Voice: The</td>
</tr>
</tbody>
</table>
Step 4. I then began the fourth phase of analysis, which involved reviewing the themes (Braun & Clarke, 2006). This process required that I organize each of the remaining codes (846) and their accompanying quotes within the appropriate subtheme and theme on MAXQDA. During this stage, I also created a category in MAXQDA which included supplementary demographic information on the participants, such as the types of informal and formal supports discussed. This category consisted of 337 codes that were not included in the themes. For my own clarity and understanding, I then printed and read through each transcript again, highlighting and reviewing the excerpts to ensure their fit with the data set as a whole. I then created an updated thematic map of these themes (see Appendix VI for the Evolution of the Thematic Map) and tested the map by inputting random excerpts. I also created a table in a Word Document to organize the themes, by subthemes and codes (See Appendix VI Table of Themes, Subthemes and Codes), which Dr. Kim Wilson then reviewed—along with my most recent thematic map. Dr. Kim Wilson and I then met and discussed the meanings and implications of these themes and subthemes (see Table 4: Second Revision of Themes and Subthemes with Codes).

Table 4: Second Revision of Themes and Subthemes with Codes

<table>
<thead>
<tr>
<th>Themes and the Number of Times the Theme Appeared across the Data Set</th>
<th>Number of Codes per Theme</th>
<th>Subthemes</th>
<th>Number of Codes per Subtheme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living (In)Visibly: Exposure to Discrimination across Changing Social Systems and</td>
<td>332</td>
<td>(1) Maturing under Extreme Conditions (LGBTQ only)</td>
<td>34</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(2) Changing Climates: Shifting policies, attitudes and status (LGBTQ + Old)</td>
<td>174</td>
</tr>
<tr>
<td>Identities</td>
<td>(3) Anticipatory Aging</td>
<td>124</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>------------------------</td>
<td>-----</td>
<td></td>
</tr>
<tr>
<td>(Dis)Connections from the Community: Finding Inclusive and Safe Supports as a Marginalized Person</td>
<td>435</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(4) Coming out and Finding Community Underground</td>
<td>38</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(5) Language is Meaningful to Individual Identity and Community Belonging a. Language as a Form of Victimization and Reclamation</td>
<td>63</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(6) The “LGBTQ Community” Doesn’t Always Mean Community</td>
<td>72</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(7) Girdling Roots and Hardy Supports</td>
<td>155</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(8) Anticipatory Coping</td>
<td>38</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(9) The Experts of Aging and LGBTQ Care Provision</td>
<td>69</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Power(lessness) and (De)Energization: Declining Power and Energy over Time</td>
<td>79</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(10) Valuable Members of our Community</td>
<td>63</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(11) Our Youth Need a Voice: The Inability to Fight at the End of Life</td>
<td>16</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Totals</td>
<td>846</td>
<td>846</td>
<td></td>
</tr>
</tbody>
</table>

**Steps 5 and 6.** The final phases of analysis, that is defining and refining the names of the themes and writing the final report, were conducted simultaneously. While writing the first draft, I had considered the themes and subthemes from Table 4. However, I noticed that certain labels (e.g., “girdling roots and hardy supports,” “changing climates,” etc.) were not representative of the participants’ voices, rather they implied my own biases and understandings of the data (i.e., see Appendix VI “Why Does Only Half of My Maple Tree Have Leaves?”). In following the suggestions of Braun and Clark (2006), I attempted to incorporate thematic labels that would allow the reader to have a better understanding as to what the theme was referencing; and as such, included direct quotes from the transcripts. For example, I included “Back when we were illegal” to
the subtheme entitled, “Maturing under Extreme Conditions” in order to convey participants’ perspectives of living through past sociohistorical and political conditions and how experiences of criminalization continue to impact their current and future health and quality of life. I also included sub-subthemes to help clarify the data. For instance, the subtheme entitled “The needs and the barriers we face”—The facilitators and barriers to receiving culturally competent, inclusive and accessible services” was quite lengthy and detailed, and so for organization and clarity, I included sub-subthemes (e.g., “Effective communication,” “Gaps in programming,” etc.) to outline the participants’ experiences of accessing supports in their communities.

I then submitted my first draft to my advisor and committee member for feedback and suggestions, some of which included the renaming of other themes (e.g., “Our Youth Need a Voice: The Inability to Fight at the End of Life” to “The younger population has to feel they have an obligation—Our Youth’s willingness and ability to carry the fight”) as well as the removal of the subthemes entitled, "the Experts of Aging and LGBTQ Care Provision,” and “Anticipatory Coping” from the second major theme. Instead, we considered the former subtheme to be its own theme, and as such, renamed it to “Requests and Recommendations for Inclusive Care Provision.” Similarly, the latter did not fit within the thematic structure of the second theme and determined that it offered more insights to the third theme entitled, “Power(lessness) and (De)Energization.” Lastly, I reviewed the draft of the thesis to ensure that the data accurately represented the themes and edited the thematic map to represent my final interpretations of the data (see Table 5 for the Final Themes, [Sub] Subthemes and Codes; see Appendix VI for the Final Thematic Map).

<table>
<thead>
<tr>
<th>Themes and the Number of Times the Theme Appeared across the Data Set</th>
<th>Number of Codes per Theme</th>
<th>(Sub) Subthemes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living (In)Visibly:</td>
<td></td>
<td>Back when we were illegal—Maturing under Extreme Conditions</td>
</tr>
<tr>
<td>Exposure to Discrimination across Changing Social Systems and Identities</td>
<td>Conditions</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td><em>We’re living in a time when transition has begun to happen</em>—Shifting policies, attitudes and status</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>We do think of the future</em>—Anticipatory Aging</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(Dis)Connections from the Community: Finding Inclusive and Safe Supports as a Marginalized Person</th>
<th>Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Because we had no organizations back then</em>—Finding Community Underground</td>
<td></td>
</tr>
<tr>
<td><em>It’s not a cohesive [...] community. People may think it is. But sometimes, it’s not even like a community</em>—The LGBTQ Community is not One Single Community</td>
<td></td>
</tr>
<tr>
<td>▪ Differences in values and political ideologies</td>
<td></td>
</tr>
<tr>
<td>▪ Difficulties connecting with other older LGBTQ people</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Power(lessness) and (De)Energization: The Fight for Autonomy and Choice</th>
<th>Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>We need to see that our life has value and when we volunteer all of a sudden we’re reinforced that it does</em>—Valuable Members of our Community</td>
<td></td>
</tr>
<tr>
<td><em>I ask myself, “Can you do more?”</em>—Declining power and energy</td>
<td></td>
</tr>
<tr>
<td><em>The younger population has to feel they have an obligation</em>—Our youth’s willingness and ability to carry the fight</td>
<td></td>
</tr>
<tr>
<td><em>How do I want to approach it?</em>—Anticipatory Coping</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Requests and Recommendations for Inclusive Care Provision</th>
<th>Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>

| Totals | 846 |
Chapter 4: Results

Participant Characteristics

This research project included the voices of 21 participants whose ages ranged from 60-79 years (mean= 67.71). Through an analysis of participant responses, there were 11 participants who were assigned “male” at birth and 10 participants who were assigned “female” at birth. Whereas, 10 participants identified their gender as “male” and 11 identified as “female”. These findings suggest that one participant transitioned from male to female; a finding that is consistent with the focus group data as only one participant self-identified as a “trans person”/“trans woman.” The questionnaire followed a similar format to that of the Canadian Census and asked participants to identify their sexual orientation as “heterosexual,” “homosexual, that is lesbian or gay”, “bisexual”, or “other”. In response, one cis-feminine participant responded as “other” and included that she identified with the term “Queer,” three cis-feminine participants and one trans-feminine participant identified as “bisexual,” while 10 cis-masculine and six cis-feminine participants identified as “homosexual,” one of which specified that she identified with the term “Dyke” while another specified during the focus groups that she identified with the term “lesbian” and not “homosexual.” For the most part participants were born and raised in Canada with seven participants indicating that they immigrated to Canada. The majority of the participants, reported their race as “Caucasian,” while the remaining participants’ responded as: “Métis,” “Indian (from India),” “Indo/Chinese/Carib” and “South Asian” (see Tables 5-8 for more information on the participants’ characteristics: education, working status, annual income, living arrangements, volunteerism, perceived health, spirituality and/or religiosity, as well as social connectedness and supports). See Appendix VII for a detailed tables and summaries of the demographic results and participant characteristics.
Thematic Interpretations of the Data

Four major themes were generated from the data: (1) Living (In)Visibly: Exposure to Discrimination Across Changing Social Systems and Identities, (2) (Dis)Connections within the Community: Finding Inclusive and Safe Supports as a Marginalized Person, (3) Power(lessness) and (De)Energization: The Fight for Choice and Autonomy, and (4) Requests and Recommendations for Inclusive Care Provision. The use of prefixes for the first three themes (i.e., “In”, “Dis,” “Lessness” and “De”) illustrate the variability of participant perceptions and the connections between the three themes. “Living (In)Visibly: Exposure to Discrimination Across Changing Social Systems” is the first and central theme, as it relates to participants’ perceptions and experiences of the second and third themes. Likewise, the second theme “(Dis)Connections within the Community: Finding Inclusive and Safe Supports as a Marginalized Person” relates to the participants’ perceptions and experiences of the third theme, “Power(lessness) and (De)Energization: The Fight for Choice and Autonomy.” The fourth theme, “Requests and Recommendations for Inclusive Care Provision,” is drawn from the hopes and wishes of the participants for ideal service provision and offers insights in terms of the recommendations for more inclusive care practice (see Chapter 5: Discussion).

Living (in)visibly: Exposure to discrimination across changing social systems and identities. While many concerns regarding the health and aging experiences of participants emerged throughout focus group discussions, the one issue that seemed to arise more frequently, as well as intersected with almost all other aspects of focus group discussions, was the perceived marginalization and rejection of LGBTQ communities across various social systems throughout time. Participants repeatedly discussed the historical experiences of discrimination that led them to live invisibly within society, and this continued to reinforce their invisibility within the
contexts of the present day, as well as participants’ perceptions of the future. Participants recognized that Canadian society, in certain respects, has become more inclusive over time as LGBTQ communities have gained rights and visibility through the introduction of various laws and policies that emphasize the equal and just treatment of diverse peoples. However, much invisibility remains, since the participants from this study, expressed continued experiences of discrimination and exclusion, based not only on their sexual and gender identities, but now, their age as well. The following subthemes will be discussed within this major theme:

1. Maturing under extreme conditions
2. Shifting policies, attitudes and identities
3. Anticipatory aging

“Back when we were illegal”—Maturing under extreme conditions. Throughout all of the focus groups, participants described past experiences of marginalization, rejection, and profound social stigma prior to LGBTQ liberation movements. In particular, participants described this period as unsafe and shared past experiences that led them to fear discrimination.

One participant, for example, described being threatened with physical abuse during her youth:

Well it was dangerous, you know? Like not just, gay men but you know women too. We were very afraid of discrimination. I mean […] I was dating someone in grade 9 and I had three women try to beat me up.

Likewise, another participant described the stress and fear that he associated with authority figures during his youth when Les Mesures de Guerre (the War Measures Act) were enacted throughout la crise d’Octobre (the October Crisis) in 1970, Quebec:

I don’t think people understand this, but during the FLQ [Front de Libération] crisis […] the army was here [in Ontario too…] The tanks were there and stopped and even as a
teenager [...] It added a whole other... if you were gay, there were soldiers asking who you are and what you are doing out at night.

Still, it was not only the fear of physical assault or legal ramifications, rather even after the amendment to Bill-C150 (an amendment to Canada’s Criminal Code, which removed the criminalization of homosexual behaviours, as well as introduced other human rights), participants continued to experience a profound sense of stigmatization and rejection from society, especially from both medical and religious communities. For many of the participants, living invisibly under the pretext of what was expected to be normal seemed to offer a sense of protection from the various consequences that posed a threat to their personal safety and well-being. For instance, one participant shared fearing the loss of employment, had she not kept her sexual identity hidden, and highlighted both the legal and social limitations that prevented her, and even her children, from feeling accepted within society:

I was an elementary school teacher in the seventies and I would have lost my job, if they had known I was a lesbian. There was [sic] many things I couldn’t do. When I had children in the eighties as a lesbian, they were bastards, you know? The list is long. I couldn’t get married until you know, 2005. All of those things.

Similarly, another participant recalled discrimination and stigma to be particularly prevalent during the 1980s HIV/AIDS epidemic. During this time, she assessed a past employer to be an unsafe environment and actively changed her appearance in order to align with heteronormative expectations of womanhood:

When AIDS came along—there was a lot of stigma.[...] I mean I was gay and [laughing] assured they didn’t even know. I was having the lipstick, the high heels, the nylons, the short-skirt and things like that and my gosh, you had to wear a façade.
Although living invisibly benefitted the participants in certain respects, it limited the opportunities that were available to them and impeded their ability to live authentically or to discuss their identities openly and with understanding. As a result, participants frequently discussed “internalizing” prejudicial or stigmatizing attitudes and “repressing” parts of themselves in order to fit within idealized heteronormative values. Often, participants described the process of internalization as one that coincided with feelings of isolation and one, which occurred at the expense of their psychological and social well-being. For instance, one participant described being raised as Roman Catholic and that during his youth he understood the constraints of living as a gay man, so he joined the Monastery to become a priest and humanitarian. However, while in the Seminary he felt without supports to discuss his sexuality, and requested exemption from his vows. Afterwards, he sought out support from both a mental health practitioner and a priest from a Catholic church, both of which treated his concerns as a need to assimilate within the normative culture, and ultimately negatively impacted his concept of self, sense of belonging and mental health:

I was raised Roman Catholic [... and] I knew, I knew that I was gay and I think I thought that... that doesn’t allow me... I’m not going to have a family. So I might as well do something good with my life and [there was] a priest who was fantastic with my mother [...and] I thought, “I want to be like him.” And um... so I didn’t mind going in [to the Monastery] but then when I went in I still could recognize those feelings and uh [...] in the Seminary there was nobody that I could talk to about being gay [...so I] wrote my letter to Rome [...] asking for a dispensation from my vows of poverty, chastity and obedience and I can assure you, poverty was no problem, chastity was a problem with myself; obedience was a bugger [...]. So anyway, I left and then went to the faculty of
education and saw this sign um…”Mental health issues… need counselling” [...] and I went into this padded room, leather padded room, bright red. And I started talking and he said, “Wow. It’s very simple. You just need to get yourself a wife and fuck—or uh-uh-a woman—and fuck her silly.” This is mental health. [Then I had an encounter with a man] actually it was my first encounter out of that Seminary and you know still very Catholic up in here and I went to confession to the priest because in those days, even if you masturbated you would go to Hell for that. If you didn’t get it confessed in time. And um… so I went to confession and he said, “Well son, [...] you have to get yourself a woman and fuck yourself silly.” Same thing. So I mean those are two big pinnacles in our world of the mental health and the religious stuff and so it took a long time to break those shackles and I was always feeling guilty and it was very difficult for the people that I was living with. [...] I ended up living with a woman for two years [...] but in the end we separated and she was the one who said, “I think it’s time we break this.” [...] but in those days [...] I didn’t have anybody to talk to, you know? Never, never, never.

Similarly, one participant in particular explained that older LGBTQ people were a unique population in terms of the level of vulnerability and isolation they experienced during their youth. As not only did living visibly as LGBTQ pose the risk for systemic and institutional discrimination, rather they also feared rejection from families and friends, and the impending isolation as a result.

 [...] I was talking to a friend of mine [...] and she’s a woman of colour and she was talking about, I mean about the problems that they had and I went, “Well at least you had family or friends, or a community that you could commiserate with.” But back when we were growing up that was very rare. You couldn’t commiserate with your family, you
would lose your friends, you would lose your family you know? So um [...] internalizing that was the only thing that you could do, is try to work these things through on your own. Which was a lot more difficult [...] Lots of people repressed themselves for a variety of reasons and you know, you look at mental health and the person who’s insecure in their mental health are going to want to fit the norm and strive to hit the norm. But it always, it seems to show.

Living under such circumstances ultimately led participants to develop additional strategies that could assist with living invisibly, including reconciling and/or assimilating within normative Canadian culture. For instance, one participant disclosed that he had been heterosexually partnered before coming out later in life, and that he had only done so, because he could no longer withstand the losses to his health.

[...] I was married for many years and thought I was going to take my gayness to the grave. Um, and then I was hospitalized and I realized that I couldn’t. I had to do something.

While another participant shared an instance in which she changed the way she perceived, or framed, her gender identity during a sexual encounter with another woman in order to engage within heteronormative scripts.

I mean growing up it’s like um... “I don’t want to be a lesbian,” you know? So I had girlfriends, which like okay, “Well I can touch you but you can’t touch me because if I touch you, I’m kind of like a tomboy anyway, so you know. I just substitute for a guy right? And so, if you touch me then we’re lesbian and I don’t want to be a lesbian.

Participants also shared knowing other LGBTQ people who had undergone religious treatment (i.e., conversion or reparative therapy) in order to engage with normative family structures and
developmental stages. However, such instances resulted in negative emotional outcomes. Overall participants perceived past experiences of discrimination as burdensome, as they continued to influence participants’ health and perceptions of their futures.

*But I think it’s like the residential school or anything else that we care and we get older these histories become more burdensome to us [...] so we carry that burden and make that burden into something big.*

“We’re living in a time when transition has begun to happen”—Shifting policies, attitudes and identities. Socio-historical discrimination and participants’ past experiences of living invisibly in Canada were quite evident. However, participants’ current experiences and perceptions of discrimination and LGBTQ visibility within society, varied. Participants explained that current political and legal rights were both inclusive and limiting to sexual and gender diversity, especially in terms of marriage. For instance, one participant described that the right to marry relieved his fears of institutional discrimination and normative conceptions of a family structure and partnerships.

*That’s something that was always one of my fears too that even when we were just living together, if something happened [...] that if you know, [my partner] ended up in the hospital, “Oh well no you’re not family.” I’m sorry now I’m married, now that fear is gone.*

While another participant agreed with this participant to a certain extent, she also recognized that the legal rights and policies that are currently in place are not static and that it is possible that the ability for same-sex couples to legally marry could be reversed.
I take comfort in the fact that we can get married, we are married, we have rings, we you know. It’s all legal now. But you know, that’s just an abstract theoretical right we have. Despite same-sex marriage becoming legal in Canada, participants perceived these rights to be contingent to current socio-political attitudes, as well as inferior to heterosexual marriage. Relatedly participants also discussed the differences between the common law rights of LGBTQ heterosexual people. So while it seems as though having the right to marry as a same-sex individual provides the LGBTQ community with the freedom to choose, one participant perceived marriage to be a necessity that helped her to evade inequalities, such as the intrusion of family members on decisions made by a Power of Attorney.

The common-law in a, in a, LGBT couple is nowhere close to the same as a straight couple. You have to be married] [...] Like my brother and [his partner] have been together for 45 years [...] they’re not married. If something happens to one of them, I can step in [...] and they’ve been together that long.

Aside from marital inequities though, participants shared that they were beginning to feel more represented and visible within Ontario and Canada. For instance, one participant shared, “I don’t think there’s more gay people or trans people now, it’s just that they are more visible.” Some participants accounted greater visibility of sexual and gender diverse people to more inclusive legislation (e.g., Bill C-16—which makes it illegal to discriminate against a person on the basis of their gender identity or expression), while others noticed a greater representation of lesbian and gay officials within the government. Some participants also accounted the transition toward greater inclusivity and acceptance of LGBTQ people as being due to the election a Liberal federal government. For participants, the election of a Liberal government was important, as it represented more inclusive social values when compared to the “Harper Regime” (i.e., the
Progressive Conservative [PC] Party). For instance, one participant in particular spoke of Prime Minister Justin Trudeau as exemplifying the qualities of a leader, especially when compared to the United States.

"[…] thank goodness our politicians, our Prime Minister is at least—a lot of people don’t like him either—but, I think he’s an excellent example of kindness […] and personal value, which is keeping our society at you know, I think a fairly good level compared to what’s happening in the US. We’ve seen how, how they have fallen, fallen, fallen, just by leadership modelling […]"

Discussions of the United States and the inauguration of Donald Trump as President came up frequently across the focus groups, especially in terms of participants fearing travel to the United States and for the safety of its LGBTQ citizens. Participants were also concerned that such popular discriminatory attitudes would negatively influence and prevent Canadians from becoming more inclusive and accepting toward LGBTQ people. For instance, one participant recognized the discrepancies between Canadian law and social attitudes, by giving an example of the Canadian Multiculturalism Act (1988)—a federal policy that respects and recognizes Canada as a country with diverse citizens.

"What I pride myself in saying to the rest of the world that Canada is the first and probably the only country that has multiculturalism as a Federal policy. However, the way we live it is very much in the shadow of the way the United States articulates itself socially."

Alternatively, some participants described feeling comfortable, accepted and recognized within society. For instance, one participant perceived LGBTQ people to have been assimilated into the dominant Canadian culture.
Well we would know because we are being integrated. We are being changed as a culture. Okay? [...] We are totally—not totally—we’re for the majority part, are totally accepted—if not cool.

Although this participant felt as though LGBTQ people were becoming more mainstream, or ordinary within society, other participants opposed these thoughts stating, “I don’t think we’re comfortable everywhere.” Participants asserted that discomfort as an older LGBTQ person within Canadian society was due to the continued experiences of discrimination as it threatened the safety and ability to live visibly, or authentically, within their communities. In particular, participants perceived normative systems to negatively impact their ability to live cohesively in Ontario; as one participant stated, “Well this notion of normal, which doesn’t exist really, it’s a social construct right? That we get oppressed by because there isn’t any normal really.” More specifically, participants articulated the negative impacts of other normative discourses, such as heteronormativity. For instance, one participant described it as being embedded in the language that is being used, even when older adults were describing sexual diversity: “Every single one of them said the same thing, ‘I am not straight.’ They didn’t say, ‘I am gay or I’m a lesbian, [...]’” While another participant shared similar thoughts regarding cis-normativity, as she noted that her long term friends still make mistakes when using her preferred pronouns.

 [...]sometimes [my friends] slip up referring to me as “he”, you know? And it’s not they’re oblivious or disrespectful. It’s just this social momentum that needs to be interrupted [...] 

Normative discourses were also internalized and described as perpetuating stereotypes of LGBTQ appearance. For instance, one participant experienced heteronormative assumptions regarding her identity (i.e., that she was straight) because she was partnered to a man. This
assumption negatively impacted her self-concept and ability to live authentically as a queer person.

_But it’s so interesting and moved me….you [speaking to another participant] speaking about your authentic self because I often struggle with that especially because I um… live with a man and you know, I don’t hide anything anywhere but again, you know, the assumption that I must be straight. I straighten them out if they ever sort of, if anyone thinks that._

Participants also acknowledged that normative assumptions of appearance were embedded within the concepts of race and ethnicity, or the colour of a person’s skin. For instance, one participant described the ways in which physical differences are perceived in Canada when compared to other cultures. In particular, this participant viewed Canada as being divided by skin tone and that those who are of colour, no matter their racial or ethnic heritage, face similar oppressions. As a result, this participant considered the ways in which these normative values are internalized within LGBTQ communities and how they may influence the ways in older adults interact and build relationships with others.

_We use the term here, people of colour. I am not a person of colour [whispers]. I am non-white and I see our world divided into whites and non-whites and non-whites share a very common thread of history right from aboriginal people to me […] Um… And so then we get to being gay old people, what we find is, we look for people along these societal divisions but we never stop to question […]_

Although such descriptions of the negative influences of normative discourses have described covert forms of discrimination, participants also shared experiences of more overt and dangerous forms of discrimination. For instance, one participant shared a specific instance in which she had
been physically assaulted because of the assumptions that were made regarding her gender identity, “I volunteer at [an organization] I—people see me as trans [and so] I have been physically assaulted going into the women’s washroom.” While another participant perceived greater risks for overt discrimination among those who are people of colour, including Indigenous older adults:

*I think things are still tough for people of colour. I [know] several Indigenous individuals who are drag queens that continually get harassed, that get spit on [here], today, in 2017. They’re looked down upon, they’re disrespected because they’re a drag queen.  

[…]

Um... so there are levels of acceptance [...] We still walk around with some privilege and acceptance in society by the nature of our skin.

Participants often related greater discrimination and oppression for those LGBTQ who had more intersecting, or overlapping social positions that differed from the norm, and as such, perceived greater exclusion from society with age, as one participant shared, “Um... I think our culture still has a disgust, hatred about aging in general. Not just about us as gays and lesbians, but like old people.” This thought seemed to resonate for other participants, as one participant described increased marginalization as he aged, which he felt doubled the level of disadvantage experienced.

 […] historically the LGBTQ community has been marginalized from society. That’s undeniable. It’s just historical fact. It is also a fact that aging is marginalized in our society. So we have a double whammy against us.

Similarly, another participant perceived her exclusion from society to be related to ageism, heterosexism, as well as racism, ableism and classism, as she felt silenced by decision makers because of her age, the colour of her skin, her use of a mobility support, and her appearance,
“[…] because when you’re older, you’re a person of colour and you’re using a cane and you’re wearing pyjamas [laughing] … nobody takes you seriously.” Participants also perceived greater disadvantage between gender and sex, as one participant shared that she perceived gay men to have greater economic advantage and social support from the straight community than lesbian women.

[…] a lot of straight women will support a gay man. But they will, if they know a woman is lesbian… ooooh. You know? It’s too dangerous […] and I mean [sighs], I saw more gay men getting ahead than gay women getting ahead.

Participants also perceived varying acceptance and recognition of sexual and gender diversity as it related to geographic location. For instance, one participant considered that due to the quantity of LGBTQ adults living in urban areas they experienced greater visibility, and as a result were more included within society than those living in rural areas.

So whenever I say, we’re accepted, I’m talking about where the gays have moved in.

They’re accepted in urban populations, things like that. Rural, because there’s not a quantity, I think there’s a lot more difficulties there.

In certain respects, participant discussions corresponded with these thoughts. For instance, when compared to past experiences of discrimination, one participant who was living in an urban setting described feeling free to live authentically as a gay man without concern for his safety or the acceptance of others in his community.

Now I can feel free. On the elevator I say “we” and the one—some person beside me says, “Oh your wife?” and I said, “No my husband.” And I can do that now and if they don’t like it, tough bananas!
However, a participant who was living in a more remote region also described feeling accepted within her communities. Rather, in spite of the small number of LGBTQ people within this community, this participant and her partner found it important to be visible and to represent LGBTQ identities.

We live on a street with uh, in our own house. Talk to the neighbours and there’s one neighbour across the street who won’t speak to us. [...] Um.. [but], we walk around the neighbourhood. We know faces, so we were accepted right? Um... and same thing at church [...] So it’s been you know, we’ve sort of been there from the beginning of that and we’re still there. And when people come we’re, you know, we’re an example. And I think that that’s important [...] That you can stand out in the community and say, “I am me, this is who I am,” and you either accept me or don’t. Right?

Furthermore, another participant who was residing in another urban location did not perceive LGBTQ visibility within a community to be related to the number of LGBTQ people, activities or services for LGBTQ people in urban settings. Rather she perceived LGBTQ acceptance to be related to the local values, dominant industries of the community and whether these industries have a past history of oppressing LGBTQ people.

I think there’s more to do, more uh, more activities, more things to do in an urban environment [...] But I, I just... the idea that where I may go [...] I mean, I still decide when I’ll say I’m a lesbian and when I won’ [...] When so many people are working for the same institution effectively—the federal government or some ancillary association and all that goes with that. Including maybe being private, or careful, or more cautious than you might be, um, about your sexual orientation. Whereas in [other major cities]
there's a million employers. There's all this diversity in so many ways [...] that really there isn't here still.

Due to the uncertainties of the level safety or inclusivity of an environment, some of the participants continued to live cautiously or invisibly and considered this to negatively impact their concept of self. For instance, one participant shared feeling as though he was living a duplicitous life, as certain social groups would not be accepting of him being gay.

I feel far more authentic today um... there’s room. And I again, I see constraints ahead of me because I cannot, as I see it, um... belong to [Indian] [...] Indian.... Um... Canadian society [...] and at the same time be gay. Um... and I envy my gay, Anglo-Canadian, mainstream friends for their ability to just be. Um... so I live a duplicitous life. Um... I don’t fake heterosexuality [...] when I’m with [Indian] Canadians, which I enjoy. Um... to an extent. Um... I don’t mask myself, neither do I speak authentically about being gay.

I don’t find the context to do that.

Ultimately, participants described experiencing visibility within society in ways that were, perceivably, unrelated to the layering of any particular social positions. In my analysis, it appeared that such descriptions could be organized into three types of experiences that detailed participants’ assessments of risks in terms of living visibly, or authentically, within society. The three types of experiences are as follows: (1) the participants that did not fear the risks of being visible, (2) the participants that assessed the risks of living visibly and, (3) the participants that continue to anticipate discrimination, and as such, live invisibly. Within the first experience, these participants described feeling as though society’s attitudes have changed when compared to the social, cultural, and political conditions of their pasts. For these participants, they described feeling as though they could live openly and as their whole authentic selves, no matter the
context, environment or people in which they have contact. The second experience, however, consisted of participants who assessed the risks of living visibly within society and evaluated every context, environment and person in order to navigate, who, where, when, and under which circumstances it was appropriate and safe to share their sexual identity. These participants described living visibly, or invisibly, within society conditionally, or as though they were living a “duplicitous life.” Lastly the third experience consisted of those participants who did not question whether they may be discriminated against, rather they anticipated that discrimination would occur, especially within certain contexts and environments, or while engaging with certain people. For instance, one participant shared that he anticipated his neighbours would discriminate against him for his sexual orientation if they witnessed him marching in the Pride Parade. As a result, he decided to no longer attend the event.

"I only live two blocks from the [Pride] Parade [...] so anybody from our building could be watching [...] that’s why I stopped walking for [a community organization] because I live so close. I don’t want them to see me because I’m in that building.

"We do think of the future"—Anticipatory aging. When asked to consider the challenges of aging, participants often referred to fearing losses in their health, abilities and supports. For instance, one participant disclosed his fears as being related to his partner’s health. Since his partner came out later in life, this participant questioned if his partner were to develop some form of cognitive impairment, whether he would still remember living authentically as a gay married man.

"[...] my fear is—and I’ve never met anybody who has Alzheimer’s or dementia who is in the LGBT community, so I’m not sure how that will affect their head. Like, will they still
be gay? Will they remember you? Will they remember their life? I mean I’m just... I have not had an experience and that scares me.

Similar thoughts were conveyed by another participant, as she discussed the unique concerns related to the health, self-care and personal hygiene needs of older trans-feminine women, especially post-vaginoplasty:

As a trans person specifically, um... there are certain things I have to do on a more ongoing basis...uh... in the realm of self-care. I have to dilate my vagina – it’s not as stretchy as it—it’s one of the factory installed versions. I have to do that, periodically. Every four months, I have to take estrogen at intervals [sighs] ... I still have a certain, small amount of facial hair. It’s soft and you know, it’s not like a beard exactly, but you know there’s times when I have to remove it and I’m sort of wondering you know, if I was incapacitated in some way or another, how would this stuff happen? How I would I continue to take estrogen? How would I continue to dilate? [...] And um...you know, so [my partner] will say, “Oh well I’ll do it,” but yeah what if you’re not around? What if you’re incapacitated also? How is this going to happen? [...] It would be really nice if I could go to the grave doing this stuff for myself, but it’s certainly not a guarantee or anything like that. And I know, I talk to other trans women and that’s essentially a universal concern. How do you do the specific, sort of unique, self-care things that trans women have to do? Um, on an going basis, if there’s something that compromises your ability. [sighs]. Maybe that’s something that a uniquely LGBTQ long term facility would have training in.

Due to the age-related losses in health and abilities (i.e., death of social resources, losses in ability to provide support, geographic shift – downsizing houses or moving to institutional care
facilities), participants considered their future care needs and how they might compensate for the loss of informal supports and connections that they were closest to (e.g., partners and friends). Accordingly, participants discussed the need for greater interdependence and reliance on other forms of informal social supports, such as children, siblings and neighbours, for assistance as they neared the end of life. Several of the participants shared concerns regarding their future care needs, if they did not have children and questioned who would provide support or advocate on their behalf otherwise. For instance, one participant without children anticipated that she would become isolated sooner than those who did have children, and as such, felt the need to develop greater relationships with the people living in her community in order to ensure her future care needs would be met.

*I do not [have children]. My partner does not [either...] so when you say alone, the rest of your family is gone, your parents are gone, you are alone, there is nobody else [...] There’s nobody else to call like, “I can’t reach that” or “I’m having difficulty pulling this out or from one place to another,” If you—like myself, I worry about this all the time. If there’s not somebody around, or if I’m not really good friends with my neighbour. I’m screwed!

Nevertheless, participants with children did not necessarily consider them to be reliable supports or potential caregivers.

*I don’t think we’re going to get [a lot of support from our children] either. Well one son lived in the country and is very engrossed in his own life, in his own self. One son lives in, uh the other side of the town and his life has been sort of hectic [...] and my daughter who’s not married is in [another province]. So I can’t expect very much from her and then my other daughter who lives here is alienated and has been [...] since I left my
husband [...] so not much hope there. Also the two boys are alienated from each other over my husband’s um…estate [...] 

Despite having children who lived nearby, this participant felt that her adult children, whether for personal or professional reasons, would be too consumed with their own lives to provide end-of-life support. While both the geographic and relational distance between herself and her other adult children, created additional barriers to receiving care. This participant also considered that even if her children were in a position to provide her with care and support, they are estranged to one another, which would ultimately make it difficult to coordinate and share the care responsibilities. Participants also demonstrated close relationships with their children. However, even under such circumstance, these participants still felt that their children would be too busy to assist with their care as they had their own children and professional goals to attend to. While some participants described developing relationships in order to request informal support from neighbours, other participants described a cultural shift which lacks community. Participants perceived such losses in connection to be due to the collapse of community run events and fewer opportunities to meet and socialize. With the anticipation of significant losses in health, abilities and social supports, came participant fears of becoming isolated. Ultimately, participants perceived greater isolation among older LGBTQ adults as being related to negative social attitudes toward sexual orientation and gender identity. For instance, one participant shared that he perceived older LGBTQ adults to be more susceptible to isolation than heterosexual seniors, since they experienced greater rates of internalized prejudice and shame that would prevent their ability to form social connections.
Because it’s bad enough you have to grow old alone, it’s even worse if you grow old alone and you identify as LGBTQ and where you might still feel that shame-based trauma that we all feel because you weren’t born straight [...] 

Likewise, another participant anticipated greater isolation as an older LGBTQ adult. However, he related it to society’s rejection of non-normative identities, including age, sexual orientation, and ethnicity.

Um…. I’m conscious about isolation. Um… isolation because of social perceptions of um… age. Social perceptions of um… gayness and social perceptions in my case of um… ethnicity. Um… assumptions are made [...] 

Aside from social resources, participants also anticipated significant losses related to financial and housing supports. Although discussions in terms of the desire to age in place (i.e., to remain at home as they near the end of their lives) were frequent among participants, several participants anticipated that they would need to downsize, or move, to a new, smaller and more manageable home before reaching a point where they could no longer do so independently and with autonomy. For instance, one participant anticipated having to sell her and her partner’s home, as she felt she would not receive consistent support.

So we think [...] about when we should sell our house because we have a house with a yard and vegetables and the whole bit. But, every year we’re like [...] you know, should we at some point, you know we’d miss it, but should we at some point, um… size right down to sort of an apartment, a minimal thing, when do we do that? Because we can’t rely on anybody coming in to keep us in our home, which I know some people do.
Several other participants shared that they had already experienced such losses. For those older LGBTQ adults, it was related to financial concerns. For instance, one participant said that he downsized, a year ago as he anticipated future financial issues.

_A year ago I did downsize. I sold my house and moved into a bi-level apartment. I needed to do it for economical reasons. Not for other reasons. I would have stayed with my house._

The fear of financial instability, and the corresponding impacts on end of life planning and negative health outcomes were a stressor for many of the participants. One participant for instance, described her concerns as being related to the government benefits she was receiving, as she anticipated gaps in her financial well-being once payments from the Ontario Disability Support Program (ODSP) would end and payment from the Canadian Pension Plan (CPP) and Old Age Security (OAS) would instead begin.

_When you turn 65, you lose your disability pensions. That’s it, it disappears […] So this is a crucial one because many of us who are queer of a certain age are living on disability pension and when you turn 65 you lose, your disability pension and you are referred to regular CPP and OAS [Old Age Security] and if you’re lucky you’re qualified for GIS [Guaranteed Income Supplement]. When I turn 65 in January, I’m going to be down $500.00. Many of us living on the brink of poverty that affects everything in our lives. Housing, our health care, how we live, being able to have good meals, a roof over our heads, how we interact with people and nobody seems to be taking this seriously._

_“They’re not necessarily… user friendly, people friendly, LGBTQ friendly” —_

Similar to the theoretical predictions of Cantor and Mayer (1978), with the anticipated losses participants also anticipated having to extend their network of social supports to include formal
(i.e., community, health and social) care services. One participant that was already facing worsening health conditions, spoke of finding acceptance in relying on formal care services, such as a housing or an institutional care facility, “I have dementia. I have been diagnosed with dementia. So [...] and that’s very personal and um, my acceptance would be in an institution or home care or home setting [...]” While another participant shared similar thoughts, however he emphasized that it was due to a lack social resources willing to provide end of life support.

I have a personal fear that the next step for me... I have no family, I do but I don’t have a family. That’s part of the uh... dreariness of isolation. Um... the next step for me would be a nursing home and I dread the prospect of going into a place that’s an institution to begin with um... because on a personal level I was raised in boarding schools and to be going in there as a gay man, to be there as a non-white gay man, whether that matters to me or not, it matters to the people who carry perceptions around with them and who might be in charge of me and my comforts.

Similar to these excerpts, apprehensions for future use of formal care services among participants were related to past encounters of discrimination, vulnerability and discomfort while within an institutional environment. Participants related future fears to past experiences of marginalization and to the current political and social state of LGBTQ rights in the United States, and as such, anticipated losses in their rights as human beings within these settings. For instance, one participant hoped that if he were to enter an institutional care facility, that he and his partner would be treated with the same respect that is afforded to straight partners. However, this participant perceived institutional attitudes to vary across facilities and that government funded institutions, more specifically, would be more discriminatory than those that are privately owned and operated.
But uh, I would fear that things would go backwards as I get older and that we would lose some rights we have now as we see in some of the Southern states, their backlashing and taking away some of those rights. So that if you ever ended up in the assisted-living, you aren’t going to have the respect that we do now. I worked in long term care for 10 years as a CEO, so I know exactly, how the, what the flavour is and generally [it takes getting] into the right place, with the right people [...] if you have the money and if it’s for a profit home and you have the money to have the private room I think they’ll treat you in whichever way you want. But, by and large, you have to think about the people who do not have the funds. The poor LGB. The lower income LGB down the road who can’t even afford that kind of thing [...] If we were both in a LGBT home, heaven forbid in some point in time. I would want us to be together [...] and um... then, be given the same rights as a heterosexual couple. Whether that is happening right now, um... I think the publically funded, the regional home, um... I think in a lot of cases they probably turn a blind-eye. Depends who you get [...] 

Due to the anticipated discrimination from both care staff and other residents, participants anticipated that entering into an institutional care facility would increase health disparities and reduce their quality of life. While some related these anticipations to fewer social connections and greater isolation, others anticipated great risks to mental and emotional well-being, as well as their physical safety.

We already know how bad some long term care homes can be, where just ordinary, you know, heterosexual older person [...] could receive beatings or emotional and physical abuse. Already that happens.
Because participants in this study were on average, a younger cohort, some hoped that social change and greater LGBTQ visibility would occur before they would need to enter institutional care. Others who were older or who presented with chronic illnesses, however, perceived that such transitions would not occur fast enough, as one participant shared “I’m over here and there’s not all that much time left for these changes to occur.”

**Summary of theme 1.** Within the first theme, “Living (In)Visibly: Exposure to Discrimination across Changing Social Systems and Identities,” three subthemes were discussed. The first subtheme, “Maturing under Extreme Conditions,” considered participants’ experiences of past sociopolitical and historical experiences of discrimination. Participants described past experiences of marginalization, rejection and profound stigma prior to the LGBTQ liberation movements, such as: physical abuse, fear of criminalization, medicalization, religious condemnation and loss of employment and exclusion of self and family. The political, cultural and social values of this period led participants to live invisibly, or to keep their sexual and/or gender identities hidden. In order to do so, participants employed strategies, such as changing their appearance, attitudes, and behaviours to align with heteronormative expectations of gender and sexuality. Participants described the past as an isolating experience that led them to internalize harmful normative discourses, which continue to negatively impact their mental, emotional, social and spiritual health within the present context, as well as their anticipations of discrimination in the future.

The second subtheme, “Shifting Policies, Attitudes and Identities,” described the differences in participants’ experiences of discrimination and visibility within the present context. Although participants recognized greater LGBTQ visibility and inclusion in society, especially when compared to the past, some participants considered it to be temporary, or
abstract, and that the rights of LGBTQ people are inferior to those who are heterosexual. Some participants also shared that they perceived tensions in Canada’s social policies (e.g., equal human rights) and social attitudes (e.g., continued discrimination), as being related to the ways in which the United States expresses negative social attitudes toward multiculturalism and sexual and gender diversity. Certain participants also considered experiences of discrimination (both overt and covert) to be related to the harmful effects of normative discourses. For instance, participants described how hetero/cis-normative assumptions and hetero/cissexism, racism, ageism, ableism, classism continue to harm older LGBTQ adults. Differences in intersecting social positions, as well as the geographic location and values of a participant’s community, therefore, were perceived as impacting a participant’s level of inclusion or advantage within Canadian society. Despite these tensions, certain participants described feeling comfortable and visible within their communities, while others described experiences of discrimination that continued to threaten their safety and ability to live visibly, or authentically. Due to past experiences of discrimination, as well as the current sociopolitical climate, participants described having to still assess the risks of living visibly within their communities.

The third subtheme, “Anticipatory Aging,” consisted of participants’ discussions regarding the challenges of aging as an LGBTQ person. For the most part, participants feared the accumulation of age-related losses (i.e., health, abilities, and supports—informal, housing, financial) and increased isolation, as this would lead to a dependence on formal care facilities. In particular, participants from this study feared that their unique health needs would not be met and that they would face even greater discrimination once institutionalized in a facility that values normativity.
(Dis)connections from the community: Finding inclusive and safe supports as a marginalized person and/or socially repressed group. Participants shared that living invisibly, on the fringes of society and without both informal and formal supports, encouraged LGBTQ people to find each other and to create a community, or circles of support, which could offer inclusion, authenticity and safety. By establishing an underground culture, a system of code words and safe spaces, LGBTQ people were able to find comfort in those with whom they shared similarities to. According to the participants, however, not all subgroups, or sub-communities, were included, as those who were trans and/or non-white were not always accepted by those who were more visible (e.g., gay and/or lesbian). Due to past experiences of discrimination certain language, or terms, may continue to be perceived by the older LGBTQ community as victimizing, despite attempts toward reclamation and empowerment. Accordingly, participants described divisions within the community that were largely founded on these differences in language, and by association the values and political ideologies, relationship status and age of other LGBTQ people. Language and the labels used to describe one’s identity are, therefore, not only meaningful to individual identity, rather the provide LGBTQ people with a sense of who shares similar, or dissimilar, values (i.e., who is safe, or unsafe). As a result, certain participants described a reduced sense of LGBTQ solidarity and support—that is, community belongingness and a commitment to unite and fight for LGBTQ rights—while others described never having experienced a singular LGBTQ community, or such a level of unity. Additionally, some participants shared relying on formal community care services, which were perceived to be both inclusive and exclusive in terms of providing culturally competent, inclusive and accessible care to older LGBTQ populations. The following subthemes will be discussed within this theme:

1. Finding community underground
2. The LGBTQ community is not one single community
   2.1. Differences in values and political ideologies
   2.2. Difficulties connecting with other older LGBTQ people
3. The facilitators and barriers to receiving culturally competent, inclusive and accessible services
   4.1. Effective communication
   4.2. Supports where the spectrum of identities and communities are represented
   4.3. Gaps in programming
   4.4. Reaching out and building community

   “Because we had no organizations back then”— Finding community underground.

Living invisibly within a society which rejected sexual and gender diversity forced the LGBTQ community of past generations to develop an alternative, or underground culture. This was evidenced by one participant as he spoke of the differences between current and historical social attitudes toward sexual and gender diversity, “Our generation lived more or less in an underground culture [...] You knew who you knew and we were seldom, if ever[went] public.”

Being without inclusive formal care services and without informal support from friends, families and/or community groups, LGBTQ people were driven to build alternative social connections, or a community of support, with others similar to themselves. As one participant shared, “there was nothing in the fifties and sixties. But they had a community of friends and it was lovely, you know?” This thought was reflected by another participant as he described the continued need for circles of supports for gay men during the eighties, after the onset of the AIDS epidemic:

   When I worked in AIDS in the early days [sighs]. Everyone who came to our doors, everyone who we got to know, everyone who we provided services to, we lost. Every
single one of them died. And frequently they were individuals who came back to the city to be with parents, who in some instances were finding out for the first time that their son was gay and dying at the same time and they weren’t getting the support they needed from their families. So we became a small circle. We became a little islands of care around them, much like what hospice does now, that was then.

Instead of living “publicly,” or visibly within Canadian society, participants referred to safe community spaces, such as parks, bathrooms, bars and private house parties. For instance, one participant described that in one Ontario-based region he was living in, the local newspaper would advertise vague, or coded, descriptions of private dances and socials.

We had a designated uh, what we called monthly social dances and they were at the usual [region name] location. Never named. And we actually ran ads in the newspaper that said that [...] November 17th social, at the usual [region name] location. Never put the street, never put the building [...] You had to know somebody who knew somebody so that you could go to the dance.

Relying on codes, or an underground language, provided participants with an ability to express their needs in a way that was intended to be understood only by the LGBTQ community. For instance, participants spoke of using slang to detect the identities and lifestyles of others within the LGBTQ community.

Participant 1: At work we used to have a code word, “on the bus,” you know like I had a lesbian friend and she would be like “he’s on the bus,’ you know? Like there was, “friends” “friends of Dorothy” [...] because at the time you weren’t—you didn’t talk too openly but you know you’d say, “he’s on the bus” or that sort of thing.

Participant 2: “From the parish” Mhmmm...
The use of underground language was not only a form of communication between individuals though, rather underground messages were also conceived within the arts. For instance, one participant described musicians incorporating lyrics that portrayed LGBTQ symbols and imagery.

*There’s turn of the century, Noel Coward I think, he wrote musical, and it’s a four-gay men quartet who sing we always wear a green carnation [...] That’s what the song was about. That’s how they identified back then [...] Interesting song [...]*

In certain respects, such strategies protected the personal safety of LGBTQ people as it gave them the ability to overcome systemic and institutional discrimination. However, according to the participants, only a few LGBTQ people were actually privy to such information; since it was only shared through word of mouth and only by a person with insider knowledge. For instance, when discussing the private dances and socials, one participant said, “*I never knew where it was!*” While another participant referred to herself as being “naïve” because she had not known that her sports team consisted of other LGBTQ members, “*For the first three years I was playing on that team, I didn’t know it was a gay team [...] That’s how naïve I was.*” Despite assumptions of a cohesive community and single system of support for those who differentiated from the mainstream, certain members remained excluded. Such exclusion was most notable among participants when discussing the fractured relationship between gay and trans communities. For instance, participants in one focus group shared that trans people were “*almost unknown,*” and that “*the gay people were prejudice against them.*” Another participant, however, responded that such divisions and rejection were imposed by the normative expectations and that the resulting systemic discrimination of difference within Canadian society had been internalized by the gay community and reflected toward other marginalized subgroups.
Well we have to look back too and do some self-introspection here because we were—back then in the fifties, sixties—we were full of prejudice [...] So we were prejudice against, against, guys who looked feminine [...] And we would be prejudiced against, well me because I looked great in a dress [...] But we had all those prejudices that our parents did and the straight community had, they were all with us. [...] we could talk going way back to basic prejudices against anybody who didn’t look White and Anglo-Protestant, you know? Even Catholic or whatever. So we were filled with hate ourselves [...] “It’s not a cohesive [...] community. People may think it is. But sometimes, it’s not even like a community”—The LGBTQ community is not one single community. Participants described experiencing the “LGBTQ community” in a variety of different ways such as a physical space, a collective cultural group, or system of support in which its members could feel safe and understood. However, some participants considered that the term “LGBTQ community” did not fully capture the differences in identities and/or sub-communities, nor did it portray the complexities of various experiences.

I just—I wanted to point out that there is no one LGBTQ community because I don’t belong to that community, as a person of colour and as an older dyke. [...] that’s why I keep saying, every time I hear the “LGBTQ community,”” drives me nuts because there’s not one community [...] I keep asking people, put an “S” on the end.

Rather, as this participant suggested, the singular use often implied one shared LGBTQ narrative that insinuated similar lived experiences, personal interests and lifestyles, while at the same time, discounting the divisive inner attitudes, inequality and at times, exclusion of certain members. Despite varying perspectives in terms of a singular “community,” or plural “communities,” there
is still a sense of cohesion that unites all LGBTQ members or sub-communities to achieve various activist related goals, such as advancing the rights and acceptance of all LGBTQ people. Throughout focus groups, participants implied the need for both the collective LGBTQ community as well as individual support form LGBTQ sub-communities. Therefore, it is for this reason that during this thesis, and more particularly during this subtheme, I refer to the “LGBTQ community” in the singular, and the divisions that participants experience.

Differences in values and political ideologies. From my analysis it became evident that with the participants of this research, there were two distinct and conflicting perspectives. The first group of participants consisted of those who value radicalism and wish to drastically alter the existing practices, institutions and social systems (e.g., normative values and essentialist distinctions) within Ontario, Canada. Participants who shared the other perspective described valuing the idea of integrating within society, while increasing LGBTQ acceptance, respect and equality. Participants, in certain respects, acknowledged these differences as well and noted that they had been experiencing increased rifts within the larger LGBTQ community, as a result. For instance, participants discussed the use of “queer” as term that was empowering to LGBTQ people, as it provided sexual and gender diverse individuals with a sense of ownership over its use, “I own it, fuck you! You know? You can’t use it against me.” Similarly, another participant discussed her use of the term “dyke” to describe her own identity (i.e., a term historically used to victimize lesbian women in particular), as she perceived the term “dyke” to challenge political and social attitudes, and to reclaim her visibility. Other participants however, disapproved of the term and its use as a label that could describe their own sexual identities, as it was often related to past experiences of victimization. For instance, one participant shared that despite the term’s
Well one word that I used to, and still am not comfortable with, but it’s grown on me… it’s the word queer. I cannot stand that word and I know that it’s becoming very popular and we’re “reclaiming the word,” [laughing]. But... um... I haven’t bought it [laughing]. [...] I, I find it offensive because when we grew up it was uh... queer was not good and um... I’d rather forget about it. And... um... I’m gay. I mean we’ve got so many terminologies now, there’s so many groups and um... queer is just one other that’s been added. It’s just, it’s just getting too much. I’m being honest.

While another participant discussed his frustrations with the increased number of LGBTQ identities and the need to demonstrate greater sensitivity to the uniqueness of their needs. “We’re trying to please too many people. We’re trying to be politically correct and it backfires [...] And actually the community, what happens is the community is divided.” Another participant identified similar challenges while accessing a local LGBTQ community group. Although he likened such conflicts to the younger cohort finding their own generational identity, he expressed sincere concern that such tensions in values may result in the collapse of programming and much needed resources

Uh... but right now what I read this morning in the post was that the divisiveness is so great and it all started with Black Lives Matter and I think what’s happening is some of the younger people in the group [...] I think it’s the younger people have more affinity to being, to wanting their own identity beyond just, you know, gay or lesbian... um ... or trans. And um... they maybe are trying to work it out themselves, but in the case of the
During the city of Toronto’s Pride in 2016, Black Lives Matter activists blockaded the parade in order to challenge Pride Toronto in terms of their inclusivity of people of colour. Black Lives Matter read out a list of demands, including that Toronto Pride hire more black transwomen and Indigenous folks, provide more funding to a black queer youth group, as well as exclude police from the event, as their presence made LGBTQ people of colour feel unsafe. Once the director of Pride Toronto signed off on the demands, the parade was able to resume. The organizers of pride however, revised these commitments and instead issued a policy in which police could attend Pride, so long as they did not wear their uniforms. This controversy was brought up several times by participants as contributing to some conflict experienced within the LGBTQ community. As such, it seems that the exclusion and rejection that participants may have experienced in the past may extend to their current perspectives of conflict within the broader LGBTQ communities.

**Difficulties connecting with other older LGBTQ people.** Participants also described how differences in social positions, such as relationship and socioeconomic status, gender and sexual orientation created barriers to building connections with other older LGBTQ individuals. For instance, one participant spoke about how she found it difficult to maintain her visibility and concept of self and identity, without a partner.

[…] I feel like I came out and I found pride and I found a lifestyle and now it’s all gone. And I don’t know how to be out as an older person and single […] And it’s frustrating because all around me are conversations all the time that I can’t participate in because they exclude me […] So I just tend to stay quiet and stay out […] And now there’s no
more need for a gay scene because there’s same-sex marriage […] But there’s no more need for uh… finding a refuge. A place together.

As such, this participant attributed her lack of a partner to feelings of exclusion, which kept her from building LGBTQ connections and accessing LGBTQ events. Accordingly, this participant felt that with greater political recognition of LGBTQ rights, such as same-sex marriage, there was less of a need for support and dependence on the LGBTQ community and safe spaces.

Similar thoughts were echoed by another participant, as he also found it more difficult to connect with other single older gay men, as there was no longer a space in which older LGBTQ adults could belong.

[… I don’t find older, single, gay men anywhere. Uh […] I’m almost too old—I don’t club anymore so that isn’t a social aspect available to me. I have—and like many local bands and if they say they’re starting at 10:00pm, that’s not my gig. You know? I’m not going to be out there, drinking in a bar, beginning at 10:00pm and closing at 2:00am. That’s no longer me, in that social scene.

While another participant found it difficult to connect with other older adults in LGBTQ spaces, she instead maintained relationships with younger people in order to avoid isolation.

And I really cherish the fact that I always have younger friends because I seem to be the only one out dancing with my younger friends. I don’t see people my age, out on the dance floor anymore. And it’s also difficult as [other participants] were saying about isolation. I make a point of taking myself out.

“The needs and the barriers we face”—The facilitators and barriers to receiving culturally competent, inclusive and accessible services. Throughout the focus groups, participants discussed their current experiences of various care services and programs within
their communities. Focus group participants were heavily involved as volunteers in their communities, and therefore, described experiences of accessing, educating, organizing, and/or providing care supports within their communities. During these discussions, participants expressed the facilitators and barriers to accessing community programs, social groups, as well as health and social services. Participant discussions were organized by the following (sub) subthemes: effective communication; supports where the spectrum of identities and communities are represented; gaps in programming and; reaching out and building community.

**Effective communication.** When accessing care services, participants described recent experiences of either culturally inclusive or exclusive encounters when communicating with care service providers. For instance, one participant described a negative experience during a health appointment, in which he perceived his family doctor to be insensitive, misinformed and assumptive of gay men’s health.

*My old doctor before we... uh... we switched over [to an LGBTQ doctor] and I came out to him and he says, “Oh I have two other gay clients... but they’re dying.” And that was it. [...] And he was just so clueless as to anything, like you know, “You got to be careful, you can’t date because you will get HIV.” “Well you could too.” “No I can’t I’m straight.”*

Various participants described similar situations in which they experienced negative encounters and incompetent care from physicians as a result of their sexual orientation. Similar to the above participant, others described transferring doctors until they found culturally competent care. However, in certain situations (such as an emergency visit to the hospital or a single visit to a specialist) the opportunity to choose alternative care service may not be available. One participant, for example, shared that a specialist communicated prejudice toward her sexual
orientation because she refused to make eye contact while the participant’s partner received radiation therapy.

I remember there was one, a radiologist, who never looked at me the whole time she was going through radiation. There I was sitting in the room and never—you know, shook my hand, but that was it. Never looked over.

Another participant similarly described experiencing ageist, heteronormative, and cis-normative discourses while being admitted to urgent care.

Over at [names hospital] I um... my eyes went blood red and there was no way you could see any of the white and uh... so I was taken into emergency and there was this [...] man who was doing admissions [...] he started asking me questions and of course because of the age uh [...] “Do you have a computer? Do you have an email address?” And I said, “Yes [...]” and then he said, “[...] are you married?” and I said, “yes” and he said, “Oh what’s her name?” And I looked at him and I said, “You know, we need some diversity education here,” and he said, “Yeah, you said Chinese, what’s [her] Chinese name?” and I said, “No! I’m gay!” [Laughing] And you could just see the look on the poor guys face, he realized he had... he could have done it in a different way and he apologized [...] And uh... then he took me into a big room [...] and I was in one room surrounded by the curtains and in the next curtain enclosure was a man and the doctor came in and said, “Oh you must be mister so and so and this must be the wife.” You know it wasn’t quite the same, but it was the same type of thing [...]
provider. This participant perceived his health care provider to show little concern for his well-being and determined that this was a result of his age, and the ageist attitudes that health care providers have, in general, toward older adults.

Um ... there’s this very heavy overlay that you sense, which is you’re old, you just have to live with it. When symptoms are provided, you’re not viewed as being a capable advocate. You are viewed as being a crotchety, complaining, old man. Um... the symptoms... might... are often—I’ve just come from [...] seeing my respirologist—minimized um... negated and when you stand your ground and you say, “No! you are convinced of my having been a very compliant patient. I am here to tell you that the side effects of the cortisol steroids you are giving me are disabling me. I do not want to take them. I have found this alternate medication to help stave off my cold from becoming an asthma flare up. I would like you to prescribe it.” “There is no scientific evidence to that, no I will not prescribe it.” It just becomes um... not frustrating, because if it were frustrating I would have gone and eaten worms or something, but I’m not. I want to be able to stand up with dignity and be treat with dignity by healthcare providers and [...] I suppose I’m not just speaking from a gay perspective, but from an old perspective as well. [...] now with medical records being electronic records, they put down in their subjective impressions about you. You switch doctors that goes with you and you are viewed as being this problem that’s just entered the office [...] So where do I go now? [...] there’s nobody else I can go to because he has my electronic record.

Due to ongoing distrust with care services and providers, this participant expressed concerns with his own communication style while advocating for his health. For this participant, he perceived that the health care practitioner might share their negative perceptions of him, with
other medical professionals, which would create even greater barriers to receiving medical
attention. Many of the participants interpreted the ineffective communication of care providers to
be related to a lack of sufficient education in aging and/or LGBTQ health. While cultural
competency trainings on LGBTQ seniors exist, some participants shared that they were not
effective in changing the attitudes of care service providers or in promoting long term
engagement with the material.

You know how much time they give for this cultural competency? Half an hour [...] And
it’s a thing you go on the computer and do true or false [...] You could walk away from
that just as [uncertain].

While another participant with similar involvements perceived that care service providers were
unwilling to engage with cultural competency trainings on LGBTQ seniors, since there are no
consequences in not doing so.

 [...] to work with the 10 long term care homes that are mandated to be LGBTQ inclusive.

Mandated. Three of them are LGBTQ inclusive. What happens to the other seven? Who
holds them accountable?

Other participants however, described positive cultural competency interventions with care
providers. For instance, one participant that was conducting educational workshops on LGBTQ
aging, found care providers engaged better when the material was delivered in a different way
(i.e., in person) and in a different format (i.e., storytelling).

 [...] you could feel a bit of, not resistance, but just “Okay what’s this about.” Until one
of the volunteers talked about her experiences and her son, who finally came out to her at
age 30 or 35 and then it was, “Oh okay, we get this,” And I’ve heard from people who to
Another participant described having experienced mostly positive encounters with care providers. However, she questioned whether it was due to more comprehensive trainings in diversity or the greater visibility of trans people in Ontario and Canada.

Um... I’ve had very limited contact with the health care system, other than just going to the GP [general practitioner] now and again. Um... but, what experiences I have had thus far have been pretty positive. Um... I had a head injury [...] and all I had to do is go to my doctor and say you know, “I’m really sore,” and they unleashed this, this, army of medical professionals and like, x-rays, ultrasounds, sports medicine doctor, physiotherapy, massage. And all these people were amazing. And it was incredible. You know? I met the ultrasound guy and the x-ray technician, their all business “lie down.” [...] But the physiotherapy, I could have sworn they had to have some fairly extensive sensitive training, but they didn’t! This was all just came naturally to them, working with a transgendered person. The sports medicine doctor, same thing. The massage therapist, same thing. You know? So I don’t know did I just luck out, or is there [...] some kind of see, change, happening in there with you know, greater visibility around trans.

Participants also described greater acceptance and LGBTQ visibility in community services and programs, such as choirs that are open to all seniors, various religious and spiritual spaces (e.g., the United church), as well as hospice palliative care centres and floors. For instance, one participant in particular shared a positive experience with a Catholic-based hospital, in which the care providers offered to remove religious symbols from the walls in order to provide those non-believing LGBTQ patients with greater comfort.
[...] I wanted to know that what if one of our people [a gay man dying from AIDS] didn’t want anything to do with religion. Is that going to be cool? This is a Catholic hospital and I said, “What about that crucifix that’s on the wall? And the answer was, “All of that can come down, the important part is to be supportive for them uh... on their way out.”

[...] That was such a critical, positive step for somebody to just let them be who they are as they’re dying.

Supports where the spectrum of identities and communities are represented. Across focus groups, participants described the importance of LGBTQ symbols, organizational mission statements that value diversity and LGBTQ advocates and allies working or volunteering within the care services. For instance, one participant described a negative encounter that he had with a specialist and how his family doctor acted as his ally to ensure that his health concerns would be addressed.

I said, I left [city] because of my health [...] Nobody could... it was not properly diagnosed and so on. So came up here, the doctor was terrific and he uh... immediately could figure out what it was and told me that the diagnosis I was given was wrong [...] I felt empowered because I could control it, I know what to do now and then I said to him, “Well what about gay sex?” He started moving this and started moving that he only look at where the ceiling and the wall met and then finally in exasperation he got up and he walked out and as he’s going out the door said, “Speak to my intern.” [...] I spoke to my GP who had recommended him so next time when he finished his spiel about are you doing this and are you doing that, any questions? “Yes.” And he looked straight at me and he told me, “You have nothing to worry about. This ... you just keep doing whatever
you want to do.” [...] And I thought, “Holy Mackerel!” So I called up the GP right away and said, “Did you talk to him?” and he said, “Yes.”

Another participant also described the importance of symbols and LGBTQ allyship however, she also included that it was important for care services and providers to use these techniques before a discriminatory event were to occur.

 [...] when I was physically assaulted, I went to my volunteer coordinator and said, “This is what happened to me.” And she said, “What do you want us to do?” Now we have Pride, now we have posters, [this organization] has amalgamated with a [hospital]. Now everybody is wearing these buttons [“Pride is good for your health”] because of what happened to me. It did not happen proactively. So the fact that [this hospital] is supposedly doing their work and [the organization] is supposedly doing their work. It’s not coming from a place of being proactive.

Although this participant described various care organizations and services incorporating LGBTQ symbols, she questioned their mission to provide an inclusive space as reactive rather than proactive. Similarly, another participant described appreciating LGBTQ symbols at his physician’s clinic, however, he also emphasized the importance of having care staff who are LGBTQ persons themselves.

My doctor is a gay doctor. He sees only gay patients [...] I wish we could have more of those in the community [...] unfortunately he’s [...] and hour and fifteen-minute drive [...] I’m looking for a doctor like that in a health community practice in [my rural community, or another rural community close by] [...] And... um... you know the other day we were in there and his receptionist is a lesbian. Is welcoming, the pride flags, in this big waiting room for the 10 doctors. [It] is a health practice that accepts all of us
and has a doctor and nurses and receptionist who attend or look after just us. Because there are questions that I had that I can ask [this doctor] that I wouldn’t ask my former doctor [...] Especially about my health.

This participant, in particular shared the benefits of being a patient at an LGBTQ health care practice, as he described feeling welcomed, accepted and comfortable discussing the health concerns that are unique to a gay man. However, this participant also addressed certain barriers and gaps that relate to the clinics accessibility, including: the patient’s ability to access reliable transportation, as well as the increase in demand for an LGBTQ only clinic to serve surrounding communities. In other focus groups, participants discussed an increased need for LGBTQ health care practitioners as well. One participant, in particular, perceived a greater need for LGBTQ medical students. However, he understood medical students as having certain preferences in terms of the geographic location in which they practice, as well as fears in terms of openly expressing their sexual and/or gender diversity.

The other thing is medical students [...] they will not come out in their class. They will not, they will ask not to be put in a small community [...] they won’t—some of them don’t come out until years after they finish their studies and get started and they’re afraid that their professors may not support them. Um [...] and many even cause some grief to them. [...] How—if they don’t have a voice, how do we have voice you know?

Another participant shared similar thoughts as she described conducting a LGBTQ presentation for a group of medical students. During this presentation, the participant learned that most medical students would not come out to their professors or their patients.

There were 40 students in the room and I asked the question how many of you identify as LGBTQ? I would say 95[%] of them put up their hands. “How many of you are out to
your professors or with your patients?” Less than 5 people in the room put their hands up because they are afraid. So again, there’s this whole thing and they’re all young, they’re all under the age of 25, they’re out to each other, but the system’s not offering them any support. Yet, we’re expected to come out, to say to our caregivers and to our medical professionals this is who we are. But they are afraid to be out.

Participants described difficulties for both care providers and patients to express their sexuality and gender in a space, or within a system, which has historically oppressed such identities.

Participants, as such, emphasized the importance of not only having a care provider who is LGBTQ, but also having a system, or space, in which both care providers and their patients could feel safe in being open about their identities. Likewise, participants also described the need for community and social programs or groups to have members or attendees that represented their identity or sub-community. For instance, one participant described going to a church that he was less interested in attending because it had an LGBTQ group.

I like to go to church, you know, like I’m Catholic. But I have to kind of shop around, like which is the parish that will be more accepting. Like, I like the one next door because I love the traditional literature and all of that. But I know, if they knew more about me […] So I gravitate more to this [other] parish has a gay group. But I don’t necessarily like their literature […] So I’m kind of stuck.

Other participants also addressed similar issues in community and social programming lacking LGBTQ diversity, such as gaps in programming and activities that represent various demographics of LGBTQ older adults, such as age, race/ethnicity, Indigeneity, language, abilities, chronic addictions, immigration and refugee status and geographic place. For instance, one participant described that she found it difficult to be the only queer senior who was
differently abled and a person of colour volunteering in various government, LGBTQ and aging committees.

What I find disheartening is that I am the only queer voice, sitting at these tables and I’m the only queer voice of colour and I’m the only differently abled queer voice. So it’s a lot of work for people to you know [be the only voice].

Gaps in Programming. Many participants also described groups that had been offered in the past and had since collapsed. While one participant described the increasing loss of formal LGBTQ groups as being related to greater inclusion within society and technological advances, others shared it was due to losses in leadership, fewer resources (e.g., funding) and issues in the accessibility of the program (e.g., barriers to sharing information, transportation and scheduling conflicts). Many of the community programs and groups that LGBTQ people relied on for support were established in the past, when there were no supports available, through the leadership and volunteer efforts of the older generations. However, as many of these activists continue to age, they also begin to move away, retire and die.

Well you see a lot of the leaders [...] passed away a couple of year ago [...] There’s [another person]. Now, I think she’s still on the board but she and um… I forget her partner’s name—they spend [part of the year] in [another province] and they spend the rest of their time in Costa Rica. You see a lot of these leaders, that have, retired from leading.

Participants perceived that many of these gaps in leadership were not being filled by the younger generation, which ultimately led to the collapse of various programs.

And they never train anyone. They never mentor, you know? And that’s one thing with maybe the education things like that with the existing leaders—the gay leaders or the
LGBT leaders—you know? Is there, after they leave, is there going to be somebody who takes over? Doing some mentoring-ship? I mean you know [names a person] she’s very known and things like but […] when she decides to leave or retire completely, who’s going to take over?

Participants, especially those living outside of heavily resourced urban centres (e.g., Toronto) shared concerns with the loss of programs, as they anticipated a greater need in order to age in place.

*It weighs out a lot of the choices or options for what should happen to us, when we can’t take care of ourselves and we don’t have a lot of those options here [in our community].*

Participants from this study also discussed the barriers that they experienced, while trying to access programs, and contributed these issues to the notable collapses. For instance, participants considered poor advertising or lack of information on the supports available to be a significant barrier. For instance, one participant shared that she had difficulties navigating the webpage of a city program online and only learned of a community-based recreational program after having been invited as a guest speaker. Despite the program having certain admirable qualities, such as affordability, the provision of food, and educational and social interactions, this participant described that it risked being eliminated due to a limited number of participants.

*Well and it’s also money, right? So look we can save some money here. I was brought in to talk at a […] lunch and learn […] and it’s apparently a program that’s been running for 30 or 35 years or something […] a city recreation program […] it used to be they announced twice a month and people pay for their own lunch, okay $5.00 a year to belong to this. And they bring in a speaker and they have lunch at a restaurant and it gets people out of their houses. And I never even heard of the program, until they asked me if I*
wanted to come talk—and I did. And, about 30 people there. There’s some in their nineties there. You know, but they said, “Well every year now they are threatening to cut that program.” Because the numbers aren’t as high and I was like, “What the hell?” It’s very hard to find that program after I heard about it. I wanted to find out more about it. To even find it on a website, to find it in any way, it’s only through the [senior centre] and you have to go to general interest programs, and you have to [here and there] [...] and you go, “Gee, I wonder why there’s no people coming?” I mean, why you don’t have other people?

Another participant, however, related barriers to accessing LGBTQ community and social programming for seniors to scheduling conflicts and programming that may not necessarily be inclusive to people with varying physical and mental health issues.

_The isolation is a huge thing for me. Actual, physical, isolation and that’s you know been going on for a long time because of um… you know, my health not being very good and so I’ve … as I said before you know, very limited circles and you know, there aren’t that many things that happen during the day. You know… and um… [...] I mean, I’m so lucky that I have access to a care but….you know if I’m not feeling well. It’s difficult to get out there and um… yeah my circle becomes very very small, you know? [...] because even senior stuff, a lot of them are in the evenings or whatever and that’s great for a lot of other people but for sort of bit sickos like me… it’s not so lovely._

Although transportation is a general aging concern, participants often discussed how they felt fortunate to have access to transportation so that they still had choice in attending the LGBTQ community and social programs and/or health services they preferred. However, other participants described the issues faced by those who did not have access to transportation, such
as those elderly LGBTQ living in rural areas. One participant however, described his concerns with limited transportation and available social supports, as it became a barrier to receiving a much needed surgical procedure.

*I was just thinking about appointments and thing, like I was going to have a colonoscopy at some point and then I think, “I got to find somebody who’s going to take you home [laughter].” You know what I mean? Like I don’t have children and that kind of thing and I have a brother, I’m not really that close to but I’m like, “I’ve got to ask him again.” You know, I have a lot of friends, a lot of them tend to be younger and they’re working, or they’re this or they’re that. So it’s just the knowing there’s somebody. [...] Thank God for Uber [...] it’s cheaper and really nice guys to talk to all the time.*

*Reaching Out and Building Community.* Participants also described community and social programs as being foundational in fostering a sense of community and companionship among older LGBTQ adults. Participants spoke quite positively of certain programs and services such as theatre, LGBTQ seniors’ organizations, HIV/AIDs groups and the library and found that these services and programs benefitted their mental and social health. For instance, one participant shared that she found accessing libraries to provide her with social support when she was feeling depressed and/or isolated.

*I mean, I think libraries are one of the things that I think about. I mean in my—I have issues with depression that I have had over the years and uh... I tell a lot of people about this, if they’re feeling isolated or alone. I used to order books and uh... back in those days the library would call me [...] I had a book. I had to go to the library. And it was pretty close to my house, so I could get out, you know. And I would go to the library and I would talk to people and it made me feel better because I would feel so isolated at home.*
Other participants described valuing companion programs, such as those that connected LGBTQ seniors and youths. For one participant, this program included gay men from across generations who would socialize and dine together. For another participant, he described working with medical students and providing them with a greater knowledge and understanding of aging LGBTQ health needs. While another participant described participating in a theatre based youth-elder program and how it was important to building community and overcoming cohort differences.

*I’m also very proud to say I’m with [an LGBTQ theatre] with a youth-elders project. Which is the first time a theatre has done a program with youth and queer elders together, which is more than just a performance it’s learning how we live together and then putting a performance on stage.*

Participants also described valuing other companionship programs that connected people who could not leave the home, over the phone, such as an LGBTQ program which connected informal caregivers and a daily check in program, “[...] you can get on a list and get phoned every day to make sure you are okay [...] just a contact to know you are still alive, you haven’t fallen over, broke a leg or anything.” Fewer participants described the importance of online technology and connecting with others with similar interests and demographics, through the social media pages of community program and social groups.

*There’s [three organizations in this community], I have seen people post on all three of those, on news in the community. Um, “Do you have any suggestions of groups I can be part of [...]”*

**Summary of theme 2.** Within the second theme, “(Dis)Connections from the Community: Finding Inclusive and Safe Supports as a Marginalized Person and/or Socially
Repressed Group,” four subthemes were discussed. The first subtheme, “Finding Community Underground,” considered participants’ experiences of past sociopolitical and historical experiences of discrimination, as described in the first theme, and how these experiences limited the participants’ social connections and supports within society. Living invisibly, or remaining hidden within society, encouraged most of the participants to find other sexual and gender diverse people to create inclusive and safe circles of support. Such circles of support were described by the participants as an underground culture, or community specifically for LGBTQ people. However, participants shared that not all sub-communities were included. Those who were trans and/or non-white were not always accepted by those individuals or subgroups who were more visible within society (e.g., gay). Some participants described that such inter-community rejection was the result of internalizing prejudice and normative social expectations, which were then reflected toward more marginalized subgroups.

The second subtheme, “The LGBTQ Community is not One Single Community,” considers participants’ experiences of divisions within the LGBTQ community, or the distinctions between sub-communities. Participants varied in terms of their values and political ideologies, as they either described valuing radicalism and a wish to drastically alter existing normative practices (e.g., essentialist distinctions), institutions and social systems or they wished to integrate within society, while also becoming more visible, respected and equal. The participants also described experiencing these similar differences in values and political ideologies, especially while engaging in activities, programs or services that were available to the entire LGBTQ community. Due to past experiences of discrimination certain terms (e.g., queer) were considered to be a point of contention among participants, as they represented both past and current experiences of victimization, or political reclamation and empowerment.
Confusion with the term “queer” more specifically, left certain participants with a sense of despair, as they realized that their lack of familiarity with non-essentialist identities would eventually lead to them offending other LGBTQ individuals and communities, especially those from a younger generation. As a result, some participants shared experiencing insider-outsider dynamics, or divisions, within the LGBTQ community. In particular, participants described tensions between the interactions of the young LGBTQ, who they perceived to be more fluid and non-normative, and those old LGBTQ, who may still appreciate categorizing and labelling identities so as to find supports that are similar in values and represent safety and comfort. Participants shared that these differences were creating within-community conflicts, that, participants feared would ultimately lead to the demise, or collapse, of supports that were perceived to be beneficial, or health promoting. Participants also shared difficulties in connecting with other older LGBTQ adults, especially among those with varying social positions, such as relationship status, socioeconomic status, gender and sexual orientation. Participants considered these difficulties to also be related to circumstances when in which they felt excluded from normative discourses (e.g., marriage and youth-centric spaces). However, some participants were able to avoid isolation by forming friendships with a younger LGBTQ cohort.

The third subtheme, “The Facilitators and Barriers to Receiving Culturally Competent, Inclusive and Accessible Services,” considered participants’ current experiences with care services, programs and activities within their communities. Since participants who volunteered for this study were also heavily involved in other volunteer activities, they were able to provide a unique perspective in terms of both accessing, educating, organizing, and/or providing care supports. Participants shared both the facilitators and barriers to receiving culturally competent, accessible and inclusive care services, as they related to aging and/or LGBTQ visibility,
including: effective communication, representation in terms of the spectrum of identities and communities, gaps in aging and/or LGBTQ programming, and programs that build capacity and community by reaching out to individuals at risk for isolation. In particular, participants described the facilitators to receiving inclusive care as: (1) sensitive and informed forms of communication that avoid assumptions and do not perpetuate harmful stereotypes, discriminatory and/or normative discourses, (2) welcoming body language, empathetic touch (e.g., shaking hands), and eye contact; (3) active listening and validation of concerns, (4) building rapport and trust, (5) increasing service providers’ time spent on professional development regarding aging LGBTQ health as well as professional development that is more engaging for service providers, (6) service provider, staff and organizational accountability to adhering to aging LGBTQ populations health and a proactive engagement with these needs, (7) LGBTQ symbols and inclusive organizational mission statements, (8) LGBTQ advocates and/or allies within the care service or organization, (9) care services that are specifically tailored to aging and/or LGBTQ people, (10) visible LGBTQ employees and volunteers, (11) increased advertising of aging and/or LGBTQ programs and services and more accessible sharing of information, (12) accessible programming and services for LGBTQ people with varying physical and mental health needs (e.g., more times in which services are offered or programs are scheduled, offer transportation or care services in more geographic locations, programs that use the telephone or internet to connect older LGBTQ people who cannot leave the home) and (13) programs that provide older LGBTQ people the opportunity to socialize, especially with other sub-communities (e.g., younger cohort).

Powerlessness and (de)energization: The fight for choice and autonomy. Finding community and fighting for human rights and visibility was a unifying and empowering
experience that shaped many of the participants’ identities as life-long activists and volunteers. Participants described the importance of volunteering within their communities, as it provided them with a sense of visibility and value as members of society. Participants also considered activism and volunteer efforts to be a sense of responsibility—that is, to be the face and voice of LGBTQ senior’s issues and health. However, some of the participants described feeling hyper-visible, fatigued and burnt out from constantly advocating and educating others on their health needs, and as such, desired for the responsibility to be shared with the next generation.

Ultimately, the participants from this study are requesting support from researchers, services providers and the community, in order to advocate for changes that will allow them to feel included in society. In the meantime however, participants described researching their options, changing their behaviours, and/or developing solutions as active coping strategies.

1. Valuable members of the community
2. Declining power and energy
3. Our youth’s willingness and ability to carry the fight
4. Anticipatory coping

“We need to see that our life has value and when we volunteer all of a sudden we’re reinforced that it does”—Valuable members of the community. Focus group participants were highly involved with volunteering in their communities, especially in terms of advocating on behalf of LGBTQ and/or aging populations. Many of the participants described themselves as leaders of the LGBTQ liberation movements, as they were the “first” to represent LGBTQ identities in their communities (e.g., religious and/or spiritual communities, employment, volunteer commitments, theatre and/or choir groups, etc.) and/or were the founders of various LGBTQ services and social groups (e.g., HIV/AIDS organizations, LGBTQ outdoor groups,
LGBTQ senior’s networks and committees, etc.). Of the seventeen participants who were active volunteers in their communities, volunteerism was described as an important aspect of their lives, as it provided them with the opportunity to both give and receive support.

I think that’s hugely important. And, and you receive, I mean it’s—there are—it’s intangible. But you receive some extremely important uh... benefits through your participant, through giving to your community. Um... validation, a sense of purpose, a sense of worth, you know... all of these things that you receive as part of the process.

Through volunteer activities, participants became visible within the rest of society and were acknowledged for their efforts. With greater LGBTQ visibility, participants considered themselves to be responsible for representing and voicing the concerns of the aging cohort.

I’m just thinking of another part of that too is, you’re maybe the face of the LGBTQ community on some of these other committees and things [...] as an older part of the LGBTQ community it almost feels like a responsibility for me to, to be a face to that and not to hide that part of me.

Participants perceived representing LGBTQ senior concerns and issues to be of great importance, as they considered that such volunteer efforts would support change within the institutional and societal structures that often discriminate against non-normative identities.

Participants volunteered for a poster campaign which raised awareness in terms of older LGBTQ adults going back into the closet once they enter institutional care, conducted cultural competency workshops for care service providers working with older LGBTQ populations and participated in research (academic and community based) studies that were exploring the health and aging experiences of LGBTQ communities. One participant though, shared that she joined various government committees so that she could implement change more directly, as she was
able to accumulate esteemed titles which allowed her to enter discussions with key decision makers and voice the intersectional concerns of aging LGBTQ communities.

[…] We don’t have a long time left to live. Our lives are not getting any better, we are losing income, we are losing housing, our healthcare is diminishing. People in long term care, the people who are supposed to be helping are not educated […] Policies have to be changed! That’s why I have myself in so many of these government ministry committees because if they don’t hear me, then nothing is going to change for us! […] I list everything about what I’m doing because when I say that I’m from [an LGBTQ seniors group] nothing happens. When I say, the Ministry of Senior’s Affairs, Ministry of Health, Ministry of Community and Social Services, right? Then I get some respect. […] So when they find out that I have all of these committees that I sit on, then they listen.

One participant, however, described the negative impacts, or sense of burden, of becoming overly visibly within her community as the only volunteer or representative discussing LGBTQ and/or aging issues.

I don’t know. It’s because I am a lesbian that means everything that I do, I’m the token one […] I know there more [LGBTQ people], but if someone needs… [an LGBTQ seniors group] will come out with, “Oh we need somebody to do the representative of LGBTQ um… committee and we want some input.” All the emails come to me […] because I’m the token.

“I ask myself, ‘Can you do more?’” – Declining power and energy. Many participants described their work as being important in terms of affording the younger LGBTQ generation with certain freedoms and privileges, as well as contributing to their own concepts of self.
We were on the first dyke march ever [for lesbians of colour] [...] I’ve done a lot of important and um...things that I’m proud of early in my life and I’m trying to remember that because sometimes, I’m like who the hell am I and what the hell am I doing? However, after having been LGBTQ activists for most of their lives, participants described a loss of momentum, or energy, to continue fighting.

I tire of advocating for myself because I just want things to happen organically. And also with age and the wisdom that comes with it, I’ve grown to approach conversations at another level so that when I hear things that are blatant and sometimes I take a stand but more often than not I just sort of think... I differ from your opinion and I don’t pursue um... the “fight”

Participants described experiencing activist fatigue, or burnout, which they associated to an accumulation of stressors such as, a burden to educate others in terms of allyship and anti-oppression. As one participant shared, “[...] you get tired of always advocating and challenging all of the different ‘isms’ and then you just want to be out and relaxed.” Although participants alluded to a desire to alleviate their responsibility to advocate for LGBTQ rights, they continued to take ownership over instituting social change. For instance, when participants were asked to think of some of the services, or resources, that they might like to see in the community, they considered themselves to be responsible for implementing such changes. For instance, one participant described his interest in a resource centre for seniors. However, due to a life time of organizing and running LGBTQ support services, he considered it too difficult a task to introduce himself.

[...] And, and I think about, “Oh my God do I want to start something else?” You know, exactly where you are and I’m too tired and uh... I’ve been a start-up guy almost all of
my life. If—and I don’t. I want somebody else to start up something that I can join. But it would take a catalyst to do it. I think that’s the critical problem about getting something going.

Another participant, however, shared that he felt raising awareness regarding the issues LGBTQ seniors face, could be a useful strategy in terms implementing social change and similarly took this action to be the responsibility of seniors, themselves.

*I don’t know what we have to do to wake people up and maybe it’s marketing. Maybe as seniors we have to put together a program that goes to media and says, “You’ve got to come to our [LGBTQ seniors’ groups] and hear these stories because the government, as well as the hospital are way behind schedule.”*

Feeling fatigued and alone in the fight for aging LGBTQ health, rights and inclusion, more specifically, older adults described a desire to handover the responsibilities of advocacy to the next generation. For instance, one participant felt that neither she, nor the LGBTQ community, resembled their past energetic selves and questioned why the younger generation of LGBTQ members were not assuming the responsibility.

*But when you say energy in going back to the past […] if that energy could be here now […] if we could start that now, but it’s, it’s too late. I don’t want to do this. Like, I want to enjoy what we have created up to date. I want to enjoy it now. I don’t want to plan it. Just enjoy it. But there’s nobody coming up behind us and I don’t know why.*

*“The younger population has to feel they have an obligation”— Our youth’s willingness and ability to carry the fight.* With greater fatigue, participants described a need to rely on the support of the younger generation and for the younger generation to take action and to assume the fight for greater inclusion and rights among the aging LGTBQ population.
However, participants worried that the younger generation would not be willing and/or able to do so.

\[ I \text{ don’t find the younger generation has, whether they were not taught or they’re just not interested, but they have no enthusiasm to carry forward anything that we fought for.} \]

\[ \text{Like it’s almost like the same people that have volunteered first ... are the same people who are still there because nobody will take over. [...]} \]

Certain participants related these perceptions to be due to cohort differences. For instance, one participant shared that she felt the priorities between the older and younger cohorts were different and related it to the younger generation having not experienced the same level of discrimination or the experience of fighting back, which she perceived contributed to a greater sense of LGBTQ community, or unity.

\[ \text{Their priorities are different. But I mean, maybe because they didn’t have to fight for it? I mean, there were raids [...] that’s the sort of thing that brought people together. That brought people—that made people committed, you know?} \]

Others felt that it was related to the changes in society’s structure, as they perceived younger adults to have greater obligations and less time to volunteer and/or support LGBTQ causes, “Like back in our church, [...] the younger generation are more busy.” Other older LGBTQ adults however, centred the need for younger advocates out of a concern for their aging futures.

\[ \text{But what I find interesting and this is where, I don’t mind doing the educating is that a lot of my younger friends don’t seem to think they’re going to get to be this age. They sort of forget. It’s like there’s this big in-between that is not happening for them [...]} \]

Participants also shared how important it was for researchers to adopt social change practices into their research initiatives, as the participants considered researchers to be in a position of
power and privilege that could significantly support the health and quality of life of older LGBTQ adults.

[…] People listen to researchers. They don’t always listen to us. Because they are tired of hearing us […] they listen to people who are doing research because you have letters after your names and you have to take the responsibility to speak for us. I don’t think it’s enough for you to be doing research groups, I feel you must go forward in the short term and use research in the short term because gives years down the road we could be dead.

“How do I want to approach it?”—Anticipatory coping. Participants from this study described feeling exposed to layers of vulnerability when accessing care services as they anticipated discriminatory attitudes from those who provide formal care and support. Accordingly, participants implemented both preventative and proactive coping skills in order to manage upcoming stressful situations and to reduce the associated risks, including: mentally preparing for the worst outcome, researching options, cognitively reframing situations, changing behaviours and/or attitudes, finding social supports and/or suggesting solutions to anticipated problems. For instance, one participant described how accessing formal care services provoke anticipatory assessments of risks in preparation for prejudicial encounters.

I think with the aging, uh, comes at some point vulnerability and the need for assistance whether that’s medical assistance, or hospital or maybe assisted living. Those kinds of things […] It’s making yourself vulnerable to people you don’t know and you don’t know if they have prejudice or they don’t and you are in a vulnerable situation and need their services. And so, when I think about it in relationship I think that will happen more and more in my life, um, and how do I want to approach it.
Another participant shared the process of moving to a new area and how he researched his options in order to reduce encounters with HIV-related stigma and promote connections with the community.

For me being HIV positive. Uh... I’ve been in [this community] for six years and before that I didn’t know the area. I didn’t know anyone in the area! And I was like, I did a little research, is there a progressive city? Some places that would be a no-no, like [a city in] Ontario [...] And so I did some research, on my own, then I looked into, at uh... the uh... agencies and there was [three organizations nearby], so I said okay where do I go? [Location 1, Location 2, or Location 3], so I decided on [Location 3]. Um... and then I um... connected with the agency and that was an opening door to meet new people, connect, make new friends and belong to the [agency’s social group] and it was uh... quite... uh... a rewarding.. uh... situation or me. [...] Um.... By linking to the agency, even now, the HIV positive, it’s a manageable chronic disease. [...] that was still when we had a group, we would meet every Monday, we had sandwiches [...] and we talk. We talk about everything [...] and nothing, is uh... is uh... off the table. We can talk about anything we want. And we do! [Laughter]

This participant also described taking control in terms of achieving his desired outcome, that is, he developed new friendships and social supports, which allowed him to engage in health promoting behaviours (i.e., the management of HIV). While another participant found that having an understanding of and experience working within institutional systems relieved his anxieties of entering institutional care, “I know how the long term care, assisted living, home care, I know how that works. And it’s really not a bad system if you know how to access it. I happen to know how to access it [...]” Similarly, another participant described incorporating
health promoting behaviours (i.e., physical fitness and a nutritious diet) in order to avoid using care services at all.

[I would wish that I’d never have to use [the services available in my community] [...] Um, I value my health and I want to live as health for as long as possible with the love of my life. And if I can—I mean we exercise [...] we try to work out at least 5 times a week, you know? And we eat really clean and we, you know, try to live as healthy as possible [...] Fitness is so important. I mean I went to one, [gay men’s meeting], that I went to and they had a psychiatrist there and they were going around the room saying what [pharmaceutical] drugs do you take? Which basically, you know, Prozac [...] And it got to me and I said, “Don’t use them, I exercise.” [...] You exercise you get your frustrations out [...] You focus somewhere else. Don’t stress about stuff you can’t change. Focus on your health. Yourself [...]"

This participant also described using physical fitness as a coping skill, which allowed him to find acceptance in situations that were frustrating or out of his control. Likewise, another participant described how she took proactive measures in order to ensure that she, and her partner, would conserve their right to legally marry.

We got married two days before the Conservatives took power [laughter] [...] it was out of straight fear. Straight fear [...] my partner was working out of town and I just phoned her up and said, “Okay, you’re home next weekend,” she goes, “Yeah,” I said, “Okay, we’re getting married.” [...] We got our license and called in our minister, in our living room. Okay done. Can’t take it away [...]"

This participant described that her decision to marry her partner was due to the fear, as she anticipated same-sex marriage—legalized in 2005 by the Liberal Party of Canada— to become
illegal once again, as soon as the federal government shifted to a Conservative majority in 2006. As a result, she described taking control of the circumstances by changing her own behaviour, in order to alleviate her anxieties. During the focus groups, participants focused heavily on the anxieties of entering institutional care near the end of life, and in doing so, devised and shared solutions that could relieve their concerns. For instance, participants discussed co-housing as a solution to retirement living and an interim step before long term care, that could provide older LGBTQ adults with a sense of community, as well as personal and financial security.

And uh... I have friends who are living on, you know, Vancouver Island but what they’re doing now, well because of economic situations and things like that, they’re going back into living in communes for self and care [...] and co-housing. One, they bought an old... um... cottage kind of little cottage area [...] and they live, you know, within kind of a community [...] They have gardens, they have animals and things like that and they bring, you know, uh [...] revenue to the, that little community. You know? So I think we’re probably going to see you know [...] communes uh... for the elderly people, start, you know sharing [...] retirement [living] [...] But you know, if we are you know, gay and things like that there’s probably going to be a little commune [...] And I would be looking, I would be looking into something like that. I mean no only, just for the company, for the security [...] Other participants however, described solutions that would support aging in place, such as recruiting informal and formal supports that either shared or were already open and accepting to their LGTBQ identities. For instance, one participant described that he had planned to recruit other gay men to his condo so that they could form their own community, or social group, within the building, “Like when I was renting, I was thinking... if I hear of guys needing a place to live,
come to this building so we can form a gay group within.” While another participant shared that he and his partner had already recruited a younger friend who works as a personal support worker, to care for them at home as they neared the end of their lives.

And well, I mean we already have sort of arranged anyways because a good friend of ours is, she’s a personal support workers and she’s younger. So, it’s like... so when we get sick, she’s like, “Oh don’t worry about it, I’ll be down and I’ll help.”

Similarly, participants also described recruiting supports in order to possibly implement a third solution, that being, medical assistance in dying and/or assisted suicide (MAiD). For instance, one participant shared that she and her friends were considering medical assistance in dying as an alternative to living without quality of life.

So this thing around suicide. All of my friends and I have been talking about assisted suicide because it’s not an option. It’s more and more being discussed out there [by] those of us of a certain age. As for my friends of colour are talking about it because when you’re not mainstream, it’s even harder to access services and I am very lucky and very privileged to have a roof over my head, but I’m struggling to hold onto that now, given that in January I’m going to be down $500.00. So this is because, it’s free now to die. But you have to prove that you’re in pain. But when you think about it, what we are actually talking about is that as an option. Rather than continue living in a way that there’s no quality of life.

Summary of theme 3. Within the third theme, “Power(lessness) and (De)Energization: The Fight for Choice and Autonomy,” four subthemes were discussed. The first subtheme, “Valuable Members of the Community,” considered participants’ discussions of their past experiences of creating a community and leading the fight for the human rights and visibility of
LGBTQ people throughout the liberation movements. In doing so, participants described discovering a sense of unity and power that shaped many of their identities as life-long activists, LGBTQ care service providers and volunteers. Participants shared that volunteering within their communities gave them a sense of visibility as valuable members of society, who both receive support and give support back to others in need. The participants considered their roles as aging LGBTQ activists, and visible volunteers within various aging services and care organizations, to be a sense of responsibility, as it provided them with an opportunity to be a recognized face and voice for LGBTQ health needs and offering support to others (e.g., the younger LGBTQ generation).

The second subtheme, “Declining Power and Energy,” considered participants’ discussions relating to hyper-visibility, fatigue and burnout from constantly expending their energy fighting, or advocating, for equal human rights and health equity. Although participants shared a desire to alleviate their activist responsibilities, throughout focus groups discussions they continued to consider themselves accountable for implementing social change strategies. For instance, when discussing participants requests and recommendations for care service providers, policy makers and other decision makers, some participants would respond that they would not be in a position to lead, or establish, another resource, while others continued to take ownership and brainstorm strategies that they could implement themselves.

The third subtheme, “Our Youth’s Willingness and Ability to Carry the Fight,” considered participants’ desires for the younger generation to fight on behalf of and support older LGBTQ health. Participants described concerns relating to the younger generation’s willingness, as well as ability, to assume their position as successors in the continuation of the LGBTQ liberation movement. Due to the younger generation of LGBTQ people having not experienced
the initial fights for liberation (e.g., the raids), participants felt as though this generation would not be prepared to unite and commit to maintaining LGBTQ rights. Participants perceived the younger generations’ lack of desire, or inability, to be related to a shift in social attitudes that value higher demands and obligations. As such, participants considered the younger generation to be too busy, and as such, took on additional responsibilities to educate the younger generation on how aging issues impact them as well. Participants also shared the importance of those conducting research on LGBTQ older adults to consider adopting social change practices and research that could implement short term solutions, as they did not feel that they had much time left to benefit from or witness such changes be implemented.

The fourth subtheme, “Anticipatory Coping,” considered the participant’s experiences of anticipated losses and included participant discussions of strategies they intended to incorporate to remain out of discriminatory care services and institutional care facilities. For instance, participants described researching their options, changing their behaviours and/or developing solutions as active coping strategies including: moving to geographic locations with inclusive values, exercising and dieting to avoid physical and mental health issues, co-housing, recruiting additional supports (e.g., other older LGBTQ people to live in their building, younger friends) to build a community and to provide informal care, and MAiD.

**Requests and Recommendations for Inclusive Care Provision.** Ultimately, the older LGBTQ adults that participated in this study requested support from researchers, services providers, and the community in order to alter current systemic values so that those who identify within non-normative identities (i.e., old, differently abled, sexually and gender diverse, lower income and/or non-white) may feel safe and visible within Ontario and Canada. In particular, participants from the current study described wanting change that would allow them to feel heard
and included, to be given choice and autonomy over the decisions being made at the end of their lives while accessing care services and participating in their communities. When speaking to care service providers or key decision makers, participants often described feeling silenced, unimportant and devalued. For instance, one focus group of participants shared that they had met with the special advisor to prime minister on LGBTQ2 issues, Randy Boissonault, to discuss the concerns of aging LGBTQ communities.

*Randy Boissonault was appointed by Trudeau as a special LGBTQ advisor. [We] met with him and we listed a whole bunch of concerns and he said, “Well it’s up to all of you to go out there and pound the pavements and make sure your voices are heard.” And we said, “Well that’s [why] we’re talking to you!” [...] And Justin Trudeau was just talking yesterday about all of these LGBTQ rights, I didn’t hear anything about LGBTQ seniors. So... what is Randy Boissonault doing [for seniors]*?

Without any evidence of change, and/or validation, from the prime minister or his special advisor, the participants from this focus group considered their needs to be unheard. While this particular participant questioned Randy Boissonault’s role as an advisor for LGBTQ2 issues, other participants questioned their own communication styles, and as such, requested educational workshops and/or additional resources that could provide older LGBTQ adults with the skills to effectively advocate on behalf of their needs. For instance, one participant shared that he would like to learn self-advocacy skills and/or communication strategies that could benefit his own health needs, without compromising the level of services he is receiving.

*46 The acronym “LGBTQ2” is used, as this is the acronym chosen by the federal government to describe Randy Boissonault’s position. See the following link: [https://pm.gc.ca/eng/news/2016/11/15/prime-minister-announces-special-advisor-lgbtq2-issues](https://pm.gc.ca/eng/news/2016/11/15/prime-minister-announces-special-advisor-lgbtq2-issues)*
workshops on how to deal with health care providers. How to advocate for yourself and be confident that you are on the right track and there’s redress if it isn’t dealt with, here is where you go. There’s nowhere else I can go as an old man, as an old gay man I would benefit tremendously from being educated on how to deal with health care providers.

Participants also desired resources in which their specific identities would be represented. Such resources included a centre for aging LGBTQ communities and separate care facilities for LGBTQ communities. In terms of a 55+ resource centre for LGBTQ adults, participants desired a physical facility with staff that could be a trusted source of information and educational opportunities by: providing accessible and affordable health advice, answering questions in terms of LGBTQ rights and their impacts on seniors, offering various activities and social groups that represented their identities (i.e., age, relationship status, sexual orientation and/or gender identity, skin colour, socioeconomic status, ability, language, etc.), as well as networking with care facilities in order to educate and advise care providers on LGBTQ aging needs.

This conversation that we’re having here today needs to replicate itself a thousand times.

Uh… [the hospice] sponsors dialogues several times a year. But there isn’t anything specific about LGBTQ, about us being able to talk with each, put our fears on the table […]. And [a] 55+ centre could be one of those centres that host something like that.

However, a few participants described a reluctance to attend LGBTQ groups and/or events (e.g., Pride) as well as community care services and programming due to discomforts with being outted. Participants also relayed these concerns as they discussed the issues in reaching out to older LGBTQ adults who may be living a closeted or quieted lifestyle or living in more remote or rural locations, without accessible or affordable means for transportation. Participants also
discussed the benefits of separate long term care facilities, such as those in Toronto (i.e., the Fudger House) or to have a separate floor in an inclusive care facility for LGBTQ older adults, in their communities. Participants perceived that such accommodations could be staffed with care providers who have an understanding of LGBTQ health and aging experiences and/or care providers who would want to work with LGBTQ older adults.

*As much as I believe in integration, I think we’re still at that point in our, in our development historically, LGBTQ home for us as a separate homes may be the answer. Ideally I think it should be an integration thing. That it shouldn’t matter who the next person at the dining table is or isn’t.[...] and I guess um… my hope is that by the time that happens for any of us really—not just for myself and my partner—that there is some sort of uh...[sighs]... broader understanding and acceptance, you know?*

Some participants perceived there to be issues in terms of comfort between sub-communities and/or genders (e.g., gay men and lesbian women) and felt it necessary to segregate by subgroup. While other participants hoped that all services to become inclusive and welcoming.

*Yes. You asked what my one wish would be? It would be where I went, whatever services I was accessing that part of their mission would be acceptance, inclusivity and I’d see a safe place, pride rainbow, everywhere I went. That would be my wish.*

Additionally, participants shared a desire for equal opportunities and the right to be autonomous over the decisions being made. Participants shared a desire to come out as LGBTQ when they desired to do so, to exercise their legal rights and to benefit from policies that other aging adults receive benefits from, to spend their time in ways that were meaningful to them and to experience the best possible ending to their lives by continuing to live in the comfort of their own homes with the people they love.
I am where I want to be, when it’s time for me to be looking at care. Okay? So, I mean the care that I get would be individualized to where I would want to live. So whether that is co-housing, or whether it is long term care, or whatever. Or whether it is with a group of gay and lesbians or another group I choose to be with. My wish is that my wishes could really be carried out. [...] There’s no reason why you choose your community right up to that time when you’re incapacitated. Why wouldn’t you be choosing your community at that point forward?

Overall, participants also described a desire to be treated like people while engaging with care providers and services, as well as within society more generally. As one participant stated, “We’re just people. We’re people like everyone else with feelings [...] everyone has value [and] everyone has differences [...] whoever we are, we are human beings.” In order to receive such treatment, participants felt it necessary for care providers, especially those in working in health services and providing care to seniors (i.e., institutional care or home care), as well as politicians to receive cultural competency trainings on LGBTQ aging. Participants considered that greater education, strategic marketing techniques, and advocacy efforts, LGBTQ researchers, and activists alike, could change the attitudes, behaviours and “hearts” of society. One participant, however, preferred that care providers be given insights as to the negative impacts and oppression that all people face who do not fit within the normative structures of society, rather than isolate the LGBTQ and/or LGBTQ seniors as rare oddity.

I believe that the way to go about um... understanding the care of a homosexual man is by being able to dissect what heterosexism is about. Don’t isolate LBGTQ as this odd unit that we’re now going to talk about because it’s the unit du jour. You need to dissect what heterosexism is about. The [LHIN] form being one example, but so much else that
we just take for granted. Just as much as when you are part of it because it’s your existence. So you’re existence is your norm. But if you enter your existence from an analytical point of view and look at it and think, “Oh my gosh that’s right, my children can do this, I can say that, I can presume this. This is my normal, beauty. This is...” When I begin to understand all of that, then I look around me and my world is much larger because I look around me and I see that humanity is a large spectrum beyond the confines of my, in this case, white privilege. Similarly when you’re talking about the LGBTQ community, people come in and say “This is how you’re supposed to approach anal sex with dignity and this is how to, nah... nah... nah...” No. You’re making me an oddity, but if you talk about what heterosexism is about, certain biases that we carry that we don’t even know we do it benignly because it’s the “norm” that I’ve lived and that person then is in charge of my comfort when I have Alzheimer’s and when I’m totally at their, at the mercy of their benevolence, if they are going to be benevolent towards me. They really have to appreciate what they are about and understand what they are about, not – and secondary what I am about.

**Summary of subtheme 4.** The fourth and final theme considered participants’ requests and recommendations for inclusive care provision and resources. Ultimately, the participants from this study desired support from researchers, decision makers, service providers, and the overall community in order to alter Canada’s current systemic values so that those who identify as older LGBTQ adults, or within non-normative identities, may be able to participate safely in society. As such, participants hoped that their concerns regarding their health and social disparities would be heard and that their voices would no longer be silenced. Participants requested educational resources, such as workshops on effective communication with care service providers and
decision makers that could support the development of skills to better communicate their needs. Participants also requested resources that could tailor and represent their specific identities, personalities and unique health needs, such as a centre for aging LGBTQ and separate care facilities (or floors) for those older LGBTQ adults living outside of heavily resourced urban centres, such as Toronto. Some participants shared, however, that would not access LGBTQ resources out of the fear that they may be outted and risk their safety. While others considered the need for all aging resources and care services and facilities to be welcoming and inclusive to LGBTQ people. Overall, participants shared a desire to be treated like people when engaging with care service providers and that they be able to do the following as they age: to exercise their legal rights to equal opportunities and to benefit from policies that other older adults receive, to spend their time in ways that would be meaningful to them, to be autonomous over the decisions being made as they enter the end of their lives, as well as to feel comfortable, supported and safe when they die.
Chapter 5: Discussion

This research project was undertaken in order to contribute to the limited body of literature on aging, sexual orientation, and gender identity in Canada. The aims of the study were to investigate the health and aging experiences of older LGBTQ adults living in Ontario and to identify the perceived care service and support needs of this population in order to make recommendations that could inform culturally competent practice in Ontario, Canada. LGBTQ adults who were living in Ontario and over the age of 60 were invited to participate in a focus group and to share their experiences of aging as a sexual and/or gender diverse person in Canada. Twenty-one lesbian, gay, bisexual, trans and/or queer (LGBTQ) participants, between the ages of 60 and 79, volunteered to respond to questions on the unique needs, challenges and rewards of aging. In particular, participants were asked about their language preferences and informal support systems, as well as their use and/or knowledge of policies (i.e., social, government, financial) and community services and supports. The focus group audio recordings were transcribed and analyzed according to Braun and Clarke’s (2006) recommendations for conducting an inductive thematic analysis. Four themes (and eleven subthemes) were generated from the data: (1) Living (In)Visibly: Exposure to Discrimination across Changing Social Systems and Identities; (2) (Dis)Connections from the Community: Finding Inclusive and Safe Supports as a Marginalized Person; (3) Power(lessness) and (De)Energization: The Fight for Choice and Autonomy; (4) Requests and Recommendations for Inclusive Care Provision.

The Implications of the Study

Past discrimination and invisibility. Similar to the findings of previous research conducted on older LGBTQ adults, profound experiences of past discrimination were considered to impact the visibility and health of older LGBTQ adults within society. Older LGBTQ adults
lived invisibly, in the past, so as to protect themselves from various social risks and threats to personal safety (i.e., abuse, loss of employment, loss of community, medical and/or religious treatment, arrest, etc.—e.g., Barrett et al., 2015; Brotman et al., 2003; Brotman et al., 2015; Detanto et al., 2014; Haber, 2009). More specifically, past Canadian research (e.g., Brotman et al., 2003) suggests that living invisibly was employed as a survival strategy in order to cope with overt forms of discrimination. In particular, Brotman and colleagues (2003) found that older LGBTQ adults remained hidden through avoidance tactics, whereby the person would not openly identify: (1) as a sexual and/or gender diverse person; (2) their partners to others; (3) with LGBT+ communities and; (4) with care services in general. These findings correspond with the results of this study, as participants from this study described additional ways in which they assimilated within normative society in order to maintain their invisibility, including: (1) changed their behaviours and/or attitudes in order to meet societal expectations (e.g., heterosexually partnered); (2) reframed their perceptions of self and identity (i.e., reframed gender identity) and/or; (3) rejected and/or treated (e.g., conversion/reparative therapy) their sexual and/or gender identity. Through the suppression of identity and denial of authentic and public self-expression, participants described internalizing normative ideals and stigma and in doing so, adopted and applied negative attitudes toward themselves (i.e., their concept of self) and toward other more marginalized groups of sexual and gender diverse people (i.e., trans, people of colour, etc.).

Living invisibly within society and without support from formal care services, friends, families and/or community groups, past generations of LGBTQ adults instead developed their own system of support underground. These older LGBTQ adults described benefitting as they found belonging, support, and comfort from others who were similar to themselves, and as such,
were resilient in finding ways to resist mainstream oppression by taking care of themselves and each other. Such coping strategies have also been documented in the research (e.g., Brotman, Ryan & Cormier, 2003; Canaday, 2009; Lyons, Croy, Barrett & Whyte, 2015). Older LGBTQ adults from this study described their reliance on safe spaces, such as parks, bathrooms, bars and private house parties and codes, or an underground language, that expressed their needs in a way that would only be understood by others who were considered to be ‘insiders,’ or privy to this information. *Gay speech* (Smorag, 2008) has been well documented in the body of literature on LGBTQ linguistics and suggests that the codes, or slang, used have been important in maintaining safety and promoting group bonding among LGBTQ people. However, as indicated by the participants in this study, few were familiar with the language. Other participants would have remained excluded from the support of other LGBTQ people. Research from the United States has found that older LGBTQ adults may experience trauma due to a lifetime of stress as a result of victimization (e.g., Fredriksen-Goldsen, 2013a; Fredriksen-Goldsen, 2013b) and the losses encountered during the HIV/AIDS epidemic (Rofes, 1998). While Older LGBTQ adults from this study did not explicitly state that such experiences were “traumatic,” participants described their past lives as “burdensome” and considered that these experiences impacted their interpretation and navigation of current and future social contexts.

Discrimination continues to reinforce participants’ invisibility within the contexts of the present day. This finding was consistent across all of the focus groups; despite whether the group was held in small, mid-sized or large urban centres. Even in regions where the participants had access to more care services (even those that emphasize aging and/or LGBTQ health, well-being

47 See the following link for a partial bibliography, from 1910-2007: http://faculty.wcas.northwestern.edu/~ward/newbib.html
and quality of life), participants still expressed experiencing overt and covert forms of discrimination and invisibility. From my analysis I came to understand that discrimination has become more complex over time as participants have increasingly gained greater visibility and rights as LGBTQ people within society, yet continue to face hetero/cis-normative and homo/bi/trans-phobic social attitudes, increased invisibility, exclusion, rejection as a result of age, as well as additional prejudices associated with non-normative social positions (e.g., racism, classism, ableism etc.). Such tensions have also been documented in a recent study conducted by Lyons, Croy, Barrett and (2015), in Australia. From the findings of their study, older gay male participants described experiencing both greater levels of acceptance and recognition (especially when compared to the past) as well as continued discrimination within society. In particular, those older gay men described concerns regarding acceptance when disclosing their identities under certain contexts, such as coming out to people of traditional religious backgrounds, employers, families, and coming out within certain geographic location (i.e., greater inclusion in cities versus the country). These findings are consistent with those of this study, as inclusivity and visibility within Ontario were also context dependent. Participants from this study perceived their own social positions, as well as the social positions of others, certain events and/or environments to impact the level of discrimination they experienced. Older LGBTQ adults of colour, with varying abilities, and less financial resources were perceived to face even greater discrimination and invisibility within society. Aligning with Canadian research, some participants in this study also perceived geographic location (i.e., urban versus rural) to influence the level of visibility and discrimination (e.g., Brotman et al., 2007). However, others contended that urban residents also faced discrimination and such experiences were related to the diversity
of employers within a location, values of a community and/or the institutions involvement with historical oppressions.

Consequently, the results from this study described divides between those older LGBTQ adults who are living visibly and authentically no matter the circumstances (e.g., “I am me this is who I am, and you can either accept me or don’t”), those who are living cautiously, or living “a duplicitous life,” as they continue to assess the risks and navigate with whom and under which circumstances, or environment, it is appropriate and/or safe to share their identity (e.g., “I still decide when I’ll say I’m a lesbian and when I won’t”) and those who only assume or anticipate discrimination (e.g., “I don’t have to come out here, it’s irrelevant that I’m a lesbian”). Conducting environmental assessments prior to disclosing identity, or anticipating discriminatory encounters, has been well documented within Canadian literature on aging, sexual orientation and gender identity, especially as older LGBTQ adults anticipate an increased need for and dependence on formal care near the end of life (e.g., Brotman et al., 2003; Furlotte et al., 2016; Kortes-Miller, Boulé, Stinchcombe & Wilson, in press). While the participants form this study described similar concerns regarding coming out to health and social care providers and anticipated risks of living authentically within a care facility, they also described using such strategies within the community (i.e., while volunteering and socializing with neighbours or other groups). Some participants in particular, described assessing their apparel and avoiding LGBTQ community events (e.g., Pride) so that people in their community would not assume their orientation.

In comparison to the limited rights of sexual and gender diverse people in Australia and the United States, participants in this study perceived Canada to have policies, that for the most part, represented sexual and gender diversity and equality. However, older LGBTQ adults noted
that systemic and institutional attitudes, within Ontario, value and emphasize normativity. For instance, participants considered same-sex marriages, although legal in Canada, to be inferior to the marriage between heterosexuals. Accordingly, LGBTQ seniors were fearful that their rights and freedoms may be revoked and that the discrimination and negative social attitudes of the past could return. These fears were exacerbated by participants’ perceptions of a rise in discriminatory attitudes since the presidential inauguration of Donald Trump in the United States, as well as the anticipation that the Progressive Conservative party may be re-elected provincially and/or federally. Research conducted in the United States have found the political elections to be significant events for LGBTQ people and to pose psychological consequences, such as trauma (e.g., Russell, 2000; Russell, Bohan, McCarroll, & Smith, 2011). This is most likely due to anti-LGBTQ sentiments during elections creating additional stress and challenges for LGBTQ individuals who are trying to manage their own identities as well as stigmatizing social attitudes (e.g., Rostosky, Riggle, Horne, Denton & Huellemeier, 2010). Researchers have described political events as contributing to LGBTQ people developing a “sense of powerlessness” (Russell et al., 2011, p.14).

A note on the health of the sample and resiliency. Despite evidence suggesting that older LGBTQ adults experience greater physical and mental health disparities (e.g., Addis et al., 2009; Brennan et al., 2010; Grossman, D’Augelli, & O’Connell, 2001; Wallace, Chrochran, Durazo, & Ford, 2011), this research project found that most of the participants characterized their health in the demographic questionnaire to be quite good, with only two participants rating their health as “poor” to “fair.” During the focus groups however, participants shared that they were living with or had sought medical attention for the following health issues: hip surgery, brain surgery, cardiovascular conditions, coma, nodes on the prostate, chronic diarrhea,
HIV/AIDS, mental health illnesses, depression, dementia, multiple sclerosis and cognitive impairments. While, two participants also mentioned that they were considering MAiD as they near the ends of their lives. These results could indicate that most of the older LGBTQ adults that participated in this study were not experiencing greater health disparities than their heterosexual counterparts, or, that most of the older LGBTQ adults that participated in this study have been able to incorporate resources that promote health and their ability to thrive—that is, older LGBTQ adults living in Ontario may be demonstrating resiliency in spite of systemic and institutional barriers that challenge health equity.

Participants in this study described their social networks as: friends, family of origin (i.e., parents, siblings, children, grandchildren, nieces and nephews, cousins, and in-laws), partner, pets and neighbours. Several participants shared during the focus groups that they had previously been in a straight, long-term, relationship (partnership or marriage) which for some, resulted in children. Only one participant described turning to their family of choice for care and support. Although some participants described strained relationships with their family of origin, others described these supports as quite meaningful. Of these participants, some considered their ex-partner, or their ex-partner’s family, to be of significant support, a finding which aligns with research conducted by Kim and Fredriksen-Goldsen (2017) and may suggest that older LGBTQ adults may have greater motivations to maintain these bonds and experience health benefits, as a result. Past research has suggested that older LGBTQ adults are more likely to be living alone or to be living with fewer social network resources (Brennan-Ing, Seidel, Larson, & Karpiak, 2014; Cantor & Brennan, 2000; Kim & Fredriksen-Goldsen, 2016; Rosenfeld, 1999; Rosenfeld, 2003; Wallace et al., 2011). However, more than half of the participants (13) from this study were living with another person (i.e., partner, friend, family member, or roommate) and on average
had approximately twenty social resources. In a large scale survey conducted in the US with LGBT adults aged 45 to 75, respondents described limited opportunities for volunteerism (SAGE, 2014). However, the participants in this study were heavily involved in the community. Seventeen participants indicated that they were volunteers, working between 2-35 hours a week, with the following: HIV/AIDS organizations, outdoor groups, theatre/chorus groups, LGBTQ and/or aging groups, abroad, sectors of government and policy, as well as other research initiatives. Each of these volunteer activities were related to promoting the health of aging and/or LGBTQ individuals and were described by the participants as resources in which they could give and receive support. Such descriptions imply the significance of generativity, as well as supports that represent older LGBTQ identities, in promoting the positive aging and health of older LGBTQ adults in stigmatizing conditions. However, those who experience hypervisibility within a volunteer or work environment, or activism fatigue, or burnout, may demonstrate greater health disparities.

Past research has also suggested that older LGBTQ adults have experienced greater oppression and harm from traditional religious institutions (Beagan & Hattie, 2015). These findings were consistent with those of this study as most participants identified with spirituality (12) and made remarks that distinctly separated their spirituality from traditional religion, such as “NOT religious, yes spiritual.” However, several participants (5) identified with traditional religions (e.g., United, Unitarian, Roman Catholic, Buddhist) and considered it to be an important support that provided them with a greater sense of community. During the focus groups some participants described living authentically within their religious and spiritual communities and that it was important to them to be visible and to represent the greater LGBTQ community while accessing such supports. Others, however described the need to conceal their
identities in order to access such resources, or feeling obliged to “shop around” in order to find a religious community that was open and accepting to LGBTQ people. These findings are therefore, consistent with emerging research on LGBTQ spirituality/religion, as past research has acknowledged spiritual and/or religious care as a determinant to LGBTQ health and quality of life (Beagan & Hattie, 2015; Brotman & Ryan, 2008; Comerford, et al., 2004; Fredriksen-Goldsen et al., 2011; Orel, 2004; Rivers, 2006; Swartz et al., 2015) and that those who experience conflict between their sexual and/or gender identity and religious and/or spiritual identity may experience greater health disparities.

Anticipating health disparities. Consistent with research conducted by Sleeman, Lewinsohn, Engleman, Maley and Allen (2017), older LGBTQ adults from this study anticipated significant age-related losses to their health, abilities and supports. Although participants shared perceptions of aging that are associated to general experiences of older adulthood (e.g., physical and cognitive deterioration, loss of independence and increased vulnerability, dying alone and without support, isolation, etc.), such losses may have greater impacts on older LGBTQ adults, who may have fewer resources and experience greater health disparities when compared to their heterosexual counterparts. Participants from this study also shared unique concerns and fears that related to the intersection of age, sexual orientation, and gender identity. Accordingly, participants described unique losses in health and ability (e.g., cognitive impairment for an LGBTQ senior who came out later in life and the personal and post-surgical care needs of trans women), which related to both the provision and receiving of informal care. Informal caregiving concerns were related to the anticipation that partners, family member, friends and neighbours may not be able to provide support later in life. More specifically, participants were particularly concerned that they would not receive informal support from children, either because they did
not have any children to do so or there were too many barriers that prevented older LGBTQ adults from perceiving their children as available or reliable support systems. Participants in this study also reflected the findings of Lyons and colleagues (2015) in that many older LGBTQ adults were also concerned about losing the LGBTQ community, as society has become more inclusive.

Financial instability and poverty among older LGBTQ adults has been documented within the research on aging, sexual orientation, and gender identity as well (de Vries, 2009; Jacobs, Ramussen, & Hohman, 1999; OSPN & Ipsos Reid, 2015). For the most part, participants from this study were highly educated, retired, and made on average between $45,001-60,000 annually (as stated on their individual tax return). Only one participant shared that they were still working, part time, during their retirement, while four participants indicated that they had not yet retired and were still working full time— one of whom specified that they were working two jobs (full time and part-time). Aligning with the work of MacFarland and Sanders (2003) the participants of this study shared that they did not feel fiscally prepared to age and did not feel as though they would be able to afford certain health and social support programs such as in home care and community services and/or private senior’s residences and institutional care.

Participants also discussed having limited insurance, or no insurance coverage to purchase their own, or family members’, medications. Similar results have been documented in the literature (e.g., Cahill et al., 2000; Cahill & South, 2002; Comerford et al., 2004; Greene, 2002; OSPN & Ipsos Reid, 2015; Porter, Russell & Sullivan, 2003; Rivers, 2006). Two participants also described that they were living on additional provincial benefits, due to chronic illnesses and/or disabilities that prevented them from working. One of which indicated that she would soon face even greater financial difficulties as she transitioned from the Ontario Disability Support Pension
to the federal retirement pensions (i.e., the Canadian Pension Plan—CPP— the Old Age Security pension—OAS— and the Guaranteed Income Supplement—GIS), since CPP affects the amount of income that may be received from other financial programs, such as GIS, provincial and territorial disability benefits and social assistance (Government of Canada, 2018). Overall, participants from this study perceived the financial losses associated with aging to greatly impact their health, and that the combination of financial losses and fractured social supports were considered to contribute to greater barriers to aging in place and keeping one’s home. Ultimately, many participants anticipated that they would become dependent on institutional care services and facilities near the end of their lives, and as such, feared for their safety, comfort and rights. Therefore, these findings echoed those of previous research studies (e.g., Butler & Hope, 1999; MacFarland & Sanders, 2003; Wilson et al., 2018) in that older LGBTQ adults perceive later life to be a period of isolation, marked by increased vulnerabilities, a greater reliance on formal care services and the potential for a greater number of discriminatory encounters.

**Dependence on home, community, long term care and retirement homes.** In line with the works of several Canadian researchers (e.g., Brotman et al., 2003; Brotman et al., 2007; Brotman & Ryan, 2008; Butler & Hope, 1999; Furlotte et al., 2016; Wilson et al., 2018), participants from this study described significant fears in terms of entering into institutional care facilities, as well as uncertainty regarding the availability and accessibility of appropriate services. Such fears were predominantly due to the anticipation that participants would experience both overt and covert forms of discrimination while accessing health and social services. When seeking formal and institutionalized care there are several avenues in which an older LGBTQ adult may be supported: (1) home and community care, (2) long term care, (3) retirement living. Home care is a supportive care service that is provided by healthcare
professionals, homemaking services and/or community programs to seniors within their home in order to assist with medical treatments as well as household and daily living activities. Subsidized home care is funded by the provincial government and administered by the Local Health Integration Networks (LHINs) in Ontario, at no cost to the senior. Long term care (i.e., nursing homes) are facilities that usually provide seniors with adverse long term health care needs, with continuous supervision and personal care. Long term care can be owned and operated by either municipal councils, private or non-for-profit organizations (e.g., religious, community or cultural, ethnic groups). Regardless of ownership, long term care service fees are set by the Ontario Ministry of Health and Long-Term Care. If a senior applicant’s income is not sufficient to pay for the most basic accommodations within long term care setting, the LHIN provide a subsidy. Retirement homes however, are multi-residence accommodations that provide seniors with services (e.g., meals, housekeeping, etc.). Retirement homes are privately owned and operated, and as such, are not mandated, administered or organized by the provincial government (i.e., the Ontario Ministry of health and Long-Term Care or the LHINs). Residents are therefore required to pay all of their own fees in terms of medical treatment and professional healthcare services with no subsidies from the government (Ontario Ministry of Health and Long-Term Care, 2016b; Sykes Assistance Services Corporation, 2017).

Since the Government of Ontario (2010) has prioritized an aging in place strategy, only those seniors with significant care needs may be eligible for admission to a long-term care facility. With the criteria to enter long term care in Ontario becoming more narrow, older LGBTQ adults in need of care may be required to use home care services or retirement living prior to being able to enter a long term care facility. However, only a few of the participants from this study discussed anticipating discrimination from home and community care providers and
they did not make reference as to the difference in service if it were privately or publicly funded. Rather, most of the participants anticipated discrimination from long term care, more specifically and that institutional care facilities that are privately owned and operated would be more accepting to older LGBTQ adults when compared to those that are subsidized. All long term care homes, no matter their ownership or operation, are legislated by the Long-Term Care Homes Act (2007) and must abide to the following laws: the safety and security of residents, admission requirements, appropriate care treatments and service provision, the operation of long term care homes (i.e., staff, funding, licensing, long term care councils), compliance with and enforcement of the Act, and reporting and complaint procedures. This Act also ensures that all long term care homes have a mission statement that is consistent with the Resident’s Bill of Rights, is developed by all of the councils, staff and volunteers of the long term care home, and is updated (if necessary) every five years. The Resident’s Bill of Rights designates 27 rights that that all residents be given while living in long term. Many of the rights within this bill aligned with the desires of older LGBTQ adults from this study.48

Participants perceived retirement living (or assisted living) to be the better of all options, as retirement homes are privately owned and operated. Retirement living however, is legislated by the Retirement Homes Act (2010), as well as the Residential Tenancy Act, and must abide by the following laws: applicable licensing, standard of care and staff training requirements, the protection of resident’s from abuse and neglect, offences, penalties and enforcement. Retirement homes are not required to have a mission statement, and while the Retirement Homes Act (2010)

48 For example: (1) to be treated with respect and dignity, (2) to be protected from abuse and neglect, (3) to have their basic human needs met (i.e., shelter, food, clothing, groomed, etc., in the manner that is consistent with their needs), (4) to exercise their rights as citizens, (5) to participate in the decision-making process, (6) to display personal possessions (as per the safety requirements and the rights of other residents), (8) to form friendships and participate in activities, (9) to have their lifestyle choices respected, (10) to pursue social, cultural, religious, spiritual and other interests and be given assistance to pursue such interests, (11) and the right to have any friend, family member, or other person who is deemed important to the resident, attend any consultation with staff.
also includes a Resident’s Bill of Rights, it only designates 11 rights; only one of which overlaps with those that are expected of long term care: (1) the right to have their lifestyle and choices respected and to pursue social, cultural, religious, spiritual and other interests (Section 51.1.9). Therefore, the differences in discrimination that older LGBTQ anticipate may be related to the variations in organizational policies, practices, attitudes and resources (e.g., the absence of sexual orientation and gender identity within the mission statement, access to training in cultural competency, the demands of the job in terms of the number of employed staff and the time allotted to building rapport with the residents, etc.), as well as lack of mechanisms to ensure long term care home’s accountability to the Long Term Care Home Act (2007).

Since July 2010 the long term care quality inspection program (LQIP) has been in effect to ensure that long term care homes are in compliance with the requirements and regulations of the Long Term Care Homes Act (2007) agreements (Ontario Ministry of Health and Long Term Care, 2013). LQIP protects the residents’ rights, safety, security, well-being and quality of life by reviewing complaints and other critical incidents at least once a year, through the unannounced inspections of 627 long term care homes across Ontario. Inspection reports are posted publicly to the Ministry of Health and Long Term Care’s website, the long term care home and given to the residents’ and family councils (Ontario Ministry of Health and Long Term Care, 2016b). If a long term care home is found to be noncompliant, the inspector will issue an action to the licensee, which may be as little as a written notification to the licensee and a request that the licensee prepare a written plan of correction for achieving compliance, to, a licensee’s long term care home license being revoked (Section 152.1). Retirement homes may also be subject to inspection for compliance with the requirements and regulations to the agreements of the Retirement Homes Act (2010) however, such inspections are conducted by the Retirement
Homes Regulatory Authority (RHRA). The RHRA licenses the owners and operators of the retirement homes and reviews complaints and critical incidents through unannounced inspections as well. However, actions that may be taken during enforcement by the RHRA may include, educating licensees, residents and public, or prescribing financial penalties or revoking licenses (Ontario Ministry of Senior Affairs, 2015). Similar to the concerns of the participants within this study, other research has documented that changes in policies and developing standardized practice may not necessarily improve a situation rather, the attitudes of staff, other residents and citizens must also be addressed (Brotman et al., 2015; Fredriksen-Goldsen, 2015; Greene, 2002; Langley, 2001).

Consistent with the findings of MAP and SAGE (2010), some of the participants from this study reported feelings of pride and responsibility to the greater LGBTQ community, while certain individuals and/or sub-communities described that they continue to feel excluded. However, feelings of rejection and exclusion from the LGBTQ community, were described in this study as being related to ageism, classism, as well as gender and sexual orientation. Some participants also shared that they found it difficult to create connections with other seniors as they perceived past LGBTQ environments (e.g., bars) to be youth-centric and no longer welcoming to those who have aged. While others felt that their relational identity (i.e., being single) created barriers to connecting with those LGBTQ seniors in partnerships. Some of the older lesbian women who participated in this study described continuing to socialize with their younger counterparts through their work, volunteerism, political contributions and mentorship. Such relationships were also considered to be beneficial in preventing isolation and providing older LGBTQ adults with a more expansive, or non-essentialist, understanding of sexual orientation and gender identity. Research on LGBTQ linguistics has shown that the LGBTQ
people have a pattern of describing their identities in ways that are meaningful and respective to their personality and/or attitudes (Smorag, 2008). Such terms are evidence to a sense of community belonging, the diversity of lifestyles, as well as a means to enhance the identification of those who share similar experiences and values (Sporag, 2008). For older LGBTQ adults, finding comfort in those who are similar to themselves may be health promoting as it does not require excessive energy to continually be assessing risks that either threaten their own personal safety or that of another LGTBQ person. Within this study, certain terms, such as “queer,” were quite controversial as some participants considered it to be representative of a history of victimizing experiences. Others however, considered the terms “queer” and “dyke” to be empowering—a way to reclaim and take ownership over discriminatory language and/or expand an identity, or concept of self. Queer, therefore, was considered to be closely related to sexual and gender fluidity, as well as the younger LGBTQ generation, and therefore represented a political ideology that valued radicalism, and at times, conflicted with essentialist views. Consequently, certain participants experienced greater barriers to accessing LGBTQ resources and feared that conflicts among LGBTQ sub-communities would ultimately, lead to collapsed LGBTQ programming and the erosion of a cohesive political identity. Others however, insisted that no single, cohesive, LGBTQ community has ever existed and that there is a greater need for programming and care services that represent the spectrum of identities and sub-communities.

Anticipatory coping. Although participants described instances in which they received culturally inclusive and visible care, it must be emphasized that discrimination and invisibility related to sexual orientation, gender identity, age as well as race and/or ethnicity, still exist within the health, social, and community institutions and continue to impact the level of comfort and trust that older LGBTQ adults have within such systems. As a result, some older LGBTQ
adults from this study have taken on the added responsibility of finding, developing and/or reinforcing culturally competent, respectful and dignifying care. While others have incorporated coping skills that will help them to avoid accessing care services. Research conducted by Sleeman and colleagues (2017) found that older LGB adults engage in coping strategies to address current and anticipated health issues in later life, including engagement in health promoting behaviours, shifting perspectives about health and body, finding comfort in spirituality and accepting the end of life. While some of the findings overlap (i.e., health promoting behaviours), participants from this study focused on ways to avoid discrimination, such as: preparing for discriminatory encounters, researching the inclusivity and visibility of LGBTQ people within a service or geographic location, changing their behaviours and/or attitudes and developing solutions to the anticipated problems (i.e. communal housing, soliciting additional supports and soliciting medical assistance in dying and/or assisted suicide).

Participants from this study also described that fighting for LGBTQ rights and visibility was a unifying and empowering experience that shaped many of the participants’ identities as life-long activists and volunteers. Volunteering within the community provided older adults with the opportunity to both give and receive supports, and as such, provided participants with both a sense of visibility and value as members of their communities. Such strategies may influence an older LGBTQ adults’ ability to thrive within Canadian society. However, older LGBTQ adults also considered activism and volunteer efforts to be a sense of responsibility, which at times, resulted in the participants feeling hyper-visible, fatigued and burnt out. As a result, the anticipation of health disparities, discrimination and planning for the end of life may require a greater expenditure of emotional energy; a finding which echoes similar results discussed in Furlotte and colleagues (2016). In order to reduce the negative impacts of activist burnout and
fatigue, older LGBTQ adults feel that the responsibility should be shared, as their issues also impact the next generation.

**Application of the Research: Recommendations for Community, Health and Social Care Services and Providers**

With consideration to the findings from this study and the specific requests of the participants, the following 13 recommendations have been developed in order to provide community, health and social care services with solutions that may facilitate accessibility and benefit older LGBTQ health and aging experiences within Ontario, Canada. These recommendations have been ordered by level of attainability (i.e., recommendation 1-6 may be more easily attainable than recommendations 7-13). While some of the recommendations may be incorporated into practice more easily, others may not be as feasible as they would require dissolving systemic values and attitudes within institutions that were created, or developed in order to encourage and maintain normativity (e.g., health and religious services).

**Recommendation 1: Develop an understanding of how past oppressions continue to influence the invisibility and the health of LGBTQ individuals and communities.** Research has shown that increased awareness of the historical impacts of oppression, discrimination and marginalization have the ability to promote empathy and understanding in care providers (e.g., Leyva, Breshaears, & Ringstad, 2014; Rogers, Rebbe, Gardella, Worlein & Chamberlin, 2013). Care providers should be able to express the ways in which past experiences of discrimination continue to negatively impact the health and aging experiences of older LGBTQ adults. Care providers should understand how past discrimination led older LGBTQ adults to remain hidden, or invisible, within society and how certain older LGBTQ adults may be reluctant to self-identify or to identify partners, families, or friends. Older LGBTQ adults may feel uncomfortable when
accessing care services due to their own past experiences of discrimination with the service, or after having learned of discriminatory encounters their peers have experienced, and now may anticipate discrimination, social isolation and/or loneliness. As such, having an understanding of past discrimination requires that care providers identify and understand their own services role in the oppression and the exclusion of LGBTQ people and/or various sub-communities. In doing so, care services should actively work toward reconciliation by building trusting relationships with LGBTQ communities and organizations.

If necessary, care providers should have an understanding of the LGBTQ adult’s social support network, as it will differ for each individual (e.g., biological families or families of choice, children or nieces and nephews, siblings, partner and/or ex-partners and their families, etc.). Care providers should also consider that LGBTQ older adults may have also experienced past exclusion from LGBTQ people and/or sub-communities and as a result may not rely on the LGBTQ community for support. Care providers should also be knowledgeable, whether through organized trainings or self-driven education, of the possible health disparities and determinants of health that impact an older LGBTQ adult’s quality of life. However, care providers should ensure to avoid using this knowledge as a means to medicalize, label, stigmatize, stereotype, or assume that these disparities are applicable to all older LGBTQ adults. Care providers should also have an understanding of the specific coping strategies used by older LGBTQ adults (i.e., remaining hidden and assimilating within normative culture, changing behaviours and/or attitudes, incorporating health promoting strategies, avoidance of care services and the development of underground solutions—that is, recruiting informal personal and housing supports and/or MAiD) and how these may impact the care being received and/or the
implementation of care strategies that may be able to assist an older LGBTQ adult through such pursuits.

**Recommendation 2: Ask questions and avoid making assumptions.** It is also important that older LGBTQ adults continue to feel as though they have a choice and/or autonomy over the care being received. In particular, participants from this study shared a desire to advocate for themselves without fearing the risks or consequences of doing so. Older LGBTQ adults would therefore, like for care providers to ask questions rather than make any assumptions regarding their identity, health, social supports, spirituality/religiosity, comforts, personal interests, and language preferences and for care providers to remain open to receiving honest responses. It is important that older LGBTQ adults do not feel silenced when sharing concerns about their health. By discussing health concerns with empathy, understanding, validation and transparency (especially in terms of the limitations or challenges a care provider may perceive in providing an older LGBTQ adult with their desired care plan) care providers may encourage positive interactions that reduce older LGBTQ adults’ anxieties.

**Recommendation 3: Communicate and use meaningful terms effectively.** Care providers should be aware that certain terms may be conceived as victimizing (e.g., homosexual) by some, and empowering for others (e.g., queer, dyke). As a result, care providers should also be attentive to the language that older LGBTQ adults use to describe their identities. Due to contentions with the use of the term “queer” among aging individuals and uncertainty as to its use by outsiders (i.e., those who do not identify as LGBTQ), care providers should omit its use as an umbrella term and instead consider terms such as, *the rainbow communities* or *the LGBT+ communities*—unless an older LGBTQ person requests otherwise. For instance, if a lesbian woman were to share that she prefers one of the following terms when describing her identity:
“homosexual,” “gay,” “dyke,” or “queer,” a care provider could ask if she is also comfortable with the care provider using these terms either while in discussions with herself, or other care staff and volunteers, and/or in written documentation. Care providers should also ensure to treat the acronym as a flexible list and include those identities accessing the service(s) or program(s) as they become known.

Care providers should go beyond an understanding of the terms and definitions of the acronym, the differences between sex and gender, and sexual orientation and gender identity or expression. Rather care providers should give special attention to the language used during a typical day and ask themselves, whether it holds negative attitudes, beliefs, or stereotypes regarding age, LGBTQ identities, race/ethnicity, ability or class. For instance, participants from this study described instances in which care providers used: stigmatizing stereotypes and assumptions regarding LGBTQ health (e.g., the level of incidence of, or risk for HIV/AIDS); body language that implied rejection of LGBTQ identities (e.g., lack of eye contact or lack of touch); intake questions or admission procedures that were framed in hetero/cis-normative discourses; tactics to silence older LGBTQ health concerns (e.g., aging health needs are not a priority) instead of validation and transparent explanations; strategies to delay a conversation that was significant to the care recipient (e.g., medically assisted death or assisted suicide). Therefore, care services may use active listening skills while speaking with care recipients, ask questions, and welcome opportunities to communicate and reflect non-normative language.

**Recommendation 4: Use symbols to signal safety to older LGBTQ adults.** Older LGBTQ adults may prepare for, or anticipate, discrimination when accessing care services, and as result, may feel uncomfortable when arriving to a care service. Once an older LGBTQ adult enters a care service they may also be evaluating the environment and people within to assess the level of
risk for personal safety. If an older LGBTQ adult enters an environment which does not reflect or represent their identity, it may impact their ability to thrive within that space. Care providers therefore, should develop the following skills in order to signal to older LGBTQ adults that they are within a safe and trustworthy environment and among LGBTQ allies. Participants from this study in particular made reference to the value of LGBTQ symbols and spaces that represented their identities (i.e., age, race/ethnicity, ability, etc.). Posters that promote older LGBTQ diversity and inclusion may be one solution, especially for a care service with budgetary restraints. For instance, the 519 has a free series of posters that care services may download from their website. For those with more financial resources however, symbols could incorporate art work, music, television programs that are relevant and meaningful to the older LGBTQ adults accessing the service. For instance, care services could include some of the slang, symbols, music, television that were identified within this study (e.g., a green carnation). If possible, activities or programs hosted by the care service could also provide those who are accessing the resources the opportunity express their identity through the creation of symbols that can be showcased in the main entrance and/or common areas. Since ally-ship and anti-oppressive practices may not always be perceived immediately, care staff could also wear rainbow wrist bands, badges or pins. However, it is extremely important that these symbols are only worn by an individual who does demonstrate the qualities of an ally. If possible, and only if an older LGBTQ adult is openly out, care staff may also greet an older LGBTQ adult with a pride flag, button or other small token that is meaningful to them and their identity. Again, if possible and/or appropriate care staff could also support older LGBTQ adults by introducing them to

49 The 519, Respect Your Elders Campaign (http://www.the519.org/education-training/training-resources/respect-your-elders).
others accessing the service who identify as aging, LGBTQ and/or share similar personal interests.

**Recommendation 5: Adopt trauma informed approaches to care.** Although participants in this study did not necessarily express past discrimination as traumatic, care providers should acknowledge that the past experiences of discrimination, victimization, abuse and anti-LGBTQ political events may impact older LGBTQ adults’ interpretations of the safety of an environment or person and their emotional and/or mental well-being (i.e., survival guilt). Therefore, special attention should be given to the environment when bringing people together or organizing an event in order to maintain the physical, psychological and emotional safety of all those within the space. When directly touching an individual, whether for bodily care or compassion, explain and receive consent before doing so. Traumatic experiences can also heighten the *rejection of care* (Volicer, 2012); which refers to a patient who resists care or shows aggression toward those who are attempting to support them. Additional training in trauma informed care and emotional support therefore, may be warranted in order to reduce negative interactions.

**Recommendation 6: Foster community by developing outreach strategies.** Maintaining a sense of community was identified within this study as an important social resource while aging. Care providers may promote community by: organizing special events (e.g., lunch and learns, singles night) or field trips to celebrations (e.g., Pride week), developing programming (e.g., youth-elder buddy programming, telephone and online support groups, etc.) and activities (e.g., hobbies and crafts that account for personal interests) or bringing in supports or entertainment (e.g., community groups, musical or theatre groups, drag queen performers, educational workshops, or student volunteers) that incorporate the many identities and abilities
of the demographics accessing the services. By building a rapport or relationships with other aging and/or LGBTQ services and/or organizations within a community, care services may be able to pool their resources together and strategize new, innovative, creative and mutually beneficial solutions that could promote the inclusivity, health, and equitable support of older LGBTQ adults.

**Recommendation 7: Include the voices of older LGBTQ adults, and their allies, in educational trainings and in the planning of inclusive practices and policies.** Older LGBTQ adults should be invited to participate in any culturally competent or inclusive practice trainings. Incorporating the personal narratives of older LGBTQ adults in trainings has shown to promote care provider understanding and empathy, as it humanizes the experiences of older LGBTQ adults (Rogers et al., 2013). This may be facilitated by including older LGBTQ adults as the experts or trainers when conducting diversity and inclusive practice educational workshops and/or by giving space for care staff and/or managers to share personal narratives regarding related topics and experiences. It is important however, to ensure that neither the care staff and/or managers, nor the older LGBTQ adults become overburdened or fatigued by such processes. In order to overcome such barriers, Wilson and colleagues (2018) recommend using knowledge mobilization techniques such as digital stories. As well, other techniques such as photo voice, voice recordings or previously developed media (e.g., movies, documentaries or podcasts on the health and aging experiences of older LGBTQ adults) may also be effective.

Care services and organizations may also consider additional discussions on older LGBTQ health and aging experiences in order to provide opportunities for care staff, managers, care receivers and/or their social networks to collaborate and develop practical solutions that address

---

50E.g., Gen Silent ([https://www.theclowdergroup.com/gensilent](https://www.theclowdergroup.com/gensilent))
various perspectives. In certain circumstances, care staff (e.g., LGBTQ community programs and service providers) who have developed a rapport with older LGBTQ adults may have a better understanding of some of their concerns and could propose areas of improvement and assist with the identification of areas of tension. Care services and those older LGBTQ adults seeking their supports may also benefit from consultation committees or councils that involve older LGBTQ people, their support networks, LGBTQ researchers and/or LGBTQ organizations. Care services would be able to seek out these committees when input is needed or certain concerns require solutions for practice or ideas in terms of offering appropriate programs and activities. These strategies may encourage more empathetic discussions between care organizations, providers, receivers and their support networks and promote greater transparency in terms of better understanding the challenges and limitations to incorporating greater visibility and representation of older LGBTQ adults.

**Recommendation 8: Critically reflect on normative structures and discourses and the implications of care providers’ identities and values on older LGBTQ health.** Personal and social biases regarding homo/bi/transphobia, hetero/cis-sexism, ageism, racism, classism and ableism negatively impact the health and quality of life of older LGBTQ adults and must be interrupted by both the care providers and the service, or organization. Health, social and community care providers may hold such biases and may, unknowingly, continue to perpetuate normative discourses that preserve discrimination, prevent trusting relationships and a rapport with older LGBTQ adults from transpiring. Such biases may also contribute to staff turnover, stress and health, and continuity of care. Certain care service providers, such as nurses, physicians and surgeons, social workers, psychologists, counsellors and therapists, are regulated by a college and are required to abide by a professional Code of Ethics that mandates
professional values surpass personal values, that services are provided without discrimination, and are competent in the services that they are providing (e.g., OAGS, 2016; The College of Physicians and Surgeons of Ontario, 2015; College of Nurses of Ontario, 2018; The Ontario College of Social Workers and Social Service Workers, 2018; the College of Psychologists of Ontario, 2013). Others, such as personal support workers, members of a spiritual or religious community, front line staff (e.g., admissions, organizers of LGBTQ support groups or programs), etc., are not held to the same standards. Critical reflexive practice, that is the analytical reflection of one’s social positions, may be an effective technique when dismantling normative dialogues. By systematically and regularly assessing institutional and individual attitudes, values and beliefs (i.e., policies and practices), care service providers may be able to better understand the ways in which normative discourses influence their ability to develop professional relationships with older LGBTQ adults and provide inclusive and competent care.51

**Recommendation 9: Promote capacity among older LGBTQ adults.** Participants from this study noted challenges in navigating community, health and social care systems and requested a resource centre which could address these issues. Participants also described interests in educational workshops and learning sessions that could provide them with a greater understanding of the rights that may uniquely impact their end of life planning. Therefore, care service providers should consider developing programs, workshops, or educational session in

51 Various tools exist in Canada to help individuals and services to reflect and critically analyze normative attitudes, beliefs and values. The City of Toronto Long Term Care Homes and Services for instance, provides a thorough guideline to providing care to older LGBTQ adults. Although it is designed for long term care services, other community, health and social services may be able to extend some of the chapters to their own practice. In order to access this resource, a copy must be requested from the City of Toronto. Additional supportive tools can be found by clicking on the following links:
which older LGBTQ adults may learn the following topics: the legal rights of same-sex common law relationships; end of life planning, power of attorney, and conflicts with biological families; effective forms of communication when self-advocating for health and/or aging concerns (for caregivers and individuals); ways in which to counteract activist burnout and fatigue; step by step instruction on accessing home and community care, long term care, retirement living (or assisted living) services; LGBTQ-friendly resources within the community (a networking session); older adults’ rights while living in long term care or retirement living (including the process of registering a complaint or incident); regulated bodies and professional codes of ethics including the process of complaint or incident); government financial benefits and conflicts.

Recommendation 10: Continue providing care to older LGBTQ adults by advocating on behalf of their health needs. Care services and providers should also be able to understand and express the ways in which local, provincial, federal and international laws and social attitudes impact older LGBTQ adults. Although older LGBTQ adults within this study described greater acceptance and recognition within society, under very specific circumstances, it should not be assumed that discrimination and LGBTQ related invisibility no longer require discussion. Older LGBTQ adults may be able to marry and have equal human rights in terms of sexual orientation and gender, yet participants from this study described fears of their rights being revoked, encountering discrimination within society and institutional care and continuing to assess the risks and contexts in which they will come out to community, health and social care providers, family, friends, neighbours, employers, other volunteers and other members of the community. Care service providers that are competent in older LGBTQ health and aging experiences are, as such, in a position to advocate for social change that promotes the inclusion, comfort, dignity, and respect of older LGBTQ adults. Participants from this study shared that it
was important to have care providers who represented and advocated on behalf of LGBTQ seniors within their own institutions and society. However, care providers should also account for the history of invisibility and silencing of older LGBTQ adults and be sure to advocate in ways that are meaningful and promote the voices and concerns of these populations.

**Recommendation 11: Co-ordinate and regulate inclusive care practices across staff, sectors and institutions.** Incorporating cultural competency strategies requires the creativity and flexibility of the care service manager and/or organization so that policies, administration, organizational planning (i.e., mission statement, vision, and value statements, annuals goals and objectives), outreach, programming and service delivery are inclusive in practice, while potentially adhering to legislation and government regulatory requirements. Care services therefore, may face challenges in regulating inclusive practice across services, programs, staff and managers. As such, care services may benefit from the creation of a cultural diversity plan. Cultural diversity plans are currently in use among long term care homes in Ontario and accredited through CARF in order to meet cultural diversity standards (Sue Cragg Consulting & the Centre for Learning, Research and Innovation in Long Term Care, 2017). Cultural diversity plans provide a platform to develop coordinated care approaches and goals to improve service, inclusive practice, and community engagement in order to facilitate better health outcomes for diverse populations, and as such, require reflexive practice on behalf of the individual care staff and institution. Plans should include explicit non-discrimination policies and may be structured to include the following information: strategic priorities, the legislation being addressed, a mission statement, vision, purpose and values of the organization in respect to diversity, as well as a list of action items (i.e., what is the goal and how will you know you have reached the goal,
who is responsible for the successfully meeting the goal, and the expected timeline). While creating a cultural diversity standpoint, care service providers should consider a proactive standpoint and continually ask, “What can we do now to prevent discrimination and promote the health and safety of older LGBTQ adults?” rather than implementing strategies after an incident has occurred. Once a diversity plan has been created, all institutional policies, assessment tools, intake forms, etc., should be reviewed to ensure inclusivity. Care services then should consider advertising their new and proactive standpoint to their own websites, social media accounts, and listervs, as well as those of other aging and/or LGBTQ organizations.

**Recommendation 12: Promote kindness, acceptance, and empathetic understanding when working with LGBTQ communities.** Some of the participants from this study discussed a desire for segregated care services, such as LGBTQ only long term care homes, communal housing, or a floor or unit, with staff that are LGBTQ, or who want to work with LGBTQ people, and specialize in LGBTQ care. Although an understandable request, it may pose challenges as care services, especially those in rural or more remote locations, may experiences difficulties in locating and appointing enough staff that meet these criteria, especially if LGBTQ care staff are not out with their employers. Care staff with a greater knowledge or understanding of LGBTQ health and aging, may also experience increased fatigue or burnout if these responsibilities are placed on top of their regular duties. Additionally, LGBTQ culture is ever evolving and reflecting the political and social contexts of its time. With there being a greater number of identities, sub-communities, values and political ideologies within the LGBTQ community, there is also an increased potential for conflict to occur even within services that offered to LGBTQ

---

52 Various samples of cultural diversity plans exist online. One organization, HIV/AIDS Resources and Community (ARCH, 2016) has developed a toolkit to help service providers assess the strengths, as well as areas for improvement, which can be used in the creation of a cultural diversity plan.
people only. Therefore, care services should encourage a culture of kindness, empathetic understanding, and acceptance across care recipients, care staff and care services in order to understand, address and manage the dynamics of differences within LGBTQ communities, as well as across culture and value systems. It may not be possible to change the attitudes of those who are accessing a service, however care services and staff may benefit from trainings in conflict management and dispute resolution in order to promote the accessibility of the care service or program, as well as intra-community and interpersonal support.

**Recommendation 13: Provide equitable care and treatment to a spectrum of identities and sub-communities.** As articulated by the participants of this study, the LGBTQ community is not one homogenous or cohesive group. Rather older LGBTQ adults considered themselves to be unique and in need of services and programs that recognize the individuality of each LGBTQ senior, as well as the unique health and social experiences of the sub-communities in which they identify. By celebrating the uniqueness of an individual, older LGBTQ adults may experience greater self-worth and positive interactions and as a result, greater health equity. Research conducted Donaldson and Vacha-Haase (2016) described that long term care staff have difficulties in demonstrating sensitivity toward LGBT residents in particular, as they perceived it to be the “favoritism” of one culture over others. However, if care staff were to build a rapport and treat all those receiving care as unique individuals, care service providers may no longer feel as though they are prioritizing one cultural group over another. By having many cultures and identities represented, it introduces the care services, staff and recipients to the comfort of their communities, while also promoting the opportunity to learn and engage with other cultures and people of diverse demographic backgrounds. Therefore, not only should care services and staff
acquire knowledge of LGBTQ health and aging experiences, they may also pay attention to the intersecting aspects of a person’s identity and connect these needs to appropriate resources.

Care services and providers may promote rapport between care staff and care receivers by using intake forms that provide basic information on the person receiving care. Participants from this study acknowledged the importance of intake forms having enough categories in order to be inclusive to older LGBTQ identities. If possible, intake forms could include questions that prompt care recipients to describe their: identities and/or communities, greatest health concerns, personal interests, hobbies and preferred outings, support networks (e.g., through the use the social convoy model), spiritual/religious identities, capabilities, as well as language and other preferences. In doing so, such forms may help care staff and services document important information on care recipients, as well as avoid asking the same questions too many times. If possible, care service providers may also request more information from care recipient’s social support networks in order to learn about important values and practices and their personal narratives. For care services with more resources (e.g., time, staff, finances) potential care recipients could be invited to an admissions session in which more in depth discussions could occur and include others from the care service (e.g., volunteers, residents, members, etc.) who are also aging and/or LGBTQ. Care services could also contact experts, or specialists, who have experience with related identities or sub-communities for greater support. Care services may also consider how youth-centric LGBTQ spaces and programs that lack diverse representation, lack of advertising or information on aging and/or LGBTQ services and programs, scheduling issues and conflicts with service or program times, transportation and limited services or programming for older LGBTQ adults create barriers to accessibility.
Summary of the Findings and Recommendations

Living (in)visibly. Participants shared experiences of past sociopolitical and historical discrimination (e.g., physical abuse, fear of criminalization, medicalization, religious condemnation and loss of employment, as well as the social exclusion of self and family) prior to the liberation movements that contributed to feelings of marginalization, rejection and profound stigma. As a result, participants lived invisibly within society by employing strategies that would keep their identities hidden, including: changing their appearance, attitudes and behaviours in order to align with heteronormative expectations of gender and sexuality. Living invisibly, however, was an isolating experience for participants that negatively impacted their physical, mental, emotional, social and spiritual health. Participants also described internalizing much of the prejudice they experienced, which they consider continues to negatively impact their current and future health.

Although participants acknowledged greater LGBTQ visibility and inclusion within society, especially when compared to the past, some participants considered it to be temporary. Participants expressed concerns that the rights of LGBTQ people may be revoked, given the social climate in the United States, and considered the rights of sexual and gender diverse people to be inferior to those who are heterosexual. Some participants shared that they felt comfortable and visible within their communities, however others, discussed current experiences of discrimination that continued to threaten their safety and ability to live visibly, or authentically, within Canada. Certain participants considered discrimination to be related to an older LGBTQ adult’s non-normative social position and described instances in which they faced harmful normative discourses, such as: hetero/cis-normativity, hetero/cis-sexism, racism, ageism, classism and ableism. Participants also considered how geographic location (i.e., the number of
LGBTQ people and services available, the values of a community, the industries, etc.) may also impact the level of inclusion or visibility and older LGBTQ person experiences. As a result, participants described having to still assess the risks of living visibly within their communities.

When participants considered the challenges of aging, they considered the accumulation of age-related losses and isolation. With fewer health resources (e.g., abilities, informal social supports, financial and housing) participants perceived barriers to be able to age in place, and as such, described their fears of becoming dependent on formal care facilities and institutions. Such fears were founded in the anticipation that they would not having their unique health needs met, that they would lose their rights and autonomy to make decisions, and that they would face even greater discrimination (i.e., overt and covert) than they do in the community and while accessing care services.

(Dis)Connections. Past experiences of discrimination led participants to live invisibly and with limited social connections and supports within society. As a result, participants described finding other sexual and gender diverse people to create inclusive and safe circles of support, or an underground culture. According to the participants though, not all LGBTQ individual, or sub-communities, were included. Those who were trans and/or non-white were not always accepted by those who were more visible within society (e.g., gay). Some participants described that rejection within community, was the result of internalized prejudice and normative social expectations, which were then reflected toward more marginalized subgroups.

Participants varied in terms of their values and political ideologies (i.e., radicalistic desires to drastically alter existing normative practices; the desire to integrate within normative society, while ensuring greater visibility and equal rights of LGTBQ people). Due to past experiences of discrimination, certain terms (i.e., queer) were considered to be a point of
contention among participants, as it represented both past and current experiences of victimization, political reclamation and empowerment. In particular, confusion with the term “queer” has left certain participants with a sense of despair, as some considered their lack of familiarity with non-essentialist, or more fluid identities, will lead to them offending other LGBTQ individual and sub-communities. Consequently, participants described insider-outsider dynamics, or divisions, within the broader LGBTQ community and tensions between the younger and older LGBTQ generations. Participants shared that such differences in values and political ideologies were creating conflicts within the community, which, participants feared would ultimately lead to the collapse of health promoting supports. Participants also shared difficulties in connecting with other older LGBTQ adults, especially with those of varying social positions to themselves (e.g., relationship status, socioeconomic status, gender and sexual orientation). Other participants however, described forming relationships with younger LGBTQ adults to avoid isolation.

Participants also considered the facilitators and barriers to receiving culturally competent, inclusive and accessible care services, programs and activities within their communities. Since participants who volunteered for this study were also heavily involved volunteerism, they were able to provide a unique perspective in terms of both accessing, educating, organizing and/or providing care supports. Overall, participants shared that more effective communication, greater LGBTQ representation in terms of the spectrum of identities and communities, more aging LGBTQ resources, and greater access to programming that builds capacity and community among older LGBTQ adults would serve as solutions to promoting their health in later life.

**Power(lessness) and (de)energization.** Participants described past experiences of creating a community, and leading the fight for human rights and visibility of LGBTQ people
throughout the liberation movements. In doing so, participants discussed uncovering a sense of unity and power that shaped many of their identities as life-long activists, LGBTQ care service providers and volunteers. Participants considered volunteer activities and working in the community to provide them with a sense of visibility as valuable members of society, who both receive and give support back to others in need. Such activities were considered to be a sense of responsibility to the participants; to be a recognized face and voice for aging LGBTQ issues and health needs. However, some participants described feeling hyper-visible, fatigued and burnt out from constantly expending their energy fighting, or advocating, for LGBTQ rights and health equity. Certain participants were unable to disassociate from volunteer and advocacy efforts, as they questioned the younger generation’s willingness and ability to assume their position as successors in the continuation of LGBTQ liberation movements. Participants also shared the importance of those conducting research on LGBTQ older adults to consider adopting social change practices and research that may implement short term solutions, as they did not feel that they had much time left to benefit or witness such changes be implemented. Due to participants anticipating age-related losses and dependence on discriminatory care facilities and institutions, participants described implementing strategies to avoid care services. For instance, participants described mentally preparing for discrimination, researching alternative options, changing their behaviours, and developing solutions (e.g., moving to geographic locations with inclusive values, exercising and dieting, co-housing, recruiting additional supports to provide informal care, and MAiD).

**Participant requests and recommendations.** Ultimately the participants from this study desired support from researchers, decision makers, service providers and the overall community to alter Canada’s current systemic values of normativity, so that older LGBTQ adults may age
safely within Ontario. Participants hoped that their concerns would be heard and that their voices would no longer be silenced. Participants also made explicit requests for educational resources, such as workshops on effective communication with care service providers, that could support their development of skills to better communicate these needs. Some participants requested resources that could tailor and represent their specific identities, personalities and unique health needs, such as centre for aging LGBTQ people and separate care facilities (or floors) for those older LGBTQ adults living outside of heavily resourced urban centres (e.g., Toronto). However, certain participants feared that such resources would risk their safety, while others considered the need for all aging resources and care services to be welcoming and inclusive to LGBTQ people. Overall, participants shared a desire to be treated like people when engaging with care service providers and the community.

**Recommendations for Inclusive Practice.** The findings from this study helped to inform thirteen recommendations for more inclusive practice among care service providers, in Ontario. The recommendations included that care service providers and/or organizations consider the following solutions: (1) develop an understanding of how past oppressions continue to influence the invisibility and health of older LGBTQ adults and communities, (2) ask questions and avoid making assumptions, (3) communicate and use meaningful terms effectively, (4) use symbols to signal safety to older LGBTQ adults, in educational trainings and in the planning of inclusive practices and policies, (5) adopt trauma informed approaches to care, (6) foster community by developing outreach strategies, (7) include the voices of older LGBTQ adults, and their allies, (8) critically reflect on normative structures and discourses, as well as the implications of care providers’ identities and values on older LGBTQ health, (9) promote capacity among older LGBTQ adults, (10) continue providing care to older LGTBQ by advocating on behalf of their
health needs, (11) coordinate and regulate inclusive care practices across staff, sectors and institutions, (12) promote kindness, acceptance, and empathetic understanding when working with older LGBTQ communities, and (13) provide equitable care and treatment to a spectrum of identities and sub-communities,

The Strengths of this Study

This research project was successful in collaborating with community, health and social care providers during the recruitment process, as well as with the participants in order to better understand older LGBTQ adults’ values and experiences of health and aging in Ontario, Canada. Using focus group discussions to collect data allowed the researchers to elicit more detail in terms of the similarities and differences of the health and aging experiences as well as the perceptions of various social issues faced by older LGBTQ adults living in Ontario. Each focus group was inclusive to all participants who identified within the spectrum of LGBTQ identity. This was an intentional decision, as we felt that the diversity of the data would be enhanced and would clarify the similarities as well as the unique distinctions in individual and subgroup life experiences. In this sense, the use of focus groups was beneficial as they allowed for us to experience more natural conversations and to analyze first-hand the various challenges and privileges across identities, the cohesion and divisiveness within communities and the points of agreement and dispute. Ultimately, the diverse nature and group dynamics of the focus groups provided a chance to better understand the complexity, the tensions and the unique community and individual needs of older LGBTQ adults living in Ontario.

The findings from this project complement the body of literature on aging, sexual orientation and gender identity and provide greater detail and insights as to the complexity of aging as an LGBTQ person within a Canadian context. Additionally, the results from this study
were interpreted using a holistic and strengths-based approach that were framed in a way that could offer a more critical understanding of the diversity of aging and health experiences among older LGBTQ adults. From the results, this study was also able to provide practical solutions, or recommendations, that could be implemented in future knowledge mobilization efforts or directly applied to local communities, services and care practitioners within Ontario. However, this study is not without its limitations and challenges. Therefore, future research within the field of aging, sexual and gender identities, should reflect the following considerations.

The Limitations of this Study

The sample. For the most part, participants from this study were quite young, with a greater proportion of participants (15) being between the ages of 60 and 69, and mostly identified as lesbian, gay and white. Although, three people of colour and one Métis person participated in this study, the sample was not representative of Ontario’s population of visible minorities (i.e., South-Asian, Chinese, Black, Filipino, Arab, Latin American and West Asian, Southeast Asian, Korean and/or Japanese—Ontario Ministry of Finance, 2016b) and Indigenous peoples (i.e., First Nations, Métis or Inuk—Ontario Ministry of Finance, 2016c). This study recruited participants from four areas within Ontario that were diverse in terms of the level of geographic isolation or remoteness, the visibility of LGBTQ populations, and the number LGBTQ and/or aging care services available. However, most participants were well educated, had a middle-class income, were active in their communities as volunteers and activists, had between 3-48 (mean=19.86) social supports, considered themselves to be spiritual and/or religious and perceived their overall health and mental health as quite good. As such, I am unable to report on the intersectional experiences of: aging cohorts 80 years and older, the spectrum of LGBTQ identities (i.e., bisexual, trans, queer, two-spirit, people of colour), those living in more rural or remote settings,
those with differing abilities (e.g., deaf) and chronic illnesses (e.g., addiction), those who are non-English speakers and those with lower levels of educational attainment. Despite the participants from this study being well resourced, it is important to acknowledge that they still expressed concerns regarding discrimination and invisibility, anticipated losses (e.g., health, social resources, community) and increased vulnerability. Therefore, more at risk populations of older LGBTQ adults may experience even greater health and care needs.

**The study design and procedures.** By asking questions that were aligned with the social determinants of health (i.e., sex, gender, age, racial/ethnic/cultural background, level of education, work status, annual income, volunteerism, health status, spirituality/religiosity and social support systems), this study was able to develop a more complete understanding of the participants’ lived experiences in relation to the intersection of multiple locations. Descriptive statistical analyses were not run on the responses to the demographic questionnaire in order to determine the relation between the participants’ social positions and their perceived health scores. Participants were also not requested to provide any further detail, or reasoning for their perceived health scores. Additionally, from an ethical standpoint, the participants were also considered to be vulnerable and an identifiable population. Therefore, the participant’s identities were not linked to their focus group data. As a result, it is unknown as to: (1) whether or not older LGBTQ adults, living in Ontario, are demonstrating fewer health disparities in comparison to older heterosexual adults; (2) whether the physical, mental, social, spiritual and/or religious health of older LGBTQ adults, living in Ontario, is determined by their individual social positions (such as age, race/ethnicity, sexual and/or gender identity); (3) whether older LGBTQ adults, living in Ontario, are experiencing greater access to care services and supports, visibility from care service providers or recognition within society.
Additionally, this questionnaire comprised of twenty-three questions, which were quite burdensome to the participants. This became especially evident once the participants reached question twenty-three (the social convoy model) as many vocalized their frustrations with the length and level of detail required; while more than half (i.e., 11) of the participants did not complete the question. While the social convoy model provided both qualifying and quantifying information in terms of the participants’ social supports, the question did not address the participants’ subjective interpretations of social supports (e.g., did they feel comfortable or uncomfortable with the number and/or quality of the supports listed). Participants, for the most part, also only included informal supports and although the demographic questionnaire asked whether participants were care providers, it failed to ask whether they were receiving care and from whom.

While the heterogeneity between participants provided in depth analyses of the aging LGBTQ experience, it also made it quite difficult to uncover similarities or new patterns of intersectional or shared experiences throughout the analysis. For instance, to the exception of one participant, three out of the four focus groups consisted of participants who were white. As a result, the discussions of these focus groups, as well as the experiences and the perceptions of social issues faced by participants varied considerably and likely differ beyond what was captured throughout this research study. Furthermore, since the responses to the demographic questionnaire were not linked to the individual identities of focus group participants, it was not possible to analyze the focus group discussion in connection to questionnaire responses (i.e., the social position(s) of participants), nor was it possible to do an in-depth follow up with an individual on their perceptions or experiences. As such, by omitting information on the identities
of the participants along with excerpts of the data, I may have inadvertently erased, instead of honoured, the unique characteristics of the participants.

Furthermore, due to the limitations of using qualitative data, in general, it was not possible to assess the health and aging experiences of participants over time or in comparison to their heterosexual counterparts. The results of this study were also based out of a very small sample size (i.e., \( n = 21 \)) and from only four locations in Ontario. Certain populations living in geographic locations with distinct health and aging needs (e.g., Indigenous people living on a reserve) were not explored. These findings, as such, cannot be considered as causal, nor should they be generalized to the broader population of older LGBTQ people living in Ontario or Canada.

**The health equity and promotion model.** By incorporating a model that uses multiple theoretical lenses (i.e., intersectional framework, life course theoretical perspective, minority stress theory, and social ecology), I was able to include a more holistic perspective of LGBTQ aging that could account for both the facilitators and barriers to promoting the health of older LGBTQ adults and equitable provision of services in Ontario, Canada. This theory allowed me to take into account the cultural and environmental contexts in order to give meaning to the health promoting and adverse pathways (e.g., discrimination, behaviour, social and community resources, identity, etc.) so that I could better understand the similarities and differences in the health and aging experiences of older LGBTQ adults across time (i.e., past, present and future), systems (e.g., macro, micro) and identities (e.g., age, sexual orientation, gender identity, race/ethnicity, etc.). However, due to the nature of the study (i.e., qualitative focus groups rather than quantitative; focus group data were not connected to the social positions of participants) and the complexity of the results, it was not possible to input the experiences of each participant into
the model in order to develop an understanding of relationships between these variables. For instance, consider the older LGBTQ adults’ experiences with volunteerism, affiliations with religious and/or LGBTQ communities. Each were discussed as having been affected by discrimination, and were met with tensions regarding whether participants viewed such resources as facilitating or challenging their health and quality of life. Even when discussing these resources with just one participant, they would describe the complexity of the support, as ebbing and flowing in terms of whether it was perceived as a benefit or hindrance to their health.

Additionally, the HEPM was developed using a successful aging model (i.e., quantitative results that consisted of factors that were related to good health, or poor health, in LGBTQ adults). Successful aging paradigms however, are based out of normative ideas that prioritize high physical functioning, low risks for chronic illness, and active engagement within the community (Rowe & Kahn, 1987). However, most of the participants form this study described the negative influences of normativity, and as such, beg the question as to whether the experiences of health and aging older LGBTQ adults should be compared to their heterosexual counterparts at all, or have their experiences measured in way that subjects them to biases of what is to be considered “successful” or not. Therefore, future research should consider incorporating critical theoretical lenses (e.g., feminist, queer, etc.) to the HEPM in order to better understand the unique health needs and concerns of older LGBTQ adults.

**Areas for Moving Forward in Future Research**

**Recruitment and working in collaboration with community partners.** Participants were recruited using a systematic procedure, known as the social network chain referral (Fredriksen-Goldsen & Kim, 2017). Although this procedure demonstrated success in the recruitment of participants who are often underrepresented in research (e.g., racial, ethnic, sexual
and gender minority communities; Walters, 2011, as cited in Fredriksen-Goldsen & Kim, 2017), it was not always effective in recruiting such diversity for this study. This could have been due to a number of issues, including: (1) lack of a relationship between the researcher (myself) and community agency; (2) a lack of community agencies that emphasize diverse aging populations in Ontario; (3) poor advertising (e.g., recruitment materials were not “liked” and/or “shared” enough to generate a wider acknowledgement of the research study taking place); (4) the recruitment method and/or materials (e.g., use of internet, posters, etc.) were not suitable to an aging LGBTQ population and/or; (5) older LGBTQ populations and/or community agencies were not incentivized to participate.

Therefore, future research studies intending to use the social network chain referral should consider establishing more extensive community partnerships with LGBTQ agencies and relationships with older LGBTQ people in order to develop and share recruitment materials in a way that will focus on reaching the target population. By implementing recruitment strategies that develop more extensive partnerships (i.e., participatory action research) with community, health and social services that emphasize the care needs of those older LGBTQ adults experiencing increased marginalization within society (i.e., increased discrimination and invisibility, fewer social and financial supports and greater barriers to accessing care), researchers may be able to account for the health and aging experiences of populations who are at risk for greater health disparities. Future research studies in public health should also consider producing research that addresses appropriate marketing, or advertising, techniques for recruiting older LGBTQ adults, more specifically. Moreover, future research studies with financial support could also consider promoting their recruitment materials through social media ads and postings with sexual and gender diverse people.
**Incentive to participate.** Ethically speaking, incentives are offered to encourage volunteers to participate in a research study and should not be so great that the incentive coerces a volunteer into participating (TCPS2, article 3.1). The TCPS2 also states that incentives to participate in research are “neither recommend[ed] nor discourage[ed].” Meaning, that researchers should not feel obligated to incentivize participants, as incentives may lead the researcher to collecting (more) identifying information on participants and may bias the altruistic reason or decision to participate. However, certain community agencies that were contacted informed the research team that the incentives to participate in this study were not great enough to encourage older LGBTQ adults to volunteer. Some participants also disclosed that they were burdened by the number of research initiatives in their community, as well as frustrated by the lack of action, or social change, being produced by researchers. Accordingly, the participants described feeling as though they were “the topic du jour.” Therefore, future research should discuss incentives to participate in the research study with participants in order to develop a better understanding as to why older LGBTQ adults continue to participate in research studies and how older LGBTQ adults may be appropriately incentivized so as to provide recommendations to researchers that will increase research uptake among this “hidden” population.

**Inclusive language and questionnaires.** In Canada, there is no consensus in terms of a question, or series of questions, that effectively ask research participants about their LGBTQ identity—especially among those who are members of older cohorts. Although in the United States, Kim and Fredriksen-Goldsen (2013) and NSAC (2013) noted higher response rates among older LGBTQ adults when the term “homosexual” was used, the question was criticized
by participants from this study. For instance, while the focus group was still in session, one participant shared the following:

Well I know you have homosexual in your questionnaire and like I wanted to say none of them because I’m not in a homosexual relationship, I don’t [...] want a medical term. I don’t want to say yes to a medical term. And I’m not sure it is in, in, the literature now. You wouldn’t see that [...] It’s a fall back.

While the terminology used in the demographic questionnaire may not necessarily be the language used in the literature on LGBTQ identities, it is still being used in studies that are being conducted at the national level (e.g., the Canadian Census, the Canadian Community Health Survey, the Canadian Longitudinal Study on Aging, etc.). In addition to insulting research participants, the use of the language used in this question is problematic as it makes several assumptions: (1) that the categories between same-sex attraction and heterosexuality are clearly distinct and that participants may not understand their identity as fluid (e.g., men who have sex with men, mostly heterosexual, etc.); (2) that one’s identity is defined by sexual behaviour (i.e., sexual relations) rather than a person’s concept of self and/or attraction to others; (3) that “bisexuality” is defined by sexual relations with two sexes rather than an affinity to all genders and/or sexes and; (4) the respondent is cis-gendered.

As part of their master’s thesis at the University of Western, Dharma (2016) evaluated sexual orientation items on population health surveys through online surveys and interviews with participants (aged 14 and older, mean= 35.3). Those who participated in Dharma’s (2016) study preferred an open ended question (e.g., How do you identify?), but suggested at least an “other” category, such as what was included in this demographic questionnaire. However, participants who do identify with “other,” may not actually select this category even if the option is available.
Dharma considered open ended responses and “other” categories to be “unfeasible” and “cumbersome” to both the participants and the researchers conducting the questionnaires (p.107). While this concern is well-founded for those researchers seeking to conduct, analyze and interpret quantitative studies that generate, reliable, generalizable and valid data (i.e., population surveys), an open ended question may be better suited to qualitative studies with small sample sizes.

Nevertheless, it still remains that there has been no research conducted in Canada that asks older LGBTQ adults about how they would prefer to self-identify, or to be asked about their identity, in surveys and questionnaires. Therefore, future research should consider conducting population-based online surveys and in-person interviews in order to better understand older LGBTQ response rates.

**Narrative interviews.** The focus group discussions were moderated by one facilitator in order to allow for the equal dispersion of talk-time among participants however, there were times when certain participants would direct the discussions and lead the group away from the topic. Such circumstances were usually due to a participant wishing to speak in greater detail to their individual life experiences. Participants desired to voice their narratives and to discuss the unique life trajectories that led them to becoming the person that they were at the time of the focus group. For instance, without solicitation from the researchers, many of the participants shared excerpts of their ‘coming out’ journey. Each description was distinctive to the individual and was defined as an important stage to their development and health, as it was perceived to be a shared experience across LGBTQ people and sub-communities. Therefore, future research should consider conducting narrative interviews that, for instance, explore the ‘coming out’ experiences of older LGBTQ adults as a determinant to healthy living.
**Mixed research methods.** Many gaps remain within the Canadian literature on the health and aging experiences of older LGBTQ adults, and their care needs. Community organizations that serve older LGBTQ adults in Ontario and volunteers have been taking on the additional responsibility of conducting research on these needs as well as creating knowledge mobilization tools in order to provide care services with guidelines and strategies to inclusive practice with diverse populations. Therefore, future research should aim to conduct a comprehensive literature review on these grey materials. Future research should also consider conducting program evaluations on services that are implementing such grey materials through comparative research approaches (e.g., pre and post-tests). Since this study only considered the health and aging experiences of older LGBTQ adults living in Ontario, future research should also endeavour to explore the perspectives of care service staff, managers and recipients; especially, in terms of services that have received little attention (e.g., LGBTQ organizations and religious, or spiritual, institutions). Additionally, if the social convoy model is to be used in future research, it should be done so in a way that lessens response burden (e.g., a single research procedure, such as an online survey), is clear in instruction (i.e., for participants to include both informal and formal supports, as well as to qualify care being received and/or provided) and allows for a more meaningful interpretation and statistical analysis across individual responses and other questionnaire items. If possible, the social convoy model may be beneficial in future longitudinal studies that use quantitative methods and a population based sample to determine the impacts or associations between a participant’s social position(s), the level of discrimination and invisibility experienced, the number of social supports (both formal and informal) and the

53 E.g., Diversity our Strength (2017), a LGBT tool kit developed by the city of Toronto Long Term Care Homes and Services for creating an inclusive and affirming long term care home.
barriers and facilitators to accessing care in order to assess and validate the health and aging experiences of older LGBTQ adults living in Ontario, Canada.

Conclusion

This study included the voices of LGBTQ adults aged 60 years and older in order to better understand their health and aging experiences as well as their perceptions of ideal service provision so as to inform more inclusive practice among community, health and social care services and providers in Ontario, Canada. Focus group discussions uncovered many tensions and diverse opinions regarding whether participants experienced greater visibility, safety or inclusion within various social systems, including: society, health and social care services, the LGBTQ community and/or sub-communities, families, friends and neighbours. Such variations, were associated to differences in the social positions, life trajectories and the values of older LGBTQ adults, as well as those they encounter. As a result, older LGBTQ adults continue to expend energy in order to assess the risks of discrimination, especially when considering the prospect of becoming dependent on care services and facilities. Older LGBTQ adults, therefore, have conceptualized solutions in order to cope with the stressors and overcome systemic and institutional discrimination, including community involvement to raise awareness and promote the health and quality of life of LGBTQ seniors. However, due to a life time of activist efforts participants described becoming fatigued and remain concerned as to who will support and advocate on their behalf, as they continue to incur age-related losses. By fostering a greater sense of community and social connectedness, as well as by combating normative values that discriminate against diverse populations, policy makers and community, health and social care service providers may be able to promote the health older LGBTQ adults living in Ontario, so as to improve quality of life.
References


Alzheimer’s Australia. (2014). Dementia, transgender and intersex people: do service providers really know what their needs are? Australia, SA: Withall.


Cahill, S., South, K., & Spade, J. (2000). *Outing age: Public policy issues affecting gay, lesbian,


http://www.parl.gc.ca/content/sen/committee/402/agei/rep/agingfinalreport-e.pdf

http://dx.doi.org/10.1080/13691057.2012.673639


http://dx.doi.org/subzero.lib.uoguelph.ca/10.1080/13607860120038366


http://dx.doi.org/subzero.lib.uoguelph.ca/10.1080/10911359.2013.831009

de Vries, B. (2009). Aspects of Life and Death, Grief and Loss in Lesbian, Gay, Bisexual and Transgender Communities in Kenneth J. Doka and Amy S. Tucci (Eds.), *Living with Grief: Diversity in End-of-Life Care*


National Resource Centre on Aging and Services & Advocacy for Gay, Lesbian, Bisexual & Transgender Elders (SAGE). (2010). *Inclusive Questions for Older Adults: A Practical*


practice and research with LGBT elders. In D. A. Harley & P. B. Teaster (Eds.), Handbook of LGBT elders: An interdisciplinary approach to principles (pp. 657 – 667). Heidelberg, GER: Springer International

Toronto Long Term Care Homes and Services. (2008). Diversity our Strength: LGBT Toolkit. Toronto, Ontario, Canada: City of Toronto. Retrieved from https://www1.toronto.ca/wps/portal/contentonly?vgnextoid=cced3293dc3ef310VgnVCM1000071d60f89RCRD&vgnextchannel=df8b3293dc3ef310VgnVCM1000071d60f89RCRD


Appendices
Appendix I: Tri-Council Policy Statement 2—CORE Certification

Certificate of Completion

This document certifies that

Jessica Boulé

has completed the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans Course on Research Ethics (TCPS 2: CORE)

Date of Issue: 24 September, 2016
Appendix II: Ethics Approval—REB#16NV050, H05-17-19, REB#026-17-18

RESEARCH ETHICS BOARDS
Certification of Ethical Acceptability of Research Involving Human Participants

APPROVAL PERIOD: February 24, 2017
EXPIRY DATE: February 23, 2018
REB: G
REB NUMBER: 16NV050
TYPE OF REVIEW: Delegated Type 1
PRINCIPAL INVESTIGATOR: Wilson, Kimberley (kwilso01@uoguelph.ca)
DEPARTMENT: Family Relations & Applied Nutrition
SPONSOR(S): SSHRC Insight Development Grant
TITLE OF PROJECT: Valuing the perspectives of LGBT in a Canadian evidence-based approach to developing inclusive research and policy agendas.

The members of the University of Guelph Research Ethics Board have examined the protocol which describes the participation of the human participants in the above-named research project and considers the procedures, as described by the applicant, to conform to the University's ethical standards and the Tri-Council Policy Statement, 2nd Edition.

The REB requires that researchers:
- Adhere to the protocol as last reviewed and approved by the REB.
- Receive approval from the REB for any modifications before they can be implemented.
- Report any change in the source of funding.
- Report unexpected events or incidental findings to the REB as soon as possible with an indication of how these events affect, in the view of the Principal Investigator, the safety of the participants, and the continuation of the protocol.
- Are responsible for ascertaining and complying with all applicable legal and regulatory requirements with respect to consent and the protection of privacy of participants in the jurisdiction of the research project.

The Principal Investigator must:
- Ensure that the ethical guidelines and approvals of facilities or institutions involved in the research are obtained and filed with the REB prior to the initiation of any research protocols.
- Submit a Status Report to the REB upon completion of the project. If the research is a multi-year project, a status report must be submitted annually prior to the expiry date. Failure to submit an annual status report will lead to your study being suspended and potentially terminated.

The approval for this protocol terminates on the EXPIRY DATE, or the term of your appointment or employment at the University of Guelph whichever comes first.

Signature: Date: February 24, 2017

Stephen P. Lewis
Chair, Research Ethics Board-General
RESEARCH ETHICS BOARDS
Certification of Ethical Acceptability of Research
Involving Human Participants

APPROVAL PERIOD: February 24, 2017
EXPIRY DATE: February 22, 2019
REB: G
REB NUMBER: 16-12-722
TYPE OF REVIEW: Delegated
PRINCIPAL INVESTIGATOR: Wilson, Kimberley (kwilso01@uoguelph.ca)
DEPARTMENT: Family Relations & Applied Nutrition
SPONSOR(S): SSHRC Insight Development Grant
TITLE OF PROJECT: Valuing the perspectives of LGBT in a Canadian evidence-based approach to developing inclusive research and policy agendas.

CHANGES:

<table>
<thead>
<tr>
<th>Type</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Renewal</td>
<td>2018-02-05</td>
</tr>
</tbody>
</table>

The members of the University of Guelph Research Ethics Board have examined the protocol which describes the participation of the human participants in the above-named research project and considers the procedures, as described by the applicant, to conform to the University’s ethical standards and the Tri-Council Policy Statement, 2nd Edition.

The REB requires that researchers:
- Adhere to the protocol as last reviewed and approved by the REB.
- Receive approval from the REB for any modifications before they can be implemented.
- Report any change in the source of funding.
- Report unexpected events or incidental findings to the REB as soon as possible with an indication of how these events affect, in the view of the Principal Investigator, the safety of the participants, and the continuation of the protocol.
- Are responsible for ascertaining and complying with all applicable legal and regulatory requirements with respect to consent and the protection of privacy of participants in the jurisdiction of the research project.

The Principal Investigator must:
- Ensure that the ethical guidelines and approvals of facilities or institutions involved in the research are obtained and filed with the REB prior to the initiation of any research protocols.
- Submit an Annual Renewal to the REB upon completion of the project. If the research is a multi-year project, a status report must be submitted annually prior to the expiry date. Failure to submit an annual status report will lead to your study being suspended and potentially terminated.

The approval for this protocol terminates on the EXPIRY DATE, or the term of your appointment or employment at the University of Guelph whichever comes first.

Signature: Date: February 5, 2018

Stephen P. Lewis
Chair, Research Ethics Board-General

Page 1 of 1
Ethics Approval Notice

Health Sciences and Science REB

Principal Investigator / Supervisor / Co-investigator(s) / Student(s)

<table>
<thead>
<tr>
<th>First Name</th>
<th>Last Name</th>
<th>Affiliation</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kimberly</td>
<td>Wilson</td>
<td>Others / Others</td>
<td>Principal Investigator</td>
</tr>
<tr>
<td>Kathy</td>
<td>Kortes-Miller</td>
<td>Others / Others</td>
<td>Co-investigator</td>
</tr>
<tr>
<td>Arne</td>
<td>Stinchcombe</td>
<td>Social Sciences / Psychology</td>
<td>Co-investigator</td>
</tr>
<tr>
<td>Jessica</td>
<td>Boulé</td>
<td>Others / Others</td>
<td>Research Assistant</td>
</tr>
</tbody>
</table>

File Number: H05-17-19

Type of Project: Professor

Title: Valuing the perspectives of LGBT in a Canadian evidence-based approach to developing inclusive research and policy agendas

Approval Date (mm/dd/yyyy) | Expiry Date (mm/dd/yyyy) | Approval Type
--------------------------|--------------------------|-----------------|
05/26/2017                | 05/25/2018               | Approval

Special Conditions / Comments: N/A
July 07, 2017

Principal Investigator: Dr. Katherine Kortes-Miller  
Co-Investigators: Dr. K. Wilson, Dr. A. Stinchcombe  
Research Assistant: J. Boule  

Faculty of Health and Behavioural Sciences  
Lakehead University  
955 Oliver Road  
Thunder Bay, ON P7B 5E1  

Dear Dr. Kortes-Miller and Research Team Members:  

Re: REB Project #: 026 17-18 / Romeo File No: 1465736  
Granting Agency: N/A  
Agency Reference #: N/A  

On behalf of the Research Ethics Board, I am pleased to grant ethical approval to your research project titled, “Valuing the Perspectives of LGBT in a Canadian Evidence-Based Approach to Developing Inclusive Research and Policy Agendas”.  

Ethics approval is valid until July 7, 2018. Please submit a Request for Renewal to the Office of Research Services via the Romeo Research Portal by June 7, 2018 if your research involving human participants will continue for longer than one year. A Final Report must be submitted promptly upon completion of the project. Access the Romeo Research Portal by logging into myInfo at:  

https://erpwp2.lakeheadu.ca/  

During the course of the study, any modifications to the protocol or forms must not be initiated without prior written approval from the REB. You must promptly notify the REB of any adverse events that may occur.  

Best wishes for a successful research project.  

Sincerely,  

[Signature]  
Dr. Lori Chambers  
Chair, Research Ethics Board  

/sm
Appendix III: Recruitment Materials

Recruitment Posters

The following recruitment posters will be emailed to supporting organizations to share via their social media accounts and/or client, or membership, lists.

Poster Options 1 and 2 (inclusive to the larger study)

Social Media Image (inclusive to the larger study).
Recruitment Scripts (Potential Organizational Supports)

Good [morning/afternoon/evening, Name of Organization]

My name is Jess Boulé and I am a Masters (MSc.) student at the University of Guelph, working with a team of investigators (Drs. Wilson, Stinchcombe and Kortes-Miller) on a research project that aims to develop a better understanding of the LGBTQ+ older adults' experience of aging in Canada. In particular, we are interested in identifying any barriers and facilitators to participating in society. As such, we are looking to recruit participants who identify as aging (60 years and older) LGBTQ+ Canadians that may have formal or informal affiliations with community based LGBTQ+ organizations and/or support groups in Guelph and the surrounding area.

We are reaching out [Name of Organization] in hopes that you might be able to share our recruitment materials through your own social media accounts and/or membership lists as you determine appropriate and in accordance with your own organizational policies. This project has been reviewed by the Research Ethics Board at the University of Guelph for compliance with federal guidelines for research involving human participants (REB#----). The Social Sciences and Humanities Research Council (SSHRC) has funded this project.

Should a participant wish to volunteer, they will be asked to engage in one focus group with 6-8 other individuals for approximately 2 hours in duration, at the University of Guelph on [DATE]. Participation in this research project will be of benefit to the participant, healthcare providers, policy makers as well as the fields of social work, gerontology and sexuality, in addition to the community at large. Partner organizations and voluntary participants will be provided with a summary of the results. Focus group participants will also be reimbursed for their travel costs (up to $10.00 with a valid receipt).

Attached please find an information letter outlining our project and recruitment materials for the upcoming Guelph focus group. If you have any questions, please do not hesitate to contact us at this email (kim.wilson@uoguelph.ca and/or jboule@uoguelph.ca) or by phone at 519-824-4120 ext. 53003. We appreciate your consideration in this request and look forward to hearing from you soon.

Sincerely,

Jess Boulé
Telephone Script

Hello (Name of Potential Participant).

My name is (Kim/Arne/Kathy/Jessica) and I am a researcher at the _________________________. Thank you for responding to our request for participants. The purpose of this project is to develop a better understanding of the LGBTQ+ older adults’ experience of aging in Canada. In particular, we are interested in identifying any barriers and facilitators to participating fully in society. This project has been reviewed by the Research Ethics Board at the University of Guelph for compliance with federal guidelines for research involving human participants (REB #-----). This project has been funded by the Social Sciences and Humanities Research Council. Your participation would include engaging in one focus group with 6-8 other individuals approximately 2 hours in duration. You may also be asked to participate in a follow up telephone call with one of the researchers for more information. Your participation will be of benefit to yourself, healthcare providers, policy makers and the field of social work, gerontology, and sexuality. Your decision to participate, or not participate, in the study will not affect the services or care that you receive from collaborating organizations. We will provide a summary result to partner organizations but no direct identifiers will be used so they will not know who participated.

Do you have any questions about the study at this time? May I have an email address or mail address so I can send you an information letter? If you are interested in participating in a focus group I will follow up with confirmed dates and times. Please contact via email at ________________________ or phone _____________________. Thank you for taking the time to listen to my request. Please do not hesitate to contact me with any questions.

Twitter:
Invitation to participate in #research Goal: to increase understanding of the lived experience of older LGBTQ+ Canadians including any barriers to participating fully in society. (REB#-----) Information letter would be attached to tweet

Facebook:
An invitation to participate in research! The purpose of this project is to develop a better understanding of the LGBTQ+ older adults’ experience of aging in Canada. In particular, we are interested in identifying any barriers and facilitators to participating fully in society. Your participation would include engaging in one focus group with 6-8 other individuals approximately 2 hours in duration. Please see the information letter below for more information. This project has been reviewed by the Research Ethics Board at the University of Guelph for compliance with federal guidelines for research involving human participants (REB #-----).
Appendix IV: Research-Designed Demographic Questionnaire

Demographic Questionnaire

Please note: All of these questions are optional. You are invited to provide as much (or as little) detail as you would like. Previous research has demonstrated that social determinants of health (such as health, race, etc.) can influence the experience of aging. These questions also help us to describe our participant sample in future publications. In publications and reports we will provide demographic summaries (e.g. participant’s ages ranged from 60-92). No individual level data will be published.

1. What is your age? ____________________________

2. What gender do you identify with? ________________

3. What sex were you assigned at birth? ________________

4. What is your sexual orientation?
   - Heterosexual (sexual relations with people of the opposite sex)
   - Homosexual, that is lesbian or gay (sexual relations with people of your own sex)
   - Bisexual (sexual relations with people of both sexes)
   - Other (please provide details):

5. What is your current marital/partner status?
   - Single
Married / Living with a partner in common-law relationship

Widowed

Divorced

Separated

Other (please provide details):

6. What is your working status (e.g., working full-time, working part-time, retired, etc.)?

__________________________________________________________________________________________

7. Are you a volunteer? If yes, please estimate the number of hours you volunteer per week:

__________________________________________________________________________________________

8. Are you currently a caregiver? If yes, for whom are you providing care?

__________________________________________________________________________________________

   ______________________________________________________________________________________

9. Were you formerly a caregiver? If yes, for whom were you providing care?

__________________________________________________________________________________________

10. What is the highest degree, certificate or diploma you have obtained?
<table>
<thead>
<tr>
<th>Education Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>High school diploma or GED</td>
</tr>
<tr>
<td>Non-university certificate or diploma from a community college, CEGEP, school of nursing, etc.</td>
</tr>
<tr>
<td>Trade certificate or diploma from a vocational school or apprenticeship training</td>
</tr>
<tr>
<td>University certificate below bachelor's level</td>
</tr>
<tr>
<td>Bachelor's degree</td>
</tr>
<tr>
<td>University degree or certificate above bachelor's degree</td>
</tr>
<tr>
<td>Other: ____________________________________________</td>
</tr>
</tbody>
</table>

11. In general, how would you describe your health?

<table>
<thead>
<tr>
<th>Health Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent</td>
</tr>
<tr>
<td>Very good</td>
</tr>
<tr>
<td>Good</td>
</tr>
<tr>
<td>Fair</td>
</tr>
<tr>
<td>Poor</td>
</tr>
<tr>
<td>Other: ____________________________</td>
</tr>
</tbody>
</table>

12. In general, how would you describe your mental health?
13. What is your living arrangement?
   a) Living alone
   b) Living with a spouse/partner
   c) Living with friends/family
   d) Living in a residence or assisted living facility
   e) Other (please describe)

14. What was your individual annual income as stated on your tax return from 2016?
   a. 0-$15,000
   b. $15,001-$30,000
   c. $30,001-$45,000
   d. $45,001-$60,000
   e. $60,001-$85,000
   f. $85,001-$100,000
   g. $100,001-$115,000
   h. $115,001-$130,000
   i. $130,001-$150,000
   j. $150,001-$200,000
   k. $200,000+

15. Do you reside in an urban or rural area (please circle)?
16. Are you a legal Canadian citizen?

17. Are you an immigrant to Canada? If yes, please specify your country of origin:

18. Do you identify as a refugee with permanent resident status in Canada? If yes, please specify your country of origin:

19. Please identify the race(s) that you most identify with (e.g., Hispanic, Asian, Caucasian, etc.):

20. Please identify the ethnicity that you most identify with (e.g., Canadian, French-Canadian, Guatemalan, Persian, Métis, etc.):

21. Do you identify as a religious or spiritual person? If yes, please specify:

22. Please describe your social network by listing your personal relationships on this chart by first name and descriptor (e.g., Ollie- Friend or Parker- Sibling). The centre of the target represents you and the relationships you feel closest to. As you move away from the centre, these rings represent those who you feel more distant to.
Appendix V: Information Letter

Project Title: Valuing the perspectives of LGBT in a Canadian evidence-based approach to developing inclusive research and policy agendas.
Investigators:

Kimberley Wilson, MSW, PhD, Assistant Professor, Guelph University
Arne Stinchcombe, PhD, Adjunct Professor, University of Ottawa
Katherine Kortes-Miller, MSW, PhD, Assistant Professor, Lakehead University

Dear Potential Participant,

Thank you for considering participation in this research study. Please read the following to understand the specifics of this study.

Purpose: The purpose of this project is to develop a better understanding of the LGBTQ+ older adults’ experience of aging in Canada. In particular, we are interested in identifying any barriers and facilitators to participating fully in society. We are interested to hear about your experience aging so far and any unique needs you may have as you age given your sexual orientation/gender identity. We will ask you questions to explore this and will ask you about the types of resources and supports that you wish you had and what messages you would like to share with decision makers. The Social Sciences and Humanities Research Council (SSHRC) has funded this project.

Your Participation: Participation in this study is completely voluntary and you may withdraw at any time. You may decline to answer any question. Should you choose to be involved, participation means that you will engage in a focus group with other adults and discuss your experiences of aging.

To be eligible for this research we are looking for people aged 60 and older who live in Canada and self-identify as lesbian, gay, bisexual, transgender and/or queer+. Individuals with severe cognitive impairment that would preclude consent are not eligible.

Your participation would include engaging in one focus group with 6-8 other individuals approximately 2 hours in duration. You may also be asked to participate in a voluntary and optional follow up telephone call with one of the researchers to clarify any findings and to discuss future opportunities for research, such as participating in additional projects including arts-based initiatives. This may include completing a photo-voice project or developing a digital story about your aging experience.

Focus groups will be held within community centres/community agencies across Canada. To support your participation, we will reimburse travel costs (taxi, parking, public transit) up to $10 with a valid receipt. Your decision to participate, or not participate, in the study will not affect the services or care you may receive from collaborating organizations. We will provide a summary result to partner organizations but no direct identifiers will be used so they will not know who participated.

To begin, you will be asked to sign a consent form to indicate your understanding of what is required of you to participate in this research study. We will also ask you to complete a demographic questionnaire. You are then invited to participate in the focus group.
Your participation in this study would span one day and take approximately 2 hours and be conducted on your personal time. If you agree to volunteer in this study you can decline to answer any questions and may withdraw from focus group by exiting the room.

Focus groups will be digitally recorded and transcripts of each focus group will be created. Any identifying information will be excluded from the transcripts. Although you are free to withdraw from the study at any time, it will not be possible to destroy the audio recording of the group conversation. We ask that you only share information that you would be willing to make public since it will not be feasible to remove your data from the study since it takes place within a group context.

**Benefits of Participation:** This research aims to improve our understanding of the lived experiences of older LGBTQ+ in order to influence research and impact Canadian policies. The goal of the research is to ultimately promote an inclusive society that addresses the needs of older LGBTQ+. Your participation will be of benefit to yourself, service providers, policy makers, the field of social work, gerontology and sexuality, and the community in general. Your participation will provide you with an opportunity to make your voice heard on this important topic. A copy of a summary of the results will be made available to you upon request, either via email or paper copy. You may request a copy of the summary of the results by emailing the principle investigator (Kim Wilson; kim.wilson@uoguelph.ca).

**Risks of Participation:** Your participation in this study poses minimal risk, however, the following steps to ensure that risk is minimized and to respect your confidentiality will be taken:

- Part of this study involves thinking and discussing aging and the experiences participants have encountered any barriers to participating fully in society. This could potentially arouse feelings of uneasiness or upset. Should this occur, you are encouraged to talk about your feelings with the appropriate professional supports. A list of local resources is available should you wish to speak with someone after this focus group.

- The research team will endeavor to keep any identifying information that is collected during this project confidential. Any data, tapes, transcripts will be identified with a code number keeping your identity separate from the data. This connection will only be known by the researchers involved in this study. Your name or any identifying information will not be released or made public in any research findings, reports, presentations or subsequent publications. Attention will be given to information you share to remove any identifying information. Pseudonymous may be used. The name of your healthcare provider or community of residence will not be released in the research findings.

- As the focus group will be group experiences and essentially a public process, your confidentiality in this study cannot be guaranteed. While all participants will be encouraged to respect what occurs in the focus group and to not speak about their experiences publicly or divulge the identity of other participants we are unable to guarantee this. To ensure your privacy is respected and to minimize any social risks is
respected; we ask that you only share things that you would be comfortable if they were made public.

- Any identified data (including recordings, master lists, etc.) will be stored on password-protected devices and in a securely locked in a filing cabinet in one of the project investigators office as per their University’s research data policy. After completion of the study, the data will be stored securely in a locked cabinet at the University of Guelph, Lakehead or the University of Ottawa and destroyed after five years. Anonymized data from this study may be used in a future study pending appropriate ethics approval.

- Only members of the research team will have access to identified data. A paid professional outside of the research team may transcribe focus group data. While this person will not have a master list with your information, they will hear the details of the focus group. Any transcriber will be asked to sign a confidentiality agreement.

This project has been reviewed by the Research Ethics Committees at the University of Guelph (REB#16NV050), University of Ottawa (H05-17-19), and Lakehead University (Romeo#1465738) for compliance with federal guidelines for research involving human participants.

If you have any questions regarding your rights and welfare as a research participant in this study, please contact one of the following offices:

1. The Director of Research Ethics; University of Guelph; reb@uoguelph.ca; 519-824-4120 ext. 56606.
2. The Office of Research Ethics and Integrity; University of Ottawa; ethics@uottawa.ca; 613-562-5387
3. Research Ethics Coordinator; Research Services; Lakehead University; research.ethics@lakeheadu.ca; 807-343-8933

Please note, you do not waive any legal rights by agreeing to take part in this study.

We look forward to your participation in this study. Consent forms will be available to be signed before the focus group. If you have any questions regarding this study, please do not hesitate to contact (insert local PI name and contact info) for further clarification. We thank you in advance for taking the time to read this information and for your consideration.

We will contact you to schedule the first individual meeting and receive your informed consent for participation in this study.

Sincerely,

Dr. Arne Stinchcombe  Dr. Kimberley Wilson  Dr. Kathy Kortes-Miller
University of Ottawa  University of Guelph  Lakehead University
Consent Form

**Project Title:** Valuing the perspectives of LGBTQ in a Canadian evidence-based approach to developing inclusive research and policy agendas.

**Investigators:**

Kimberley Wilson, MSW, PhD, Assistant Professor, Guelph University  
Arne Stinchcombe, PhD, Adjunct Professor, University of Ottawa  
Katherine Kortes-Miller, MSW, PhD, Assistant Professor, Lakehead University

My signature on this sheet indicates I agree to participate in a study being led by Drs. Wilson, Stinchcombe & Kortes-Miller. The purpose of this project is to develop a better understanding of the LGBTQ+ older adults’ experience of aging in Canada, with a particular focus on identifying any barriers and facilitators to participating fully in society. My signature also indicates that I understand the following:

- I understand to my satisfaction the information regarding participation in this study;  
- I am a volunteer participating on my own time and can withdraw from this study at any time;  
- My participation in this research study will be recorded by audio taping in the focus group and verbatim quotes (that exclude identifying information) may be included in future publications and reports;  
- The research procedures, risks and benefits have been fully explained to me;  
- I have had the opportunity to ask questions regarding this study and am satisfied with the answers to my questions;  
- I understand that my decision to participate or not participate in the study will not affect the services or care I receive from collaborating organizations. Partner organizations will receive a summary of the findings, but I understand that they will not include any direct identifiers and they will not know who participated.  
- Information gathered from this study will be shared with and may be used for additional education and publication purposes in a manner that will protect my identity;  
- This consent will be reviewed with me throughout the study to ensure I am fully informed;  
- A summary of the results from this research will be made available in report form by September 2018 if I email a request to the researchers (Kim Wilson, kim.wilson@uoguelph.ca)  
- I am encouraged to ask the researchers any questions at any time during my participation;  
- I can withdraw from this study at any time by notifying the researcher that I wish to stop my participation however my data, however it may not be possible to remove my data from the study since this is a focus group.

With this understanding, I agree to participate in this research.

Participant Name: ___________________________________________
Participant Signature: ___________________________  Date: _______________

Witness Name: ________________________________

Witness Signature: ___________________________  Date: _______________

☐ Please check if you agree to be contacted by a member of the research team for any clarification and/or to for invitation to a new phase of this research.
Appendix VI: Inductive Thematic Analysis

Figure 2: Why Does Only Half of my Maple Tree have Leaves?

- Consider what your tree was exposed to before its lack of leaf growth.
  - Harsh weather (Sociohistorical)
  - Insufficient planting space (lack of facts, services)
  - A nearby construction project (continued oppression)
- Sparse leaves are also linked to abnormally cold winter temperatures and soil moisture.

- GIRDING ROOTS - which wrap around other roots or the tree's trunk and cut off the flow of water and nutrients.
- Nasty people in your life
  - Negative experiences (some surprising)
  - People - not feeling heard.

Solutions:
- Regular check-ins
- Treat your trees with water, fertilizer, and pruning
  - Annually, competent, routine, accessible

PROGRESSIVE

INTERSECTIONALITY

Opportunities vs. society

OCCUPATIONAL

- Root
  - Systemic
- NORMS & VALUES

Root

Barnes.
Figure 3: Original Thematic Map
Figure 4: Evolution of Thematic Map
Figure 5: Final Thematic Map
<table>
<thead>
<tr>
<th>THEMES</th>
<th>SUBTHEMES</th>
</tr>
</thead>
</table>
| **Living (In)Visibly** | [Past] Maturing under Extreme Conditions (LGBTQ)  
[Present] Changing Climates: Shifting Policies, Attitudes and Status (LGBTQ + Old)  
[Present/Future] Assessing for Risk  
[Future] Anticipatory Aging  
[Future] Anticipatory Aging  
[Future] Anticipatory Aging  
[Future] Anticipatory Aging  
[Future] Anticipatory Aging  
[Present/Future] Assessing for Risk  
[Future] Anticipatory Aging  
[Future] Anticipatory Aging  
[Future] Anticipatory Aging  
[Future] Anticipatory Aging  
[Future] Anticipatory Aging  
[Future] Anticipatory Aging  
| o The Perceived and Experienced Rewards of Aging  
| iv) Generativity, Time, Choice and an Accumulation of Life Experiences  
| o The Ultimate Reward: Aging in Place and Being with Loved Ones  
| o The Perceived and Experienced Losses in Health, Ability and Informal Supports  
| iv) Who will support me?  
| o The Ultimate Loss: Dependent Care and Dying Alone and Afraid |
| **(Dis)Connections within the Community** | [Past] Coming Out and Finding Community Underground  
[Present] Language is Meaningful to Individual Identity and Community Belonging  
[Present/Future] Language as a Form of Victimization or Reclamation  
[Present] The “LGBTQ Community” Doesn’t Always Mean Community  
[Present] Girdling Roots and Hardy Supports [The Facilitators and Barriers to Accessing Care Services]  
[Past + Future] Anticipatory Coping  
| o Researching Options  
| o Changing Behaviours (e.g., closeting/hiding; volunteering to impact social change)  
| o Developing Solutions Underground  
| [Past + Future] Experts of Aging LGBTQ Care  
| o Inclusive, Dignifying and Safe Care  
| iv) Resources Tailored Specifically to Older LGBTQ Adults  
| iv) Cultural Competency Trainings and the Dissection of Systemic Norms  
<p>| iv) Individualized Care and Rapport |</p>
<table>
<thead>
<tr>
<th>Power(lessness) and (De)Energization</th>
<th>[Declining Power and Energy/Time]</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Youthful Activists and Leaders</td>
<td></td>
</tr>
<tr>
<td>[Present] The Fight to Change Policies and Social Attitudes / The Fight for Choice and Autonomy when Accessing Care Services</td>
<td></td>
</tr>
<tr>
<td>o Valuable Members of the Community</td>
<td></td>
</tr>
<tr>
<td>o Losing Energy</td>
<td></td>
</tr>
<tr>
<td>o Collapsed Programming</td>
<td></td>
</tr>
<tr>
<td>[Future] Our Youth Need a Voice/The Inability to Fight at the End of Life</td>
<td></td>
</tr>
</tbody>
</table>
### LIVING (IN)VISIBLY IN HISTORY

<table>
<thead>
<tr>
<th>Codes : Maturing Under Extreme Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internalized Prejudice</td>
</tr>
<tr>
<td>Living in Sin</td>
</tr>
<tr>
<td>Conversion Therapy/Rejection of Identity</td>
</tr>
</tbody>
</table>

#### CODES: Changing Climates: Shifting Policies, Attitudes and Status (LGBTQ + Old)

| “It’s just a very different world […]” | Exclusive structures /attitudes= barriers for LGBTQ | Tensions between inclusion and exclusion (i.e., polarized attitudes) | Personal accounts of discrimination from care providers |
| Inclusive social structures (macro) | Inclusive spaces and positive encounters with care providers | The types of discrimination: hetero/cisnormativity, classist, ableist, stigma, abuse, victimization, prejudice, colonization, racism, marginalization/rejection/exclusion | Intersectionality and the recognition of privilege/categorical divisions between identity | Tensions between policy and social attitudes |

| Urban vs rural= level of LBGTQ inclusion | Assisted suicide legislation |
| Not all urban centres are inclusive |
| Polarized political attitudes |
Canada’s discrimination is coming from the US

Living authentically versus living a duplicitous life

<table>
<thead>
<tr>
<th>CODES: Risk Assessments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living authentically versus living a duplicitous life</td>
</tr>
<tr>
<td>Evaluating the safety of an environment/person</td>
</tr>
<tr>
<td>Navigating when to disclose identity</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Codes: Anticipatory Aging and Coping</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assisted Suicide Legislation</td>
</tr>
<tr>
<td>The fears and joys of aging</td>
</tr>
<tr>
<td>Fearing losses in health/ability and support</td>
</tr>
<tr>
<td>Human rights and safety</td>
</tr>
<tr>
<td>-------------------------</td>
</tr>
<tr>
<td>Losses in choice, autonomy and safety</td>
</tr>
<tr>
<td>Housing and formal care options</td>
</tr>
<tr>
<td>Care providers /facilities are not safe or accepting</td>
</tr>
<tr>
<td>Fear of becoming vulnerable/becoming dependent on care staff</td>
</tr>
</tbody>
</table>

**DIS)CONNECTION WITHIN COMMUNITY**

**Codes: Coming Out and Finding Community Underground**

<table>
<thead>
<tr>
<th>The Coming Out Experience</th>
<th>Being singled out for LGBTQ identity</th>
</tr>
</thead>
<tbody>
<tr>
<td>The closet: hidden and/or invisible identity</td>
<td></td>
</tr>
<tr>
<td>Came out later in life</td>
<td></td>
</tr>
<tr>
<td>Underground Culture to compensate for the lack of community/isolation</td>
<td></td>
</tr>
</tbody>
</table>
The quieted (current) not the closeted [e.g., rural/government workers]

Living authentically versus a duplicitous life

**CODES: Girdling Roots and Hardy Supports**

<table>
<thead>
<tr>
<th>The importance of having circles of supports</th>
<th>transportation</th>
<th>Institutional policies that prioritize LGBTQ+</th>
<th>Reaching out to isolated individuals and building community</th>
<th>Online resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Culturally Competent, Inclusive, Accessible and Safe</td>
<td>Cultural competency trainings/toolkits</td>
<td>Visible symbols of LGBTQ-inclusiveness</td>
<td>Lack of community (overall in society)</td>
<td></td>
</tr>
<tr>
<td>Youth-elder programming</td>
<td>Advocates/allies/LGBTQ care practitioners</td>
<td>To those with […]</td>
<td>LGBTQ workshops on their rights</td>
<td></td>
</tr>
<tr>
<td>“I’m not seeing myself represented out there as I get older: Supports where your identity is represented and visible</td>
<td>Building a rapport</td>
<td>Collapsed programming/groups</td>
<td>Supports that connect older LGBTQ</td>
<td></td>
</tr>
</tbody>
</table>

**CODES: The “LGBTQ Community” Doesn’t Always Mean Community**

| The institution of marriage/common law | Ability to maintain LGBTQ identity | Generational differences and conflicting ideologies | |

216
<table>
<thead>
<tr>
<th>The effects of diluting solidarity</th>
<th>Difficulties connecting with LGBTQ community/other members</th>
<th>Sexual fluidity as a form of abdication</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is our root and who should be included in the LGBTQ community</td>
<td>Categorical divisions between LGBTQ communities</td>
<td></td>
</tr>
<tr>
<td>Black lives matter</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CODES: Language is Meaningful to Individual Identity and Community Belonging</strong></td>
<td><strong>Language as a Form of Victimization and Reclamation</strong></td>
<td></td>
</tr>
<tr>
<td>How we label/define ourselves is meaningful</td>
<td>Perspective taking</td>
<td>How do others perceive me/us</td>
</tr>
<tr>
<td>Language as a form of victimization/reclamation</td>
<td>Sexual and gender fluidity</td>
<td>Offending others</td>
</tr>
<tr>
<td>Queer</td>
<td>Confusion with the number and meaning of labels</td>
<td></td>
</tr>
<tr>
<td>Who can use which terms (insider vs. outsider language)</td>
<td>There are many labels for identifying as LGBTQ</td>
<td></td>
</tr>
<tr>
<td>Homosexual dyke</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CODES: Aging LGBTQ are the Experts</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wishing and Resources</td>
<td>Cultural competency</td>
<td>Decisions Makers need</td>
</tr>
</tbody>
</table>
homing specifically tailored to older LGBTQ adults training and dissecting systemic norms to be held accountable

<table>
<thead>
<tr>
<th>Inclusive, dignifying and safe care</th>
<th>Resources specifically tailored to older LGB</th>
<th>Changing policies</th>
<th>Individualized care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Choice and autonomy over the decisions being made</td>
<td>KMb</td>
<td>Researchers need to conduct more inclusive studies and Km</td>
<td></td>
</tr>
</tbody>
</table>

**POWER(LESSNESS) AND (DE)ENERGIZATION**

<table>
<thead>
<tr>
<th>Activism/advocacy/fight</th>
<th>We need the younger LGBTQ generation’s help</th>
<th>Past Accomplishments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Energy</td>
<td>Worry about the younger LGBTQ generation’s well-being</td>
<td>Valuable members of our community</td>
</tr>
<tr>
<td>I no longer wish to advocate, I need a break</td>
<td>Past Advocacy</td>
<td>Volunteering in the Community</td>
</tr>
</tbody>
</table>

**CODES: The Fight for Human Rights and Visibility**

| Why volunteerism was a support | |
|--------------------------------| |
### Table 7: Participant Identities

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Summary of Responses</th>
<th>Number of Participants</th>
<th>Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>60</td>
<td>1</td>
<td>Range: 60-79</td>
</tr>
<tr>
<td></td>
<td>61</td>
<td>1</td>
<td>Mean: 67.71</td>
</tr>
<tr>
<td></td>
<td>63</td>
<td>2</td>
<td>Mode: 64</td>
</tr>
<tr>
<td></td>
<td>64</td>
<td>5</td>
<td>Median: 66</td>
</tr>
<tr>
<td></td>
<td>66</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>67</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>69</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>71</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>72</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>73</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>76</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>78</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>79</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Sex Assigned at Birth</td>
<td>Female</td>
<td>10</td>
<td>1 Trans-Feminine Participant</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>11</td>
<td>10 Cis-Feminine Participants</td>
</tr>
<tr>
<td>Gender</td>
<td>Female</td>
<td>11</td>
<td>10 Cis-Male Participants</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td>Heterosexual (sexual relations with people of the opposite sex)</td>
<td>0</td>
<td>--</td>
</tr>
<tr>
<td></td>
<td>Homosexual, that is lesbian or gay (sexual relations with people of your own sex)</td>
<td>16</td>
<td>10 Gay</td>
</tr>
<tr>
<td></td>
<td>Bisexual (sexual</td>
<td>4</td>
<td>5 Lesbian</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1 Dyke</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3 Cis-Feminine</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1 Trans-Feminine</td>
</tr>
<tr>
<td>Canadian Citizenship</td>
<td>Born and raised in Canada</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>---------------------------</td>
<td>----</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Immigrant to Canada</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Refugee with permanent resident status in Canada</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>1 Cis-Feminine Queer</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

---

---

---
Table 8: Participant Education, Occupation and Socioeconomic Status

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Level</th>
<th>Number of Participants</th>
<th>Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education</td>
<td>High school diploma or GED</td>
<td>1</td>
<td>Some participants specified their field, the level of the degree attained and/or the number of degrees or certificates attained.</td>
</tr>
<tr>
<td></td>
<td>Non-university certificate or diploma from a community college, CÉGEP, school or nursing, etc.</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>University degree or certificate below a bachelor’s degree</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bachelor’s degree</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td></td>
<td>University degree or certificate above bachelor’s degree</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Working Status</td>
<td>No Response</td>
<td>1</td>
<td>Some participants described their occupations.</td>
</tr>
<tr>
<td></td>
<td>Retired</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Working Full Time</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Working Part Time</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Annual Income</td>
<td>No Response</td>
<td>1</td>
<td>Mode: $45,001-$60,000</td>
</tr>
<tr>
<td></td>
<td>0-$15,000</td>
<td>2</td>
<td>Median: $45,001-$60,000</td>
</tr>
<tr>
<td></td>
<td>$15,001-$30,000</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$30,001-$45,000</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$45,001-$60,000</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$60,001-$85,000</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$85,001-$100,000</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$100,001-$115,000</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Above $115,000</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Volunteer</td>
<td>Yes</td>
<td>No</td>
<td>Other</td>
</tr>
<tr>
<td>----------------</td>
<td>-----</td>
<td>----</td>
<td>-------</td>
</tr>
<tr>
<td>Volunteer Hours per Week</td>
<td>0</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>12</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>20</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>35</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Characteristic</td>
<td>Level</td>
<td>Number of Participants</td>
<td>Analysis</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>-------------</td>
<td>------------------------</td>
<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Overall Health Status</td>
<td>Excellent</td>
<td>2</td>
<td>1 participant qualified that their health was “very good, for my age.”</td>
</tr>
<tr>
<td></td>
<td>Very Good</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Good</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fair</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Poor</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Overall Mental Health Status</td>
<td>Excellent</td>
<td>2</td>
<td>Note: Participants did not necessarily respond the same for overall health and mental health (e.g., 1 participant indicated that they had “excellent health” and then indicated that they had “very good” mental health). 1 participant indicated that their mental health was both good and very good.</td>
</tr>
<tr>
<td></td>
<td>Very Good</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Good</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fair</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Poor</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Spirituality and/or Religiosity (open ended)</td>
<td>“No”</td>
<td>3</td>
<td>Non-religious/non-spiritual (3)</td>
</tr>
<tr>
<td></td>
<td>“Spiritual”</td>
<td>7</td>
<td>Spiritual (8)</td>
</tr>
<tr>
<td></td>
<td>“Yes, spiritual”</td>
<td>1</td>
<td>Spiritual/non-religious (4)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Religious (5)</td>
</tr>
<tr>
<td>Marital/Partner Status</td>
<td>Single</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>------------------------</td>
<td>--------</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>1 participant responded that they were single and</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- “healer/teacher”
- “Spiritual Atheist”
- “Spiritual, I am a Catholic in recovery!”
- “Spiritual not religious. No longer interested in condemnations and judgments of many religious people or denominations.”
- “NOT religious, yes spiritual”
- “Religious, United Church”
- “Unitarian”
- “Yes, Unitarian/Humanist”
- “Yes, Roman Catholic”
- “Buddhist”
- Hmm…

No Response (1)
<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>Count</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married/living with a partner in a common</td>
<td>11</td>
<td></td>
<td>divorced. 1 participant responded to “other” as having a partner who lives in another city.</td>
</tr>
<tr>
<td>law relationship</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Widow</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Divorced</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Separated</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Geographic Place</td>
<td>Urban</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Semi-Rural</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rural</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Living Arrangements</td>
<td>Living alone</td>
<td>8</td>
<td>1 participant responded to “other” as “a student rents a room.”</td>
</tr>
<tr>
<td></td>
<td>Living with a partner</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Living with friends/family</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Living in a residence or assisted living facility</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Current Caregiver</td>
<td>Yes</td>
<td>3</td>
<td>Participants who responded as “yes,” indicated that they were caring for their mothers or a partner. 1 participant indicated that they</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>17</td>
<td>were caregiving, “part-time for my mother and myself.” 1 participant responded to the question with, “?” Partner has cancer but mobile.”</td>
</tr>
<tr>
<td>Past Caregiver</td>
<td>Yes</td>
<td>6</td>
<td>Participants were caregivers for: “my father, my</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>aunt”; “my family”; “sister, parents (as they were dying”; “my mother”, “HIV/AIDS patients,” “my mother and father.”</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Table 10: Summary and Impressions of Participant Responses to the Social Convoy Model

<table>
<thead>
<tr>
<th>Participant Age and Sexual/Gender Identities</th>
<th># Per Ring 1</th>
<th># Per Ring 2</th>
<th># Per Ring 3</th>
<th># Per Ring 4</th>
<th>Total Number of Social Resources</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>61 Year Old Gay Cis-Male</td>
<td>0</td>
<td>14</td>
<td>15</td>
<td>14</td>
<td>43</td>
<td>Certain relationships unquantifiable. Family, friends, social groups, health care providers, volunteers, staff, neighbours, acquaintances.</td>
</tr>
<tr>
<td>64 Year Old Bisexual Cis-Female</td>
<td>1</td>
<td>6</td>
<td>18</td>
<td>10</td>
<td>35</td>
<td>Friends and family only.</td>
</tr>
<tr>
<td>66 Year Old Gay Cis-Male</td>
<td>0</td>
<td>3</td>
<td>9</td>
<td>7</td>
<td>19</td>
<td>Certain relationships were not qualified. Family and friends only.</td>
</tr>
<tr>
<td>64 Year Old Bisexual Trans-Female</td>
<td>2</td>
<td>8</td>
<td>13</td>
<td>16</td>
<td>39</td>
<td>Detailed descriptors of family, friends, colleagues.</td>
</tr>
<tr>
<td>69 Year Old Gay Cis-Male</td>
<td>1</td>
<td>15</td>
<td>17</td>
<td>10</td>
<td>43</td>
<td>Certain relationships were not qualified. Certain relationships unquantifiable. Children only.</td>
</tr>
<tr>
<td>66 Year Old Gay Cis-Male</td>
<td>0</td>
<td>3</td>
<td>11</td>
<td>11</td>
<td>25</td>
<td>Certain relationships unquantifiable. Certain relationships were not qualified. Family, friends, social/advocacy groups, community supports, neighbours.</td>
</tr>
<tr>
<td>64 Year Old Lesbian Cis-Female</td>
<td>0</td>
<td>4</td>
<td>7</td>
<td>4</td>
<td>15</td>
<td>Certain relationships unquantifiable. Family, friends, social/advocacy groups, community supports, neighbours.</td>
</tr>
<tr>
<td>Age</td>
<td>Gender/Sex</td>
<td>Relationship Type</td>
<td>Description</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------</td>
<td>--------------</td>
<td>-------------------</td>
<td>----------------------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>63 Year Old Lesbian Cis-Female</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>Family only.</td>
</tr>
<tr>
<td>79 Year Old Bisexual Cis-Female</td>
<td>9</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>12</td>
<td>Certain relationships unquantifiable. Family, church, community.</td>
</tr>
<tr>
<td>73 Year Old Gay Cis-Male</td>
<td>4</td>
<td>12</td>
<td>12</td>
<td>20</td>
<td>48</td>
<td>Friends only and “acquaintances who would be invited to a party.”</td>
</tr>
<tr>
<td>72 Year Old Bisexual Cis-Female</td>
<td>4</td>
<td>8</td>
<td>4</td>
<td>1</td>
<td>17</td>
<td>Certain relationships unquantifiable. Certain relationships were not qualified. Detailed descriptors of family, church, friends, neighbours</td>
</tr>
<tr>
<td>67 Year Old Lesbian Cis-Female</td>
<td>7</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>13</td>
<td>Family and friends only.</td>
</tr>
<tr>
<td>69 Year Old Gay Cis-Male</td>
<td>1</td>
<td>4</td>
<td>3</td>
<td>8 in 3 groups</td>
<td>16</td>
<td>Certain relationships unquantifiable. Detailed descriptors friends and family only.</td>
</tr>
<tr>
<td>71 Year Old Gay Cis-Male</td>
<td>0</td>
<td>2</td>
<td>7</td>
<td>7</td>
<td>16</td>
<td>No relationships were not qualified.</td>
</tr>
<tr>
<td>63 Year Old Lesbian Cis-Female</td>
<td>0</td>
<td>7</td>
<td>7</td>
<td>0</td>
<td>14</td>
<td>Family and friends only.</td>
</tr>
<tr>
<td>64 Year Old Lesbian Cis-Female</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Age</td>
<td>Gender</td>
<td>Sexual Orientation</td>
<td>Friends</td>
<td>Family</td>
<td>Pets</td>
<td>Relationships</td>
</tr>
<tr>
<td>-----------</td>
<td>--------</td>
<td>--------------------</td>
<td>---------</td>
<td>--------</td>
<td>------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>69 Year Old Gay Cis-Male</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>6</td>
<td>Friends only.</td>
</tr>
<tr>
<td>76 Year Old Gay Cis-Male</td>
<td>0</td>
<td>1</td>
<td>7</td>
<td>0</td>
<td>8</td>
<td>Family and friends only.</td>
</tr>
<tr>
<td>64 Year Old Dyke Cis-Female</td>
<td>0</td>
<td>10</td>
<td>10</td>
<td>0</td>
<td>20</td>
<td>No relationships were qualified.</td>
</tr>
<tr>
<td>64 Year Old Queer Cis-Female</td>
<td>0</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>7</td>
<td>Family, friends, pet.</td>
</tr>
<tr>
<td>78 Year Old Gay Cis-Male</td>
<td>5</td>
<td>8</td>
<td>3</td>
<td>2</td>
<td>18</td>
<td>Detailed descriptions of family, friends and a health service provider.</td>
</tr>
</tbody>
</table>