

EXPLORING THE HEALTH NEEDS OF OLDER LESBIANS AND GAY MEN IN METRO VANCOUVER

by

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ABSTRACT

Gerontological research examining the lives of older lesbian and gay adults is limited. The unique health needs of this sub-population remains unclear. This research addresses this gap by exploring the following research questions: 1) What are the specific health needs of older lesbian and gay adults? 2) How are the specific needs of older lesbian and gay adults unmet? and 3) How can healthcare agencies better address the needs of older lesbian and gay adults? This study is guided by a feminist/queer perspective synthesized with an ecological framework. In depth qualitative interviews were conducted with 17 individuals aged 50+ who reside in Metro Vancouver. Participants self-identified as either lesbian or gay and reported at least one chronic health condition. The findings of this research can be used to increase equitable health service delivery, inform policy development and resource allocation, as well as provide a foundation for critical health research.

Keywords: Lesbian; Gay; Health; Homosexuality; Aging; Older gays

Subject Terms: Older gays -- Congresses; Gerontology -- Congresses; Aging -- Congresses; Older people -- Care; Homosexuality -- Canada; Homosexuality -- Health aspects -- Canada

The 30th Anniversary of Vancouver's Pride parade illustrated the ongoing fight for human rights worldwide. Homosexuality remains illegal in approximately seventy countries and is punishable by death in seven at the time this study was published. This research is dedicated to the participants who trusted me with their expression(s) as well as those without perceived or actual freedom of expression.

This research is also dedicated to Tracy Knoop – Your life, and your death, has been part of this journey. You taught me the importance of individuality, positive thinking and living everyday to the fullest.

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CHAPTER 1: INTRODUCTION

Social scientists have documented the many social determinants of health that affect the Canadian population including gender, education, and income (Raphael, 2004). Although sexual orientation is not considered a determinant of health, mounting research indicates that it can influence health and aging. While it seems intuitive that all older adults share many common health issues, older lesbians and gay men may have additional health needs related to their sexual orientation over the life course. Notably, research suggests that health problems such as cancer, HIV/AIDS, mental health issues and substance abuse are more common among lesbians and gay men (D'Augelli *et al.*, 2001; Dean *et al.*, 2000; Ramirez-Barranti & Cohen, 2000). As health declines with age, healthcare access becomes increasingly important.

Although amendments to North American social policies have awarded lesbians and gay men greater equity and more protection against discrimination, research suggests that significant constraints accessing health services remain (Boxer, 1997; Brotman, Ryan & Cormier, 2003; Cahill, South & Spade, 2000; Dean *et al.*, 2000; Kochman, 1997; Quam & Whitford, 1992; Ryan, Brotman & Rowe, 2000). This is particularly worrisome given the rapid rate at which the population is aging. As the general population of older adults rises, an increasing number of older lesbian and gay adults will face both increased health needs and restricted access to healthcare services.

The looming discourse of apocalyptic demography underscores the eminent need for greater understanding of health needs and resource allocation (Gee & Gutman, 2000). An investigation of older lesbian and gay adults' health needs is essential to establishing

the unique health challenges of this sub-population of older adults; with this information we can begin to evaluate if healthcare services are being equitably delivered. This research investigates the specific health needs of older lesbian and gay adults and the degree to which such needs are perceived to be unmet. For the purposes of this research 'health' is conceptualized as physical, mental and social wellbeing rather than the absence of disease. Finally, this research explores crucial elements needed within a healthcare system that addresses the needs of older lesbian and gay adults.

1.1 Research Questions

The main research questions addressed in this study attend to the specific health needs of aging lesbian and gay men in Metro Vancouver. Whereas it seems intuitive that older lesbian and gay adults have the same health needs as older heterosexual adults, Canadian researchers Brotman, Ryan, and Meyer (2006) point out that there is an absence of information about the health and healthcare needs of older lesbian and gay people. Furthermore, there are indications that unmet healthcare needs among lesbians and gay men in general may also occur among older adults. This research will attend to this issue by addressing the following interrelated questions:

1. What are the specific health needs of older lesbian and gay adults?
2. How are the specific health needs of older lesbian and gay adults unmet?
3. How can healthcare agencies better address the needs of older lesbian and gay adults?

1.1.1 Health needs of older lesbian and gay adults

Studies establish that lesbians and gay men are more susceptible to substance abuse, depression, and high-risk behaviour (Dean *et al.*, 2000). More specifically, gay men have a higher incidence of contracting HIV/AIDS, and the prevalence of breast

cancer is higher among lesbians (Ramirez-Barranti & Cohen, 2000). However, there is an absence of research indicating the unique health needs and meanings of health among older lesbian and gay adults. Given this research gap, it is premature to assume that sexual orientation does not influence the health of older lesbian and gay adults.

1.1.2 Unmet health needs

In 2003, the Canadian Community Health Survey indicated that ‘homosexuals’ and ‘bisexuals’ between the ages of 18 and 59 were nearly twice as likely to report having unmet health needs (Cycle 2.1). Unfortunately, these data do not provide the prevalence rates for those aged 60+. Given the increasing importance of health associated with aging, these findings suggest that older lesbian and gay adults may also have a significant amount of unmet needs. Unmet health needs could lead to the increased likelihood of developing chronic health conditions, increased life stress and poor psychological health, and thus potentially be more expensive to the healthcare system.

1.1.3 Service improvement

The only unique need to date that has been established for older lesbian and gay adults in Canada is the desire to live in a retirement home or community that is specifically designed to address their needs (Brotman, Ryan & Meyer, 2006). The proposed research will investigate health needs beyond residential care by assessing the general health needs of older lesbian and gay adults and their recommendations for service improvements.

1.2 Gaps in the Literature & the Importance of this Research

The topic of aging and sexuality has traditionally been taboo. Institutional settings such as the healthcare system are no exception. Learning about the health needs of older

lesbian and gay adults requires education combined with a degree of comfort discussing sexuality. Prejudicial beliefs, repressive attitudes, and concerns about privacy issues make discussions about sex and sexuality uncomfortable for workers and contribute to making sexuality a neglected and often feared subject in elder care settings. This also filters up to the level of policy (Brotman, Ryan & Cormier, 2003). As a result, the health needs of older lesbian and gay adults often go unnoticed in healthcare settings and remain understudied by health researchers (Herdt & de Vries, 2004). Lack of enumeration and the inability to articulate that the lesbian and gay population is of sufficient size to justify special attention contributes to this gap in our understanding of health needs.

Furthermore, older lesbian and gay adults themselves contribute to this lack of understanding by choosing to remain invisible in predominantly heterosexual society. Older lesbian and gay adults have lived through times of intolerance and have likely experienced “hostility” throughout their lifetime (Boxer, 1997; Brotman, Ryan & Cormier, 2002 & 2003; Ryan, Brotman & Rowe, 2000, Brotman, Ryan & Meyer, 2006). Fearing that they will experience “hostility” from healthcare staff, Canadian studies show that older lesbian and gay adults may remain invisible by seeking alternative therapies, avoid disclosing their sexuality to healthcare staff, and/or avoid accessing healthcare overall (Brotman *et al.*, 2003 & 2006). The finding of this research could lead to improvements in the physical and psychological health and wellbeing of older lesbian and gay adults by making health needs and compulsory changes to health services more explicit.

With healthcare agencies not accustomed to asking questions about sexuality and older lesbian and gay adults choosing to remaining invisible, there is an absence of

Canadian research on the topic of aging, homosexuality and health. However, baby boomers have been traditionally known to demand accommodations for their healthcare needs. This tendency suggests that policy makers and healthcare professionals will increasingly be forced to recognize the needs of older lesbian and gay adults. The results of this study could have significant implications for health policies. Indeed, these findings could influence the delivery of health services for older adults with respect to resource and service allocation and provide a foundation for further research.

Finally, it has been recognized that obtaining a representative sample of older lesbian and gay adults is “an impossible task” (Lee, 1987). Most research to date on the topic of aging and homosexuality has lumped the diverse group of lesbian, gay, transsexual /transgendered, bisexual, intersexed, and two-spirited people together. These studies typically have insufficient sample sizes based on convenience samples of white, middle-class, educated people who live in urban areas and frequent gay bars (Boxer, 1997). This research focuses only on the health experiences of older lesbian and gay adults who reside in Metro Vancouver (formerly known as the Greater Vancouver Regional District - GVRD). This geographical area is populated by individuals from a wide array of different backgrounds ranging from low income residents living in the Downtown East Side to high income residents residing on the North Shore.

CHAPTER 2: REVIEW OF THE LITERATURE

A review of the literature was conducted to establish a contextual understanding of potential factors influencing the health needs and/or health status of older lesbian and gay adults. This chapter begins by estimating the prevalence of older lesbians and gay adults in Canada and a brief summary of the legislative changes and social-historical context in which older lesbian and gay adults have aged. Health status and the experiences of older lesbian and gay adults accessing healthcare will be discussed followed by a summary of the limited Canadian research available on the health of older lesbian and gay adults.

2.1 Estimating the Prevalence of Older Lesbian and Gay Adults

In the 1940s the ‘father of sexology,’ Alfred Kinsey estimated that 10% of Americans were homosexual. However, Kinsey’s controversial research methods have been questioned by academics and challenged by studies that indicate significantly lower numbers. In 2000, Dean *et al.* estimated between 1.4% and 4.3% of women and 2.8% and 9.1% of men in the United States are classified as lesbian, gay, or bisexual warning that these estimates sharply increase in larger urban centres. The Canadian Community Health Survey (CCHS) marked the first time that Statistics Canada included questions about the sexual orientation of Canadians (Cycle 2.1, 2003). Results indicate 316,800 people or 1.7% of the population self-identify as homosexual or bisexual with the largest portion residing in Quebec (2.3%) followed by British Columbia (1.9%). Grouped by age these data indicate that a majority (2.0% of the total Canadian population) of homosexuals and bisexuals are between 18 and 34, followed by 1.9% between age 35 and 44, and 1.2% between age 45 and 59.

Although population estimates are not available for all age groups, the numerical trend of these data suggests that approximately 1% of Canadians over the age of 60 could be homosexual or bisexual. However, the reliability of these data is questionable. Of all provinces, five warn that the data are not reliable, and one is too unreliable to be published due to high sampling variability. Unreliable statistics could be attributed to a general reluctance of enumeration for fear of persecution. Furthermore, this phenomenon may be more pronounced among the older population of lesbian and gay adults given greater stigma in the past. The demographic trends of older lesbian and gay adults are omitted in British Columbia's *Fact Book on Aging* (2006) for the same reasons.

2.2 Historical Context and Legislative Changes

The gay rights movement has led to legislative changes that have improved the social status of lesbians and gay men in Canada. Before the Canadian federal government decriminalized homosexuality in 1969, it was commonly deemed a religious sin, a mental illness, and/or deviant behaviour. Psychologists such as Krafft-Ebing, Moreau, and Freud developed theories on the pathology of homosexuality (Kochman, 1997). As a result, health professionals believed that the health needs of lesbians and gay men included harsh treatments like *Aversion* and *Electric Shock Therapy*. In fact, the American Psychological Association (APA) did not remove homosexuality from their Diagnostic and Statistical Manual of Mental Disorders (DSM-II) until 1973.

Throughout the last 40 years, Canada has begun to amend social policies that subordinate lesbians and gay men. A significant legislative change was an addition to the Human Rights Code making it unlawful to discriminate on the basis of sexual orientation. Furthermore, some provinces have legislated same-sex adoption, the federal government

legislated gay marriage, and the Ontario Court of Appeal granted same-sex partners retroactive survivor benefits for CPP contributions (CBC News Online, 10/27/2004). These events triggered a ‘coming out’ process starting in the 1990s which in turn cultivated more media coverage, reduced common stereotypes, and brought ‘queer’¹ issues to light.

2.3 Unique Health Concerns and Contexts

The influence of social determinants on individual health has become customary. In his assessment of the health dynamics of baby boomers, Wister (2005) explains that maintaining a healthy lifestyle is a lifelong process shaped by specific health behaviours that are constructed by a person’s social network, social status, social expectations, and health beliefs. Social conditions impact the health of lesbians and gay men in a number of ways. Given the social environment in which older lesbian and gay adults have come of age, their health status could be particularly influenced. The following section outlines key health concerns found in the literature.

2.3.1 Unmet health needs

The first Statistics Canada dataset capturing sexual orientation as a variable was collected in 2003. Cycle 2.1 of the Canadian Community Health Survey (CCHS) asked, “Do you consider yourself to be heterosexual, homosexual-that is lesbian or gay, or bisexual?” With respect to health needs, survey respondents were asked “During the past 12 months, was there ever a time when you felt that you needed healthcare but didn’t receive it?” Respondents who answered ‘yes’ were asked to think about the most recent

¹ The word ‘queer’ appears throughout this document to: a) reference Queer Theory, and b) to refer to the LGTB community at large. The word ‘queer’ may or may not fit with the lived experiences of the participants or their understanding(s) of what it means. Research indicates that language such as ‘queer’ has unpredictable meanings and outcomes (Norton, 2002).

time and explain why they didn't get it. Interviewers were given a probable list of 16 reasons and instructed to record all that apply: 1) not available – in the area, 2) not available – at time required, 3) waiting time too long, 4) felt would be inadequate, 5) cost, 6) too busy, 7) didn't get around to it / didn't bother, 8) didn't know where to go, 9) transportation problems, 10) language problems, 11) personal or family responsibilities, 12) dislikes doctor / afraid, 13) decided not to seek care, 14) doctor – didn't think it was necessary, 15) unable to leave the house because of a health problem, and 16) other - specify.

The findings reveal that 21.8% of 'homosexual' or 'bisexual' people between the age of 18 to 59 report having unmet health needs compared to 12.7% among heterosexual adults of the same age group. Thus, 'homosexuals' and 'bisexuals' were nearly twice as likely to report having unmet health needs. These data do not capture the health status of older lesbian and gay adults over the age of 60. However, it should be noted that CCHS data also indicate that older adults are the least likely to report unmet healthcare needs compared to other age groups. Only 8.1% of older adults aged 65+ report unmet needs compared to over 13% among people age 12 to 34 and 35 to 64.

2.3.2 Communication Barriers

Lesbian and gay men face significant obstacles communicating with healthcare providers. In 1994, the membership of the Gay and Lesbian Medical Association was surveyed (O'Hanlan *et al.*, 1997). Over half (67%) of the 711 respondents reported observing substandard or denial of care to lesbian and/or gay patients, and 88% reported that their physician colleagues had made publicly disparaging remarks about gay and/or lesbian patients. Although 98% of respondents felt it medically important to disclose

sexual orientation with physicians, 64% believed that by doing so, patients risk receiving substandard care. In Canada, 32 older lesbian and gay adults and community partners participated in four focus groups conducted in three cities (Halifax, Montreal, and Vancouver). These discussions reveal that healthcare institutions and health professionals are perceived as the largest perpetrators of oppression and discrimination (Brotman *et al.*, 2003). More specifically, older lesbian and gay adults report experiencing the following treatment by healthcare professionals at some point throughout their lifetime:

...embarrassment, anxiety, inappropriate reactions, direct rejection of the patient or exhibition of hostility, harassment, excessive curiosity, pity, condescension, ostracism, refusal of treatment, detachment, avoidance of physical contact, and breach of confidentiality (Brotman *et al.*, 2003, pg.192).

These findings could be attributed to the failure of medical schools in educating providers and researchers on the unique health concerns of lesbians and gay men. Of the 126 medical schools in the US in 1991, 82 (65%) responded to a survey assessing the number of curriculum hours devoted to the topic of homosexuality (Wallick, Cambre & Townsend, 1992). The mean number of hours reported across four years of study was three hours and 26 minutes. Although a similar inventory of Canada's medical schools cannot be found there is some research supporting the prevalence of homophobia among Canadian physicians and physicians-in-training. In 1995, 501 general interests were surveyed to identify the frequency of psychological and emotional abuse, gender discrimination, verbal sexual harassment, physical sexual harassment, physical assault and homophobia (Cook *et al.*); approximately 40% reported homophobic remarks by both staff and patients.

The following year research was done to survey the extent to which internal medicine housestaff experience abuse and discrimination in their training (vanInveld, Cook, Kane, King, 1996). Of 543 residents in training (in 13 programs) half of the residents reported racial discrimination and homophobic remarks in the workplace committed by all groups of health professionals. The authors concluded that psychological abuse, gender discrimination, sexual harassment, physical abuse, homophobia, and racial discrimination are prevalent during residency training. Thus, it seems likely that gay and lesbian physicians in training face considerable challenges. In 2000 the Canadian Medical Association Journal published a qualitative study surveying 29 gay and lesbian medical students and residents in four cities (Risdon, Cook, Willms). The results indicate that sexual orientation had an effect on all participants' decision to enter and remain in medicine. Their risk assessment was influenced by the presence of identifiable supports, inclusive curricula, and policies reprimanding discrimination based on sexual orientation. Thus, there is research endorsing the problem of homophobia in the Canadian medical profession and medical training. Physicians may be unprepared to engage in an appropriate dialogue on the topic of sexual orientation and could furthermore be unaware of why this communication is necessary (Dean *et al.*, 2000).

Failure to establish rapport with physicians is associated with decreased levels of adherence to physician advice and treatment plans, and decreased rates of satisfaction (Dean *et al.*, 2000). White and Dull (1998) surveyed a convenience sample of 324 lesbians in Portland Oregon to attain insight on lesbians' perceptions of communication with their primary care provider. Although 65.3% reported having primary care physicians, 31.6% received primary care from alternative providers including naturopaths, chiropractors and nurse practitioners. Respondents rated alternative

providers easier to communicate with than physicians (4.53 vs. 3.99, $p \leq .001$) and believed that alternative providers understand lesbian health needs better than medical doctors (4.21 vs. 3.45, $p \leq .001$). Of the respondents who were 'out' to their primary care physician, they were more likely to seek health and preventative care ($p \leq .05$), to have had a pap smear ($p \leq .02$), and feel comfortable discussing sensitive issues ($p \leq .0001$). Hence, disclosure of sexual orientation has been associated with positive health behaviours. Altogether, research on communication between younger lesbians and gay men and healthcare professionals suggests that communication could be a significant influence on health. There is no research indicating the degree to which Canadian older lesbian and gay adults are influenced by past or present communication with healthcare providers.

2.3.3 Cancer

Some research designates lesbians have increased risk factors for the development and increased morbidity of breast and gynaecologic cancers (Boxer, 1997; Dean *et al.*, 2000; Ramirez-Barranti & Cohen, 2000; Ryan *et al.*, 2000). Risk factors include obesity, alcohol consumption, nulliparity, less birth control pill use, and lower rates of screening (O'Hanlan *et al.*, 1997). Both lesbians and their healthcare providers neglect breast cancer screening (Ryan, Brotman & Rowe, 2000). Breast cancer affects one in eight American women. However, Rounds (1993) reports that lesbians have a one in three lifetime risk of developing breast cancer.

With regard to gay men, research also points to increased incidence in some cancers. Between 1978 and 1980, Koblin *et al.* (1996) traced incidence of cancer in 15,565 gay men from New York and California. Cancer registries and the National Death Index, indicated excessive incidence of non-Hodgkin's lymphoma (SIR = 12.7;

95% CI), Hodgkin's disease (SIR = 2.5; 95% CI), and anal cancer (SIR = 24.2; 95% CI). The authors found that increased risk for both non-Hodgkin's lymphoma and Hodgkin's disease was related to human immunodeficiency virus (HIV) comorbidity; anal cancer was unrelated. There is some research indicating that anal cancer is increased by anal intercourse, the human papillomavirus (HPV), and anal squamous intraepithelial lesions (ASIL) (Dailing *et al.*, 1987).

Innovative research in psychoimmunology draws attention to an association between psychological stresses, reduced immunity and tumor growth (Cole *et al.*, 1996; Stevens & Hall, 1988). Given the increased likelihood of risk factors and years of living in stressful social environments, cancer screening and prevention could be a significant health need for older lesbian and gay adults.

2.3.4 HIV/AIDS

In 2006, positive tests for HIV and AIDS totalled 2,557 and 269 respectively in Canada (*HIV and AIDS in Canada*, 2007). Although heterosexual exposure has increased to an all time high of a third of new reported cases among adults (33.2% in 2006; HIV endemic country + sexual contact with person at risk + no identified risk-heterosexual), men who have sex with men (MSM) account for the largest proportion of new HIV cases (40.8% in 2006; MSM + MSM/injection drug use). Interestingly, the proportion of annual positive HIV tests among adults 50+ increased from 7.6% between 1985 and 1998 to a high of 13.8% (350) in 2006; two-thirds of positive HIV tests with exposure information were attributed to MSM (35.1%) and heterosexual contact (31.6%) (*HIV/AIDS Epi Updates*, 2007). The United States Center for Disease Control and Prevention (CDCP) report similar findings (*HIV/AIDS Surveillance Report*, 2008). This

increase is attributed to the common belief that aging people are asexual, that HIV/AIDS is only a gay man's disease, and poor preventative health precautions as pregnancy no longer motivates the practice of safe-sex (Dean *et al.*, 2000; Ramirez-Barranti & Cohen, 2000). Although lesbian sex is not a major mode of transmission of HIV/AIDS, injection drug use and sex with men put women at risk.

Shankle *et al.*, (2003) note that there has been some research on the impact of HIV/AIDS on older adults. They note the following general concerns among HIV positive older lesbian and gay adults: 1) could be more symptomatic compared to younger individuals, 2) may elevate the risk of cancers, cognitive impairment, and mortality, 3) may have increased difficulty metabolizing treatment drugs, 4) may have increased risk of sexual dysfunction related to treatment drugs, 5) may feel marginalized by peers and services for people with HIV/AIDS, and 6) there may be increased caregiving responsibilities associated with HIV/AIDS. It is thus likely that the health of older lesbian and gay adults is influenced by HIV/AIDS.

2.3.5 Mental Health

Prevalence rates of mental illness among older lesbian and gay adults in Canada have not been researched. However, CCHS data indicate that among individuals age 18 to 59, homosexuals and bisexuals (35%) are more likely than heterosexuals (28%) to find life stressful (Cycle 2.1, 2003). Although methodologically sound research on this issue is lacking, available American research remains inconclusive with regard to a higher prevalence of mental illness among older lesbian and gay adults (Shankle *et al.*, 2003). There have been a number of studies reporting increased psychological acceptance of the aging process and higher life satisfaction compared to heterosexual older adults (Brown

et al., 2001; Friend, 1989 & 1991; Howell & Beth, 2004; Quam & Whitford, 1992; Shippy, Cantor & Brennan, 2004; Waite, 1995; Whitford, 1997). A commonality among these studies is the belief that older lesbian and gay adults have increased crisis competence when faced with challenges associated with aging (Kimmel, 1978). Augmented coping mechanisms have been attributed to managing the stigma of sexual orientation throughout the lifecourse. The results of Lee's (1987) study however failed to confirm that aging homosexual men have better crisis competence.

In another study, Dorfman *et al.* (1995) surveyed a convenience sample of homosexual (23 female & 33 male) and heterosexual (32 female & 20 male) older adults (n=108) in urban Central and Southern California to test the assumption that older lesbian and gay adults are more depressed and socially-isolated than their heterosexual counterparts. The findings reveal no significant differences in depression or social isolation but found that older lesbian and gay adults get more support from friends compared to family. Yet, another study examining mental health among a convenience sample of 416 older lesbian and gay adults aged 60 to 91 found that men reported significantly more internalized homophobia, alcohol abuse, and suicidality related to their sexual orientation when compared to women (D'Augelli *et al.*, 2001). Diminished mental health was significantly associated with increasing age, low rates of self-reported health and cognitive functioning, living alone, having no children, lower self-esteem, and being lonely. Reasons for the mixed findings described above could relate to methodological flaws such as lack of representative sampling and sampling bias. Participants were drawn from older lesbian and gay adults belonging to gay-identified agencies and thus may not reflect the feelings of older adults who have not acknowledged

their sexual orientation publicly. Regardless of confounding research, older lesbian and gay adults could have increased mental health needs.

Also related to the mental health of older lesbian and gay adults is the psychological influence of body dissatisfaction associated with aging. It is commonly believed that gay culture places increased emphasis on the physical attractiveness of gay men and decreased emphasis on lesbians. One study of 247 adult homosexuals (N=127) and heterosexuals (N=130) found that gay men were more distressed in many psychosocial areas related to body dissatisfaction compared with heterosexual men; and were thus at greater risk of developing an eating disorder (Beren *et al.*, 1996). Interestingly, the study found no significant differences between lesbians and heterosexual women in body dissatisfaction. The mean ages of the groups in this study were 34 years for lesbians, 18 years for heterosexual men, 30 years for gay men, and 18 years for heterosexual men. Similar research pertaining to older lesbian and gay adults is unavailable. However, as nutrition and food security becomes more important with age, body dissatisfaction or a lack of dissatisfaction leading to obesity could influence the health of older lesbian and gay adults.

2.3.6 Substance Abuse

The prevalence of substance abuse among older lesbian and gay adults in Canada remains unknown. However, studies with younger lesbians and gay men indicate that compared to the general public they are more likely to use alcohol and drugs and have higher rates of substance abuse (Bickelhaupt, 1995; Bradford, Ryan & Rothblum, 1994; Dean *et al.*, 2000; O'Hanlan *et al.*, 1997; Shankle *et al.*, 2003). The American National Lesbian Health Care Survey found that almost one third used tobacco on a daily basis,

30% drank alcohol more than once a week, and 6% drank alcohol daily (Bradford, Ryan & Rothblum, 1994). Dean *et al.* (2000) document a number of studies indicating higher rates of marijuana, cocaine, 'poppers', methadone and psychedelics related to unsafe sexual behaviour. Even though research on substance abuse and aging lesbians and gay men is unavailable, an increased history of substance abuse among older lesbian and gay adults seems probable. Lingering effects of substance abuse and/or continued use could impact their health needs.

2.3.7 Violence, Sexual Assault & Abuse

Research on aggressive behaviour toward lesbians and gay men has been done in the area of childhood sexual abuse, adult sexual assault, domestic violence among same-sex partners and hate crimes (Dean *et al.*, 2000). In 1992, a meta-analysis of 23 surveys given to American lesbians and gay men observed that 17% had been physically assaulted, 44% had been threatened with violence, and 80% had been verbally assaulted (Berrill, 1992). Historical experiences of aggressive behaviour could influence the help seeking behaviour of older lesbian and gay adults. Shankle *et al.* (2003) explain that aging lesbians and gay men have spent a significant amount of their life fighting the fear of being outed and associated societal stigma; thus, they create an existence free of the need to depend upon the outside world and may unfortunately choose self-neglect over becoming dependent on healthcare institutions. Similarly, Brotman *et al.* (2006) found that among 38 interviews with older lesbian and gay Canadians, there was a common desire to live in a retirement home or community that is specifically designed to address the needs of aging homosexual adults due to corresponding fear or mistrust of mainstream residential care settings. Fear of institutional environments and dependency

could relate to prior incidence of violence, sexual assault, and/or abuse. Even though the specific housing needs of older lesbian and gay adults were not outlined, this study stresses that aging lesbians and gay adults may be fearful or uncomfortable accessing community-based healthcare services. It was further suggested that older lesbian and gay adults would benefit from the protection of policies if homophobia was added as grounds for elder abuse. In sum, past experiences with violence, sexual assault and abuse could have an influence on the actual and perceived health needs of older lesbian and gay adults.

2.4 Accessing Healthcare

Lesbians and gay men face multidimensional barriers accessing healthcare services. Consequently, North American researchers describe older lesbian and gay adults as having lost faith in healthcare institutions and subsequently avoid accessing medical attention as much as possible (Boxer, 1997; Brotman *et al.*, 2002; Cahill, South & Spade, 2000; Ramirez-Barranti & Cohen, 2000; Ryan *et al.*, 2000; Shankle *et al.*, 2003). There is some evidence indicating that older lesbian and gay adults are more likely to use alternative therapies such as naturopathy and chiropractic services (Ryan *et al.*, 2000). Reasons for not seeking traditional healthcare among a convenience sample of 503 women (73% lesbians) include: 1) low-cost/alternative care is not provided, 2) little prevention care and education are provided, 3) lack of communication and respect, and 4) few women-managed clinics (Trippet & Bain, 1992). There is no Canadian research describing a relationship between accessibility, perceived accessibility, and the use of alternative therapies among aging lesbians and gay adults.

The issue of accessible healthcare and perceived access is important to the understanding of health needs. Feelings of anxiety associated with perceived barriers could prevent older lesbian and gay adults from receiving preventative care as well as care for acute conditions; this could lead to a systematic avoidance of healthcare services. The implications of avoiding healthcare could thus increase unmet health needs and decrease the overall health and wellbeing of older lesbian and gay adults. The following section is a summary of large-scale institutional barriers, community-level barriers, and individual-level barriers that could influence access to healthcare.

2.4.1 Institutional Barriers

Ettlebrick (1996) notes that older lesbian and gay adults and their partners experience lack of legal protection. For example, in instances where there is a lack of advanced directives, the law often does not recognize same-sex partners as legal substitute decision makers. Another common barrier is the failure of community needs assessment and census surveys to identify sexual orientation. This contributes to the overall lack of information on aging lesbians and gay adults (Anetzberger *et al.*, 2004; Boxer, 1997; Cahill *et al.*, 2000; Clark *et al.*, 2001; Ramirez-Barranti & Cohen, 2000). Furthermore, the inability to enumerate older lesbian and gay adults can lead to underestimating the actual size of this sub-group. This omission could lead to the assumption that aging lesbians and gay adults are not sufficient in size to justify special attention or be considered for priority funding (Navarro, 2002; Ryan *et al.*, 2000), and are thus overlooked during planning initiatives (Harrison, 1999; Ryan *et al.*, 2000). Another key barrier includes the failure to incorporate materials on older lesbian and gay adults within geriatric education curricula and professional licensing examinations (Cahill *et al.*,

2000; Harrison, 1999; Ryan *et al.*, 2000). Moreover, Hamburger (1997) explains that proprietary housing and healthcare services are inadequate for older lesbian and gay adults. Brotman *et al.* (2002, 2003) highlight that there is a lack of policies prohibiting discrimination on the basis of sexual orientation. Finally, there is an insufficient amount of advocacy and lobbying in political forums that leads to an overall lack of political accountability (Harrison, 1999).

2.4.2 Community-Level Barriers

On a smaller scale, health barriers exist in the community among healthcare staff and within practice. Employers fail to consider the ideologies of staff in relation to lesbian and gay issues and staff fail to address concerns related to the sexuality of older adults (Dean *et al.*, 2000). Some research describes intake procedures as a significant barrier citing that healthcare agencies and researchers routinely ask heterosexually-biased questions (Dean *et al.*, 2000; Ryan *et al.*, 2000; White & Dull, 1998). Furthermore, healthcare agencies commonly fail to create a culture of inclusiveness that is free of homophobia and heterosexism (Brotman *et al.*, 2002; Ryan *et al.*, 2000). In addition, staff training modules on diversity commonly focus on ethno-racial issues and exclude issues related to sexual orientation (Dean *et al.*, 2000). Quam and Whitford (1992) note that there are limited resources/directories indicating gay-friendly healthcare services. Moreover, healthcare resources for older lesbian and gay adults are also limited in the gay community. Studies describe the needs of older lesbian and gay adults as unrecognized due to the youth-oriented focus of the community (Brotman *et al.*, 2003; Cahill *et al.*, 2000; Maccio & Doueck, 2002; Ramirez-Barranti & Cohen, 2000). Another

major issue is the lack of domestic partner recognition and benefits for same-sex partners other than in the province of Ontario (Cahill *et al.*, 2000; Etlebrick, 1996; Metz, 1997).

2.4.3 Individual Barriers

Aging lesbian and gay adults also meet individual barriers when accessing health services. Studies reveal that internalized experiences of heterosexism and/or homophobia can result in a desire to remain invisible, go ‘back into the closet’, as well as develop distrust for authority and established organizations (Boxer, 1997; Brotman *et al.*, 2002; Dean *et al.*, 2000; Ramirez-Barranti & Cohen, 2000; Ryan *et al.*, 2000; Shankle *et al.*, 2003). In turn, older lesbian and gay adults could increase their risk of the negative social, psychological, and physical health outcomes associated with isolation. In sum, it can be argued that aging lesbian and gay adults may not be receiving equitable healthcare on many levels compared to older heterosexual adults. If substantiated, this situation would violate the principle of accessibility under the Canadian Health Act.

2.5 Canadian Research on Older Lesbian and Gay Adults

In 2003, Brotman *et al.* (2006) launched a three-year participatory qualitative research project to uncover multiple experiences of care with respect to access and delivery of services to older lesbian and gay adults and their caregivers. It is the first research study on the topic of aging lesbians and gay men in Canada. Between February 2003 and January 2006, two phases of this project took place in three regions across Canada (Quebec, Nova Scotia, and British Columbia). The authors used the snowball technique to recruit participants in each location. Participants addressed the following questions: 1) What are the experiences of older lesbian and gay adults in accessing healthcare services in the community? 2) What are the experiences and perspectives of

caregivers caring for older lesbian and gay adults? and 3) How well understood are the needs, realities and experiences of older lesbian and gay adults and their caregivers by health and social service providers? How well prepared is the healthcare sector to respond to these needs?

Data for the first phase of the study was generated through four focus group sessions (1=Quebec, 1=Nova Scotia, 2=British Columbia). Thirty-two people ranging from older lesbian and gay adults to representatives from governmental political bodies participated in four tape-recorded group discussions that lasted approximately two hours. The discussions were transcribed, analysed for common themes, tested for intercoder reliability and followed by member checking to insure accuracy. The results, published in 2003, indicate that the profound marginalization experienced by older lesbian and gay adults in all aspects of social and political life was the most frequent theme. More specifically, participants discussed the impacts of discrimination on health, difficulties accessing health services, issues relating to invisibility, barriers to care, and the nature of service options for aging lesbian and gay adults. Recommendations for change were indicated.

Phase two of the study involved 90 open-ended qualitative interviews across the three provinces (Montreal n=29, Vancouver n=37, Halifax n=24) with older lesbian and gay adults (n=38), caregivers (n=21), and service providers (n=31). Only five participants self-identified as a member of an ethno-cultural community. In March 2006, the executive summary (Brotman *et al.*, 2006) of the findings discussed three common themes: 1) identity, 2) discrimination, and 3) service use. In relation to health needs, older lesbian and gay adults expressed that invisibility and isolation was their most

common difficulty. Most aging lesbian and gay adults expressed a need for specialized homecare and residential care services. Recommendations to “put ‘A. S.T.O.P.P’ (Advocacy, Social & political voice, Training & education, Outreach, Policy, Practice) to institutionalized homophobia and heterosexism” were indicated. Thus, this study has many important implications with respect to the understanding and awareness of the health experiences of older lesbian and gay adults, their caregivers, and the health services that serve them. Recommendations from this research call for increased training and education to social groups and health organizations on older lesbian and gay adults’ needs.

The main limitation of the Brotman and colleagues study is that health needs are not specifically outlined within this research. It is unclear whether participants feel that they have unmet health needs, what needs (other than proprietary housing) are specific to older lesbian and gay adults, and how they would like to see healthcare agencies specifically address these needs. A second major limitation of this study is that it failed to indicate how the ‘health and social service needs’ are similar to or different from participants from ethno-cultural communities. For example, it remains unclear whether ‘ethnic’ aging lesbians and gay adults have specific health needs compared to ‘white’ counterparts. Other limitations include the absence of theoretical grounding and the use of a small, non-random convenience sample. Participation in this study is also limited to those from urban centres who are more likely to be open about their sexual orientation and therefore may not accurately represent the population in rural communities.

2.6 Research Limitations

In order to better understand older lesbian and gay adults through previous studies, it is important to recognize their limitations. Research in the area of homosexuality is fraught with methodological limitations. First, there is no general consensus with respect to definitions and measures of sexual orientation. Laumann *et al.* (1994) explain that the definition of sexual orientation could be considered a sexual identity, a sexual behaviour, or a sexual attraction. This highlights the possibility that older lesbian and gay adults' perception of their sexual orientation could have changed over time and self-reported orientation may not be consistent. Thus, variance in definitions across studies limits the ability to draw reliable comparisons. Another important consideration is the influence of cohort effects such as WWII, the McCarthy era, pre and post civil rights movement, and the advent of AIDS (Shankle *et al.*, 2003). These cohort effects may have uniquely influenced the lives of aging lesbian and gay adults. In addition, issues relating to race, ethnicity and religion should be taken into consideration as each group could have unique morals and traditions related to sexual behaviour (Shankle *et al.*, 2003).

Sampling methods with members of a population who are hard to locate are limited. To date, the CCHS (Cycle 2.1) is the only population-based research study in Canada that addressed some of the social conditions of aging lesbian and gay adults. Other research examining the experiences of older lesbian and gay adults sample from middle-class highly educated Caucasian males and lesbians who: are out are out of the closet, members of lesbian/gay organizations, and live in urban centres (Shankle *et al.*, 2003). Participants are more likely to be biased through selection as sample sizes are typically small and almost always non-random. Among older lesbian and gay adult samples, selection bias could be more prevalent if participation is dominated by people

who are generally more public about their sexual orientation. Furthermore, these sampling limitations could influence the quality and quantity of data, increase the variance among research, and make it more difficult to draw comparisons in the literature. With limited research available on the health of aging lesbian and gay adults, these limitations are important to consider when reviewing the literature.

CHAPTER 3: THEORETICAL FRAMEWORK

Ideally, public healthcare services are shaped and re-shaped to address the evolving health needs of society. The creation and ongoing maintenance of healthcare services is multidimensional; it involves policy and institutional organizations, the health professionals who carry out policy in communities, and the individuals who receive health services. In order to address this dynamic process with respect to the health needs of older lesbian and gay adults, this research is guided by a feminist/queer perspective synthesized with an ecological framework. The chapter begins by outlining both the feminist and queer perspectives followed by the ecological framework. The rationale for adopting these perspectives and how they complement each other for the purposes of this research is discussed.

3.1 Feminist/Queer Perspectives

As early as the late 19th century, the feminist perspective has been an organized movement aimed at combating the unfair treatment of women as compared to men. The feminist perspective has been criticized for perpetuating inequality based on gender through its strict emphasis on women's issues; thus, men are disadvantaged by feminism because it assumes they have inherent privileges and focuses less on issues men face. Up until the 1960s and 70s, feminism was largely focused on the plights of white, western, middle-class women claiming to represent all women (Clarke, 2000). Consequently, feminist theorists began to challenge the assumption that women constitute a homogeneous group. Since then, the focus of feminist theory and feminist activism has broadened to capture diverse communities as well as the relationships of gender, sexuality, ability/disability, race, class, and ethnicity combined. Although there are many

varieties to the feminist approach, there are some common themes. Clarke (2000) explains that feminist theory and research can be distinguished by the following principles:

- 1) By virtue of gender, men and women occupy different places in the social structure and live in distinct yet overlapping cultures.
- 2) Men tend to dominate in all institutions in society. They tend to have more power, more money, and more access to all types of resources.
- 3) Sociology, including the sociology of health, illness, and medicine, has historically reflected male dominance with respect to subject matter and styles of theorizing and research.
- 4) Feminist researchers theorize, problematize, describe, and explain the social world so that women and gender are always central foci. (p.23)

The main strengths of the feminist perspective include the focus on ethnicity, power, class, sexuality, gender, how they intersect, and the associated outcomes. Feminism highlights the elements of society that afford some people a relative position of advantage and disadvantage. The literature review reveals that older lesbian and gay adults have more likely experienced discrimination and oppression due to their sexual preference; and may even continue to experience it today. Thus, the historical context that older lesbian and gay adults have come of age could influence their perceptions and understanding of entitlement, healthcare and personal health needs. To meaningfully understand the health needs of aging lesbian and gay adults it is also important to be aware of how past personal experiences influence perceptions of health. This research used the feminist perspective during interview dialogues and analysis to better understand the dynamic perspectives of older lesbian and gay adults and their perception of health needs.

Also related to this perspective is the underlying premise of *Queer Theory* which grew out of gay/lesbian studies and the feminist perspective (Kirsch, 2000; Wilchins,

2004). While feminists are concerned with the separation of social and biological identities by insisting that gender is not an essential aspect of an individual's identity, queer theorists are concerned with the rejection of all essential categories. Essentialism describes the belief that there are specific characteristics that define membership and belonging. For example, women must embody specific characteristics to be recognized as a 'good' member of the female group. In this regard, queer theorists mandate the blurring of all defining essentialist categories. The beginnings of queer theory are rooted in early 1970s disengagement with leftist politics (Kirsch, 2000). The word 'queer' espouses notions of oddity, peculiarity, and things out of the ordinary. Hence, queer theorists are concerned with all forms of sexuality that are non-normative and by association, to normative identities and behaviours that define things as 'queer'.

Queer theorists resist essentialist notions of identity; especially those pertaining to sexuality. They believe that social constructions associated with sexual identities lead to inaccurate social, political, and cultural consequences. The main focus of this approach is the 'queering' of identities and rejection of categorization handed down by dominant power structures (Kirsch, 2000). In principle then, queer theorists do not present this theory as a formal, static and essential framework but are rather fluid and detached on purpose. Hence, this approach has been criticized for being less of a formal theory and more of a social movement (Kirsch, 2000).

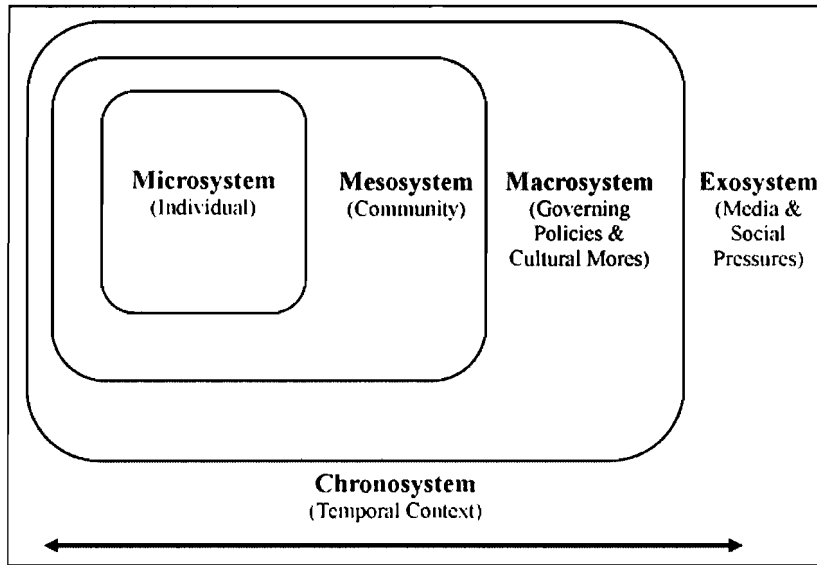
Although any application of queer theory seems contrary to its fundamental anti-essentialist quality, this research used it to emphasize the subjective nature of social research and the need for self-reflection during the research process. To foster a more complete understanding of older lesbian and gay adult's health needs, researchers must

interpret and organize information. A review of the literature reveals that older lesbian and gay adults could have untraditional health needs and/or perceptions of health. Even though research requires the categorization of information, queer theory encourages the researcher to be reflexive about how information is being interpreted and categorized. This is particularly important for exploratory research of this kind because the researcher is an ‘outsider’ (i.e. not a member of the aging lesbian and gay community) studying uncommon aspect of health and aging.

3.2 Ecological Framework

Bronfenbrenner’s *Ecological Theory* of social environments (1986) can help conceptualize the multidimensional health needs of older lesbian and gay adults. This framework is useful for examining the different levels of society and the relationships between each level (Stokols, 1992). Bronfenbrenner emphasized that people are embedded in a series of nested environmental systems that interact with one another. Rooted in child development, this framework helps explain the ways in which environmental systems influence development. In other words, interconnections among governments, communities and individuals are deemed to foster human development. This model is illustrated in Figure 3.2.1.

Figure 3.2.1 Bronfenbrenner's Ecological Model



Source: Adapted from Bronfenbrenner, 1986.

The macrosystem represents the social context of society at large. It includes all values, norms, policies, and institutional/cultural laws that govern the public. It is the largest system influencing all others. The mesosystem represents areas where connections between immediate and larger environments are made. This includes communities, neighbourhoods, and settings where public services are delivered. The microsystem represents the individual's immediate environment. Finally, the exosystem is defined as external settings that individuals do not participate in directly but are nonetheless affected by decisions and outcomes. An example of exosystem influence is the progression of the gay rights movement. Although this model is comprehensive in capturing the different levels of society, its particular strength is the chronosystem. This element of the model highlights the significance of time in relation to social systems.

The social-ecological framework described above incorporates a variety of concepts from systems theory (Stokols, 1992). The basic assumption of this framework

is that health is a complex and multileveled phenomenon. Although the strength of this framework is multidimensionality, it has been criticized for being too inclusive. For example, it may be difficult for researchers to examine smaller components or focus on specific interactions. However, the ecological framework provides a way to conceptualize the complexity of human environments and is less of a scientific theory than a concept map that can be used to hypothesize and test specific phenomena.

To understand the health needs of older lesbian and gay adults, a multidimensional framework is needed to integrate individual (micro), community (meso), and structural (macro) level factors. A review of the literature reveals that health concerns and potential barriers to healthcare services among aging lesbian and gay adults can range from personal attributes to organizational factors. Bronfenbrenner's ecological approach is useful in examining the multiple ways in which micro processes (older lesbian and gay adults' needs) and meso/macro (structure of health services) interact to affect health. The social ecological component of the chronosystem will give a temporal component to the understanding of health needs. More specifically, the health experiences of older lesbian and gay adults could be influenced by past experiences, changing social policies, etc. This consideration of time could help gain a deeper understanding of perceived health and healthcare behaviours.

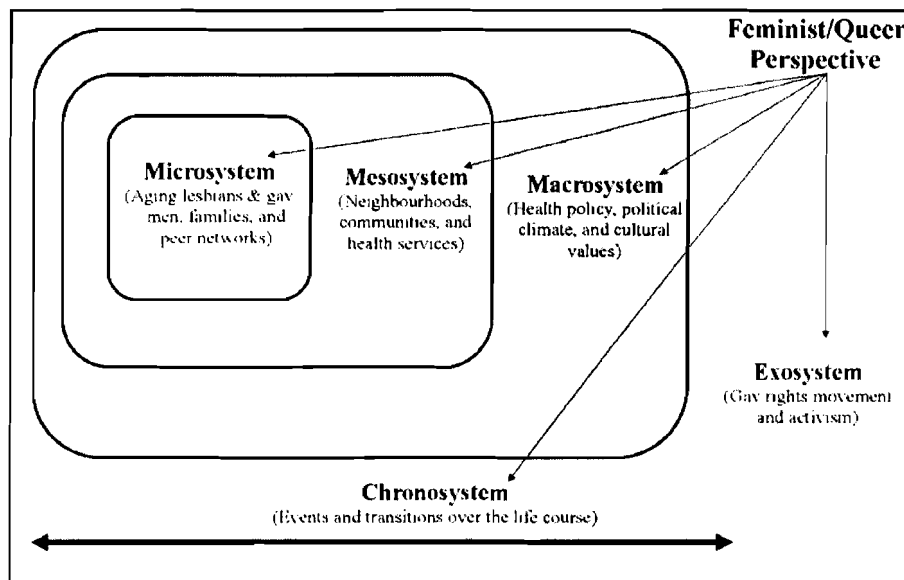
3.3 Applying a Feminist/Queer Perspective to an Ecological Framework

The interpretation of participant responses should be guided by a perspective that considers the social conditions of older lesbian and gay adults. The social-ecological approach to understanding health needs allows the researcher to locate health problems on different levels. The feminist perspective complements the ecological approach by

drawing attention to individual positionality; multiple elements of social existence and their relative social outcomes. For example, it highlights how sexual orientation can intersect macro, meso, and micro conditions such as social class, community support/barriers and individual perceptions. Since an application of the ecological framework involves classification, the queer perspective can be used to emphasize the importance of reflexivity when categorizing the individual characteristics of participants.

Thus, in order to comprehensively address the health needs of older lesbian and gay adults within one framework, this research will be guided by a feminist/queer perspective using an ecological framework. The synthesis of these theories is illustrated in Figure 3.3.1.

Figure 3.3.1 Bronfenbrenner's Ecological Model with F/Q Perspective



Source: Adapted from Bronfenbrenner, 1986.

CHAPTER 4: METHODOLOGY

The following chapter outlines the methods by which data were collected and analysed. It begins by explaining how the feminist/queer perspective guides the methodology followed by an overview of the research design, data collection and recruitment strategy. A profile of the socio-demographic characteristics of the participants is provided. Finally, the process of data analysis is discussed as well the trustworthiness and methodological limitations of this study.

4.1 Research Orientation

Maintaining objectivity is a virtue when collecting and analyzing data.

Researchers should make all theoretical and interpretive perspectives explicit to their audience. A feminist/queer perspective has guided the research methods of this study. In addition to providing conceptual and analytical direction, the feminist/queer perspective also provided methodological orientation by emphasizing participatory, collaborative, change-oriented, and empowering forms of enquiry (Patton, 2002). Through the use of qualitative methodology and a feminist/queer lens, this research is especially sensitive to the importance of gender, positionality, ethnicity, social class, sexual orientation, and the subjective meaning of human behaviour. This research orientation also emphasizes the importance of self-reflection during the research and analysis process.

4.2 Study Design

This research was designed as an exploratory study based on primary data collection. Exploratory studies are useful when little is known about a phenomenon (Babbie, 2001; David, 2004). Hash and Cramer (2003) advocate the use of qualitative

methods when studying lesbians and gay men in order to empower participants and better uncover their unique experiences. Informal quota sampling using the snowball technique was used to recruit seventeen participants: eight lesbians and nine gay men. This sample size is consistent with purposeful sampling methods where in-depth understandings are sought with information rich individuals (Patton, 2002). The adequacy of sample size in qualitative studies may refer to the number of participants, but it is also related to the number of interviews and observations (Sandelowski, 1995). In order to achieve an in-depth understanding of health needs among aging lesbian and gay men, all participants were interviewed two times for a total of 34 interviews. Qualitative interviews allow respondents to tell their story and make meanings from their experiences, while sending the message that the researcher values their experiences (Rubin & Rubin, 1995). This study required participants to answer multidimensional questions regarding their perceptions of individual health status and experiences accessing healthcare. More specifically, participants were asked questions about their personal health, the delivery of healthcare, as well as health administration and reform (Appendix B).

In order to qualify for participation in this study, participants had to be 65 years of age or older, reside in the Lower Mainland, self identify as either lesbian or gay, and self-report as having at least one chronic health condition. In this context, a chronic condition is defined as an illness that persists over a long period of time (e.g. diabetes, arthritis, hypertension, etc). Respondents who had been diagnosed with a chronic health condition for a period of three months or more were eligible to participate in this research. The age of 65 was selected for two reasons: 1) it corresponds with the age of retirement and is thus widely accepted as the start of older age, and 2) the social conditions during the younger years for older lesbian and gay men now aged 65+ could influence present day

health. As of 2008, participants 65+ would have lived through a minimum period of 26 years when homosexuality was a criminal offence; which could influence current health experiences. However, due to recruitment difficulties the age requirement for participation in this study was lowered to fifty years or older.

Metro Vancouver was selected as the setting for this study since it provides the opportunity to study participants who reside in diverse regional and ethnic communities. This research is limited to aging lesbians and gay men only. The health experiences of older transsexual/transgendered, bisexual, intersexed, and two-spirited people are potentially more complex and thus require separate consideration. Finally, participants were required to have at least one chronic health condition to increase the likelihood that they have had experiences with the healthcare system. Participants with chronic ailments can draw upon their experiences to better answer questions regarding how their sexual orientation may or may not influence their health needs.

4.3 Recruitment Strategy

Recruitment for this study took place over a one year period between April 2007 and April 2008. This study used a pre-existing partnership with a community program for aging lesbian, gay, transgendered and bi-sexual adults named *The Generations Project*. Located in Vancouver, British Columbia, this program was sought out by the author in order to gain access to prospective participants. *The Generations Project* is based on a partnership between The Centre and Service Options of Family Services of Greater Vancouver and is (in part) funded by the Vancouver Coastal Health Authority. The program is described as an exciting and innovative approach to age specific service

delivery, education and community development to support older lesbian, gay, transgendered, bisexual people and their allies residing in Metro Vancouver.

The Office of Research Ethics at Simon Fraser University approved the recruitment strategy of this study (see Appendix A). Participants were initially recruited via group email lists based on membership to *The Generations Project*. For example, an email was sent to members of ‘Chronically Queer’ – a group of adults who share a queer orientation and chronic diagnosis. This study was also endorsed and advertised via email to other groups through partnerships with *The Generations Project* (e.g. ‘The Menopausal Old Bitches’ - a group comprised of older lesbians, and ‘Prime Timers’ - a group comprised of aging gay men). Participants were subsequently recruited by word of mouth during the author’s volunteer activities within the community (e.g. Accessibility Tent management at Vancouver’s Pride celebration) and at community events attended by the author (e.g. annual awareness breakfast to observe the National Day Against Homophobia).

Fliers were posted in densely populated neighbourhoods of Vancouver including the West End and the Commercial Drive area; with special efforts made during Pride Week and the Celebration of Light festivities (Appendix C). Information about the study was posted at the 411 Senior’s Centre, in coffee shops, banks, and other businesses known to be frequented by members of the queer community. The snowballing technique was used to identify acquaintances of existing participants who qualify and might be keen to participate in a study of this kind. Finally, advertisements were posted on free websites including the widely used Craigslist (Vancouver). Mass emails and

poster advertisements were used multiple times throughout the year corresponding with the timing of community events and the change in the age requirement for participation. An effort was made to recruit participants from ethno-cultural backgrounds, different social classes, as well as equal proportions of older lesbians and older gay adults.

A total of nineteen people participated in this research however two were omitted from the study after failing to meet the eligibility criteria (one person identified as transgendered and one could not recall suffering from any chronic health conditions). Of the remaining seventeen participants, the majority (9) were drawn from mass email lists (Table 4.3.1).

Table 4.3.1 Recruitment Origin

	Female (n=8)	Male (n=9)	TOTAL (n=17)
Email	5	4	9
Snowball	2	1	3
Advertisements	0	2	2
Events	1	2	3

4.4 Data Collection

Prior to data collection all participants received a copy of the Informed Consent Form (Appendix A) and the Interview Guide (Appendix B). This step was added to fully inform participants of the purpose of the study, participant responsibilities, and to minimize any potential discomfort related to subject matter. All participants were reminded that participation was voluntary and that refusal to answer questions and/or withdraw from the study could occur at any time. Participant's contact information and signed identities were kept confidential. Anonymity was increased by assigning numerical codes to all interview data files and by storing signed consent forms separately.

Any proper names mentioned during the interview process were omitted from record and replaced by a description of the relationship (e.g. “Jane and I went to dinner” was recorded as “[Wife] and I went to dinner”). All materials were kept in a secured location accessible only to the author.

Data was collected for this study via two face-to-face interviews per participant administered by the author. Comfortable and convenient settings were negotiated: twelve occurred at Simon Fraser University, eighteen occurred in people’s homes, and four at places of work. All interviews were audio recorded and transcribed verbatim by the author or by hired transcribers. Participants were made aware that the study used multiple transcribers during the consent process. The interview guide was pilot tested with two participants: one male and one female. Data from these interviews were recorded, transcribed, and reviewed for missing elements and clarity. This exercise led to changes in the interview guide (e.g. addition of religion/spiritual background to the interview guide). Data from both pilot interviews are included in the main findings of this study.

4.4.1 Interview #1

The duration of the first interview lasted between 1.5 to 2 hours on average. The guide for this interview is divided into two sections (Appendix B). Section one is comprised of structured socio-demographic questions relating to gender, marital status, class, etc. Section two is comprised of nineteen semi-structured and open-ended questions related to individual health and sexual orientation. The interview questions addressing individual health needs have been generated using the following multidimensional needs assessment tools as a guide: 1) the Minimum Data Set Home

Care Canadian Version (M.D.S.-H.C.), and 2) The Camberwell Assessment of Need for the Elderly (C.A.N.E.).

These measurement tools have acceptable levels of reliability and validity and have been widely used to collect health needs data on older adults. The MDS is commonly used by North American healthcare providers to attain client socio-demographic and healthcare information. Although the CANE is less used, it is known as a comprehensive person-centred needs assessment (Orrell & Hancock, 2004). It was selected to help guide this research because it involves a wide range of information. Comprehensive measurement tools like CANE provide greater inclusiveness when exploring potentially untraditional health needs. These instruments have been used to collect a variety of data from behaviours and physical health to intimate relationships. The CANE has 26 separate categories in order to achieve a larger assessment of need (Reynolds *et al.*, 2000). It is important to note that this research has only used themed sections of these assessment tools to guide the construction of an original interview guide. Thus, these assessment tools have been used to assist the researcher in asking comprehensive questions about health needs.

4.4.2 Interview #2

After the first interview had been transcribed, coded, and member checked by the participant, the second and final interview was arranged. This interview began with a review of the first interview including emerging codes and themes. This process allowed the researcher the opportunity to verify and/or clarify data with the participant. Member checking decreases threats to internal validity and increase the trustworthiness of the research (Lincon & Guba, 1985). Following this, the remaining section of the interview

guide addressing health and social services for older adults was administered (ten questions). Emerging questions based on the researcher’s notes were also discussed and/or clarified during this interview in order to gain a deeper level of understanding. The duration of the second interview was approximately one hour. After data from the second interview had been transcribed and coded, participants again received copies and were asked to review the analysis for accuracy and points of disjuncture.

4.5 Sample Profile

The socio-demographic characteristics of the research participants (N=17) are summarized from Table/Figure 4.5.1 to 4.5.5. The findings of this research are based on the experiences of eight lesbians and nine gay men ranging from 52 to 87 years of age. When asked to describe their sexual orientation identities, seven men identified themselves as ‘gay’ or ‘homosexual’ and five women identified as a ‘lesbian’. The remaining five participants defined their orientation in other terms (Table 4.5.1).

Table 4.5.1 Sexual Orientation

Number (n=9)	Male - Description
5	Gay
2	Homosexual
1	Ambisexual – Gay dominant
1	“A very troubled man”
Number (n=8)	Female - Description
5	Lesbian
1	Gay Woman
1	Various (Queer, dyke, lesbian, etc)
1	“I’m just me - I dress the way that want to”

Male participants were on average almost five years older (67.89) compared to female participants (63.00) with an overall mean age of 65.59. Male participants reported higher annual household incomes, however, the majority of participants (n=10 or 59%) reported

incomes of \$29,000 or less. All respondents less three males were satisfied with their current financial situation. Participants were on average well educated with 13 or 76% having university undergraduate or graduate degrees; six people had backgrounds in psychology, five in divinity, and five in education.

There is great diversity among participants with respect to current and past partnerships. Only half of the female respondent were currently single (n=4), whereas almost all of the males were single (n=8 or 89%). Eight participants had been in heterosexual marriages at some point in their life and three women were currently in same-sex marriages; one respondent is a same-sex widow and seven had never been married. Interestingly, eight participants reported having either biological or adopted children from previous marriages and nine reported no children.

Five participants were fully retired (29%), four had full time jobs (24%), and eight (47%) reported having to leave their jobs due to disability although five of them were also working part-time. Nine respondents were receiving a Canada Pension and/or a private pension at the time of the interview. Seven people were receiving Old Age Security, five were receiving disability insurance and only one received the Guaranteed Income Supplement. All participants had basic Medical Service Plan coverage and all but two also had extended health coverage.

Table 4.5.2 Socio-Demographic Characteristics

	Female (n=8)	Male (n=9)	TOTAL (n=17)
AGE			
Min	54	52	52
Max	71	87	87
Average	63.00	67.89	65.59
INCOME (\$)			
-10,000	0	1	1
10,000-19,000	0	0	0
20,000-29,000	5	4	9
30,000-39,000	2	0	2
40,000-49,000	0	1	1
50,000+	1	3	4
Average	20,000-29,000	30,000-39,000	20,000-29,000
EDUCATION			
-High School	0	0	0
High School	2	1	3
College	0	1	1
University	5	3	8
Graduate Studies	1	4	5
PARTNERSHIP			
Single Now	4	8	12
Partnered Now	1	1	2
Same Sex Marriage	3	0	3
Heterosexual Marriage	4	4	8
Common Law	1	0	1
Same Sex Marriage/Widowed	0	1	1
Heterosexual Marriage/Widowed	0	1	1
Never Married	2	5	7
Kids	4	4	8
No Kids	4	5	9

Table 4.5.3 Socio-Demographics Continued

	Female (n=8)	Male (n=9)	TOTAL (n=17)
WORK STATUS			
Part Time	0	0	0
Full Time	2	2	4
Retired	1	4	5
Disability	1	2	3
Disability + Part Time	4	1	5
LANGUAGE			
English Only	4	3	7
English & French	0	2	2
English & Other	1	2	3
English + Limited Other	3	2	5
CULTURAL BACKGROUND/ETHNICITY			
Canadian	0	5	5
English/British	5	2	7
First Nations	1	1	2
Other	2	1	3
Not Born in Canada	4	1	5
BENEFITS			
CPP	4	5	9
OAS	4	3	7
GIS	1	0	1
Private Pension	4	5	9
Other	0	3	3
Disability	1	4	5
MSP	8	9	17
Extended Health Coverage	8	7	15

Participants self-reported between one and six chronic health conditions at the time of the interview (Table 4.5.4). Psychological conditions were most common (n=11) followed by arthritis (n=5), heart conditions (n=5), and cancer (n=5). Study participants also suffered from chronic migraines, fibromyalgia, diabetes, asthma, obesity, eye problems, and other chronic conditions that will not be mentioned to maintain confidentiality. When asked to rate the severity of their chronic health participants reported moderate levels for the most part. The duration of these conditions ranged between one to forty years.

Table 4.5.4 Chronic Health Profile

	Female (n=8)	Male (n=9)	TOTAL (n=17)
Min	3	1	1
Max	6	6	6
Average	3.63	4.00	3.82

Ethnic backgrounds were predominately Canadian and English/British (12 or 71%) and all but five (29%) participants were born in Canada. Seven people (41%) know English only whereas the remaining ten respondents (59%) are multilingual or have limited knowledge of other languages. All participants were fluent in the English language. In general, living arrangements differed among the men and women in this study (Table 4.5.5). Ownership of single family homes was most common among lesbian women (4 or 24%); home owners also reported the longest average duration of 11.5 years. Condominium ownership was the most common living arrangement among gay men in this study (3 or 18%) with the longest average duration of 20.5 years. A total of four respondents lived in subsidized housing at the time of the interview. Eight (four

women and four men) live in Vancouver’s West End and Kitsilano neighbourhoods. The remaining participants live in other Vancouver communities including the Commercial Drive area, and the University of British Columbia’s Endowment Lands. When asked about community satisfaction only one male was unsatisfied and two females had difficulties with the accessibility of their neighbourhoods. Most participants used the bus as their main form of transportation (13 or 76%) followed by walking (11 or 65%) and driving (9 or 53%).

Table 4.5.5 Living Arrangements / Transportation

	Female (n=8)		Male (n=9)		TOTAL (n=17)	
	#	Duration/Years	#	Duration/Years	#	Duration/Years
Apartment – Rent	1	2	2	*8 †(4-12)	3	*5
House – Rent	1	10	2	*6.5 †(3-10)	3	*8.25
Condo – Own	0	0	3	*20.5 (3-36)	3	*20.5
House – Own	4	*11.5 †(6-17)	0	0	4	*11.5
Subsidized Housing	2	*5 †(1-10)	2	*7 †(4-10)	4	*6
TRANSPORTATION						
		#		#		#
Bus		6		7		13
Walking		4		7		11
Friends/Family		1		2		3
Bicycle		1		2		3
Taxi		1		0		1
Drive		4		5		9
Scooter		3		0		3

*Mean

† Range

4.6 Data Analysis

All transcripts, notes, and observations were open-coded for emerging codes and themes. Open coding can be defined as the part of analysis that pertains specifically to

the naming and categorizing of phenomena through close examination of data (Babbie, 2001). During open coding, interview data were broken into codes and then grouped into larger themes (Miles & Habetman, 1994; Strauss & Corbin, 1998). Subsequently, a summary of themes, codes, and corresponding dialogue was generated from each interview (e.g. Appendix D). This step made the information more manageable for analysis. All data displayed in interview summary sheets were member checked by participants, therefore, data analysis was an ongoing process.

Once all data were collected and coded, codes and themes from interview summaries were entered into an Excel spreadsheet. Quinn Patton (1992) notes that although computer software can be valuable tools for organizing and comparing data, the analysis of qualitative data involves creativity, intellectual discipline and analytical rigor. A comparative pattern analysis via the Excel spreadsheet was used to interpret the data generated by this study (Quinn Patton). Emerging thematic categories were especially helpful with identifying relationships between participants' responses to interview questions. Finally, emerging themes relating to health needs were summarized using the ecological framework guiding this study (Appendix E).

Interview notes were also included in the data analysis process. These data were useful insofar as it allowed the author to be reflexive about conclusions and observations. This process generated further questions for participants which the author followed up on during the second interview.

4.7 Trustworthiness

The value of qualitative research is measured by methodological considerations. Quinn Patton (1992) notes that the quality of qualitative research can be increased

through rigorous methods and building up the credibility of the researcher. With respect to rigor, this study used a guiding research orientation and systematic methods to increase the reliability and validity of findings. The interview guide was developed using reliable needs assessment tools as a reference and was pilot tested for accuracy. Pilot subjects were solicited for further questioning after changes were made to the interview guide to ensure a more consistent interview process. Reliability of data was increased by providing participants with the interview guide prior to the interview. This step oriented participants to the content of the interview thereby minimizing elements of surprise. The author followed the same procedure of data collection in each interview. Data analysis was conducted by the author alone and member checked by each participant for points of disjuncture and clarification. Member checking is a form of triangulation that involves having those who were studied review the findings to offer a measure of accuracy (Quinn Patton, 1992). The beginning of the second interview was dedicated to asking outstanding and clarifying questions thus increasing the reliability of the findings. Finally, the Microsoft Office Excel software was used to help organize information in a more systematic fashion.

Since the researcher is charged with data collection and analysis they become an integral research instrument; researcher credibility is an asset. Strauss and Corbin (1998) note that researchers should be both reflexive about their influence on the research process and be aware of the reactivity of participants. This study used interview notes to reflect on these processes. The author has spent a considerable amount of time volunteering in the queer community and has previous experience interviewing older adults and older lesbian and gay adults specifically. Building trust among the subjects in

this study was done to minimize negative reactions and maximize the depth and reliability of data.

CHAPTER 5: RESULTS

Needs assessments are systematic tools used to explore the way things are and/or the way things should be. Research indicates that age-prepared communities “are places that actively involve, value, and support older adults, both active and frail with infrastructure and services that effectively accommodate their changing needs” (Alley, Liebig, Pynoos, Banerjee, & Hee Choi, 2007, p. 1). Needs assessments are integral to planning and establishing elder-friendly services and communities. To reveal the needs of older lesbian and gay men, a needs assessment was conducted. This chapter presents the following health profiles: physical health, social health, mental health, and sexuality. Each research question is subsequently addressed.

5.1 Physical Aspects of Health

This section summarizes the physical health data generated from the needs assessment. Participants were first asked to rate their subjective health through the following question: ‘Compared to other adults your age, how would you describe your overall health?’ The majority of respondents rated their health as ‘good’ (8 or 47%), five as ‘excellent’ (29%), three as ‘fair’ (18%), and two as ‘poor’ (12%). Participants commonly answered this question with the explanation that their health status is lower first in comparison to others, but also due to prevailing health conditions and chronic pain. One woman explains,

I guess when you look at everything, it’s fair. But in actual fact, I experience it more as good cause I do a lot with it. In terms of my function I’d say it was good but I do know that in comparison with other people it’s probably fair or poor (age 68).

Gay males reported a slightly higher subjective health status when compared to lesbian participants. Five women reported either an 'excellent' or 'good' health status compared to seven male respondents.

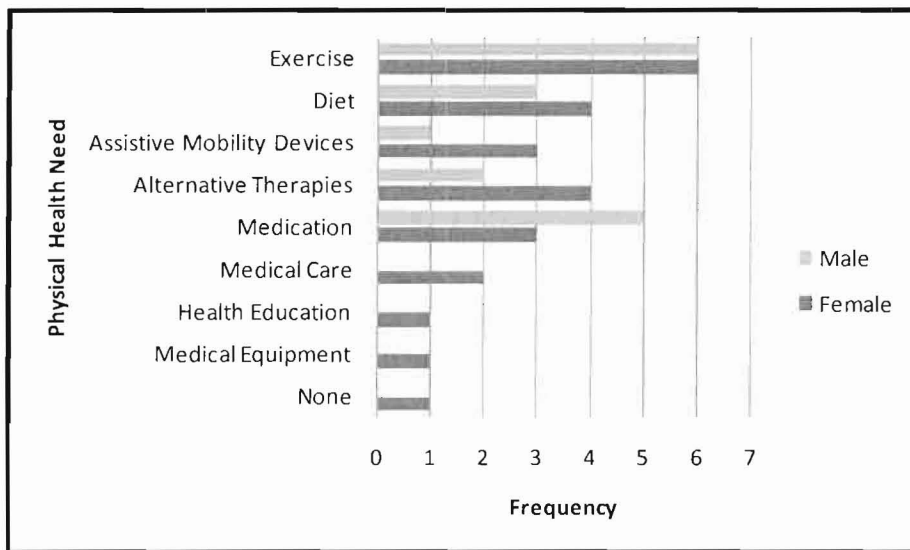
Assistance with activities of daily living is another indicator of health status. In this study, activities of daily living were defined to include meal preparation, bathing, dressing, and housekeeping. Participants were asked if they required assistance with any of these types of activities, and if so, whether or not they receive assistance from formal care providers, informal care providers, or both. The majority of respondents (13 or 76%) were fully independent reporting no need for formal or informal support (females=6, males=7). Four participants (24%) were receiving between one and three and a half hours of assistance from public/formal care providers per week at the time of the interview. These participants received assistance with instrumental activities such as housekeeping, laundry and meal preparation. Three participants reported paying for out-of-pocket housekeeping expenses, one of which due to inadequate formal services.

In total, almost half (8 or 47%) of the participants provided at least some form of care to another person with the majority (9 or 53%) being non-caregivers. With respect to caregiving there was great variation between the lesbian and gay male respondents. Seven men were not providing any type of care, one provided minimal care to his partner and one provided emotional support to a family member. Only two lesbian women reported non-caregiving roles while six provided care to a daughter, mother, neighbour, friend and partner; one was providing care to both their partner and a friend.

When asked 'What (if any) physical health needs do you have?' participants gave varied responses (Figure 5.1.1). The most popular response among lesbians and gay men

was exercise (12 or 71%). The study participants were an active group overall. Many discussed strength training, playing sports, swimming, going to the gym, yoga, and walking with regularity (at least twice per week). A greater number of men perceived medication as a physical health need (n=5) compared to women who reported dietary changes (n=4) and alternative therapy use (n=4). Alternative therapies included yoga, chiropractic care, herbal supplements, meditation, and Chinese medicines.

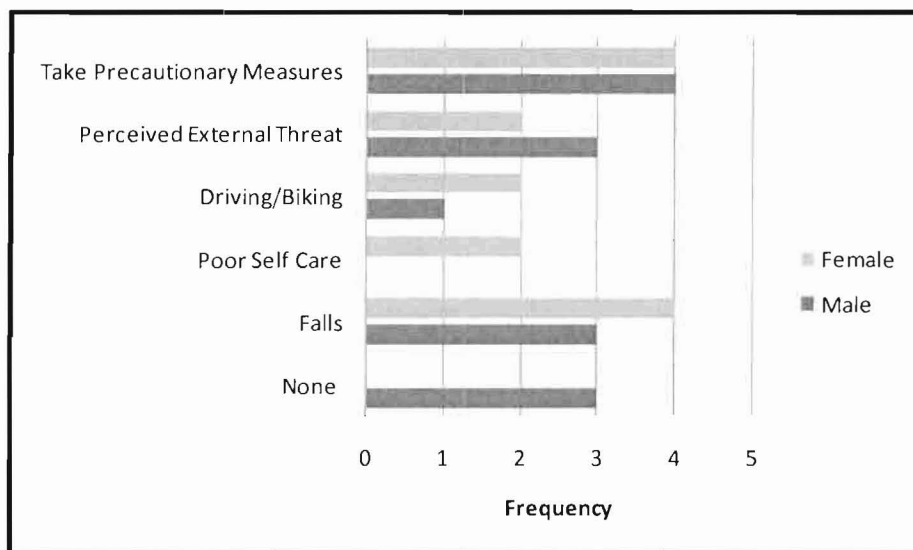
Figure 5.1.1 Physical Health Needs



Respondents were specifically asked about alternative therapy use; ‘To what extent do you rely on alternative therapies or medicines? If so, how is it more desirable?’ One male and two females preferred alternative therapy use over traditional biomedical services. When asked why one woman explained, “Because it’s what’s worked. I go to my GP for diagnosis then I see my naturopath for treatment” (age 68). An additional six respondents who have tried alternative therapies in the form of acupuncture, yoga, naturopathy, and meditation remained impartial with respect to preferential treatment. Seven individuals noted cost as a prohibitive factor and six had never tried an alternative therapy at the time of the interview.

Participants were asked, ‘What (if any) health risks do you face with respect to your personal safety?’ Seven people (41%) reported balance and falling as a major safety concern and five people (29%) professed external safety threats such as being robbed and/or being gay bashed (Figure 5.1.2). “I was gay bashed a lot so where it would be isolated, night time, or somewhere where there are a lot of straight males together, I don’t feel too safe around” (male, age 62). In addition to these five participants, others also indicated that they took precautionary measures by restricting activities (n=8 or 47%). For example one man said “I try to avoid Granville at night...and I know there’s been bashings on Davie but I stay away from Thurlow and Davie. I generally don’t hang around that area” (age 64). The study participants were further probed by the author to address accidental harm, deliberate self harm as well as abuse and neglect. Only two women perceived poor self care practices as a safety risk.

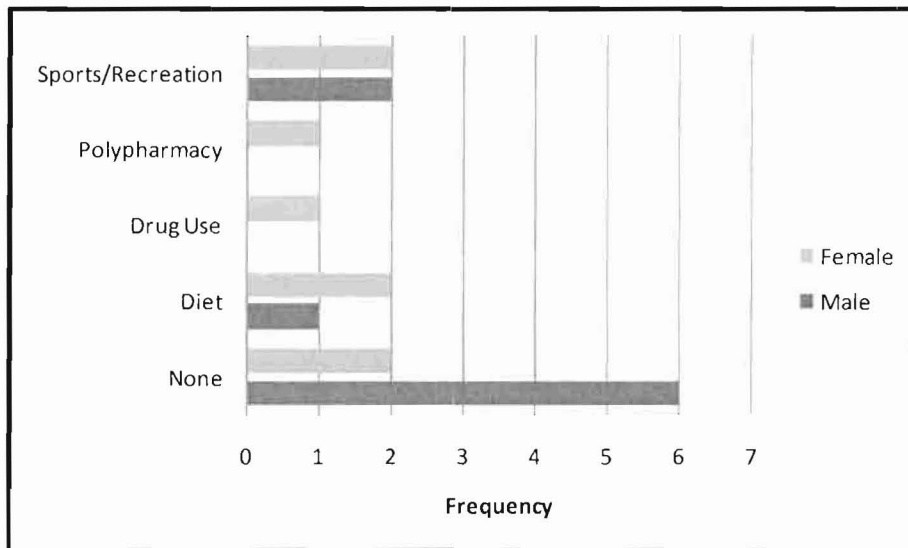
Figure 5.1.2 Personal Safety Risks



Finally, participants were asked, ‘What (if any) high risk behaviours do you engage in?’ The majority of study participants reported no current high risk behaviours (n=8 or 47%) (Figure 5.1.3). There was greater variation among female participants who

reported polypharmacy, drug use, diet, and sport/recreation as high risk. No participants reported stereotypical high risk behaviours such as sexual promiscuity and risky sex.

Figure 5.1.3 High Risk Behaviours



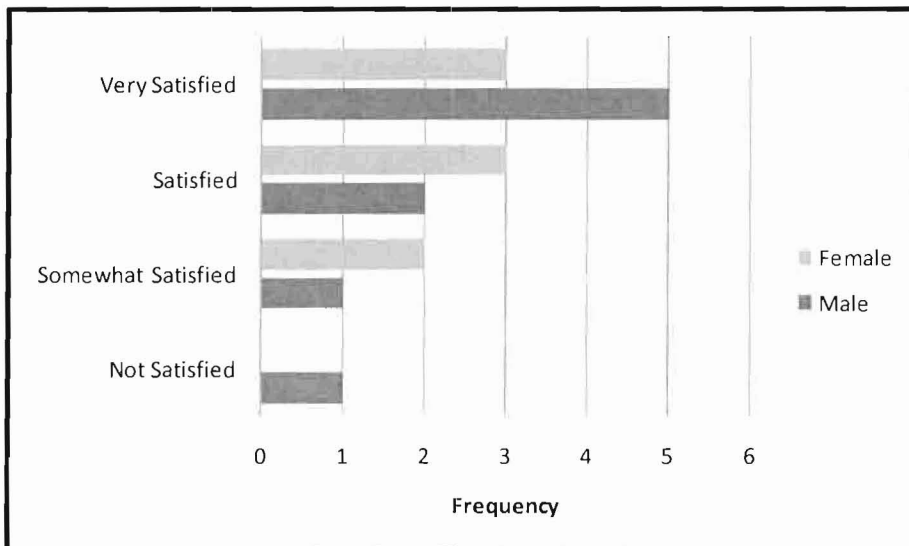
5.2 Mental Aspects of Health

This section summarizes the mental health data generated from the needs assessment. Participants were asked, ‘Have you been diagnosed with psychological distress and/or mental health issues? And if so, what are they?’ Study participants reported the following diagnoses throughout their life span: depression, anxiety, post traumatic stress disorder, obsessive compulsive disorder, borderline personality disorder, seasonal affective disorder, panic disorder, and medication induced temporary psychosis. One person replied ‘yes’ and chose not to discuss the details of their diagnosis. Three people are survivors of physical, emotional, and sexual abuse. Only one participant has never suffered from psychological distress over their life course. Eight men and six women (n=14 or 82%) have suffered from depression at some point in their lives. Seven participants were currently managing chronic depression at the time of the interview with

an additional seven participants reporting acute episodes. After depression, anxiety was the second most common response (n=6 or 35%).

When asked to rate their level of life satisfaction, participants had gradual decreasing levels (Figure 5.2.1). Most participants answered very satisfied (8 or 47%), followed by satisfied (5 or 29%), somewhat satisfied (3 or 18%), with only one not satisfied (6%). One male participant who reported being very satisfied said, “I have friends, I have activities, I have enough help...I’m probably the happiest that I’ve ever been” (male, age 76). Respondents who reported being somewhat satisfied and/or satisfied reported a lack of contentment with their current health status, companionship, and financial situation. For example, one participant who reported being somewhat satisfied stated, “Well if I can get this knee fixed up then I’ll be very satisfied again” (female, age 71). The participant who was not satisfied explained, “I’m not where I want to be. I’m not doing what I want as far as a job. I don’t have companionship really. So in almost every area of my life right now is not what I would like it to be” (male, 62).

Figure 5.2.1 Life Satisfaction

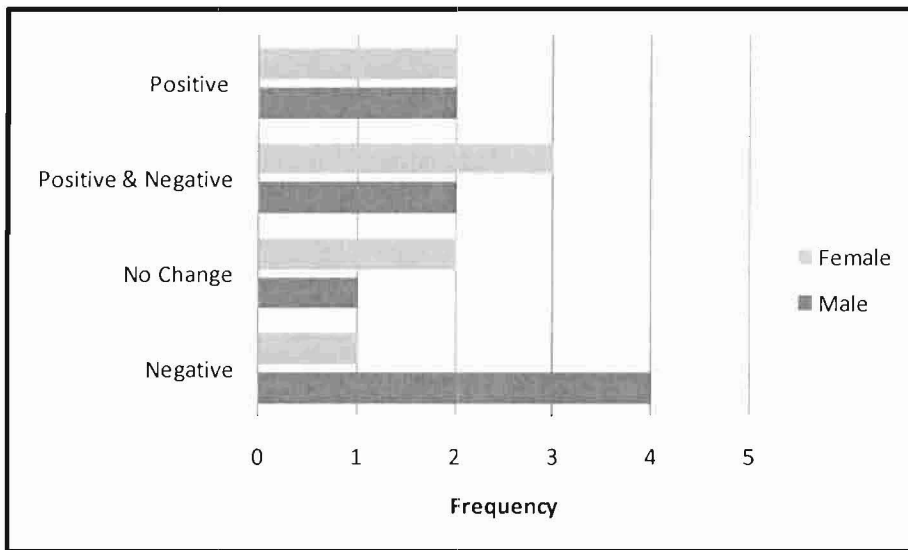


Chapter two highlighted literature indicating a psychological impact of body dissatisfaction related to aging (Beren *et al.*, 1996). Participants of this study were asked, ‘In what ways has the aging process influenced your self perception?’ (Figure 5.2.2) Male participants reported negative self perceptions (n=4), followed by answers that indicated positive change (n=2), and both positive and negative change (n=2). One male commented, “I don’t like it when I look in the mirror, especially with my shirt off” (age 62) while a female said, “I just feel more fragile and like digestion is inefficient, and memory is not fantastic and everything is kind of dumping down” (age 71). Female responses were more evenly distributed with most giving both positive and negative answers. For example,

I’m really capable of experiencing this on more than one level you know. There’s of course a certain happiness that the kids are raised...I would say emotionally my inner child is kicking and screaming all the way there. It doesn’t want to go, forget it! So, I’m just going to put ‘intellectually okay but the inner child hates it’. It doesn’t think it’s very beautiful at all (age 55).

Respondents attributed positive changes to improved self image, increased coping mechanisms, acceptance of the aging process, and taking pride in wisdom.

Figure 5.2.2 Aging Self Perception



5.3 Social Aspects of Health

This section summarizes the social health data generated from the needs assessment. Study participants were asked to openly describe their social life. Ten people (5=female, 5=male) portrayed positive social lives while the remaining seven (3=female, 4=male) expressed negative aspects. Positive respondents used the words ‘full, active, comfortable, busy, satisfied, and fun’. For example, “I think that it’s reasonably full. As a matter of fact I don’t get enough time to do all of the things that I want to do!” (male, age 80). Negative respondents used words such as ‘minimal, low, forced, limited, and none’ to describe their lack of satisfaction. “I would describe it as not very good...because of my mental health issues in the gay community I never get invited out to parties. That’s very subtle discrimination...” (female, age 55).

After this question, study participants were asked how happy they were with the type and amount of peer support they had at the present time. Seven males and three females gave positive responses (n=10 or 59%) suggesting that males were more satisfied. For example, one man said, “I’m perfectly happy because I don’t have

anything except support. I don't know anybody who doesn't support me" (age 87). Two males and five females gave negative responses (n=7 or 41%) citing limited support and a need for more. "I'm not very happy with the amount of peer support I get at all" one woman said (age 55). Another woman said, "It's not easy to connect with other lesbians. Women are different from men and we love different things so I would like there to be more things that are just for women" (age 68).

At this point in their life, study participants were asked who they maintain close relationships with. Most participants (11 or 65%) listed family members amongst partners, kids, friends, neighbours and colleagues. "I'm close with family, I'm close with my partner for sure, we're quite inseparable. And a handful of close friends that are very significant to me" (female, age 54). Six (35%) respondents did not report having close relationships with family. This group described their friendships as being more like family. One man said, "I don't feel any closeness with my family...my friend here in Vancouver and a friend of mine who lives overseas; I would consider them more my family than anything else" (age 52).

In addition to being asked how the aging process has influenced individual self perception, participants were also asked how their cultural background may (or may not) have influenced how they have aged. The majority of participants had difficulties answering this question explaining "I don't often think about getting older culturally" (male, age 52). The definition of 'cultural background' was left open to participants; the author encouraged a range of responses including ethno-cultural heritage, sexual culture, nationality, rural vs. urban, and any other way one's culture could be interpreted. Five

participants (29%) discussed ethno-cultural aspects of aging although some explained that they did not identify with it. One man explained,

To some degree I think that negative perception that I've had are very much North American because North America is a very youth focused culture and doesn't have a lot of space for elderly people and they're tolerated but there's not much respect... (age 62).

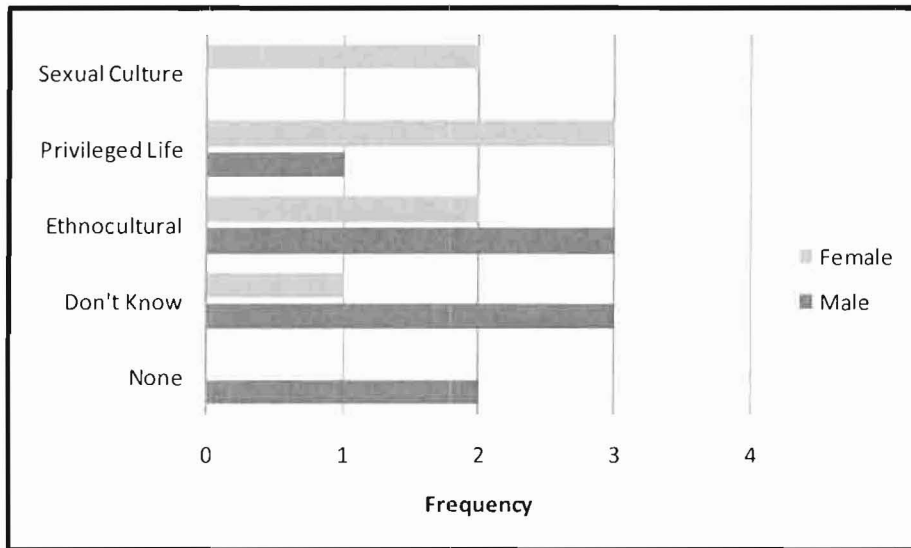
One woman said,

I grew up in la la land' [Los Angeles]...and there were all sorts of subtle reminders constantly about weight, looks, this that and the other thing. I don't see it as having ever had a positive thing to say about women and aging... But it's getting better and better all the time in terms of diversity. When you go into a situation where there's people of all different cultural backgrounds and visible minorities and all this other stuff then you're in a place that becomes more comfortable (age 55).

Four participants (24%) talked about having a privileged life as they age; "Because of the facilities that are available and because of a more stable environment" (male, age 74).

Two females (12%) chose to discuss how their lesbian culture has influenced their aging process.

Figure 5.3.1 Cultural Background and Aging



5.4 Sexual Aspects of Health

This section is a summary of two questions that the study participants were asked as part of the needs assessment regarding aspects of their sexual health. Participants were asked, ‘How satisfied currently are you with respect to your intimate relationship(s)?’ Responses to this question were mixed (Table 5.4.1). In total, nine participants (53%) reported being satisfied with either their current intimate relationship(s) or their lack of. A sample of responses include, “I don’t want to be in a relationship with someone else at this point in time...so I’m totally satisfied with that” (male, age 62) and “I’ve come to a place in my life where I think the security and the comfort and the familiarity is important to me. So that’s what this relationship brings. We’ve been together for 30 years” (female, 66). An additional five people (29%) reported being dissatisfied with their current status; all of which were currently single. “Yeah I’m a bit disappointed because like I say, I’m not dead yet! It would be something to have someone who I could really hold and hug and give a kiss to...” (female, age 71). Finally, three participants stressed that they were

conflicted with being neither satisfied nor dissatisfied with the status of their current intimate relationship(s). One man explained,

I'm conflicted on that at the moment because there are a couple of people I get together and have sex with but in the back of my mind is do I really want to meet someone that I would have another relationship with in terms of partnership?.. I'm ambivalent on that one (age 74).

Another man explained, "Although many of my issues have been resolved, there's stuff there that still creates problems. I mean I am and I'm not satisfied with the fact that I'm single and always have been" (age 52).

Table 5.4.1 Satisfaction with Intimate Relationship(s)

	Female (n=8)	Male (n=9)	TOTAL (n=17)
Satisfied + Partnership	3	1	4
Satisfied + No Partnership	2	3	5
Dissatisfied + Partnership	0	0	0
Dissatisfied + No Partnership	2	3	5
Satisfied + Dissatisfied + Partnership	1	1	2
Satisfied + Dissatisfied + No Partnership	0	1	1

Also related to sexuality is the degree to which participants are 'out' about their sexual orientation. Study participants were asked, 'To what extent are you 'out'? How long? And to whom?' This question triggered detailed discussions around the identity histories of the respondents. In some cases the study participants had never been 'out' whereas other participants had been out as far back as they can remember or could tie their coming out to an event such as a heterosexual divorce. Five major themes emerged from the responses. The first theme, 'in and out' has been used to describe the state of

being both 'in' and 'out' at the same time (e.g. "It depends on whom and to what group" – age 71), as well as going between states throughout the life course. For example one woman explains:

Well I started being out in the 70s in terms of my behaviours and not really caring who knew it but when I moved in the 80s with my ex-husband, I did everything I could to try to be as normal and as hetero as possible... then when I left my husband in the beginning of '97, I came out totally..." (age 55).

In these situations the author asked additional questions around how disclosure was decided. Two themes emerged as a result: avoidance of rejection and disclosure based on relevance. One man described his most recent change, "I was more out while I was waiting to get into this building. And then when I moved into this building I could tell there was some homophobia and so I'm not as out as I was" (age 62). Other participants have described their status as being on more of a need-to-know basis based on relevance; "Any time that I feel that it's relevant... and that's purely subjective" (age 71). Some study participants alluded to their in/out status as being an 'ongoing process' (theme) where it is problematic to just say 'I am' or 'I'm not.' The subjects and/or environments in which participants were 'out' to were also discussed in this evolutionary manner.

Finally, regardless of their level of disclosure almost all study participants discussed the 'influences of being out' (theme). Some participants talked about the positive and negative experiences of being 'in/out' at the workplace and how it influences communication and assumptions inferred by others. One woman discussed the impact of physical and emotional safety, "...to me safety is in being out. The more hidden you are the more at risk you are" (age 68). The assortment of responses to this question indicates diversity among the identity careers of the study participants.

5.5 Healthcare and Accessibility

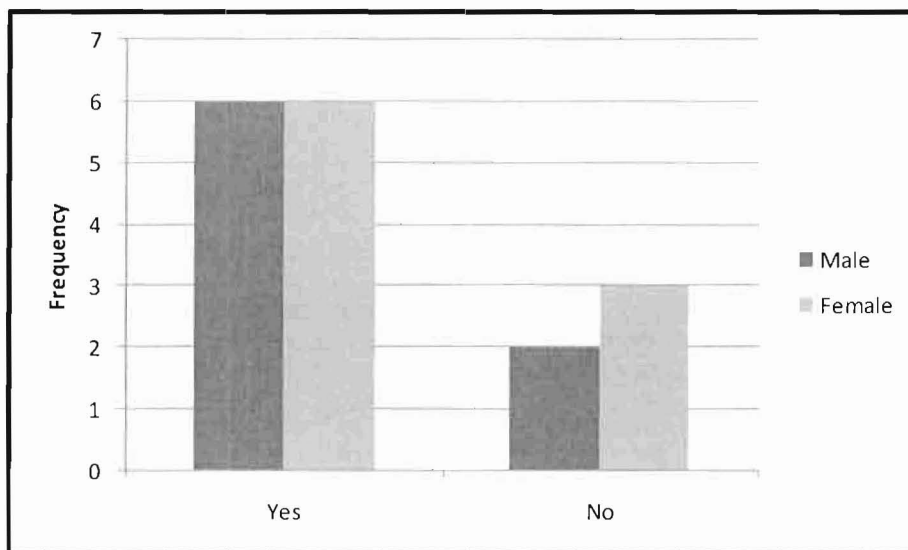
A review of the literature indicates that past experiences within the healthcare system continue to influence the health seeking behaviours of older lesbian and gay men. Thus, the second interview of this study included a number of questions related to experiences accessing health and social services as part of the needs assessment. This section summarizes those results.

Study participants were asked about their level of satisfaction with the information that they have received about eldercare services. Four main themes emerged: 1) don't know – too young, 2) satisfied, 3) Generations Project, and 4) limited. Since the age requirement for participation in this study was lowered for recruitment purposes, six respondents were younger than 65 at the time of the interview. Participants often expressed that they were not aware of such services citing in some cases that it was because they were too young; "I don't receive any information about elder care services. I'm only 55 so I don't really fit into that category" (female). Participants who reported being satisfied commonly explained that it was because they had been proactive and had gone looking for information independently or that they know where to access information if they needed it. *The Generations Project* was often cited as an important information hub among study participants. One man said, "*The Generations Project* basically keeps us in touch with what is going on for seniors on the Gay and Lesbian community" (age 80). Respondents who were unsatisfied were for the most part recruited independent of *The Generations Project* and therefore were less connected.

To help create a portrait of the help seeking behaviour of study participants, they were asked how often they visit physicians and how often they or their doctor discuss sexual orientation. At minimum all participants reported seeing a physician at least once

per year failing any unforeseen circumstances. Many reported regular visits for prescription renewals, specialist, and follow up appointments. Most participants (12 or 71%) reported that either they or their physician have initiated a discussion about sexual orientation (Figure 5.5.1); “She knows I’m a lesbian...I don’t leave it to chance. I’m just a little more proactive” (age 66). Those who did not discuss sexual orientation commonly felt that physicians did not need to know as it was not important to patient health. When asked if they think that it is important that physicians know sexual orientation, one man said “Well, what’s he going to do for me?” (age 62). Another woman expressed discomfort, “I just don’t feel comfortable with that. And I also don’t feel comfortable with my own sexuality. I don’t feel it’s a pressing need to discuss it” (age 55).

Figure 5.5.1 Discuss Sexual Orientation with Physicians



Study participants were asked, ‘Throughout your life, have you ever experienced heterosexism and/or hostility from healthcare staff? Please describe your experiences and associated feelings’. Lesbian women were three times more likely to have experienced

hostility and/or heterosexism in a healthcare setting (Figure 5.5.2). For example one woman recalled her most recent experience,

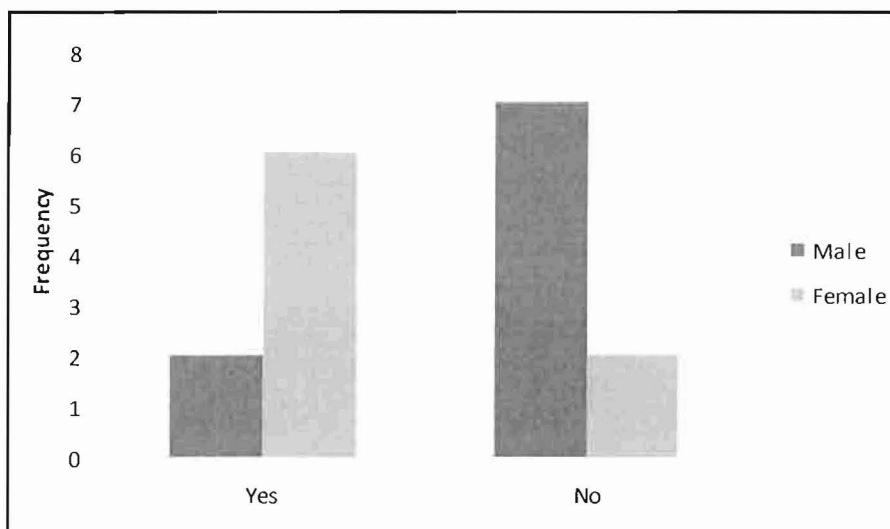
He first called me Mrs. and then I told him that I was not a Mrs. that I was a lesbian. And the next question that he asked me was, ‘did I work outside the home?’ Isn’t that an outdated heterosexist assumption (age 66).

Another woman replied “Yeah sure. But I don’t know whether that’s because of my sexuality or whether they don’t like people with mental illness” (age 55). The most noteworthy theme emerging from this set of answers was the prevalence of ‘knowing stories’ about others experiences.

We’re very good story tellers. All I need to do is hear one story from one person about something bad that’s happened and the story’s going to go on and on. We’re good at that. We like to scare ourselves silly (female, age 66).

Almost all participants who did not report a personal experience of heterosexism/hostility reported knowing someone who had.

Figure 5.5.2 Experiences of Hostility/Heterosexism



Participants were asked how their sexual orientation affects the quality of services they receive. This question provoked mixed discussion. The first of four main themes

was 'no influence'. For example one woman said, "I actually don't think it does. And that's primarily because I'm careful who I pick for my service providers" (age 66). The second theme of 'improved treatment' was also expressed; "I think that I have gotten better services after I revealed my orientation than I might have otherwise" (male, age 80). Some respondents shared their stories of 'poor treatment', the third theme. One female disclosed "Some staff are really quite hostile. They just don't like gay people and they're really quite prejudiced around gay people" (age 55). The fourth commonly occurring theme is 'knowing stories' of other people in the queer community who have experienced compromised quality of service because of their sexual orientation. A number of respondents shared these stories.

Finally, study participants were asked how satisfied they were using services that are provided to both heterosexual and other sexually oriented people. As a follow up to this question they were asked about their level of comfort receiving care in this kind of environment as well as how their sexual orientation influences (if at all) where they seek healthcare services. Excluding one respondent who expressed "I don't know" and two who expressed the general feeling that eldercare services are less than desirable regardless of sexual orientation, all were satisfied using mixed healthcare services. One woman explains,

I think at this point unfortunately we do need to have something separate and that's sad because I think it's the only way we're going to get recognized and get what we need but that's not my ideal. My ideal would be to have something where you could do both (age 68).

All respondents reported being comfortable receiving mixed services. Interestingly, the theme 'non heterosexist/homophobic' emerged since many participants prefaced their level of comfort with this circumstance. "To me what is important is that you feel

comfortable and that you're being treated respectfully regardless" (female, age 71).

Another woman explained,

I obviously don't want this place to be heterosexist. And at the moment, I'd say the majority of them are still very heterosexist. Especially elder services because over the years there has been a lot of work done with hospitals and those contexts. But in the elder care field, there's been very little (female, age 66).

Various responses emerged to the third part of this question addressing how sexual orientation influences where healthcare is sought. Four main themes transpired including: 1) physician preference, 2) competency/reaction, 3) fractured service provision, and 4) non heterosexist/homophobic. Many study participants expressed a preference for gay physicians; "I only want to see service providers that are not heterosexual" (female, age 66). Reasons for this preference include an increased level of comfort and understanding as well as the need for less explanation. A few respondents felt burdened by the need to educate service providers. As a follow up question the author asked these participants if they used gay directories, word of mouth, or referrals from acquaintances when selecting service providers. Responses were mixed since some participants found preferred services by chance because of where they lived (e.g. Davie Village), while others reported researching services and using social networks. Alternately, one woman expressed a preference for heterosexual service providers due to difficulties finding skilled homosexual professionals.

Other study participants were indifferent to the sexual orientation of their service providers expressing competency as the most important factor; "All I want is somebody who knows what in the hell they're doing when they're doing my thing" (male, age 76). Another man said, "I would probably go to anyone and then confront them myself and

see how they responded” (age 80). Fractured service provision evolved into a common theme after participants explained that a heterosexual healthcare system breaks people up into components thereby forcing homosexual patients to supplement their care to feel recognized as a whole person. For example, one woman felt that her affinity for alternative therapies is linked to seeing the world differently due to her orientation. Lastly, study participants frequently expressed a general feeling of complacency with service providers as long as they were not heterosexist or homophobic; “If I thought that they were very uncomfortable with the whole issue, or if they told me they were uncomfortable, I would change” (male 80).

5.6 Research Question #1

The first research question addressed in this study is ‘What are the specific health needs of older lesbian and gay adults?’ To answer this question all study participants were directly asked what unique health needs they have. Although all participants eventually answered the question, four (24%) reported that they didn’t know and five (29%) reported having no unique needs; “Any of my needs are not unique. They are just because I’m 76” (male) (Figure 5.6.1). Accordingly, the eight (47%) remaining participants perceived having unique health needs due to their sexual orientation.

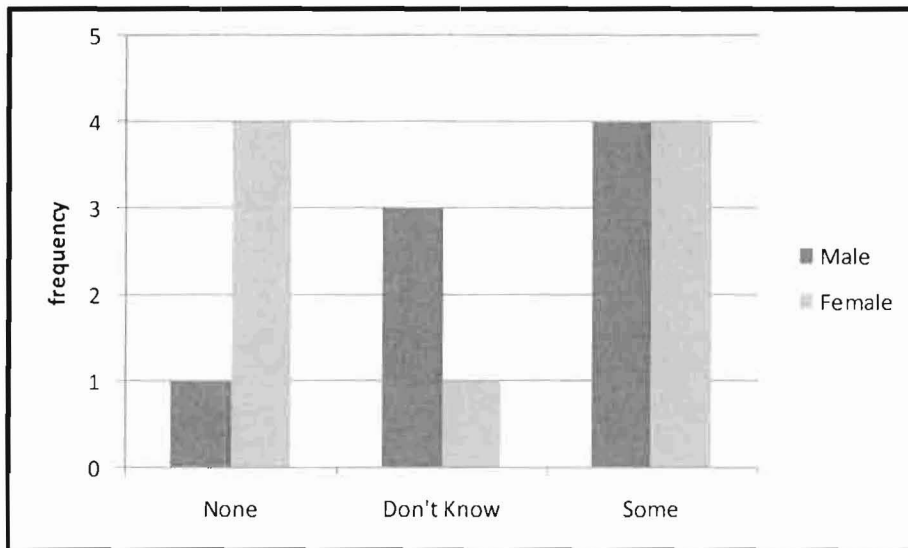
Yeah, I definitely think that LGTB people are different than straight people. The way they see members of their own gender and see members of the opposite gender is different because of that. The way they relate to their own gender and their opposite gender is different and what heteros do and because there’s so many of them, they reinforce their own reality in saying ‘this is the norm and therefore it’s a moral norm and an ethical norm’ rather than recognizing that human diversity is like plant diversity, etc. and animal diversity is the norm (male, age 63).

Five main themes transpired: 1) residential care, 2) social networking/peer support, 3) support for mental health, 4) recognition/visibility, and 5) caregiving.

Residential care – Institutionalization emerged as a common concern among the participants of this study. One man explained,

There's really no nursing homes, retirement homes in this part of Canada that are geared for gay people. In a lot of the retirement homes that do exist, gays aren't welcome. Or, if you go, basically you go back in the closet. I know that is a concern for a lot of the gay community (age 62).

Figure 5.6.1 Perceived Unique Health Need(s)



Another participant expressed the desire to have other lesbian peers in residential care in order to have support creating a comfortable environment. Most respondents articulated feelings of trepidation when it came to staff's ability to embrace individuality in a residential setting. With respect to other types of housing one male communicated a need for living arrangements that were both gay friendly and affordable. Another man expressed his apprehensions by specifically referencing homophobic qualities within BC Housing.

Social networking/Peer support – Isolation was outlined by many respondents as a common problem. Accordingly the majority of study participants expressed a need for support from an accepting social network of peers. "I think that one of the things for a

health need would be companionship...I think that [peer support] should be part of a health need because that would help the physical health” (female, age 71). Another female respondent expressed a general need for cooperation among the queer community to organize assistance and increase the frequency of meaningful communication. One man stressed the need for diversity in interests groups explaining that there should be social situations for men only, females only, as well as mixes.

Support for mental health – Participants noted a considerable need for services that support mental health and aging. One woman specifically noted mental health and addiction support as a more pronounced need in the aging queer community compared to heterosexual counterparts. One man expressed the following thoughts about body dissatisfaction:

The medical needs are different. There needs to be counsellors who are aware of... well I mean the straights need the same thing but we can ace them. Okay you're gay, this is what you can expect to happen to your body and this is what you can do. This is how you can maintain your desirability quotient. Are you meeting your emotional needs or are you meeting a fixation (age 64)?

Also noteworthy here were participants needing various levels of continued support as a result of surviving physical, sexual, and emotional abuse.

There was a lot of physical punishment, a lot of emotional put downs. And so all that stuff eventually catches up with you and then dealing with what I call the trauma of being gay, it's like one thing piling on top of one another... Being whipped with a dog leash or an extension cord. Always being told that I was stupid and I was useless and that I would never amount to anything. I have health problems, I have self esteem problems in a big way even now. I see myself as a failure even though there are successes there (male, age 52).

But you know basically what happened for me in those years was that there was no safety anywhere. There was no safety outside of the home

and then with the incest in the home, there was no safety anywhere (female, age 68).

Recognition/Visibility – This theme emerged as the strongest unique need for older lesbians and gay men. “In the larger picture it’s not being visible. I think that’s probably the major one because it affects the physical health. It affects the emotional health. It affects mental health. Just generally it affects my whole being” (female, age 66). Under this theme participants needed increased communication around sexual orientation with service providers, a greater presence of gay culture in service provision, and recognition of alternate lifestyles, worldviews, gender norms, and sexual relationships as older adults. It was believed that medical research concerning unique aspects of aging and homosexuality would transpire with increased visibility. A need for special recognition in the queer community, especially among younger cohorts was also expressed. Furthermore, some needed access to resources in the queer community, noting limited supports for adults without HIV/AIDS.

Caregiving – This theme captures a unique need for caregivers since respondents noted limited supports from caregiving families especially in cases where the person in need is missing the support of their family of origin, and has no children and/or partner. A few study participants in this scenario expressed feelings of uncertainty for their future. Consequently unique needs around representation and advocacy surfaced. One woman directly expressed her need to have someone from the queer community look after her physical needs.

As a follow up to this question study participants were asked what adaptive strategies they rely on to help meet these needs. Six people (35%) identified ways by which they have adapted. Three have sought peer support/social contact (e.g. programs

offered by The Generations Project), one exercises caution accessing care for fear of intolerance, and another woman relies on her partner to help meet her unique needs. One woman continually affirms her persona as a lesbian to combat recognition and visibility issues. Finally, one woman said the following:

I talk with friends about things, sometimes educate healthcare professionals... look at alternative programs that might meet my needs better than your standard medical approach to things. I look to my own community for answers before I look to medicine so that's an adaptive strategy I guess. And I do a lot of my own research and my own reading on things (age 54).

This study attempted to further explore how ethno-cultural issues uniquely influence health. Participants were asked what unique health needs (if any) older lesbian and gay adults from diverse ethnic or cultural backgrounds have? All but one participant who had an aboriginal cultural heritage were not visible minorities. Efforts were made to recruit ethnically diverse participants using the snowball technique however no one who fit the eligibility criteria of this study was identified. As a result, most responses to this question are based on stories or speculation and often prefaced by a comment recognizing their relative position of privilege. Two main themes emerged: 1) isolation, and 2) queering ethno-cultural differences.

Isolation – Study participants stressed that isolation could be more pronounced among ethnic lesbians and gay men relative to both heterosexual and homosexual communities.

One woman recalled the following conversation,

They were saying that they don't feel at home in the queer community because they're not white and because they're seen by other gay men as exotic sexual partners and they also didn't fit fully in their cultural and/or religious community because they had to hide their sexual orientation (age 66).

A more pronounced lack of advocacy, caregiving families and familial support in general was discussed. Thus increased availability of counselling and supportive services was brought up as a unique need. Since the consequences of homophobia are different across cultures at a macro level and trickle down to influence social networks and self perceptions at the meso and micro levels, a unique need to recognize individual circumstance was expressed.

Queering ethno-cultural differences – Study participants stressed that the cumulative effects of religion, background, experiences, history, and cultural expectations in a queer context results in unique needs. One respondent commented that the impact of this stress on physical, emotional, and mental well-being could be more severe. Another stressed that ethnocentric barriers hinder recognition of ethno-cultural differences. For example, one individual explained that Asian gay men are typically attracted to older Caucasian men and will often hide in heterosexual marriages due to the consequences associated with coming out in cultural communities. Hence, recognition of norms, gender roles, and differences concerning attraction, courtship, and life circumstances often go unnoticed.

At the second interview participants were reminded of the unique needs that they outlined (if any) during the first interview. They were then asked if they had ever presented them to a healthcare professional and if so, what response did they receive? Three study participants answered yes, two were generally well received and one reported that it was not appreciated.

Well I did have a gay doctor and I faxed him to death because I used him like a psychiatrist. I would write out all of my feelings, psychological problems or whatever and kept faxing them to him. The guy did not appreciate it (male, age 62).

Respondents who answered no did so because they lacked faith in types of responses they anticipated. One woman said, “I just can’t see the point. I don’t find a lot of them are very knowledgeable” (age 55). Another one anticipated lip service from her healthcare professional explaining, “The impression I get is that they know what is politically correct but they really don’t know what I mean” (age 68).

5.7 Research Question #2

The second research question addressed in this study is ‘how are the specific health needs of older lesbian and gay adults unmet?’ This question is similar to the first research question in that it asks participants to comment on health issues particular to sexual orientation and aging. Furthermore, it requires a perception of unique health situations. Research question number two builds on the first by asking participants in what ways they perceive their specific health needs to be unmet. To answer this question all study participants were directly asked in what ways their needs were not being met. Ten participants (female=6, male=4) felt that they had unmet health needs at the time of the interview whereas seven reported having none (female=2, male=5) (Figure 5.7.1). Compared to male participants, women reported having more unmet health needs. Those who reported having their needs met explained that they were successfully proactive with their care needs or were satisfied with imperfection. One male said, “My emotional, psychological, physiological and sexual needs aren’t being met. But does anyone have their needs met 100% of the time? Even in a relationship? Committed, fixed relationship? No....there’s ways I can compensate” (age 64). The ten respondents with unmet health needs cited physical, social, and systemic needs.

Physical health needs – Pain management was the most frequent unresolved need followed by chronic disease and mental health management. Other people were dissatisfied with the lack of information their doctor provided with respect to sex and aging, perimenopause, and aging women and health issues in general. Chronic fatigue management was also insufficient for one person.

Social health needs – Three people who previously expressed being isolated noted missing peer support and companionship as an unresolved need.

I think that one of the things for a health need would be companionship. Somebody who you could talk to and not just on a basis of straight or gay but even if it's a companionship that you can talk the same language and maybe have a few laughs (female, age 71).

Other participants were dissatisfied with transportation services to the extent that it influenced their mobility. Unmet spiritual needs were also mentioned.

Systemic health needs – This theme emerged after four participants expressed dissatisfaction with the level of competence their care providers were able to provide them.

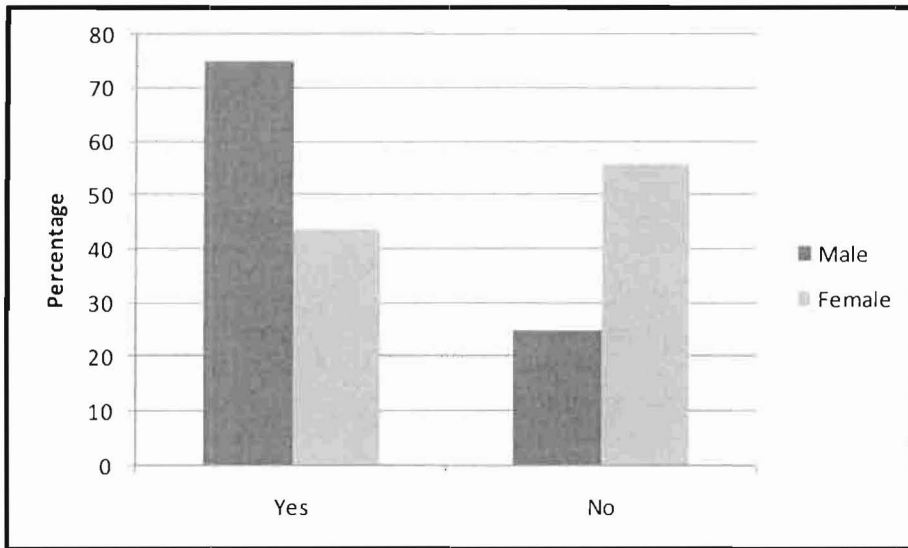
In terms of where our needs have not been met, the main issue for me is cohesion. That to be able to put us together as whole people with an understanding of our aging and our physical health and our emotional well-being and our culture as queers, lesbians, however you want to name that, it's difficult (female, age 68).

Others expressed frustration with the ignorance of their healthcare provider in establishing a safe environment to come out; "He [doctor] certainly didn't speak to my life experiences, my health experience, what was going on with my body in that initial interview at all" (female, age 54). Other respondents were dissatisfied with the general lack of acceptance they experienced in the healthcare system.

There's a difference between accepting in a way that means 'it doesn't make any difference'. That to me is not acceptance. It does not take into account that it does make a difference. You know when somebody says 'well it doesn't make a difference to me', well sorry, it should. Because it is different (female, age 68).

Finally, three people expressed frustrations with wait times.

Figure 5.7.1 Percentage with Unmet Health Needs



5.8 Research Question #3

The third research question addressed in this study is 'how can healthcare agencies better address the needs of older lesbian and gay adults?' All study participants were asked if they saw room for improvements in eldercare services and if so, where? All respondents answered yes and offered improvement suggestions in the areas of living arrangements, education, and supportive services for older adults.

Living arrangements – Many respondents expressed a desire for greater availability and choice in residential care. In this context choice refers to residential care options offered to lesbians and gay men only, as well as a mix of heterosexual and homosexual older

adults. Some were dissatisfied with availability of comfortable living accommodations in general and conveyed a desire to increase housing options near their communities of origin.

Education – This theme emerged when study respondents communicated a need for improvements within eldercare services’ understanding of the aging queer community. It was expressed that more research and staff education would increase recognition, inclusivity, and meaningful interactions in eldercare services.

Supportive services – Most participants discussed improvements that have been classified by this theme. Among the more common responses were better wait times, greater accessibility to service information, and increases to home support to promote aging in place. “Keeping people in their homes as long as possible and again having queer or queer knowledgeable folk to support people... I’m certainly advocating that all of the agencies hire queer folk and let it be known” (female, age 68). Others wanted improvement to the Handy Dart transportation system, better food in hospitals and residential care, and increased social services for isolated people over weekends and holidays. Increases in funding for eldercare services in general were commonly discussed.

To follow up to this question, study participants were asked how healthcare agencies in general can better address the needs of older lesbian/gay adults. Similar themes emerged: education and evaluation, advertisement/communication and housing options.

Education and evaluation – Respondents expressed an overwhelming need for education.

A lot of straight people will see the gay lifestyle and they think going down to the bars and snorting ecstasy and all that kind of stuff. There are so many varieties of gays and lesbians. I think the staff need to be better educated (female, age 55).

It's not my first choice of a fun thing to do on a Saturday night...have my prostate removed. And it does affect one's self image and so on. When I came out [to a sex clinic worker] a gay and asked about certain practices, I don't know I just did not get a... I got a professional front. But there was something about the way they responded, it just left me feeling just a little bit icky (age 64).

Education was specifically mentioned for the following areas: queer lifestyles, understanding unique challenges, behaviours associated with internal homophobia, and economic variability. With respect to evaluation, it was felt that agencies could better address the specific needs of older lesbians and gay men if they identified and addressed inherent heterosexism.

I think that all, certainly all residential care, all assisted living, all adult day programs, all senior centres, neighbourhood houses that provide services for seniors, all of them need to stop and take a look at the heterosexism that exists within their agency. Because they all have it. They all need to do what I call organizational development for change. That brings more visibility to aging and older queers. And that guarantees that people's sexual orientation will be respected and that their needs will be met in ways that allows them to be out if they choose to be (female, age 66).

Advertising/Communication – Many study participants wanted healthcare agencies to advertise queer competency. For example, display queer images and symbols on promotional materials, websites and window fronts. One person suggested that agencies need to explicitly state within their statement of inclusion that they provide services to all people regardless of age, race, sexual orientation, and gender identity. “We need to see it spelled out... We don't trust the system. We don't trust agencies because they never have been inclusive for us so why would we think it now unless they tell us they are” (female,

age 66). Agencies can communicate queer acceptance by celebrating pride and including queer content in movies, games and discussions for example during service delivery.

Some respondents suggested that healthcare staff need to ask for the individual needs and wants of their clients free of heterosexist assumptions. Asking health related questions in the 'right' way allows people to come out if they choose as well as express the diversity of individual situations.

Housing options – Some study participants expressed fear of separation, privacy, and choice should their failing health require residential care services. It was suggested that campus of care designs and private room options be increased.

5.9 Summary of Findings

This summary highlights the major findings of this study. The majority of respondents self-report their physical health as good compared to other adults their age. Physical health is maintained by exercise and medication; only a few preferring alternative therapy use (n=3). Most respondents are fully independent, do not report any high risk behaviours, and perceive falling and external hostility as main safety threats. The majority describe their social health positively and are satisfied with the amount of peer support they receive. Most maintain close relationships with families, friends and neighbours, while 35% (n=6) report having no close relationships. With respect to sexual health, most (53% or n=9) were satisfied with the current status of their intimate relationship(s). Disclosure of sexual orientation was varied among respondents depending on the relevance of the situation and perceived rejection. All participants visited their GP at least once per year and 71% (n=12) discuss sexual orientation with

their doctor. Eight people (47%) had personally experienced hostility and/or heterosexism from healthcare professionals and all participants knew someone who had.

All but one participant has experienced mental health issues at some point throughout the lifecourse. Depression emerged as a prevalent condition among study participants with 14 (82%) people reporting acute or chronic episodes throughout their lifetime; seven of which (41%) were managing depression at the time of the interview. The majority reported being satisfied or very satisfied with life. Compared to females, males reported more negative self perception with aging.

The specific research questions addressed in this study revealed that older lesbian and gay men feel that they have unique health needs for residential care, social networking/peer support, mental health support, recognition/visibility, and caregiving. Ten respondents (59%) felt they had unmet health needs at the time of the interview (significantly more lesbians than gay men) in the areas of physical, social, and systemic health. Finally, respondents felt that their health needs could be better addressed by healthcare systems with improved housing options, education, communication, and advertising.

CHAPTER 6: DISCUSSION

This chapter discusses the main findings of this study relative to their relationship with the literature available from previous research. It also highlights the contribution of the guiding theoretical framework for future research. The usefulness of this study is elaborated through practical implications and recommendations. The chapter ends by outlining some of the limitations of this study and directions for future research.

6.1 Study Findings and Previous Research

Unique health concerns affecting lesbians and gay men were outlined in chapter two. The following section highlights how the needs assessment conducted in this study confirms (or rejects) the health concerns identified in the broader research literature.

Physical Health

Five study participants (29%) reported diagnoses of cancer at some point in their life at the time of the interview. A literature review revealed increased risk factors for the development and increased morbidity of some cancers among lesbians and gay men. The Canadian Cancer Society reports increasing rates of new cancer cases and deaths for two main reasons: 1) a growing population and 2) an aging population (*Canadian Cancer Statistics*, 2008). Current incident rates project that almost 40% of all women and 45% of all men will develop cancer during their lifetimes, with 42% of new cases and 60% of deaths due to cancer occurring among people 70+ years old. Incident rates by age and sexual orientation remain unavailable. While there are a considerable number of participants diagnosed with cancer in this study, additional research is needed to make

definitive conclusions pertaining to differential rates. Furthermore the sample size of this study is too small to make meaningful comparisons to populations at large.

In addition, three of the five participants felt dissatisfied by a lack of relevant information, heterosexist assumptions, and/or how information about their diagnosis was communicated. Specific research on homosexuality and cancer, better cancer screening, health promotion and supportive services, could lessen the impact on the Canadian healthcare system and provide more relevant care.

The proportion of annual positive HIV tests among Canadian adults 50+ is increasing (*HIV/AIDS Epi Updates*, 2007). No study participants reported diagnoses of HIV or AIDS although it was frequently brought up during interviews. Many respondents, especially gay men, recalled the impact that HIV/AIDS has had on their life; loss of friendships, diminishing peer networks, and the influence that this has had on how they have aged. “A great number of gays have died from AIDS leaving a gap in the population especially in my age group... that would make it harder to make friends because they’re not here, they’re dead” (male, age 62). Another male participant felt that too many healthcare dollars are allocated to programs for HIV/AIDS relative to the number of well lesbians and gay men who could benefit from an increase in other supportive services. This is consistent with Shankle *et al.* (2003) who found that older adults may feel marginalized by peers and services for people with HIV/AIDS.

The literature review also showed that younger lesbians and gay men are more likely to use alcohol and drugs and have higher rates of substance abuse (Bickelhaupt, 1995; Bradford, Ryan & Rothblum, 1994; Dean *et al.*, 2000; O’Hanlan *et al.*, 1997; Shankle *et al.*, 2003). Even though prevalence rates for older homosexual adults are

unknown, one could speculate that past drug use influences aging, health, and health needs. Several participants reported cigarette smoking and experimental drug use in younger days. Only two participants in this study reported current substance use; one who continues to battle alcoholism and another who has a prescription for medicinal marijuana to manage pain. Interestingly, both expressed frustration with their current situation. One person was disappointed by the stigma of drug use in their peer group. The other person felt like they could not relate to the heterosexual dominant nature of Alcoholics Anonymous support, as well as the dominance of younger people using hard drugs at a queer support group.

These two cases illustrate an age divide in levels of social acceptance (and perhaps prevalence) and relevant supportive services for older adults. Both instances highlight some of the isolating effects of drug use and demonstrate a need for increased support and research.

Mental Health

Research profiling the mental health status of older lesbians and gay men in Canada is unavailable. A literature review reveals contradictory hypotheses, namely higher life satisfaction, crisis competence, and acceptance of the aging process as well as higher prevalence rates of mental illness. Sixteen study participants (94%) reported being diagnosed with acute or chronic psychological distress or mental health issues at some point in their life. "I had a minister, I had a psychologist, and I had a psychiatrist all trying to turn me into a straight person, and I was a willing compliant" (male, age 62). Among the diagnoses, depression was most prevalent with 14 (82%) people reporting acute or chronic episodes throughout their lifetime (8 men, 6 women). Seven (41%)

people were managing depression at the time of the interview. These data are consistent with those found in studies such as D'Augelli *et al.* (2001) showing that mental illness is a common health concern among older lesbian and gay men. There is no current Canadian data available to compare the prevalence rates of mental illness between hetero and homosexuals.

This study also indicates that the majority of respondents (13 or 76%) are satisfied or very satisfied with life. Research showing a significant relationship between homosexuality and advanced crisis competence or mastery of stigma among older adults remains inconclusive (Berger, 1995). Interestingly, the participants of this study report relatively high life satisfaction despite experiencing psychological distress and mental health issues. These findings suggest that there are both similarities and differences in the way health problems are perceived and experienced by older lesbians and gay men.

Self perception related to aging is also relevant to understanding psychological health. Beren *et al.* (1996) found that younger gay men were more distressed over body dissatisfaction compared to heterosexual men; there were no significant differences found between lesbians and heterosexual women. The findings of this study lend new insight on changing self perceptions of aging lesbians and gay men 50+ years of age. Specifically, gay men reported more negative changes related to self perception and aging compared to lesbians. Consequently, this finding supports the theory that the aging process influences the self perceptions of lesbians and gay men differently.

The literature review revealed that homosexual people have often been victims of abuse, sexual assault and violence throughout their lifetime. Since aging lesbians and gay men have spent a significant amount of their lifetime dealing with these experiences,

Shankle *et al.* (2003) hypothesized that it could influence help seeking behaviour and lead to increased isolation with age. Although five people reported incidents of violence and abuse, three participants of this study are survivors of extreme physical, emotional, and sexual abuse. Relative to other study participants reporting no aggressive experiences, these three individuals appeared to be more isolated reporting little to no social activity. Another three expressed strong feelings of mistrust toward medical practitioners. These respondents were particularly worrisome of external safety threats such as being robbed and/or gay bashed and subsequently restricted activities. Brotman *et al.* (2006) report fear of institutional environments and dependency among survivors of violence, abuse and/or assault. As a result, they found a common desire to live in a retirement home or community that addresses the needs of aging homosexual adults. Respondents in this study echoed this desire.

The findings of this study support the notion that experiences of violence, sexual assault, and abuse influence health. This is troublesome since restricted activity and mistrust could lead to increased isolation and negative health consequences such as inactivity and limited social connectivity.

Accessing Healthcare

North American literature has identified multidimensional barriers that older lesbians and gay adults face when accessing healthcare services (Boxer, 1997; Brotman *et al.*, 2002; Cahill, South & Spade, 2000; Ramirez-Barranti & Cohen, 2000; Ryan *et al.*, 2000; Shankle *et al.*, 2003). As a result, it is believed that older lesbian and gay adults may avoid accessing medical services and in turn rely on alternative therapies (Ryan *et al.*, 2003). This study addressed this supposition by asking questions about the health

seeking behaviour and perceived accessibility of services. Overall the findings of this study refute the hypothesis described above. Participants were generally satisfied with the information they had accessed or received on services. They also acknowledged the *Generations Project* as a key resource. All participants reported having seen their family doctors at least once per year. Moreover, the majority of respondents (n=12 or 71%) felt comfortable discussing sexual orientation with their physician(s). Only three people relied on alternative therapies over traditional biomedical services (this number would be higher if cost was not a prohibitive factor for many participants). The contradictions between these findings in relations to past research may be explained by the uniquely large amount of resources available to gay adults in Metro Vancouver in comparison to other cities.

A significant finding to note, however, is the tendency for participants to report experiencing hostility/heterosexism from healthcare staff at some point in their life. Almost half (n=8 or 47%) had these experiences and almost all who had not, reported knowing a peer who had. It was expected that these experiences would translate into significant barriers influencing help seeking behaviour, as well as a desire for proprietary services. However, this study found that all participants were comfortable receiving mixed services despite being heterosexually dominant. Emerging themes in the data indicate that participants are selective when choosing service providers, which may account for this discrepancy. Respondents were more concerned that their service providers were competent and not heterosexist or homophobic.

These results describe a general feeling that services are accessible. Thus, a systematic avoidance of medical services suggested in the literature was unsupported in

this study. As previously stated, this finding may be attributed to the infrastructure of support that exists in Vancouver through programs like the *Generations Project*. The increasing population of homosexual people in Vancouver creates a demand for gay and/or gay-friendly service personnel. Furthermore, participants may also perceive limited barriers because of increased coping skills and perseverance.

Unique Health Needs

Literature focussing on gay issues commonly recommends that service providers be more in tune with the needs of homosexual clientele without stating exactly what those needs are. How are these needs unique compared to heterosexual counterparts? The findings of this study partly address this gap in the literature. Interestingly, nearly half (n=8 or 47%) of the participants believed they had unique needs as an aging lesbian or gay man, while the remaining participants did not feel they had any unique needs or were unsure. A comparison was made between participants who believed that they had unique needs versus those who did not. No traits emerged with consistency. The unique group is comprised of adults who are both very isolated with little social connectivity and those who are very active in the community and out of the closet. They also vary with respect to education, socio-economic status, and experiences of hostility/heterosexism. This indicates that there is great variation in the ways older lesbians and gay men actualize their sexuality.

Unique components expressed by participants include: a need for gay-friendly residential care options, need for social networking/peer support, need for supportive services around mental health, increased recognition and visibility, and a need for assistance with caregiving/advocacy. In their 2003 study, Brotman *et al.* also found a

unique need for proprietary long term care and housing options, and identified visibility and isolation as a common difficulty. Moreover, culturally relevant supportive housing options are a concern in American literature (de Vries, 2006).

It can be argued that these needs are common to both aging heterosexual and homosexual adults. What appears to be unique however is the need for housing, socialization and other supportive services to recognize and address existing practices that perpetuate heteronormativity. The assessment of needs conducted in this study revealed two substantive findings: 1) there is great diversity in the health experiences and perceptions of health among older lesbians and gay men, and 2) their unique needs involve change in others. The concept of a health need is commonly understood as something personal, existing within the self rather than in others. In this context, supportive services (others) need to recognize that systemic change is needed at a macro level rather than within the client at the micro level.

Emerging themes from participants who reported having unmet needs support this contention. Ten respondents expressed having unmet needs related to information that their doctor could not provide on sexuality and aging, limited peer support and isolation, heterosexist assumptions from healthcare professionals leading to discomfort and communication barriers, as well as a general lack of acceptance/competence within the healthcare system.

6.2 Study Findings and Theoretical Framework

This study was approached from a feminist/queer perspective within an ecological framework. More specifically Bronfenbrenner's *Ecological Theory* was used to conceptualize health needs within micro, meso, and macro nested environments. Data

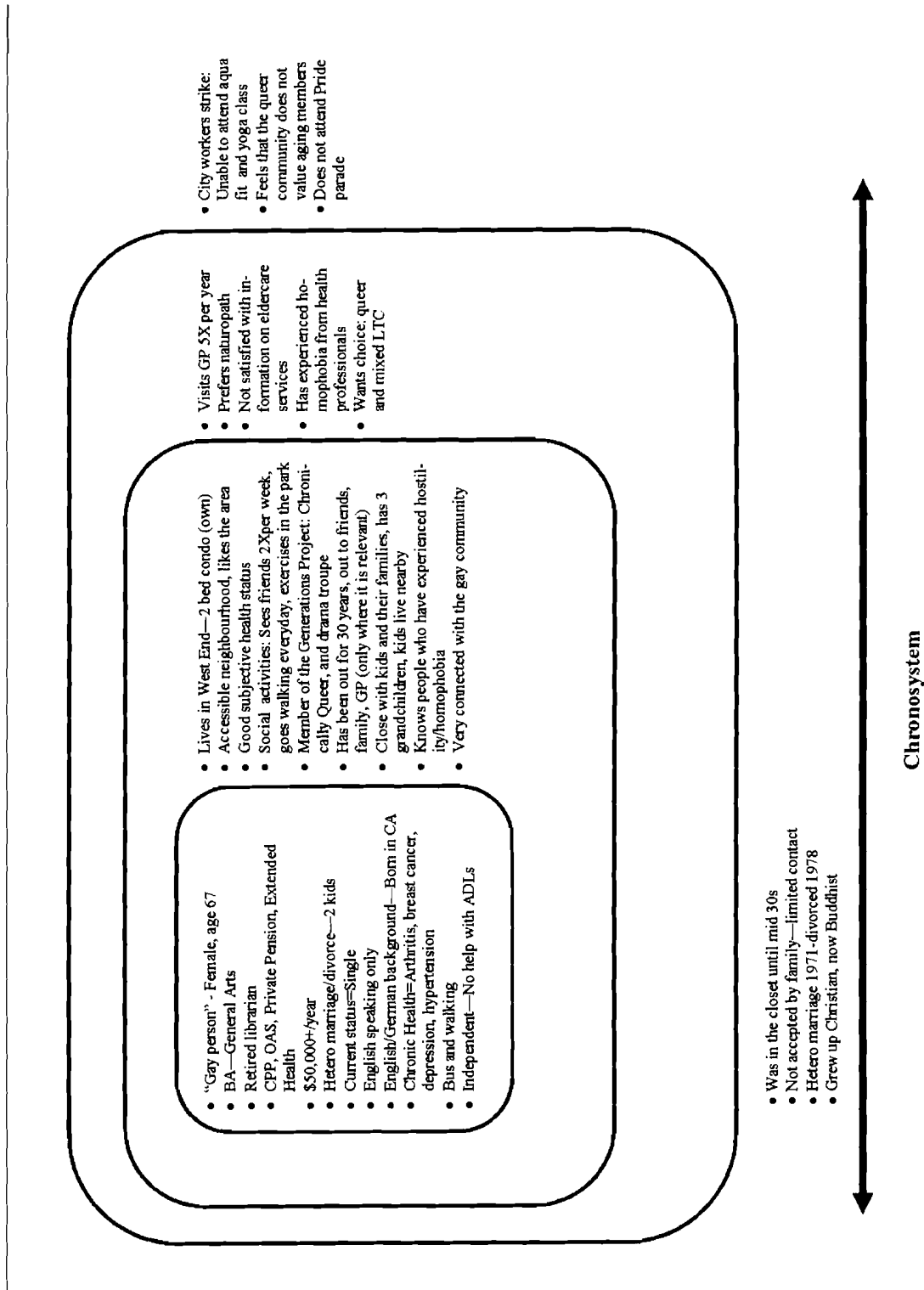
from both interviews were placed within this framework to better understand the circumstances of each participant. This method helped to view individual characteristics and experiences more broadly and assisted with conceptualizing how these factors could influence perceived health (Figure 6.2.1). By doing this, the author observed that some participants described their personal experiences independent from their surrounding communities and larger cultural influences. When asked questions about how cultural background has influenced aging for example, these participants often answered ‘I don’t know’ or ‘I’m not sure’. These participants appeared to be less interested in multidimensional conceptualizations of health. Failing to make these linkages could be attributed to lack of trust with the author, limited introspection and analysis of experiences, limited concepts of entitlement or internal homophobia, experiences of homophobia/hostility, and/or the effects of social marginalization over the life course. Yet, other respondents expressed a clear overlap between aspects of their self, communities and culture.

My lesbian culture does mean that I’ve aged differently than if I was heterosexual... it’s just that understanding and ability to be outside of the box in all kinds of ways because we are outside of the box. And it affects our whole life (female, age 72).

Some respondents described lack of cohesion between aspects of their life as a consequence of their sexuality: personal characteristics, family dynamics, community, social networks, political views, spirituality, etc. In these situations, the social ecological model helped to explain why and how the study participant made micro, meso, and/or macro connections.

The ecological framework was especially useful in considering linkages between the data, the chronosystem and the exosystem. There is a considerable difference

Figure 6.2.1 Socio-Ecological Profile Example



between the youngest (age 53) and the oldest (age 87) study participant. Taking into account the differences in social acceptance and services available to homosexual people, health may be experienced (and perceived) differently for someone in their 50s compared to 80s. In addition, a number of participants discussed how the influences of their chronic conditions for example have progressed over the life course (e.g. mental illness). This progression became a valuable aspect in understanding how health was being conceptualized by participants at the time of the interview. Also noteworthy is the temporal component of being 'in the closet', coming 'out', or somewhere in between. There is considerable variability in the identity careers of aging lesbians and gay men. The chronosystem highlighted these types of changes that happen over time and, in turn, helped to demonstrate potential influences. The exosystem, a structure that includes events occurring regardless of the person as an active participant was useful for recording the impact of the Vancouver Civic Workers strike, for example. Some study participants were unable to attend routine recreation programs due to closures.

Although the ecological framework helped to consider multidimensional information on health, it also presents some limitations. This theory requires researchers to consider multiple social ecological environments that may not be the motivation for participants' responses. Consequently, researchers are at risk of over analyzing and over stating conclusions. It should also be noted that the design of this study limits the full potential of an ecological framework. It was designed as a micro level study, where macro and meso issues were explored through individual experience (micro) only. Thus, this limitation is attributed to study design rather than the framework. The feminist/queer perspective guiding this study also presents limitations. By their nature, they focus on inequality, power dynamics and differences. Risks associated with this perspective may

include looking for differences where they may be absent or less pronounced. For example, study data revealed that the health needs of older lesbians and gay men are not too different from the needs of older heterosexual adults in general. Through self reflection (recorded memos) and member checking the author found instead that the need for recognition from others (aging peers, social services, professionals, etc) was the unique component.

6.3 Recommendations and Practical Implications

This explorative study is an attempt to bring a new awareness and understanding to the specific needs and experiences of aging lesbians and gay men, and in turn, advance service development. Since one of the main research questions in this study was directed at how healthcare agencies can better address the needs of older lesbians and gay men, participants offered areas of suggestion and recommendation. Emergent themes are discussed in Chapter 5. The following section builds on suggestions made by participants and by highlighting recommendations and outlining practical and methodological implications.

First, greater development of residential care options for lesbians and gay men only, as well as mixed care is recommended. Public and private housing providers need to consider how sexuality influences existing and new housing models. Privacy, level of care, and room occupancies are imperative features for aging lesbians and gay men. Campus of care models can be increased to allow caregiving partners and spouses with limited and sometimes non-existent support networks to remain more together. Consistent with the general population, institutionalization was perceived negatively by all participants thus development around living arrangements is most pressing. The City

of Toronto is a leading example for publicly funded models of long term care for aging homosexual people. In Vancouver, *Plum Living* is building a private retirement community offering assisted living style rentals, condominiums and service packages. Affordable housing developments should take into consideration differences in the socio-economic status of the queer community. Although the perception exists that there is a considerable number of highly educated and wealthy gay men, lesbians and unattached gay males often have limited economic resources.

Second, education is an integral part of meeting the specific needs of aging lesbians and gay men. More specifically, healthcare agencies need to be educated about queer lifestyles, unique challenges in the queer community, behaviours associated with internal homophobia, inclusive communication styles, and socio-economic variability among queer people. This kind of staff training will help establish gay-friendly values into the professional culture. Hiring homosexual staff will also bring queer issues to the forefront. In some cases, organizations may not know where to access training resources. Since achievements have in large part been made from the bottom up, resources are more widely available from grass roots organizations. For example, *The 519 Community Centre* in Toronto and *The Centre* in Vancouver offer in-service training for professionals. Reports, brochures, tool kits, learning modules and other useful resources are also available at these types of organizations. Furthermore *The Generations Project* provides a unique example of community services for aging homosexual people that can be used as a template for development in other rural and urban centres across Canada. Involving aging lesbians and gay adults in training and community development is important to gaining trust and providing better inclusivity in a predominately heterosexual service industry.

Third, service providers should undergo systemic evaluation assessing queer competence. This course of action will help uncover systemic heterosexism and highlight areas where greater inclusivity is needed. Some progressive organizations now employ diversity officers to help meet the multidimensional needs of ethno-cultural clientele. Gender identities and sexual orientation are often missed in diversity policies and training mandates.

Fourth, services and organizations should advertise their knowledge and support of the queer community. Queer competency can be publicized by using queer images on promotional materials, displaying a rainbow sticker on store fronts, and adding queer content and symbols to websites for example. A general lack of trust among lesbians and gay men requires that organizations be explicit about inclusivity to the queer community within diversity statements, mission statements, etc. Agencies providing services to older adults can show their support by adding queer content to programming (e.g. movies, games, discussions, trivia, etc), celebrate Pride, march in Pride parades, and participate in fundraising opportunities for persons living with HIV/AIDS and other queer issues.

Fifth, service providers should be mindful of heterosexist assumptions and how health-related questions are asked. Learning inclusive language can help to create safe environments where clients feel comfortable disclosing their sexual orientation. Since homosexual adults vary with respect to their degree of comfort being out, asking questions in the right way will allow people to come out if they so choose. It has become customary for public healthcare agencies to conduct some form of needs assessment. Given the vast diversity of perceptions and life experiences of their older lesbian and gay clients, agencies should tailor their needs assessment by asking open-ended questions

about health needs. It is important that healthcare providers do not perpetuate heteronormativity by avoiding discussions related to sexuality. Rather, they should be familiar with the meaning and context of queer terms and initiate communication that respects privacy. Language can be used as verbal clues to indicate safety and understanding to clients. Clients may not articulate any or accurate information concerning sexuality, thus assumptions about hetero/homosexuality should not be made.

Practical Implications:

Data from this study generated information about how the health needs of respondents are currently being unmet, what health needs are perceived as unique, and how healthcare agencies can better meet these needs. This information is useful in a variety of contexts. It can be used by researchers to identify gaps in the literature and necessary areas of future research and development. Studies of this kind illustrate a need for even basic information, such as reliable population estimates and health profiles. Health organizations and authorities can use these to inform resource allocation and areas of development such as housing options, social networking and mental health support. Agencies providing services to older adults can use the results of this study to promote internal evaluation; assess heterosexism and level of inclusivity.

This study provides an overview of physical, social, mental, and sexual aspects of health as perceived by aging lesbians and gay men. Their health experiences and perceptions of accessible healthcare services have also been presented. This information can be used in published journal, magazine and newspaper articles to promote greater visibility and recognition of aging queer culture.

Methodological Implications and Recommendations:

Qualitative researchers should be mindful of trust issues in the queer community. Accordingly, researchers should increase confidence and participant levels by becoming more present in the queer community as an ally: contact queer organizations, attend community events, donate time as a volunteer, etc. The author's affiliation with *The Generations Project* was useful in revealing information resources and learning opportunities, as well as promoting recruitment. Advertising for studies of this kind should make use of multiple outlets in order to help attract a range of participants. For example, researchers can advertise in gay directories, community newspapers, billboards (especially during Pride week and other widely attended events), store fronts, senior's centres, and online community postings. Advertising should not be limited to known gay ghettos and organizations to help ensure representative samples. Recruitment difficulties in this study resulted in lowering the age requirement from 65+ to 50+. The author found it easier to recruit participants between 50 to 65 years of age. Researchers should be mindful of this cohort effect since baby boomers may be more willing to participate in research studies. Researchers interested in studying aging homosexual adults should also be encouraged to seek funding to assist with the cost of transcription services, advertising, and participant compensation.

This study required participants to self report their health profile. In some cases the author suspected that failing memory influenced the accuracy of this information. Researchers using this design should consider administering a brief mini mental examination to potential participants. When designing explorative needs assessments, the author recommends phrasing interview questions in an open-ended format. This style of

questioning is a non-threatening communication style that promotes a diversity of responses. However, it also prolongs interview times and makes coding, analysis and cross comparing a more difficult process. Member checking is strongly recommended to help qualitative researchers maintain accuracy while working through an abundance of information and analysis. More comprehensive needs assessments with closed ended or Likert scale-based questions should be considered for researchers with sample sizes of 20+.

Finally, the author advocates the use of a theoretical framework to guide research studies of this kind. This research was guided by a feminist/queer perspective synthesized with a socio-ecological framework. This framework was used to direct the research towards exposing the intersection of gender, sexuality, ability/disability, race, class, and ethnicity, and how these factors subsequently advantage or disadvantage people and/or influence their perception of health needs. Self reflections were recorded through memos and became an important part of the data collection and analysis process. These memos lead to additional questions, points of clarification, and changes that were followed up on during member checking. Finally, the ecological model helped to create a one-page, multidimensional character profile that was used to organize information at a glance and compare participants' cases. The author feels that this framework would also be useful for researchers using a case study design.

6.4 Study Limitations

Methodological limitations are common among populations of people who are hard to locate. Establishing a representative sample of older lesbian and gay respondents is currently impossible due to gaps in enumeration. Strict definitions qualifying

membership as a lesbian or gay man were not used in this study; participants self identified only. The same limitation applies to participants' self disclosure of chronic health profiles. Another threat to the accuracy of information includes the use of transcription services. Three transcribers, including the author, were used to generate interview transcripts for this study. To help with accuracy the author reviewed each transcript for omissions and phrasing since hired transcribers were not always familiar with slang and other language used in queer communities.

Due to recruitment difficulties the age requirement for participation was reduced from 65+ to 50+. With an age range of 52 to 87, it is reasonable to assume that the health experiences of someone in their 50s significantly differ from someone in their 80s. Also noteworthy here is the consequence of the decriminalization of homosexuality in Canada in 1969. A 50 year old participant would have lived through 11 years of criminalization versus 41 years for an 80 year old participant. Due to the limited sample size of this study, cohort differences were not explored.

Although 34 interviews took place to achieve a richness of data, the sample size of this research (n=17) is small and non-random. Informal quota sampling methods and the snowball technique could have created selection bias. This recruitment strategy could have also influenced participation and in turn limit the generalizability of the findings. Member-checking data was important to increase the reliability of the findings. This process provided the opportunity for participants to review analysis for accuracy and consistency and in some cases led to valuable clarification and further explanation. Most participants were recruited through affiliation with *The Generations Project*. Thus, it could be argued that participants of this study could be better connected to community

services and/or in greater need of support (e.g. more depressed, lonely, etc). Ultimately, the geographical restriction of Metro Vancouver also imposes limitations, because it does not allow for the experiences of rural dwelling older lesbian and gay adults. For instance, one participant stated:

When I meet people from smaller cities like Anchorage there's like two lesbians in the whole city and they talk about isolation and then I tell them what it's like in Vancouver, they say well its like heaven. So there's opportunity for everybody here. You don't have to get invisible when you get older (age 71).

Making comparisons between male and female participants is problematic given the small sample size of this study. Although the age range of participants was 52 to 87, differences among cohorts were not analyzed. The author was unable to recruit a significant number of ethno-cultural minorities to explore how ethnicity and homosexuality influence the needs of aging lesbians and gay men. Also missing from this research are the experiences of bisexual, intersexed, transgendered, kink, two-spirited, and other sexual oriented older adults.

As with all social research, there is a certain degree of subjectivity imposed by the researcher in both interpretation and analysis; the proposed research is no exception. Quinn Patton (2002) explains that experience affects perspective and perspective shapes experience. The researcher's prior experiences, assumptions, and goals are especially pertinent to the topic of this research and methodology. Over the last four years the author has been interacting with older lesbian, gay, transgendered, and bi-sexual adults in Vancouver who attend *The Generation Project's* community groups. The author has previous experience interviewing older lesbian and gay adults on the topic of health for smaller research papers. Furthermore the researcher's experience in the gay community

provides a degree of exposure that could also influence communication styles and queer competency. The author is familiar with queer contexts and comfortable discussing issues related to sexual identity. The author's education in post-modern cultural anthropology has also led to an awareness of socially constructed contexts and inequality, an understanding that could also influence subjectivity. Finally, the researcher is a heteroflexible young adult and therefore an 'outsider' in the arena of non-'traditional' sexual identities and the aging queer community.

6.5 Future Research

There are copious opportunities for further research addressing homosexuality and aging. This discussion is limited to suggestions for research relating to the health needs of aging lesbian and gay adults. First, macro level enumeration is required to help establish the extent to which research is needed. Significant research has explored how the social determinants of health influence Canadians' patterns of health, illness, and coping capacity. Missing from this literature is how sexual orientation intersects with the following known determinants: gender, aboriginal status, early life experiences, education, employment and working conditions, food security, healthcare services, housing, income and income distribution, social safety net, social exclusion, and unemployment (Raphael, 2004). Research is required in each of these areas to better understand how the health of lesbians and gay men may or may not be impacted.

In terms of known physical, social, and mental health consequences there is a need for considerable research. Empirical research produced by experiment, observation, and comparisons with heterosexual counterparts are required to broaden our understanding of older sexual minorities. Future studies on homosexuality and aging need to take place

with individuals, communities, organizations as well as the queer population at large. Findings from the multidimensional needs assessment used in this study were used to generate a number of outstanding research questions. Drawing upon the social-ecological model that guided this study, these research questions are outlined in Table 6.5.1. Marked system levels represent where the scope of future research should be directed. For example, the first research question addresses similarities and differences in physical activity. Future research in this area should be designed to capture individual perspectives at a micro level as well as from a population health perspective (macro).

Table 6.5.1 Areas for Future Research

Theme	Research Question	System Level		
		Micro	Meso	Macro
Physical Health	How does physical activity differ between aging lesbian and gay men, homosexual and heterosexual adults?	✓		✓
	How prevalent are some cancers in heterosexual and homosexual older adults?			✓
	How prevalent is chronic illness among aging gay adults?			✓
	How does HIV/AIDS impact the surviving members of the queer community?	✓	✓	
	How do perceived safety risks and precautionary measures influence the health of aging lesbians and gay men?	✓		
	How prevalent is substance abuse, violence, sexual assault, and abuse among aging homosexual adults?			✓
Mental Health	How does chronic mental illness influence the health and aging of lesbians and gay men?	✓		✓
	How are aging homosexual people influenced by negative and positive self perceptions of aging?	✓		✓
	How do criteria for measuring life satisfaction differ between heterosexual and homosexual older adults?			✓

	What are the effects of internal homophobia on aging homosexual adults?	✓		
Social Health	How is aging influenced by homosexual partnership?		✓	
	What are the experiences of aging lesbian and gay men living in residential care? How do experiences in public and private housing differ?	✓	✓	
	What changes do residential care agencies need to meet the needs of aging lesbians and gay men?	✓		✓
	What housing models are needed to accommodate aging homosexual older adults?	✓		✓
	How do heterosexual caregiving/grandparenting roles differ for aging lesbians and gay men?		✓	
	What ways of communicating with aging lesbian and gay adults yields the most comfort?		✓	
	How does being a same-sex widow or widower impact health?	✓		
	How does being a homosexual ethno-cultural minority influence aging?		✓	
	How does knowing someone who has experienced heterosexism/hostility influence the help-seeking behaviour of aging lesbians and gay men?	✓		

Building on this research specifically, quantitative and qualitative needs assessments should be conducted on a wider scale. Data from larger studies can reveal differences between unmet health needs and the perceived unique health needs of older lesbians and gay adults living in rural and urban centres for example. Explorative needs assessments are also required to reveal the unique needs in each of the bisexual, intersexed, transgendered, and two-spirited communities. Finally, with methodological barriers becoming less insurmountable, researchers should feel more confident in making contributions to the sparse literature on homosexuality and aging.

6.6 Conclusion

The costs of healthcare are rising. In a climate of unprecedented population aging, assessments of need become a vital component of determining policy priorities, health promotion initiatives and resource allocation. Lesbians and gay men are not overtly visible in the aging world and are thus not explicitly included in these processes. These omissions create barriers to healthcare services that in turn violate the principle of equality of access under the Canadian Health Care Act. It is also particularly troublesome given increasing emphasis on successful aging. Critical gerontologists are starting to discuss the concept of successful aging and its tendency to be built on the assumption of equal opportunity (Zimmerman, in press). The supposition that older adults can choose a lifestyle that enables successful aging perpetuates heteronormativity. Research studies like the one presented here highlight the necessity for further research by adding to the limited understanding of health risks, which may disproportionately affect aging lesbians and gay adults.

As I reflect back on the journey of this research, I am reminded of the diversity of aging queer communities: variations in identity career, levels of disclosure, generational differences, family dynamics, experiences of stigma, spirituality, etc. What became even more apparent was the enormous social change that participants of this study have witnessed throughout their lifecourse. I exit this study feeling hopeful that society will continue to evolve into a space that recognizes, protects, and celebrates the diversity of aging adults.

APPENDIX

A) Statement of Informed Consent

Research Study Title: *Exploring the health needs of older lesbian and gay adults in the Greater Vancouver Area*

Study Description:

The health needs of older lesbian and gay adults often go unnoticed in healthcare settings and remain understudied by health researchers. This research could lead to improvements in the physical and psychological health and well-being of older lesbian and gay adults by exposing unmet needs, and by making these health needs and the necessary changes to health services more explicit. The findings of this research could also influence the delivery of health services for older adults with respect to resource and service allocation as well as provide a foundation for further research.

This research will require you to participate in two face-to-face interviews that will be tape recorded and transcribed for analysis. The duration of the first interview is approx. 1.5 to 2 hours and contains questions about individual health. The duration of the second interview is approx. 1 hour and involves questions relating to health and social services for older adults, and health service improvement. You will also be asked to review coded transcripts of both interviews for accuracy.

Participation in this study will involve disclosure of sexual orientation and associated health experiences. It is reasonably possible that participants may feel uncomfortable answering questions listed in the interview guide. For this reason, all participants will be provided with a copy of the interview guide prior to consent.

Your participation in this study is entirely voluntary. You may refuse to answer any question that you do not feel comfortable answering and you can withdraw from the study at any time without explanation. If you withdraw from the study, this will have no effect on your relationship with Simon Fraser University or any other organization. Any information that is obtained during this study will be kept confidential to the full extent permitted by the law. Knowledge of your identity is not required. You will not be required to write your name or any other identifying information on research materials. Anonymity will be assured by assigning fictitious names and a numbering system to all tapes, transcripts, and written reports.

There is the possibility that transcripts could be produced by individual transcribers hired by the investigator (Angela Johnston). In this case, all transcribers will sign a confidentiality agreement agreeing to preserve the confidentiality of all information gathered and transcribed, as well as the identities of participants in the interviews. Furthermore, all digital audio files used for transcription and/or documents created in the process of transcription will be destroyed/deleted after their submission to Angela Johnston.

Informed Consent:

The University and those conducting this research study subscribe to the ethical conduct of research and to the protection at all times of the interests, comfort, and safety of participants. This research is being conducted under permission of the Simon Fraser Research Ethics Board. The chief concern of the Board is for the health, safety and psychological well-being of research participants. Should you wish to obtain information about your rights as a participant in research, or about the responsibilities of researchers, or if you have any questions, concerns or complaints about the manner in which you were treated in this study, please contact the Director, Office of Research Ethics by email at hweinber@sfu.ca or phone at 778-782-6593.

Your signature on this form will signify that you have received a document which describes the procedures, whether there are possible risks, and benefits of this research study, that you have received an adequate opportunity to consider the information in the documents describing the study, and that you voluntarily agree to participate in the study.

I certify that I have read and understand the procedures to be used in this study and the personal risks to me in taking part in the study. I have been informed that the research will be confidential. I also understand that I may register any complaint with the Director of the Office of Research Ethics:

Simon Fraser University
888 University Drive
Burnaby, British Columbia
Canada, V5A 1S6
1-778-782-3447
Email: dore@sfu.ca

I understand the risks and contributions of my participation in this study and agree to participate:

Participant's Last Name: _____ Participant's First Name: _____

Contact Information: _____

Participant Signature: _____ Date: _____

Witness Signature: _____ Date: _____

To obtain copies of the results of this study upon its completion please contact:

Angela Johnston: 515-2800 West Hastings St. Vancouver, BC, V6B 5K3,
Department: 778-782-5062, Home: 778-371-9250, Email Address: ajohnsto@sfu.ca

Interview Code:

B) Interview Guide

SECTION 1: SOCIO-DEMOGRAPHICS		
Gender:	Partnership history/marital status:	Year of Birth: <input type="text"/>
Education:	Household Income:	Sexual Orientation Identity:
	-\$10,000 \$10,000-19,999 \$20,000-29,999 No Response \$30,000- 39,999 \$40,000-49,000 \$50,000+	Occupation: F/T P/T Ret
Cultural Background:	Language used most often: Other:	
Description of Living Arrangements (length):		
Place of residence/Community:		
Religion/Spirituality:		
Self-reported Chronic Health Condition(s):		
1) _____ Duration: _____ Severity: mild/moderate/severe Why? _____		
2) _____ Duration: _____ Severity: mild/moderate/severe Why? _____		
3) _____ Duration: _____ Severity: mild/moderate/severe Why? _____		
Benefits: CPP GIS OAS Private pension Extended healthcare		
Main Transportation: Car Bus Bicycle HandyDart Family/Friends		

SECTION 2: Semi-Structured Interview

Individual Health

1. Compared to other adults your age, how would you describe your overall health? (Excellent, good, fair, poor)
2. Activities of daily living include things like meal preparation, bathing/dressing, finances and housekeeping. Do you require any assistance with these activities?
 - 2.b.If so, do you receive assistance from formal care providers, informal care providers, or both?
 - 2.c.Are you currently providing care for another person? If so, who?
3. What (if any) physical health needs do you have?
 - 3.b.What kind of exercise do you do on a regular basis?
4. What (if any) risks do you face with respect to your personal safety?
5. What (if any) high-risk behaviours do you engage in?
6. Have you been diagnosed with psychological distress and/or mental health issues? If so, what are they?
7. Overall, would you say that you are not satisfied, somewhat satisfied, satisfied, or very satisfied with life?
8. How satisfied are you with your current financial situation?
9. In what ways has the aging process influenced your self-perception?
10. How has your cultural background influenced how you have aged?
11. How would you describe your social life?
12. To what extent are you 'out'? How long? And to whom?
13. How happy are you with the type and amount of peer support that you have?
14. At this point in your life, who do you maintain close relationships with?
15. Currently, how satisfied are you with respect to your intimate relationship(s)?
16. Of the health aspects that we discussed, for which issues have your needs not been met?
17. What unique health need(s) do you have as an older lesbian/gay adult?
 - 17.b.What adaptive strategies do you rely on to help meet these needs?
18. What unique health needs (if any) do older lesbian and gay adults from diverse ethnic or cultural backgrounds have?

INTERVIEW #2

SECTION 3: Health & Social Services for Older Adults

(For example: Adult day programs, day hospitals, rehabilitation, counselling, recreation groups, physician care, etc)

19. How satisfied are you with the information that you receive about eldercare services?

20. To what extent do you rely on alternative therapies or medicines? If so, how is it more desirable?

21. How often do you visit physicians?

21.b. How often do you or your doctor discuss sexual orientation?

22. With respect to the unique health needs that we discussed in the first interview, have you ever presented them to a healthcare professional?

22.b. If so, what response did you get?

23. Throughout your life, have you ever experienced heterosexism and/or hostility from healthcare staff? Please describe your experiences and associated feelings.

24. How does your sexual orientation affect the quality of services that you have received?

25. How satisfied are you using eldercare services provided to both heterosexual and other sexually oriented people?

25.b. How comfortable are you receiving these services?

25.c. How does your sexual orientation influence where you seek healthcare services?

26. How connected are you to the gay community? Do you find it supportive? How?

Service Improvement

27. With respect to current eldercare services, do you see room for improvement? Please explain where.

28. How can healthcare agencies better address the needs of older lesbian/gay adults?

C) Recruitment Flier

Lesbian/Gay & 50+?

Seeking older adult research participants

The health needs of older LGBT adults often go unnoticed in healthcare settings and remain understudied by health researchers. This study specifically addresses this gap so that changes can be made. If you are concerned, participate in change!

You qualify to participate if:

- You are 50+ years of age
- You reside in the lower mainland
- You identify as lesbian or gay
- You have at least one chronic health condition

The findings of this research will:

- Reveal unmet health needs
- Reveal individual, community, and organizational health needs
- Make recommendations for change with respect to the delivery of eldercare services
- Lead to further necessary research

This research will require you to:

- Sign an informed consent form
- Participate in 2 interviews
- Answer questions about health, sexual orientation, services for older adults, and service improvements

If you would like to participate in this study or require further information, please contact Angela (S.S.W., B.A., M.A.candidate) by email at ajohnsto@sfu.ca or leave a confidential message by phone at 778-371-9250

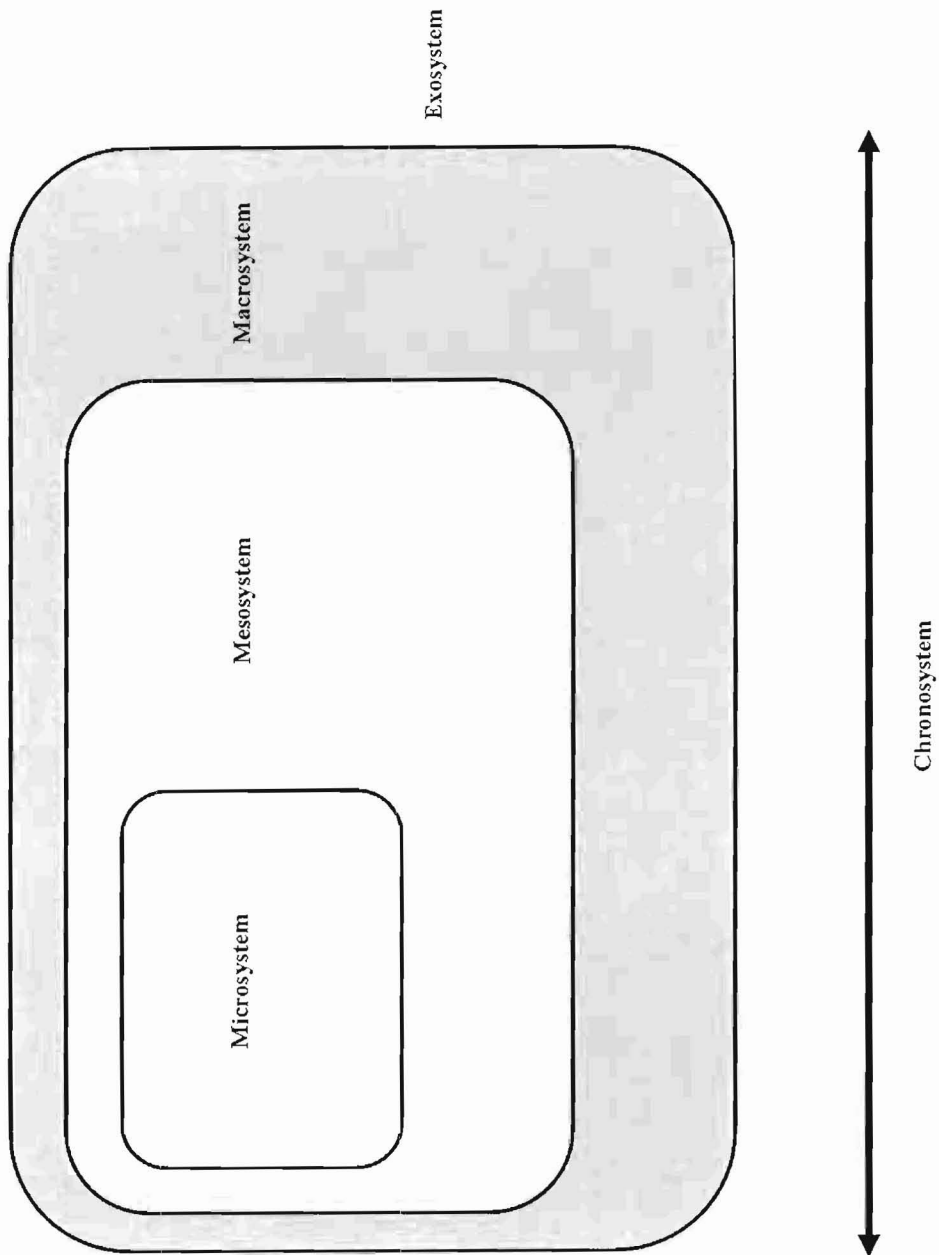
This research has been approved by the Ethics Board of Simon Fraser University

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D) Coding Sample

Question	Themes	Codes	Quotation
1	Good subjective health Physically active Better than peers	Good -Aqua fit -Walking Comparatively better	"It's good. There are very few things I can't do." "I'm able to do aqua fit, I walk, I exercise..." "I guess maybe even in some cases better than some of the other people my age."

E) Ecological Model



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