

**SENIOR CENTER STAFF PERCEPTIONS OF LESBIAN, GAY, BISEXUAL, AND
TRANSGENDER OLDER ADULTS: A RESEARCH PROPOSAL**

by

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ABSTRACT: Lesbian, gay, bisexual, and transgender (LGBT) older adults are a unique and vulnerable population who are largely overlooked by the gerontological literature and by aging service providers. As the number of older adults in the United States continues to grow so does the LGBT older adult population, which is expected to double from approximately three million to six million by 2030. The literature highlights disparities in physical and mental health, socioeconomic status, and social support among LGBT older adults. Aging services providers are undoubtedly unprepared to serve this population; there is little training or education on sexual minority seniors. Most aging service providers assume their clients are heterosexual, and LGBT older adults are reluctant to be open about their sexual orientation or gender identity due to lifetime experiences with discrimination and internalized stigma. This mistrust of providers leads to delayed care and nonparticipation in services for older adults, which directly contributes to disparities. This research proposal aims to address these issues in Allegheny County by assessing staff at the fifty-five senior centers contracted with the Area Agency on Aging. The proposed research is relevant to the field of public health because it seeks to address the lack of culturally competent providers who serve LGBT older adults, which is specifically mentioned in Healthy People 2020. Using a mixed methods approach, the proposed study will examine 1) policies of senior centers in Allegheny County that seek to address the needs of LGBT seniors, 2) staff attitudes towards and perceptions of LGBT older adults, and 3) differences in perceptions and

experiences between executive staff and direct service staff. First, senior center staff will participate in focus groups to determine community norms and attitudes. Next, a survey will be administered electronically to senior center staff through email. These data will be analyzed and will help inform future senior programming at senior centers in Allegheny County. While the sampling frame is somewhat limited and results from this convenience sample will not be generalizable, this study hopes to identify areas for future research and identify training needs within the senior center network.

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PREFACE

I would like to thank Drs. Ron Stall, Mark Friedman, and Nina Markovic for their input regarding this thesis. Your flexibility, reassurance, and kindness were a tremendous help to me while I navigated this process. I would also like to thank Dr. Martha Terry for her feedback and support, and Natalie Arnold for her insight and patience. Thanks to my parents, Wendy and Zeke Branca, and to my queer family, whose unwavering support and love helped me through what at times seemed like an impossible task. Thank you for always believing in me.

1.0 INTRODUCTION

The health and wellness needs of lesbian, gay, bisexual, and transgender (LGBT) older adults have been increasingly cited as an important public health issue in both the world of aging services and within the broader LGBT community. Due to lifetime experiences with discrimination and stigma, LGBT older adults do not seek out health and human services (D'Augelli & Grossman, 2001; Grant, 2010). Additionally, aging services providers either overlook or outright ignore the health and wellness needs of this population (Behney, 1994; Hughes, Harold, & Boyer, 2011; Knochel, Quam, & Croghan, 2011). Sexual minority older adults have exhibited significant needs around support services for health, housing, legal, and financial matters that are different than heterosexuals, yet most providers in the field of aging and geriatrics offer few, if any, culturally competent services for this population (Fredriksen-Goldsen et al., 2011). More often than not, social services for older adults either fail to address the specific needs of LGBT seniors or are simply unaware that those needs exist (Price, 2005).

Marginalization of LGBT individuals has dramatically decreased during the past 50 years, yet LGBT older adults still encounter discrimination and hostility. Not only do they tend to not ask for fair treatment when seeking social services, they are willing to stop disclosing sexual minority status when interacting with aging services providers to avoid fear of victimization, stigma, harassment, and even violence (Morrow, 2001). Preparing aging service providers to serve LGBT older adults could help prevent this population from facing

marginalization in senior services environments, therefore allowing them to seek services and care without fear. However, there is very little research on the topic of LGBT older adults, and even less research on how aging providers view this population.

1.1 PURPOSE OF STUDY AND RESEARCH QUESTIONS

This thesis describes proposed methods for conducting an exploratory research project to determine how senior community centers in Allegheny County are addressing the needs of LGBT older adults. This research proposal expands upon work by Behney (1994); Hughes, Harold, and Boyer (2011); and Knochel, Quam, and Croghan (2011) whose work addressed the attitudes, experiences, and readiness of aging providers to serve lesbian and gay older adults. This study aims to measure how individual provider attitudes and beliefs, as well as agency policy and practice, address LGBT aging. Specifically, the study proposes to address the unmet needs of LGBT older adults by collecting data to answer the following research questions:

1. Do senior centers in Allegheny County have agency policies such as targeted outreach, programs, and staff training that seek to address the needs of older LGBT individuals?
2. How do senior center staff members in Allegheny County rate their own comfort with and knowledge of LGBT older adults?
3. Do Allegheny County senior center executive staff and direct service staff have differing attitudes and beliefs towards LGBT older adults?

This thesis begins with a review of the literature on LGBT older adults in the United States, including a comprehensive review of research on the impact of historical context on health and social support, and determinants of successful aging among LGBT populations. It will go on to

describe theoretical models that explain aging outcomes among LGBT older adults. It then describes proposed qualitative and quantitative methodologies, the proposed data analysis plan, and strengths and limitations of this proposal. Lastly, this thesis discusses how the proposal hopes to address disparities among the LGBT older adult population, and how the Allegheny County Area Agency on Aging will use the findings to better serve LGBT older adults in Allegheny County.

2.0 LITERATURE REVIEW

The following literature review explores the historical context of and cohort issues among the aging LGBT community; theories on LGBT aging; and health, social support, and financial considerations that are tied to successful aging. Literature on aging service providers, particularly senior center staff, will also be reviewed.

2.1 LGBT OLDER ADULTS IN THE UNITED STATES

Lesbian, gay, bisexual, and transgender (LGBT) older adults are a largely invisible population, yet they make up a sizable, growing percentage of both the LGBT community and older adults in the United States (U.S.) (Grant, 2010; Grossman, D'Augelli, & O'Connell, 2002). Experts estimate that roughly three million people over 65 in the U.S. identify as LGBT, and that number is projected to grow to between four and six million by 2030 (Grant et al., 2011). Adults ages 65 years and older are the fastest growing cohort in the U.S. (Werner, 2011). In 2010, more people were 65 years or over than in any previous census; 40 million people, or roughly 13 percent of the U.S. population, were 65 years or older when census data were collected (Werner, 2011). By 2030, it is estimated that 20 percent of the population, or roughly 70 million people in the U.S., will be 65 years or older (Werner, 2011). This significant increase is partially due to the aging of the Baby Boomers, a cohort of individuals born during the years 1943-1960 (Werner, 2011). The

state of Pennsylvania has a large population of older adults, as does the greater Pittsburgh metropolitan area. According to the 2011 census, 205,059 individuals ages 65 and older live in Allegheny County, accounting for 16.6% of the county's population (U.S. Census Bureau, 2013). This is well above 13.3%, the U.S. average (U.S. Census Bureau, 2013). While Allegheny County does not collect population-wide data on sexual orientation, experts agree that a conservative prevalence rate of 3.5% can be used to estimate the LGBT population living in the U.S., which would mean that roughly 7,177 of the individuals ages 65 and over in Allegheny County self-identify as LGBT (U.S. Census Bureau, 2013; Grant, 2010).

Describing the demographic makeup of LGBT individuals remains a challenge due to a lack of basic, scientific data collection on sexual orientation. Research pertaining to LGBT aging on the federal and state level is almost non-existent (Grant, 2010). Most national surveys do not collect data specific to sexual orientation, sexual behavior, or gender identity and expression, and this is especially true among older adult populations (Anetzberger et al., 2004). Defining and measuring sexual orientation itself presents a problem in research, and cohorts of older adults who are currently in their 70s or older are less likely to self-identify as LGBT or disclose same-sex sexual behavior due to fear of discrimination, internalized stigma, or a desire for privacy (Morrow, 2001).

Another challenge with describing demographic characteristics of LGBT older adult is the inadequate number and strength of published studies. In 2010, the U.S. Department of Health and Human Services (U.S. DHHS) added two LGBT-specific health goals to Healthy People 2020, a document that establishes health-related goals for the U.S. (U.S. DHHS, 2012). Both goals emphasized the need for more diverse, comprehensive research and data collection on LGBT populations (U.S. DHHS, 2012). Currently, most data on LGBT older adults come from

small convenience samples that primarily capture the experiences of white, middle-class, college educated, urban-dwelling individuals. Population data are gathered in a few states such as Washington and Massachusetts, where population-based health surveys collect data on self-reported sexual orientation. However, this information only gives us a small glimpse at the true demographic makeup and needs of LGBT populations and fails to address those older adults who are reluctant to self-identify as LGBT (Conron, Mimiaga, & Landers, 2010). Yet even with the limitation on available data, it is possible to make some general observations about the experiences of aging LGBT individuals from looking at the existing literature.

2.2 HISTORICAL CONTEXT

When considering the needs of LGBT older adults, it is important to understand how historical context and lifetime experiences influence attitudes, behaviors, and perceptions. The LGBT community can be grouped into different cohorts that have dramatically different worldviews, experiences, and shared language. For example, older cohorts of lesbians and gay men may be comfortable using the term “homosexual” to describe themselves while young lesbians and gay men today may prefer the term “queer,” simply because of variation in the historical context in which each cohort came into a LGBT identity (Fredriksen-Goldsen & Muraco, 2010). Because of increasing awareness of and support for the LGBT community, younger cohorts are less likely to be closeted about their sexual orientation; compared to those under 30 years of age, adults 30-55 are 16 times more likely to be closeted, and those over 55 are 83 times more likely to be closeted (Gates, 2010).

In the 1940s and 1950s, LGBT individuals were routinely subject to institutionalized

homophobia and institutionally justified violence beyond just individuals' experiences of hostility and marginalization. Media depicted LGBT individuals as lonely deviants on the outside of society who were had no friends or family (Morrow, 2001). Sexual minorities were systematically criminalized and pathologized (Crisp, Wayland, & Gordon, 2008). Many LGBT adults during this time entered a heterosexual marriage or lived a completely closeted life in order to avoid social stigma (de Vries, 2006). Homosexuality was considered a mental illness until it was removed from the Diagnostic and Statistical Manual of Mental Illness (DSM) in 1974 (Byne et al., 2012). Transgender and gender variant individuals were, and continue to be, heavily stigmatized; "gender identity disorder" is still classified as a mental illness in the current version of the DSM (Byne et al., 2012).

Police routinely raided gay bars, which were considered one of the only safe places for LGBT people to meet and socialize (Crisp, Wayland, & Gordon, 2008). Patrons of gay bars were rounded up and jailed, often to find their names published in the papers the next day, which could result in the loss of job or rejection from friends and family. In 1969, the Stonewall Riots began in response to a raid on the Stonewall Inn, a gay bar in New York City. The Stonewall Riots are widely considered to be the birth of the modern gay liberation movement; within a year gay rights organizations began to form to publically advocate for LGBT equality for the first time ever (Concannon, 2009; Shankle et al., 2003). Discrimination against LGBT individuals began to be viewed as a human rights issue. Gay pride parades, which take place in major cities across the U.S., celebrate the anniversary of the Stonewall Riots and the birth of the gay liberation movement.

Much of the research on LGBT aging makes a distinction between two cohorts of LGBT older adults: the "pre-Stonewall" cohort and the post-Stonewall or "gay liberation" cohort (Price,

2005; Shankle et al., 2003). “Pre-Stonewall” LGBT individuals developed their sexual identity during the 1950s and early 1960s before the Stonewall Riots, and are much more likely to be hidden or closeted because of internalized homophobia (Price, 2005). The “gay liberation” cohort that came of age after the Stonewall Riots has been increasingly willing to demand fair treatment, advocating openly for itself and the community within legal, political, and social structures (Shankle et al., 2003). This cohort includes the Baby Boomer generation. As LGBT Baby Boomers begin to enter retirement age, they will be more out and visible than previous cohorts of older adults; LGBT older adults ages 50 to 64 tend to be more comfortable disclosing sexual orientation and gender identity than those ages 65 or older (Fredriksen-Goldsen et al., 2011). Additionally, LGBT older adults ages 50-64 are much more likely to report feeling positive about belonging to the LGBT community than those 65 and older (Fredriksen-Goldsen et al., 2011). However, Baby Boomers still fear discrimination; in a sample of 1,000 sexual minorities ages 40-61, 30% of participants reported concerns about anti-gay bias as they age (MetLife Mature Marketing Institute, 2010). Some LGBT older adults internalize this stigma and feel shame regarding their sexual orientation. Those who experience disproportionate stigma about their sexual orientation or gender identity include men, older adults who are 80 and older, and Asian/Pacific Islanders (Fredriksen-Goldsen et al., 2011).

2.3 THEORIES OF LGBT AGING

The literature primarily identifies two theoretical frameworks for explaining the ways in which LGB older adults view themselves: the minority stress model and crisis competence. These two frameworks deal are useful and relevant for exploring the complexities of LGB seniors’ mental

health outcomes and aging expectations. One major downfall of both theories is the failure to address the needs of aging transgender individuals. Presumably the added social stigma of being gender non-conforming would increase experiences of minority stress, and lifetime experiences with this stress could potentially increase levels of crisis competence, but more research is needed in this area.

2.3.1 Minority Stress Model

The minority stress model is a conceptual framework that has been used to explain disparities in mental health outcomes among minority groups. The model describes ways in which individuals of minority status experience psychosocial stress related to their stigmatization, which causes poor mental health (Meyer, 2003). Meyer (2003) conducted a synthesis of the literature related to minority stress and sexual minorities, and developed a model that depicts the ways in which stress and coping impact the mental health outcomes of LGB individuals. The model is a synthesis of several different sociological theories that occur throughout the literature.

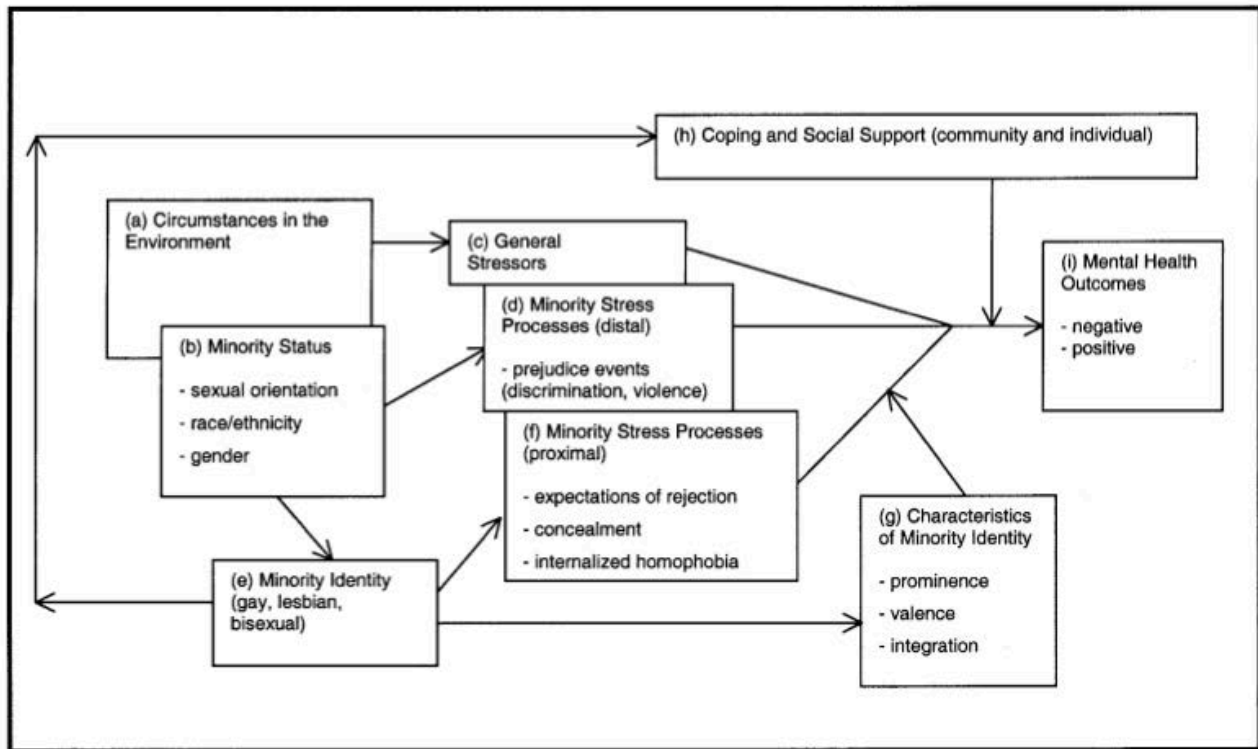


Figure 1: Minority Stress Process in Gay, Lesbian, and Bisexual Populations (Meyer, 2003)

While the minority stress model does not specifically address senior populations, issues pertaining to aging can easily be applied to the model's constructs. The minority stress model first acknowledges that this stress is situated in the general environmental (box a). These circumstances may offer advantages or disadvantages related to privilege. In the case of aging individuals, higher income or younger age may offer some protection against minority stress. The environment overlaps with minority status, implying that there is a close relationship between environment and minority status, in this case sexual orientation, perhaps in addition to being female (gender minority) and/or a racial/ethnic minority (box b). Circumstances in the general environment lead to general stressors (box c), and minorities experience stress directly related to minority status (box d). For example, older adults usually experience stressors regarding housing and health, but lesbian and gay older adults experience more stressors in the

health and housing realm due to experiences with prejudice and violence (box d) as well as expectations of rejection and internalized homophobia due to sexual minority status (box f).

Minority status often leads to a minority identity, in this case, self-identifying as gay, lesbian, or bisexual (box e). A minority identity leads to stress related to how an individual views himself or herself as a stigmatized member of society (box f). Viewing oneself as part of an oppressed minority group can lead to expectations of rejection, concealing identity, and internalized homophobia (box f). Minority stressors can have a greater impact on mental health when the LGB identity is a primary identity (box g), but identifying as LGB can be a source of strength, as it gives individuals access to coping and social support resources, both on the individual and community level (box h), which can reduce experiences of stress. It is important to consider that many LGB older adults come into a sexual minority identity later in life, are less likely to access supports, and are more likely to experience internalized homophobia than younger cohorts (Meyer, 2003). The result of maintaining this stress, both internal and external, is mental health outcomes (box i). Coping skills (box h) and positive characteristics of a minority identity (box g) can moderate levels of stress and increase positive mental health outcomes.

2.3.2 Crisis Competence

Crisis competence is another model that helps explain the process of aging and mental health outcomes. The term “crisis competent” has been used by several researchers to describe the ways in which older gays and lesbians are actually more equipped for dealing with oppression and marginalization that comes along with aging, because they have spent their entire lives navigating the marginalization as a sexual minority and/or dealing with internalized homophobia and heterosexism (D’Augelli & Grossman, 2001; Marrow, 2001). Early research found that gay

men and lesbians experience more successful aging outcomes than their heterosexual counterparts (Friend, 1987). The management of this sexual minority stress makes gay and lesbian older adults more resilient and capable of dealing with being part of an oppressed group, especially the social discrimination and loss that are accompanied with aging (Morrow, 2001). In a recent study, 89% of LGBT older adults reported feeling positively about belonging to the LGBT community (Fredriksen-Goldsen, 2011). However, it is important to keep in mind that these individuals self-identify as LGBT and felt comfortable self-identifying on an anonymous survey.

2.4 SUCCESSFUL AGING AMONG LGBT OLDER ADULTS

There is currently no universal definition for successful aging. A literature review of over 170 papers found that models of successful aging generally refer to either biomedical markers of health such as absence of disease and high levels of physical and mental functioning; psychosocial markers of health such as life satisfaction, mental and psychological health, and social well being; or a combination of the two (Bowling & Dieppe, 2005). Few studies directly address successful aging among LGBT older adults, but trends in the existing literature highlight some of the specific challenges faced by this population.

2.4.1 Physical and Mental Health

Current research suggests that LGBT older adults experience many of the same challenges associate with aging as heterosexual older adults (Fredriksen-Goldsen & Muraco, 2010; Quam,

1992). However, LGBT older adults experience increased rates of risk factors that can negatively impact morbidity and mortality outcomes. For instance, LGBT individuals experience higher rates of alcohol, tobacco, and drug use across the lifespan, putting them at disproportionate risk of chronic illness and premature death (Conron, Mimiaga, & Landers, 2010; Fredriksen-Goldsen & Muraco, 2010). While there may be little difference in current alcohol consumption between older lesbians and heterosexual women, older lesbians report higher rates of alcoholism (13% compared to 3% in heterosexual women) (Valanis et al., 2000).

Mental health is a particular concern for LGBT individuals. Managing lifetime experiences with homophobia and heterosexism is thought to contribute to high rates of mental health problems including depression, anxiety, and poor self-rated mental health status (Addis et al., 2009; Mays & Cochran, 2001; Meyer, 2003; Morrow, 2001). One review of five studies showed that lesbian women were more than three times as likely as heterosexual women to have had a mental disorder, and gay and bisexual men were twice as likely as heterosexual men (Meyer, 2003). The Women's Health Initiative study found that lesbians and bisexual women had higher rates of depression than heterosexual women, even though all three groups of women rated their emotional well-being roughly the same (Valanis et al., 2000).

Existing data suggest that LGBT older adults experience significantly increased rates of disability when compared to the general population (Fredriksen-Goldsen et al., 2011; Conron, Mimiaga, & Landers, 2010; Holmes et al., 2009). The prevalence of chronic disease and disability among the general population increases exponentially with age; at least 80% of people older than 60 are living with one chronic illness and 50% older than 60 are living with two chronic illnesses (CDC, 2003). Data collected from the Behavioral Risk Factor Surveillance System in Washington State (BRFSS-WA) found that 41% of LGBT adults ages 50 and over

experienced disability, compared to 35% of heterosexuals (Fredriksen-Goldsen et al., 2011). A survey of 2,560 LGBT adults age 50 to 95 across the United States and found that 47% of survey participants had a disability and 20% used a device such as a cane, wheelchair, or a hearing assistance device (Fredriksen-Goldsen et al., 2011).

Increased rates of HIV/AIDS among gay men and obesity among lesbians may partially account for increased rates of disability. The aging of HIV/AIDS has significant implications for the aging population, as people are living longer with HIV infection (Fredriksen-Goldsen et al., 2011). Although men who have sex with men (MSM) represent approximately four percent of the male population in the United States, MSM accounted for 78% of new HIV infections among men and 63% of all new HIV infections in the United States in 2010 (CDC, 2012). The BRFSS in Massachusetts and analysis of the Women's Health Initiative study data both found that adult lesbian women have higher rates of obesity than heterosexuals, but rates of diabetes and cardiovascular disease are the same (Conron, Mimiaga, & Landers, 2010; Valanis et al., 2000).

LGBT individuals may have more difficulty accessing medical insurance than heterosexuals. Though 97% of LGBT older adults reported having health insurance, seven percent reported being unable to see a doctor within the past year due to cost (Fredriksen-Goldsen et al., 2011). Everything from preventive screening services to medications and diagnostic testing are more difficult to access without the ability to pay for it. Without regular health care, LGBT individuals are more likely to have diseases diagnosed later and die from preventable diseases. In an analysis of data from participants in the Women's Health Initiative, older lesbians and bisexual women were less likely than heterosexual women to have health insurance (Valanis et al., 2000).

2.4.2 Poverty and Financial Insecurity

While there is no available information about the number of LGBT older adults living in poverty, it is estimated that LGBT older adults experience high rates of poverty because of lifetime unemployment and underemployment, as well as discrimination in hiring, firing, and wages (Fredriksen-Goldsen et al., 2011). Sexual orientation is not protected by non-discrimination laws in 25 states, and gender identity and expression are not protected in 30 states (Grant et al., 2011). In a survey of adults over the age of 25, 39% of lesbian and bisexual women and 23% of gay or bisexual men reported not being hired for a job due to sexual orientation (Mays & Cochran, 2001).

There is some evidence that LGBT older adults feel financially unstable and unprepared to support themselves through old age. In MetLife's study of Baby Boomers, fewer LGBT respondents reported being able to retire by age 70 due to financial constraints (48% compared to 40% of the general population), and 59% of LGBT respondents (compared with 48% of the comparison group) reported having less than \$50,000 in "investible and disposable assets" (MetLife Mature Market Institute, 2010). In a survey of 59 older lesbians and gay men, 70% reported that they did not have the financial resources to meet their physical and psychosocial needs as they age (McFarland & Sanders, 2003). Another small (n=71) study of lesbians and gay men over 50 years of age found that 24% of participants ranked income as the largest problem they currently experienced, above discrimination, loneliness, housing, and health care (Jacobs, Rasmussen, & Hohman, 1999). Sexual minority older adults who earned 200% of the federal poverty level or below are at elevated risk for poor mental health, likely due to the additional stress of financial insecurity (Fredriksen-Goldsen et al., 2011). More research is needed on poverty and financial insecurity among older LGBT individuals.

2.4.3 Social Support

Social support among older adults is widely researched yet the importance and significance of social support remain unclear (Barker, Herdt, & de Vries, 2006). Early research established that higher quantity and quality of social support are associated with lower mortality rates (Sabin, 1993). During the past 30 years, studies have linked strong social connectedness to living longer; older adults with few or unsupportive social relationships are more likely to experience poor health outcomes such as depression, loneliness, poor self-esteem, cardiovascular disease, high blood pressure, and premature death (Cutrona & Russell, 1987; Fredriksen-Goldsen & Muraco, 2010; Kawachi & Berkman, 2001; Sabin, 1993; Sorkin, Rook, & Lu, 2002). However, the protective effects of social relationships are not uniform across all groups of people; research suggests that some individuals, such as women who live alone, may gain more protection from poor mental health outcomes than others who have access to more resources (Kawachi & Berkman, 2001).

Studies on LGBT older adults' systems of social support have found that LGBT older adults experience more risk factors for loneliness and inadequate social support. Several studies have shown that LGBT older adults are more likely to live alone, less likely to have children, and often do not have the same familial supports as older heterosexuals (Fredriksen-Goldsen et al., 2011; Jacobs, Rasmussen, & Hohman, 1999; Sabin 1993). These risk factors imply that LGBT older adults are at higher risk for inadequate social support. In a recent study, 53% of LGBT older adult survey participants reported loneliness and 59% felt that they lacked companionship (Fredriksen-Goldsen et al., 2011).

Although LGBT older adults have fewer familial supports than heterosexuals, research suggests that they create non-traditional support networks of friends or "family of choice" (Crisp,

Wayland, & Gordon, 2008; Hughes & Kentlyn, 2011; Jacobs, Rasmussen, & Hohman, 1999; Morrow, 2001). The support of LGBT “family of choice,” or friends who provide more intensive support and act as family members, can take the place of “family of origin” that was lost due to homophobia and heterosexism (Morrow, 2001). A review of the literature on LGBT aging found that older lesbians and gay men consider their friends, especially those who are also gay or lesbian, a critical element of their social support networks (Addis et al., 2009). Sexual minority older adults rely primarily on LGBT friends, current and former romantic partners, and the LGBT community in general, and to a lesser extent siblings, extended family members, and adult children (Grossman, D’Augelli, & Hershberger, 2000; Hughes & Kentlyn, 2011; Jacobs, Rasmussen, & Hohman, 1999; MetLife Mature Market Institute, 2010; Morrow, 2001). Large social support networks can also serve as a buffer from minority stress (Kuyper & Fokkema, 2010). These social support networks can also include social services providers and formal care providers such as home assistants and social workers (Hughes & Kentlyn, 2011). Because friends and community members provide the most support, LGB older adults in one study reported that they were more likely to receive socializing support (72%) and emotional support (62%) than financial support (13%) from their support network (Grossman, D’Augelli, & Hershberger, 2000).

2.4.4 Transgender Aging

It is important to acknowledge the lack of available research on successful aging outcomes among transgender older adults in the U.S. While research on aging sexual minorities is limited, it focuses almost exclusively on the experiences of gay men and lesbians, and sometimes includes bisexuals as well. Even studies that attempt to capture the experiences of transgender

older adults often lack statistical power; for example, Beauchamp, Skinner, and Wiggins (2010) surveyed 280 individuals in Chicago and had only one self-identified transgender respondent. Research pertaining to transgender aging is also very limited. The medical and scientific community does not know how long-term hormone use affects the body, or how to properly address the needs of transgender individuals in long-term care and other aging facilities (Shankle et al., 2003). It is also important to consider that many older adults who currently identify as transgender may have “come out” later in life; in a nation-wide survey, 70% of transgender adults ages 65 and older reported having delayed gender transition to avoid discrimination, and many transgender individuals chose to keep their identities hidden most of their adult lives (Grant et al., 2011).

A survey of 2,560 LGBT older adults across the United States found that the 174 transgender participants had the worst health outcomes in nearly every area when compared to non-transgender older adults (Fredriksen-Goldsen et al., 2011). Transgender older adults were much more likely to report poor general health (33% compared to 23% of lesbians and 22% of gay men) (Fredriksen-Goldsen et al., 2011). Compared to non-transgender older adults, transgender older adults were more likely to live below the federal poverty line; reported significantly higher rates of verbal and physical abuse; and had higher rates of obesity, cardiovascular disease, asthma, and diabetes (Fredriksen-Goldsen et al., 2011). Nearly half (48%) of transgender older adults had depressive symptoms at the clinical level compared with 31% of all LGBT participants, 27% of lesbians, and 36% of gay men (Fredriksen-Goldsen et al., 2011). A staggering 71% of transgender older adults had seriously considered suicide at some point, compared to 39% of all LGBT older adults surveyed (Fredriksen-Goldsen et al., 2011).

2.5 DISCRIMINATION AND VICTIMIZATION

Though social attitudes towards the LGBT community have shifted dramatically over the past 50 years, LGBT older adults still experience high rates of discrimination. According to the National Survey of Midlife Development in the United States, LGB adults more frequently than heterosexuals reported both lifetime and day-to-day experiences with discrimination, and 42% attributed this discrimination to their sexual orientation (Mays & Cochran, 2001). A survey of LGBT older adults found that nearly two-thirds (63%) of participants had experienced verbal abuse and more than a quarter (29%) had been threatened with physical violence due to sexual orientation (Grossman, D'Augelli, & O'Connell, 2002).

Discrimination is not just perpetrated by strangers; LGBT older adults are often discriminated against by their health providers. Eleven percent of LGBT older adults in Chicago reported having a negative experience with a personal care provider due to their sexual orientation or gender identity (Beauchamp, Skinner, & Wiggins, 2010). According to the National Transgender Discrimination Survey Report on Health and Health Care, 19% of transgender individuals had been refused care at one point in their life (Grant et al., 2011). McFarland and Sanders (2003) surveyed LGBT older adults and found that 38% were concerned about discrimination in healthcare systems and 33% specifically worried about lack of understanding from providers. Healthy People 2020 explicitly states that “elderly LGBT individuals face additional barriers to health because of isolation and a lack of social services and culturally competent providers” (U.S. DHHS, 2012).

History and cohort affect LGBT older adults' willingness to be “out” with service providers. Lifetime histories of victimization, discrimination, and stigma prevent LGBT older adults from disclosing sexual orientation or gender identity due to fear. Up to one-quarter of

participants in a community needs assessment of LGBT older adults did not disclose their sexual orientation to aging services providers (de Vries, 2006). This phenomenon has been described as “going back in the closet”; some LGBT older adults, after living as openly LGBT, choose to stop disclosing sexual orientation to protect themselves from discrimination. In one pilot study on barriers to care, 33% (n=19) felt that lack of understanding from a service provider would be a barrier to good care (McFarland & Sanders, 2003). A survey of LGBT seniors found that 72% of participants felt tentative about using aging services because of lack of trust (Behney, 1994).

Much of the literature on LGBT older adults’ experiences with providers focuses exclusively LGBT older adults who are residents in long-term care facilities such as assisted living and skilled nursing homes (Anetzberger et al., 2004; Stein, Beckerman, & Sherman, 2010). While this is an important and particularly marginalized population, the overwhelming majority of older adults are community-dwelling and do not require high-level care (Anetzberger et al., 2004; Stein, Beckerman, & Sherman, 2010). More research is needed on community-dwelling LGBT older adults to determine what community senior services they utilize.

Few aging services offer LGBT-specific programming, and few LGBT centers provide services for seniors. There is conflicting research on where LGBT older adults want to receive care. Some studies suggests that supportive services for LGBT older adults may be best provided in LGBT-specific environments, but other studies indicate that LGBT older adults do not want segregated care (Jacobs, 1999; McFarland & Sanders, 2003). In 2012, Services and Advocacy for GLBT Elders (SAGE) established the nation’s first full-time LGBT senior center in New York City. However, many places, including suburban and rural areas, do not have the population or infrastructure to support LGBT-only senior centers. Nevertheless, senior center staff should be aware of issues pertaining to their LGBT clients.

2.6 AGING SERVICES PROVIDERS

Provider attitudes about the sexuality of older people are generally negative; research shows that staff in long-term care facilities view sexual expression among residents as problem behavior (Rheume & Mitty, 2008). It is estimated that there are more LGBT older adults living in the United States than older adults living in nursing home facilities, yet resources and funds overwhelmingly overlook LGBT older adult populations (Anetzberger et al., 2004). Training and education for social workers and other professionals in the field of aging give little attention to the sexuality of older adults, and even less to LGBT older adults (Concannon, 2009). There is a tremendous need to recognize the gaps in care and deliver trainings to support aging services providers in providing LGBT-affirming care. Aging services providers do not receive adequate training nor are they offered support to better serve LGBT older adults. In a 1994 study of Area Agency on Aging offices, only 37% reported that lesbian and gay clients would be welcome at their local senior center (Behney, 1994), compared to 64% in a similar survey conducted in 2007 (Knochel, 2011). Attitudes towards LGBT older adults are slowly shifting, but although aging services providers may believe LGBT clients would be welcome, they seldom have supports in place to assure that services are competent and affirming. In a survey of adults in eastern Washington State, 93% of LGBT individuals and 86% of heterosexuals felt that diversity and sensitivity training would help build tolerance of LGBT individuals among aging service staff (Jackson, Johnson, & Roberts, 2008).

2.6.1 Heterosexism and Homophobia Among Providers

Homophobia and heterosexism are pervasive among aging services providers (Price, 2005). The American Heritage dictionary defines homophobia as “aversion to gay or homosexual people or their lifestyle or culture” and “behavior or an act based on this aversion.” (Houghton Mifflin Company, 1994). In his work about anti-gay violence, Herek (1990) defines heterosexism as the following:

Heterosexism is an ideological system that denies, denigrates, and stigmatizes any non-heterosexual form of behavior, identity, relationship, or community. Like racism, sexism, and other ideologies of oppression, heterosexism is manifested both in societal customs and institutions, such as religion and the legal system (*cultural heterosexism*) and in individual attitudes and behaviors (*psychological heterosexism*) (p. 316).

Invisibility of LGBT older adults in senior housing and health is two-dimensional; it shows that LGBT older adults are not “out,” or choose not to disclose their sexual orientation or gender identity to providers, and also it indicates high levels of heterosexism in these senior community settings (Addis et al., 2009). Providers tend to exercise heterosexism by assuming heterosexuality among the clients they serve because they are used to the silence and invisibility of LGBT older adults (Crisp, Wayland, & Gordon, 2008). Homophobia and heterosexism among aging services providers cause stress in the process of accessing care (Crisp, Wayland, & Gordon, 2008; Hughes, Harold, & Boyer, 2011). Concannon (2009) describes how simply implementing agency policies recognizing homophobia as an unacceptable form of discrimination, while difficult, creates a powerful message to providers.

Educating providers to ensure culturally appropriate services is the best way to meet the needs of LGBT older adults. Aging services providers are generally unaware of the historical context that shapes the lives and views of LGBT older adults, and have little knowledge about

disparities in care and fear of stigma among this population (Knochel et al., 2012). One challenge to LGBT-affirming care is that aging service providers are generally resistant to targeted services for sexual minority populations. In a nation-wide survey, 53% of Area Agency on Aging (AAA) providers did not believe in establishing separate aging services for LGBT seniors (Knochel, Quam, & Croghan, 2011). A survey of AAA directors' attempts at LGBT-targeted services or outreach received responses such as "People are people" and "The services we provider are applicable to all seniors over the age of 60" (Knochel et al., 2012, p. 437). These responses can be viewed as welcoming or as hostile (Knochel et al., 2012). Providers also viewed separate services as a discriminatory practice.

2.6.2 Area Agency on Aging Providers in the United States

Very few studies have examined the attitudes and beliefs of Area Agency on Aging (AAA) providers. Hughes, Harold, and Boyer (2011) surveyed AAA providers who attended the Michigan Area AAA 2010 conference. Knochel, Quam, and Crogan (2011) surveyed AAA providers in the Minneapolis-St. Paul metro area, duplicating the work that had been done earlier by Behney (1994). Of the providers surveyed, 94% of agencies did not have special outreach to the LGB community, and 98% of providers did not offer any special LGB-focused services (Knochel, Quam, & Crogan, 2011). Knochel and colleagues (2012) also administered a survey to fewer than half (316 of 636) of the directors of AAA across the U.S.; only about one-third of agencies surveyed had offered LGBT staff training, though the overwhelming majority of respondents (80%) were willing to offer such training (Knochel et al., 2012). Hughes, Harold, and Boyer (2011) found, similarly, that over half of participants (63%) indicated that they would like training on LGBT aging. Common themes across these studies are: low response rate

(around 50% or lower), lack of awareness about LGBT-specific aging services, and inadequate training supports (Hughes, Harold, & Boyer, 2011; Knochel et al., 2012). A majority of agencies in all of these studies reported not serving LGBT older adults, or being unaware of any out LGBT clients (Hughes, Harold, & Boyer, 2011; Knochel et al., 2012).

2.6.3 The Role of Senior Centers

In the United States, approximately 11,000 senior centers serve one million older adults every day (National Council on Aging, 2012). Senior centers offer many different functions within communities, but generally serve as a multipurpose place to promote health and well being for seniors. Most community centers offer meals, social activities, opportunities for volunteering, exercise classes, job placement assistance, health and educational workshops, and connection with other senior services at low or no cost (National Council on Aging, 2012). Previous research on women who live alone has shown a strong correlation between participation in senior center activities and positive mental and physical health outcomes (Aday, Kehoe, & Farney, 2006).

If services were appropriate, senior community centers could play a vital role in linking LGBT older adults to social, financial, housing, and health resources they need. Gay and lesbian older adults are five times less likely to access senior services than their heterosexual peers (Fredriksen-Goldsen et al., 2011). In a small sample (n=80) of lesbians and gay men in the Midwest, only eight percent had participated in activities at a senior center or club open to the general senior population during the past two months (Quam, 1992). This is due to a combination of fear and lack of awareness that these services exist. A small survey of LGBT older adults in Allegheny County (n=77) found that over half of participants had never heard of

the Allegheny County Area Agency on Aging, the organization that contracts a large number of aging service providers in the county (Baumgartner, 2007). Turner (2004) found that senior center participants' personal characteristics, such as race and class, "exert a notable influence on the experiences and perceived benefits of activities engaged in at senior centers" (p. 41). Though the study does not measure consider sexual orientation or gender identity and expression, the findings call for senior centers to better recognize the diversity of seniors in order to attract participants and meet their diverse needs (Turner, 2004).

2.6.4 Cultural Competency

Cultural competency is a widely discussed concept in the field of public health, but defining cultural competence and its constructs is highly contentious. The U.S. Department of Health and Human Services Office of Minority Health uses the following definition adapted by Cross, Bazron, Dennis, and Issacs (1989):

Cultural and linguistic competence is a set of congruent behaviors, knowledge, attitudes, and policies that come together in a system, organization, or among professionals that enables effective work in cross-cultural situations. "Culture" refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. 'Competence' implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities (p. 13).

Measures of competence generally include awareness, attitudes, knowledge, and skill (Cross et al., 1989). Intention and readiness to serve a population have also been used as measures of competence (Campinha-Bacote, 2002). Cultural competence should be viewed as a process that occurs throughout one's lifetime or career rather than a skill which providers either have or do not have (Campinha-Bacote, 2002). However, cultural competence cannot occur in a vacuum; in

order to determine whether or not individuals are receiving competent care, measures of policy and environment must be included.

Competency trainings for providers who work with older adults are key. Trainings can provide information as well as an opportunity to learn and practice new skills. Organizations such as the National Resource Center on LGBT Aging provide trainings to providers across the U.S. and have developed a comprehensive train-the-trainer model. Training resources like these, if accessed properly, could ensure the availability of LGBT competent and affirming providers throughout the country.

3.0 RESEARCH PROPOSAL

The proposed research study aims to investigate barriers and facilitators to LGBT-inclusive services in Allegheny County senior community centers. The proposed study is exploratory in nature. The observational cross-sectional study design will allow the study team to employ a mixed methods approach, focusing on the perceptions and attitudes of senior center staff who are contracted through the Allegheny County Area Agency on Aging. First, focus groups will gather qualitative data about the attitudes and norms of senior center staff towards LGBT older adults. Second, a survey will be sent electronically to all staff at the senior centers contracted through the Allegheny County Area Agency on Aging.

3.1 AGENCY DESCRIPTION

The Allegheny County Department of Human Services (DHS) is comprised of four county programs, including the Allegheny County Area Agency on Aging (AC-AAA). The AC-AAA provides a range of services to adults 60 years of age and older. In 2011, the AC-AAA served roughly 42,000 consumers ages 60 and older, and contracted with 93 community providers throughout Allegheny County, creating a network of over 100 community-based service organizations and local governments throughout the county (ACDHS, 2012). The AC-AAA

offers a range of services for older adults to target both active, independent older adults to those who need long-term care (ACDHS, 2012).

Fifty-five senior community centers in Allegheny County are contracted with the AC-AAA. These senior centers are operated by either community-based providers or local municipal government and offer health and fitness, social, recreational, and educational services, in addition to daily meals and other programs that consumers can enjoy with their peers in their community (National Council on Aging, 2012). The AC-AAA senior center network staff, programs, and services have never been evaluated for LGBT competency, though the AC-AAA has offered LGBT competency training during the past three years. As far as the AC-AAA is aware, none of the senior centers in Allegheny County are currently offering programming that is LGBT-specific. The proposed project will help to evaluate the existing programs and inform the development of new programs.

3.2 FOCUS GROUPS

The proposed project will first utilize focus groups to analyze senior center staff perceptions and beliefs about LGBT older adults, and how the needs of LGBT older adults are being met by AC-AAA senior centers. These data will help inform the survey and begin a dialogue about LGBT older adults among senior center staff. The focus groups will be divided by position; one focus group will be comprised of executive staff and administrative staff and a second focus group will consist of direct service staff. These focus groups will explore group attitudes and norms among senior center staff towards LGBT clients. The focus groups will offer a chance to pilot the survey and ask senior center staff for feedback, understandability, and suggestions for improvement.

Study staff will also solicit information about ways senior center staff conduct outreach to LGBT older adults, and what barriers and facilitators exist. This information will be reported back to the AC-AAA deputy director.

The population size of senior center staff working for DHS-contracted senior centers is unknown. The sampling frame is a list of all senior center directors, provided by the AC-AAA. Our research team will rely on the senior center directors to forward on information about our study to his or her entire staff. Although this is bound to lead to sampling bias, the AC-AAA executive staff have identified this as the best method with which to reach senior center staff.

3.2.1 Recruitment and Inclusion Criteria

Participant selection for these focus groups will be conducted using non-probability convenience sampling. Individuals are eligible to participate in this study if they are 18 years or older and are currently employed at one of the 55 DHS-contracted senior centers in Allegheny County. All recruitment will take place through email. The AC-AAA Independent Services Bureau Chief, who oversees all senior center activities, will be responsible for initiating recruitment. Emails will be sent to all 55 senior community centers asking individuals to volunteer for participation in a focus group on issues pertaining to LGBT seniors. Those interested in participating will respond via email and the study staff will call interested participants to screen for eligibility. Those who are eligible will give their contact information and availability. Two focus groups of eight to ten people each will be held for approximately 1.5 hours each at the Human Services office of DHS in downtown Pittsburgh. Focus groups will take place during lunch and although there will be no monetary compensation for participating, lunch will be catered courtesy of DHS and participants will have access to free parking. Staff members who do not drive will be

reimbursed for bus fare. A staff member who works in the office of Data Analysis, Research, and Evaluation (DARE) will moderate the groups in order to allow open discussion and criticism of the AC-AAA by focus group participants, and a DHS graduate student intern will take notes on discussions and behaviors in both groups.

Focus group participants will be given an informed consent document to read and sign before the focus groups begin. The consent form will consist of general information about the purpose of the research project, risks and benefits of participating, the voluntary nature of participation, and the name and contact information of the focus group moderator if any questions or concerns come up later on. Participants will be assured about the confidentiality and anonymity of the information to be obtained, and they will be informed of their right to refuse participation in any part of the discussion.

3.2.2 Focus Group Discussion Guide Development

The focus group discussion guide will be developed as a collaborative effort between staff at the DARE office of DHS, DHS graduate student interns, and the University of Pittsburgh Graduate School of Public Health faculty. Discussion guide questions will be crafted in order to assess AC-AAA staff attitudes and cultural norms towards the LGBT older adult community. The script will describe the purpose of the study, risks and benefits of participating, and the overall research goals. These questions will be piloted with the LGBTQ Advisory Council at DHS to ensure that they are accurate, appropriate, and understandable.

3.3 SURVEY

A survey tool (Appendix A) will be developed and administered online using Survey Monkey. This project is exploratory, as there is no existing research that focuses specifically on senior center staff attitudes towards and knowledge of LGBT aging issues, as well as readiness and willingness to serve the LGBT community. A survey was identified as the best method for reaching this population to decrease burden of time and resources. The survey will consist of both quantitative and qualitative questions. The author is a graduate student intern at Allegheny County DHS and has support from key DHS staff who intend to assist with this project, including the Deputy Director, Administrator, and Independent Services Bureau Chief of AC-AAA. Staff members will promote and incentivize the completion of the survey in ways that are relevant and appropriate within the AC-AAA community. The survey will be distributed via email, which will link to an online Survey Monkey survey. IP addresses will be tracked to avoid survey duplication.

3.3.1 Recruitment and Inclusion Criteria

Individuals are eligible to participate in this study if they are 18 years or older and are currently employed at one of the 55 DHS-contracted senior centers in Allegheny County. All recruitment will take place through email. The AC-AAA Independent Services Bureau Chief will solicit participation via email, sending a link to the Survey Monkey survey tool to senior center staff. Because the AC-AAA does not have email addresses for all senior center staff, directors will be contacted separately and asked to forward the survey on to all staff members. Three email

reminders about participation will be sent out one week apart. Additionally, the link will be embedded in the monthly AC-AAA staff newsletter.

3.3.2 Survey Development

The survey was designed to build upon and adapt measures that have previously been used with aging service providers (Hughes, Harold, and Boyer, 2011; Knochel et al., 2012). The DARE staff members at DHS provided the author of this paper with mentorship and assistance in the development of a preliminary survey tool. The survey questions are based on measures of LGBT competence that have been used in surveys of DHS providers in the past. The preliminary survey tool will be reviewed by the DHS LGBTQ Advisory Council, which consists of LGBT community members who receive DHS services as well as community service providers. The Advisory Council will offer feedback and suggestions, which will be used to finalize the survey tool. These measures will assess the cultural competency of individuals and agencies by asking about current ways the agency is serving older adults, preparedness to serve LGBT older adults, and individual participant perceives LGBT older adults' needs. The survey is designed to obtain descriptive data about senior center staff perceptions towards LGBT older adults. The first page of the Survey Monkey survey will be a brief description of the study, outlining the purpose and IRB-approved risks involved in taking the survey. In previous research, many AAA providers surveyed did not answer "yes/no" questions provided and instead wrote in comments or explanations in the margins of the paper survey (Knochel et al., 2012). Because of this, Knochel's original questions have been adapted to a five-point likert scale ("strongly agree" to "strongly disagree") in order to better capture where providers see their opinions, experiences, and knowledge on a continuum.

The survey will yield data that identify senior centers whose directors are willing and interested in LGBT competency trainings. This survey can be administered after those trainings are conducted to determine whether or not the senior centers who received training are more well equipped to address the needs of LGBT older adults.

3.3.2.1 Measures

The following measures will be used to determine individual and agency cultural competency pertaining to LGBT older adults:

Demographics: [age, gender, sexual orientation, race/ethnicity, educational attainment]

Details about current position: [titles of position, number of years at current position, number of years working as a direct service provider]

Targeted Programming: [targeted programming or services for the LGBT community, plans for LGBT-targeted programming, percentage of services which are LGBT-affirming]

Targeted Outreach: [targeted outreach activities, targeted outreach materials]

Agency Policies: [data collection about sexual orientation, gender identity and expression, and marital status; non-discrimination policies; reporting mechanisms for anti-LGBT behavior]

Perception of Agency Competency: [perception of how direct service staff, executive staff, and other clients would welcome LGBT clients; level of priority placed on LGBT older adults; requests from LGBT clients]

Familiarity and Comfort with the LGBT Community: [familiarity and comfort with LGBT terminology; comfort providing assistance to LGBT clients; comfort making LGBT-specific referrals; experiences with LGBT clients, co-workers, friends, and family members]

Knowledge About LGBT Older Adults: [Perceptions about the needs of LGBT older adults; knowledge about LGBT aging issues]

Training: Training [preparedness to serve LGBT older adults, promotion or availability of staff trainings, desire to complete training]

3.4 DATA ANALYSIS

3.4.1 Analysis of Focus Group Data

The focus groups will be audio-recorded, and the recordings will be transcribed into Microsoft Word. Notes taken by the interviewer and observer during the focus groups will also be entered into Microsoft Word. Focus group transcripts will be analyzed for broad themes or group norms among senior center staff. Focus group transcripts will be entered into Dedoose Version 3.3, a web-based application used to manage and analyze qualitative and mixed methods research data.

3.4.2 Analysis of Survey Data

The results of the survey will be uploaded directly into Survey Monkey for analysis. The data analysis will begin by describing the demographic characteristics of the senior center staff. Our survey contains no continuous data, so categorical data (agency practices and policies, individual attitudes and knowledge) and dependent variables (completed training about LGBT older adults, title of position) will be reported in frequency distributions. Survey results will be available in analysis of the survey data will be descriptive rather than explanatory. Chi-squared tests will allow distinctions between the perceptions of executive staff and direct service staff, as well as between staff who have received LGBT training and those who have not. Finally, written

responses will be coded by hand as themes emerge to allow for more depth of participant response.

3.5 STRENGTHS AND LIMITATIONS OF STUDY DESIGN

The proposed study is innovative in many ways. The study will provide, for the first time, an examination of senior center staff perceptions of LGBT older adults. This is also the first study attempting to differential between perceptions of LGBT older adults held by executive staff and direct-service staff. Previous research has only captured the attitudes and beliefs of AAA directors, and this study assesses those who tend to work more closely with older adult clients. Another strength of the study design is the inclusion of qualitative data, gathered both in the focus groups and to a lesser extent in the surveys. The qualitative data will allow for exploration of what barriers and facilitators exist to providing LGBT-affirming care in the AC-AAA senior centers beyond the measures included in the survey. The survey tool can also be replicated throughout the U.S. to determine if other senior center staff believe they are providing LGBT-affirming care in their agencies.

However, there are some limitations with this study design. Sampling is perhaps the largest limitation; asking the AC-AAA senior center directors to forward on information to their staff leaves room for bias, as some directors will likely not follow our request. Issues pertaining to sexual minority populations are still seen as somewhat political at DHS and thus some directors may be resistant to participation and distribution of the survey. Some of this bias will be eliminated by reaching out directly to senior center directors through the Independent Services Bureau Chief of the AC-AAA, who is offering high levels of support on this project and

has good rapport with this population. Relying on a convenience sample means that the data will not be generalizable to the general population of senior center providers, and a cross-sectional survey cannot determine causation. With that said, this study has important implications for the fields of aging and LGBT health and, specifically, for the AC-AAA.

4.0 DISCUSSION

The proposed research study has two distinct end goals: to further the field of LGBT health research and to assist the Allegheny County Area Agency on Aging in better serving the LGBT older adult community. Health research on the LGBT population is limited, especially the literature on LGBT older adults and aging concerns. The proposed study will contribute information about senior center providers' perceptions of the LGBT community for the first time, and hopefully new research questions will emerge from this study and can be explored further in future studies. This is especially imperative as the population continues to age, and as the Baby Boomer population feels more and more comfortable being "out" in senior services environments and demanding fair and adequate treatment.

The study will help meet several of the needs identified earlier in this thesis. Assessing senior center providers for LGBT-affirming attitudes and behaviors will give the AC-AAA an accurate snapshot of where providers currently are in terms of LGBT competence. Based on findings of previous research, as well as input from executive staff at the AC-AAA, the author of this paper expects the results of the study to indicate that senior center staff in Allegheny County are not aware of LGBT aging needs, nor are they prepared to serve the LGBT community. As previously mentioned, Knochel (2011) found that 98% of AAA directors reported that there were no targeted services for the LGBT community. Allegheny County has no known targeted services for the LGBT older adult community, and while this survey may uncover LGBT-

affirming services that are happening in the senior center network unbeknownst to the AC-AAA executive staff, it is more likely that there are simply no services like this. However, the AC-AAA plans to use the survey results to determine whether or not there are the LGBT allies among senior center staff, and eventually identify and organize allies in order to best serve LGBT older adults. In addition, the survey results will also help identify strengths exist among current providers.

The AC-AAA also plans to use the results of this proposed study to set priorities for LGBT competency training throughout the senior center network. Competency trainings that address LGBT-specific issues have been offered in the past to AAA staff, but on a limited and voluntary basis. Using the results from this study, trainings will be scheduled and adjusted to meet the needs identified by the focus groups and survey. Training efforts are more effective if they are targeted to the population being trained, so LGBT competency trainings will be as tailored as possible. A unique aspect of the survey is that it can be administered to the entire senior center network again after trainings are more tailored and frequent, to serve as a pre- and post-test to a training intervention.

Once senior center staff members in Allegheny County are adequately trained, the AC-AAA will identify policies and procedures in senior centers that need to be adjusted in order to reflect a more LGBT-affirming environment at senior centers. The survey will determine whether or no senior center staff know that sexual orientation and gender identity and expression are protected in the county's non-discrimination policy; if staff do not know, then it will be important to include information on the non-discrimination policy in future trainings. The AC-AAA has expressed interest in implementing new LGBT-specific programming throughout Allegheny County, but the best methods for this are still unclear. The results of the proposed

study, along with information gathered during training efforts, will allow the AC-AAA to identify where and how to best provide LGBT-specific senior programs. Targeted outreach for senior center services that is specific to the LGBT community will alert LGBT older adults to the availability of competent services. The hope is that the availability and advertisement of LGBT competent services will decrease levels of fear and increase levels of participation in senior community center programming. This will allow for LGBT older adults to connect to medical, financial, and social supports offered by DHS, which will in turn decrease disparities in these areas.

5.0 CONCLUSION

The nation's population is growing rapidly, and preparing for the so-called graying of America is imperative. Aging LGBT individuals have special needs that are overwhelmingly being ignored by aging services providers. As the Baby Boomers age, they will decrease the amount of silence and invisibility surrounding LGBT older adults who access senior services. Fortunately, preventive measures can be taken to ensure that aging services providers are prepared for this shift. Training is an important aspect of providing competent care in a health or social services setting, and competent care is not only essential for clients seeking services, it is an essential part of public health.

This proposal will allow a unique look at Allegheny County aging providers' perspectives on LGBT older adults. The results from this proposed project will contribute directly to the field of LGBT health research, as well as inform senior services provision in Allegheny County. The findings, while not generalizable, can help to identify new research questions and continue developing the depth of research on LGBT older adults.

APPENDIX A

PRELIMINARY SURVEY INSTRUMENT

Survey of Senior Center Staff Perceptions of LGBT Aging Issues

Purpose: The purpose of this survey is to examine the attitudes of Allegheny County senior center staff towards Lesbian, Gay, Bisexual, Transgender, and Queer/Questioning (LGBTQ) older adults. The information we obtain from this survey will help the Area Agencies on Aging provide you and your agency with better training and support in the future.

This survey is completely anonymous, confidential, and voluntary. It is expected to take 10-20 minutes of your time.

Definitions: The following definitions for terms will be used throughout the survey:

- **Heterosexual/Straight** – A self-identified male or female who has their primary sexual and emotional connections with individuals of the opposite sex (e.g., a male who is attracted to females).
- **Lesbian** – A self-identified female who has her primary sexual and emotional connections with other females.
- **Gay** – A self-identified male who has his primary sexual and emotional connections with other males.
- **Bisexual** – Self-identified males or females who have sexual and emotional connections with both males and females (e.g., a male who is attracted to both males and females).
- **Transgender** – People who do not fit into societal gender roles or expectations, including, but not limited to people who are transsexual, transvestite, and cross-dressers. Transgendered people may be heterosexual, lesbian, gay, or bisexual in their sexual orientation.
- **Sexual Orientation** – an enduring pattern of emotional, romantic and or sexual attractions to the opposite sex, the same sex, both, or neither.
- **Gender Identity/Gender Expression** – the manner through which an individual identifies with a gender category, for example, as being either a man or a woman, or in some cases neither, which can be distinct from biological sex.

DEMOGRAPHICS

1. Age:

- 18-29 years
- 30-39 years
- 40-49 years
- 50-59 years
- 60-69 years
- 70 years or older

2. Race/Ethnicity (Please choose all that apply):

- Asian / Pacific Islander
- Black / African-American
- Hispanic
- Native American
- White / Caucasian
- Other (Please specify: _____)

3. Gender:

- Male
- Female
- Transgender (Male to Female)
- Transgender (Female to Male)
- Other (Please specify: _____)

4. Sexual Orientation:

- Straight/Heterosexual
- Bisexual
- Gay or Lesbian
- Queer
- Questioning or Unsure
- Other (Please specify: _____)

5. Highest level of education completed:

- Less than High School
- High School or GED
- Some College
- 2 year College Diploma (Associates)
- 4 year College Diploma (BA or BS)
- Master's or Doctoral degree
- Other professional degree (JD or MD)

6. Your current position:

- Direct Service Provider
- Supervisor
- Administrator, Director, or Manager

Other (Please specify: _____)

7. Number of Years at Current Position:

- Less than 1 year
- 1-2 years
- 3-5 years
- 6-10 years
- 10+ years

8. Number of Years working as a direct care service provider with older adults:

- Not Applicable - I have never worked as a provider
- Less than 1 year
- 1-2 years
- 3-5 years
- 6-10 years
- 10+ years

TARGETED PROGRAMMING

10. Are there currently established programs or services at your agency to address the needs of LGBT older individuals?

For example, legal workshops or social events that are aimed at LGBT older adults.

- Yes
- No
- Unsure

10a. If Yes, please describe:

10b. If Yes, how long have these efforts or activities been occurring?

- Less than 1 year
- 1-2 years
- 3-5 years
- 6-10 years
- 10+ years

10c. If No, is there any planning for programs or activities to address the needs of LGBT older adults currently occurring?

- Yes
- No
- Unsure

11. What percentage of services provided by your agency are appropriate for LGBT older adults?

- 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
- Unsure

OUTREACH

12. Does your agency conduct targeted outreach to the LGBT older adult community to make them aware of the services your agency offers?

For example, advertising in local LGBT publications or at the Gay and Lesbian Community Center.

- Yes
- No
- Unsure

13. Does your agency have outreach materials or information specifically designed for the LGBT older adult population?

For example, pamphlets on lesbian health, rainbow flags, or materials featuring same-sex couples.

- Yes
- No
- Unsure

AGENCY POLICIES

14. Does your agency conduct intakes for the programs and services it offers?

- Yes
- No
- Unsure

14a. If Yes, are clients asked about their sexual orientation during the intake process?

- Yes
- No
- Unsure

14b. If Yes, are clients asked about their gender identity and expression during the intake process?

- Yes
- No
- Unsure

14c. If Yes, are clients asked about their relationship status in a way that goes beyond just marital status?

For example, including questions about long-term or domestic partner.

- Yes
- No
- Unsure

15. Does your agency include sexual orientation in the non-discrimination statement?

- Yes
- No
- Unsure

16. Does your agency include gender identity and expression in your non-discrimination statement?

- Yes
- No
- Unsure

17. Are there formal mechanisms to report anti-LGBT biased behavior?

- Yes, for clients and staff
- Yes, for clients only
- Yes, for staff only
- No
- Unsure

17a. If Yes, please describe:

FAMILIARILY AND COMFORT WITH THE LGBT COMMUNITY

18. I am familiar with LGBT terminology.

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

19. I am comfortable using LGBT terminology.

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

20. I am comfortable providing assistance to lesbian, gay, or bisexual older adult clients.

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

21. I am comfortable providing assistance to transgender older adult clients.

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

22. If a client asked for referrals to LGBT-specific services, I feel confident that I could find that information for him or her.

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

23. I currently have one or more client who openly identifies as LGBT.

- Yes
- No, but I have had openly LGBT clients in the past
- No, but I have clients I suspect are LGBT
- No, I have never had openly LGBT clients
- Unsure

24. I currently have one or more co-worker who openly identifies as LGBT.

- Yes
- No
- Unsure

25. I have one or more close friend or family member who openly identifies as LGBT.

- Yes
- No
- Unsure

26. I consider myself to be an ally to the LGBT community.

- Yes
- No
- Unsure

PERCEPTION OF AGENCY COMPETENCY

27. Direct service staff at my agency would welcome LGBT clients.

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

28. Supervisors and executive staff at my agency would welcome LGBT clients.

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

29. Other clients at my agency would welcome LGBT clients.

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

30. What are the strengths of your organization in providing assistance to LGBT clients?
Please describe:

31. What are the challenges of your organization in providing assistance to LGBT clients?

Please describe:

32. How much of a priority does your agency place on the needs of LGBT older adults?

- Top priority
- Somewhat of a priority
- Low priority
- Not a priority

33. My agency has received requests in the past year to aid an older LGBT person.

- Yes
- No
- Unsure

KNOWLEDGE ABOUT LGBT OLDER ADULTS

34. LGBT older adults have different needs than heterosexual adults as they age.

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

35. It is easy to tell LGBT people apart from straight people.

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

36. A client's sexual orientation or gender identity is his or her own personal business and should not be discussed.

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

37. LGBT older adults may experience aging in different ways than the general public. How would you rate your knowledge of the following issues faced by LGBT older adults?

	Very Knowledgeable	Somewhat Knowledgeable	A Little Knowledgeable	Not Knowledgeable
Legal				
Financial				
Medicare and Medicaid				
Medical Concerns				
Barriers to Services				

TRAINING

38. My training and experience have adequately prepared me to serve gay, lesbian, or bisexual older adults.

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

39. My training and experience have adequately prepared me to work with transgender older adults.

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

40. The agency where I work has offered or promoted staff trainings about LGBT older adults.

- Yes
- No
- Unsure

40a. If Yes, please describe.

41. I have received training about LGBT older adults.

- Yes
- No
- Unsure

41a. If Yes, please describe where you received this training.

42. I would like to receive training about LGBT older adults.

- Yes
- No

42a. If Yes, what topics or issues would you like the training to cover?

42b. If Yes, what would be the best or most preferable way to receive this training?

- Online
- In-Service Training
- Written Materials
- Other (Please specify: _____)

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