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## Creating and Maintaining the Therapeutic Relationship with LGBT Elders: An Exploratory Study

Natasha K. Satre  
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Creating and Maintaining the Therapeutic Relationship with LGBT Elders:

An Exploratory Study

by

Natasha K. Satre, B.A.

MSW Clinical Research Paper

Presented to the Faculty of the  
School of Social Work  
St. Catherine University and the University of St. Thomas  
St. Paul, Minnesota  
in Partial fulfillment of the Requirements for the Degree of

Master of Social Work

Committee Members

Ande Nesmith, Ph.D., MSW (Chair)  
Christopher Bargeron, MSW, LICSW  
Mary Beth Gustafson, MSW, LICSW

The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, MN and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

### **Abstract**

As the aging population rapidly rises in the United States, so does the need for social workers who are competent to practice with older adults. Social workers must also be prepared to serve subpopulations within their generational context that may have unique needs and histories of inequality and oppression. The LGBT elder community has historically been overlooked in generalist and clinical practice with older adults. The purpose of this qualitative research study was to explore how mental health practitioners create and maintain the therapeutic relationship with LGBT elders. Individual interviews were conducted with nine mental health practitioners holding LICSW, LISW, and LGSW degrees. The major themes that emerged from the data were: 1) definition of the therapeutic relationship, 2) the importance of avoiding assumptions, 3) the importance of cultural competency, 4) the validation and recognition of life experience, 5) the development of trust, 6) the importance of safety and acceptance, and 7) challenges in developing the therapeutic relationship. Implications for social work, future research, and policy are discussed.

## Acknowledgments

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Creating and Maintaining the Therapeutic Relationship with LGBT Elders:  
An Exploratory Study

Within the next twenty years, the generation known as the baby boomers, born between 1943 and 1964, will be entering into older age, leading to an aging boom in the population (Lyon, Legg, & Toulson, 2005). According to the Administration on Aging (2013), in 2011 persons age 65 and older represented 13.3% of the United States population. The population is expected to grow to 21% of the overall population by 2040. According to the Minnesota Department of Human Services (2013), by 2030, 1.2 million people, or one in four, age 65 or older will reside in the state of Minnesota. The demand in aging services to meet the needs of this rapidly growing population is at an all-time high. Social workers in the area of aging are not only in demand to serve the general aging population but also to meet the needs of subpopulations that may have unique needs and histories of inequality and oppression. The lesbian, gay, bisexual, and transgender (LGBT) population will be the focus of this study.

While many facilities have implemented diversity and nondiscrimination policies addressing race, ethnicity, and religion, the needs of LGBT elders are just beginning to be addressed. Many elders share the fear of being unable to care for themselves as they age, resulting in the need for in-home care, assisted living, or long term care facilities. LGBT elders share such fears but may have additional apprehensions receiving care from aging service providers where policies have not been implemented to be inclusive towards them and training on LGBT issues have not been received (Landers, Mimiaga, & Krinsky, 2010). With the major policy changes occurring at the state and federal level with the

legalization of gay marriage in Minnesota and the defeat of the Defense of Marriage Act, aging service providers will be working with married same-sex couples in the same legal manner as with heterosexual married couples. One particular area that social workers will be key advocates in is couple's living arrangements in assisted living facilities. Married couples often co-habitate in such facilities and LGBT couples did not have the equal right under law for this possibility.

The scope of this problem reaches across the LGBT population, whether they are currently in their elder years or soon approaching later life as well as family and friends who may be caregivers to LGBT elders. While more research is being conducted on the needs of LGBT elders, the scope of the problem remains broad because the research available is just scratching the surface towards more specific areas to address such as caregiving, financial stability, and psychotherapeutic considerations (Croghan, Moone, & Olson, 2012; Jackson, & Johnson, 2008; Knochel, Croghan, Moone, & Quam, 2012; Landers et al., 2010; Metlife, 2010; Smith, McCaslin, Chang, Martinez, & McGrew, 2010; Stein, Beckerman, & Sherman, 2010; Witten, 2009). A gap exists in provider competency and readiness to work with this population and it must begin to close as the aging boom is beginning (Croghan et al., 2012).

The population statistics are difficult to exactly pinpoint for this population because the LGBT elder population has not historically been easy to reach or has not been acknowledged. While the U.S. Census Bureau does not specifically account for this population, it is estimated that 1 to 3 million Americans age 65 and older are LGBT (Landers et al., 2010; SAGE, 2010; U.S. Census Bureau, 2004). This population is expected to grow to 2 to 6 million by 2030 (U.S. Census Bureau, 2004). Although the



population estimates cannot be cleanly pinpointed, the potential influx of LGBT elders within the aging boom will be significant.

It is critical that aging service providers begin to gain competency and get prepared to work with this population now. Research consistently demonstrates that LGBT elders and LGBT baby boomers have significant apprehension about receiving care from providers that have not received sensitivity training and do not market themselves as inclusive (Croghan et al., 2012; Jackson, & Johnson, 2008; Knochel, Croghan, Moone, & Quam, 2012; Landers et al., 2010; Metlife 2010; Smith, McCaslin, Chang, Martinez, & McGrew, 2010; Stein, Beckerman, & Sherman, 2010; Witten, 2009). This is critical for social workers to act upon because they may work with elders in a variety of different agencies such as long term care facilities, case managers, hospice, and as therapists. Social justice for underserved populations is a core value for social workers and social workers will be needed as advocates for LGBT elders as they navigate the many systems that interact with each other as individual's age. Competency in the area of aging and competency in working with the LGBT population will be invaluable to current elders and those who will be elders in the upcoming decades.

Historically, the relationship between the mental health field and the LGBT community has often been complex, controversial, and painful. LGBT elders may approach psychotherapy differently than their heterosexual elder peers because of the era in which they lived. Not only was homosexuality considered criminal but it was also classified as pathological by the American Psychiatric Association (APA) (Cook-Daniels, 2008). Although society, culture, and the law is ever-changing, this was the reality that they knew for a large part of their lives.

This long and stigmatizing history may still be in the memory of LGBT elders alive today. Trust in medical and mental health professionals may not be easy to come by simply based on expertise alone. As members of the social work profession, being aware and sensitive of the shared history of LGBT elders will be critical in developing trust with clients. A foundation of clinical work with any population is the development of the therapeutic alliance, or therapeutic relationship. LGBT elders are more likely to be wary of mental health professionals based on the discrimination and oppression they have lived through. It is the duty and responsibility of social workers to develop inclusive policies and receive competency training in order to be prepared and competent to work with the LGBT elder community.

## **Literature Review**

### **Competency in Working with Older Adults**

Before addressing specific considerations in working with LGBT older adults, it is important to discuss overall competency in working with older adults. Gerontological social work is a specialty practice area within the field of social work. Gerontology is defined as “the study of aging processes and individuals as they grow from middle age through later life” and includes the study of biopsychosocial changes in older people as they age, societal changes, and the application of gerontological knowledge to policies and programs (AGHE, 2013). Related to gerontology is geriatrics, which is the study of health and disease in later life and the comprehensive health care of older adults and the well-being of their caregiver (AGHE, 2013). As previously discussed, the aging population is rapidly growing and the need for competent practitioners within the field of gerontology and geriatrics is at an all-time high.

As social workers, competence is one of our core values and ethical standards as detailed in the NASW Code of Ethics (2008). As the demand for social workers to enter the aging field rises, social workers must develop competency in this specialty field to adhere to our guiding practice principles, which includes the guideline when: generally recognized standards do not exist with respect to an emerging area of practice, social workers should exercise careful judgment and take responsible steps (including appropriate education, research, training, consultation, and supervision) to ensure the competence of their work and to protect clients from harm (p. 9).

According to the National Center for Gerontological Social Work Education, the generalist competency goals for practice with older adults and families include values,

ethics and theoretical perspectives, assessments and interventions specific to older adults and caregivers, and aging services, programs, and policies (CSWE, 2013).

Additionally, an understanding of health issues that affect older adults is critical as the vast majority are diagnosed with at least one chronic health condition and many have two or more conditions (CSWE, 2013; Karel, Gatz, & Smyer, 2012; Knight & Sayegh, 2011). With advances in medical technology such as vaccines, medications, and life-sustaining treatments as well as public health campaigns such as clean water initiatives, hygiene, and food standards, people are living decades longer than in the past (Helmuth, 2013; Knight & Sayegh, 2011; Richardson & Barusch, 2006). Older adults may be living with chronic disease for decades and the progression of diseases such as dementia may inevitably lead to housing in assisted living facilities, residential care homes, or long-term care facilities which offer skilled nursing care. Therefore, gerontological social work requires a multidisciplinary approach to working with clients because they must navigate through multiple care systems. A geriatric interdisciplinary team may involve physicians, nurses, care coordinators, social workers, dietitians, respiratory therapists, and physical and occupational therapists.

When working with an elder client and the interdisciplinary team, providers are also frequently also working with caregivers. According to the Council on Social Work Education (CSWE, 2013), approximately 65% of elders with long term care needs exclusively rely on family and friends (referred to as informal caregivers) to provide care and another 30% receive care from paid providers in addition to informal caregivers such as in-home services or care from facilities. When a caregiver is involved with an older adult, they are also considered to be a client of the interdisciplinary team.

## **Aging Considerations for LGBT Elders**

LGBT elders are often referred to as an “invisible” population (Croghan et al., 2012; Crisp, 2008). Many practitioners and aging services providers have not considered that their clients or patients may be LGBT but it is likely that they are or have worked with an LGBT elder. With this lack of consideration, it is not realistic to assume that aging services know how to effectively serve these elders in culturally competent ways (Grant, 2010). The literature revealed several key areas that are important to consider with respect to serving LGBT elders.

**Historical Considerations.** Working with older adults requires practitioners to approach their clients with an understanding of the historical framework or generation in which they have lived. It is especially important to develop a historical framework for marginalized or minority client populations such as LGBT elders. Today’s LGBT elders have witnessed both immense progress as well as accompanied setbacks, where rights have been won and taken away (Cook-Daniels, 2008). They were coming of age before the Stonewall Riots of 1969, before gay pride events, and before the AIDS epidemic (Crisp, 2008). They have now witnessed the repeal of sodomy laws, the legalization of gay marriage, and openly gay and lesbian politicians and media figures.

The history of the mental health establishment and its early treatment of LGBT individuals is of particular importance to this study. In its first official list of mental disorders in 1952, the APA included homosexuality under “sociopathic personality disturbance” (Cook-Daniels, 2008). In 1968, the APA moved homosexuality from “sociopathic” to the category of “sexual deviation”. The APA did not remove homosexuality from its list of mental illnesses until 1973. Within four years, the

American Psychological Association and the National Association of Social Workers also depathologized homosexuality (Jones & Gabriel, 1999). To put the dates in perspective regarding the age of today's elders, when the APA initially listed homosexuality as sociopathic, folks that are in their early 80's would have been in their early 20's at the time. Although homosexuality was removed from the DSM as a mental illness, the stigma did not evaporate overnight. According to Dunlap (2004), eight years after the APA's decision to remove homosexuality from the DSM, the American Medical Association adopted a policy encouraging doctors to counsel gay patients about sexual orientation reversal. This policy was not removed until 1994.

**Social Support Systems.** LGBT individuals often have social support systems that involve a unique concept: families of choice. Blank, Asencio, Descartes, and Griggs (2009) define families of choice as a group of individuals who are not biologically related but fill supportive and intimate roles normatively filled by biological family members. While many LGBT individuals have happy and healthy relationships with their families of origin, there are also many that have been ostracized due to their sexual orientation. Developing families of choice provide the love and support that may otherwise be missing if the relationship with a family of origin is strained or nonexistent. Caregiving of elders is most often provided by biological family members thus making families of choice especially important to understand (Blank et al., 2009). The people making up families of choice may be friends, past intimate partners, or members of their partner's family.

Social support is essential to healthy aging. Social support has been linked to good health, well-being, and quality of life of elders (Witten, 2009). Jackson et al. (2008)

discuss that elder gay men often live alone and are at risk of losing social support systems if they become more limited by chronic diseases. Blank et al. (2009) also notes that elder gay men often lack social support over elder lesbians due to a greater prevalence of ageism within the gay community and alienation from families of origin. This fear of isolation may be amplified if upon entering a long-term care facility it is evident that nondiscrimination and inclusive policies pertaining to LGBT individuals have not been implemented and staff have not had the opportunity to develop cultural competence. In a needs assessment study by Smith et al. (2010), when asked what concerned them most about being an elder LGBT person, the most frequent response was loneliness and loss with half believing their sexual orientation would be a factor in their loneliness.

Families of choice may be particularly important for transgender individuals because many have little to no contact with their families of origin. It may be hypothesized that without a social support group of choice, trans-elders will face extreme difficulty because their supportive systems are more limited than gay, lesbian, and bisexual individuals (Witten, 2009). Unfortunately, little to no research has been conducted on the social support networks of transgender individuals. Additionally, very little research has been conducted on transgender elders. They are often barely represented in large-scale quantitative studies (Croghan et al., 2012; Jackson et al., 2008; Metlife, 2010; Smith et al., 2010;). Future research is direly needed to specifically address the needs of transgender elders, as it is beyond the scope of this study.

The implications of social support networks of LGBT individuals for social work practitioners are being aware that “family” may have a different meaning than it does for heterosexual individuals. When working with an LGBT elder, it is important to advocate

for familial social support networks that do not fit the mold of biologically related (or legally adopted into) families. At a micro level, this includes visitors to facilities who may be considered family members and who should be informed about health care issues or emergencies. At the macro level, advocating for institutional changes to supportive groups to include discussions for same-sex partners and spouses into the reminiscence or grief groups.

**Long-Term Care Concerns.** The literature overwhelmingly supports the concern that bias and discrimination based upon an elder's LGBT status would occur if residing in a long-term care facility (Croghan et al., 2012; Jackson et al., 2008; MetLife, 2010; Meyer, 2011; Smith, et al., 2010; Stein et al., 2010; Witten, 2009). No scholarly articles were found that researched the actual experiences of LGBT elders who currently reside in long-term care facilities. Therefore, the following discussion is based upon perceptions that have been formed by LGBT individuals regarding potential experiences in long-term care facilities. This is relevant because of the rapidly expanding aging baby boomer generation. As baby boomers came of age and entered into adulthood, the contemporary movement for LGBT rights became visible to the wider public (MetLife, 2010). With the reality that elders are living longer and often die from long-term chronic disease in our current healthcare system (Navasky and O'Connor, 2006), a significant percentage of individuals that will have to consider long-term care will be LGBT individuals. As potential residents, the time is now to develop inclusive, welcoming, and trustworthy facilities.

According to the MetLife (2010) study on 1,000 gay and lesbian baby boomers, 32% of gay men and 26% of lesbians cited discrimination due to sexual orientation as



one of their greatest aging concerns. This fear was most prevalent for those in civil unions and domestic partnerships because their relationship was more visible. Out of the these respondents, one out of three listed discrimination as a major fear versus one in four who were not in such partnerships. The 2012 Twin cities LGBT aging needs assessment found a “profound lack of confidence” in the LGBT community that they would receive sensitive senior services and housing as they age should their sexual orientation be known to the service provider (p. 14).

The Smith et al. (2010) study of thirty-eight LGBT elders examined perceived friendliness of senior services, unmet needs that were both related to the general senior population as well as issues specifically problematic for LGBT seniors, and open ended questions regarding concerns about being an elder LGBT person. 27.8% felt their needs for LGBT-friendly assisted living were met and about a quarter felt that knowledgeable mental health counselors or competent social workers to find services were available to them. None of the respondents felt that nursing homes were “very friendly” and 52.6% felt that nursing homes were not LGBT friendly at all (p. 394).

Open ended response examples to the question of what concerned them most about aging in general were “Aging and being alone when I die” and “Isolation because of the discrimination” (Smith et al., 2010, p. 395). When asked specifically what need may not get met as they aged, respondents most frequently cited lack of nursing home or assisted living services that are LGBT friendly. As social workers, we have a responsibility to ensure this will not be the case in attendance to the principle of human dignity, which states that the “measure of every institution is whether it threatens or enhances the life and dignity of the human person” (School of Social Work, 2006). As

previously mentioned, LGBT elders are at a higher risk of social isolation as they age and the Smith et al. (2010) findings note that additionally, LGBT elders may refrain from accessing services when the need for dependency is critical to their safety in old age due to a lack of trust in how they will be received by aging service providers.

In another study that compared perceptions of LGBT age discrimination between LGBT and heterosexual respondents, both groups similarly believed that LGBT residents of care facilities are victims of discrimination (Jackson et al., 2008). The groups did not show similar agreement regarding access to social and health care services. 61.3% of heterosexual respondents believed that LGBT elders have equal access to health care services as heterosexual elders while only 39.7% of LGBT respondents believed that to be true (p. 332). One issue that had been touched on in previous articles was whether LGBT elders would hide their sexual orientation which in turn would suggest hiding their partners or families of choice, if making the move to a long-term care facility. Jackson et al. (2008) reported that 66% of LGBT respondents would not hide their sexual orientation if they were to reside in a long-term care facility.

**Policy Considerations.** While major policy victories have been achieved with regard to LGBT equality, such as more states legalizing same-sex marriage and the ruling that section three of the Defense of Marriage Act (DOMA) is unconstitutional by the United States Supreme Court, nationwide equality for LGBT individuals has not yet been realized. Section three of DOMA had prevented the federal government from recognizing marriages of same-sex couples. The federal government now recognizes marriages of gay and lesbian couples in states that have legalized same-sex marriages thus entitling these couples to federal benefits and programs (GLAAD, 2013). For LGBT elders that do not

live in a state with such recognition or who have lost life partners prior to the legalization of same-sex marriage, may not have had the freedom to participate in health care decisions with and for their partner, may not have had the ability to make end-of-life and funeral preparations for their partner, and may not be allowed to share living areas with their life partner in retirement facilities. LGBT couples have been denied important spousal benefits such as social security retirement benefits, social security survivor benefits, and Medicaid benefits when one partner falls ill (Grant, 2010). Furthermore, LGBT elders have experienced the invalidation of their relationships by public policy throughout most of their lives. Jackson et al. (2008) notes that this marginalization of life partnerships may increase the sense of distrust LGBT elders have for social and health services because these services have been marketed towards the LGBT community by a mainly heterosexual provider community.

Numerous studies have reported that LGBT elders would be more trusting and willing to access aging services if agencies made it known they have received competency training and have LGBT inclusive policies (Croghan et al., 2012; Jackson et al., 2008; Knochel et al., 2012; Landers et al., 2010; Metlife, 2010; Meyer, 2011; Smith, et al., 2010; Stein et al., 2010; Witten, 2009).

**Resiliency.** LGBT elders may face challenges that are unique from other elder communities. It must be noted that LGBT elders face these challenges with strength and resiliency, with a history of self-advocacy, activism, and heroism. LGBT elders have developed coping skills that have been instrumental when faced with accepting their sexual orientation, managing the coming out process, coping with homophobia and heterosexism, and adapting to flexible gender roles (Crisp, 2008). Smith et al. (2010)

discusses that LGBT elders have faced many challenges and the resulting resilience may have prepared the LGBT elder population more effectively than others for the challenges of old age. Respondents to the MetLife (2010) study on baby boomers reported themselves to have developed positive character traits, have greater resilience, and better support networks as a direct result of being gay, lesbian, bisexual, or transgender. Transgender elders, being one of the most stigmatized and misunderstood groups, have developed highly effective coping and survival strategies worthy of great respect (Witten, 2009).

### **Mental Health Considerations for Elders**

Clinical practice with older adults has often been an overlooked area of practice. It is currently gaining traction due to the anticipation of the aging baby boomers and empirical evidence demonstrating the effectiveness of mental health treatment for older adults. Older adults are increasingly seeking the services of mental health professionals to help with their problems. They are most often a highly motivated and resilient population to serve, who seek treatment with readiness for change (Zarit & Zarit, 2007). Also, caregivers currently in their 50s or 60s are more likely to learn about or seek out services for themselves or their loved ones, thus making it more likely that the baby boom generation will seek access to mental health services as they age (Knight & Sayegh, 2011; Zarit & Zarit, 2007).

Mental illness may be present in older adults, as it is in the younger population. Characteristics of specific disorders may present differently but elders may be diagnosed with depression, anxiety, and schizophrenia. Additionally, as life expectancy has increased, so have diagnoses of dementia. According to Zarit and Zarit (2007), between

20 and 30% of adults in their 80s have a diagnosis of dementia. Additionally, the rate of older Americans with dementia will increase by 1.5 million within the next ten years (Karel et al., 2012). This is especially critical because high rates of comorbidities exist between cognitive and psychiatric disorders in older age. For example, many people diagnosed with mild cognitive impairment also show high rates of anxiety, depression, and other behavioral concerns. Depression itself may be a symptom of the early stages of dementia in some older adults (Karel et al., 2012).

While the trend is moving towards accessing services, older adults with symptoms of a mental disorder are currently less likely to receive mental health services than younger or middle age adults and when they do, they are more likely to receive services in a primary or long-term care facility and not from a mental health specialist (Karel et al., 2012 & Kaskie & Estes, 2001). Knight and Sayegh (2011) note that they perceive this occurrence to be the result of a mental health care system that is a conglomeration of multiple, separate systems of care. These systems include specialty mental health services, acute medical care, long-term care, dementia and substance-abuse care, and the overall aging services network. Suggestions on strategies to improve the overall delivery of service are advocating on the behalf of older adult clients for access to specialty mental health services within facilities and the communities, getting involved with lawmakers to effect policy changes in mental health care coverage through Medicare and Medicaid, and working as part of an effective interprofessional team as mental health care providers will be tied to medical health care in elders (Knight & Sayegh, 2011; Karel et al., 2012; Kaskie & Estes, 2001; Meyer, 2011).

## **Mental Health Considerations for LGBT Elders**

**Additional Historical Considerations.** While all of the above mental health considerations affect LGBT elders, the field of mental health has a sordid history with its treatment of the LGBT population. The current cohort of LGBT elders have largely lived a portion of their lives in secrecy, revealing their sexual orientation to trusted friends and family. Some may not have ever revealed their sexual orientation because they came of age during a time where it was both illegal and a mental illness to be gay or lesbian.

As previously mentioned, LGBT elders are referred to as an “invisible” population, which Crisp (2008) attributes to the failure of national studies to inquire about sexual orientation, lack of funding on LGBT issues, difficulty recruiting subjects, and fear of disclosure. Additionally, Blando (2009) points out that older adults were raised in an era where discretion was valued and therefore disclosing one’s sexual orientation was not considered a necessary part of their identity. Within recent years, several studies have emerged that draw attention to LGBT groups as well as organizations such as Training to Serve in the Twin Cities, whose primary focus is educating aging service professionals about LGBT aging issues (Croghan et al., 2012; Jackson et al., 2008; Knochel et al., 2012; Landers et al., 2010; Metlife, 2010; Smith et al., 2010). Currently, transgender individuals must still accept a mental health diagnosis of gender identity disorder in order to receive hormonal or surgical transition services if they are seeking to surgically change genders (Grant, 2010).

Additionally from a policy standpoint, until our most recent history LGBT couples could not have access to partner’s medical insurance benefits because same sex marriage was not legally recognized by the state or federal government, which presented

a barrier to accessing mental health services. As our society continues the upward trend of acceptance and equality and the mental health field's work towards affirmative, inclusive practice, the trend for future cohorts of LGBT elders to seek out services will also continue upward. Practitioners should be aware that some LGBT elders may have grief or anger over what they were unable to have with regard to legalized marriage or open acceptance. It will be critical to have culturally competent practitioners ready to serve the LGBT elder population who have an understanding of the unique needs of both elders and the LGBT community.

**Treatment Approaches.** While evidence based practices such as cognitive behavioral therapy (CBT) can be effective for many populations, several distinct models have been studied with regard to LGBT elders. In the 1980s and 1990s, a new model of therapy emerged called Gay-Affirmative Psychotherapy (GAP). This approach to clinical work began when gay and lesbian psychotherapists began writing about their lives and the need for therapy and therapists without heterosexist and homophobic prejudice (Kort, 2004). The model combines a person-in-environment perspective as well as a strengths perspective. Specifically the model encourages practitioners to support self-determination, view LGBT identities as healthy, and assist clients in self-advocacy and to challenge oppressive structures in their lives (Crisp, 2008). Additionally, specific cultural competencies can be identified for practitioners. Kort (2004) recommends these basic principles in becoming a GAP therapist: do not make assumptions about sexual orientation, clinicians should be open and honest about their sexual orientation, loosen up and discard a neutral stance, be sensitive to the effects of homophobia on LGBT

individuals, be sensitive to language, and be aware of personal knowledge about gay issues and give oneself the permission to ask.

Buddhist psychotherapy and life-review workshops have also been examined in working with gay and lesbian elders. Galassi (1991) found that the majority of participants in the life-review workshop reported a higher sense of well-being and collective pride at sharing life-marker material. The sharing of life-marker material was notable because LGBT elders may not have enjoyed the accustomed and anticipated life markers of “change, conflict, celebration, and resolution” that heterosexuals experience and share with family, friends, co-workers, and practitioners (p. 78). The development of shared meaning resulted in feelings of empowerment and connection. Similarly, Croghan et al. (2012) found that the majority of LGBT elders reported preferring support groups designed for the LGBT community.

Buddhist psychotherapy had been applied to work with LGBT elders because of the focus on well-being, mindfulness (focus on the present), equanimity, liberatory message, and acceptance (Blando, 2009). Additionally, Buddhist psychotherapy takes a nonpathologizing approach to psychological distress. For example, Blando (2009) describes coming out (disclosing an individual’s sexual orientation) as a lifelong process, one that is experienced over and over again with friends, family, co-workers, and/or others. This process may result in psychological distress for some, particularly LGBT elders who may have mixed experiences with the process of coming out. Blando (2009) notes that the importance of not pathologizing these feelings as they “represent real human responses to a real, oppressive social situation” (p. 67). This systemic approach has also been noted by Gonsiorek (1981) who emphasized that issues unique to LGBT



elders such as hardships encountered by the loss of a life-partner without the legal grounds to access finances and property as well as their own medical problems may result in depressive and/or anxious symptoms. Treatment that focused on grieving, working through painful events, and establishing a support system was effective in lifting the depression and anxiety. Although writing from a psychological perspective, this systemic approach is unique to social workers, who assess the systemic impact on a client's well-being and advocate for systemic interventions to alleviate distress.

### **Therapeutic Alliance**

As previously mentioned, trust is an essential component to working with LGBT elders. Numerous studies have shown that lack of cultural competency and training in LGBT issues is a barrier to accessing services (Croghan et al., 2012; Jackson et al., 2008; Metlife, 2010; Meyer, 2011; Smith, et al., 2010; Stein et al., 2010; Witten, 2009). The essential component to effective therapy is the therapeutic alliance, or therapeutic relationship, which is built on trust. The therapeutic alliance can be defined as, "the collaborative nature of the relationship, the affective bond between patient and therapist, a trust in the therapist by patient, and agreement on goals by both" (Hyer, Kramer, & Sohnle, 2004). Zarit and Zarit (2007) further refines this definition in working with older adults to include empathy as a tool to not only accept clients as their unique selves and convey a sense of understanding but also as a tool to bridge the generation gap. For example, feelings that older adults may have, such as loneliness, can be experienced by people of any age. The core, human feeling can be the necessary connection point. Warmth and genuineness are also key components.

While the literature has emphasized the importance of trust when working with LGBT elders, the importance in providing mental health care to elders, and the importance of the therapeutic alliance, no research was found that specifically addressed the therapeutic alliance with LGBT elders. The purpose of this study was to examine how clinicians create and maintain the therapeutic relationship with LGBT elders. In order to answer this question, clinicians were interviewed to gain knowledge and insight into their personal approaches to working with this population.

## Conceptual Framework

This research project was conceptualized through the gay affirmative practice framework which combines person-in-environment, strengths, and cultural competency perspectives (Crisp, 2006). Gay affirmative practice is defined as practice that “affirms lesbian, gay, or bisexual identity as an equally positive human experience and expression to heterosexual identity” (Davies, 1996, p. 25). This framework is well-suited to work with LGBT elders because of the many systems of care elders must interact with in their environment, the unique strength and resilience developed by the elder LGBT community, and the cultural factors present in a community of elders that have lived through significant cultural and political change that has directly impacted lives and freedoms.

The person-in-environment (PIE) perspective takes into context the many environments in which an individual interacts and the roles they play within these environments (Crisp, 2006). Environments in which LGBT elders may interact include their family-of-origin, family of choice, the facility in which they may reside such as long-term care, and the agencies providing care such as home health aides or hospice.

The strengths perspective is based on the belief that human beings inherently have the strength within themselves to exact change and personal growth. With empowerment, these strengths can be realized and clients can become agents of change for themselves. The strengths perspective is tied to the PIE perspective because it assumes that problems occur as a result of transactions between environments rather than the individual having a pathological problem (Miley et al., 2011). For work with LGBT elders, this perspective encourages self-determination, views elder’s sexual orientation as healthy and not

pathological, and supports the questioning and challenging of oppressive systems within client's lives (Crisp, 2008). As previously mentioned, LGBT elders have developed unique strengths as a result of the oppression and stigma of LGBT individuals. Self-advocacy is one of these strengths and social workers can assist LGBT elder clients in continuing advocacy as they increasingly interact with aging agencies that may not be as well prepared to work with the LGBT community.

This framework guided the development of interview questions because in order to be a competent clinician when working with the elder LGBT population, a knowledge of the systemic impacts of history, policy, and society on the LGBT community must be in place as well as an understanding of the inherent strengths and resiliency LGBT elders have developed as a response to environmental forces.

Gay affirmative practice guided the gathering of data because it focuses on the strengths of LGBT individuals formulating questions that pertain to how clinicians will become part of the environment with which elder LGBT clients will interact. As elders, the likelihood that they will also be interacting with aging systems is high and understanding these systems will be important in developing a therapeutic relationship.

## **Methods**

### **Design**

The purpose of this research project was to explore how clinicians create and maintain the therapeutic relationship with LGBT elders. This study was retrospective in design, as respondents were asked to reflect upon their practice experiences with LGBT elders. The research conducted was qualitative. The researcher interviewed mental health professionals to gather data. The research was exploratory in nature and the objective was to gain an understanding of how clinicians are currently working with the elder LGBT community or if they are not, what their perspectives would be if working with this population.

### **Sampling**

The sample for this study was obtained through the snowball sampling method, which is defined by Monette, Sullivan, & DeJong (2011) as a:

non-probability sampling characterized by a few cases of the type that we wish to study, which lead to more cases which, in turn, lead to still more cases, until a sufficient sample achieved (p. 507).

Additionally, Padgett (2008) notes that this sampling method is often used for isolated or hidden populations. As LGBT elders are often referred to as an invisible group, this was a practical choice for a sampling method.

The researcher consulted with clinicians known to the researcher to obtain contact information for potential respondents. The researcher contacted potential respondents by telephone or by email. One clinician known to the researcher, placed an informational posting about the study on the LGBT Therapists of MN e-newsletter (see Appendix A).

To be included in the study, respondents had to be mental health practitioners who work with elder LGBT clients and/or LGBT clients such as social workers (LICSW and LGSW), psychologists, and licensed marriage and family therapists (LMFT). Clinicians who did not work with the elder LGBT clients and/or the LGBT community were excluded from this study.

A total of nine mental health practitioners participated in this study, eight women and one man. Of the nine participants, seven were licensed independent clinical social workers (LICSW), one was a licensed independent social worker (LISW), and one was a licensed graduate social worker (LGSW). Of the nine participants, six had professional experience with LGBT elder clients and three had experience with LGBT clients of younger generations. Five of the nine participants identified themselves as members of the LGBT community and two identified themselves as an LGBT older adult.

### **Protection of Human Subjects**

To ensure the protection of human subjects, the research proposal was submitted to the University of St. Thomas Institutional Review Board (IRB) on November 29th, 2013 which included study methodology, informed consent process, and recruitment information. On January 6th, 2014 the proposal was approved by the IRB.

During recruitment and based on an IRB approved script (see Appendix B), study participants were informed about the subject of the study, the length of time it would take for participation, and that participation was optional. Study participants were sent copies of the informed consent form (see Appendix C) for their review prior to the interview. Interviews took place at a time and setting most convenient to the participants.

The records of this study were kept confidential. Participants' identities were known only to the researcher and not included in the study. Research records were kept in a locked file in the researcher's home office. Electronic copies of the transcripts were saved in a password protected file on the researcher's computer. Identifying information has been deleted from the transcripts. Findings from the study were disseminated to attendees of the clinical research presentations and a copy of the final report may be obtained from the School of Social Work and through the online library system of the University of St. Thomas and St. Catherine University. The audio recordings and transcripts were destroyed by June 1, 2014.

### **Measurement**

For this study, respondents were asked a series of open-ended questions (see Appendix D) and their responses were audio-recorded. Questions pertained to clinician's experiences in working with elder clients, LGBT clients, and elder LGBT clients. The interviews sought to obtain insight from the perspectives of clinicians who currently serve the elder LGBT population as well as those who may have not yet served the elder LGBT population but do serve the younger LGBT community.

### **Analysis**

The data analysis was based in the grounded theory approach. This approach often involves interviewing subjects, transcribing a segment or the entire interview, inductively coding the interview (moving from specific words to more general themes), writing memos regarding the analytic decision making, and developing themes pertinent to the overall research question based upon the coded transcripts (Padgett, 2008). At the conclusion of the interviews, the interviews were reviewed in their entirety and themes

that could be coded were noted. After transcribing the interviews, the material was coded in an open format, or line by line. After openly coding the document the transcripts were reviewed, the codes were compared and any recurring codes were considered and were grouped into themes. The themes that address the research question were identified.

### **Strengths and Limitations**

**Sample.** The sample of participants for this study were mental health practitioners who either currently or recently have worked with LGBT elder clients or LGBT clients. Insight into important considerations for clinicians when working with this population will be useful and informative to current practitioners and those just entering the field. The sample was limited in that clinicians who only worked with older adults were not included. The older adult population in general may be overlooked when it comes to mental health services so perspectives and insight into clinical work with the general aging population was limited. A unique and unexpected strength to this study was that several participants were older adults themselves which provided both personal and professional insight. Additionally, half of the participants were members of the LGBT community, which also added both personal and professional insight to the study.

The advantage to the snowball method of sampling is that the respondents were obtained from clinicians who currently practice in the area to be studied and thus recommended practitioners who are knowledgeable in this particular area of research. The disadvantage to this method is that the clinicians interviewed likely knew the same people so there may not have been strong diversity within the sample. For example, most clinicians interviewed resided or practiced within the Twin Cities Metro area. Only one clinician practiced in a rural community.



The design of the study included clinicians who work with the elder LGBT community, elders, and the LGBT community who are not considered elders. We did not learn about professionals who work with the elder and LGBT community who are not mental health practitioners but who may have relevant and important information and experience to share related to the research question. Also, the participants were all social workers so perspectives from psychologists, psychiatrists, or licensed marriage and family therapists were not obtained. Furthermore, LGBT elders themselves were not interviewed for this study, although two of the clinicians shared they were sixty-seven years old. Future research that explores the experiences of LGBT elders from their perspective would be highly influential to this area of study. Due to the nature and scope of this research project, first-hand experiences of LGBT elders were not obtained.

**Mental health considerations.** While the study examined how to develop and maintain the therapeutic relationship in a clinical setting, the study did not examine specific mental health considerations or treatment modalities. Treatment approaches were discussed in the literature review but it was beyond the scope of this study to focus interview questions on specific interventions that clinicians are using with their clients.

**Methodology.** The researcher used a semi-structured interview format to conduct the interviews with participants. The research asked all the questions on the interview schedule but also asked clarifying questions when necessary or further questions when the answer led to additional notes of inquiry. Occasionally, the initial question would get lost in the answer provided by the participant. Additionally, the researcher used the term “elder” in this study which was often questioned by participants. “Elder” or “older adult”

could be used interchangeably for this study and the researcher conceptualized elder or older adult by definition of the participant's clients.

## **Findings**

Several key themes emerged with consideration to creating and maintaining the therapeutic relationship with LGBT elders. The emergent themes included the definition of the therapeutic relationship, the importance of avoiding assumptions, the importance of cultural competency, the validation and recognition of life experience, the development of trust, the importance of safety and acceptance, and challenges in developing the therapeutic relationship. Additionally, several sub themes were identified. The following is a presentation of the identified themes with supportive quotes from the transcripts.

### **The definition of the therapeutic relationship**

The first theme to emerge is the definition of the therapeutic alliance. All participants in this study described the therapeutic relationship as being the most important, core aspect of therapy, regardless of what therapeutic model is being used, as demonstrated by quotes such as,

“I think it’s everything. The therapeutic relationship and the therapeutic alliance is at the core of all of my work”, and, “I would describe the therapeutic relationship as the most important component in terms of success of any sort of treatment.”

Most participants included trust in their definition of the therapeutic relationship such as, “I believe that it is one that is established with trust,” and, “It’s basically built with trust and a strong rapport.” Two participants discussed the concept of unconditional positive regard and affirmation with quotes such as, “No matter what people come in with, I want to do that. I want to affirm them”, and:

It's the unconditional positive regard. Like being willing to sort of take what comes at you and transform it and try to give it back as something else. That kind of relationship I think is important.

Describing the therapeutic relationship as an authentic, real connection was also described by several participants, as demonstrated by the following quote, "I think it should be strong and nurturing but also a challenging, humor filled, authentic, real connection between two people."

### **The importance of avoiding assumptions**

The second theme to emerge is that participants felt that avoiding assumptions about a client's sexual orientation when working with older adults is critical. Nearly all participants touched on this theme. Sub themes of general assumptions, assumed heterosexuality, and institutional assumptions emerged within this primary theme as participants discussed the importance in general of not making assumptions and then expanded this to discuss the issue of assumed heterosexuality of older adults within aging services.

**General assumptions.** While most of the participants advised against making assumptions, they discussed this theme in different ways. The importance of avoiding assumptions when working with elders, either heterosexual or LGBT, in general was discussed by one participant:

I think you just can't make assumptions about anyone's life. And with LGBT elders, and elders in general, it's important to ask about their lives and the people that are important to them in their lives and not assume that because they are of a

certain generation that they are heterosexual or they have a partner that is of the opposite sex.

Another participant, who is part of the LGBT community, made this statement:

I think they've been one of the populations that has made me realize that I can't assume things about my gay clients. Some of their struggles with self image and self esteem certainly are ageless in a way but since they have been more clearly present, older people, I've gotten insights, more insights than my experience or my friend's experience that I've helped people cope with. That can help me with younger people too and to not overlook some aspect of shame or some aspect of fear. They have good stories to tell.

**Assumed heterosexuality.** Several participants touched on the issue of assumed heterosexuality; that it is assumed that all older adults are heterosexual or it is likely not considered that an older adult may be part of the LGBT community. One participant explains:

I think that older generations have grown up in an era of heteronormativity anyways and are used to invalidating environments. For us to then, as professionals, go in and to enforce or reinforce this invalidating environment where it is again assumed that because you were in the military or because you were married at one time and you do have children that you don't identify as being part of the LGBT community.

Another participant describes that the assumption of heterosexuality is something that her LGBT elder clients are aware of and sensitive to:

I do find that a lot of professionals just assume that everybody that is an older adult is also heterosexual. I think that assumption is definitely out there more so for older adults than it is for other generations. And I think that is something that they struggle with as well.

One participant who has extensive experience with the younger LGBT community reinforced the above quotation as demonstrated by this quote, “Even when I got your email I was like, huh, LGBT elders - yeah, I hadn’t thought about that much. Which is a shame.”

**Institutional assumptions.** Additionally, participants described the assumption of heterosexuality is made at the institutional level, as evidenced by intake forms. The following quotes demonstrate this sub theme, as related to older adults entering into senior care facilities:

I think that that’s a lot of what I saw in doing intake assessments of people coming into the nursing home; that it was assumed that the individual was married and had a family and was heterosexual. So I think one of the most important things is to not make assumptions and to ask all of those questions right off the bat to find who it is you’re working with and to find out what their life looks like. I think just the sensitivity - sensitivity around not making assumptions. Well you should see the forms. Oh my gosh - the forms alone! How do you identify your partner or spouse? It’s all opposite sex. It’s all assumed. I go, “Well do I put it down on this form? Do I cross it off?”

Additionally, one participant discussed the concern of assumed heterosexuality when conducting a standard social history:

A social history is taken and a common phrase is, “Tell me when you were born, your education level, what you did for a living and your marital status. Who’s involved in your life today? What does your daily life consist of?” I have more often than not, had my clients who are older adults and LGBT refer to themselves as single . . . . So my next question is do you have children because that is a big assumption: that if you weren’t married you didn’t have children because that is also in the social history and they’ll say no.

The participant goes on to describe, “I think you need to go with the conversation instead of a checklist”, referring to a social history checklist when assessing for important relationships. She further shares that most of her LGBT elder clients do not appreciate direct questions regarding their sexual orientation saying, “With a younger generation, they would appreciate that questions up front. I think with older adults, they often do not.”

### **Importance of cultural competency**

The third theme to emerge is the importance of cultural competency. Within this theme were two sub themes: LGBT elder cultural awareness and generational awareness with regard to the general elder population.

**Generational competency.** Participants discussed the importance of generational awareness with regard to working with the older adult population, whether they are part of the LGBT community or not, as demonstrated by this quote:

Regardless of our clinical skills and abilities, if we don’t have the perspective of what a different generation would have, we really aren’t going to be able to

significantly help anyone of that generation. It's their foundation. It's not right or wrong, or good or bad. It's their foundation. And it needs to be respected.

Another participant spoke on how a session with an older adult client may look different from a session with a younger client:

For seniors, there is the beauty of reminiscing and there's the onset of that somewhere in the early 60's for most people. There is a beginning to remember many things and recall life events that may or may not have been important, and there are some that need resolution. I think with other populations there would be a more direct conversation and in the population with seniors, oftentimes there is a back and forth of what's happening today. In there with the reminiscing and remembering, there is addressing something that comes up as a person reminisces. Where I would say to a younger person in a different population is maybe we need to return to the issue of why you're here. Where with seniors, I would let that reminiscing occur and we would talk about it and then I would gently return to why the person is seeking counsel or counseling.

**LGBT elder competency.** Participants spoke on the importance of knowing the history of the LGBT community so that clinicians have a baseline awareness of important issues of diversity, adversity, and the cultural change that LGBT elders may have experienced in their lifetime. When asked what is important to know about LGBT elders when developing the therapeutic relationship, one participant replied:

Their version. What I've learned, which I didn't know in the early 1970's when we all thought we were all one struggling community together, all had one lifestyle, it's important to have knowledge and understanding about a minority



group or a particular lifestyle. And it's important to back off and get them to say what it means to them. The way that it's helpful to have that knowledge is that they don't have to start explaining themselves from square one. They don't have to start educating about their lifestyle, their community, etc. All they have to do is start educating me about themselves and how they deal with it.

Another participant, when describing a specific client relationship, similarly stated:

I think it's very important that I know their history . . . . I'm sure you don't want to keep bringing that up to someone that doesn't know that. So for me to hold that knowledge with him and experience, I think is important.

The necessity of cultural competency does not imply that clinicians are then experts on the community, as demonstrated by this quote:

It's different in a sense that you as a clinician would need to educate yourself on what the LGBT community has gone through or may have gone through. And what adversities they've faced. So it's just that cultural competency and being aware of it. Being aware of your language, asking questions, and if you don't know, being direct about it – like, “Hey, I'm trying to figure this out. Can you help me understand?”

### **Validation and recognition of life experience**

The fourth theme to emerge is the importance of validating and recognizing the history and the cultural change that LGBT elders may have experienced throughout their life journey; that LGBT elders came of age and came out at a time that was different from the level of acceptance today. One participant referred to the pre-Stonewall era in this way:

I walked into the happy hour part of the Gay 90's in December of 1967. So the dark ages for sure, and I was aware of how stressful it was to be gay and how difficult it was to come to terms with that yourself, much less how to live in the world because you were considered criminal, sinful, and sick.

Validating and recognizing that this may have been the reality for many LGBT elders is also demonstrated by the following quotes:

The times are so different so it just seems more seamless for younger people and more full of hard knocks for older people. It's just that, what you've been through is so much more. Again I just come back to that, to squeeze that validation and that recognition. It's different, it's been harder. I think it just needs to be remembered and not lost.

Another participant echoed the importance of remembering what the elder LGBT community may have experienced in their lifetime:

It's a big deal. I'm thinking about the veterans of the second world war. They just don't want you to forget what they've been through. They want you to know about it, they don't want the whole thing to disappear after they die. They want some memorials. They want some recognition for what they went through. And it's the same feeling. It's a big deal. A lot of stuff went on and you don't want it all to just disappear.

More than one participant emphasized the difference between the older LGBT generation and younger LGBT generation as well as the difference between LGBT elders and heterosexual elders with regard to the cultural changes experienced within a lifetime, as demonstrated by this quote:

I think that they as individuals have had a wealth of experience in life and I think there's a lot to learn from that. And then I think that others don't always recognize that. And I know that to be true of straight elders but I think it's even more apparent to me when working with GLBT folks because they've lived throughout a lot of change in terms of acceptance of who they are and their coming out process is different than others who are younger.

Discussing the importance of validation and recognition for this community led some participants to discuss the personal impact that LGBT elders have made on them, as this quote demonstrates:

It's like you feel this connection to this older generation of your community and look up to them and are humbled by their experiences and what they've gone through. It's a part of your history so I think it's really important as an LGBT clinician and for other clinicians and professionals who are going to be working with the LGBT elder community, to recognize their trials and tribulations and what they've gone through. Truly because it is so much of what the social service field sort of looks to overcome and move through. They've done it.

### **The development of trust**

The fifth theme, the development of trust, was noted by several participants as an important factor in developing the therapeutic relationship with LGBT elders. While trust is a critical aspect with any client population, the development of trust with LGBT elders has unique factors to consider. One participant described the development of trust with consideration that the elder LGBT population is more likely to be isolated:

I think creating a space where they can trust in me and others that we're not going to be judgmental of them. I think one of the hardest things about being GLBT and also aging is the sense of isolation. And because of that sense of isolation people sometimes don't come out or don't seek out the services they might need because they don't know where to go in terms of supportive environments. It's sort of sad to be able to say that in this day and age. That's really true - it's really true. They find that people in the GLBT community access medical services far less than other demographic groups. And that's also true of GLBT elders too. They tend to not know where to go where they feel like they will be accepted and supported in that community.

A lack of connectivity with resources and services as it related to trust was also discussed by another clinician:

I think it's the trust piece to ensure they feel trusted and supported here so they can talk about their health concerns. That if they need help in finding resources, I can help them with that. I find that to be different than with just elder people. In my population, in my work, they're already very well connected sometimes. But I don't find that always to be the case necessarily with GLBT folks because they're not as well connected.

Another aspect of trust discussed was allowing for the development of trust based on the pace of disclosure that the client is comfortable with, while considering that LGBT elders have lived through a time when it may have been dangerous to disclose their sexual orientation, as demonstrated by this quote:

I could say that my experience has been to allow for the client to set the pace of which we go and the pace of which they disclose information or share, and to what detail. That freedom of that pace is a wonderful thing to have because these older adults that came from a different generation (that's true for all older adults) but specifically LGBT seniors who come from experience and a time in which being gay or being anything outside of the norm of "Leave It to Beaver" families was a shameful and sometimes even dangerous thing to disclose to people. They've lived their life a lot of times trusting very few people and not being open to discussing it with somebody.

### **Safety and acceptance**

The sixth theme that emerged, safety and acceptance, is tied to the theme of trust in that in order for LGBT elder clients to develop trust, they must also feel safety and acceptance in their relationship with the therapist. Again, safety and acceptance are key aspects of all therapeutic relationships but there were distinctions made by participants pertaining to LGBT elders. One participant explained this distinction with the following quote:

I think the core issues for GLBT elders are the same as for most elders except that they're more likely to live alone, they're more likely to not have the support of children. They may still not be comfortable living in society because of how they grew up and came into it and had to think about it. They may be worried about particular forms of discrimination, particularly if they're institutionalized in some way.

The sense of concern about particular forms of discrimination if residing in an institutional setting was also demonstrated by this quote:

It's that sort of picking and choosing of when to disclose, how to disclose, is it safe to disclose? That is still a huge barrier and I think, it's just difficult. It's one of the first things people are asked. They're asked about their families, they're asked about their spouses, their children, etcetera, etcetera. And it's like, you have to know going in, is this safe? Is this not safe? Am I going to lose housing based on my answer, if I say that I have a partner?

Another participant discussed the sense of safety in terms of accessing aging and health care resources in general:

I think it's their sense of safety with health care providers; that they don't always feel safe so then instead of trying to find someone they feel safe with, they don't go. So they resist going to the doctor when they need to instead of trying to find supportive resources.

One participant shared the story of an elder lesbian client, whose partner had died and she was isolated from her family of origin and not accepted by her partner's family of origin. She did not feel safe or trusting to disclose this great loss with anyone and years later, the participant in this study was assisting her client with serious unresolved grief:

The social isolation was really about not trusting. She didn't want to share who she was because in her most intimate circle she wasn't accepted for who she was. And in her grief, she really felt lost with her grief. She felt that the people that were her same age wouldn't understand her grief. She really felt isolated and alone.

### **Challenges in developing the therapeutic relationship**

Many of the participants in this study reported they had no challenges in developing the therapeutic relationship with LGBT elders. The following quote is similar to other received responses when asked if participants encountered any challenges developing the therapeutic relationship with LGBT elders, “No different than I think with any client that you feel some similarities with and some with experiences that you didn’t have. So just really trying to empathize with that.”

Another clinician commented that the challenge lay in taking a social history and developing the skill to gently ask questions of clients in a respectful and non-threatening way:

I’ve learned to kind of assess, then bring it up and then hopefully . . . . you’re asking the question in a safe and nonjudgmental way and I’ll ask if there is anyone special in their life, or if they’ve had any long term relationships. I’ll ask more of those questions versus the generic checklist ones. I think it’s more respectful and it leads to more open ended questions. So if they’re comfortable they can share.

Two other participants responded that the challenge in developing the therapeutic relationship lay with themselves. The following quote comes from a clinician who is part of the LGBT community:

I think I’ve come up against some of my own personal challenges as part of the community and in hearing and recognizing what struggles older generations have gone through. So it has been more of a person journey for me, where I’ve been like, I can’t even believe that. I’m in awe and dumbstruck by some of the LGBT

community's stories. What they've been through and experienced. So, not in working with the population, but in recognizing and sort of the vicarious experiences that I've had in listening to what they've been through and identifying with them.

Similarly another participant spoke on her own challenges when she had little experience working with the LGBT community:

I feel like I did a lot more at the beginning than I do now. Now it feels pretty normalized to me so I think usually the challenges are about your own internalized homophobia, or my own discomfort with sexuality in general at the beginning, or my own "how do I" . . . . Like at the beginning there was a lot of, "Do I have to say that I'm straight? Do I have to disclose my own sexuality? How do I do that?" So all of that noise in my head made that more challenging. There was never really a challenge from the client's side of things.



## **Discussion and Implications**

### **Interpretation of Findings**

The emergent themes from the interviews were almost always shared by all the participants. The first theme, the definition of the therapeutic relationship, was developed directly from the asking participants how they would define the therapeutic relationship. The researcher felt this was an important theme to include based on the purpose of this study. Participants described the therapeutic relationship as the core component to successful therapy. They felt it is an authentic, real relationship between two people that is established with trust, rapport, unconditional positive regard, and affirmation.

The second theme, the importance of avoiding assumptions, emerged when the researcher inquired on what clinicians felt was important to know when developing the therapeutic relationship with LGBT elders. Participants discussed this theme in several different ways, which lead to the development of sub themes. The first sub theme was avoiding any general assumptions. An individual's sexual orientation is not apparent externally and furthermore, participants emphasized that clients define all spectrums of themselves. Our role as a therapist is to learn the story of our clients through their words. One of the two participants quoted in this section, who is part of the LGBT community, noted that assumptions cannot be made whether or not a clinician is a member of the LGBT community. Each individual has their story to tell and their unique experience in which to find meaning. While a shared community or experience may guide a clinician in understanding some aspect of an individual's story, it is still their story to be told.

The second sub theme that developed out of the importance of avoiding assumptions was assumed heterosexuality, or the prevailing assumption that all older

adults/elders are heterosexual. Participants noted that LGBT elders grew up in an era of heteronormativity, where invalidation of this part of themselves was not only common, but expected in society. LGBT elders did not come of age and enter into meaningful, intimate relationships at a time when it was accepted to do so openly. This aspect of societal acceptance is a contributing factor to the invisibility component of LGBT elders. If they are not currently out with their sexuality, the assumption is that they are not even present in society. The researcher noted that participants who did not have experience with LGBT elders but did have experience with younger generations of LGBT clients had given little to no consideration for this elder cohort. This was not a factor of ignoring that the population was there but an unawareness that they are there.

The third sub theme that developed was institutionalized assumptions. Several participants discussed the problematic language of facility intake forms and mental health assessments. In their experience, they had either professionally or personally observed that the forms were not written in a manner that allowed LGBT elders to express their relationships and partnerships in an equal way to married heterosexual couples. While it is hopeful for many participants that this will change with the legalization of same-sex marriage in the state of Minnesota as well as the federal recognition of such unions, these changes are not moving fast enough for the current generation. With regard to mental health assessments, one participant discussed her concern over standard social history forms, describing the assessments as a checklist to go through with clients. She frequently deviated from the written checklist because it did not allow for a sensitive assessment for elders who may be reluctant to disclose their sexual orientation based on safety and trust concerns.

The third theme to emerge was the importance of cultural competency.

Participants noted that having knowledge of the history of LGBT civil rights and the history of the community was important because it provided clinicians with an awareness of what LGBT elders may have experienced, may have lived through, and the messages given by society. Additionally, competency in working with the older adult population in general is important because an awareness of generational experiences, values, and societal components is, as one participant said, a client's foundation.

The fourth theme, validation and recognition of life experience, emerged as participants spoke on the significance of what the older generation has lived through and what many have contributed to the progress, openness, and acceptance of the LGBT community today. Change and social justice movements came from within the community and the validation and acknowledgement of who laid the foundation for this effort, the accomplishments, the perseverance, the pain, and the triumph is critical in joining with the elder LGBT community. Participants noted how important validation is because the history of invalidation for this population runs so deep. Several participants spoke from both a professional and personal point of view. These are the stories they have heard from their clients and these are the stories they share together, which resonated deeply with the researcher. It was not the researcher's intention to explore the personal experiences of clinicians but the empathic connections this group of participants had with their clients was so profound and powerful that it drew the personal experience outward.

The fifth theme, the development of trust, emerged from the researcher's inquiry into the important factors in the development of the therapeutic relationship. Participants

noted that this is an important aspect for any client but it bears special consideration for LGBT elders because more barriers to develop trust may be in place. This is due to the history of invalidation and judgment by professionals, faith institutions, and society in general. Ensuring trust, acceptance, and a supportive environment is key to developing and maintaining the therapeutic relationship with LGBT elders.

The sixth theme, safety and acceptance, is related to the theme of trust in that participants noted that safety was a huge concern for LGBT elders. Without a sense of safety and security, trust cannot be developed. Participants noted that LGBT elders share core issues with other elder cohorts but there are increased risk factors of isolation and lack of support. Discrimination is still a major concern and deciding on the safety of disclosure is prevalent. While society has moved towards acceptance, many elders experienced an era where society moved away from acceptance. This generational reality may have reverberating effects to the elder population.

The final theme, challenges in developing the therapeutic relationship with LGBT elders, revealed challenges experienced by participants or lack thereof. Several clinicians, who are part of the LGBT community, noted that they had not experienced any challenges themselves in developing the therapeutic relationship with LGBT elders. One participant noted that the challenge she experienced occurred as a result of the nature of initial assessments and disclosure barriers. Two other participants noted that the only challenge was their own countertransference. Their clients did not present a challenge but rather they had to work through their own inner dialogue and self-awareness.

### **Connection with Literature Review**

There are significant connections between the researcher's literature review and the study findings. First, participants confirmed that competency in working with older adults and competency in working with the elder LGBT subpopulation is essential to developing the therapeutic relationship. Many participants discussed the importance of having an understanding of the historical framework or generation in which their older adult clients have lived, which is supported by the literature review research. Previous studies have examined what is important to know from a historical perspective and that LGBT elders themselves report that they are more likely to seek out services with professionals who have received cultural sensitivity training or who are already well known within the community (Cook-Daniels, 2008; Crisp, 2008; Croghan et al., 2012). Indeed, one participant expressed that many of her LGBT clients are referred to her because she has "street cred" in which she is referred by other LGBT clients or other professionals in the LGBT community.

When discussing the importance of safety and trust, participants often mentioned that LGBT elders are more likely to not trust aging service providers, to live alone, and to be isolated from the community, which puts them at increased risk of being unsafe as well as the development of mental health concerns such as depression or anxiety. This is also supported by the literature, which notes that isolation and lack of social support systems is a concern and may be amplified when entering into a facility (Blank et al., 2009; Jackson et al., 2008). Several participants noted that LGBT elders are more likely to not seek needed services because of their fears of safety and comfort in trusting professionals. Therefore, fostering trust and creating a safe environment for this

population is essential to assisting LGBT elders with aging resources and improved mental health, as mental health may be affected by social isolation and lack of resource connectivity.

Throughout the interviews, participants often discussed problematic long-term care concerns, from aging service professionals and institutions often assuming heterosexuality and therefore not creating an inclusive, welcoming environment, to fears of discrimination, safety, and not being accepted into a facility based on being a part of the LGBT community. Participants noted that as professionals, they had experienced barriers during intake assessments and mental health assessments due to the language of standard forms and checklists. Such concerns were largely supported by the literature. Literature findings indicate that LGBT elders feel that discrimination is likely if residing in an assisted living or long-term facility and that they do not feel confident that they would receive sensitive senior services and housing as they age if their sexual orientation is known to the aging service provider (Croghan et al., 2012; Jackson et al., 2008; Metlife, 2010; Meyer, 2011; Smith et al., 2010; Stein et al., 2010; Witten, 2009).

The literature review discusses resiliency as an important aging consideration for LGBT elders. Resiliency and strength are noted characteristics of LGBT elders because they have a history of self-advocacy, strong coping skills, activism, and survival strategies (Crisp, 2008; Witten, 2009). The development of effective coping skills and resiliency were necessary to survive and thrive when living through a time of an invalidating and unaccepting society (Smith et al., 2010). During the interviews for this study, resiliency was discussed through the emphasis on validation and recognition of the life experiences and life journey's of LGBT elders. Participants emphasized that LGBT

elders have incredible stories to tell and offer rich learning experiences and mentorships for younger generations. Their success and experiences of living through adversity and marginalization is important to affirm, validate, and recognize.

Another supported finding was how participants described the therapeutic alliance with clients and what they found to be important in developing it with LGBT elders. The literature suggests that cultural competency and training in LGBT issues is important because it has been a barrier to accessing services (Croghan et al., 2012; Jackson et al., 2008; Metlife, 2010; Meyer, 2011; Smith, et al., 2010; Stein et al., 2010; Witten, 2009). A primary theme for this study was cultural competency, which includes having a historical framework from which to join with LGBT elder clients. The awareness that the therapeutic relationship is the essential component to effective therapy and that this relationship is built on trust, collaboration, rapport, and affection was part of the participant's clinical practice and is supported by the literature (Hyer, Kramer, & Sohnle, 2004). The findings demonstrate that the provision of mental health care to the elder LGBT community is important and timely, that trust is a key component, and that the therapeutic alliance was key to creating a safe, trusting, and affirmative environment for LGBT elder clients.

### **Implications for social work practice**

Clinical social workers practice in a wide variety of settings and most work with diverse client populations. Older adults may be referred to social workers who are currently working in the field of gerontology, in a health care setting, or in a clinical practice setting. The findings in this study are important for any social worker engaged in clinical practice or any social worker in an age-related field because LGBT elders are

present in our client populations and many may be underserved and underrepresented due to a lack of awareness in aging related and mental health services in general, trust in aging related services and professionals, a feeling of not being safe with regard to disclosure, the comfort of not disclosing due to generational reasons, and isolation. From a systemic perspective, the aging population is rapidly growing and the need for housing for older adults and supportive resources will rise accordingly. Social workers are in a unique role to provide supportive resources, counseling, advocacy services, and therapy. Clinical social workers can be found in a variety of settings and are often referred to by general practitioners and others in the aging field. Therefore, clinical social workers have the opportunity to address the needs of this population from various agencies and settings and are also in the position to educate and advocate on behalf of these clients to other professions.

Additionally, this is a social justice issue because LGBT elders are considered to be an invisible population still at risk and still experiencing marginalization, discrimination, and invalidation. Social workers are the only professionals in the mental health field where social justice is part of their code of conduct. We must honor our code of conduct and be representatives for this resilient population who laid the foundation for social, cultural, and legal change experienced today. They deserve recognition and to age successfully and with dignity.

### **Implications for policy**

Enormous civil rights policy changes have occurred in the state of Minnesota and at the federal level for the LGBT community. LGBT partners may now be legally married with all the state and federal benefits that go along with marriage, such as social



security benefits, retirement benefits, pensions, housing rights, and medical rights to name several. Such rights can be critical for older adults. Access to spousal social security and retirement benefits can make the difference between living in poverty or not living in poverty, what services they are or are not eligible for, their access to health care, and what kind of housing they are or are not eligible for. Marriage allows for spouses to have outright legal claims to property, to make medical decisions, and to make death and dying decisions when the loss of a spouse occurs. Social workers are needed to assist LGBT older adults navigate through these policy changes, to help them prepare for retirement, and assist in planning and preparing for decisions in later life.

Changes in living arrangements in assisted living facilities and long-term care facilities must be addressed with these policy changes. Often spouses can obtain housing space together in senior living facilities. Until now, LGBT elders may likely have not had this option or to have it, they may have been required to refer to their long-term partner as a sister or brother, as an example.

Policy advocacy to increase LGBT senior living communities is also needed. Within the United States, only a handful of senior housing exists specifically for the LGBT community, one of which is here in the Twin Cities. The need is high for such housing and one option is simply not enough to support the population.

### **Implications for research**

The purpose of this study was to explore creating and maintaining the therapeutic relationship with LGBT elders. In doing so, many other options for further research became apparent. First of all, research involving LGBT older adults themselves would be highly beneficial. There have been little to no qualitative studies conducted with LGBT

elders themselves as study participants. Their stories and perspectives would contribute to the understanding of the needs of this population.

Further research examining clinical interventions would also be interesting. This scope of this study did not allow for such a focus, although it is discussed in the literature review.

Additionally, research into each individual community within the LGBT community would also be highly beneficial. Most studies look at the gay, lesbian, bisexual, and transgender community together however each have individual communities with unique needs and cultural aspects. In looking individually at the communities, research has mainly looked at the gay and lesbian communities. Little to no research has been conducted on the bisexual community and one participant in this study remarked that he is just beginning to see the formation of a community for this group. Very little research has been conducted on transgender elders or the transgender community in general.

Further research on the importance of senior living facilities and how they are addressing the needs of their LGBT elders is also warranted. As we live longer and with more chronic disease, the likelihood of an increased need for assisted living and skilled nursing facilities is growing. Potential research could focus on what facilities are doing now to support the needs of this population and exploring if differences exist in the well-being between LGBT elders that reside in LGBT exclusive senior housing versus nonexclusive senior housing.

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## **Appendix A**

### **E-Newsletter Recruitment Posting for Research Study Participation**

Mental health practitioners are being recruited for a research project exploring the therapeutic relationship with LGBT elders. The research project is being conducted by a Master's of Social Work student through the MSW program at the University of St. Thomas and St. Catherine University. Participation in the project will involve being interviewed about your professional experience and insight regarding the research topic. Interviews will last approximately one hour. Please contact Natasha Satre at [satr2778@stthomas.edu](mailto:satr2778@stthomas.edu) if you would be interested in participating in this study.



## **Appendix B**

### **Email Introduction and Invitation to Participate in Research Study**

Hello \_\_\_\_\_,

My name is Natasha Satre and I am contacting you today because I am conducting a research project for my Master's of Social Work program. My study will be exploring how mental health practitioners create and maintain the therapeutic relationship with LGBT elder clients. I am contacting you to see if you be interested in participating in this study based upon your professional experience with LGBT elder clients or LGBT clients. Participation in this study will involve being interviewed by me at a time and location most convenient to you. The interview will last approximately one hour. All information will be kept confidential in locked and password protected formats. My committee chair and I will have access to the data and records. Participation in this study is optional and you may choose to stop participation in this study at any time. The study has the risk that you may find some questions uncomfortable to answer when discussing work with the targeted population. In order to minimize potential discomfort in discussing clients during the interview process, the interview can stop at any time. Data and records will be kept until June, 2015, after which they will be destroyed.

## Appendix C

# CONSENT FORM UNIVERSITY OF ST. THOMAS

## Creating and Maintaining the Therapeutic Relationship with LGBT Elders: An Exploratory Study

525582-1

I am conducting a study about creating and maintaining the therapeutic relationship with LGBT elders. I invite you to participate in this research. You were selected as a possible participant because you are a mental health practitioner with current or recent experience working the LGBT elder and/or LGBT clients. Please read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by: Natasha Satre, a graduate student at the School of Social Work, Catherine University/University of St. Thomas and supervised by Dr. Ande Nesmith.

### **Background Information:**

The purpose of this study is: to explore how clinicians create and maintain the therapeutic relationship with LGBT elders.

### **Procedures:**

If you agree to be in this study, I will ask you to do the following things: participate in a 45 - 60 minute interview pertaining to the purpose of this study and your related professional experience. The interview will be audio taped and the data from the interview will be reviewed and transcribed by me, the principal investigator. Data from the transcribed interview will be included in the final research report. Data collection will take place at a location most convenient to the you. The time commitment for this study is expected to be approximately one hour.

### **Risks and Benefits of Being in the Study:**

The study has the risk that you may find some questions uncomfortable to answer when discussing work with the targeted population. In order to minimize potential discomfort in discussing clients during the interview process, the risk will be minimized by stopping the interview at any time if you are uncomfortable.

The direct benefits you will receive for participating are: there are no direct benefits to participating in this study.

### **Compensation:**

You will receive a \$5.00 gift card to Caribou Coffee for your participation in this study. The gift card will be provided to you at the conclusion of the interview.

**Confidentiality:**

The records of this study will be kept confidential. In any sort of report I publish, I will not include information that will make it possible to identify you in any way. The types of records I will create include audio recordings, computerized notes, and transcripts, which will be stored on my personal, secured password computer. Signed consent forms will be stored in my home office in a locked filing cabinet. Data and records will be kept until June, 2015, after which they will be destroyed. My committee chair and I will have access to the data and records. Data identifying the participants will be only be available to me.

**Voluntary Nature of the Study:**

Your participation in this study is entirely voluntary. Your decision whether or not to participate will not affect your current or future relations with the University of St. Thomas, St. Catherine University, or the School of Social Work. If you decide to participate, you are free to withdraw at any time up to and until May, 1st 2014. Should you decide to withdraw data collected about you will not be used. You are also free to skip any questions I may ask.

**Contacts and Questions**

My name is Natasha Satre. You may ask any questions you have now. If you have questions later, you may contact me at 651-319-3661. You may also contact my committee chair, Ande Nesmith at 651-962-5805. You may also contact the University of St. Thomas Institutional Review Board at 651-962-5341 with any questions or concerns.

**You will be given a copy of this form to keep for your records.**

**Statement of Consent:**

I have read the above information. I agree to be audio recorded for this study. My questions have been answered to my satisfaction. I consent to participate in the study. I am at least 18 years of age.

\_\_\_\_\_  
Signature of Study Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Study Participant

\_\_\_\_\_  
Signature of Researcher

\_\_\_\_\_  
Date

## **Appendix D**

### **Creating and Maintaining the Therapeutic Relationship with LGBT Elders: An**

#### **Exploratory Study: Interview Questions**

1. How long have you been a clinician?
2. What drew you to the field of mental health?
3. Please describe your client population.
4. During your education and continuing education training, describe any training you have received in the area of aging.
5. During your education and continuing education training, described any training you have received in the area of LGBT issues.
6. How would you describe the therapeutic relationship?
7. Describe to me how you develop the therapeutic relationship.
8. How do you assess the strength of the therapeutic relationship between yourself and clients?
9. Given your professional experience, what is important to know when developing the therapeutic relationship with LGBT elders?
10. How would the development of the therapeutic relationship look different when working with LGBT elders compared to other client populations?
11. Have you experienced any challenges in developing therapeutic relationships with LGBT elder clients?
12. What have you experienced in your clinical work with LGBT elders that has informed your practice?